SENATE COMMITTEE ON PUBLIC SAFETY

Senator Loni Hancock, Chair
2015 - 2016 Regular

Bill No:	SB 955	**Hearing Date:**	April 19, 2016
Author:	Beall		
Version:	April 4, 2016		
Urgency:	No	**Fiscal:**	Yes
Consultant:	JM		

Subject: ***State Hospital Commitment: Compassionate Release***

HISTORY

Source: Union of American Physicians and Dentists

Prior Legislation: SB 1399 (Leno) Ch. 495, Stats. 2010
AB 29 (Villaraigosa) Ch. 751, Stats. 1997

Support: American Federation of State, County, and Municipal Employees, AFL-CIO; American Federation of State, County, and Municipal Employees Local 2620; American Civil Liberties Union; California Association of Psychiatric Technicians; California Public Defenders Association; California Psychiatric Association; California Attorneys for Criminal Justice; Disability Rights California; National Association of Social Workers, California Chapter; Legal Services for Prisoners with Children

Opposition: California District Attorneys Association; California State Sheriffs' Association

PURPOSE

The purpose of this bill is to enact a process for compassionate release from the Department of State Hospitals (DSH) for a person who has been involuntarily committed to DSH but becomes now terminally ill, permanently medically incapacitated, not dangerous and not likely to live more than six months, as specified.

Existing law includes a number of "forensic" civil commitment schemes for persons who have been in the criminal justice system, have a mental disorder that caused or contributed to the persons' criminal conduct and are involuntarily committed to the Department of State Hospitals for treatment. These include persons who are incompetent to stand trial (IST), not guilty by reason of insanity (NGI), mentally disordered offender-parolees (MDO) and sexually violent predators (SVP). The maximum period of confinement for treatment varies with the category of forensic patient, but generally lasts for the length of time necessary to treat the person's condition, with limits determined by the maximum criminal sentence for the underlying conduct in the case of an IST or NGI patient. MDO and SVP patients are subject to recommitment hearings, as specified. (Pen. Code §§ 1026, 1367, 2980; Welf. & Inst. Code § 6600 .)

Existing law allows a state prison inmate to be treated in a DSH facility. California Department of Corrections and Rehabilitation (CDCR) can recommend that a mentally ill prisoner be transferred to DMH if recovery can be expedited by treatment at a DMH hospital. DMH must determine if the inmate would benefit from treatment. DMH shall keep the inmate until the inmate will not benefit from further treatment. (Pen. Code § 2684.)

Existing law provides that if the Secretary of the Department of Corrections and Rehabilitation or the Board of Parole Hearings or both determine that a prisoner is either:

- Terminally ill with an incurable condition caused by an illness or disease that would produce death within six months, as determined by a physician employed by the department; or
- The prisoner is permanently medically incapacitated with a medical condition that renders him or her permanently unable to perform activities of basic daily living, and results in the prisoner requiring 24-hour total care, including, but not limited to, coma, persistent vegetative state, brain death, ventilator-dependency, loss of control of muscular or neurological function, and that incapacitation did not exist at the time of the original sentencing;
- And that the conditions under which the prisoner would be released or receive treatment do not pose a threat to public safety;
- The secretary or the board may recommend to the court that the prisoner's sentence be recalled and that the court shall have the discretion to resentence or recall if the court finds that the facts described above exist. (Pen. Code §§ 1170, subd. (e)(1) and (e)(2).)

Existing law provides that any physician employed by the department who determines that a prisoner has six months or less to live shall notify the chief medical officer of the prognosis. If the chief medical officer concurs with the prognosis, he or she shall notify the warden. Within 48 hours of receiving notification, the warden or the warden's representative shall notify the prisoner of the recall and resentencing procedures, and shall arrange for the prisoner to designate a family member or other outside agent to be notified as to the prisoner's medical condition and prognosis, and as to the recall and resentencing procedures. If the inmate is deemed mentally unfit, the warden or the warden's representative shall contact the inmate's emergency contact and provide the information described above, as specified. (Pen. Code §1170, subd. (e)(4).)

Existing law provides that the warden or the warden's representative shall provide the prisoner and his or her family member, agent, or emergency contact, updated information throughout the recall and resentencing process with regard to the prisoner's medical condition and the status of the prisoner's recall and resentencing proceedings. (Pen. Code § 1170, subd. (e)(5).)

Existing law provides that the prisoner or his or her family member or designee may independently request consideration for recall and resentencing by contacting the chief medical officer at the prison or the secretary. Upon receipt of the request, the chief medical officer and the warden or the warden's representative shall follow the procedures described above. If the secretary determines that the prisoner satisfies the criteria for sentencing recall described above, the secretary or board may recommend to the court that the prisoner's sentence be recalled. The secretary shall submit a recommendation for release within 30 days in the case of inmates sentenced to determinate terms and, in the case of inmates sentenced to indeterminate terms, the secretary shall make a recommendation to the Board of Parole Hearings with respect to the inmates who have applied under this section. The board shall consider this information and

make an independent judgment of eligibility and make findings related thereto before rejecting the request or making a recommendation to the court. This action shall be taken at the next lawfully noticed board meeting. (Pen. Code §1170, subd. (e)(6).)

Existing law provides that any recommendation for recall submitted to the court by the secretary or the Board of Parole Hearings shall include one or more medical evaluations, a postrelease plan, and findings pursuant to paragraph (2). (Pen. Code §1170 (e)(7).)

Existing law provides that, if possible, the matter shall be heard before the same judge of the court who sentenced the prisoner. (Pen. Code §1170, subd. (e)(8).)

Existing law provides that if the court grants the recall and resentencing application, the prisoner shall be released by the department within 48 hours of receipt of the court's order, unless a longer time period is agreed to by the inmate. At the time of release, the warden or the warden's representative shall ensure that the prisoner has each of the following in his or her possession: a discharge medical summary, full medical records, state identification, parole medications, and all property belonging to the prisoner. After discharge, any additional records shall be sent to the prisoner's forwarding address. (Pen. Code §1170, subd. (e)(9).)

Existing law provides that the secretary shall issue a directive to medical and correctional staff employed by the department that details the guidelines and procedures for initiating a recall and resentencing procedure. The directive shall clearly state that any prisoner who is given a prognosis of six months or less to live is eligible for recall and resentencing consideration, and that recall and resentencing procedures shall be initiated upon that prognosis. (Pen. Code § 1170, subd. (e)(10).)

This bill gives the court that committed the person to DSH the sole discretion to dismiss a DSH patient's commitment for compassionate release when specified criteria are met.

This bill specifically extends compassionate release to DSH patients committed as NGI.

This bill provides that where an MDO patient meets the requirements for compassionate release, DSH shall inform the Board of Parole Hearings and DSH shall stop treating the patient.

This bill does not include specific references to patients in any other categories of commitment other than the MDO and NGI programs.

This bill requires a physician employed by DSH to notify the DSH medical director and the patient advocate when a prognosis is made of a patient being eligible for compassionate release.

This bill does not limit the categories of patients that physicians and medical directors shall review to determine if patients meet the criteria for compassionate release.

This bill requires the medical director to notify the DSH Director if he or she concurs with the prognosis that a patient meets the criteria for compassionate release. The DSH Director or a designee shall to notify the patient of the discharge procedures and to obtain the patient's consent.

This bill requires the DSH Director or a designee to arrange for a patient to designate a family member, outside agent, emergency contact, or the patient advocate to be notified of the patient's

medical condition, prognosis, and release procedures, and to provide those individuals with updated information throughout the process.

This bill allows a patient or his or her family member or designee to contact the DSH medical director or director of the state hospital where the patient is located, or the DSH Director, to request consideration for a recommendation from the DSH Director to the court that the patient's commitment be dismissed for compassionate release.

This bill requires the court to hold a hearing within 10 days of receiving a recommendation from DSH for compassionate release. The hearing shall be held before the same court that originally committed the patient, if possible. The court shall determine whether the patient's release would pose a threat to public safety.

This bill requires that a recommendation to the court shall include at least the following:

- A medical evaluation;
- Discharge plan; and
- Post-release plan for the relocation and treatment of the patient.

This bill requires the court to order the DSH medical director to send copies of all medical records reviewed in developing the recommendation to the district attorney of the county from which the patient was committed and to the public defender of the county of commitment or the patient's private attorney.

This bill requires the DSH Director to release a patient from DSH confinement where the court finds that the patient meets the following criteria:

- The patient is terminally ill with an incurable condition caused by an illness or disease that would likely produce death within six months;
- The patient is permanently medically incapacitated and requires 24-hour total care, and the medical director responsible for the patient's care and the DSH Director both certify that the patient is incapable of receiving mental health treatment; or
- The release conditions do not pose a threat to public safety.

This bill requires DSH to release a patient within 72 hours of receipt of the court's order for release unless a longer time period is requested by the director and approved by the court.

This bill requires the DSH Director or a designee to ensure that upon release the patient or the patient's representative has the following in his or her possession: a discharge plan, discharge medical summary, medical records, identification, all necessary medications, and any property belonging to the patient.

This bill requires any additional records to be sent to the patient's forwarding address after discharge.

This bill provides that these provisions do not preclude a patient who is granted compassionate release from being committed to a state hospital under the same commitment or another commitment.

RECEIVERSHIP/OVERCROWDING CRISIS AGGRAVATION

For the past several years this Committee has scrutinized legislation referred to its jurisdiction for any potential impact on prison overcrowding. Mindful of the United States Supreme Court ruling and federal court orders relating to the state's ability to provide a constitutional level of health care to its inmate population and the related issue of prison overcrowding, this Committee has applied its "ROCA" policy as a content-neutral, provisional measure necessary to ensure that the Legislature does not erode progress in reducing prison overcrowding.

On February 10, 2014, the federal court ordered California to reduce its in-state adult institution population to 137.5% of design capacity by February 28, 2016, as follows:

- 143% of design bed capacity by June 30, 2014;
- 141.5% of design bed capacity by February 28, 2015; and,
- 137.5% of design bed capacity by February 28, 2016.

In December of 2015 the administration reported that as "of December 9, 2015, 112,510 inmates were housed in the State's 34 adult institutions, which amounts to 136.0% of design bed capacity, and 5,264 inmates were housed in out-of-state facilities. The current population is 1,212 inmates below the final court-ordered population benchmark of 137.5% of design bed capacity, and has been under that benchmark since February 2015." (Defendants' December 2015 Status Report in Response to February 10, 2014 Order, 2:90-cv-00520 KJM DAD PC, 3-Judge Court, *Coleman v. Brown, Plata v. Brown* (fn. omitted).) One year ago, 115,826 inmates were housed in the State's 34 adult institutions, which amounted to 140.0% of design bed capacity, and 8,864 inmates were housed in out-of-state facilities. (Defendants' December 2014 Status Report in Response to February 10, 2014 Order, 2:90-cv-00520 KJM DAD PC, 3-Judge Court, *Coleman v. Brown, Plata v. Brown* (fn. omitted).)

While significant gains have been made in reducing the prison population, the state must stabilize these advances and demonstrate to the federal court that California has in place the "durable solution" to prison overcrowding "consistently demanded" by the court. (Opinion Re: Order Granting in Part and Denying in Part Defendants' Request For Extension of December 31, 2013 Deadline, NO. 2:90-cv-0520 LKK DAD (PC), 3-Judge Court, *Coleman v. Brown, Plata v. Brown* (2-10-14). The Committee's consideration of bills that may impact the prison population therefore will be informed by the following questions:

- Whether a proposal erodes a measure which has contributed to reducing the prison population;
- Whether a proposal addresses a major area of public safety or criminal activity for which there is no other reasonable, appropriate remedy;
- Whether a proposal addresses a crime which is directly dangerous to the physical safety of others for which there is no other reasonably appropriate sanction;
- Whether a proposal corrects a constitutional problem or legislative drafting error; and
- Whether a proposal proposes penalties which are proportionate, and cannot be achieved through any other reasonably appropriate remedy.

COMMENTS

1. Need for This Bill

According to the author:

> Currently, the state's compassionate release program only covers DSH patients who are committed from state prison. First, this creates an inequity for other DSH patients who would like to spend the last months of their lives with their families and loved ones, but are not able to apply for the program. Second, it also creates unnecessary costs. End-of-life care can be very expensive, and when a state hospital patient requires such care, the department is responsible for 100 percent of the costs. If these patients were instead receiving medical care in the community, they would be eligible for a variety of federal matching programs (such as Medi-Cal, Medicare, and Social Security). Third, these patients are often unable to benefit from treatment because of their medical condition (for example, a coma), but are occupying beds in the state hospitals that could otherwise be used to provide treatment to patients who are awaiting transfer to a state hospital (the state hospitals consistently have a waiting list for treatment).
>
> This bill creates a compassionate release program for all state hospital patients who are not covered by the current compassionate release program. SB 955 would authorize the DSH to petition for the compassionate release of state hospital patients. Specifically, this bill would authorize DSH to petition a patient's committing court to release the patient from his or her commitment if the patient is terminally ill and likely to die within six months or permanently incapacitated.

2. Forensic Commitments of Persons From the Criminal Justice System to DSH

Existing law includes procedures and substantive rules for involuntary commitment to DSH of a person from the criminal justice system of a defendant who has a mental disorder that renders him or her incompetent to stand trial or too dangerous to release without treatment. The major categories of forensic patients are described below.

- Incompetent to Stand Trial: A criminal defendant who, because of a mental disorder, can neither understand the court process nor assist his attorney in conducting his defense is incompetent to stand trial or face punishment. An IST defendant is returned to court upon restoration of competency. (Pen Code § 1367 et seq.)

- Not Guilty by Reason of Insanity (NGI): One is NGI if he or she has a mental disorder rendering him or her incapable of knowing or understanding the nature and quality of the charged act, or he or she could not distinguish right from wrong at the time of the offense. (Pen. Code §§ 25 and 1026 et seq.)

    - An NGI defendant is committed to a state hospital for treatment. He or she can be held as long as the sentence for crime for which the not guilty by reason of insanity verdict was rendered.
    - An NGI defendant can petition for release on the grounds that his or her sanity has been restored. The NGI defendant has the burden of proof in a hearing in the superior court in which the defendant was tried. (Pen. Code §§ 1026, subd. (b), 1026.2)

- An NGI patient can be confined for as long as the maximum sentence for the underlying offense. At the expiration of the normal maximum confinement time, the commitment can be extended if the person's mental disorder makes him or her a danger of substantial harm to others. (Pen. Code § 1026.5, subd. (b).)

- Mentally Disordered Offenders (MDO

An MDO is an inmate who committed a specified violent crime that was caused or exacerbated by his or her mental disorder and who cannot be safely released into society. An MDO is involuntary committed for treatment during parole. The commitment can be extended without limitation in one-year increments. (Pen. Code § 2960 et seq.

- Sexually Violent Predators

An SVP is a person who has committed a specified sex crime and has a mental disorder that renders him likely to violent sex crimes if released. At the time an SVP would otherwise be released on parole, he is indeterminately committed for treatment in a state hospital. Annual evaluations are performed to assess the person's status as an SVP.

3. Unclear Provisions About Which Patients are Eligible for Compassionate Release and the Process for Release of MDO Patients

This bill appears to apply to patients who were found not guilty by reason of insanity or were determined during incarceration to be mentally disordered offenders. However, the classes or categories of patients eligible for compassionate release are not entirely clear.

The provisions directing DSH physicians to review patients for compassionate release eligibility appear to apply to all patients, regardless of commitment category. However, the bill amends two sections of the Penal Code governing commitments of NGI defendants and MDO parolees. The bill does not similarly amend the operative statutes concerning patients in any other DSH commitment programs, including the SVPs, IST defendants and non-forensic (LPS)[1] commitments.

The provisions concerning NGI patients specifically give the court that committed an NGI defendant the authority to release him or her on compassionate release. As to MDO patients, the bill specifically directs the Board of Parole Hearings and DSH discontinue treatment of an MDO "prisoner" who meets the criteria for compassionate release. However, it would appear that after an MDO is retained in treatment upon expiration of parole, BPH would not be involved in the matter. Prior to expiration of parole, an MDO patient could have been committed by BPH or the court. The initial order for treatment is made by BPH, but an inmate pending parole has a right to a jury trial on the issue.

The bill *does* specifically provide that the court that committed the patient to DSH shall rule on the petition or request for compassionate release. The bill also provides that notice must be given to the district attorney in the county of commitment, indicating that the bill would not apply to LPS patients.

[1] Lanterman-Petris-Short Act. (Welf. & Inst. Code § 5000 et seq.)

In its current form, the bill would likely be difficult to implement. Courts asked to review a petition or request for compassionate release would face a difficult task in interpreting and applying the bill. It is recommended that the bill be amended to clarify the patients to whom it applies and the procedures applicable to MDO patients.

SHOULD THE BILL BE AMENDED TO CLARIFY THE PATIENTS TO WHOM IT APPLIES AND CLARIFY THE PROCESS APPLICABLE TO MDO PATIENTS?

4. Relatively few Recommendations for Compassionate are Made by CDCR; Courts Reject Approximately One-third of CDCR Recommendations

Between 1991 and 2006, 833 compassionate release cases were considered by CDCR. CDCR referred 411 cases to the court with a recommendation for sentence recall (53%). Courts recalled 275 sentences for compassionate release. Those actually released constituted 33% of the total considered and 67% of those recommended by CDCR to the court. (Assembly Appropriations Committee analysis of AB 1539 (Krekorian), 2007.)

5. Likely Limited Use of This Bill

DSH housed and treated approximately 9,400 patients in 2014. According to the April 4, 2016 weekly census there were approximately 6,730 patients in DSH, excluding those on leave. Of the total, 1,200 were MDO patients and 1,381 were NGI patients[2]

During the 15-year period from 1991 through 2006 when CDCR referred 833 inmates for compassionate release CDCR populations ranged from approximately 99,000 in December of 1991 to approximately 171,000 in December of 2006. If the proportion of DSH patients granted compassionate release if this bill is enacted are similar to those granted to CDCR inmates, very few DSH patients would be granted compassionate release.

-- END –

[2] There are also 1,444 IST patients and 896 SVP patients, apparently including those pending trial, in DSH as of April 4, 2016