JUDICIAL COUNCIL
OF CALIFORNIA

MENTAL HEALTH ISSUES
IMPLEMENTATION TASK FORCE

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MENTAL HEALTH ISSUES IMPLEMENTATION TASK FORCE

MINUTES OF OPEN MEETING

February 25, 2015
12:15 p.m. – 1:15 p.m.
Teleconference Meeting

Advisory Body Members Present:	Hon. Richard J. Loftus, Jr., Hon. Hilary A. Chittick, Hon. Rogelio R. Flores, Hon. Susan M. Gill, Hon. Clifford L. Klein, Hon. Stephen V. Manley, Hon. Heather D. Morse, Hon. Jaime R. Román, Hon. Maria E. Stratton, Hon. Garrett L. Wong
Advisory Body Members Absent:	Hon. Suzanne N. Kingsbury, Mr. Michael D. Planet, Mr. Michael M. Roddy, Hon. Michael Anthony Tynan
Others Present:	Hon. James Bianco (Los Angeles Superior Court); Ms. Pamela Ahlin, Ms. Francie Cordova, Mr. Matthew Garber, Ms. Pamela Holmes, Mr. Kristopher Kent, and, Mr. Michael Wilkening (Department of State Hospitals); Ms. Sharon Reilly and Mr. Alan Herzfeld (OGA); Ms. Francine Byrne, Ms. Audrey Fancy, Ms. Marymichael Miatovich, Ms. Karen Moen, Ms. Nancy Taylor, Ms. Charina Zalzos, and Ms. Carrie Zoller

OPEN MEETING

Call to Order and Roll Call

The chair called the meeting to order at 12:20 p.m., and took roll call.

Approval of Minutes

The advisory body reviewed and approved the minutes of the October 20, 2014, Mental Health Issues Implementation Task Force meeting.

DISCUSSION AND ACTION ITEMS (ITEMS 1 – 1)

Item 1

Work Plan and Priorities for 2015

Task force members discussed work plan priorities for 2015 including work within judicial branch and with mental health and criminal justice partners.

Action: Preliminary priorities were identified including providing input on the need for treatment and programming facilities as a requirement in new jail house construction projects, continuing work with criminal justice partners to develop and implement discharge planning protocols for offenders with mental illness, reviewing and commenting on legislative proposals related to offenders with mental illness, continuing work on the juvenile competency/remediation project, supporting judicial and court staff mental

health-related education, continuing work with the Department of State Hospitals addressing the incompetent to stand trial (IST) and restoration/statewide capacity issues, and continuing to collaborate with criminal justice and mental health partners on issues related to expanding local treatment and restoration to sanity options to reduce delays in the management of IST cases, CIT education for first responders including law enforcement personnel, and standardization of medication formularies to better address the delays and complications (including the necessity to return to a state hospital because of a return to IST status) resulting from medication changes when defendants are returned to county jails once restoration to sanity is achieved at the state hospital.

ADJOURNMENT

There being no further business, the meeting was adjourned at 1:25 p.m.

Approved by the advisory body on TBD.

Mental Health Issues Implementation Task Force
Pending Legislation of Interest: 2015
As of March 30, 2015*
(Provided by the Judicial Council's Office of Governmental Affairs)

Forensic bills:

AB 1006 (Levine), as introduced – Prisoners: mental health treatment
http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1001-1050/ab_1006_bill_20150226_introduced.pdf
This bill, which is sponsored by the California Attorneys for Criminal Justice (CACJ), would authorize, if a defendant has pled guilty or nolo contendere to, or been convicted of, an offense that will result in a sentence to state prison, the defendant or the prosecutor to file a petition for a hearing to determine if the defendant suffers from a diagnosable mental condition and would authorize the court, on its own motion, to order that hearing. The bill would also require that petition to be filed after the defendant's conviction, but before his or her sentencing, and to allege that the defendant suffers from a diagnosable mental illness and requests mental health treatment. The bill would require the court, after a hearing on the matter, and if the court finds by a preponderance of the evidence that the defendant suffers from a diagnosable mental illness, to make one or more specified orders, including, among others, an order that the Department of Corrections and Rehabilitation place the defendant in a mental health program within the state prison. The bill would also provide that the defendant has the right to counsel for these proceedings.
Status: Assembly Public Safety Committee

AB 1237 (Brown), as introduced – State hospitals: placement evaluations
http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1201-1250/ab_1237_bill_20150227_introduced.pdf
This bill, which is sponsored by AFSCME, requires the Department of State Hospitals (DHS) to establish a pool of psychiatrists and psychologists with forensic skills who are employees of the department. The bill also requires the department to create evaluation panels from this pool of psychiatrists and psychologists, with each panel consisting of three to five, inclusive, forensic psychiatrists or psychologists for the purpose of determining whether a defendant who has been found incompetent to stand trial should be placed on outpatient status or confined in a state hospital or other treatment facility. In addition, the bill specifies that when a defendant pleads guilty by reason of insanity or the question of mental competence is before the court, the court must select an evaluation panel established by the Department of State Hospitals (DHS) to examine the defendant and investigate his or her mental status. [*Note: This bill is virtually identical to the April 23, 2014 version of last year's AB 2543 (Levine), which the MHIITF opposed.*]
Status: Set for April 14 hearing in Assembly Health Committee

SB 453 (Pan), as introduced – Prisons: involuntary medication
http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_0451-0500/sb_453_bill_20150225_introduced.pdf
This bill would amend the provisions in Penal Code section 1370 governing involuntary medication of persons found incompetent to stand trial by authorizing a psychiatrist designated by the facility medical director, instead of the treating psychiatrist, to make the determination and certification as to whether antipsychotic medication is medically necessary and appropriate and to administer that medication to the defendant for up to 21 days. [*Note: according to the author's office, this bill will be amended soon to provide that the treating psychiatrist would have to request another clinician to prescribe the medications with the goal of preserving the doctor/patient relationship. The medical director of the facility would not be allowed to make such a change unilaterally, and the prescribing clinician would be required to fully review the defendant's case. As soon as the new version of the bill goes into print, it will be forwarded to the task force members.*]
Status: Set for April 7 hearing in Senate Public Safety Committee

LPS bills:

AB 59 (Waldron), as amended March 9, 2015 – Mental health services: assisted outpatient treatment
http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_0051-0100/ab_59_bill_20150309_amended_asm_v98.pdf
This bill would expand the application of "Laura's Law" by requiring counties with available funding to implement its involuntary outpatient treatment provisions. The bill would also delete the January 1, 2017, repeal date of those provisions, thereby extending the program indefinitely. In addition, the bill would authorize the court to order a person to obtain assisted outpatient treatment for an initial period not to exceed 12 months (vs 6 months under current law) if requisite criteria are met.
Status: Set for April 14 hearing in Assembly Health Committee

AB 193 (Maienschein), as introduced - Mental health: conservatorship hearings
http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_0151-0200/ab_193_bill_20150128_introduced.pdf
This bill, which is sponsored by the Conference of California Bar Associations (CCBA), permits a probate court, after a hearing attended by the proposed conservatee or the proposed conservatee's counsel, or both, to recommend an LPS conservatorship to the county officer providing conservatorship investigations when the court in a probate conservatorship hearing determines, based on evidence presented to the court, including medical evidence, that a person for whom a probate conservatorship has been established, may be gravely disabled as a result of mental disorder or chronic alcoholism and is unwilling to accept, or incapable of accepting treatment voluntarily. The bill also specifies that if the conservatee cannot afford counsel, the court shall appoint counsel for him or her. In addition, the bill requires the officer providing the conservatorship investigation to file his or her report with the probate court that made the conservatorship recommendation within 30 days of receiving the recommendation.

Finally the bill specifies that if the officer providing the conservatorship investigation concurs with the recommendation of the probate court, he or she shall petition the appropriate superior court to establish the LPS conservatorship. [*Note: the introduced version of this bill tracks the April 30, 2014 version of the author's AB 1725 of last year, which was held in the Assembly Appropriations Committee*.]
Status: Set for April 7 hearing in Assembly Health Committee

AB 1193 (Eggman), as introduced – Mental health services: assisted outpatient treatment
http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1151-1200/ab_1193_bill_20150227_introduced.pdf
This bill would delete the provisions that authorize a county to elect to participate in the involuntary outpatient treatment ("Laura's Law") program, and instead would require each county to implement the provisions of Laura's Law unless the county elects not to participate in the program by enacting a resolution passed by the county board of supervisors. The bill would also extend the January 1, 2017, repeal date of those provisions until January 1, 2022. In addition, the bill would authorize a superior court judge to request a petition be filed for involuntary outpatient commitment pursuant to Laura's Law for a person meeting specified criteria who appears before the judge.
Status: Set for April 14 hearing in Assembly Health Committee

AB 1194 (Eggman), as introduced – Mental health: involuntary commitment
http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1151-1200/ab_1194_bill_20150227_introduced.pdf
This bill would amend WIC section 5150 (i.e., 72-hour holds under the LPS Act) to provide that, for purposes of determining whether a person, as a result of a mental health disorder, is a danger to others, or a danger to himself or herself, danger constitutes a present risk of harm that requires consideration of the historical course of a person's mental health disorder pursuant to Section 5150.05, and shall not be limited to imminent or immediate risk of harm to others or to himself or herself. The bill would also require the application for a 72-hour hold to include whether the historical course of a person's mental disorder was considered in the applicant's determination of probable cause.
Status: Set for April 14 hearing in Assembly Health Committee

AB 1300 (Ridley-Thomas), as introduced – Mental health: involuntary commitment
http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1300_bill_20150227_introduced.pdf
This bill would authorize counties to designate one or more persons to act as a local or regional liaison to assist a person who is a patient in an emergency department of a defined non-designated hospital and who has been detained, or who may require detention, for evaluation and treatment, as specified. The bill would reorganize and make changes to the provisions relating to the detention for evaluation and treatment of a person who may be subject to the above provisions, including specifying procedures for delivery of those individuals to various facilities; evaluation of the person for probable cause for detention for evaluation and treatment; terms and length of detention, where

appropriate, in various types of facilities; and criteria for release from defined designated facilities and non-designated hospitals. The bill would also authorize a provider of ambulance services to transfer a person who is voluntarily transferring to a designated facility for evaluation and treatment. In addition, the bill would make changes to the methods by which law enforcement is notified of the release of a person detained for evaluation and treatment.
Status: Set for April 14 hearing in Assembly Health Committee

Dependent children/juveniles – psychotropic medication bills:

AB 1067 (Gipson), as amended March 26, 2015 – Foster children: psychotropic medication
http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1051-1100/ab_1067_bill_20150326_amended_asm_v98.pdf
This bill would specify that all minors and non-minors in foster care have certain rights relating to the administration of psychotropic medication, including the right to: be informed of the risks and benefits of the medication; appear before the judge determining if psychotropic medication should be administered, with an advocate of his or her choice, and state that he or she objects to any recommendation to prescribe psychotropic medication; refuse the administration of psychotropic and other medications consistent with applicable law or unless immediately necessary for the preservation of life or the prevention of serious bodily harm; and have a prescribing doctor disclose any financial ties he or she may have to pharmaceutical companies.
Status: Assembly Human Services Committee

SB 238 (Mitchell), as amended March 24, 2015 – Foster care: psychotropic medication
http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_0201-0250/sb_238_bill_20150324_amended_sen_v98.pdf
Among other things, this bill would require the Judicial Council, on or before July 1, 2016, to, in consultation with the State Department of Social Services, the State Department of Health Care Services, and stakeholders, develop updates to the rules and forms for implementation of the provisions governing court orders regarding the administration of psychotropic medications for certain wards or dependent children. The bill would require the updates to ensure, among other things, that the child and his or her caregiver and court-appointed special advocate, if any, have an opportunity to provide input on the medications being prescribed, and would require the updates to include a process for periodic oversight by the court of orders regarding the administration of psychotropic medications.
Status: Senate Rules Committee

SB 253 (Monning), as amended March 23, 2015 – Dependent children: psychotropic medication
http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_0251-0300/sb_253_bill_20150323_amended_sen_v98.pdf

This bill would require that an order authorizing the administration of psychotropic medications to a dependent child be granted only upon the demonstration of clear and convincing evidence that specified criteria are met, including a requirement that the prescribing physician attest under penalty of perjury that he or she has conducted a comprehensive evaluation of the child, as specified. The bill would prohibit the court from authorizing the administration of psychotropic medications to a child under other specified circumstances, unless a 2nd independent medical opinion is obtained from a child psychiatrist or a psychopharmacologist. The bill would also prohibit the court from authorizing the administration of a psychotropic medication unless the court is provided documentation that appropriate screenings and tests for the child have been completed no more than 30 days prior to submission of the request to the court. The bill would further impose additional requirements on the court to implement these provisions and to conduct review hearings, as specified. Finally, the bill would require the Judicial Council, on or before July 1, 2016, to adopt rules and forms to implement these provisions.
Status: Set for April 14 hearing in Senate Human Services Committee

SB 484 (Beall), as introduced – Juveniles: psychotropic medications
http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_0451-0500/sb_484_bill_20150226_introduced.pdf
Among other things, this bill would require the director of the State Department of Social Services to include in the annual list of licensed community care facilities specified information regarding administering psychotropic medications to children in those facilities. The bill would also require the department, if it determines based on that information that a facility is administering psychotropic medications to children at a rate exceeding the average authorization for all group homes, to inspect that facility at least once a year to examine specified factors that contribute to the high utilization of psychotropic medications. In addition, the bill would require an inspected facility to submit to the department, within 60 days of that inspection, a corrective action plan including steps the facility shall take to reduce the utilization of psychotropic medications.
Status: Set for April 14 hearing in Senate Human Services Committee

Peace officer training bills:

AB 1227 (Cooper), as amended March 26, 2105 – Peace officer training: mental health
http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1201-1250/ab_1227_bill_20150326_amended_asm_v98.pdf
This bill would require the Commission on Peace Officer Standards and Training (POST), in collaboration with relevant stakeholders, to study and submit a report to the Legislature, on or before December 31, 2017, that assesses the statuses of the training courses described above, assesses whether the courses cover all appropriate topics, and identifies areas where additional training may be needed.
Status: Assembly Public Safety Committee

SB 11 (Beall), as amended March 23, 2015 - Peace officer training: mental health
http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_0001-0050/sb_11_bill_20150323_amended_sen_v97.pdf
This bill would require the Commission on Peace Officer Standards and Training (POST) to include in its basic training course an evidence-based behavioral health classroom training course and instructor-led active learning, such as scenario-based training, to train law enforcement officers to recognize, deescalate, and refer persons with mental illness or intellectual disability who are in crisis. The bill would require that this evidence-based behavioral health classroom training course and instructor-led active learning be 20 hours long and be in addition to the basic training course's current hour requirement. The bill would also require POST to establish and keep updated an evidence-based behavioral health training course as part of its perishable skills training under its continuing professional training requirement. The bill further would require that this evidence-based behavioral health training course be a minimum of 4 consecutive hours of the total hours required in each 4-year period for perishable skills training.
Status: Set for April 7 hearing in Senate Public Safety Committee

SB 29 (Beall), as amended March 23, 2015 - Peace officer training: mental health
http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_0001-0050/sb_29_bill_20150323_amended_sen_v97.pdf
This bill would require POST to require field training officers who are instructors for the field training program to have 40 hours of evidence-based behavioral health training, as specified. The bill would also require POST to require a 20-hour evidence-based behavioral health training course relating to law enforcement interaction with persons with mental illness or intellectual disability, to be completed as specified.
Status: Set for April 7 hearing in Senate Public Safety Committee

SVP bills:

AB 1003 (Nazarian), as amended March 26, 2015 – Mental health: Sexually violent predators
http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1001-1050/ab_1003_bill_20150326_amended_asm_v98.pdf
This bill would require the annual examination report of the mental condition of a sexually violent predator (which is used to determine whether conditional release to a less restrictive alternative or unconditional release is in the best interest of the person and the conditions imposed would adequately protect the community) to also be signed by the Director of the State Department of State Hospitals.
Status: Assembly Public Safety Committee

SB 507 (Pavley), as introduced – Sexually violent predators
http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_0501-0550/sb_507_bill_20150226_introduced.pdf
This bill would provide that attorneys in SVP civil commitment proceedings have the same access to medical and psychological records as the evaluators performing a replacement evaluation, and would direct the court to issue a subpoena or court order

for those records upon request. The bill would also authorize the attorneys to use the records in the commitment proceeding, but would prohibit disclosure of the records for any other purpose.
Status: Set for April 14 hearing in Senate Public Safety Committee

Other bills of general interest:

AB 253 (Hernandez), as amended March 26, 2015 – Mental Health
http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_0251-0300/ab_253_bill_20150326_amended_asm_v98.pdf
Among other things, this bill would expand the membership of the Mental Health Services Oversight and Accountability Commission (created under Prop. 63) to include a person with knowledge and experience in reducing mental health disparities, and a veteran with knowledge about veteran's mental health issues.
Status: Assembly Committee on Housing and Community Development

AB 468 (Jones), as introduced - Wards and conservatees: mental health
http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_0451-0500/ab_468_bill_20150223_introduced.pdf
This technical bill, which is sponsored by the Conference of California Bar Associations, would delete an obsolete provision that requires the Director of the Department of State Hospitals to adopt and issue regulations defining "mental health treatment facility" for the purposes of Probate Code section 2356 (which generally prohibits the involuntary commitment of a ward or conservatee to a mental health treatment facility).
Status: Set for April 7 hearing in Assembly Judiciary Committee

AB 745 (Chau), as introduced - Mental Health Services Oversight and Accountability Commission
http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_0701-0750/ab_745_bill_20150225_introduced.pdf
This bill would require the Speaker of the Assembly to appoint an additional member to the Mental Health Services Oversight and Accountability Commission (created under Prop. 63) who has experience providing supportive housing to persons with a severe mental illness. The bill also states the findings and declarations of the Legislature that this change is consistent with and furthers the intent of the act.
Status: Set for April 14 hearing in Assembly Health Committee

AB 847 (Mullin and Ridley-Thomas), as amended March 26, 2015 – Mental health: community-based services
http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_0801-0850/ab_847_bill_20150326_amended_asm_v98.pdf
This bill would require the State Department of Health Care Services to apply for a specified grant administered by the federal Secretary of Health and Human Services that is designed to improve mental health services provided by certified community behavioral health clinics to certain Medi-Cal beneficiaries.
Status: Set for May 5 hearing in Assembly Health Committee

AB 861 (Maienschein), as amended March 26, 2015 – Mental health: community-based services
http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_0851-0900/ab_861_bill_20150326_amended_asm_v98.pdf
This bill would require the State Department of Health Care Services to apply for a specified grant administered by the federal Secretary of Health and Human Services that is designed to improve mental health services provided by certified community behavioral health clinics to certain Medi-Cal beneficiaries. This bill would also require the department to work with counties and other stakeholders in developing its proposal. In addition, the bill would require the proposal to include plans for counties to redirect a portion of the funds currently used to match federal funds to providing increased housing opportunities for individuals with severe mental illnesses, as specified.
Status: Set for May 5 hearing in Assembly Health Committee

AB 918 (Stone), as introduced – Health and care facilities: seclusion and behavioral restraints
http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_0901-0950/ab_918_bill_20150226_introduced.pdf
This bill would require specified health and care facilities to report to the statewide protection and advocacy agency each death or serious injury of a person occurring during, or related to, the use of seclusion or behavioral restraints.
Status: Set for April 7 hearing in Assembly Health Committee

SB 621(Hertzberg), as introduced – Mentally ill offender crime reduction grants
http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_0601-0650/sb_621_bill_20150227_introduced.pdf
This bill would authorize the funds from a mentally ill offender crime reduction grant to be used to fund specialized diversion programs that offer appropriate mental health and treatment services.
Status: Set for April 7 hearing in Senate Public Safety Committee

Legislative intent/spot bills (not currently active):

SB 130 (Roth), as introduced – Mental Health
http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_0101-0150/sb_130_bill_20150122_introduced.pdf
This bill would make technical, non-substantive changes to specified provisions governing community mental health services.
Status: Senate Rules Committee

SB 301 (Vidak), as introduced - Mental health
http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_0301-0350/sb_301_bill_20150223_introduced.pdf
This bill would make technical, non-substantive changes to specified provisions governing community mental health services.

The 2015-16 Budget:

Improved Budgeting for the Department of State Hospitals

MAC TAYLOR • LEGISLATIVE ANALYST • FEBRUARY 9, 2015

LAO

EXECUTIVE SUMMARY

The state provides about $1.6 billion in funding to the Department of State Hospitals (DSH) to provide inpatient treatment to mental health patients in the eight DSH facilities. This includes funding for both clinical and nonclinical staff, as well as non-staff costs (such as food and clothing). In determining how much funding to request for the upcoming fiscal year, DSH uses the amount of funding it received in the state budget for the current year as a base budget or starting point. The department then requests adjustments to the base budget to account for projected increases or decreases in the patient population during the budget year.

DSH's Budgeting Process Has Several Shortcomings. Based on our review, we find that the current DSH budgeting process has several shortcomings. Specifically, we find that (1) the department has a large amount of funded beds that are not used; (2) the level of staff needed to operate DSH facilities is unclear; (3) the budgeting methodology used by the department creates poor incentives for it to operate efficiently; and (4) other state departments have more transparent, updated, and efficient budgeting processes than DSH.

Redesigning DSH's Budgeting Process. In view of the above findings, we make several recommendations to improve the DSH budgeting process. First, we recommend the Legislature require the department to establish or update several key components used to develop its budget to ensure that they are accurate and adequate. Second, we recommend that the Legislature direct DSH to use the updated information to develop its budget and staffing requests based on expected changes in the number and acuity (or level of care) of its patient population, as well as make adjustments to its budget if the actual population differs from its projections. Given the resources and time necessary to implement these recommendations, we also recommend that the Legislature require DSH to provide additional justification for its budget requests during the development and implementation of the new budgeting process. In combination, we believe our recommendations will (1) ensure that DSH receives the appropriate amount of funding to account for changes in its patient population and the services it provides, (2) improve incentives for the department to operate efficiently, and (3) allow the Legislature to provide increased oversight of DSH's budget and operations.

INTRODUCTION

The DSH provides a variety of inpatient behavioral health services to more than 6,600 patients at five state hospitals and three prison-based psychiatric programs. In recent years, the number of patients referred to DSH for treatment has increased, and the patient population has grown about 14 percent since 2010-11. As part of the 2014-15 budget, the state provided additional funding to the department to accommodate this increase, including resources to activate nearly 250 additional beds. Despite the increased resources, the department had a patient waitlist of nearly 550 individuals as of January 2015. Maintaining such a long waitlist for DSH placement delays access to care for patients, as well as poses legal risks for the department. This is because if DSH fails to admit patients waiting for care within certain time frames, the department can be required to appear in court and potentially be held in contempt.

In recent years, concerns have been raised about DSH's budgeting process, including some problems that contribute to the department's increasing waitlist. For example, in our report *The 2014-15 Budget: Analysis of the Health Budget,* we noted that the department's process for patient placement does not efficiently utilize bed space across the system and that there are large discrepancies between the number of beds the department is budgeted for and their actual patient population. In this report, we examine these and other problems with the DSH budget process. Specifically, we (1) provide an overview of how the department develops its annual budget requests, (2) highlight some shortcomings of that process and contrast those with best practices in other departments, and (3) recommend steps the Legislature can take to make DSH's budget process more transparent and to incentivize the department to deliver care more cost-effectively.

In preparing this report, we spoke with state hospital administrators and behavioral health care providers in California and other states. We also spoke with other large state health care providers, including the federal court-appointed Receiver overseeing prison health care, the California Department of Corrections and Rehabilitation (CDCR), and the California Department of Public Health (CDPH). In addition, we visited various state hospitals and psychiatric programs operated by DSH. We also reviewed academic literature regarding inpatient behavioral health treatment and analyzed data from numerous sources, including DSH and similar departments in other states.

BACKGROUND

Overview of DSH

The DSH was established in 2012. Specifically, Chapter 29, Statutes of 2012 (AB 102, Committee on Budget), eliminated the Department of Mental Health (DMH) and transferred the responsibility for delivering inpatient behavioral health services to patients at state hospitals from DMH to DSH. The Governor's budget includes a total of $1.7 billion for DSH, which is roughly the same level provided in the 2014-15 budget. The department currently treats 6,600 patients at its eight facilities. (Please see the box on the next page for additional information regarding DSH's facilities.) The average length of stay for DSH patients is less than one year.

Patients at the state hospitals receive 24-hour care (including therapy and medication) and fall into one of two categories: civil commitments or forensic commitments. Civil commitments are generally referred to the state hospitals for treatment by counties. This is because they have a mental illness that makes them a danger to themselves or others or makes them gravely disabled. Forensic commitments are typically committed by the courts and include state prison inmates referred by CDCR as well as individuals classified as incompetent to stand trial, not guilty by reason of insanity, mentally disordered offenders (individuals referred by the Board of Parole Hearings to DSH as a condition of state parole), or sexually violent predators. The forensic population of the state hospitals has been consistently high in the past decade, averaging roughly 90 percent of the state hospital population. Currently, 92 percent of state hospital patients are forensic commitments.

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.

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.

How DSH Develops Its Annual Budget Requests

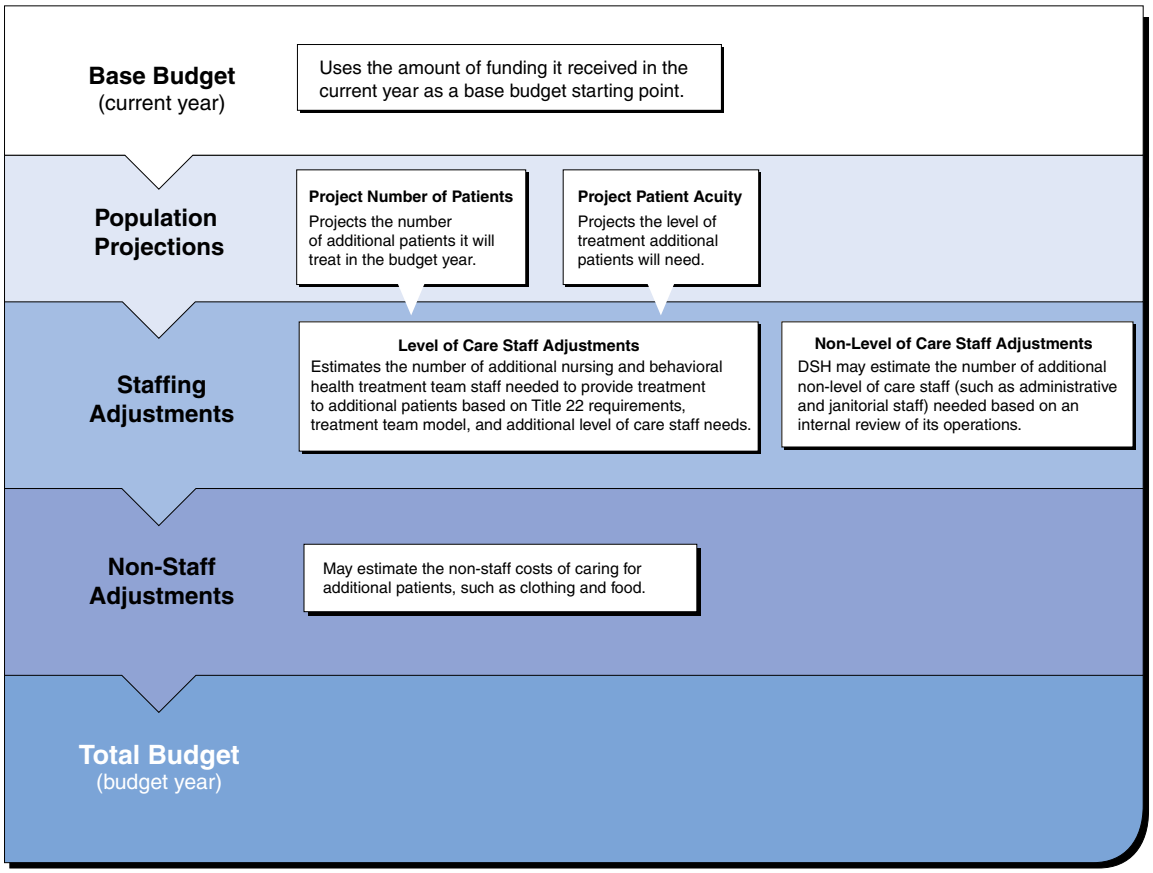
The vast majority (about 98 percent) of DSH's budget is devoted to treating patients in the eight DSH facilities. Below, we discuss how DSH develops its annual budget requests to provide such treatment. Specifically, we describe how the department (1) uses the base budget as a starting point, (2) projects changes in its patient population, (3) adjusts staffing levels to account for such population changes, and (4) sometimes adjusts for non-staff costs. Figure 1 provides an overview of the department's budgeting process.

Base Budget

In determining how much funding to request for the upcoming fiscal year, the department uses the amount of funding it received in the state budget for the current year as a base budget or starting point. For example, the department's budget for 2014-15 becomes the base budget for 2015-16. The base budget includes the total amount of funding to treat DSH patients, including non-staff and staff costs. The department then requests adjustments to the base budget to account for projected increases or decreases in the patient population during the budget year, as we describe below.

Figure 1

How the Department of State Hospitals Builds Its Budget Request



Population Projections

Projecting the Number of Patients. In developing its annual budget request, DSH projects the number of patients it will treat in the upcoming fiscal year—particularly in terms of changes relative to the current fiscal year. The main factors that inform the department's projections are (1) the number of patients being treated in the current year and (2) the number of patients on its waitlist for treatment. Based on the expected change in the patient population, DSH then estimates how many beds it will need to treat those patients. If the department projects an increase in the population, as has been the case in recent years, it requests funding to activate enough new beds to accommodate the increase. We note, however, that the department may propose activating a smaller number of beds if it lacks the infrastructure or operational capacity to activate the full amount needed to accommodate the increase. After estimating the number of additional beds it needs to activate relative to the current year, the department's next step is estimating the acuity level of the patients who will fill those beds.

Projecting Patient Acuity. Patients treated in DSH facilities require varying levels of treatment based on the severity of their diagnoses and the treatment plan that their treatment teams develop. Based on these assessments, the department classifies patients as needing one of three levels of care (commonly referred to as acuity levels).

- Intermediate Care Facility, which provides inpatient skilled nursing services to patients who do not require continuous nursing care.
- Acute, which provides 24-hour inpatient care services, including medical, behavioral health, and pharmaceutical services.
- Skilled Nursing Facility, which provides long-term skilled nursing care, including 24-hour inpatient treatment and a variety of physical and behavioral health services.

These acuity levels are associated with the licensing standards specified in Title 22 of the California Code of Regulations and specific clinical staffing levels developed by DSH, which we discuss in more detail below. Because the acuity levels of patients affect the number and cost of clinical staff necessary to provide care, the department must estimate the acuity level of any additional patients for the budget year. The estimate is developed in consultation with clinical executives and facility staff and is generally based on the acuity profile of the current patient population.

Staffing Adjustments

Based on the projected number of additional patients that will need to be treated in the coming fiscal year, as well as the estimated acuity profile of those patients, the department requests additional staff. If DSH estimates a reduction in its patient population, which has not happened in recent years, a similar methodology could be used to make staffing reductions.

Level of Care Staff Adjustments. Level of care staff provide treatment services to DSH patients, and include nursing staff and behavioral health treatment team staff. When DSH requests adjustments to its level of care staffing levels based on the expected change in the patient population, it considers the following three factors.

- ***Title 22 Requirements.*** Title 22 of the California Code of Regulations sets the standards for operating an acute psychiatric hospital. Specifically, Title 22 requires hospitals to be licensed by CDPH and sets minimum requirements for staffing and facilities. In particular, it

requires a certain minimum number of nursing staff based on patient acuity and associated treatment needs for different nursing shifts (meaning morning, afternoon, or overnight), as shown in Figure 2. Title 22 nursing staff have many responsibilities, including patient observation, medication distribution, and patient escorting.

Figure 2

Title 22 Staffing Requirements[a]

Nursing Shift	Patient Acuity: Intermediate Care Facility	Patient Acuity: Acute	Patient Acuity: Skilled Nursing Facility
Morning	1:8	1:6	1:6
Afternoon	1:8	1:6	1:6
Overnight	1:16	1:12	1:12

[a] Requirements reflect the minimum ratio of nurses to patients.

- ***Treatment Teams.*** In addition to the nursing staff required by Title 22, DSH also uses a behavioral health treatment team model. Under this model, clinicians work together to provide individual and group treatment to a set number of patients. Each treatment team includes five providers—a psychiatrist, psychologist, social worker, rehabilitation therapist, and a registered nurse. Treatment team nursing staff are distinct from Title 22 nursing staff in that they are responsible for developing treatment plans and participating in treatment team meetings. They have an assigned group of patients, rather than being assigned to morning, afternoon, or overnight nursing shifts. The number of patients assigned to each treatment team is determined by patient acuity, as detailed in Figure 3.

- ***Additional Level of Care Staff.*** According to DSH, the staffing ratios described above do not account for certain services the department currently provides to patients. For example, the department indicates that the ratios do not account for an increase in recent years in the number of episodes where patients experience a severe crisis that requires one-to-one monitoring. As we discuss later in this report, the department has identified other workload that is also not reflected in the staffing ratios. To accommodate this workload, the department often augments its staffing requests with additional level of care staff beyond the Title 22 and treatment team staffing ratios. However, because these augmentations are not based on the department's staffing model, it is difficult for the Legislature to assess the basis for these augmentations and whether they are appropriate.

Non-Level of Care Staff Adjustments. In addition to level of care staff, DSH also requires a variety of other staff to ensure its effective operation. These staff include nonbehavioral health clinicians, such as dieticians, medical doctors, administrative staff, janitors, firefighters,

Figure 3

Treatment Team Staffing Ratios[a]

Acuity Level	Staffing Ratio
Intermediate care facility	1:35
Acute	1:15
Skilled nursing facility	1:15

[a] Ratios reflect the average ratio of treatment team to patients.

and hospital police. The number of non-level of care staff assigned to a particular facility is not necessarily directly related to the number of patients at the facility, and may be influenced by the design or age of the facility. As a result, non-level of care staff is not ratio-driven and the level of such staff at each facility varies. Currently, DSH determines the number of non-level of care staff at a facility based on internal assessments of its operations and needs. Headquarters may consult with specific facilities to determine whether changes to the patient population, services provided, or facility design requires an adjustment to the number or type of non-level of care staff at the facility. For example, the department could determine that activating a new patient treatment area results in a need for additional hospital police to monitor that area. Based on the department's internal review, requests for adjustment to the number of non-level of care staff are sometimes included in population budget adjustments.

Non-Staff Adjustments

While DSH's annual budget requests are typically limited to the staffing related adjustments described above, the department sometimes also requests adjustments for non-staff costs. These costs can include clothing, food, and facility costs. Generally, if the patient population increases, the department is required to absorb these costs within its existing base budget. However, that is not always possible. For example, if the department opens a new facility or experiences a large increase in the patient population compared to the previous year, the department could decide to request augmentations to its non-staff costs.

DSH'S BUDGETING METHODOLOGY HAS SEVERAL SHORTCOMINGS

In order for DSH to ensure that its patients receive treatment in a timely, cost-effective manner, it is important that the department maintain efficient budgeting and bed management practices. These practices must also be transparent so that the Legislature has the information necessary to provide effective oversight. However, based on our review, we find that the DSH budgeting process has several shortcomings. Specifically, we find that (1) the department has a large amount of funded beds that are not used; (2) the level of staff needed to operate DSH facilities is not clear; (3) the budgeting methodology used by the department creates poor incentives for the department to operate efficiently; and (4) other state departments have more transparent, updated, and efficient budgeting processes than DSH. Figure 4 provides a summary of our major findings, which we discuss in further detail below.

Bed Vacancy Rate Has Been High in Recent Years

The number of patients that DSH actually treats relative to the number of patients it is funded to treat is known as the bed vacancy rate. As shown in Figure 5 (see page 12), DSH has consistently maintained several hundred vacant beds in recent years even through the department received funding to activate them. As of December 2014, DSH had 588 vacant beds, which is about 8 percent of their total budgeted capacity. This unutilized capacity comes at a high cost to the state, as each bed costs an average of almost $230,000 annually. Moreover, keeping funded beds vacant contributes

to the department's waitlist and delays access to care for patients. This is because beds that are vacant could otherwise be used to treat patients who are on the waitlist.

There are a variety of reasons why beds remain vacant even though the department received funding to fill them. Some of these reasons relate to how hospital facilities operate and are largely unavoidable. For example, about one-third of the department's vacant beds are reserved for patients who are expected to return to the facility, such as those patients out for court or medical appointments. These patients are generally only away from the facility for short periods of time. Since the patients have not been discharged, they are still the responsibility of the department.

Currently, it is difficult to determine what factors account for the remaining two-thirds of the bed vacancies because DSH does not maintain the data necessary to conduct such an analysis. (We note that the department is in the beginning stages of collecting such data.) However, based on our review of the department's budget, certain flaws in the department's budgeting process could be contributing to the number of vacant beds. As discussed in detail below, the DSH budgeting process does not include appropriate fiscal incentives for the department to fill its vacant beds. In addition, according to the department, its staffing models have not been recently updated to reflect workload changes—creating pressure to redirect resources that would otherwise be used to fill the vacant beds.

Department Staffing Needs Are Unclear

We have identified several areas of concern with DSH's current staffing. First, the department's approach for determining its staffing levels has not been recently updated and thus may not account for certain workload. Second, our analysis indicates that there are significantly more level of care staff working for the hospitals than the department's staffing ratios would suggest are necessary. Third, independent audits of DSH in recent years have raised questions regarding the appropriateness of the department's staffing levels. Finally, despite these issues, the department's staffing levels have not been recently independently reviewed.

Level of Care Staffing Model Does Not Account for Certain Workload. The DSH provides an array of treatment services to patients using a range of clinical staff. Since the department last revisited its level of care staffing levels in 2012, the type of services and the responsibilities of needed staff have evolved. However, according to DSH, the department's clinical staffing model has not been adjusted to account for such changes. As discussed earlier in the report, the department typically

Figure 4

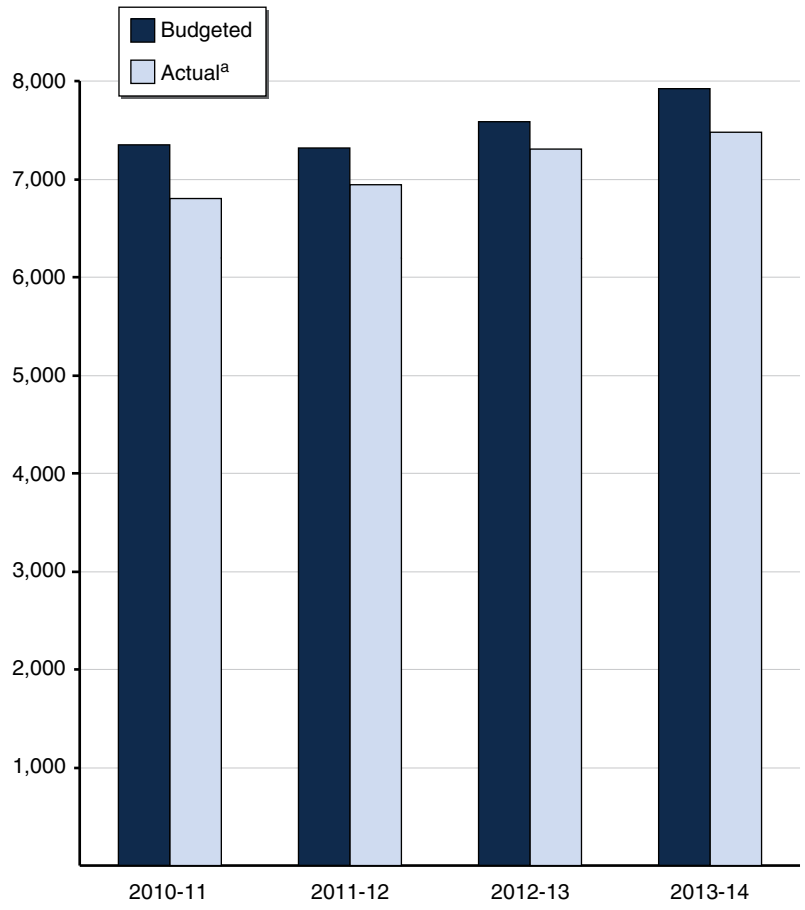
DSH Budgeting Methodology Has Several Shortcomings

- ✓ Bed Vacancy Rate Has Been High in Recent Years
- ✓ Department Staffing Needs Are Unclear
  - Level of care staffing model does not account for certain workload.
  - Actual staffing exceeds Title 22 requirements and treatment team staffing model.
  - Independent audits identified concerns with level of care staffing.
  - Staffing needs have not been independently reviewed.
- ✓ DSH Budgeting Methodology Creates Poor Incentive Structure
  - Budget process creates fiscal disincentive for DSH to fill vacant beds.
  - Facilities have incentive to overestimate patient acuity.
- ✓ Other State Departments Have More Effective Budgeting Practices

DSH = Department of State Hospitals.

Figure 5

DSH Budgeted Population Exceeds Actual Population



[a] Population reflects the annual average daily population, excluding patients on temporary leave.
DSH = Department of State Hospitals.

redirects staff or requests additional level of care staff to support the services not accounted for in the staffing model. For example, the model does not account for a recent change in how the department provides group treatment. Historically, DSH patients have received treatment exclusively from treatment teams assigned to their housing unit (or nearby units). In recent years, however, the department started providing group therapy outside of a patient's housing unit. This allows the department to provide group treatment to patients with similar diagnoses or treatment needs, regardless of whether they live in the same housing unit. Level of care staff manage these group treatment sessions, and may also be required to escort patients from their housing units to the group treatment areas. According to DSH, the current level of care staffing ratios do not account for such off-unit services and escorting needs.

The level of care staffing also does not account for changes in the needs of the patient population. According to the department, the patient population has become more difficult and violent in recent years, which has increased the need for more intensive care. For example, patients experiencing a mental health crisis or feelings of suicidality require one-to-one staffing. This often requires the department to shift staff from treating other patients to provide enhanced services to these particular patients. As a result, the department may not be consistently providing all the services that patients require.

The changes to level of care workload without corresponding changes to the staffing model could be contributing to the department's high bed vacancy rate in recent years. Specifically, it is possible that the department is redirecting staff from beds for which it is funded to operate in

order to provide the level of group treatment and one-to-one monitoring described above, which would then result in the beds being vacant. While the additional services and activities may be warranted, the redirection of staff for this purpose raises a few concerns. In particular, the redirection of staff could be limiting the department's ability to reduce its waitlist. In addition, while these new services may be consistent with legislative priorities, the Legislature has not approved funding for this specific purpose. As such, the practice of redirecting funding in this manner undermines the Legislature's ability to ensure that its priorities are being met.

Actual Staffing Exceeds Title 22 Requirements and Treatment Team Staffing Model. To account for the shortcomings in the model discussed above, in recent years DSH has requested, and the Legislature has approved, augmentations to its staffing. Because of these augmentations, DSH has consistently maintained higher staffing levels than would be expected based on Title 22 standards and the treatment team staffing model. In order to assess this difference, we compared the expected number of statewide nursing and treatment team staff, based on the department's actual patient population, to its actual staffing levels in 2013-14. We found that the department employed about 35 percent more staff than required under Title 22 and DSH's own staffing model. This equates to nearly 2,000 nurses and more than 200 psychiatrists, psychologists, rehabilitation therapists, and social workers in excess of the expected staffing level. We note that in recent years the gap between the level of care staffing and actual staffing levels has declined. However, the fact that such a significant discrepancy persists provides further evidence that the department's level of care staffing ratios are no longer useful. Additionally, while some deviation from the staffing ratios may be needed to cover additional workload, the large size of the gap raises questions about whether the augmentations are necessary.

Independent Audits Identified Concerns With Level of Care Staffing. In recent years, the Office of State Audits and Evaluation (OSAE) at the Department of Finance and the *Coleman* Special Master (who provides court oversight for state prison inmates who are committed to DSH facilities) have raised concerns with DSH's staffing. Their findings, which we summarize below, provide additional evidence that the department's staffing methodology is outdated.

- ***Staffing Does Not Result in Optimal Patient Outcomes.*** In May 2014, the *Coleman* Special Master released a report that raised several concerns with the quality of care provided in DSH facilities. The report noted that the department was providing far less group therapy than it should. According to the report, care was widely inconsistent, often nontherapeutic, and did not include certain types of treatment, even when patients clearly required such treatment.

- ***Clinical Staff May Be Performing Tasks That Could Be Performed by Lower Skill Classifications.*** A 2008 OSAE report cited concerns from hospital staff that clinical staff were performing administrative functions that could be performed by non-level of care staff. The audit noted that shifting administrative workload to nonclinical staff could result in costs savings for the department.

- ***Staff Savings Are Redirected for Operating Expenditures.*** The 2008 OSAE report noted that DSH had a practice of redirecting savings from its staffing budget to cover deficiencies in its operations budget.

Staffing Needs Have Not Been Independently Reviewed. Until 2013, DSH was under a consent decree pursuant to the federal Civil Rights for Institutionalized Persons Act (CRIPA), which is designed to protect individuals in public institutions such as mental hospitals. The terms of the consent decree limited the state's ability to adjust DSH's level of care staffing. Given that the department is no longer under court oversight, it is now in a position to reassess whether its existing staffing levels are appropriate. While the department performed an internal review of level of care staffing upon exiting CRIPA court oversight, that review was limited and culminated in only a slight modification to its treatment team staffing ratios. Recently, DSH initiated an additional internal review of its nursing staffing levels and responsibilities. However, the department has not yet undertaken a comprehensive review of its other clinical staffing levels. Moreover, reviews performed in the past, and the current nursing staffing review, have not been performed by an independent agency. As we discuss below, this is in contrast to independent staffing reviews completed by the Receiver in recent years.

There is also evidence that the department's non-level of care staff may not be adequate. In May 2012, the department reported that non-level of care staffing in the hospitals may be insufficient. Since that time, however, the DSH has not comprehensively reviewed the non-level of care staffing at its facilities to ensure that staffing levels are adequate to achieve the department's mission. In addition, the department has not reviewed the responsibilities of these staff to ensure that staff are being efficiently used. Although the department hopes to do an internal review of its non-level of care staffing in the near future, it does not have plans for an independent review.

DSH Budgeting Methodology Creates Poor Incentive Structure

The current budget process provides little fiscal incentive for the department and individual DSH facilities to fully utilize their budgeted capacity and accurately project patient acuity. As noted above, failure to operate efficiently means patients may wait longer for treatment or treatment may be more costly than necessary. As we discuss below, the current budget process does not incentivize such efficient operation.

Budget Process Creates Fiscal Disincentive for DSH to Fill Vacant Beds. Unlike other similar state departments, DSH's budget is not typically adjusted to reflect its actual patient population, including the number of vacant beds. In 2013-14, the department had an average bed vacancy of nearly 450 beds. At an annual average bed cost of $230,000, the total cost of these vacant beds was more than $100 million. However, at the end of 2013-14, the department only reverted $28 million to the General Fund. This is despite the fact that most of the funding tied to the unutilized capacity (such as for staff, clothing, and food costs) was not needed for its intended purpose and could have been reverted to the General Fund.

Because the department's budget is not typically adjusted based on the actual population, it has no fiscal incentive to ensure that all its beds are filled. This incentive to maintain vacant beds is further compounded by workload for which the department is not specifically funded. As we note above, the department has expanded the services it provides and has experienced an increase in workload associated with higher patient care needs. However, the department has not been specifically funded for those responsibilities. This creates an incentive for the department to maintain vacant beds so that it can redirect staff associated with the vacant beds to support these unfunded services.

Facilities Have Incentive to Overestimate Patient Acuity. According to DSH, facilities receive additional funding and staff if they expect to have an increase in high acuity patients. Since the additional funding is not adjusted for actual patient acuity, there is an incentive for facilities to overestimate the needs of their patients. If a facility projects that incoming patients will have acute (as opposed to intermediate) care needs, it will receive additional staff and funding to provide such care. On the other hand, if the patient population is actually more acute than expected, DSH's budget and staffing is not adjusted to reflect the costs of providing the higher level of care. If the actual patient population is not as acute as projected, though, the department is not required to revert any funding. As such, an overestimation of patient acuity can result in the department spending more than is necessary to treat its patients.

The incentive for facilities to overestimate patient acuity is strengthened by the fact that the current acuity model may not accurately reflect patients' needs. According to the department, there has been an increase in the number of violent incidents and some patients require more care and monitoring than is possible under any of the current acuity designations. For example, Chapter 718, Statutes of 2014 (AB 1340, Achadjian), established a program in DSH facilities to provide enhanced treatment for the most violent patients. The enhanced treatment unit (ETU) requires a staff-to-patient ratio of 1:5, which is higher than the ratios required for any of the existing acuity levels. However, the ETU staffing requirements are currently not part of the department's acuity model and projection process. If patients have higher care needs—such as those found in the ETUs—than are accounted for under the current acuity model, facilities may need additional staff beyond what is estimated by the model. Since those staff are not accounted for with the current acuity model, there is an incentive to assume that new patients will have a high level of acuity in order to receive additional funding and additional staff that could then be redirected to provide more intensive services to those patients that actually have high needs.

Although the DSH budgeting process creates poor incentives such as those described above, it is possible to establish a budgeting process that better incentivizes efficiency. As we discuss below, other state departments take a different approach to budgeting, which creates more transparency and appropriate incentives to accurately budget and staff facilities.

Other State Departments Have More Effective Budgeting Practices

While DSH provides unique services, it does have some similarities to other state departments, particularly CDCR and the Receiver's office. For example, these two agencies face similar issues (such as balancing patient needs with security concerns) as well as require similar staffing mixes, including level of care and non-level of care staff. However, CDCR and the Receiver have a different approach than DSH in terms of budgeting and allocating staff positions. Some of the major differences between their process and the DSH process include:

- ***Independent Staffing Analysis.*** Like DSH, the Receiver also had a staffing plan that until recently did not account for all the workload and requirements the department faced. Because of the discrepancies between the Receiver's staffing plan and actual workload, the Receiver's office recently contracted for independent analyses of its staffing. The analyses included a review of staff responsibilities, patient acuity, the volume and variety of services that must be provided, facility-specific factors (such

as proximity to community hospitals), and other related factors. These analyses developed new clinical staffing ratios and provided comparisons to the staffing ratios of other similar organizations.

- ***Ratio-Driven Level of Care Staffing.*** Based on the above independent staffing analyses, the Receiver now uses a ratio-driven staffing model. Under the model, the Receiver estimates inmates' medical acuity based on the projected inmate population for the budget year. The Receiver then applies these estimates to the staffing ratios developed by the staffing analyses. Under this model, statewide staffing levels are determined by a formula that accounts for all clinical workload—meaning separate staffing augmentations are not necessary. Once statewide staffing levels are determined, the Receiver determines the appropriate allocation of staff positions to each prison.

- ***Non-Level of Care Staffing.*** In response to the *Farrell v. Brown* court case, the CDCR Division of Juvenile Justice (DJJ) contracted with a consultant to develop a new staffing model, which includes both facility-specific and population-driven non-level of care staffing. For example, each DJJ facility receives one groundskeeper position for every 30 acres. These staff are adjusted annually based on changes to the population or facilities. For example, if a facility closes, the groundskeeper position would be eliminated. In contrast, DSH makes adjustments to non-level of care staff on occasion, but does not do so in a regular and standardized manner.

- ***Adjustment for Actual Population.*** The Receiver's office adjusts its staffing levels for the actual patient population. Like DSH, the Receiver's office must project its future population. However, unlike DSH, the Receiver's office (1) biannually reviews any differences between its estimated population and acuity and the actual population and acuity and (2) adjusts its staffing and budget based on those reviews. For example, if the inmate population is higher than expected, the Receiver may request additional funding. On the other hand, if the population is lower than expected, the corresponding amount of savings may revert to the General Fund. We note that CDCR has a similar process to the Receiver for adjusting its budget based on actual population levels.

- ***Adjustment for Acuity Level.*** The Receiver has an acuity classification model similar to DSH, with funding and staff tied to patient acuity. At the beginning of each calendar year, the Receiver projects the number of inmates who will require each level of care. Every six months, the Receiver reviews its projections and adjusts its budget based on that review. If patient acuity was underestimated, the Receiver may request additional funding to cover the higher workload. If patient acuity is overestimated, the corresponding amount of savings may revert to the General Fund.

- ***Validation of Acuity Designations.*** The Receiver also uses a quality control process to ensure that inmates are assigned to the correct level of care, in order to avoid, for example, classifying an inmate as needing a higher level of care than they actually require. The Receiver's

quality control process requires at least two clinical staff to review whether an inmate's acuity level has been appropriately assessed. If the reviewers find that patients are inappropriately placed, then the department may refine or clarify acuity criteria, or provide additional staff training. This ensures that the process by which inmates are assigned to acuity levels is accurate and consistent.

LAO RECOMMENDATIONS: REDESIGNING DSH'S BUDGET PROCESS

In this report, we reviewed the process that DSH currently uses to develop the population-driven portion of its budget and identified several concerns with the process. Based on our findings, we make several recommendations below to improve the DSH budgeting process in order to ensure that the department provides inpatient behavioral health services in a timely, cost-effective manner. Specifically, we recommend the Legislature (1) require the department to establish or update several key components used to develop its budget to ensure that they are accurate and adequate and (2) direct DSH to use the updated information to develop its budget and staffing requests based on expected changes in the number and acuity profile of its patient population. Given the resources and time necessary to implement these recommendations, we also recommend that the Legislature require DSH to provide additional justification for its budget requests during the development and implementation of the new budgeting process. Figure 6 summarizes our recommendations, which we discuss in greater detail below.

Revise Components of DSH's Budget Process

Based on our findings, we recommend several changes to the DSH budgeting and staffing process. For that process to be effective, however, the information that is used to build the staffing and population adjustments must be up-to-date. Specifically, we recommend (1) validating the patient acuity model, (2) updating the department's staffing methodology, and (3) establishing a standardized non-staff cost per patient.

Validate Patient Acuity Model

As discussed earlier, DSH facilities currently have an incentive to overestimate patient acuity and the current acuity model may not capture the higher care needs of a forensic patient population. We also note that the department has not recently

Figure 6

LAO Recommendations for Redesigning DSH's Budget Process

- ✓ Revise Components of DSH's Budget Process
  - Validate patient acuity model.
  - Update staffing methodology.
  - Establish standardized per patient non-staff cost.
- ✓ Make Adjustments Based on Actual Patient Population and Acuity Levels
- ✓ In Short Run, Require DSH to Provide Additional Information to Justify Budget Requests

DSH = Department of State Hospitals.

updated its acuity model. Based on those findings, we recommend that the Legislature require the department to (1) contract for an independent analysis of its patient acuity designations and (2) establish an ongoing acuity designation process.

Independent Analysis of Acuity Designations. The independent analysis should include a review of the appropriateness of the current acuity levels and recommendations for any revisions or additions to the current model. Based on the results of this analysis, the department should adjust its acuity model to ensure that it is up-to-date and accurately reflects the treatment needs of its patients. We expect that such a review could be achieved with minimal cost by leveraging existing resources and contracts. The department is currently negotiating a contract to inventory its capacity of beds by acuity and use. The assessment of the appropriateness of the acuity model could be added to the scope of that related project.

Ongoing Acuity Review Process. After DSH updates its acuity model based on the findings of an independent analysis, the department should establish an ongoing process to control for the quality of how it designates patient acuity. In order to facilitate this process, we recommend that the Legislature adopt language similar to the Title 22 requirements for general acute care hospitals, which require hospitals to annually review the reliability of their patient acuity designation model. This review is performed by clinical staff, at least half of whom must provide direct care. There are two major benefits to this quality control process. First, it would ensure that patients are being appropriately assigned to acuity levels and that the process to assign patients is consistent statewide. Second, it would reduce the ability of facilities to systematically overestimate patient acuity.

Update Staffing Methodology

We recommend that the Legislature require DSH to make several changes to the process by which it determines the appropriate level of staffing for its facilities, including updating staffing models for both level of care and non-level of care staffing.

Update Level of Care Staffing. As discussed earlier, DSH's level of care staffing models have not been updated to account for recent operational changes and independent audits have raised questions about the appropriateness of the department's staffing methodology. Accordingly, we recommend that the Legislature require DSH to contract with an independent consultant for a comprehensive clinical staffing analysis. Such an analysis should include: (1) an evaluation of the department's clinical staffing, including treatment team and nursing staff; (2) an assessment of the appropriate number and type of clinical staff necessary to provide treatment for patients assigned to each acuity level; (3) an assessment of whether staff are assigned appropriate responsibilities, or whether some tasks could be assigned to nonclinical staff or less costly clinical staff; and (4) recommendations to ensure the department is utilizing its staff as efficiently and effectively as possible. We estimate that such an analysis would likely cost less than $100,000.

We further recommend the Legislature require DSH to use the findings of the above analysis to implement a new, ratio-driven treatment team staffing model similar to the one used by the Receiver. Under this approach, the department would set staffing ratios as determined by the independent analysis and Title 22 requirements. As we discuss below, the department would project its patient population for the coming fiscal year and then apply the staffing ratios to determine a

statewide staffing level. The DSH would then be able to allocate those staff positions to each facility based on its assessment of each facility's needs. Our proposal would streamline the population adjustment process and ensure transparency about how DSH determines the level of staff necessary to provide care to the patient population.

Update Non-Level of Care Staffing. In addition to revising the level of care staffing, we also recommend the Legislature require DSH to contract for an independent review of its non-level of care staffing. Because this type of staffing is frequently facility-specific and includes a wide variety of classifications, we recommend the analysis be performed separately from the above level of care staffing analysis. The non-level of care staffing analysis should review the number and type of staff assigned to each facility, as well as an assessment of their responsibilities. This analysis should also ensure that all staffing levels are consistent and up-to-date, and include recommendations to ensure efficient and effective delivery of treatment. It should also result in staffing ratios similar to those used by DJJ, including ratios based on facility factors and patient population. This analysis, which would likely cost less than $100,000, could be included with the level of care staffing analysis contract. Under our proposal, the Legislature would be able to ensure that non-level of care staffing is appropriate and accounts for current department workload.

Establish Standardized Per Patient Non-Staff Cost

We recommend that the Legislature require DSH to use a per patient, non-staff cost estimate, similar to the estimates used by CDCR and the Receiver. The estimate should include all variable non-staff costs associated with caring for an individual patient (such as clothing and food), but exclude fixed costs associated with operating all DSH facilities (such as facilities maintenance). The Legislature could use this cost estimate to adjust DSH's budget to account for changes in the patient population, such as slower than projected growth in the patient population, as we discuss in more detail below.

Make Adjustments Based on Actual Patient Population and Acuity Levels

Given the lack of appropriate incentives for DSH to utilize its full capacity and appropriately assess patient acuity, we recommend that the Legislature require the department to submit budget requests based on the number and acuity profile of the patients it actually serves, similar to the budgeting methodology used for CDCR and the Receiver. Our proposed process for adjusting DSH's budget would resemble its existing process in a couple respects. As with the current budget process, the department would submit as part of the Governor's January budget an estimate of the patient population by acuity level for the upcoming fiscal year. These estimates would be the basis for the department's budget requests. Also, like the current process, the department would make any necessary adjustments to its budget request based on updated population information as part of the Governor's May Revision.

Current-Year Funding Adjustments. However, our proposed process would differ from the existing process in a couple important respects. First, under our proposal, DSH would biannually provide updated information comparing its current-year patient population by acuity level (based on actual year-to-date data) to the levels assumed in the enacted budget for the current year. Second, the department's proposed budget and staffing adjustments would be directly and explicitly based on the updated cost estimates we described above.

For example, when the department submits its budget request as part of the Governor's January budget for 2017-18, the department would include an updated estimate of its population by acuity level for 2016-17. As part of the Governor's May Revision for 2017-18, the department would submit an updated estimate of its 2016-17 population using actual data available at that time for 2016-17. Based on that updated information, the Legislature could make an adjustment to DSH's 2016-17 budget. If the population is smaller and/or less acute than initially budgeted for that year, the Legislature would be in a position to revert the corresponding savings to the General Fund. Conversely, if the population is higher than projected and/or more acute, the Legislature could provide additional funding to the department. Additionally, the actual spending and staffing information could also serve as the new baseline. For example if the 2016-17 population was smaller or less acute, the Legislature could base the 2017-18 budget on that smaller population.

Newly Licensed Capacity. We note that newly licensed capacity, such as treatment units the department newly licenses and staffs to accommodate additional patients, require additional resources that would not be accounted for if the budget was adjusted strictly based on the actual population. For example, staff may need to be hired in advance of a new unit being licensed by CDPH, which could result in additional costs and staffing. Therefore, we recommend the Legislature require the department to separately submit requests for any additional funding necessary for new units. Such requests would be in addition to the population-adjusted funding described above.

Benefits of Recommended Approach

We believe that our recommended approach for adjusting DSH's budget has several major benefits. First, it would ensure the department receives an appropriate amount of funding to account for changes in its patient population and the services it provides. Second, DSH would be incentivized to accurately project the patient population and patient acuity levels. Third, the department would have a fiscal incentive to fill all available beds. Fourth, our recommended approach would make DSH's budget requests more transparent and allow the Legislature to evaluate whether budget adjustments requested by the department to account for population changes are appropriate. While our proposal would likely require additional work for the department in the short run to develop the updated component costs, it would create a more simplified process for the department to develop budget proposals, and for the Legislature to review them in the long run.

In Short Run, Require DSH to Provide Additional Information To Justify Budget Requests

We acknowledge that our various recommendations may require time for the department to implement. As such, we recommend that in the interim, the Legislature require DSH to provide additional information to justify any budget requests and address some of the concerns we identified in this report. Specifically, we recommend that the department's population-driven budget requests be accompanied by additional information to justify those proposals, such as the size and acuity of the patient population and the staffing ratios used for patients of each acuity level. To the extent that any of the proposed staffing exceeds the department's staffing ratios, DSH should provide justification. This additional information would assist the Legislature in determining the appropriateness of population-driven budget proposals, as well as in making any necessary adjustments to those requests.

CONCLUSION

Based on our review of the DSH budget process, we find that several improvements can be made to increase the transparency of the process, account for increases in the department's responsibilities, and increase the operating efficiency of the department and its facilities. We make several recommendations to achieve those goals. Specifically, we recommend budgeting the department for its actual patient population, contracting for an independent review of the department's staffing, and developing a new, ratio-driven staffing model. We also recommend the Legislature require the department to provide additional justification in the short run to ensure the Legislature has all necessary information to evaluate the department's budget requests and adjustments.

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This report was prepared by Sarah Larson and reviewed by Aaron Edwards. The Legislative Analyst's Office (LAO) is a nonpartisan office that provides fiscal and policy information and advice to the Legislature.

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2015 WL 1137884
Court of Appeal,
Third District, California.

The PEOPLE, Plaintiff,
v.
Joseph BREWER, Defendant and Respondent;
State Department of State
Hospitals, Objector and Appellant.
[And 16 Other Cases [*]]

C075255 | Filed March 13, 2015

Synopsis

Background: After county sheriff was ordered to deliver prisoners, who had been found mentally incompetent to stand trial, to state hospital for restorative treatment on county public defender's petition for writ of habeas corpus filed on behalf of prisoners, public defender sought order to show cause for contempt, alleging that sheriff had violated order by holding prisoners at county jail rather than timely transferring them to hospital. The Superior Court, Sacramento County, No. **13F03215**, Steve White, J., denied Department of State Hospitals' motion to set aside order and extended deadline to transfer prisoners. Department appealed.

Holdings: The Court of Appeal, Duarte, J., held that:

[1] trial court had authority to impose deadline for transferring prisoners;

[2] order commanding sheriff to deliver prisoners to hospital did not constitute improperly promulgated local rule; but

[3] trial court did not have authority to issue modification to its order for transfer of prisoners.

Reversed and remanded with directions.

Nicholson, Acting P.J., filed separate opinion concurring in part and dissenting in part.

West Headnotes (17)

[1] Injunction
Nature of remedy in general

Injunction
Mandatory injunctions; restoration of status quo

While statute seems to limit definition of injunction to prohibitory injunctions, an injunction may also be a "mandatory injunction," compelling the performance of an affirmative act, such that "injunction" may be more completely defined as a writ or order commanding a person either to perform or to refrain from performing a particular act. Cal. Civ. Proc. Code § 525.

Cases that cite this headnote

[2] Appeal and Error
Continuing, vacating, or dissolving

Injunction
Authority and discretion of court

Order refusing to dissolve permanent or preliminary injunction rests in the sound discretion of trial court upon consideration of all particular circumstances of each individual case, and order will not be modified or dissolved on appeal except for abuse of discretion. Cal. Civ. Proc. Code §§ 525, 533, 904.1(a)(6); Cal. Civ. Code § 3424(a).

Cases that cite this headnote

[3] Courts
Acts and proceedings without jurisdiction

"Lack of jurisdiction" in its most fundamental or strict sense means an entire absence of power to hear or determine the case, an absence of authority over subject matter or parties.

Cases that cite this headnote

[4] Criminal Law
Jurisdiction

When court lacks jurisdiction in a fundamental sense, ensuing judgment is void, and thus vulnerable to direct or collateral attack at any time.

Cases that cite this headnote

[5] Courts
Acts and proceedings without jurisdiction

When a statute authorizes prescribed procedure, and court acts contrary to authority thus conferred, it has exceeded its jurisdiction.

Cases that cite this headnote

[6] Courts
Acts and proceedings without jurisdiction

Judgment
Errors and Irregularities

Judgment
Erroneous or Irregular Judgment

Judgment
Erroneous or irregular judgment

When court has fundamental jurisdiction, but acts in excess of its jurisdiction, its act or judgment is merely voidable, that is, its act or judgment is valid until it is set aside, and a party may be precluded from setting it aside by principles of estoppel, disfavor of collateral attack, or res judicata.

Cases that cite this headnote

[7] Appeal and Error
Appeal

Judgment
Errors and Irregularities

Judgment
Errors and Irregularities

Errors which are merely in excess of jurisdiction should be challenged directly, for example by motion to vacate the judgment, or on appeal, and are generally not subject to collateral attack once the judgment is final unless unusual circumstances were present which prevented earlier and more appropriate attack.

Cases that cite this headnote

[8] Constitutional Law
Prisons

Habeas Corpus
Mentally disordered and chemically dependent persons

Trial court had authority to impose deadline for transferring prisoners, who had been found mentally incompetent to stand trial, from county jail to state hospital for restorative treatment when granting writ of habeas corpus filed on behalf of prisoners, despite contention that court was violating separation of powers doctrine by acting in a legislative capacity; statute governing transfer of prisoners found mentally incompetent to stand trial to state hospital provided deadline for transfer and, thus, in setting a deadline for transfer, court was not rewriting or adding to statute but, rather, was enforcing statutory imperative. Cal. Penal Code § 1370.

Cases that cite this headnote

[9] Constitutional Law
Making, Interpretation, and Application of Statutes

Court acts within its constitutional core function and does not violate separation of powers doctrine when it interprets and applies existing laws and carries out legislative purpose of statutes.

Cases that cite this headnote

[10] Courts
Time of making objection

Whereas a lack of fundamental jurisdiction may be raised at any time, challenge to ruling in excess of jurisdiction is subject to forfeiture if not timely asserted.

Cases that cite this headnote

[11] Habeas Corpus

Limitations and conditions; treatment and discipline

Habeas corpus may be sought by one lawfully in custody for purpose of vindicating rights to which he is entitled in confinement.

Cases that cite this headnote

[12] Habeas Corpus

Other objectives; damages, etc

Habeas Corpus

Necessity and Effect of Writ; Mootness and Prematurity

Irrespective of mootness, habeas corpus petition is acceptable vehicle for a general declaration of procedural rights of individuals detained involving issue of general public concern, particularly if it pertains to administration of criminal justice.

Cases that cite this headnote

[13] Habeas Corpus

Representative or class actions

Habeas Corpus

Determination and Disposition; Relief

Trial court may grant habeas corpus petitioners prospective or class relief to redress recurring deprivations of rights at correctional facilities.

Cases that cite this headnote

[14] Courts

Making and promulgation of rules

Habeas Corpus

Mentally disordered and chemically dependent persons

Trial court's order on petition for writ of habeas corpus commanding sheriff to deliver prisoners, who had been found mentally incompetent to stand trial, to state hospital for restorative treatment within specified deadline did not constitute improperly promulgated local rule; order functioned as an injunction. Cal. Civ. Proc. Code § 525; Cal. Penal Code § 1370.

Cases that cite this headnote

[15] Habeas Corpus

Relief from judgment; revocation or modification

Trial court did not have authority to issue modification to its order on petition for writ of habeas corpus directing sheriff to transfer prisoners, who had been found mentally incompetent to stand trial, to state hospital in response to legislative changes to statute governing such transfers, such that modification, which required sheriff to deliver prisoners to hospital within 14 days of commitment or as soon as packet of documents necessary for transfer was made available, was void; changes to statute, which required packet of documents to be sent to Department of State Hospitals prior to prisoners' admission to hospital and under which trial court was no longer permitted to designate state hospital as treatment facility, had potential to affect the reasonableness of trial court's transfer deadline, and change in law required additional modifications to court's order. Cal. Civ. Proc. Code § 533; Cal. Penal Code § 1370; Cal. Civ. Code § 3424(a).

Cases that cite this headnote

[16] Criminal Law

Effect of transfer or proceedings therefor

Trial court's power to enforce, vacate, or modify an appealed judgment or order is suspended while appeal is pending. Cal. Civ. Proc. Code § 916(a).

Cases that cite this headnote

[17] Criminal Law

Public and private acts and proclamations

Court of Appeal would not take judicial notice of orders from other counties establishing timeframes for transferring criminal defendants found incompetent to stand trial on appeal from trial court's decision to extend deadline for transferring prisoners, who had been found mentally incompetent to stand trial, to state hospital for restorative treatment and denying Department of State Hospitals' motion to set aside order requiring sheriff to deliver prisoners

to state hospital; such documents were not necessary to resolve appeal. Cal. Penal Code § 1370.

See 5 Witkin & Epstein, Cal. Criminal Law (4th ed. 2012) Criminal Trial, § 843.

Cases that cite this headnote

APPEAL from a judgment of the Superior Court of Sacramento County, Steve White, Judge. Reversed with directions. (Super. Ct. No. **13F03215**)

Attorneys and Law Firms

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Paulino Duran, Public Defender, Steve Lewis, Chief Assistant Public Defender, and Arthur L. Bowie, Supervising Assistant Public Defender, for Defendant and Respondent.

Opinion

DUARTE, J.

***1** When a criminal defendant is found mentally incompetent to stand trial (IST), the trial court orders such defendant to be delivered by the sheriff to a state hospital or other treatment facility for treatment to restore the defendant to mental competence, or places the defendant on outpatient status. (Pen.Code, § 1370, subd. (a)(1)(B)(i).) [1]

In 2005, the Sacramento County Public Defender (the Public Defender) filed a petition for writ of habeas corpus on behalf of David Osburn and others, contending the Sacramento County Sheriff (the Sheriff) had unlawfully detained petitioners at the county jail by failing to transfer them on a timely basis to a state hospital for restorative treatment. After several rounds of briefing, and an evidentiary hearing, the trial court issued an order (the Osburn Order) commanding that the Sheriff deliver to Napa State Hospital (NSH) all criminal defendants ordered committed to NSH pursuant to section 1370 within seven days of the commitment. The Osburn Order was amended to require the prisoners' delivery within seven days or as soon as the packet of documents required under section 1370 (the 1370 packet) was available. There was no appeal from the Osburn Order.

In 2013, the Public Defender sought an order to show cause for contempt, alleging the Sheriff had violated the Osburn Order by holding several defendants who had been found IST at the jail rather than timely transferring them to NSH. In response, the State Department of State Hospitals (the Department) moved to set aside the Osburn Order. The trial court denied the motion but modified the Osburn Order to extend the 7–day deadline to 14 days. The Department appealed from this 2013 order "denying [the Department's] motion to set aside the transfer deadline established by this Court" in the Osburn Order.

On appeal, the Department contends (1) the trial court acted in excess of its jurisdiction, and violated the separation of powers doctrine, by inserting a 14–day deadline into section 1370 and thereby undermining the Department's duties; (2) the original Osburn Order and the 2013 modification were contrary to established habeas procedures and constituted improperly promulgated local rules; and (3) the Osburn Order should be set aside due to changes in the law and because it results in unequal treatment of defendants found IST in different counties.

We view the Osburn Order as an injunction (as did the trial court) and the Department's 2013 motion to vacate as a motion to dissolve the injunction. Such a motion can be granted upon a showing of a change in the facts, a change in the law, or because the interests of justice so require. (Civ.Code Proc., § 533.) During the pendency of this appeal, there was a material change in the law. Recent amendments to section 1370 and other statutes affect various aspects of the Osburn Order. Accordingly, we remand the matter to the trial court to reconsider its ruling on the Department's motion in light of the change in the law, and to conduct a new evidentiary hearing. We dissolve the Osburn Order pending reconsideration of the ruling.

BACKGROUND

The Statutory Scheme for and the Constitutional Rights of IST Defendants

***2** If at any time before judgment in a criminal trial a doubt arises as to the defendant's mental competence, the court shall order a hearing into the present mental competence of the defendant. (§ 1368.) If the defendant is

found mentally competent, the criminal process shall resume. (§ 1370, subd. (a)(1)(A).) "If the defendant is found mentally incompetent, the trial, the hearing on the alleged violation, or the judgment shall be suspended until the person becomes mentally competent." (*Id.*, subd. (a)(1)(B).)

"In the meantime, the court shall order that the mentally incompetent defendant be delivered by the sheriff to a state hospital," or other approved available treatment facility that "will promote the defendant's speedy restoration to mental competence." (§ 1370, subd. (a)(1)(B)(i).) Alternatively, the court may order the defendant placed on outpatient status. (*Ibid.*) Before a court makes a commitment order to a state hospital, the court shall order the community program director, or his designee, to evaluate defendant and submit to the court, within 15 judicial days, a written recommendation as to whether the defendant should be committed to a state hospital or other treatment facility or required to undergo outpatient treatment. (§ 1370, subd. (a)(2).)

The court is also required to provide the 1370 packet. These documents include the commitment order, a computation of defendant's maximum term of commitment and amount of credit for time served, criminal history information, arrest reports, any court-ordered psychiatric examination or evaluation reports, the community program director's placement recommendation, records of any finding of incompetence arising out of a complaint charging a felony specified in section 290, and medical records. [2] (§ 1370, subd. (a)(3).)

Once the defendant has been admitted to a state hospital, a progress report on his restoration to competence is required. "Within 90 days of a commitment ..., the medical director of the state hospital or other treatment facility to which the defendant is confined shall make a written report to the court and the community program director for the county or region of commitment, or a designee, concerning the defendant's progress toward recovery of mental competence." (§ 1370, subd. (b)(1).)

In *Jackson v. Indiana* (1972) 406 U.S. 715, 738, 92 S.Ct. 1845, 1858, 32 L.Ed.2d 435, 451 (*Jackson*), the United States Supreme Court held "a person charged by a State with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future. If it is determined that this is not the case, then the State must either institute the customary civil commitment proceeding that would be required to commit indefinitely any other citizen, or release the defendant. Furthermore, even if it is determined that the defendant probably soon will be able to stand trial, his continued commitment must be justified by progress toward that goal." (Fn. omitted.)

The next year, our Supreme Court reviewed "the constitutionality of the procedures ([§ 1367 et seq.]) for the commitment to, and release from, state hospital of defendants in criminal cases who have been found to lack sufficient mental competence to stand trial." (*In re Davis* (1973) 8 Cal.3d 798, 801, 106 Cal.Rptr. 178, 505 P.2d 1018, fn. omitted (*Davis*).) The court concluded that petitioners' initial commitments were proper, but "acknowledge [d] that some provision must be made to assure that petitioners do not face an indefinite commitment without regard to the likelihood that they will eventually regain their competence, for such an indefinite commitment has been held to offend constitutional principles of equal protection and due process. [Citation.] [¶] Accordingly, we adopt the rule of the *Jackson* case that no person charged with a criminal offense and committed to a state hospital solely on account of his incapacity to proceed to trial may be so confined more than a reasonable period of time necessary to determine whether there is a substantial likelihood that he will recover that capacity in the foreseeable future. Unless such a showing of probable recovery is made within this period, defendant must either be released or recommitted under alternative commitment procedures." (*Ibid.*)

***3** Following *Davis*, section 1370 was amended to provide for a maximum period of confinement of three years for defendants found IST. (Stats.1974, ch. 1511, § 6, p. 3319.) Section 1370, subdivision (c)(1), provides as follows: "At the end of three years from the date of commitment or a period of commitment equal to the maximum term of imprisonment provided by law for the most serious offense charged in the information, indictment, or misdemeanor complaint, or the maximum term of imprisonment provided by law for a violation of probationer mandatory supervision, whichever is shorter, but no later than 90 days prior to the expiration of the defendant's term of commitment, a defendant who has not recovered mental competence shall be returned to the committing court. The court shall notify the community program director or a designee of the return and of any resulting court orders."

In *In re Mille* (2010) 182 Cal.App.4th 635, 105 Cal.Rptr.3d 859 (*Mille*), another appellate court addressed the claim that an 84–day delay in transferring an IST defendant from the county jail to the state hospital was unlawful. The court focused on the requirement in section 1370, subdivision (b)(1), that the medical director of the state hospital report to the court within 90 days of commitment on the defendant's progress toward recovery of mental competence. (*Mille,* at p. 645, 105 Cal.Rptr.3d 859.) "When a defendant arrives at Patton [State Hospital] on day 84 of the 90–day period, there is no meaningful opportunity for the defendant to make progress toward recovery of mental competence, let alone for the medical director of the hospital to make a written report to the court concerning such progress by the defendant." (*Ibid.*)

The court rejected the argument that the defendant was receiving appropriate treatment at the jail, which was a designated treatment facility under section 1369.1 and thus able to provide antipsychotic medications. It found that providing a defendant with antipsychotic medication alone was not the equivalent of treatment in a state hospital where each patient had a treatment team of a psychiatrist, psychologist, nurse, social worker, and psychiatric technician, and received both pharmacological and nonpharmacological treatment. (*Mille, supra,* 182 Cal.App.4th at p. 648, 105 Cal.Rptr.3d 859.)

The *Mille* court found a defendant must be transferred from the county jail to a state hospital within a reasonable time, determined in the context of the 90–day reporting requirement. "Constitutional principles prohibit a defendant from being held 'more than the reasonable' period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future. [Citation.] Therefore, when the court orders a defendant committed to a state mental hospital for treatment that will promote a defendant's 'speedy restoration to mental competence' (§ 1370, subd. (a)(1)(B)(i)), the court must also ensure that the defendant is actually transferred to the state hospital within a reasonable period of time." (*Mille, supra,* 182 Cal.App.4th at p. 650, 105 Cal.Rptr.3d 859.)

The *Mille* court declined " 'to attempt to prescribe arbitrary time limits' " for the transfer from the county jail to state hospital for treatment. (*Mille, supra,* 182 Cal.App.4th at p. 649, 105 Cal.Rptr.3d 859; see also *id.* at pp. 649–650, 105 Cal.Rptr.3d 859.) The court noted, however, that Mille filed his initial habeas petition 30 days after the order for his commitment, and the trial court denied it 49 days into the 90–day reporting period. (*Id.* at p. 649, 105 Cal.Rptr.3d 859.) The court found the superior court should have granted the petition. (*Ibid.*) "[A] defendant needs sufficient time at the state mental hospital to be duly evaluated, potentially to derive some benefit from the prescribed treatment, and for such progress to be reported to the court." (*Id.* at p. 650, 105 Cal.Rptr.3d 859.)

The 2005 and 2006 Proceedings and the Osburn Order

***4** In the fall of 2005, the Public Defender filed a petition for a writ of habeas corpus on behalf of Osburn and three others. The petition alleged petitioners were criminal defendants with pending cases who had been found IST. The court had ordered each transferred to NSH. Petitioners had been held at the county jail for months after the commitment orders. Although Osburn had finally been transferred to NSH, the issue was not moot because the three others were still held at the county jail and the issue of prolonged detention before transfer to a state hospital was an ongoing problem. The petition alleged the prolonged confinement in the county jail was an unlawful restraint on liberty, citing *Oregon Advocacy Center v. Mink* (9th Cir.2003) 322 F.3d 1101 (*Mink*), in which the Ninth Circuit upheld an injunction mandating that incompetent criminal defendants be transferred to a state hospital within seven days of the commitment order.

The trial court issued an order to show cause to the Sheriff and set a shortened briefing schedule. The Sheriff's return alleged the delay in transfer was due to incomplete commitment orders, NSH's lengthy classification process, and the shortage of bed space. The Sheriff indicated the entire process for admission to a state hospital takes 60 to 90 days.

The court issued a supplemental order to show cause to permit the Attorney General and the Department of Mental Health (now the Department; see Stats.2012, ch. 440) to respond. The court ordered the parties to brief issues concerning the availability of beds at NSH, alternatives if no beds were available, and whether the court should issue a permanent injunction requiring delivery of a defendant to NSH within seven days of the commitment order and that the Sheriff should return to court if unable to comply with the injunction. Subsequently, the court ordered an evidentiary hearing to determine what remedies, if any, should be ordered to alleviate the problem of delayed transfers to NSH.

Following the evidentiary hearing, the trial court issued a 65–page order, the Osburn Order. The Osburn Order first detailed the procedural background of the case and testimony received

at the hearing. The court then made several findings of fact. Criminal defendants in Sacramento County who had been charged with a felony, found IST, and ordered committed to a state hospital pursuant to section 1370 "are being held in the Sacramento County Jail for months while awaiting transportation to a state hospital." These defendants were administered psychiatric medications in the jail, but received no treatment toward restoration of competency. Under current policies, these defendants were to be transferred only to NSH, and only after an intake package (including more documentation than required by section 1370) had been received by NSH, the defendant had been placed on a waiting list, and a bed became available. In some cases, the delay was due to the delay of court personnel in compiling the intake package. There were no available local alternatives to the state hospital.

The court declined to find the matter moot, although all the petitioners had been transferred to the state hospital. The court found the matter to be one of broad public interest and likely to recur. The court found *Mink, supra,* 322 F.3d 1101 to be persuasive authority, and that the California statutory scheme was similar to that in Oregon. The court concluded, "It is abundantly clear that the constitutional rights of [section 1370] committees are being violated as each day passes and they remain in the Sacramento County Jail awaiting transfer to a state hospital." If this violation continued, "the result will be the constitutionally compelled release of such persons." The court found a remedy was required for the constitutional violation and a remedy similar to that in *Mink* was appropriate.

***5** The court granted the petition for writ of habeas corpus, and ordered the Sheriff to deliver all section 1370 committees who had been committed to NSH more than seven days before and were still in the county jail to NSH within 60 days of the order. Thereafter, such deliveries were to occur within seven days of the order of commitment. NSH was ordered to accept delivery of these persons, to house them, and to provide treatment as required by section 1370.

The Department moved for reconsideration or clarification as to whether it was now required to accept section 1370 committees before it had received the 1370 packet, and whether it could send such persons to other state hospitals or facilities.

The trial court amended the Osburn Order to provide that the deadline for transfer to a state hospital would be extended if the 1370 packet had not been prepared. In that case, the Sheriff was to deliver the defendant to the state hospital as soon as the 1370 packet was made available. The court declined to amend the Osburn Order to permit the Department to transfer a section 1370 committee to another facility. The statute required the court, not the Department, to designate the state hospital.

No appeal was taken from the Osburn Order.

The 2013 Proceedings and Modification of Osburn Order

On September 9, 2013, the Public Defender requested an order to show cause on behalf of Joseph Brewer and four other defendants as to why NSH should not be held in contempt for violating the Osburn Order by failing to accept petitioners after their 1370 packets were complete and more than seven days after their orders of commitment. The Public Defender subsequently filed a similar order to show cause on behalf of seven other defendants.

In response, the Department moved to set aside the Osburn Order. The Department argued that (1) it was no longer able to comply with the Osburn Order due to the increase in the number of defendants found IST, while the number of beds for such patients remained static; (2) because Sacramento County required transfer of these prisoners within seven days of the commitment order, the San Joaquin County Public Defender was now claiming a violation of equal protection based on the delays in transporting its similarly-situated prisoners; and (3) the Osburn Order was subject to question after *Mille, supra,* 182 Cal.App.4th 635, 105 Cal.Rptr.3d 859.

The Department requested the court take judicial notice of charts showing the increase in section 1370 referrals, particularly from Sacramento County, and a report about a pilot program to treat in county jails those prisoners found IST. A declaration from a Department staff psychiatrist stated that since 2010, the number of IST admittees had increased, and the number from Sacramento County was greater than from other counties of the same size. Due to the Osburn Order, those committed in Sacramento County received preference in admission. Although the Department had taken steps to reduce the length of stay from admittance to discharge from an average of 180 days to an average of 60 days, NSH was unable to meet the 7–day deadline, or even a 30–day deadline. A declaration from the Department's Chief of Business Management confirmed that the Department could not guarantee a 30–day, let alone a 7–day, admission, and

asked that the Osburn Order be set aside to permit uniform triage.

As to the request for an order to show cause for contempt, the trial court ordered the Department to provide documentary evidence by a certain date showing that all defendants had been transferred to and accepted by a state hospital. If the Department timely submitted the evidence, the matter would be moot and the order to show cause discharged; if the Department failed to timely submit the evidence, it would face a contempt finding.

***6** The trial court declined to vacate the Osburn Order, but modified it to extend the seven-day period for delivery to a state hospital to 14 days. The court recognized the seven-day deadline in the Osburn order "may be unrealistic in light of the severe budget cuts suffered by a plethora of state agencies in the past few years. Nevertheless, this court remains firm in the stance that the Legislature and due process require delivery of [section 1370] committees, within a reasonable time frame as noted in *In re Mille* (2010) 182 Cal.App.4th 635, 105 Cal.Rptr.3d 859." The court also added a provision to the Osburn Order requiring the Sheriff to notify the state hospital that an order has been made as soon as the Sheriff takes custody of the defendant upon order of commitment.

The Department appealed from this 2013 order modifying the Osburn Order but declining to set it aside.

DISCUSSION

I

Standard of Review

[1] The Osburn Order, in directing the Sheriff to deliver to the state hospital within a certain time period criminal defendants who have been committed to a state hospital after having been found incompetent to stand trial, granted injunctive relief. "An injunction is statutorily defined to be 'a writ or order requiring a person to refrain from a particular act.' (Code Civ. Proc., § 525.) While the statute seems to limit that definition to prohibitory injunctions, an injunction may also be mandatory, i.e., may compel the performance of an affirmative act. [Citations.] In short, an injunction may be more completely defined as a writ or order commanding a person either to perform or to refrain from performing a particular act. [Citation.]" (*McDowell v. Watson* (1997) 59 Cal.App.4th 1155, 1160, 69 Cal.Rptr.2d 692.)

Accordingly, the Department's motion to set aside the Osburn Order was a motion to dissolve the injunction. "In any action, the court may on notice modify or dissolve an injunction or temporary restraining order upon a showing that there has been a material change in the facts upon which the injunction or temporary restraining order was granted, that the law upon which the injunction or temporary restraining order was granted has changed, or that the ends of justice would be served by the modification or dissolution of the injunction or temporary restraining order." (Code Civ. Proc., § 533; accord Civ.Code, § 3424, subd. (a) [grounds for modifying or dissolving "final" injunction].) An order refusing to dissolve an injunction is an appealable order. (Code Civ. Proc., § 904.1, subd. (a)(6).)

[2] An order " ' "refusing to dissolve a permanent or preliminary injunction rests in the sound discretion of the trial court upon a consideration of all the particular circumstances of each individual case" ' and 'will not be modified or dissolved on appeal except for an abuse of discretion.' " (*Salazar v. Eastin* (1995) 9 Cal.4th 836, 850, 39 Cal.Rptr.2d 21, 890 P.2d 43.)

II

Trial Court's Authority to Issue the Osburn Order

The Department contends the trial court lacked authority to issue the Osburn Order, offering several reasons why the court could not issue the order. We reject some arguments and find the Department has forfeited others by failing to raise them in 2006 when the Osburn Order first issued.

First, in a cursory argument, the Department contends the trial court "acted in excess of its jurisdiction by inserting a 14–day deadline into [section 1370] in violation of the separation of powers doctrine." The Department argues the court acted in a legislative capacity by inserting any admission deadline into section 1370.

[3] **[4]** **[5]** **[6]** **[7]** "Essentially, jurisdictional errors are of two types. 'Lack of jurisdiction in its most fundamental or strict sense means an entire absence of power to hear or determine the case, an absence of authority over the subject matter or the parties.' [Citation.] When a court lacks

jurisdiction in a fundamental sense, an ensuing judgment is void, and 'thus vulnerable to direct or collateral attack at any time.' [Citation.]" (*People v. American Contractors Indem. Co.* (2004) 33 Cal.4th 653, 660, 16 Cal.Rptr.3d 76, 93 P.3d 1020 (*American Contractors*).) The phrase lack of jurisdiction "may also 'be applied to a case where, though the court has jurisdiction over the subject matter and the parties in the fundamental sense, it has no "jurisdiction" (or power) to act except in a particular manner, or to give certain kinds of relief, or to act without the occurrence of certain procedural prerequisites.' [Citation.] ' "[W]hen a statute authorizes [a] prescribed procedure, and the court acts contrary to the authority thus conferred, it has exceeded its jurisdiction." ' [Citation.] When a court has fundamental jurisdiction, but acts in excess of its jurisdiction, its act or judgment is merely voidable. [Citations.] That is, its act or judgment is valid until it is set aside, and a party may be precluded from setting it aside by 'principles of estoppel, disfavor of collateral attack or res judicata.' [Citation.] Errors which are merely in excess of jurisdiction should be challenged directly, for example by motion to vacate the judgment, or on appeal, and are generally not subject to collateral attack once the judgment is final unless 'unusual circumstances were present which prevented an earlier and more appropriate attack.' [Citations.]" (*Id.* at p. 661, 16 Cal.Rptr.3d 76, 93 P.3d 1020.)

***7** **[8]** **[9]** The Osburn Order originally provided a seven-day deadline for transferring defendants to the state hospital. It is the imposition of a deadline—any deadline—that the Department attacks in this appeal, rather than the time period of the deadline; after all, the subsequent (2013) modification (to 14 days) is more favorable to the Department than was the original order. The Department's basic contention that the court lacks fundamental jurisdiction to impose any transfer deadline fails. As *Mille* teaches, section 1370 itself provides a deadline for transfer to a state hospital by requiring the medical director of the state hospital to provide a progress report to the court within 90 days of commitment. (§ 1370, subd. (b)(1).) To permit a meaningful progress report, the transfer must occur before the end of 90 days. *Mille* requires the transport of an IST defendant to a state hospital within a reasonable time; the reasonable time must be determined by reference to the 90–day report. (*Mille, supra,* 182 Cal.App.4th at p. 648, 105 Cal.Rptr.3d 859.) In setting a deadline for transfer, a court is *not* rewriting or adding to the statute. Instead, the court is enforcing the statutory imperative for a meaningful progress report within 90 days of the commitment order. The court can do this only by "ensur [ing] that the defendant is actually transferred to the state hospital within a reasonable period of time." (*Id.* at p. 650, 105 Cal.Rptr.3d 859.) Setting a deadline—establishing the outer limit of a reasonable time—does not violate the separation of powers doctrine. A court acts within its constitutional core function and does not violate the separation of powers doctrine when it interprets and applies existing laws and carries out the legislative purpose of statutes. (*Perez v. Roe I* (2006) 146 Cal.App.4th 171, 176–177, 52 Cal.Rptr.3d 762.) That is all the transfer deadline does.

[10] The Department contends the Osburn Order "is untethered to the unique circumstances and health needs of individual IST defendants." The Department's objection to a single deadline for transfer of all IST defendants is not a claim that the court exercised a power it did not legally possess. Instead, this contention objects to the *manner* in which the court exercised its power, by applying it to all IST defendants rather than specific defendants individually. Thus, the Department's argument is that the court had no power " 'to act except in a particular manner, or to give certain kinds of relief, or to act without the occurrence of certain procedural prerequisites.' " (*American Contractors, supra,* 33 Cal.4th at p. 661, 16 Cal.Rptr.3d 76, 93 P.3d 1020.) The Department does not offer any "unusual circumstances" that "prevented an earlier and more appropriate attack" on the original Osburn Order and none are apparent. The Department has forfeited its claim that the court's actions were in excess of its jurisdiction because it failed to raise it in a timely manner. "Whereas a lack of fundamental jurisdiction may be raised at any time, a challenge to a ruling in excess of jurisdiction is subject to forfeiture if not timely asserted. [Citation.]" (*People v. Ramirez* (2008) 159 Cal.App.4th 1412, 1422, 72 Cal.Rptr.3d 340.)

Second, the Department contends the Osburn Order "obviates established habeas procedures" by granting relief beyond the claims of petitioners and dispensing with briefing and hearing process by permitting immediate issuance of an order to show cause as to contempt. We do not read the Department's contention to be a challenge to the court's fundamental jurisdiction to issue the Osburn Order. If it is such a challenge, it fails.

[11] **[12]** **[13]** "It is a well established rule that habeas corpus may be sought by one lawfully in custody for the purpose of vindicating rights to which he is entitled in confinement. [Citations.]" (*In re Jordan* (1972) 7 Cal.3d 930, 932, 103 Cal.Rptr. 849, 500 P.2d 873.) "Irrespective of mootness, a habeas corpus petition is 'an acceptable

vehicle for a general declaration of the procedural rights of individuals detained' involving an issue of general public concern, particularly if it pertains to the administration of criminal justice. [Citation.]" (*In re Brindle* (1979) 91 Cal.App.3d 660, 675, 154 Cal.Rptr. 563.) "[A] trial court may grant habeas corpus petitioners 'prospective or class relief' to redress recurring deprivations of rights at correctional facilities. [Citing *Brindle.*] The writ is thus an effective and versatile means by which to remedy persistent violations of prisoners' rights, and has been so used. [Citation.]" (*Mendoza v. County of Tulare* (1982) 128 Cal.App.3d 403, 420, 180 Cal.Rptr. 347; see *In re Morales* (2013) 212 Cal.App.4th 1410, 152 Cal.Rptr.3d 123 [writ of habeas corpus to enforce order prohibiting preferential treatment to inmates on basis of ethnicity].) The scope of the writ of habeas corpus has been expanded to include "use by one lawfully in custody to obtain a declaration and enforcement of rights in confinement." (*In re Bittaker* (1997) 55 Cal.App.4th 1004, 1010, 64 Cal.Rptr.2d 679.)

***8 [14]** Third, the Department contends the Osburn Order is really a local rule and it was improperly promulgated, without the required notice, comment period, and adoption by the majority of the judges on the Sacramento Superior Court. We disagree with the Department's characterization; as discussed *ante*, we find the Osburn Order to be an injunction, not a local rule. In its reply brief, the Department agrees the Osburn Order "functions as an injunction."

III

Grounds to Vacate Osburn Order/Dissolve Injunction

As set forth *ante*, Code of Civil Procedure section 533 "articulates three independent bases on which a modification of an injunction may be predicated—(1) [material] change in the facts, (2) change in the law, or (3) ends of justice." (*Luckett v. Panos* (2008) 161 Cal.App.4th 77, 85, 73 Cal.Rptr.3d 745.)

A. *Change in the Facts*

The Department sought to set aside the Osburn Order, in part, due to a change of facts: the increased number of defendants committed under section 1370, the lack of new beds to accommodate the increase, and budget constraints. The trial court accepted that the state agencies' budgets had been further constrained and modified the Osburn Order accordingly. *On appeal*, the Department does not contend that the modification is insufficient to address the changed facts, or that the change of facts requires that the Osburn Order be set aside and the trial court's failure to do so was an abuse of discretion. Because the Department does not raise this issue on appeal, it has abandoned the issue. (*Tan v. California Fed. Sav. & Loan Assn.* (1983) 140 Cal.App.3d 800, 811, 189 Cal.Rptr. 775 [issues not raised in an appellate brief are deemed abandoned].)

B. *Change in Law*

1. The *Mille* Decision

The Department contends the amended Osburn Order violates *Mille, supra*, 182 Cal.App.4th 635, 105 Cal.Rptr.3d 859, a decision filed four years after the original Osburn Order. The Department contends the 14–day deadline contradicts *Mille* 's "reasonable period of time" standard. The Department focuses on the need for discretion to determine the admission date on a patient-by-patient basis, citing the time needed to evaluate the patient's security risk, to review the 1370 packet, and to comply with population caps at certain state hospitals. The *Mille* decision, however, did not discuss any of these concerns. Instead, it focused solely on the progress report that must be issued within 90 days of the order of commitment. (§ 1370, subd. (b)(1).) "For all of this to occur, a defendant needs *sufficient time at the state mental hospital* to be duly evaluated, potentially to derive some benefit from the prescribed treatment, and for such progress to be reported to the court." (*Mille*, at p. 650, 105 Cal.Rptr.3d 859, italics added.) The *Mille* court was concerned with the period of time within which the defendant must be evaluated while at the state hospital, not the time the Department needed to secure his admission thereto.

In issuing the Osburn Order, the trial court determined the "reasonable period of time" was seven days, later modified to 14 days. In this regard, the Osburn Order fulfills the mandate of *Mille* that the trial court "ensure that the defendant is actually transferred to the state hospital within a reasonable period of time." (*Mille, supra*, 182 Cal.App.4th at p. 650, 105 Cal.Rptr.3d 859.) While the Department could have challenged the original seven-day order as unreasonable, it did not. The Department does not explain why 14 days is now unreasonable where seven days was not. Nothing in *Mille* changes the law so as to classify the trial court's refusal to dissolve the Osburn Order as an abuse of discretion.

2. Amendments to Section 1370

***9** **[15]** In 2014, the Governor signed Assembly Bill No. 1468 (2013–2014 Reg. Sess.) June 20, 2014 (Assembly Bill 1468), an urgency measure that amended section 1370 and other statutes. (Stats.2014, ch. 26 (Assem. Bill 1468), eff. June 20, 2014.) We requested supplemental briefing from the parties as to the effect, if any, of these amendments on this case. Both parties agree that Assembly Bill 1468 made changes that affect the Osburn Order, but without specifically addressing the timeframe for transferring an IST defendant to a state hospital.

Assembly Bill 1468 is a lengthy budget bill relating to public safety. As pertinent to this case, the bill made changes that affect the commitment of IST defendants to a state hospital. The Legislative Counsel's Digest summarized these changes: "This bill would repeal the provision requiring the court to select the state hospital in accordance with the policies established by the [Department] when directing that the defendant be confined in a state hospital. The bill would instead require, prior to admission to the [Department], the [D]epartment to evaluate each patient committed pursuant to specified provisions of law to determine the placement of the patient to the appropriate state hospital. The bill would also require a court that orders that a defendant be committed to the [Department] or other public or private treatment facility to provide copies of any medical records with the documents described above prior to the admission of the defendant to the [D]epartment or other treatment facility where the defendant is to be committed. The bill would require the [D]epartment to utilize specified documents, including those described above and any medical records, to make the appropriate placement. The bill would make conforming changes." (Legis. Counsel's Dig., Assem. Bill 1468, Stats.2014, ch. 26.)

Under the former version of section 1370, the trial court selected the state hospital to which the IST defendant was committed. "When directing that the defendant be confined in a state hospital pursuant to this subdivision, the court shall select the hospital in accordance with the policies established by the [Department]." (Former § 1370, subd. (a)(5); Stats.2012, ch. 24, § 27.) Now, under Assembly Bill 1468, the court commits the defendant to the Department, which selects the placement location. (§ 1370, subd. (a)(5).) Assembly Bill 1468 amended Welfare and Institutions Code section 7228, which now provides: "Prior to admission, the [Department] shall evaluate each patient committed pursuant to Section 1026 or 1370 of the Penal Code to determine the placement of the patient to the appropriate state hospital. The [Department] shall utilize the documents provided pursuant to subdivision (e) of Section 1026 of the Penal Code and paragraph (2) of subdivision (b) of Section 1370 of the Penal Code to make the appropriate placement. A patient determined to be a high security risk shall be treated in the [D]epartment's most secure facilities pursuant to Section 7230. A Penal Code patient not needing this level of security shall be treated as near to the patient's community as possible if an appropriate treatment program is available."

Another change affected by Assembly Bill 1468 is that the 1370 packet must now to be sent to the Department *prior* to the defendant's admission. (§ 1370, subd. (a)(3).) Previously, the documents "shall be taken *with the defendant* to the state hospital or other treatment facility where the defendant is to be confined." (Former § 1370, subd. (a)(3); Stats.2012, ch. 24, § 27, italics added.)

***10** Both of these changes in the law affect the Osburn Order. The Osburn Order directs the Sheriff to deliver the defendant to the state hospital designated in the commitment order. But the commitment order will no longer designate the state hospital. The Osburn Order also requires the Sheriff to deliver the defendant within 14 days of the commitment order or as soon as the 1370 packet is available. Now the law requires that the 1370 packet be sent to the Department *prior to* the defendant's admission. These provisions of the Osburn Order are no longer valid.

While Brewer contends the Osburn Order remains valid if the invalidated provisions are changed to conform to Assembly Bill 1468, the Department counters that Assembly Bill 1468 demonstrates the legislative intent to vest the Department with discretion in the admission of IST defendants to state hospitals, and the Osburn Order improperly infringes upon that discretion and therefore must be overturned.

In response to Assembly Bill 1468, the trial court issued an order modifying the amended Osburn Order. This modification requires the Sheriff to deliver a defendant committed under section 1370 to the state hospital designated by the Department within 14 days of the commitment order unless the 1370 packet has not been prepared, in which case the sheriff shall deliver the defendant to the state hospital as soon as the 1370 packet is made available. We requested supplemental briefing from the parties as to whether the trial court retained jurisdiction to issue this modification and,

assuming the modification is valid, its effect on the parties' respective positions in this case. The parties disagree as to the trial court's jurisdiction to issue the modification, but agree the modification did not change their positions.

[16] We find the trial court lacked jurisdiction to issue the modification so it is void. As discussed *ante*, we view the Osburn Order as an injunction and the Department's motion to set aside the Osburn Order as a motion to dissolve the injunction. The trial court's 2013 order denied the Department's motion, but amended the Osburn Order. That 2013 order is the subject of this appeal. "The trial court's power to enforce, vacate or modify an appealed judgment or order is suspended while the appeal is pending. [Citations.]" (*Elsea v. Saberi* (1992) 4 Cal.App.4th 625, 629, 5 Cal.Rptr.2d 742, cited with approval in *Varian Medical Systems, Inc. v. Delfino* (2005) 35 Cal.4th 180, 189–190, 25 Cal.Rptr.3d 298, 106 P.3d 958.) "[T]he perfecting of an appeal stays proceedings in the trial court upon the judgment or order appealed from or upon the matters embraced therein or affected thereby ..." (Code Civ. Proc., § 916, subd. (a).)

We find Assembly Bill 1468 may have a greater effect on the Osburn Order than simply the changes discussed *ante*. These changes in the law may also affect the reasonableness of a mandatory 14–day deadline for transfer to the state hospital after the commitment order. The Department now has additional duties to perform before admission of a defendant to a state hospital, including selecting the most appropriate hospital or treatment facility for restorative treatment after review of the 1370 packet and other documents. Compilation of the 1370 packet may take additional time as it now must include the defendant's medical records. (§ 1370, subd. (a)(3)(I).) The trial court must carefully consider whether the 14–day deadline is reasonable in light of these additional duties.

Indeed, given the additional individualized assessment now required after the Department receives the 1370 packet, the trial court must determine not only whether a short 14–day deadline from the date of the commitment order is reasonable, but also whether *any* deadline should be triggered by the commitment order or by the Department's receipt of the 1370 packet. The trial court must hold a new evidentiary hearing to ascertain how much time is reasonable, after the 1370 packet is prepared and sent to the Department, to accommodate both the Department's duties prior to delivering IST defendants to the designated hospital or other treatment facility and the statutory requirement of a progress report from such hospital or facility within 90 days of commitment. (§ 1370, subd. (b)(1).)

***11** A material change in the law, Assembly Bill 1468, which was not before the trial court, requires reconsideration of the Department's motion to set aside the Osburn Order. The change in the law requires, at the very least, additional modifications to the Osburn Order. We shall direct the trial court to vacate its order denying the motion to set aside the Osburn Order and we remand for reconsideration of that motion with an evidentiary hearing and any further proceedings the trial court determines necessary or appropriate. We shall dissolve the injunction currently in place in the form of the Osburn Order pending ruling on reconsideration of the motion to set aside.

[17] Given our disposition of this action, we do not address the Department's contention that the Osburn Order has exposed the Department to lawsuits from criminal defendants in other counties claiming a violation of equal protection. We deny the Department's related request for judicial notice of orders from other counties establishing timeframes for the transfer of criminal defendants found incompetent to stand trial because such documents are unnecessary to our resolution of this appeal. (*County of San Diego v. State of California* (2008) 164 Cal.App.4th 580, 613, fn. 29, 79 Cal.Rptr.3d 489.)

DISPOSITION

The trial court's order denying the motion to set aside the Osburn Order (dissolve the injunction) is reversed. The matter is remanded to the trial court with directions to reconsider the Department's motion to set aside the Osburn Order, in light of the changes to the law in Assembly Bill 1468. Pending resolution of the reconsideration of the Department's motion, the injunction is dissolved.

I concur:

BUTZ, J.

Nicholson, Acting P. J., Concurring and Dissenting.

I concur in the majority's conclusion that the permanent injunction must be dissolved. I also concur in the majority's conclusion that the superior court's attempt to modify the permanent injunction after the notice of appeal was filed is

void. I respectfully dissent, however, as to what is to be done on remand. In my opinion, the law does not allow the superior court to craft a new permanent injunction, but instead requires the court to decide each defendant's petition for writ of habeas corpus on its own unique facts.

I

Due Process Rights of Defendants Found Incompetent to Stand Trial

A. *Jackson*

The constitution protects defendants found incompetent to stand trial (IST defendants) from being confined indefinitely. (*Jackson v. Indiana* (1972) 406 U.S. 715, 738–739, 92 S.Ct. 1845, 1858–1859, 32 L.Ed.2d 435, 451 (*Jackson*).) The *Jackson* court held that, as a matter of due process, "a person charged by a State with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future." (*Id.* at p. 738, 92 S.Ct. 1845.) The court, however, cautioned: "In light of differing state facilities and procedures and a lack of evidence in this record, we do not think it appropriate for us to attempt to prescribe arbitrary time limits. We note, however, that petitioner Jackson has now been confined for three and one-half years on a record that sufficiently establishes the lack of a substantial probability that he will ever be able to participate fully in a trial." (*Id.* at pp. 738–739, 92 S.Ct. 1845.)

B. *Davis*

The California Supreme Court followed the lead of the *Jackson* court and held that "no person charged with a criminal offense and committed to a state hospital solely on account of his incapacity to proceed to trial may be so confined more than a reasonable period of time necessary to determine whether there is a substantial likelihood that he will recover that capacity in the foreseeable future." (*In re Davis* (1973) 8 Cal.3d 798, 801, 106 Cal.Rptr. 178, 505 P.2d 1018 (*Davis*).) Concerning the specific defendants in *Davis,* the court wrote: "[P]etitioners are not entitled to immediate release from confinement for they have not established, nor do they allege, either that they are now competent to stand trial or that no substantial likelihood exists that they will soon recover their competence. On the other hand, petitioners are entitled, under *Jackson,* to a prompt determination by state hospital authorities regarding the probability of their ultimate recovery...." (*Id.* at p. 803, 106 Cal.Rptr. 178, 505 P.2d 1018.)

***12** Applying the due process principles discussed in *Jackson* to California's procedure, the *Davis* court directed: "With respect to future commitments, we think that in order to comply with *Jackson* 's demands the trial courts should henceforth direct the appropriate state hospital authorities to commence an immediate examination of the person committed and, within a reasonable time, report to the court the result of that examination and estimate the additional time probably necessary to restore the person to competence. Should the person committed desire to challenge the report's conclusions, reasonable opportunity should be provided him to do so." (*Davis, supra,* 8 Cal.3d at p. 806, 106 Cal.Rptr. 178, 505 P.2d 1018, fns. omitted.)

Concerning the defendants at issue in *Davis,* the court ordered the Department of Mental Health (now the State Department of State Hospitals) "to report without undue delay to the appropriate superior courts regarding the progress, if any, achieved by the petitioners in their respective care, and their prognosis as to the future." [1] (*Davis, supra,* 8 Cal.3d at p. 810, 106 Cal.Rptr. 178, 505 P.2d 1018.) Notably, the *Davis* court did not set an arbitrary deadline applicable to all defendants.

C. *Mink*

In 2003, the Ninth Circuit of the United States Court of Appeals decided that IST defendants in Oregon had a constitutional due process right to be transferred from county jail to the state hospital for treatment in a timely manner. (*Oregon Advocacy Center v. Mink* (9th Cir.2003) 322 F.3d 1101, 1119–1123 (*Mink*).) In *Mink,* the federal district court found the due process rights of IST defendants were being violated because they were not being promptly transferred to the state hospital. It therefore imposed an injunction, applicable statewide, requiring the state hospital to admit IST defendants within seven days after the determination of incompetence had been made. (*Id.* at pp. 1107 & 1122, fn. 13.) The district court based the seven-day deadline on an Oregon statute. That statute provided: "When a court determines that a defendant lacks fitness to proceed and commits the defendant to the custody of the [state hospital], the defendant shall be transported to the hospital ... as soon as practicable. Transport shall be completed within seven days after the court's determination unless doing so would jeopardize the

health or safety of the defendant or others....” (Or.Rev.Stat. former § 161.370(3) (1999).) Because the legislature had chosen the seven-day time limit, the *Mink* court rejected the state hospital's argument that the time limit was an abuse of discretion. (*Mink, supra,* at p. 1122, fn. 13.)

D. *Mille*

In 2010, the Court of Appeal (Division Three of the Second Appellate District) discussed the application of Penal Code section 1370 and constitutional due process in *In re Mille* (2010) 182 Cal.App.4th 635, 105 Cal.Rptr.3d 859 (*Mille*). In that case, an IST defendant filed a petition for writ of habeas corpus in the trial court because he had not yet been transported to the Department 30 days after he was committed under Penal Code section 1370. The court denied the petition, finding no due process violation. (*Id.* at p. 640, 105 Cal.Rptr.3d 859.) The defendant refiled the petition in the Court of Appeal, where it was denied summarily, but the Supreme Court granted review and transferred the case back to the Court of Appeal to determine whether the defendant's due process rights had been violated even though the case had become moot because the defendant had been transported to the Department. (*Id.* at pp. 640–641, 105 Cal.Rptr.3d 859.)

On remand, the Court of Appeal held that the deadline for transporting the defendant to the Department, consistent with due process, was subject to the “basic premise” that the defendant could not be held for more than a reasonable period of time as discussed in *Jackson* and *Davis.* The court wrote that “[w]hat constitutes a reasonable length of time will vary with the context,” and, citing *Jackson* 's caution that it should not attempt to prescribe arbitrary time limits, it concluded the trial court should have ordered the sheriff to deliver the defendant to the state hospital when the defendant filed his petition for writ of habeas corpus 30 days after the commitment order. (*Mille, supra,* 182 Cal.App.4th at pp. 649–650, 105 Cal.Rptr.3d 859.) “[T]he court must also ensure that the defendant is actually transferred to the state hospital within a reasonable period of time.” (*Id.* at p. 650, 105 Cal.Rptr.3d 859.)

***13** The *Mille* court did not cite or discuss *Mink.*

When the trial court in this case made its 2013 order, *Mille* was binding precedent. “Decisions of every division of the District Courts of Appeal are binding upon all the justice and municipal courts and upon all the superior courts of this state, and this is so whether or not the superior court is acting as a trial or appellate court. Courts exercising inferior jurisdiction must accept the law declared by courts of superior jurisdiction.” (*Auto Equity Sales, Inc. v. Superior Court* (1962) 57 Cal.2d 450, 455, 20 Cal.Rptr. 321, 369 P.2d 937.)

E. Current Statutory Scheme in California

In its current form, Penal Code section 1370 gives the Department 90 days after commitment to report to the superior court on whether an IST defendant has regained competence or is substantially likely to regain competence in the foreseeable future. (Pen.Code, § 1370, subd. (b)(1).) The California Legislature has enacted no statute like the one in Oregon requiring delivery of a defendant to the Department within a specific number of days after the order of commitment.

II

The Proceedings

In 2006, the Sacramento County Superior Court imposed an “Order Granting Habeas Corpus” in the case of four IST defendants whose delivery to the Department for evaluations had been improperly delayed. The court held an evidentiary hearing concerning not just the status of the defendants at issue but of the circumstances of the county jails and Department, such as availability of beds and treatment options for IST defendants. The court's order summarized the testimony and quoted much of *Mink.*

In its 2006 order, the superior court found that IST defendants were being held in county jail for months while waiting for transportation to the Department; they received psychiatric medications in county jail but did not receive treatment toward restoring competency; under policies then in place IST defendants were to be transported to Napa State Hospital (and there was no alternative); and, in some cases, the court delayed in providing the intake packet required by Penal Code section 1370. The Sacramento County Sheriff (sheriff) was not transporting these defendants to Napa State Hospital because Napa State Hospital had informed the sheriff that no beds were available.

Holding that it was “abundantly clear that the constitutional rights of felony Penal Code § 1370 committees are being

violated as each day passes and they remain in the Sacramento County Jail awaiting transfer to a state hospital," the court directed the sheriff to "deliver to Napa State Hospital all felony Penal Code § 1370 committees ordered committed to Napa State Hospital pursuant to that statute, within seven days of the order of commitment" and directed Napa State Hospital to "accept delivery of those Penal Code § 1370 committees, house them, and give them treatment...."

The Department sought clarification of the order. In doing so, the Department reminded the court that (1) the court must prepare the intake packets before the defendants could be admitted to the Department and (2) the court failed to provide intake packets for some defendants months after the order of commitment. In response to the motion, the superior court changed its order. Instead of ordering transportation to Napa State Hospital within seven days after commitment, the court ordered the sheriff to deliver IST defendants to Napa State Hospital "within seven days of the order of commitment, unless the defendant's intake package ... has not been prepared, in which case the Sheriff shall deliver the defendant to the designated state hospital as soon as the package is made available."

***14** The Department did not appeal.

Contempt proceedings were initiated against the Department in 2013 for failure to accept IST defendants within the time provided in the court's 2006 order. The Department responded by asking the superior court to dissolve the permanent injunction imposed by the 2006 order because changed circumstances had rendered the Department unable to comply with the order.

In support of its motion to dissolve the injunction and in opposition to the order to show cause, the Department submitted a request for judicial notice, including similar actions in other superior courts. In Yolo County, for example, the superior court has ordered the Department to admit IST defendants within 30 days after the commitment order. The Department also filed declarations informing the court of increases each year in admissions of IST defendants while, at the same time, the number of beds did not increase. As a result of the 2006 order, defendants from Sacramento County gained preference for admission to the Department over defendants from other counties. Additionally, Sacramento County has three to five times more IST defendants than other Northern California counties of similar population, indicating a possible problem in court-appointed trial competency evaluations. Because of the lack of resources, the Department was unable to comply with the 2006 order.

The Department argued that the superior court could not hold the Department in contempt because it did not have the ability to comply with the order, and the Department asked the court to discharge the order to show cause. (See *In re Jones* (1975) 47 Cal.App.3d 879, 881, 120 Cal.Rptr. 914 [ability to comply an element of valid contempt judgment].)

The superior court ordered the Department to provide evidence that the defendants named in the contempt proceeding had been delivered to the Department. While the court did not dissolve the permanent injunction, it found that circumstances had changed, requiring a change in the injunction. It wrote:

"With regard to [the Department's] motion to vacate [the 2006 order], the court recognizes the future needs of the Department of State Hospitals to have uniformity of accepting transferred Penal Code § 1370 committees to the state hospitals within a timely fashion, and that the seven-day deadline set forth in the [2006 order] may be unrealistic in light of the severe budget cuts suffered in a plethora of state agencies in the past few years. Nevertheless, this court remains firm in its stance that the Legislature and due process require prompt delivery of Penal Code § 1370 committees, within a reasonable period of time as noted in *In re Mille* (2010) 182 Cal.App.4th 635, 105 Cal.Rptr.3d 859. The parties should be aware that the [2006 order] requires delivery within *either* seven days *or immediately* upon preparation of the Penal Code § 1370 intake package if not prepared within the seven-day period. There is no seven-day period allowed following preparation of the Penal Code § 1370 intake package, if it is not prepared in the initial seven-day period.

***15** "In light of the concerns voiced by [the Department] at the hearing, the court will now modify its [2006 order] to extend the seven-day period to instead be a 14–day period, which should be sufficient to allow the Department to not only realistically meet this deadline for the Sacramento defendants committed under Penal Code § 1370, but also on a statewide basis."

This time, the Department appealed.

Despite the notice of appeal and the superior court's resulting loss of jurisdiction over the permanent injunction, the

superior court has continued to tinker with the permanent injunction, as noted in the majority opinion.

III

Change in Circumstances Permitting Dissolution or Modification

The majority declines to consider the legal merit of the superior court's original injunction because (1) the Department did not appeal the order and (2) there was no change of facts or law between the 2006 order and the 2013 petition to find the Department in contempt. The former is true—there was no appeal—but the latter is not. In the superior court, the Department asserted there had been a change of facts and law, and the superior court so found, thus justifying its modification of the permanent injunction. At oral argument on appeal, the parties agreed that there had been a change of facts allowing the superior court to modify the permanent injunction.

The law allows dissolution or modification of a permanent injunction if there is a material change in the facts or law relating to the injunction or if the ends of justice would be served by dissolution or modification.[2] (Code Civ. Proc., § 533.) In justifying its own modification of the permanent injunction, the superior court found a material change of facts —that is, the fiscal shortages in the past few years have made it impossible for the Department to admit IST defendants within seven days after commitment.

On appeal, neither party argues that there was no material change of facts or law. That leaves the superior court's finding that there was a material change unchallenged. Incongruously, however, the majority turns this absence of argument into a forfeiture of the issue by the Department. The logic of this position escapes me. The Department does not assert, either explicitly or implicitly, that the superior court erred by finding a change in the material facts. And there is no requirement in reason or law for the Department to raise or contest that settled issue on appeal.

In addition to the facts, the law relating to the 2006 order changed materially when Division Three of the Second Appellate District decided *Mille,* which became precedent, binding on the superior court in this case. I explain below, regarding the merits of the 2013 order, why I believe the *Mille* decision represents a change in the law requiring dissolution of the 2013 order.[3]

***16** Therefore, my view of what is in play in this appeal departs from the majority's view. I would conclude that there was a material change in the facts and law relating to the 2006 order. Because the Department agreed with superior court that there was a change, at least in the material facts, there was no need to spend its appellate resources in establishing that condition for dissolution or modification of the 2006 order. Consequently, the Department did not forfeit a challenge of the 2013 order, and we must determine whether the superior court abused its discretion in denying the motion to dissolve the permanent injunction.

IV

The Merits of the Permanent Injunction as Imposed in 2013

On the merits, I would find that the superior court abused its discretion in denying the motion to dissolve the permanent injunction. Neither the injunction as originally ordered in 2006 nor the modified injunction ordered in 2013 properly, or even rationally, protects the constitutional rights of IST defendants.

The standard for reviewing the denial of a motion to dissolve an injunction is abuse of discretion. " ' "It is a rule so universally followed and so often stated as to need only to be referred to that the granting, denial, dissolving or refusing to dissolve a permanent or preliminary injunction rests in the sound discretion of the trial court upon a consideration of all the particular circumstances of each individual case" ' and 'will not be modified or dissolved on appeal except for an abuse of discretion.' [Citation.]" (*Salazar v. Eastin* (1995) 9 Cal.4th 836, 849–850, 39 Cal.Rptr.2d 21, 890 P.2d 43.)

Applying the abuse of discretion standard, I would conclude that the permanent injunction is arbitrary and capricious because: (1) it is unhinged from constitutional due process doctrine and inconsistent with precedent binding on the superior court, (2) it ignores the rights of IST defendants when the superior court fails to prepare the intake packet, and (3) it forces the Department to give defendants from Sacramento County, but one of 58 counties, preference when resources are limited.

A. Constitutional Due Process

At the time the superior court made its 2013 order, Penal Code section 1370, subdivision (b)(1) provided: "Within 90 days of a commitment made pursuant to subdivision (a), the medical director of the state hospital or other treatment facility to which the defendant is confined shall make a written report to the court...." (Stats.2012, ch. 24, § 27.) It did not, and still does not, provide a time limit for transporting the IST defendant from the county jail to wherever the defendant will go for evaluation and preparation of the report to the court and for treatment to restore capacity.

Because there is no statutory right to be transported to the Department within 14 days after the superior court orders commitment, the only theoretical basis for the 2006 and 2013 orders is the constitutional right to be free of unlawful restraint on liberty, a due process right. The superior court's 2006 order was that all IST defendants must be delivered to the Department within seven days after the order of commitment. The necessary conclusion is that, in 2006, the superior court believed that the constitutional due process rights of those committed were violated when they were not delivered to the Department within seven days. By 2013, those constitutional rights had changed, in the superior court's view, because the rights would not be violated unless it took more than 14 days to deliver the defendant to the Department. The only reason the superior court gave for the change was the Department's shortage of resources. [4]

***17** The actual constitutional requirement on these matters is quoted in *Mille, supra,* 182 Cal.App.4th at page 638, 105 Cal.Rptr.3d 859:

"A 'person charged by a State with a criminal offense who is committed solely on account of his incapacity to proceed to trial *cannot be held more than the reasonable period of time* necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future.' [Citations to *Jackson* and *Davis.*]" (*Mille, supra,* 182 Cal.App.4th at p. 638, 105 Cal.Rptr.3d 859, original italics.)

The "reasonable period of time" applies to the whole process to "determine whether there is a substantial probability" that the defendant will soon have capacity to stand trial. Therefore, the 2013 order was arbitrary, as proved by the court itself when it modified the 2006 order for no reason other than lack of agency resources. The 2013 order also assumes that every case is substantially the same. This is the type of uniform but arbitrary time limit rejected in *Jackson, supra,* 406 U.S. at page 738, 92 S.Ct. 1845.

The majority credits the 2006 and 2013 orders as being consistent with *Mille's* holding that constitutional due process requires an IST defendant to be transported to the Department "within a reasonable period of time." (*Mille, supra,* 182 Cal.App.4th at p. 650, 105 Cal.Rptr.3d 859.) The majority concludes: "Nothing in *Mille* changes the law so as to classify the trial court's refusal to dissolve the Osburn Order as an abuse of discretion." (Maj. opn., *ante,* at p. ——.)

This view that the 2006 and 2013 orders are "consistent" with *Mille* misses the point. [5] *Mille* dealt with what constitutional due process requires, which is transfer to the Department and evaluation within a "reasonable period of time," a period that "will vary with the context." (*Mille, supra,* 182 Cal.App.4th at p. 649, 105 Cal.Rptr.3d 859.) In other words, constitutional due process does not prescribe a set number of days to be applied in every instance.

Reliance on *Mink* for a seven-day or 14–day rule is particularly irrational. In that case, the federal courts (trial and appellate) concluded, based on an Oregon statute requiring delivery of an IST defendant to the state hospital within seven days, that IST defendants in that state had a due process right to be delivered within seven days. Applying *Mink* here effectively bases California IST defendants' due process rights on an Oregon statute. We are not bound by the decisions of the Ninth Circuit Court of Appeals, even on constitutional issues. (*People v. Bradley* (1969) 1 Cal.3d 80, 86, 81 Cal.Rptr. 457, 460 P.2d 129.) And in this case there are good reasons not to follow *Mink* which is state-specific and code-specific in its analysis and remedy.

***18** Because the 2013 order is unhinged from the requirements of constitutional due process, which is the only basis for the order, I would conclude that it is arbitrary and capricious and, thus, an abuse of discretion. Beyond the precedential dimensions of the order, however, there are additional reasons to conclude that it was an abuse of discretion.

B. Intake Packets and Impossible Burdens

While the 2013 order imposes a duty on the Department to accept an IST defendant within 14 days after the commitment order, there is a gaping hole in the order that potentially

allows a defendant to languish in county jail long after any reasonable period of time to transfer the defendant to the Department has expired. That gaping hole is the exception that there is no duty to transfer an IST defendant unless the superior court gives the Department an intake packet. In this case, for example, it took the superior court 42 days to deliver the packet for one of the IST defendants to the Department.

The 2013 order also imposes an impossible burden on the sheriff. If, outside the initial 14–day period, the court prepares an intake packet and makes it available to the Department, the sheriff is in violation of the order as soon as the Department receives the packet. The problem is that the sheriff cannot transport the IST defendant until the Department tells the sheriff where to transport the defendant, and the Department cannot determine where to place the defendant until the superior court provides the packet and the Department has a reasonable opportunity to assess the packet and select a facility for the IST defendant.

These are problems that may be susceptible to legislative resolution, applicable to all cases, but the superior court is not equipped to foresee all the eventualities and provide an all-inclusive remedy. This is evident from the superior court's ongoing tweaking of the permanent injunction.

The judicial remedy imposed by the 2013 order and its permanent injunction is broadly applicable to Sacramento County IST defendants, but poorly focused. That is like prescribing aspirin to treat every illness. It may be helpful in some cases, but it may be harmful in others. In any event, it is no way to run a clinic. The problem of failure to transfer any particular IST defendant to the Department within a reasonable period of time should be addressed in individual petitions for writ of habeas corpus. In those proceedings, the court can consider the specific needs of the defendant and the legislative requirement that the Department report back to the superior court within 90 days after commitment, as well as any other considerations that affect the due process rights of the defendant. Such defendants are not without a remedy if the 2013 permanent injunction is dissolved.

C. Preference for Sacramento County Defendants

Finally, the order pertains only to a relatively small fraction of statewide IST defendants. It applies only to Sacramento County IST defendants.

The Chief of Business Management for the Department said in his declaration: “Setting aside the *Osburn* order, as well as the [Yolo County] order, will enable [the Department] to apply a uniform triage process for the equitable admission of IST [defendants] referred from counties.”

A staff psychiatrist at the Department said in her declaration: “Because Sacramento has a seven-day transfer timeline for its IST patients, Sacramento IST patients are admitted before IST patients from counties without such orders and those IST patients from other counties must wait longer (sometimes months longer) for admission.”

***19** There is no rational or constitutional justification for affording Sacramento County's IST defendants preference over defendants from other counties. Indeed, the effect of doing so is to encourage other superior courts, like Yolo County, to impose their own arbitrary orders on the beleaguered Department. Chaos ensues.

V

Appropriate Remedy

The appropriate remedy for the general problem lies in the legislative and administrative processes of the state and its counties, not in the courts. As the experience with the superior court's 2006 and 2013 orders has shown, any general remedy from the courts will be arbitrary and uneven.

That is not to say that the superior court is powerless to provide remedies for actual due process violations. The writ of habeas corpus is available to contest an unlawful restraint on liberty.

“Although in form the Great Writ is simply a mode of procedure, its history is inextricably intertwined with the growth of fundamental rights of personal liberty. For its function has been to provide a prompt and efficacious remedy for whatever society deems to be intolerable restraints. Its root principle is that in a civilized society, government must always be accountable to the judiciary for a man's imprisonment: if the imprisonment cannot be shown to conform with the fundamental requirements of law, the individual is entitled to his immediate release.” (*Fay v. Noia* (1963) 372 U.S. 391, 401–402, 83 S.Ct. 822, 828–829, 9 L.Ed.2d 837, 846–847.)

Two last matters bear mentioning. First, the superior court's permanent injunction is not a habeas corpus proceeding as to each IST defendant. Therefore, the only way to enforce the order is by contempt proceedings. But the Department cannot be held in contempt if it is unable to comply with the permanent injunction. (See *In re Jones, supra*, 47 Cal.App.3d at p. 881, 120 Cal.Rptr. 914.) And second, in habeas corpus proceedings IST defendants cannot be released based on a violation of due process rights unless they establish that (1) they have been held more than the reasonable period of time necessary to determine whether there is a substantial probability that they will attain the capacity to stand trial in the foreseeable future or (2) their continued commitment is not justified by progress toward that goal. (*Davis, supra*, 8 Cal.3d at pp. 801, 804, 106 Cal.Rptr. 178, 505 P.2d 1018; *Jackson, supra*, 406 U.S. at p. 738, 92 S.Ct. 1845.) Violation of a permanent injunction does not establish a constitutional violation requiring release.

Here, it was an abuse of discretion to do anything other than to dissolve the injunction because it imposes arbitrary deadlines under the guise of constitutional compulsion. I would dissolve the 2013 order imposing a permanent injunction and remand for individual habeas corpus proceedings.

Parallel Citations

15 Cal. Daily Op. Serv. 2635, 2015 Daily Journal D.A.R. 3028

Footnotes

* People v. Juan Harrison (No. 13F03657); People v. Chaderick Ingram (No. 12F06567); People v. Pathom Ketphanh (No. 13F01635); People v. Daniel Maciuca (No. 13F02539); People v. Don Clemens (No. 13F04065); People v. Tony Cooper (No. 13F03283); People v. Christopher Dargen (Nos. 09F08924, 11F05776, 13M02488); People v. Timothy Dobrinen (No. 13F03068); People v. Gregory Gunter (No. 13F03155); People v. Troy Charles (No. 13F03363); and People v. Gary Wright (Nos. 11F00627, 12F00076, 12F05014, 13F02691).

1 Further undesignated statutory references are to the Penal Code.

2 As we discuss *post*, the Legislature recently added medical records to the list of documents required to be included in the 1370 packet.

1 Hereafter, I refer to the State Department of State Hospitals as “the Department.”

2 “In any action, the court may on notice modify or dissolve an injunction or temporary restraining order upon a showing that there has been a material change in the facts upon which the injunction or temporary restraining order was granted, that the law upon which the injunction or temporary restraining order was granted has changed, or that the ends of justice would be served by the modification or dissolution of the injunction or temporary restraining order.” (Code Civ. Proc., § 533.)

3 While it is unnecessary to go so far, I would also conclude that the ends of justice require modifying or dissolving the permanent injunction because of the widespread, detrimental effect the injunction has had, as described below. (Code Civ. Proc., § 533.)

4 The modification from seven days to 14 days raises the question, unanswered by the superior court, whether constitutional due process rights are dependent on an agency's resources. I doubt it.

5 If we were reviewing legislation requiring transfer of a defendant found incompetent to stand trial within 14 days after commitment, we would approach the question of its validity differently and would uphold it unless it was inconsistent with due process rights. That approach would be required because of the legislative powers involved. Here, on the other hand, the superior court has no such legislative powers and can impose only what the statutes and constitution require.