**WELFARE AND INSTITUTIONS CODE - WIC**

**DIVISION 4. MENTAL HEALTH [4000 - 4390]** *( Heading of Division 4 amended by Stats. 1977, Ch. 1252. )*

**PART 2. ADMINISTRATION OF STATE INSTITUTIONS FOR THE MENTALLY DISORDERED [4100 - 4336]** *( Heading of Part 2 renamed from Chapter 2 (of Part 1) by Stats. 1977, Ch. 1252. )*

**CHAPTER 1. Jurisdiction and General Government [4100 - 4148]** *( Heading of Chapter 1 renamed from Article 1 (of former Chapter 2) by Stats. 1977, Ch. 1252. )*

**4100.** The department has jurisdiction over the following facilities:

(a) Atascadero State Hospital.

(b) Coalinga State Hospital.

(c) Metropolitan State Hospital.

(d) Napa State Hospital.

(e) Patton State Hospital.

(f) (1) The Admission, Evaluation, and Stabilization (AES) Center in the County of Kern, and other AES Centers as defined by regulation.

(2) The Director of State Hospitals may adopt emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division of 3 of Title 2 of the Government Code) to implement this subdivision. The adoption of emergency regulations under this paragraph is deemed to address an emergency, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the Director of State Hospitals is hereby exempted for this purpose from the requirements of subdivision (b) of Section 11346.1 of the Government Code.

(g) A county jail treatment facility under contract with the State Department of State Hospitals to provide competency restoration services.

(h) A facility under contract with the State Department of State Hospitals pursuant to Section 4361.6, excluding community-based restoration of competency services that are operated by the county.

(i) Any other State Department of State Hospitals facility subject to available funding by the Legislature.

*(Amended by Stats. 2021, Ch. 143, Sec. 348. (AB 133) Effective July 27, 2021.)*

**4100.2.** (a) Commencing January 10, 2009, and each year thereafter, the State Department of Mental Health, or its successor, the State Department of State Hospitals, shall provide the fiscal committees of the Legislature with a fiscal estimate package for the current year and budget year for the state hospitals by January 10 and at the time of the Governor's May Revision.

(b) At a minimum, the estimate package shall address patient caseload by commitment category, non-level-of-care and level-of-care staffing requirements, and operating expenses and equipment.

(c) In addition to subdivision (b), each estimate submitted shall include all of the following:

(1) A statement articulating the assumptions and methodologies used for calculating the patient caseload factors, all staffing costs, and operating expenses and equipment.

(2) Where applicable, individual policy changes shall contain a narrative and basis for its proposed and estimated costs.

(3) Fiscal bridge charts shall be included to provide the basis for the year-to-year changes.

(d) The department may provide any additional information as deemed appropriate to provide a comprehensive fiscal perspective to the Legislature for analysis and deliberations for purposes of appropriation.

*(Amended by Stats. 2012, Ch. 24, Sec. 78. (AB 1470) Effective June 27, 2012.)*

**4100.5.** The department may contract with the State Department of Developmental Services to provide services to persons with mental disorders in state hospitals under the jurisdiction of the State Department of Developmental Services.

*(Added by Stats. 1978, Ch. 429.)*

**4101.** Except as otherwise specifically provided elsewhere in this code, all of the institutions under the jurisdiction of the State Department of State Hospitals shall be governed by uniform rule and regulation of the State Department of State Hospitals and all of the provisions of this chapter shall apply to the conduct and management of those institutions.

*(Amended by Stats. 2012, Ch. 24, Sec. 79. (AB 1470) Effective June 27, 2012.)*

**4101.5.** (a) Notwithstanding any other law, the State Department of State Hospitals may contract with providers of health care services and health care network providers, including, but not limited to, health plans, preferred provider organizations, and other health care network managers. Hospitals that do not contract with the department for emergency health care services shall provide these services to the department on the same basis as they are required to provide these services pursuant to Section 489.24 of Title 42 of the Code of Federal Regulations.

(b) The department may only reimburse a noncontract provider of hospital or physician services at a rate equal to or less than the amount payable under the Medicare Fee Schedule, regardless of whether the hospital is located within or outside of California. An entity that provides ambulance or any other emergency or nonemergency response service to the department, and that does not contract with the department for that service, shall be reimbursed for the service at the rate payable under the Medicare Fee Schedule, regardless of whether the provider is located within or outside of California.

(c) Until regulations or emergency regulations are adopted in accordance with subdivision (g), the department shall not reimburse a contract provider of hospital services at a rate that exceeds 130 percent of the amount payable under the Medicare Fee Schedule, a contract provider of physician services at a rate that exceeds 110 percent of the amount payable under the Medicare Fee Schedule, or a contract provider of ambulance services at a rate that exceeds 120 percent of the amount payable under the Medicare Fee Schedule. The maximum rates established by this subdivision shall not apply to reimbursement for administrative days, transplant services, services provided pursuant to competitively bid contracts, or services provided pursuant to a contract executed prior to September 1, 2009.

(d) The maximum rates set forth in this section shall not apply to contracts entered into through the department's designated health care network provider, if any. The rates for those contracts shall be negotiated at the lowest rate possible under the circumstances.

(e) The department and its designated health care network provider may enter into exclusive or nonexclusive contracts on a bid or negotiated basis for hospital, physician, and ambulance services contracts.

(f) The Director of State Hospitals may adopt regulations to implement this section. The adoption, amendment, or repeal of a regulation authorized by this section is hereby exempted from the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(g) The Director of State Hospitals may change the maximum rates set forth in this section by regulation or emergency regulation, adopted in accordance with the Administrative Procedure Act, but no sooner than 30 days after notification to the Joint Legislative Budget Committee. Those changes may include, but are not limited to, increasing or decreasing rates, or adding location-based differentials such as those provided to small and rural hospitals as defined in Section 124840 of the Health and Safety Code. The adoption, amendment, repeal, or readoption of a regulation authorized by this subdivision is deemed to address an emergency, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the director is hereby exempted for this purpose from the requirements of subdivision (b) of Section 11346.1 of the Government Code.

(h) For persons who are transferred from the Department of Corrections and Rehabilitation to, or are housed in, a state hospital or psychiatric program under the jurisdiction of the State Department of State Hospitals, and while these persons remain under the jurisdiction of the Department of Corrections and Rehabilitation as inmates or parolees, health care or emergency services provided for these persons outside of a State Department of State Hospitals state hospital or psychiatric program shall continue to be paid for or reimbursed by the Department of Corrections and Rehabilitation in accordance with Section 5023.5 of the Penal Code.

*(Amended by Stats. 2012, Ch. 24, Sec. 80. (AB 1470) Effective June 27, 2012.)*

**4102.** Each state hospital is a corporation.

*(Repealed and added by Stats. 1967, Ch. 1667.)*

**4103.** Each such corporation may acquire and hold in its corporate name by gift, grant, devise, or bequest property to be applied to the maintenance of the patients of the hospital and for the general use of the corporation.

*(Repealed and added by Stats. 1967, Ch. 1667.)*

**4104.** All lands necessary for the use of the state hospitals specified in Section 4100, except those acquired by gift, devise, or purchase, shall be acquired by condemnation as lands for other public uses are acquired.

The terms of every purchase shall be approved by the State Department of State Hospitals. No public street or road for railway or other purposes, except for hospital use, shall be opened through the lands of any state hospital, unless the Legislature by special enactment consents thereto.

*(Amended by Stats. 2012, Ch. 24, Sec. 81. (AB 1470) Effective June 27, 2012.)*

**4105.** The Director of General Services shall grant to the County of San Bernardino under such terms, conditions, and restrictions as he or she deems to be for the best interests of the state, the necessary easements and rights-of-way for all purposes of a public road on the Patton State Hospital property. The right-of-way shall be across, along, and upon the following described property:

The east 40 feet of the east one-half of the northwest one-quarter of Section 32, Township 1 North, Range 3 West, San Bernardino Base and Meridian, in the County of San Bernardino, State of California.

*(Added by renumbering Section 4445.5 by Stats. 1986, Ch. 224, Sec. 9. Effective June 30, 1986.)*

**4106.** Notwithstanding the provisions of Section 4104, the Director of General Services, with the consent of the State Department of State Hospitals, may grant to the County of Napa a right-of-way for public road purposes over the northerly portion of the Napa State Hospital lands for the widening of Imola Avenue between Penny Lane and Fourth Avenue, upon such terms and conditions as the Director of General Services may deem for the best interests of the state.

*(Amended by Stats. 2012, Ch. 24, Sec. 82. (AB 1470) Effective June 27, 2012.)*

**4107.** (a) The security of patients committed pursuant to Section 1026 of, and Chapter 6 (commencing with Section 1367) of Title 10 of Part 2 of, the Penal Code, and former Sections 6316 and 6321, at Patton State Hospital shall be the responsibility of the Secretary of the Department of Corrections and Rehabilitation.

(b) The Department of Corrections and Rehabilitation and the State Department of Mental Health shall jointly develop a plan to transfer all patients committed to Patton State Hospital pursuant to the provisions in subdivision (a) from Patton State Hospital no later than January 1, 1986, and shall transmit this plan to the Senate Committee on Judiciary and to the Assembly Committee on Criminal Justice, and to the Senate Health and Welfare Committee and Assembly Health Committee by June 30, 1983. The plan shall address whether the transferred patients shall be moved to other state hospitals or to correctional facilities, or both, for commitment and treatment.

(c) Notwithstanding any other law, the State Department of State Hospitals shall house no more than 1,336 patients at Patton State Hospital. However, until September 2030, up to 1,530 patients may be housed at the hospital.

(d) This section shall remain in effect only until all patients committed, pursuant to the provisions enumerated in subdivision (a), have been removed from Patton State Hospital and shall have no force or effect on or after that date.

*(Amended by Stats. 2020, Ch. 12, Sec. 38. (AB 80) Effective June 29, 2020. Section inoperative on date prescribed by its own provisions.)*

**4107.1.** Consistent with the authority of the State Department of State Hospitals to maintain and operate state hospitals under its jurisdiction, the State Department of State Hospitals shall provide internal security for the patient population at Patton State Hospital. The State Department of State Hospitals may employ hospital police at Patton State Hospital for this purpose.

This section is not intended to increase or decrease the duties and responsibilities of the Department of Corrections and Rehabilitation at Patton State Hospital.

*(Amended by Stats. 2012, Ch. 24, Sec. 84. (AB 1470) Effective June 27, 2012.)*

**4109.** The State Department of State Hospitals has general control and direction of the property and concerns of each state hospital specified in Section 4100. The department shall:

(a) Take care of the interests of the hospital, and see that its purpose and its bylaws, rules, and regulations are carried into effect, according to law.

(b) Establish such bylaws, rules, and regulations as it deems necessary and expedient for regulating the duties of officers and employees of the hospital, and for its internal government, discipline, and management.

(c) Maintain an effective inspection of the hospital.

*(Amended by Stats. 2012, Ch. 24, Sec. 85. (AB 1470) Effective June 27, 2012.)*

**4109.5.** (a) Whenever the department proposes the closure of a state hospital, it shall submit as part of the Governor's proposed budget to the Legislature a complete program, to be developed jointly by the State Department of State Hospitals and the county in which the state hospital is located, for absorbing as many of the staff of the hospital into the local mental health programs as may be needed by the county. Those programs shall include a redefinition of occupational positions, if necessary, and a recognition by the counties of licensed psychiatric technicians for treatment of persons with developmental disabilities, persons with mental health disorders, drug abusers, and alcoholics.

(b) The Director of State Hospitals shall submit all plans for the closure of state hospitals as a report with the department's budget. This report shall include all of the following:

(1) The land and buildings affected.

(2) The number of patients affected.

(3) Alternative plans for patients presently in the facilities.

(4) Alternative plans for patients who would have been served by the facility assuming it was not closed.

(5) A joint statement of the impact of the closure by the department and affected local treatment programs.

(c) These plans may be submitted to the Legislature until April 1 of each budget year. Plans submitted after that date shall not be considered until the fiscal year following that in which it was submitted.

(d) The plan shall not be placed into effect unless the Legislature specifically approves the plan.

(e) This section shall not apply to the proposed closure of a developmental center.

*(Amended by Stats. 2014, Ch. 144, Sec. 65. (AB 1847) Effective January 1, 2015.)*

**4110.** The executive director shall provide detailed expenditure estimates of all anticipated hospital expenditures, all supplies, expenses, buildings, and improvements as required for the best interests of the hospital, and for the improvement of the hospital and of the grounds and buildings connected with the hospital. These estimates shall be submitted to the State Department of State Hospitals, which may revise them. The department shall certify that it has carefully examined the estimates, and that the supplies, expenses, buildings, and improvements contained in the estimates, as approved by it, are required for the best interests of the hospital. The department shall thereupon proceed to purchase the supplies, make the expenditures, or conduct the improvements or buildings in accordance with law.

*(Amended by Stats. 2012, Ch. 24, Sec. 87. (AB 1470) Effective June 27, 2012.)*

**4111.** The state hospitals may manufacture supplies and materials necessary or required to be used in any of the state hospitals which can be economically manufactured therein. The necessary cost and expense of providing for and conducting the manufacture of such supplies and materials shall be paid in the same manner as other expenses of the hospitals. No hospital shall enter into or engage in manufacturing any supplies or materials unless permission for the same is obtained from the State Department of State Hospitals. If, at any time, it appears to the department that the manufacture of any article is not being or cannot be economically carried on at a state hospital, the department may suspend or stop the manufacture of the article, and on receipt of a certified copy of the order directing the suspension or stopping of its manufacture, by the medical superintendent, the hospital shall cease from manufacturing the article.

*(Amended by Stats. 2012, Ch. 24, Sec. 88. (AB 1470) Effective June 27, 2012.)*

**4112.** (a) All money belonging to the state and received by state hospitals from any source, except appropriations, shall, at the end of each month, be deposited in the State Treasury, to the credit of the General Fund. This section shall not apply to the funds known as the industrial or amusement funds.

(b) There is hereby continuously appropriated from the General Fund to the State Department of State Hospitals that amount which is necessary to pay the premium, as specified in Section 7353, for third-party health coverage for Medicare beneficiaries who are patients at state hospitals under the jurisdiction of the State Department of State Hospitals. It is the intent of the Legislature that the General Fund expenditures authorized by this subdivision not exceed the proceeds to be deposited in the General Fund from Medicare payments to the State Department of State Hospitals in any fiscal year.

*(Amended by Stats. 2012, Ch. 24, Sec. 89. (AB 1470) Effective June 27, 2012.)*

**4112.1.** Section 4112 does not apply to the funds known as the "sheltered workshop funds."

*(Added by Stats. 1969, Ch. 722.)*

**4113.** The state hospitals and the officers thereof shall make such financial statements to the Controller as the Controller requires.

*(Repealed and added by Stats. 1967, Ch. 1667.)*

**4114.** The executive director or other person in charge of a hospital shall, within 10 days after the admission of any person to the hospital, cause an abstract of the medical certificate and order on which the person was received and a list of all property, books, and papers of value found in the possession of or belonging to the person to be forwarded to the office of the department, and when a patient is discharged, transferred, or dies, the superintendent or person in charge shall within three days thereafter, send the information to the office of the department, in accordance with the form prescribed by it.

*(Amended by Stats. 2012, Ch. 24, Sec. 90. (AB 1470) Effective June 27, 2012.)*

**4115.** The department may permit, subject to such conditions and regulations as it may impose, any religious or missionary corporation or society to erect a building on the grounds of any state hospital for the holding of religious services. Each such building when erected shall become the property of the state and shall be used exclusively for the benefit of the patients and employees of the state hospital.

*(Repealed and added by Stats. 1967, Ch. 1667.)*

**4116.** The department may establish and supervise under its rules and regulations training schools or courses for employees of the department or of state institutions under its jurisdiction.

*(Repealed and added by Stats. 1967, Ch. 1667.)*

**4117.** (a) Whenever a trial is had of any person charged with escape or attempt to escape from a state hospital, whenever a hearing is had on the return of a writ of habeas corpus prosecuted by or on behalf of any person confined in a state hospital except in a proceeding to which Section 5110 applies, whenever a hearing is had on a petition under Section 1026.2, subdivision (b) of Section 1026.5, Section 2966, or Section 2972 of the Penal Code, Section 7361 of this code, or former Section 6316.2 of this code for the release of a person confined in a state hospital, whenever a hearing is had for an order seeking involuntary treatment with psychotropic medication, or any other medication for which an order is required, of a person confined in a state hospital pursuant to Section 2962 of the Penal Code, and whenever a person confined in a state hospital is tried for a crime committed therein, the appropriate financial officer or other designated official of the county in which the trial or hearing is had shall make out a statement of all mental health treatment costs and shall make out a separate statement of all nontreatment costs incurred by the county for investigation and other preparation for the trial or hearing, and the actual trial or hearing, all costs of maintaining custody of the patient and transporting him or her to and from the hospital, and costs of appeal. The statements shall be properly certified by a judge of the superior court of that county. The statement of mental health treatment costs shall be sent to the State Department of State Hospitals and the statement of all nontreatment costs, except as provided in subdivision (c), shall be sent to the Controller for approval. After approval, the department shall cause the amount of mental health treatment costs incurred on or after July 1, 1987, to be paid to the county behavioral health director or his or her designee when the trial or hearing was held out of the money appropriated for this purpose by the Legislature. In addition, the Controller shall cause the amount of all nontreatment costs incurred on and after July 1, 1987, to be paid out of the money appropriated by the Legislature, to the county treasurer of the county where the trial or hearing was had.

(b) Commencing January 1, 2012, the nontreatment costs associated with Section 2966 of the Penal Code and approved by the Controller, as required by subdivision (a), shall be paid by the Department of Corrections and Rehabilitation pursuant to Section 4750 of the Penal Code.

(c) The nontreatment costs associated with any hearing for an order seeking involuntary treatment with psychotropic medication, or any other medication for which an order is required, of a person confined in a state hospital pursuant to Section 1026, 1026.5, or 2972 of the Penal Code, as provided in subdivision (a), shall be paid by the county of commitment. As used in this subdivision, “county of commitment” means the county seeking the continued treatment of a mentally disordered offender pursuant to Section 2972 of the Penal Code or the county committing a patient who has been found not guilty by reason of insanity pursuant to Section 1026 or 1026.5 of the Penal Code. The appropriate financial officer or other designated official of the county in which the proceeding is held shall make out a statement of all of the costs incurred by the county for the investigation, preparation, and conduct of the proceedings, and the costs of appeal, if any. The statement shall be certified by a judge of the superior court of the county. The statement shall then be sent to the county of commitment, which shall reimburse the county providing the services.

(d) (1) Whenever a hearing is held pursuant to Section 1604, 1608, 1609, or 2966 of the Penal Code, all transportation costs to and from a state hospital or a facility designated by the community program director during the hearing shall be paid by the Controller as provided in this subdivision. The appropriate financial officer or other designated official of the county in which a hearing is held shall make out a statement of all transportation costs incurred by the county. The statement shall be properly certified by a judge of the superior court of that county and sent to the Controller for approval. The Controller shall cause the amount of transportation costs

incurred on and after July 1, 1987, to be paid to the county treasurer of the county where the hearing was had out of the money appropriated by the Legislature.

(2) As used in this subdivision, “community program director” means the person designated pursuant to Section 1605 of the Penal Code.

*(Amended (as amended by Stats. 2015, Ch. 26, Sec. 47) by Stats. 2015, Ch. 455, Sec. 16. (SB 804) Effective January 1, 2016.)*

**4119.** (a) The State Department of State Hospitals shall investigate and examine all nonresident persons residing in a state hospital and shall cause these persons, when found to be nonresidents as defined in this chapter, to be promptly and humanely returned under proper supervision to the states in which they have legal residence. The department may defer that action by reason of a patient’s medical condition.

(b) Prior to returning the judicially committed nonresident to his or her proper state of residency, the department shall do either of the following:

(1) Obtain the written consent of the prosecuting attorney of the committing county, the judicially committed nonresident person, and the attorney of record for the judicially committed nonresident person.

(2) In the department’s discretion request a hearing in the superior court of the committing county requesting a judicial determination of the proposed transfer, notify the court that the state of residence has agreed to the transfer, and file the department’s recommendation with a report explaining the reasons for its recommendation.

(c) The court shall give notice of the hearing to the prosecuting attorney, the judicially committed nonresident person, the attorney of record for the judicially committed nonresident person, and the department, no less than 30 days before the hearing. At the hearing, the prosecuting attorney and the judicially committed nonresident person may present evidence bearing on the intended transfer. After considering all evidence presented, the court shall determine whether the intended transfer is in the best interest of, and for the proper protection of, the nonresident person and the public. The court shall use the same procedures and standard of proof as used in conducting probation revocation hearings pursuant to Section 1203.2 of the Penal Code.

(d) For the purpose of facilitating the prompt and humane return of these persons, the State Department of State Hospitals may enter into reciprocal agreements with the proper boards, commissions, or officers of other states or political subdivision thereof for the mutual exchange or return of persons residing in any state hospital in one state whose legal residence is in the other, and it may in these reciprocal agreements vary the period of residence as defined in this chapter to meet the requirements or laws of the other states.

(e) The department may give written permission for the return of a resident of this state confined in a public institution in another state, corresponding to a state hospital of this state. When a resident is returned to this state pursuant to this chapter, he or she may be admitted as a voluntary patient to an institution of the department as designated by the Director of State Hospitals. If he or she has a mental health disorder and is a danger to himself or herself or others, or he or she is gravely disabled, he or she may be detained and given care and services in accordance with the provisions of Part 1 (commencing with Section 5000) of Division 5.

*(Amended by Stats. 2014, Ch. 144, Sec. 66. (AB 1847) Effective January 1, 2015.)*

**4120.** (a) Except as otherwise provided in this section, in determining residence for purposes of being entitled to hospitalization in this state and for purposes of returning patients to the states of their residence, an adult person who has lived continuously in this state for a period of one year and who has not acquired residence in another state by living continuously therein for at least one year subsequent to his residence in this state shall be deemed to be a resident of this state. Except as otherwise provided in this section a minor is entitled to hospitalization in this state if the parent or guardian or conservator having custody of the minor has lived continuously in this state for a period of one year and has not acquired residence in another state by living continuously therein for at least one year subsequent to his residence in this state. The parent, guardian, or conservator shall be deemed a resident of this state for the purposes of this section, and the minor shall be eligible for hospitalization in this state as a person with a mental health disorder. The eligibility of the minor for hospitalization in this state ceases when the parent, guardian, or conservator ceases to be a resident of this state and the minor shall be transferred to the state of residence of the parent, guardian, or conservator in accordance with the applicable provisions of this code. Time spent in a public institution for the care of persons with developmental disabilities or mental health disorders, or on leave of absence therefrom, shall not be counted in determining the matter of residence in this or another state.

(b) Residence acquired in this or in another state shall not be lost by reason of military service in the Armed Forces of the United States.

*(Amended by Stats. 2014, Ch. 144, Sec. 67. (AB 1847) Effective January 1, 2015.)*

**4121.** (a) All expenses incurred in returning these persons to other states shall be paid by this state, the person, or his or her relatives, but the expense of returning residents of this state shall be borne by the states making the returns.

(b) The cost and expense incurred in effecting the transportation of these nonresident persons to the states in which they have residence shall be advanced from the funds appropriated for that purpose, or, if necessary, from the money appropriated for the care of persons who are delinquent or have mental health disorders.

*(Amended by Stats. 2014, Ch. 144, Sec. 68. (AB 1847) Effective January 1, 2015.)*

**4122.** The State Department of State Hospitals, when it deems it necessary, may, under conditions prescribed by the director, transfer any patients of a state institution under its jurisdiction to another institution. Transfers of patients of state hospitals shall be made in accordance with Section 7300.

The expense of any transfer shall be paid from the moneys available by law for the support of the department or for the support of the institution from which the patient is transferred. Liability for the care, support, and maintenance of the transferred patient in the institution to which they have been transferred shall be the same as if they had originally been committed to the institution. The State Department of State Hospitals shall present to the county, not more frequently than monthly, a claim for the amount due the state for care, support, and maintenance of those patients and which the county shall process and pay pursuant to Chapter 4 (commencing with Section 29700) of Division 3 of Title 3 of the Government Code.

*(Amended by Stats. 2021, Ch. 143, Sec. 349. (AB 133) Effective July 27, 2021.)*

**4123.** The Director of State Hospitals may authorize the transfer of persons from any institution within the department to any institution authorized by the federal government to receive the person.

*(Amended by Stats. 2012, Ch. 24, Sec. 95. (AB 1470) Effective June 27, 2012.)*

**4124.** The State Department of State Hospitals shall send to the Department of Veterans Affairs whenever requested a list of all persons who have been patients for six months or more in each state institution within the jurisdiction of the State Department of State Hospitals and who are known to have served in the Armed Forces of the United States.

*(Amended by Stats. 2012, Ch. 24, Sec. 96. (AB 1470) Effective June 27, 2012.)*

**4125.** (a) The director may deposit any funds of any patient in the possession of each hospital administrator of a state hospital in trust with the treasurer pursuant to Section 16305.3 of the Government Code or, subject to the approval of the Department of Finance, may deposit these funds in an interest-bearing bank account or invest and reinvest these funds in any security described in Article 1 (commencing with Section 16430) of Chapter 3 of Part 2 of Division 4 of Title 2 of the Government Code, and for the purposes of deposit or investment only may mingle the funds of any patient with the funds of any other patient. The hospital administrator with the consent of the patient may deposit the interest or increment on the funds of a patient in the state hospital in a special fund for each state hospital, to be designated the “Benefit Fund,” of which the hospital administrator shall be the trustee. He or she may, with the approval of the director, after taking into consideration the recommendations of representatives of patient government and recommendations submitted by patient groups, expend the moneys in this fund for the education or entertainment of the patients of the institution.

(b) On and after December 1, 1970:

(1) The funds of a patient in a state hospital or a patient on leave of absence from a state hospital shall not be deposited in interest-bearing bank accounts or invested and reinvested pursuant to this section except when authorized by the patient.

(2) Any interest or increment accruing on the funds of a patient on leave of absence from a state hospital shall be deposited in his or her account.

(3) Any interest or increment accruing on the funds of a patient in a state hospital shall be deposited in his or her account, unless the patient authorizes their deposit in the state hospital’s benefit fund.

(c) Any state hospital charges for patient care against the funds of a patient in the possession of a hospital administrator or deposited pursuant to this section and used to pay for that care, shall be stated in an itemized bill to the patient.

(d) No later than August 15 of each year, the director shall provide to the Legislature a summary data sheet containing information on how the benefit fund at each state hospital was expended in the previous fiscal year.

*(Amended by Stats. 2002, Ch. 352, Sec. 1. Effective January 1, 2003.)*

**4126.** Whenever any patient in any state institution subject to the jurisdiction of the State Department of State Hospitals dies, and any personal funds or property of the patient remains in the hands of the superintendent thereof, and no demand is made upon the superintendent by the owner of the funds or property or his or her legally appointed representative all money and other personal property of the decedent remaining in the custody or possession of the superintendent thereof shall be held by him or her for a

period of one year from the date of death of the decedent, for the benefit of the heirs, legatees, or successors in interest of the decedent.

Upon the expiration of the one-year period, any money remaining unclaimed in the custody or possession of the superintendent shall be delivered by him or her to the Treasurer for deposit in the Unclaimed Property Fund under the provision of Article 1 (commencing with Section 1440) of Chapter 6 of Title 10 of Part 3 of the Code of Civil Procedure.

Upon the expiration of said one-year period, all personal property and documents of the decedent, other than cash, remaining unclaimed in the custody or possession of the superintendent, shall be disposed of as follows:

(a) All deeds, contracts or assignments shall be filed by the superintendent with the public administrator of the county of commitment of the decedent;

(b) All other personal property shall be sold by the superintendent at public auction, or upon a sealed-bid basis, and the proceeds of the sale delivered by him or her to the Treasurer in the same manner as is herein provided with respect to unclaimed money of the decedent. If he or she deems it expedient to do so, the superintendent may accumulate the property of several decedents and sell the property in lots that he or she may determine, provided that he or she makes a determination as to each decedent's share of the proceeds;

(c) If any personal property of the decedent is not salable at public auction, or upon a sealed-bid basis, or if it has no intrinsic value, or if its value is not sufficient to justify the deposit of such property in the State Treasury, the superintendent may order it destroyed;

(d) All other unclaimed personal property of the decedent not disposed of as provided in subdivision (a), (b), or (c), shall be delivered by the superintendent to the Controller for deposit in the State Treasury under the provisions of Article 1 (commencing with Section 1440) of Chapter 6 of Title 10 of Part 3 of the Code of Civil Procedure.

*(Amended by Stats. 2012, Ch. 24, Sec. 97. (AB 1470) Effective June 27, 2012.)*

**4127.** (a) Whenever any patient in any state institution subject to the jurisdiction of the State Department of State Hospitals escapes, is discharged, or is on leave of absence from the institution, and any personal funds or property of the patient remains in the hands of the superintendent, and no demand is made upon the superintendent by the owner of the funds or property or his or her legally appointed representative, all money and other intangible personal property of the patient, other than deeds, contracts, or assignments, remaining in the custody or possession of the superintendent shall be held by him or her for a period of seven years from the date of the escape, discharge, or leave of absence, for the benefit of the patient or his or her successors in interest. Unclaimed personal funds or property of minors on leave of absence may be exempted from this section during the period of their minority and for a period of one year thereafter, at the discretion of the Director of State Hospitals.

(b) Upon the expiration of the seven-year period, any money and other intangible property, other than deeds, contracts, or assignments, remaining unclaimed in the custody or possession of the superintendent shall be subject to Chapter 7 (commencing with Section 1500) of Title 10 of Part 3 of the Code of Civil Procedure.

(c) Upon the expiration of one year from the date of the escape, discharge, or parole, the following shall apply:

(1) All deeds, contracts, or assignments shall be filed by the superintendent with the public administrator of the county of commitment of the patient.

(2) All tangible personal property other than money, remaining unclaimed in the superintendent's custody or possession, shall be sold by the superintendent at public auction, or upon a sealed-bid basis, and the proceeds of the sale shall be held by him or her subject to Section 4125 of this code and Chapter 7 (commencing with Section 1500) of Title 10 of Part 3 of the Code of Civil Procedure. If the superintendent deems it expedient to do so, the superintendent may accumulate the property of several patients and may sell the property in lots that the superintendent determines, provided that the superintendent makes a determination as to each patient's share of the proceeds.

(d) If any tangible personal property covered by this section is not salable at public auction or upon a sealed-bid basis, or if it has no intrinsic value or its value is not sufficient to justify its retention by the superintendent to be offered for sale at public auction or upon a sealed-bid basis at a later date, the superintendent may order it destroyed.

*(Amended by Stats. 2012, Ch. 24, Sec. 98. (AB 1470) Effective June 27, 2012.)*

**4128.** Before any money or other personal property or documents are delivered to the State Treasurer, State Controller, or public administrator, or sold at auction or upon a sealed-bid basis, or destroyed, under the provisions of Section 4126, and before any personal property or documents are delivered to the public administrator, or sold at auction or upon a sealed-bid basis, or destroyed, under the provisions of Section 4127, of this code, notice of said intended disposition shall be posted at least 30 days prior to the disposition, in a public place at the institution where the disposition is to be made, and a copy of such notice shall be mailed to the last known address of the owner or deceased owner, at least 30 days prior to such disposition. The notice prescribed by this section need not specifically describe each item of property to be disposed of.

*(Repealed and added by Stats. 1967, Ch. 1667.)*

**4129.** At the time of delivering any money or other personal property to the State Treasurer or State Controller under the provisions of Section 4126 or of Chapter 7 of Title 10 of Part 3 of the Code of Civil Procedure, the superintendent shall deliver to the State Controller a schedule setting forth a statement and description of all money and other personal property delivered, and the name and last known address of the owner or deceased owner.

*(Repealed and added by Stats. 1967, Ch. 1667.)*

**4130.** When any personal property has been destroyed as provided in Sections 4126 or 4127, no suit shall thereafter be maintained by any person against the state or any officer thereof for or on account of such property.

*(Repealed and added by Stats. 1967, Ch. 1667.)*

**4131.** Notwithstanding any other provision of law, the provisions of Sections 4126 and 4127 shall apply (1) to all money and other personal property delivered to the State Treasurer or State Controller prior to the effective date of said sections, which would have been subject to the provisions thereof if they had been in effect on the date of such delivery; and (2) to all money and other personal property delivered to the State Treasurer or State Controller prior to the effective date of the 1961 amendments to said sections, as said provisions would have applied on the date of such delivery if, on said date of delivery, the provisions of Chapter 1809, Statutes of 1959, had not been in effect.

*(Repealed and added by Stats. 1967, Ch. 1667.)*

**4132.** (a) It is hereby declared that the provisions of this code reflect the concern of the Legislature that persons with mental health disorders are to be regarded as patients to be provided care and treatment and not as inmates of institutions for the purposes of secluding them from the rest of the public.

(b) Whenever any provision of this code heretofore or hereafter enacted uses the term “inmate,” it shall be construed to mean “patient.”

*(Amended by Stats. 2014, Ch. 144, Sec. 69. (AB 1847) Effective January 1, 2015.)*

**4133.** All day hospitals and rehabilitation centers maintained by the State Department of State Hospitals shall be subject to the provisions of this code pertaining to the admission, transfer, and discharge of patients at the state hospitals, except that all admissions to those facilities shall be subject to the approval of the chief officer thereof. Charges for services rendered to patients at those facilities shall be determined pursuant to Section 4025. The liability for the charges shall be governed by the provisions of Article 4 (commencing with Section 7275) of Chapter 2 of Division 7, except at the hospitals maintained by the State Department of Developmental Services the liability shall be governed by the provisions of Article 4 (commencing with Section 6715) of Chapter 3 of Part 2 of Division 6 and Chapter 3 (commencing with Section 7500) of Division 7.

*(Amended by Stats. 2012, Ch. 24, Sec. 99. (AB 1470) Effective June 27, 2012.)*

**4134.** The state mental hospitals under the jurisdiction of the State Department of State Hospitals shall comply with the California Food Sanitation Act, Article 1 (commencing with Section 111950) of Chapter 4 of Part 6 of Division 104 of the Health and Safety Code.

The state mental hospitals under the jurisdiction of the State Department of State Hospitals shall also comply with the California Retail Food Code (Chapter 4 (commencing with Section 113700) of Part 7 of Division 104 of the Health and Safety Code).

Sanitation, health and hygiene standards that have been adopted by a city, county, or city and county that are more strict than those of the California Retail Food Code or the California Food Sanitation Act shall not be applicable to state mental hospitals that are under the jurisdiction of the State Department of State Hospitals.

*(Amended by Stats. 2012, Ch. 24, Sec. 100. (AB 1470) Effective June 27, 2012.)*

**4135.** Any person committed to the State Department of State Hospitals as a mentally abnormal sex offender shall remain a patient committed to the department for the period specified in the court order of commitment or until discharged by the medical director of the state hospital in which the person is a patient, whichever occurs first. The medical director may grant the patient a leave of absence upon the terms and conditions as the medical director deems proper. The petition for commitment of a person as a mentally abnormal sex offender, the reports, the court orders, and other court documents filed in the court in connection therewith shall not be open to inspection by any other than the parties to the proceeding, the attorneys for the party or parties, and the State Department of State Hospitals, except upon the written authority of a judge of the superior court of the county in which the proceedings were had.

Records of the supervision, care, and treatment given to each person committed to the State Department of State Hospitals as a mentally abnormal sex offender shall not be open to the inspection of any person not in the employ of the department or of the state

hospital, except that a judge of the superior court may by order permit examination of those records.

The charges for the care and treatment rendered to persons committed as mentally abnormal sex offenders shall be in accordance with the provisions of Article 4 (commencing with Section 7275) of Chapter 3 of Division 7.

*(Amended by Stats. 2012, Ch. 24, Sec. 101. (AB 1470) Effective June 27, 2012.)*

**4136.** (a) Each patient in a state hospital who has resided in the state hospital for a period of at least 30 days shall be paid an amount of aid for his or her personal and incidental needs that, when added to his or her income, equals twelve dollars and fifty cents ($12.50) per month. If a patient elects to do so, a patient may save all or any portion of his or her monthly amount of aid provided for personal and incidental needs for expenditure in subsequent months.

(b) Each indigent patient in a state hospital shall be allotted sufficient materials for one letter each week, including postage in an amount not to exceed the cost of one stamp for first-class mail for a one-ounce letter, at no cost to the patient.

(c) Each newly admitted patient, for the first 30 days after his or her initial admission, shall be allotted sufficient materials for two letters each week, including postage for first-class mail for up to two one-ounce letters per week. The hospital administrator shall ensure that additional writing materials and postage are available for purchase by patients at the store or canteen on hospital grounds.

(d) For purposes of this section, “indigent patient” means a patient whose income is no more than twelve dollars and fifty cents ($12.50) per month.

*(Amended by Stats. 2014, Ch. 144, Sec. 70. (AB 1847) Effective January 1, 2015.)*

**4137.** Whenever a patient dies in a state mental hospital and the coroner finds that the death was by accident or at the hands of another person other than by accident, the State Department of State Hospitals shall determine upon review of the coroner’s investigation if the death resulted from the negligence, recklessness, or intentional act of a state employee. If it is determined that the death directly resulted from the negligence, recklessness, or intentional act of a state employee, the department shall immediately notify the State Personnel Board and any appropriate licensing agency and shall terminate the employment of the employee as provided by law. In addition, if the state employee is a licensed mental health professional, the appropriate licensing board shall inquire into the circumstances of the death, examine the findings of the coroner’s investigation, and make a determination of whether the mental health professional should have his or her license revoked or suspended or be subject to other disciplinary action. “Licensed mental health professional,” as used in this section, means a person licensed by any board, bureau, department, or agency pursuant to a state law and employed in a state mental hospital.

*(Amended by Stats. 2012, Ch. 24, Sec. 102. (AB 1470) Effective June 27, 2012.)*

**4138.** (a) Upon receiving a request from the director of a state hospital listed in Section 4100, the Director of State Hospitals may prohibit the possession or use of tobacco products on the grounds of the requesting facility. The Director of State Hospitals shall provide an implementation plan that shall include a phase-in period for any of the state hospitals listed in Section 4100 that prohibits the possession or use of tobacco products by patients or any other persons on hospital grounds, except on the premises of residential staff housing where patients are not present.

(b) This prohibition shall include an exemption for departmentally approved religious ceremonies.

(c) As part of the implementation plan, the department shall provide any requesting patient with a smoking cessation plan that may include, at minimum, an individual medical treatment plan, counseling, prescription drugs, or nicotine replacement, as determined to be medically necessary and appropriate.

(d) Nothing in this section shall be construed to restrict the outside activity time currently available to hospital patients.

(e) If an implementation plan is adopted pursuant to subdivision (a), the store or canteen at any facility subject to the prohibition shall not sell tobacco products.

*(Amended by Stats. 2012, Ch. 24, Sec. 103. (AB 1470) Effective June 27, 2012.)*

**4139.** (a) Except as otherwise authorized by law, or when authorized by the director of the state hospital, and except as provided in subdivision (b), a person who possesses with the intent to deliver, or delivers, to a patient in a state hospital listed in Section 4100 any item listed in paragraphs (1) to (3), inclusive, that has been prohibited for possession by a patient either by statute or by regulation is guilty of a misdemeanor, punishable by a fine not to exceed one thousand dollars ($1,000) for each item.

(1) A cellular telephone or other wireless communication device, or any component thereof, including, but not limited to, a subscriber identity card (SIM card) or memory storage device.

(2) Tobacco products, if the state hospital has a ban on tobacco products.

(3) Money, in excess of the limitations and restrictions adopted by the state hospital.

(b) If a person visiting a patient in a state hospital listed in Section 4100, upon being searched or subjected to a metal detector, is found to be in possession of an item prohibited for patient possession pursuant to subdivision (a), the item shall be subject to confiscation but shall be returned on the same day the person visits the patient, unless the item is held as evidence in a case where the person is cited for a violation of subdivision (a). If, upon investigation, it is determined that no prosecution will take place, the item shall be returned to the owner at the owner's expense. Notice of this provision shall be posted in all areas where visitors are searched prior to visitation with a patient and outside the facility in a location easily visible to visitors so that they can leave prohibited items in their cars before entering the visitor area.

*(Added by Stats. 2011, Ch. 201, Sec. 1. (SB 796) Effective January 1, 2012.)*

**4141.** (a) (1) Each state hospital shall update its injury and illness prevention plan at least once a year to include necessary safeguards to prevent workplace safety hazards in connection with workplace violence associated with patient assaults on employees.

(2) Updated injury and illness prevention plans shall address, but shall not be limited to, all of the following:

(A) Control of physical access throughout the hospital and grounds.

(B) Alarm systems.

(C) Presence of security personnel.

(D) Training.

(E) Buddy systems.

(F) Communication.

(G) Emergency responses.

(3) (A) The department shall submit the updated injury and illness prevention plans to the Legislature every two years.

(B) (i) The requirement for submitting the updated injury and illness prevention plans imposed pursuant to subparagraph (A) is inoperative four years after the date the first report is due, pursuant to Section 10231.5 of the Government Code.

(ii) Updated injury and illness prevention plans submitted pursuant to subparagraph (A) shall be submitted in compliance with Section 9795 of the Government Code.

(b) Each state hospital shall establish an injury and illness prevention committee comprised of hospital management and employees designated by the hospital's director in consultation with the employee bargaining units. The committee shall be responsible for providing recommendations to the hospital director for updates to the injury and illness prevention plan. The committee shall meet at least four times per year.

(c) Each state hospital shall develop an incident reporting procedure that can be used, at a minimum, to develop reports of patient assaults on employees and assist the hospital in identifying risks of patient assaults on employees. Data obtained from the incident reporting procedures shall be accessible to staff. The incident reporting procedure shall be designed to provide hospital management with immediate notification of reported incidents. The hospital shall provide for timely and efficient responses and investigations to incident reports made under the incident reporting procedure. Incident reports shall also be forwarded to the injury and illness prevention committee established pursuant to subdivision (b).

*(Amended by Stats. 2013, Ch. 76, Sec. 203. (AB 383) Effective January 1, 2014.)*

**4142.** (a) Notwithstanding any other law, whenever a patient is committed to the State Department of State Hospitals, a director of a state hospital or a clinician, as defined in subdivision (f), shall obtain the state summary criminal history information for the patient. The information shall be used to assess the violence risk of a patient, to assess the appropriate placement of a patient, to treat a patient, to prepare periodic reports as required by statute, or to determine the patient's progress or fitness for release. The state summary criminal history information shall be placed in the patient's confidential file for the duration of his or her commitment.

(b) The information may be obtained through use of the California Law Enforcement Telecommunications System (CLETS). Law enforcement personnel shall cooperate with requests for state summary criminal history information authorized pursuant to this section and shall provide the information to the requesting entity in a timely manner.

(c) A law enforcement officer or person authorized by this section to receive the information who obtains the information in the record and knowingly provides the information to a person not authorized by law to receive the information is guilty of a misdemeanor as specified in Section 11142 of the Penal Code.

(d) Information obtained pursuant to this section shall not be used for any purposes other than those described in subdivision (a).

(e) For purposes of this section, the State Department of State Hospitals law enforcement personnel, pursuant to Section 830.38 of the Penal Code, may act as the law enforcement personnel described in subdivision (b).

(f) For purposes of this section, "clinician" means a state licensed mental health professional working within the State Department of State Hospitals who has received, and is current in, CLETS training that is appropriate for a person who has ongoing access to information from the CLETS and is not a CLETS operator, following the policies on training, compliance, and inspection required by the Department of Justice.

(g) State summary criminal history information secured pursuant to this section shall remain confidential and access shall be limited to the director of the state hospital and the clinician. Within 30 days of discharge from the state hospital, the state summary criminal history information shall be removed from the patient's file and destroyed.

*(Amended by Stats. 2015, Ch. 303, Sec. 572. (AB 731) Effective January 1, 2016.)*

**4143.** (a) Commencing July 1, 2015, and subject to available funding, the State Department of State Hospitals may establish and maintain pilot enhanced treatment programs (ETPs), as defined in Section 1265.9 of the Health and Safety Code, and evaluate the effectiveness of intensive, evidence-based clinical therapy and treatment of patients described in Section 4144.

(b) At least 60 days prior to activating an ETP, the State Department of State Hospitals shall submit written draft policies and procedures that will guide the operation of the ETP, including, but not limited to, admittance criteria, staffing levels, services to be provided to patients, a transition planning process, and training requirements, to the appropriate policy and fiscal committees of the Legislature and to the Joint Legislative Budget Committee.

*(Amended by Stats. 2015, Ch. 26, Sec. 48. (SB 85) Effective June 24, 2015.)*

**4144.** (a) A state hospital psychiatrist or psychologist may refer a patient to a pilot enhanced treatment program (ETP), as defined in Section 1265.9 of the Health and Safety Code, for temporary placement and risk assessment upon determining that the patient may be at high risk of most dangerous behavior and when safe treatment is not possible in a standard treatment environment. The referral may occur after admission to the State Department of State Hospitals, and after sufficient and documented evaluation of violence risk of the patient, with notice to the patients' rights advocate at the time of the referral. A patient shall not be placed into an ETP as a means of punishment, coercion, convenience, or retaliation.

(b) Within three business days of placement in an ETP, a dedicated forensic evaluator, who is not on the patient's treatment team, shall complete an initial evaluation of the patient that shall include an interview of the patient's treatment team, an analysis of diagnosis, past violence, current level of risk, and the need for enhanced treatment.

(c) (1) Within seven business days of placement in an ETP and with 72-hour notice to the patient and patients' rights advocate, the forensic needs assessment panel (FNAP) shall conduct a placement evaluation meeting with the referring psychiatrist or psychologist, the patient and patients' rights advocate, and the dedicated forensic evaluator who performed the initial evaluation. A determination shall be made as to whether the patient clinically requires ETP treatment.

(2) (A) The threshold standard for treatment in an ETP is met if a psychiatrist or psychologist, utilizing standard forensic methodologies for clinically assessing violence risk, determines that a patient meets the definition of a patient at high risk of most dangerous behavior and ETP treatment meets the identified needs of the patient and safe treatment is not possible in a standard treatment environment.

(B) Factors used to determine a patient's high risk of most dangerous behavior may include, but are not limited to, an analysis of past violence, delineation of static and dynamic violence risk factors, and utilization of valid and reliable violence risk assessment testing.

(3) If a patient has shown improvement during his or her placement in an ETP, the FNAP may delay its certification decision for another seven business days. The FNAP's determination of whether the patient will benefit from continued or longer term ETP placement and treatment shall be based on the threshold standard for treatment in an ETP specified in subparagraph (A) of paragraph (2).

(d) (1) The FNAP shall review all material presented at the FNAP placement evaluation meeting conducted under subdivision (c), and the FNAP shall either certify the patient for 90 days of treatment in an ETP or direct that the patient be returned to a standard treatment environment in the hospital.

(2) After the FNAP makes a decision to provide ETP treatment and if ETP treatment will be provided at a facility other than the current hospital, the transfer may take place as soon as transportation may reasonably be arranged, but no later than 30 days after the decision is made.

(3) The FNAP determination shall be in writing and provided to the patient and patients' rights advocate as soon as possible, but no later than three business days after the decision is made.

(e) (1) Upon admission to an ETP, a forensic needs assessment team (FNAT) psychologist who is not on the patient's multidisciplinary treatment team shall perform an in-depth violence risk assessment and make an individual treatment plan for the patient based on the assessment. The individual treatment plan shall:

(A) Be in writing and developed in collaboration with the patient, when possible. The initial treatment plan shall be developed as soon as possible, but no later than 72 hours following the patient's admission. The comprehensive treatment plan shall be developed following a complete violence risk assessment.

(B) Be based on a comprehensive assessment of the patient's physical, mental, emotional, and social needs, and focused on mitigation of violence risk factors.

(C) Be reviewed and updated no less than every 10 days.

(2) The individual treatment plan shall include, but is not limited to, all of the following:

(A) A statement of the patient's physical and mental condition, including all mental health and medical diagnoses.

(B) Prescribed medication, dosage, and frequency of administration.

(C) Specific goals of treatment with intervention and actions that identify steps toward reduction of violence risk and observable, measurable objectives.

(D) Identification of methods to be utilized, the frequency for conducting each treatment method, and the person, or persons, or discipline, or disciplines, responsible for each treatment method.

(E) Documentation of the success or failure in achieving stated objectives.

(F) Evaluation of the factors contributing to the patient's progress or lack of progress toward reduction of violence risk and a statement of the multidisciplinary treatment decision for followup action.

(G) An activity plan.

(H) A plan for other services needed by the patient, such as care for medical and physical ailments, which are not provided by the multidisciplinary treatment team.

(I) Discharge criteria and goals for an aftercare plan in a standard treatment environment and a plan for post-ETP discharge follow up.

(3) An ETP patient shall receive treatment from a multidisciplinary team consisting of a psychologist, a psychiatrist, a nurse, a psychiatric technician, a clinical social worker, a rehabilitation therapist, and any other necessary staff who shall meet as often as necessary, but no less than once a week, to assess the patient's response to treatment.

(4) The staff shall observe and note any changes in the patient's condition and the treatment plan shall be modified in response to the observed changes.

(5) Social work services shall be organized, directed, and supervised by a licensed clinical social worker.

(6) (A) Mental health treatment programs shall provide and conduct organized therapeutic social, recreational, and vocational activities in accordance with the interests, abilities, and needs of the patients, including the opportunity for exercise.

(B) Mental health rehabilitation therapy services shall be designed by and provided under the direction of a licensed mental health professional, a recreational therapist, or an occupational therapist.

(7) An aftercare plan for a standard treatment environment shall be developed.

(A) A written aftercare plan shall describe those services that should be provided to a patient following discharge, transfer, or release from an ETP for the purpose of enabling the patient to maintain stabilization or achieve an optimum level of functioning.

(B) Prior to or at the time of discharge, transfer, or release from an ETP, each patient shall be evaluated concerning the patient's need for aftercare services. This evaluation shall consider the patient's potential housing, probable need for continued treatment and social services, and need for continued medical and mental health care.

(C) Aftercare plans shall include, but shall not be limited to, arrangements for medication administration and follow-up care.

(D) A member of the multidisciplinary treatment team designated by the clinical director shall be responsible for ensuring that the aftercare plan has been completed and documented in the patient's health record.

(E) The patient shall receive a copy of the aftercare plan when referred to a standard treatment environment.

(f) Prior to the expiration of 90 days from the date of placement in an ETP and with 72-hour notice provided to the patient and the patients' rights advocate, the FNAP shall convene a treatment placement meeting with a psychologist from the treatment team, a patients' rights advocate, the patient, and the FNAT psychologist who performed the in-depth violence risk assessment. The FNAP shall determine whether the patient may return to a standard treatment environment or whether the patient clinically requires continued treatment in an ETP. If the FNAP determines that the patient clinically requires continued ETP placement, the patient shall be certified for further ETP placement for one year. The FNAP determination shall be in writing and provided to the patient and the patients' rights advocate within 24 hours of the meeting. If the FNAP determines that the patient is ready to be transferred to a standard treatment environment, the FNAP shall identify appropriate placement within a standard treatment environment in a state hospital, and transfer the patient within 30 days of the determination.

(g) If a patient has been certified for ETP treatment for one year pursuant to subdivision (f), the FNAP shall review the patient's treatment summary at least every 90 days to determine if the patient no longer clinically requires treatment in the ETP. This FNAP determination shall be in writing and provided to the patient and the patients' rights advocate within three business days of the meeting. If the FNAP determines that the patient no longer clinically requires treatment in the ETP, the FNAP shall identify appropriate placement, and transfer the patient within 30 days of the determination.

(h) Prior to the expiration of the one-year certification of ETP placement under subdivision (f), and with 72-hour notice provided to the patient and the patients' rights advocate, the FNAP shall convene a treatment placement meeting with the treatment team, the patients' rights advocate, the patient, and the FNAT psychologist who performed the in-depth violence risk assessment. The FNAP shall determine whether the patient clinically requires continued ETP treatment. The FNAP determination shall be in writing and provided to the patient and the patients' rights advocate within 24 hours of the meeting.

(i) If after the treatment placement meeting described in subdivision (h), and after discussion with the patient, the patients' rights advocate, patient's ETP team members, and review of documents and records, the FNAP determines that the patient clinically requires continued ETP placement, the patient's case shall be referred outside of the State Department of State Hospitals to a forensic psychiatrist or psychologist for an independent medical review for the purpose of assessing the patient's overall treatment plan and the need for ongoing ETP treatment. Notice of the referral shall be provided to the patient and the patients' rights advocate within 24 hours of the FNAP meeting as part of the FNAP determination. The notice shall include instructions for the patient to submit information to the forensic psychiatrist or psychologist conducting the independent medical review.

(1) The forensic psychiatrist or psychologist conducting the independent medical review shall be provided with the patient's medical and psychiatric documents and records, along with any additional information submitted by the patient, within five business days from the date of the FNAP's determination that the patient requires continued ETP placement.

(2) After reviewing the patient's medical and psychiatric documents and records, along with any additional information submitted by the patient, but no later than 14 days after the receipt of the patient's medical and psychiatric documents and records, the forensic psychiatrist or psychologist conducting the independent medical review shall provide the State Department of State Hospitals, the patient, and the patients' rights advocate with a written notice of the date and time for a hearing. At least one FNAP member is required to attend the hearing. The notice shall be provided at least 72 hours in advance of the hearing, shall include a statement that at least one FNAP member is required to attend the hearing, and advise the patient of his or her right to a hearing or to waive his or her right to a hearing. The notice shall also include a statement that the patient may have assistance of a patients' rights advocate or staff member at the hearing. Seventy-two-hour notice shall also be provided to any individuals whose presence is requested by the forensic psychiatrist or psychologist conducting the independent medical review in order to help assess the patient's overall treatment plan and the need for ongoing ETP treatment.

(3) If the patient waives his or her right to a hearing, the forensic psychiatrist or psychologist conducting the independent medical review shall make recommendations to the FNAP on whether or not the patient should be certified for ongoing ETP treatment.

(4) If the patient does not waive the right to a hearing, both of the following shall be provided:

(A) If the patient elects to have the assistance of a patients' rights advocate or a staff person, the requested person shall provide assistance relating to the hearing, whether or not the patient is present at the hearing, unless the forensic psychiatrist

or psychologist conducting the hearing finds good cause why the requested person should not participate. Good cause includes a reasonable concern for the safety of a staff member requested to be present at the hearing.

(B) An opportunity for the patient to present information, statements, or arguments, either orally or in writing, to show either that the information relied on for the FNAP's determination for ongoing treatment is erroneous, or any other relevant information.

(5) The conclusion reached by the forensic psychiatrist or psychologist who conducts the independent medical review shall be in writing and provided to the State Department of State Hospitals, the patient, and the patients' rights advocate within three business days of the conclusion of the hearing.

(6) If the forensic psychiatrist or psychologist who conducts the independent medical review concludes that the patient requires ongoing ETP treatment, the patient shall be certified for further treatment for an additional year.

(7) If the forensic psychiatrist or psychologist who conducts the independent medical review determines that the patient no longer requires ongoing ETP treatment, the FNAP shall identify appropriate placement and transfer the patient within 30 days of determination.

(j) At any point during the ETP placement, if a patient's treatment team determines that the patient no longer clinically requires ETP treatment, a recommendation to transfer the patient out of the ETP shall be made to the FNAT or FNAP.

(k) The process described in this section may continue until the patient no longer clinically requires ETP treatment or until the patient is discharged from the State Department of State Hospitals.

(l) As used in this section, the following terms have the following meanings:

(1) "Enhanced treatment program" or "ETP" means a supplemental treatment unit as defined in Section 1265.9 of the Health and Safety Code.

(2) "Forensic needs assessment panel" or "FNAP" means a panel that consists of a psychiatrist, a psychologist, and the medical director of the hospital or facility, none of whom are involved in the patient's treatment or diagnosis at the time of the hearing or placement meetings.

(3) "Forensic needs assessment team" or "FNAT" means a panel of psychologists with expertise in forensic assessment or violence risk assessment, each of whom are assigned an ETP case or group of cases.

(4) "In-depth violence risk assessment" means the utilization of standard forensic methodologies for clinically assessing the risk of a patient posing a substantial risk of inpatient aggression.

(5) "Patients' rights advocate" means the advocate contracted under Sections 5370.2 and 5510.

(6) "Patient at high risk of most dangerous behavior" means the individual has a history of physical violence and currently poses a demonstrated danger of inflicting substantial physical harm upon others in an inpatient setting, as determined by an evidence-based, in-depth violence risk assessment conducted by the State Department of State Hospitals.

(m) The State Department of State Hospitals may adopt emergency regulations in accordance with the Administrative Procedures Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) to implement the treatment components of this section. The adoption of an emergency regulation under this paragraph is deemed to address an emergency, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the State Department of State Hospitals is hereby exempted for this purpose from the requirements of subdivision (b) of Section 11346.1 of the Government Code.

*(Amended by Stats. 2015, Ch. 303, Sec. 573. (AB 731) Effective January 1, 2016.)*

**4145.** (a) The State Department of State Hospitals shall monitor the pilot enhanced treatment programs (ETP), evaluate outcomes, and report on its findings and recommendations. This report shall be provided to the fiscal and policy committees of the Legislature annually, beginning on January 10 of the first year after which the first ETP is opened and services have commenced, and shall be in compliance with Section 9795 of the Government Code. The evaluation shall include, but is not limited to, all of the following:

(1) Comparative summary information regarding the characteristics of the patients served.

(2) Compliance with staffing requirements.

(3) Staff classification to patient ratio.

(4) Average monthly occupancy.

(5) Average length of stay.

(6) The number of residents whose length of stay exceeds 90 days.

(7) The number of patients with multiple stays.

(8) The number of patients whose discharge was delayed due to lack of available beds in a standard treatment environment.

(9) Restraint and seclusion use, including the number of incidents and duration, consistent with paragraph (3) of subdivision (d) of Section 1180.2 of the Health and Safety Code.

(10) Serious injuries to staff and residents.

(11) Serious injuries to staff and residents related to the use of seclusion and restraints as defined under Section 1180 of the Health and Safety Code.

(12) Staff turnover.

(13) The number of patients' rights complaints, including the subject of the complaint and its resolution.

(14) Type and number of training provided for ETP staff.

(15) Staffing levels for ETPs.

(b) The State Department of State Hospitals' reporting requirements under Section 4023 of the Welfare and Institutions Code, shall apply to the ETPs.

*(Added by Stats. 2014, Ch. 718, Sec. 6. (AB 1340) Effective January 1, 2015.)*

**4146.** (a) This section applies in cases in which a patient has been committed to the department as a mentally disordered offender, including a person found not guilty by reason of insanity, or a person found incompetent to stand trial or be adjudged to punishment.

(b) (1) A physician employed by the department who determines that a patient meets the criteria set forth in subparagraph (A) or (C) of paragraph (5) shall notify the medical director and the patient advocate of the prognosis. If the medical director concurs with the diagnosis, he or she shall immediately notify the Director of State Hospitals. Within 72 hours of receiving notification, the medical director or the medical director's designee shall notify the patient of the discharge procedures under this section and obtain the patient's consent for discharge. The medical director or the medical director's designee shall arrange for the patient to designate a family member or other outside agent to be notified as to the patient's medical condition, prognosis, and release procedures under this section. If the patient is unable to designate a family member or other outside agent, the medical director or the medical director's designee shall contact any emergency contact listed, or the patient advocate if no contact is listed.

(2) The medical director or the medical director's designee shall provide the patient and his or her family member, agent, emergency contact, or patient advocate with updated information throughout the release process with regard to the patient's medical condition and the status of the patient's release proceedings, including the discharge plan. A patient shall not be released unless the discharge plan verifies placement for the patient upon release.

(3) The patient or his or her family member or designee may contact the medical director or the executive director at the state hospital where the patient is located or the Director of State Hospitals to request consideration for a recommendation from the medical director or the medical director's designee to the court that the patient's commitment be suspended for compassionate release and the patient released from the department facility.

(4) Upon receipt of a notification or request pursuant to paragraph (1) or (3), respectively, the Director of State Hospitals may recommend to the court that the patient's commitment be suspended for compassionate release and the patient released from the department facility.

(5) The court has the discretion to suspend the commitment for compassionate release and release the patient if the court finds that the facts described in subparagraphs (A) and (B) or subparagraphs (B) and (C) exist:

(A) The patient is terminally ill with an incurable condition caused by an illness or disease that would likely produce death within six months, as determined by a physician employed by the department.

(B) The conditions under which the patient would be released or receive treatment do not pose a threat to public safety.

(C) The patient 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 patient requiring 24-hour total care, including, but not limited to, coma, persistent vegetative state, brain death, ventilator-dependency, or loss of control of muscular or neurological function, the

incapacitation did not exist at the time of the original commitment, and the medical director responsible for the patient's care and the Director of State Hospitals both certify that the patient is incapable of receiving mental health treatment.

(c) Within 10 days of receipt of a recommendation for release by the director, the court shall hold a noticed hearing to consider whether the patient's commitment should be suspended and the patient released.

(d) A recommendation for compassionate release submitted to the court shall include at least one medical evaluation, a discharge plan, a postrelease plan for the relocation and treatment of the patient, and the physician's and medical director's determination that the patient meets the criteria set forth in subparagraph (A) or (C) of paragraph (5) of subdivision (b). The court shall order the medical director to send copies of all medical records reviewed in developing the recommendation to all of the following parties:

(1) The district attorney of the county from which the patient was committed.

(2) If the patient is a mentally disordered offender on parole, the district attorney of the county from which the patient was committed to the state prison.

(3) The public defender of the county from which the patient was committed, or the patient's private attorney, if one is available.

(4) If the patient is a mentally disordered offender on parole, the public defender of the county from which the patient was committed to the state prison, if one is available, or the patient's private attorney, if applicable.

(5) If the patient is a mentally disordered offender on parole, the Board of Parole Hearings.

(6) If the patient is on mandatory supervision or postrelease community supervision and has been found incompetent to be adjudged to punishment, the county entity designated to supervise him or her.

(e) (1) The matter shall be heard before the same judge that originally committed the patient, if possible.

(2) If the patient is a mentally disordered offender on parole and was committed for treatment by the Board of Parole Hearings, the matter shall be heard by the court that committed the patient to the state prison for the underlying conviction, if possible.

(f) If the court approves the recommendation for compassionate release, the patient's commitment shall be suspended and the patient shall be released by the department within 72 hours of receipt of the court's order, unless a longer time period is requested by the director and approved by the court.

(g) The executive director of the state hospital or his or her designee shall ensure that upon release, the patient has each of the following in his or her possession, or the possession of the patient's representative:

(1) A discharge plan.

(2) A discharge medical summary.

(3) Medical records.

(4) Identification.

(5) All necessary medications.

(6) Any property belonging to the patient.

(h) After discharge, any additional records shall be sent to the patient's forwarding address.

(i) The Director of State Hospitals may adopt regulations to implement this section. The adoption of regulations for the implementation of this section by the department is exempt from the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(j) For the purposes of this section, a patient whose commitment has been suspended for compassionate release shall not be considered to be under the custody of, or the responsibility of, the State Department of State Hospitals.

(k) If a patient's commitment order is suspended pursuant to this section, it may be reinstated by the court pursuant to a finding by the State Department of State Hospitals that the patient's condition has changed such that he or she poses a threat to public safety, or no longer meets the criteria for compassionate release described in subparagraph (A) or (C) of paragraph (5) of subdivision (b).

(l) The State Department of State Hospitals, in consultation with relevant stakeholders, including, but not limited to, local law enforcement and correctional officials, shall promulgate regulations in accordance with subdivision (i) to establish a process for petitioning the court for reinstatement of a suspended commitment order, pursuant to subdivision (k).

*(Added by Stats. 2016, Ch. 715, Sec. 4. (SB 955) Effective January 1, 2017.)*

**4147.** (a) To confront the crisis of individuals found incompetent to stand trial (IST) and in recognition of the importance of these defendants who are committed to the State Department of State Hospitals to begin receiving competency treatment as soon as

practicable, the California Health and Human Services Agency along with the State Department of State Hospitals shall convene an Incompetent to Stand Trial Solutions Workgroup to identify short, medium, and long-term solutions to advance alternatives to placement at the State Department of State Hospitals.

(b) Workgroup members shall be appointed by the Secretary of California Health and Human Services and the workgroup shall be chaired by the Director of the State Department of State Hospitals. Members of the workgroup shall serve without compensation. Members may include, but are not limited to, representatives from the following entities and interested parties:

(1) California Health and Human Services Agency.

(2) State Department of Health Care Services.

(3) State Department of Developmental Services.

(4) Department of Corrections and Rehabilitation.

(5) Department of Finance.

(6) Other state agencies, as needed.

(7) Judicial Council.

(8) Other partners, including local government and justice system representatives of entities involved in the commitment of IST defendants to the State Department of State Hospitals and representatives of patients and their family members, as needed.

(c) The workgroup shall submit recommendations to the California Health and Human Services Agency and the Department of Finance no later than November 30, 2021, outlining short-term solutions that can be accomplished by April 1, 2022, medium-term solutions that can be accomplished by January 10, 2023, and long-term solutions that can be accomplished by January 10, 2024, and January 10, 2025, to support the State Department of State Hospitals in serving individuals with the most intensive behavioral health treatment needs and providing timely access to treatment for individuals found IST on felony charges.

(d) The workgroup may meet as often as bi-weekly until the workgroup is disbanded by the Secretary of California Health and Human Services.

(e) The workgroup may consider, but is not limited to, recommendations that accomplish any of the following:

(1) Reduce the total number of felony defendants determined to be IST.

(2) Reduce the lengths of stay for felony IST patients.

(3) Support felony IST defendants to receive early access to treatment before transfer to a restoration of competency treatment program to achieve stabilization and restoration of competency sooner.

(4) Support increased access to felony IST diversion options.

(5) Expand treatment options for felony IST individuals, such as community-based restoration programs, jail-based competency treatment programs, and state hospital beds.

(6) Create new options for treatment of felony IST defendants including community based, locked and unlocked facilities.

(7) Establish partnerships to facilitate admissions and discharges to reduce recidivism and ensure that the most acute, high-risk, and at need patients receive access to State Department of State Hospitals beds, while patients with lower risk or acuity are treated in appropriate community settings.

(f) (1) Until December 31, 2024, if the Secretary of California Health and Human Services determines that either of the conditions stated in subparagraphs (A) or all of the conditions stated in subparagraph (B) have occurred, the State Department of State Hospitals may take the actions described in paragraph (2), if authorized by the Secretary of California Health and Human Services and the Department of Finance, and after Department of Finance has provided no less than a 30-day notification to the Joint Legislative Budget Committee and the State Department of State Hospitals has provided notification to the county public guardian and county behavioral agencies.

(A) The recommendations required to be completed by subdivision (c) cannot be completed due to reasons outside of the control of the California Health and Human Services Agency or the State Department of State Hospitals.

(B)(i) Insufficient progress has been made in implementing the recommendations in a timely manner to provide timely access to competency treatment for IST defendants committed to the State Department of State Hospitals.

(ii) IST commitments to the State Department of State Hospitals continues to exceed the capacity available, in facilities the department has jurisdiction over pursuant to Section 4100, to provide restoration of competency treatment.

(iii) The State Department of State Hospitals continues to maintain an IST admission waitlist that exceeds the capacity of the facilities within its jurisdiction pursuant to Section 4100 to admit IST commitments.

(iv) As a result of the conditions described in clauses (i) through (iii), inclusive, IST defendants committed to the State Department of State Hospitals are not able to receive timely access to restoration of competency treatment and no reasonable state solutions are available, including timely solutions to increase capacity within the facilities within its jurisdiction pursuant to Section 4100 that may admit IST commitments.

(2) If the requirements of paragraph (1) are met, the State Department of State Hospitals may take the following actions:

(A) The State Department of State Hospitals may discontinue admissions for new patients committed to a state hospital pursuant to Section 5358.

(B) The State Department of State Hospitals may, following the determination by the Secretary of California Health and Human Services pursuant to paragraph (1), impose patient reduction targets over the next three fiscal years for patients committed to a state hospital pursuant to Section 5358. Reduction targets shall only be to the minimum level necessary to achieve timely access to treatment for IST commitments, as determined by the State Department of State Hospitals and the Secretary of California Health and Human Services and will allow no less than a minimum of six months for the first reduction target to be achieved.

(C) The State Department of State Hospitals may charge 150 percent of the daily bed rate for counties, pursuant to Section 4330, that exceed the bed usage for patients admitted pursuant to Section 5358 and that are above the specified patient reduction targets made pursuant to subparagraph (B).

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of State Hospitals may implement, interpret, or make specific this section by means of a departmental letter or other similar instruction, as necessary.

(h) Contracts awarded pursuant to this section, including contracts to implement solutions developed by the Incompetent to Stand Trial Solutions Workgroup, shall be exempt from the requirements contained in the Public Contract Code, Section 19130 of the Government Code, Section 4101.5, and the State Administrative Manual and shall not be subject to approval by the Department of General Services.

*(Added by Stats. 2021, Ch. 143, Sec. 350. (AB 133) Effective July 27, 2021.)*

**4148.** (a) On or before January 31, 2026, the State Department of State Hospitals shall submit a report to the Senate Committee on Budget and Fiscal Review and the Assembly Committee on Budget providing amounts expended during the 2024–25 fiscal year, pursuant to Article 10.15 of the Bargaining Unit 16 Memorandum of Understanding between the State of California and the Union of American Physicians and Dentists, related to the following:

(1) The amount budgeted for civil service psychiatrists.

(2) The amount expended for civil service psychiatrists.

(3) The amount expended on civil service psychiatrists working additional caseload.

(4) The number of civil service psychiatrists who participated in working additional caseload.

(5) The amount expended on contract psychiatrists.

(b) This section shall become inoperative on June 30, 2026, and, as of January 1, 2027, is repealed.

*(Added by Stats. 2024, Ch. 231, Sec. 1. (AB 310) Effective January 1, 2025. Inoperative June 30, 2026, by its own provisions. Repealed as of January 1, 2027, by its own provisions.)*