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AMENDED IN SENATE APRIL 3, 2014
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AMENDED IN ASSEMBLY MAY 24, 2013
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CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL

No. 1340

Introduced by Assembly Member Achadjian
(Coauthor: Assembly Member Yamada)
(Coauthors: Senators Beall and Wolk)

February 22, 2013

An act to amend Section 1250 of, and to add Section 1265.9 to, the Health and Safety Code, and to amend Sections 4100 and 7200 of, and to add Sections 4142 and 4143 to, the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

AB 1340, as amended, Achadjian. Enhanced treatment programs.

Existing law establishes state hospitals for the care, treatment, and education of mentally disordered persons. These hospitals are under the jurisdiction of the State Department of State Hospitals, which is authorized by existing law to adopt regulations regarding the conduct and management of these facilities. Existing law requires each state hospital to develop an incident reporting procedure that can be used to, at a minimum, develop reports of patient assaults on employees and

assist the hospital in identifying risks of patient assaults on employees. Existing law provides for the licensure and regulation of health facilities, including acute psychiatric hospitals, by the State Department of Public Health. A violation of these provisions is a crime.

This bill would, commencing July 1, 2015, and subject to available funding, authorize the State Department of State Hospitals to establish and maintain enhanced treatment programs (ETPs), as defined, for the treatment of patients who are at high risk for most dangerous behavior, as defined, and when treatment is not possible in a standard treatment environment. The bill would require, until January 1, 2018, that an ETP meet the licensing requirements of an acute psychiatric hospital, except as specified. Commencing January 1, 2018, an ETP that is operated by the State Department of State Hospitals would be required to be licensed by the State Department of Public Health.

The bill would authorize a state hospital psychiatrist or psychologist to refer a patient to an ETP for temporary placement and risk assessment upon a determination that the patient may be at high risk for most dangerous behavior. The bill would require the forensic needs assessment panel (FNAP) to conduct a placement evaluation to determine whether the patient clinically requires ETP placement and ETP treatment can meet the identified needs of the patient. The bill would also require a forensic needs assessment team (FNAT) psychologist to perform an in-depth violence risk assessment and make a treatment plan upon the patient's admission to an ETP.

The bill would require the FNAP to conduct a treatment placement meeting with specified individuals prior to the expiration of 90 days from the date of placement in the ETP to determine whether the patient may return to a standard treatment environment or the patient clinically requires continued ETP treatment. If the FNAP determines that the patient clinically requires continued ETP treatment, the bill would require the FNAP to certify the patient for further ETP treatment for one year, subject to FNAP reviews every 90 days, as specified. The bill would require the FNAP to conduct another treatment placement meeting prior to the expiration of the one-year certification of ETP placement to determine whether the patient may return to a standard treatment environment or be certified for further ETP treatment for another year.

Because this bill would create a new crime, it imposes a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.

State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. (a) The Legislature finds and declares that the
2 State Department of State Hospitals delivers inpatient mental health
3 treatment to over 6,000 patients through more than 10,000
4 department employees. Their goal is to improve the lives of patients
5 diagnosed with severe mental health conditions who have been
6 assigned to their hospitals and units. In the experience of the
7 department, there can be no effective clinical treatment without
8 safety for its patients and employees, and no safety without
9 effective clinical treatment.

10 (b) It is the intent of the Legislature in enacting this bill to
11 expand the range of available clinical treatment by establishing
12 enhanced treatment programs for those patients determined to be
13 at the highest risk for aggression against other patients or hospital
14 staff. The goal of these enhanced treatment programs is to deliver
15 concentrated, evidence-based clinical therapy, and treatment in an
16 environment designed to improve these patients' conditions and
17 return them to the general patient population.

18 SEC. 2. Section 1250 of the Health and Safety Code is amended
19 to read:

20 1250. As used in this chapter, "health facility" means any
21 facility, place, or building that is organized, maintained, and
22 operated for the diagnosis, care, prevention, and treatment of
23 human illness, physical or mental, including convalescence and
24 rehabilitation and including care during and after pregnancy, or
25 for any one or more of these purposes, for one or more persons,
26 to which the persons are admitted for a 24-hour stay or longer, and
27 includes the following types:

28 (a) "General acute care hospital" means a health facility having
29 a duly constituted governing body with overall administrative and
30 professional responsibility and an organized medical staff that

1 provides 24-hour inpatient care, including the following basic
2 services: medical, nursing, surgical, anesthesia, laboratory,
3 radiology, pharmacy, and dietary services. A general acute care
4 hospital may include more than one physical plant maintained and
5 operated on separate premises as provided in Section 1250.8. A
6 general acute care hospital that exclusively provides acute medical
7 rehabilitation center services, including at least physical therapy,
8 occupational therapy, and speech therapy, may provide for the
9 required surgical and anesthesia services through a contract with
10 another acute care hospital. In addition, a general acute care
11 hospital that, on July 1, 1983, provided required surgical and
12 anesthesia services through a contract or agreement with another
13 acute care hospital may continue to provide these surgical and
14 anesthesia services through a contract or agreement with an acute
15 care hospital. The general acute care hospital operated by the State
16 Department of Developmental Services at Agnews Developmental
17 Center may, until June 30, 2007, provide surgery and anesthesia
18 services through a contract or agreement with another acute care
19 hospital. Notwithstanding the requirements of this subdivision, a
20 general acute care hospital operated by the Department of
21 Corrections and Rehabilitation or the Department of Veterans
22 Affairs may provide surgery and anesthesia services during normal
23 weekday working hours, and not provide these services during
24 other hours of the weekday or on weekends or holidays, if the
25 general acute care hospital otherwise meets the requirements of
26 this section.

27 A “general acute care hospital” includes a “rural general acute
28 care hospital.” However, a “rural general acute care hospital” shall
29 not be required by the department to provide surgery and anesthesia
30 services. A “rural general acute care hospital” shall meet either of
31 the following conditions:

32 (1) The hospital meets criteria for designation within peer group
33 six or eight, as defined in the report entitled Hospital Peer Grouping
34 for Efficiency Comparison, dated December 20, 1982.

35 (2) The hospital meets the criteria for designation within peer
36 group five or seven, as defined in the report entitled Hospital Peer
37 Grouping for Efficiency Comparison, dated December 20, 1982,
38 and has no more than 76 acute care beds and is located in a census
39 dwelling place of 15,000 or less population according to the 1980
40 federal census.

1 (b) “Acute psychiatric hospital” means a health facility having
2 a duly constituted governing body with overall administrative and
3 professional responsibility and an organized medical staff that
4 provides 24-hour inpatient care for mentally disordered,
5 incompetent, or other patients referred to in Division 5
6 (commencing with Section 5000) or Division 6 (commencing with
7 Section 6000) of the Welfare and Institutions Code, including the
8 following basic services: medical, nursing, rehabilitative,
9 pharmacy, and dietary services.

10 (c) (1) “Skilled nursing facility” means a health facility that
11 provides skilled nursing care and supportive care to patients whose
12 primary need is for availability of skilled nursing care on an
13 extended basis.

14 (2) “Skilled nursing facility” includes a “small house skilled
15 nursing facility (SHSNF),” as defined in Section 1323.5.

16 (d) “Intermediate care facility” means a health facility that
17 provides inpatient care to ambulatory or nonambulatory patients
18 who have recurring need for skilled nursing supervision and need
19 supportive care, but who do not require availability of continuous
20 skilled nursing care.

21 (e) “Intermediate care facility/developmentally disabled
22 habilitative” means a facility with a capacity of 4 to 15 beds that
23 provides 24-hour personal care, habilitation, developmental, and
24 supportive health services to 15 or fewer persons with
25 developmental disabilities who have intermittent recurring needs
26 for nursing services, but have been certified by a physician and
27 surgeon as not requiring availability of continuous skilled nursing
28 care.

29 (f) “Special hospital” means a health facility having a duly
30 constituted governing body with overall administrative and
31 professional responsibility and an organized medical or dental staff
32 that provides inpatient or outpatient care in dentistry or maternity.

33 (g) “Intermediate care facility/developmentally disabled” means
34 a facility that provides 24-hour personal care, habilitation,
35 developmental, and supportive health services to persons with
36 developmental disabilities whose primary need is for
37 developmental services and who have a recurring but intermittent
38 need for skilled nursing services.

39 (h) “Intermediate care facility/developmentally
40 disabled-nursing” means a facility with a capacity of 4 to 15 beds

1 that provides 24-hour personal care, developmental services, and
2 nursing supervision for persons with developmental disabilities
3 who have intermittent recurring needs for skilled nursing care but
4 have been certified by a physician and surgeon as not requiring
5 continuous skilled nursing care. The facility shall serve medically
6 fragile persons with developmental disabilities or who demonstrate
7 significant developmental delay that may lead to a developmental
8 disability if not treated.

9 (i) (1) “Congregate living health facility” means a residential
10 home with a capacity, except as provided in paragraph (4), of no
11 more than 12 beds, that provides inpatient care, including the
12 following basic services: medical supervision, 24-hour skilled
13 nursing and supportive care, pharmacy, dietary, social, recreational,
14 and at least one type of service specified in paragraph (2). The
15 primary need of congregate living health facility residents shall
16 be for availability of skilled nursing care on a recurring,
17 intermittent, extended, or continuous basis. This care is generally
18 less intense than that provided in general acute care hospitals but
19 more intense than that provided in skilled nursing facilities.

20 (2) Congregate living health facilities shall provide one of the
21 following services:

22 (A) Services for persons who are mentally alert, persons with
23 physical disabilities, who may be ventilator dependent.

24 (B) Services for persons who have a diagnosis of terminal
25 illness, a diagnosis of a life-threatening illness, or both. Terminal
26 illness means the individual has a life expectancy of six months
27 or less as stated in writing by his or her attending physician and
28 surgeon. A “life-threatening illness” means the individual has an
29 illness that can lead to a possibility of a termination of life within
30 five years or less as stated in writing by his or her attending
31 physician and surgeon.

32 (C) Services for persons who are catastrophically and severely
33 disabled. A person who is catastrophically and severely disabled
34 means a person whose origin of disability was acquired through
35 trauma or nondegenerative neurologic illness, for whom it has
36 been determined that active rehabilitation would be beneficial and
37 to whom these services are being provided. Services offered by a
38 congregate living health facility to a person who is catastrophically
39 disabled shall include, but not be limited to, speech, physical, and
40 occupational therapy.

1 (3) A congregate living health facility license shall specify which
2 of the types of persons described in paragraph (2) to whom a
3 facility is licensed to provide services.

4 (4) (A) A facility operated by a city and county for the purposes
5 of delivering services under this section may have a capacity of
6 59 beds.

7 (B) A congregate living health facility not operated by a city
8 and county servicing persons who are terminally ill, persons who
9 have been diagnosed with a life-threatening illness, or both, that
10 is located in a county with a population of 500,000 or more persons,
11 or located in a county of the 16th class pursuant to Section 28020
12 of the Government Code, may have not more than 25 beds for the
13 purpose of serving persons who are terminally ill.

14 (C) A congregate living health facility not operated by a city
15 and county serving persons who are catastrophically and severely
16 disabled, as defined in subparagraph (C) of paragraph (2) that is
17 located in a county of 500,000 or more persons may have not more
18 than 12 beds for the purpose of serving persons who are
19 catastrophically and severely disabled.

20 (5) A congregate living health facility shall have a
21 noninstitutional, homelike environment.

22 (j) (1) "Correctional treatment center" means a health facility
23 operated by the Department of Corrections and Rehabilitation, the
24 Department of Corrections and Rehabilitation, Division of Juvenile
25 Facilities, or a county, city, or city and county law enforcement
26 agency that, as determined by the department, provides inpatient
27 health services to that portion of the inmate population who do not
28 require a general acute care level of basic services. This definition
29 shall not apply to those areas of a law enforcement facility that
30 houses inmates or wards who may be receiving outpatient services
31 and are housed separately for reasons of improved access to health
32 care, security, and protection. The health services provided by a
33 correctional treatment center shall include, but are not limited to,
34 all of the following basic services: physician and surgeon,
35 psychiatrist, psychologist, nursing, pharmacy, and dietary. A
36 correctional treatment center may provide the following services:
37 laboratory, radiology, perinatal, and any other services approved
38 by the department.

39 (2) Outpatient surgical care with anesthesia may be provided,
40 if the correctional treatment center meets the same requirements

1 as a surgical clinic licensed pursuant to Section 1204, with the
2 exception of the requirement that patients remain less than 24
3 hours.

4 (3) Correctional treatment centers shall maintain written service
5 agreements with general acute care hospitals to provide for those
6 inmate physical health needs that cannot be met by the correctional
7 treatment center.

8 (4) Physician and surgeon services shall be readily available in
9 a correctional treatment center on a 24-hour basis.

10 (5) It is not the intent of the Legislature to have a correctional
11 treatment center supplant the general acute care hospitals at the
12 California Medical Facility, the California Men's Colony, and the
13 California Institution for Men. This subdivision shall not be
14 construed to prohibit the Department of Corrections and
15 Rehabilitation from obtaining a correctional treatment center
16 license at these sites.

17 (k) "Nursing facility" means a health facility licensed pursuant
18 to this chapter that is certified to participate as a provider of care
19 either as a skilled nursing facility in the federal Medicare Program
20 under Title XVIII of the federal Social Security Act (42 U.S.C.
21 Sec. 1395 et seq.) or as a nursing facility in the federal Medicaid
22 Program under Title XIX of the federal Social Security Act (42
23 U.S.C. Sec. 1396 et seq.), or as both.

24 (l) Regulations defining a correctional treatment center described
25 in subdivision (j) that is operated by a county, city, or city and
26 county, the Department of Corrections and Rehabilitation, or the
27 Department of Corrections and Rehabilitation, Division of Juvenile
28 Facilities, shall not become effective prior to, or if effective, shall
29 be inoperative until January 1, 1996, and until that time these
30 correctional facilities are exempt from any licensing requirements.

31 (m) "Intermediate care facility/developmentally
32 disabled-continuous nursing (ICF/DD-CN)" means a homelike
33 facility with a capacity of four to eight, inclusive, beds that
34 provides 24-hour personal care, developmental services, and
35 nursing supervision for persons with developmental disabilities
36 who have continuous needs for skilled nursing care and have been
37 certified by a physician and surgeon as warranting continuous
38 skilled nursing care. The facility shall serve medically fragile
39 persons who have developmental disabilities or demonstrate
40 significant developmental delay that may lead to a developmental

1 disability if not treated. ICF/DD-CN facilities shall be subject to
2 licensure under this chapter upon adoption of licensing regulations
3 in accordance with Section 1275.3. A facility providing continuous
4 skilled nursing services to persons with developmental disabilities
5 pursuant to Section 14132.20 or 14495.10 of the Welfare and
6 Institutions Code shall apply for licensure under this subdivision
7 within 90 days after the regulations become effective, and may
8 continue to operate pursuant to those sections until its licensure
9 application is either approved or denied.

10 (n) “Hospice facility” means a health facility licensed pursuant
11 to this chapter with a capacity of no more than 24 beds that
12 provides hospice services. Hospice services include, but are not
13 limited to, routine care, continuous care, inpatient respite care, and
14 inpatient hospice care as defined in subdivision (d) of Section
15 1339.40, and is operated by a provider of hospice services that is
16 licensed pursuant to Section 1751 and certified as a hospice
17 pursuant to Part 418 of Title 42 of the Code of Federal Regulations.

18 (o) (1) “Enhanced treatment program” or “ETP” means a health
19 facility under the jurisdiction of the State Department of State
20 Hospitals that provides 24-hour inpatient care for mentally
21 disordered, incompetent, or other patients who have been
22 committed to the State Department of State Hospitals and have
23 been assessed to be at high risk for most dangerous behavior, as
24 defined in subdivision (k) of Section 4143 of the Welfare and
25 Institutions Code, and cannot be effectively treated within an acute
26 psychiatric hospital, a skilled nursing facility, or an intermediate
27 care facility, including the following basic services: medical,
28 nursing, rehabilitative, pharmacy, and dietary service.

29 (2) It is not the intent of the Legislature to have an enhanced
30 treatment program supplant health facilities licensed as an acute
31 psychiatric hospital, a skilled nursing facility, or an intermediate
32 care facility under this chapter.

33 (3) Commencing July 1, 2015, and until January 1, 2018, an
34 enhanced treatment program shall meet the licensing requirements
35 applicable to acute psychiatric hospitals under Chapter 2
36 (commencing with Section 71001) of Division 5 of the California
37 Code of Regulations, unless otherwise specified in Section 1265.9
38 and any related emergency regulations adopted pursuant to that
39 section.

1 (4) Commencing January 1, 2018, an ETP shall be subject to
2 licensure under this chapter as specified in subdivision (a) of
3 Section 1265.9.

4 SEC. 3. Section 1265.9 is added to the Health and Safety Code,
5 to read:

6 1265.9. (a) On and after January 1, 2018, an enhanced
7 treatment program (ETP) that is operated by the State Department
8 of State Hospitals shall be licensed by the State Department of
9 Public Health to provide treatment for patients who are at high
10 risk for most dangerous behavior, as defined by subdivision (k) of
11 Section 4143 of the Welfare and Institutions Code. Each ETP shall
12 be part of a continuum of care based on the individual patient's
13 treatment needs.

14 (b) (1) Notwithstanding subdivision (a), commencing July 1,
15 2015, and until January 1, 2018, the State Department of State
16 Hospitals may establish and maintain an ETP for the treatment of
17 patients who are at high risk for most dangerous behavior, as
18 described in Section 4142 of the Welfare and Institutions Code, if
19 the ETP meets the licensing requirements applicable to acute
20 psychiatric hospitals under Chapter 2 (commencing with Section
21 71001) of Division 5 of the California Code of Regulations, unless
22 otherwise specified in this section or emergency regulations
23 adopted pursuant to paragraph (2).

24 (2) Prior to January 1, 2018, the State Department of State
25 Hospitals may adopt emergency regulations in accordance with
26 the ~~Administrative Procedures~~ *Procedure* Act (Chapter 3.5
27 (commencing with Section 11340) of Part 1 of Division 3 of Title
28 2 of the Government Code) to implement this section. The adoption
29 of an emergency regulation under this paragraph is deemed to
30 address an emergency, for purposes of Sections 11346.1 and
31 11349.6 of the Government Code, and the State Department of
32 State Hospitals is hereby exempted for this purpose from the
33 requirements of subdivision (b) of Section 11346.1 of the
34 Government Code.

35 (c) An ETP shall meet all of the following requirements:

36 (1) Maintain a staff-to-patient ratio of one to five.

37 (2) Limit each room to one patient.

38 (3) Each patient room shall allow visual access by staff 24 hours
39 per day.

40 (4) Each patient room shall have a bathroom in the room.

1 (5) Each patient room door shall have the capacity to be locked
2 externally. The door may be locked when clinically indicated and
3 determined to be the least restrictive environment for provision of
4 the patient's care and treatment pursuant to Section 4143 of the
5 Welfare and Institutions Code, but shall not be considered seclusion
6 for purposes of Division 1.5 (commencing with Section 1180).

7 (6) Provide emergency egress for ETP patients.

8 (d) The ETP shall adopt and implement policies and procedures
9 consistent with regulations adopted by the State Department of
10 State Hospitals that provide all of following:

11 (1) Policies and procedures for admission into the ETP.

12 (2) Clinical assessment and review focused on behavior, history,
13 dangerousness, and clinical need for patients to receive treatment
14 in the ETP.

15 (3) A process for identifying which ETP along a continuum of
16 care will best meet the patient's needs.

17 (4) A process for a treatment plan with regular clinical review
18 and reevaluation of placement back into a standard treatment
19 environment that includes discharge and reintegration planning.

20 (e) Patients who have been admitted to an ETP shall have the
21 rights guaranteed to patients not in an ETP with the exception set
22 forth in paragraph (5) of subdivision (c).

23 (f) (1) Commencing January 1, 2018, the department shall
24 monitor the ETPs, evaluate outcomes, and report on its findings
25 and recommendations to the Legislature, in compliance with
26 Section 9795 of the Government Code, every two years.

27 (2) The requirement for submitting findings and
28 recommendations to the Legislature every two years under
29 paragraph ~~(2)~~ (1) is inoperative on January 1, 2026.

30 (g) Notwithstanding paragraph (2) of subdivision (b), the State
31 Department of Public Health and the State Department of State
32 Hospitals shall jointly develop the regulations governing ETPs.

33 SEC. 4. Section 4100 of the Welfare and Institutions Code is
34 amended to read:

35 4100. The department has jurisdiction over the following
36 institutions:

37 (a) Atascadero State Hospital.

38 (b) Coalinga State Hospital.

39 (c) Metropolitan State Hospital.

40 (d) Napa State Hospital.

1 (e) Patton State Hospital.

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

4 SEC. 5. Section 4142 is added to the Welfare and Institutions
5 Code, to read:

6 4142. Commencing July 1, 2015, and subject to available
7 funding, the State Department of State Hospitals may establish
8 and maintain enhanced treatment programs (ETPs), as defined in
9 subdivision (o) of Section 1250 of the Health and Safety Code,
10 for the treatment of patients described in Section 4143.

11 SEC. 6. Section 4143 is added to the Welfare and Institutions
12 Code, to read:

13 4143. (a) A state hospital psychiatrist or psychologist may
14 refer a patient to an enhanced treatment program (ETP), as defined
15 in subdivision (o) of Section 1250 of the Health and Safety Code,
16 for temporary placement and risk assessment upon determining
17 that the patient may be at high risk for most dangerous behavior
18 and when treatment is not possible in a standard treatment
19 environment. The referral may occur at any time after the patient
20 has been admitted to a hospital or program under the jurisdiction
21 of the department, with notice to the patient’s advocate at the time
22 of the referral.

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

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

37 (2) (A) The threshold standard for treatment in an ETP is met
38 if a psychiatrist or psychologist, utilizing standard forensic
39 methodologies for clinically assessing violence risk, determines
40 that a patient meets the definition of a patient at *high* risk for most

1 dangerous behavior and ETP treatment can meet the identified
2 needs of the patient.

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

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

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

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

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

27 (e) (1) Upon admission to the ETP, a forensic needs assessment
28 team (FNAT) psychologist who is not on the patient’s treatment
29 team shall perform an in-depth violence risk assessment and make
30 a treatment plan for the patient based on the assessment within 14
31 business days of placement in the ETP. Formal treatment plan
32 reviews shall occur on a monthly basis, which shall include a full
33 report on the patient’s behavior while in the ETP.

34 (2) An ETP patient shall receive treatment from a team
35 consisting of a psychologist, a psychiatrist, a nurse, ~~and~~ a
36 psychiatric technician, a clinical social worker, a rehabilitation
37 therapist, and any other staff as necessary, who shall meet as often
38 as necessary, but no less than once a week, to assess the patient’s
39 response to treatment in the ETP.

1 (f) Prior to the expiration of 90 days from the date of placement
2 in the ETP and with 72-hour notice provided to the patient and the
3 patient’s advocate, the FNAP shall convene a treatment placement
4 meeting with a psychologist from the treatment team, a patient
5 advocate, the patient, and the FNAT psychologist who performed
6 the in-depth violence risk assessment. The FNAP shall determine
7 whether the patient may return to a standard treatment environment
8 or the patient clinically requires continued treatment in the ETP.
9 If the FNAP determines that the patient clinically requires
10 continued ETP placement, the patient shall be certified for further
11 ETP placement for one year. The FNAP determination shall be in
12 writing and provided to the patient and the patient’s advocate
13 within 24 hours of the meeting. If the FNAP determines that the
14 patient is ready to be transferred to a standard treatment
15 environment, the FNAP shall identify appropriate placement within
16 a standard treatment environment in a state hospital, and transfer
17 the patient within 30 days of the determination.

18 (g) If a patient has been certified for ETP treatment for one year
19 pursuant to subdivision (f), the FNAP shall review the patient’s
20 treatment summary every 90 days to determine if the patient no
21 longer clinically requires treatment in the ETP. This FNAP
22 determination shall be in writing and provided to the patient and
23 the patient’s advocate within three business days of the meeting.
24 If the FNAP determines that the patient no longer clinically requires
25 treatment in the ETP, the FNAP shall identify appropriate
26 placement, and transfer the patient within 30 days of the
27 determination.

28 (h) Prior to the expiration of the one-year certification of ETP
29 placement under subdivision (f), and with 72-hour notice provided
30 to the patient and the patient’s advocate, the FNAP shall convene
31 a treatment placement meeting with the treatment team, the patient
32 advocate, the patient, and the FNAT psychologist who performed
33 the in-depth violence risk assessment. The FNAP shall determine
34 whether the patient clinically requires continued ETP treatment.
35 If after consideration, including discussion with the patient’s ETP
36 team members and review of documents and records, the FNAP
37 determines that the patient clinically requires continued ETP
38 placement, the patient shall be certified for further treatment for
39 an additional year. The FNAP determination shall be in writing

1 and provided to the patient and the patient’s advocate within three
2 business days of the meeting.

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

7 (j) The process described in this section may continue until the
8 patient no longer clinically requires ETP treatment or until the
9 patient is discharged from the state hospital.

10 (k) As used in this section, the following terms have the
11 following meanings:

12 (1) “Enhanced treatment program” or “ETP” means a health
13 facility as defined in subdivision (o) of Section 1250 of the Health
14 and Safety Code.

15 (2) “Forensic needs assessment panel” or “FNAP” means a
16 panel that consists of a psychiatrist, a psychologist, and the medical
17 director of the hospital or facility, none of whom are involved in
18 the patient’s treatment or diagnosis at the time of the hearing or
19 placement meetings.

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

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

27 (5) “Patient advocate” means the advocate contracted under
28 Sections 5370.2 and 5510.

29 (6) “Patient at high risk ~~of~~ *for* most dangerous behavior” means
30 the individual has a history of physical violence and currently
31 poses a demonstrated danger of inflicting substantial physical harm
32 upon others in an inpatient setting, as determined by an in-depth
33 violence risk assessment conducted by the State Department of
34 State Hospitals.

35 SEC. 7. Section 7200 of the Welfare and Institutions Code is
36 amended to read:

37 7200. There are in the state the following state hospitals for
38 the care, treatment, and education of the mentally disordered:

39 (a) Metropolitan State Hospital near the City of Norwalk, Los
40 Angeles County.

- 1 (b) Atascadero State Hospital near the City of Atascadero, San
- 2 Luis Obispo County.
- 3 (c) Napa State Hospital near the City of Napa, Napa County.
- 4 (d) Patton State Hospital near the City of San Bernardino, San
- 5 Bernardino County.
- 6 (e) Coalinga State Hospital near the City of Coalinga, Fresno
- 7 County.
- 8 (f) Any other State Department of State Hospitals facility subject
- 9 to available funding by the Legislature.

10 SEC. 8. No reimbursement is required by this act pursuant to
11 Section 6 of Article XIII B of the California Constitution because
12 the only costs that may be incurred by a local agency or school
13 district will be incurred because this act creates a new crime or
14 infraction, eliminates a crime or infraction, or changes the penalty
15 for a crime or infraction, within the meaning of Section 17556 of
16 the Government Code, or changes the definition of a crime within
17 the meaning of Section 6 of Article XIII B of the California
18 Constitution.