

Department of Mental Health:

**Changes in State Hospital Security
Measures Can Reduce Annual Costs
While Maintaining Public Safety**



March 1998
97121

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CALIFORNIA STATE AUDITOR

KURT R. SJOBERG
STATE AUDITOR

MARIANNE P. EVASHENK
CHIEF DEPUTY STATE AUDITOR

March 12, 1998

97121

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning security measures for forensic patients at the Department of Mental Health's four hospitals. This report concludes that the State's annual security costs at the four hospitals could be reduced by approximately \$7.4 million. Cost reductions could be achieved by replacing security officers in fixed guard posts with double-fencing, electronic detection systems, and mobile patrols. In addition, internal security at the hospitals could be improved by centralizing security decision-making and standardizing important operating practices. Also, when transporting forensic patients off-grounds, officers should be armed to protect themselves and the public. Finally, we found that after June 2003, patient population growth will exceed the number of available beds.

Respectfully submitted,

KURT R. SJOBERG
State Auditor

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Summary



Audit Highlights . . .

Our review of the Department of Mental Health's security over its hospitals revealed:

- ☑ ***Enhanced security measures, such as double-fencing and electronic detection systems, could reduce security costs at two of the four hospitals.***
- ☑ ***Additional savings could result if the department took over the Department of Corrections perimeter security at Patton hospital.***
- ☑ ***Security can be improved by standardizing procedures, reducing staff complacency, upgrading officer training, and arming officers.***
- ☑ ***Forensic patient population growth will exceed the number of available beds after June 2003.***

Results in Brief

The Department of Mental Health (department) operates four hospitals for mentally disabled patients. Our audit focused on the security measures used to prevent forensic patients at these hospitals from adversely affecting the safety of the staff, other patients, and the public (forensic patients have either been convicted of a crime or found incompetent to stand trial). During our review of the security measures at the four hospitals, we found the following areas where security costs could be reduced:

- The perimeter security at Napa and Patton hospitals could be operated more cost-effectively by using enhanced security measures such as double-fencing, redundant electronic detection systems, and dedicated patrols.
- Additional savings could result at Patton hospital if the department took over the perimeter security function currently provided by the Department of Corrections.

During our audit, we also identified the following security issues:

- Internal security procedures and practices should be standardized.
- Staff at some hospitals are complacent toward security policies and needs.
- Qualifications and training for hospital police officers need to be upgraded.
- In limited situations, hospital police officers should be armed.

Finally, we reviewed the department's estimates for forensic population growth, and found that after June 2003, patient population growth will exceed the number of available beds. In addition, because the department's security risk-assessment process is based on excessively narrow criteria,

patients are considered high-security risks solely based on their history of prior escape. Moreover, some patients may be considered low- or medium-security risks even when their behavior may suggest that they represent a threat to the community.

Recommendations

To increase the cost-effectiveness of its perimeter security operations, and to reduce the State's annual security costs by approximately \$7.4 million, the Department of Mental Health (department) should:

- Complete the detailed planning, design, and construction of an enhanced double-fence security system at Napa and Patton hospitals, including redundant electronic detection systems.
- Upon completion of the Napa and Patton fence projects, initiate mobile internal and external patrols, thereby permitting reductions in staffing. All patrol units should be equipped with portable alarm receivers for immediate notification when the fence sensors are activated.
- Eliminate two of the four guard posts at Metropolitan hospital.
- Install additional perimeter fencing with disturbance sensors at the front of Atascadero hospital and on roof lines of the administration building.

To increase the overall internal security at each hospital and to reduce staff complacency toward internal security matters, the department should:

- Implement a plan to improve the internal physical security at all hospitals. The plan should survey all buildings to identify the specific needs, including glass and window spaces, fences and courtyards, exterior door alarms, personal alarm systems, portable metal-detection equipment, X-ray and metal scanning equipment, and alarm systems for courtyards.
- Centralize fundamental physical security decisions for all hospitals.

- Improve the standardization of important operating practices, especially daily patient counts, key control, locking and alarming doors, and patient transportation.
- Conduct periodic unannounced audits of internal and perimeter security. Such audits could be conducted by staff from headquarters and other hospitals as a form of training and peer review.

To protect staff and the public from potential assaults by patients, the department should seek legislative change to make certain patient acts a felony. Specifically, any forensic patient who escapes or assaults staff should be charged with a felony.

To increase the overall qualifications, training, and effectiveness of its hospital police officers (HPOs), the department should require all new HPOs to complete the same level of certified training that Napa and Metropolitan HPOs receive. In addition, to protect patients and officers, officers who transport patients off-grounds should be armed. The department should ensure that all armed officers are fully trained and screened.

To improve overall coordination and control of security at its hospitals, the department should centralize coordination and control of hospital security.

Finally, to meet the expected shortage of hospital beds in June 2003, the department should plan facilities with more beds. In addition, to allow the greatest flexibility to treat and house its growing population of forensic patients, the department should revise its security risk-assessment process and request that the Legislature remove the current law that restricts admitting forensic patients directly to Napa hospital.

Agency Comments

The Department of Mental Health generally agreed with our recommendations and indicates that it will review the findings with local legislators, law enforcement agencies, concerned community groups, and others to determine the course of action it will take.

Introduction

Background

The Department of Mental Health (department) services include prevention and control of mental illness through community education and consultation, crisis evaluation and emergency care, and 24-hour acute care. The department also sets policy for statewide mental health services, oversees contracts with county mental health departments and various state-funded programs, and monitors their compliance with federal and state statutes.

The department operates four hospitals for mentally ill patients. In addition, it operates an acute psychiatric program for the California Department of Corrections (CDC) inmates at the California Medical Facility at Vacaville. In fiscal year 1996-97, the four hospitals served approximately 3,800 patients. Their operating budget was approximately \$437 million, or about \$115,000 annually for each patient.

Description of State Hospital Patients

Hospital patients fall into three categories: those committed under the Lanterman-Petris-Short Act (LPS) and funded by the counties, those committed by the courts and funded by the State, and those referred and funded by the CDC.

The LPS patients are referred for placement at state hospitals by each county. LPS commitments are governed by Sections 5150, 5250, or 5350 of the California Welfare and Institutions Code. In general, Section 5150 patients are deemed dangerous to themselves or others and are detained, evaluated, and treated for up to 72 hours. Section 5250 allows for a 14-day detention if additional treatment or evaluation is required. For treatment beyond the 14 days, Section 5350 requires the court to appoint a conservator for a person unable to obtain their own food, clothing, or shelter. As of December 10, 1997, there were approximately 1,000 LPS patients in the State's four mental hospitals, about 26 percent of the total patient population.

The remaining patients, those committed by the courts or referred by the CDC, are called “forensic” patients. In general, forensic patients have either been convicted of a crime or found incompetent to stand trial. Forensic patients are grouped into six categories:

- Incompetent to stand trial
- Not guilty by reason of insanity
- Transfers from the CDC
- Mentally disordered offender
- Sexually violent predator
- Other patients who do not fit the above categories

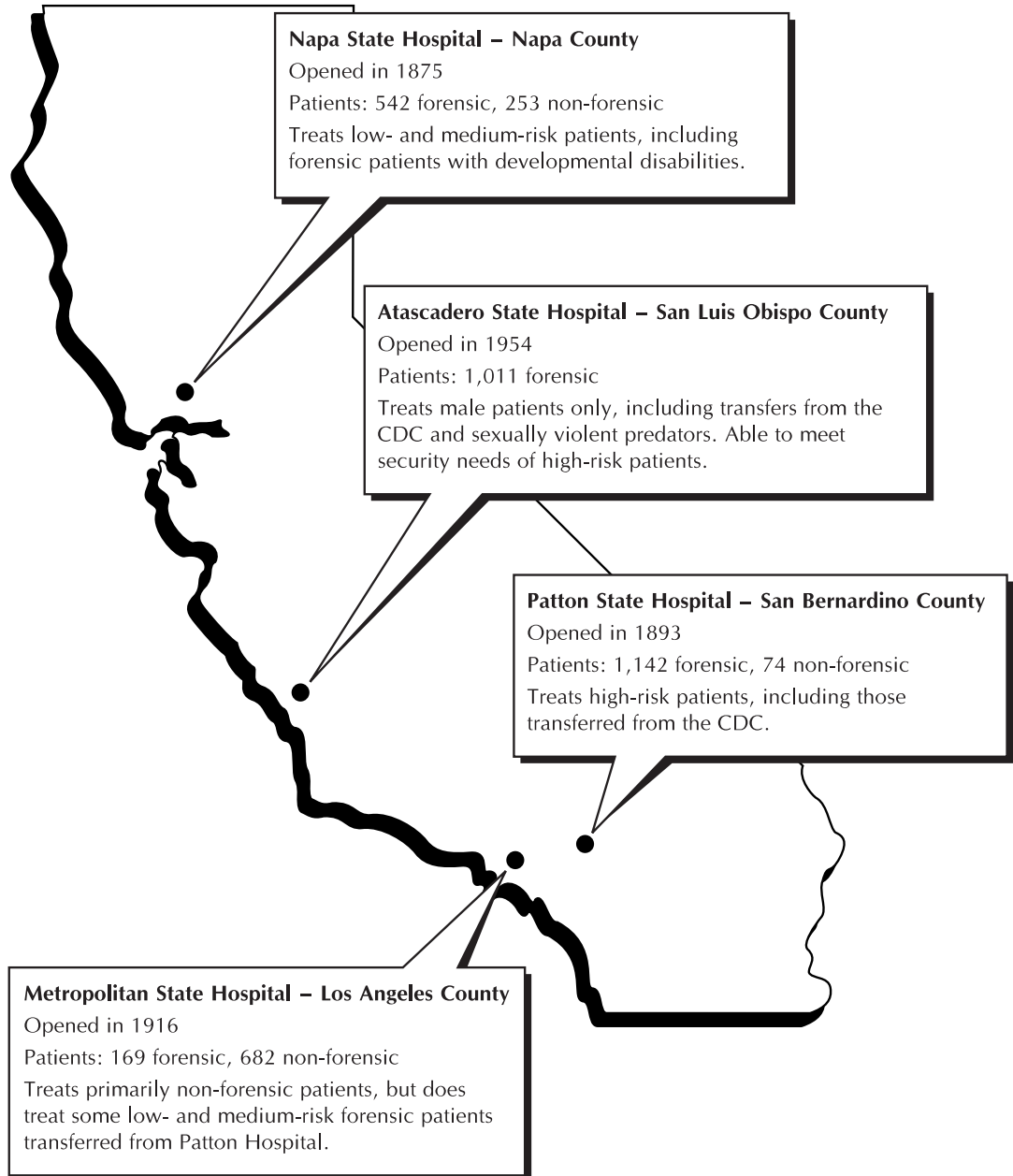
Figure 1 shows the location and patient population of each hospital. Further, each category is defined in greater detail in Appendix A.

Hospital Staffing

Hospital staffing, including the number of level-of-care staff such as nurses and psychiatric technicians who work directly with patients, is determined each year through the State’s budgetary process. The specific numbers are based on the patient-to-staff ratios, types of patients at each hospital, and the patients’ medical needs. Management’s decisions on how to deploy staff include a number of factors. For example, employee union agreements generally require a minimum of one level-of-care staff for every 8 patients, a 1:8 ratio, which may increase when patients’ health or behavior warrants. For cases when a patient demonstrates aggressive behavior that increases the security risks to other patients or staff, management may temporarily add staff. In extreme cases, management may assign staff to a patient on a one-to-one basis.

In summary, as daily treatment needs for the hospital change, hospital management has the flexibility to allocate staff to meet those needs. We reviewed the hospital patient-to-staff ratios for fiscal years 1990-91 through 1996-97, and for the six-month period ending December 1997. We generally found that hospitals adjust their staffing levels relative to patient populations.

Figure 1
Location and Description of Hospitals



Patient populations as of December 10, 1997

Escapes and Assaults

Over the past three years, a small number of patients have escaped from the State's mental health hospitals. The department defines an escapee as "a patient who left from a supervised activity, secured unit, or patio." Some patients, primarily non-forensic patients, are called "walk-aways." Walk-aways are defined as "a patient who left from an unsupervised ground privilege, did not return from a home visit, or did not return from a day pass." Table 1 illustrates recent escapes and walk-aways.

Table 1

***Escapes and Walk-Aways From State Hospitals
1995 Through 1997***

Hospital	Forensic Patients		Non-Forensic Patients		Totals
	Walk-Aways	Escapes	Walk-Aways	Escapes	
Atascadero					
1995	0	0	0	0	0
1996	0	0	0	0	0
1997	0	0	0	0	0
Metropolitan					
1995	0	0	16	8	24
1996	0	0	21	5	26
1997	0	0	21	6	27
Napa					
1995	4	2	11	9	26
1996	4	2	8	6	20
1997	0	3	4	1	8
Patton					
1995	0	1	0	0	1
1996	0	0	0	0	0
1997	0	0	0	0	0
Totals	8	8	81	35	132

Source: Department of Mental Health.

As Table 1 illustrates, nearly all walk-aways and escapes have occurred at less-secure facilities (Napa and Metropolitan) and were committed by non-forensic patients.

Assaults against other patients and staff do occur in the State's mental health hospitals, making up 19 percent of all incidents the department requires hospitals to report. Table 2 illustrates the most recent number of reported incidents.

Table 2

***Reported Assaults by Patients
January Through November 1997***

Hospital	Assaults by Patients Against Staff		Assaults by Patients Against Other Patients		Other Incidents*		Total Non- Forensic and Forensic
	Non-Forensic	Forensic	Non-Forensic	Forensic	Non-Forensic	Forensic	
Atascadero	N/A	6	N/A	0	N/A	9	15
Metropolitan	5	1	37	4	215	8	270
Napa	5	0	16	5	75	32	133
Patton	0	0	0	2	1	10	13
Totals	10	7	53	11	291	59	431

* Unauthorized absences, alleged staff abuse, aggressive acts to self, accidental injury, childbirth, death, and fire/property damage.

As Table 2 indicates, non-forensic patients committed 63 of the 81 (78 percent) assaults reported by state hospitals.

As discussed in our Scope and Methodology, our audit focused on forensic patient security. However, as indicated in Tables 1 and 2, non-forensic patients, who comprise about 26 percent of the total patient population, are responsible for most escapes, walk-aways, and assaults. Based on our observations and staff interviews at each hospital, we noted several factors that may explain this. Staff describe non-forensic patients as more difficult to supervise, and more prone to escape and assault. Second, non-forensic patients are not subject to the same security constraints as forensic patients. At Napa hospital for example, non-forensic patients are not housed behind a perimeter security fence, can wear street clothing instead of the khaki clothing required of forensic patients, and are issued grounds passes, giving them more freedom on hospital grounds. Similarly, most non-forensic patients at Metropolitan hospital are not housed behind a perimeter fence.

Scope and Methodology

At the request of the Joint Legislative Audit Committee, we audited security measures at the four Department of Mental Health (department) hospitals. We assessed the department's security measures, particularly those related to forensic patients, to determine whether any deficiencies may adversely affect the safety of the staff, patients, or the public. The Joint Legislative Audit Committee also requested that we analyze growth patterns within patient populations, and determine whether staffing ratios are adjusted as the patient population changes.

To gain an understanding of the overall security requirements for the department, we reviewed applicable laws, regulations, and other background information.

To review and assess security measures, we visited each hospital and interviewed appropriate staff to obtain an understanding of the policies and procedures governing security. To assist us in our audit, Joe Hill and Associates, a consultant with expertise in law enforcement and security issues, reviewed the physical security measures, such as fences, used at each facility, as well as such operational measures as the number of hospital police officers deployed at each facility. We additionally obtained the services of another consultant, Nacht & Lewis Architects, to develop cost estimates for our proposed security measures, by using existing architectural drawings.

To analyze the growth patterns of patient populations, we obtained past population information from the department. We also analyzed the department's projections for future growth by interviewing appropriate department staff. Finally, we determined whether the department's planned construction of additional bed space at its hospitals would meet future population growth.

To assess whether the department adjusts staffing ratios as its patient population changes, we reviewed staffing levels and patient populations since fiscal year 1990-91. We also interviewed appropriate department staff to understand how staff are allocated within each hospital.

Chapter 1

Alternative Security Measures Could Protect the Public While Minimizing Costs

Chapter Summary

Perimeter security at three of the four hospitals operated by the Department of Mental Health (department) is staff-intensive; that is, hospital police officers (HPOs) or correctional officers observe fences from guard posts. Over 160 officers are required to staff these posts on a 24-hour basis. Equivalent yet cost-effective alternatives exist, including closed-circuit television (CCTV), double-fences, fence-disturbance sensors, motion sensors, special lighting, razor wire, and dedicated patrols.

Our security consultant estimates these alternative security measures could reduce proposed annual operating costs at Napa hospital by \$2.2 million and at Patton hospital by \$3.9 million. Capital costs to accomplish these savings would total \$1.4 million for Napa and \$2.5 million for Patton. In addition, replacement of California Department of Corrections (CDC) correctional officers with appropriately trained HPOs would reduce annual security costs by approximately \$804,000 at Patton hospital without negatively affecting security. Further, minor changes at Metropolitan hospital would save approximately \$470,000 annually. Finally, the consultant also identified needed improvements at Atascadero hospital that will eliminate a weakness in its security. Estimated capital costs for these improvements will total \$370,000.

Background

The department's security has two interrelated components: perimeter security, used to keep patients within all grounds and buildings, and internal security, the management and control of patients within a complex. Internal security includes staff supervision as well as the structural and technological approaches intended to assist in controlling patient behavior and retaining patients within designated areas. Both types of security should be reasonably effective, as significant weaknesses in one may tend to minimize the strengths of the other.

There currently are a variety of security approaches employed at the department's hospitals in California, by the Department of Developmental Services, and in other states where the objective is to prevent escapes by forensic patients. Table 3 summarizes the results in terms of patients, annual escapes, and selected characteristics of the physical security measures.

Table 3
Comparison of California Hospitals and Out-of-State Hospitals

Hospital	Atascadero State Hospital	Napa State Hospital	Metropolitan State Hospital	Patton State Hospital	Porterville Developmental Center PORTERVILLE, CALIFORNIA	Colorado State Hospital PUEBLO, COLORADO	Florida State Hospital CHATTahoochee, FLORIDA	Oregon State Hospital SALEM, OREGON	St. Elizabeth's Hospital WASHINGTON, D.C.	Western States Hospital TACOMA, WASHINGTON
Number of Patients FORENSIC	1,011	542	169	1,142	150	300	400	331	275	240
NON-FORENSIC	6	253	682	74	680	268	600	307	550	777
Average Annual Escapes FORENSIC	0	5	0	.3	10	1	2	1.5	0	0
SECURITY FEATURES USED FOR FORENSIC PATIENTS										
Number of Perimeter Fences	2	1-P	1	1	2-P	2	2	1	1	2-P
Razor Wire on Fences	✓	P	✓	✓	-	-	✓	✓	-	-
Guard Towers	✓	-	-	✓	-	-	✓	-	-	-
Guard Kiosks	-	P	✓	✓	P	-	-	-	✓	-
Perimeter Patrol	✓	P	✓	-	P	✓	✓	✓	-	✓
Internal Patrol ^a	✓	✓	-	-	-	✓	✓	✓	✓	✓
Vehicle Sallyport ^b	✓	P	P	✓	P	✓	✓	-	✓	P
Pedestrian Sallyport	✓	P	P	✓	P	✓	✓	✓	✓	✓
Closed Circuit TV for Perimeter Fences	✓	P	P	✓	P	✓	✓	✓	✓	✓
Sensors with Fences	-	P	P	✓	P	-	✓	-	-	P

✓ In use at this facility P - Planned

^aInternal patrols by security officers inside the forensic area to supplement internal security provided by treatment staff.

^bA sallyport is a series of double-gates or doors that restrict and control access to a secure area.

California Department of Mental Health

The current (or planned) perimeter security approaches tend to be staff-intensive at Napa, Patton, and Metropolitan hospitals, with over 160 guards and 33 guard posts. Atascadero hospital, in contrast, is uniquely constructed to provide much of its perimeter security by the walls of its main housing and treatment buildings.

HPOs provide security at all facilities except Patton hospital, where the CDC provides perimeter security, as well as patient transportation services. The total budgeted annual salary and benefit costs for security officers at the four hospitals are over \$18 million for fiscal year 1998-99.

California Department of Developmental Services


*A variety of security
measures are employed
for forensic patients.*

The Department of Developmental Services (DDS) hospital at Porterville houses 830 patients and provides care and treatment for developmentally disabled persons with serious medical problems or severe behavior challenges. This includes a forensic compound with 170 beds. To upgrade the current facilities, the DDS is enclosing the forensic area with a double-fence plus sallyports. Fence-disturbance sensors and CCTV will be used, but no razor wire. Six fixed guard posts will be staffed at all times. The guards will be "security guards," not HPOs, and will have lower pay levels.


Hospitals in Other States

We conducted a telephone survey on the key security characteristics at five mental health hospitals in other states that treat both forensic and non-forensic patients. While the survey indicated that most use security measures similar to those used in California, it did not identify which measures correlated with the lowest levels of escapes or other patient security objectives.

***Effective Perimeter Security
Could Be Achieved With
Significantly Lower Operating Costs***

Our security consultant reviewed the security measures and determined that the four hospitals could maintain perimeter security while reducing operating costs. In some cases, the consultant proposed significant changes, such as converting single-fencing to double-fencing and reducing the number of guard stations, and in other cases, he proposed relatively minor changes, such as reducing redundant visual coverage along certain fence lines. Because our concerns are similar, we have combined our discussion of Napa and Patton hospitals, whereas Metropolitan and Atascadero hospitals are addressed separately.

***Napa and Patton Hospitals Can
Reduce Security Costs By Using
Double-Fencing and Other Measures***


We recommend an approach combining significant physical barriers, redundant electronic alarms, and active police officer patrols.

Our consultant believes that perimeter security at both Napa and Patton hospitals can be accomplished with less cost and equal public safety by using double-fencing, technology-based security measures, and dedicated patrols similar to those at other states' hospitals and in medium security prisons. Napa hospital currently has no perimeter security system. The hospital is planning a \$6.5 million security project that includes a 16-foot fence topped with razor wire, anti-climb mesh, and disturbance sensors. Also planned are improved lighting, complete CCTV fence coverage, ten guard posts, additional employee parking, one sallyport, and a new visitors' center. Patton hospital's current security system has most of the features planned for Napa hospital, including razor-wire topped fences, anti-climb mesh, anti-shake sensors, guard posts, and sallyports.

We recommend an approach combining significant physical barriers, redundant electronic alarms, and active police officer patrols. Our consultant believes this is an effective approach because it uses two fences and dual sensors (rather than one of each), plus internal and external dedicated patrols. Other enhancements can be considered, such as a night time bicycle patrol, higher fences, and additional razor wire coils on the inside of one or both fences.

Alternative measures have saved significant sums for the State of Georgia. Specifically, the Georgia Department of Corrections has reduced escapes and saved an estimated \$14 million per year with a major change to its perimeter security at 23 medium- and maximum-security state prisons. It has replaced old double-fences and guard towers with new double-fencing, anti-shake sensors, razor wire, and full CCTV coverage. The changes have eliminated 246 full-time correctional officer

positions. As indicated in Table 3, double-fencing is already being used or proposed at three of the five other state hospitals we contacted. In addition, the CDC, which currently provides the perimeter security for Patton hospital, has told us that it is currently studying various possible modifications to the fence at Patton hospital, including double-fencing and enhanced technology-based sensor systems. These measures may reduce up to 60 staff positions and are consistent with our recommendations.

We estimate that construction costs of \$1.4 million for these changes at Napa hospital would yield annual savings of \$2.2 million. Likewise, construction costs of \$2.5 million for Patton hospital could save \$3.9 million per year. By dividing the annual savings into the estimated costs, we calculate that the “pay-back” period would be less than one year for both hospitals. Specific details for our proposed changes at Napa and Patton hospitals are located in Appendix B.

Critics may be concerned that the technology is not always reliable, and

that constant visual observation of all fence lines is necessary. While no security system is infallible, frequent testing and proper engineering will offset potential false alarms with disturbance sensors. In addition, overlapping, or redundant systems reduce the lack of notification when alarms are activated; that is, if the fence-disturbance sensor fails, the motion sensor would be activated or vice versa. Mobile patrols and CCTV coverage provide further backup. Concerns that escapees can cut through fencing without activating the disturbance alarms can be addressed by attaching several coils of razor wire to the bottom of the fence, properly engineering the sensors, and by installing redundant systems. Further,

Security Enhancements at Napa and Patton Hospitals Recommended by Our Consultant

- Install a double-fence, each 14-feet high, razor wire, CCTV and anti-climb mesh, and a space of about 20 feet between fences.
- Include an electronic detection system using disturbance sensors on both fences plus a motion sensor in the space between fences.
- Use two patrol assignments staffed at all times. A vehicle patrol around the outside perimeter and a bicycle patrol on the inside. All patrols would be equipped with a portable alarm receiver (a small device, similar to a pager, that warns the officer that an alarm has been activated and gives a general location of the alarm). Alarms would be wired into the sallyport and/or the radio dispatch center.


Estimated annual savings are \$2.2 million at Napa hospital and \$3.9 million at Patton hospital.

dedicated patrols equipped with portable alarm receivers are available for observation and immediate response. Overall, our consultant believes that effectiveness of the recommended perimeter security approach is at least equivalent to current or planned operations at Napa and Patton hospitals.

Finally, additional concerns over the appearance of a double-fence can be partially mitigated by appropriate landscaping. For example, Napa hospital plans to screen its fence from nearby roads with an earth berm, shrubs, and trees.

The Department Should Operate the Security System at Patton Hospital


In addition to the proposed fence modifications, we identified additional potential savings at Patton hospital. Specifically, the department could employ HPOs to operate the perimeter security system at Patton hospital instead of the CDC's correctional officers.


CDC correctional officers
could be replaced by
HPOs.



Currently, the CDC provides perimeter security at Patton hospital, while the department provides all internal security. Prior to 1982, a small force of HPOs provided security at Patton hospital. However, an excessive number of patient escapes resulted in legislative action that reassigned the security for certain patients to the CDC. By fiscal year 1988-89, the CDC determined that it required nearly 175 full-time equivalent security positions. Between 1992 and 1995, the CDC eliminated 43 of these positions from Patton hospital due to budget reductions. Although the department was aware of the personnel reductions, it had no control over them. It is now operating with 127 security positions at the hospital.

This shared responsibility for security at Patton hospital presents a problem because the department does not set budgetary or other priorities for the CDC's security force. Its priorities for Patton hospital therefore may not be in line with the CDC's. For example, the significant reduction in staff starting in 1992 may have been treated differently had the security force consisted of department HPOs. Because installing extensive fencing, CCTV, disturbance sensors, and anti-climb mesh has reduced escapes, our consultant believes that the security environment at Patton hospital is much improved over 1982 conditions. The consultant thus believes that there is no reason to suspect that a well-planned, phased transfer of the CDC's security responsibilities at Patton hospital will compromise the existing perimeter security system.


A well-planned transfer of the security function at Patton hospital could save \$804,000 annually.

Current improved circumstances suggest that replacing the CDC officers with appropriately trained HPOs would be a more cost-effective approach without negatively affecting security. In addition, budgetary authority over the security function would transfer to the department. If an enhanced double-fence system is installed, Patton hospital will need only 46 correctional officer positions, a reduction of over one-half of its security force. Additionally, transferring security to HPOs would produce annual cost reductions for salaries, benefits, and overtime of over \$804,000.

Metropolitan Hospital Could Reduce Annual Security Costs by \$470,000


Our consultant identified potential savings at Metropolitan hospital. Two security posts could be eliminated without sacrificing overall security, resulting in annual savings of approximately \$470,000.

Perimeter security surrounding the forensic unit at Metropolitan hospital is small compared to the other hospitals. It encompasses a single housing and treatment building enclosed with a single 14-foot security fence topped with razor wire. Anti-climb mesh, CCTV, and disturbance sensors are in place or planned. Additionally, the patient courtyards have razor wire atop security fencing and anti-shake sensors, and are monitored by CCTV, while 24-hour mobile patrol is provided throughout the hospital grounds, usually by two patrol units. A sallyport and visitors' center are under construction. Finally, 24-hour guard posts, about 600 to 700 feet apart, are located on all four corners. According to our consultant, the four guards' double-visual coverage of these fence lines, given all the other security features, is not cost-effective. Two of these posts could be eliminated without sacrificing system integrity, reducing staffing by about ten HPO positions and one sergeant's position, using the State's supervisory ratio. Using mid-range salaries, plus 25 percent benefits, annual savings would be approximately \$470,000.


Atascadero Hospital's Perimeter Security Could Be Improved With Roof-Top and Perimeter Fencing

Overall, our consultant found that Atascadero hospital has an effective security system. This is supported by its escape history of only two escapes in the past five years. He did, however, note two areas where preventive security improvements should be considered.

The hospital currently uses a combination of double- and single-fencing, a single guard tower overlooking the rooftops and part of the fence line, and active mobile patrol around the perimeter. The patient housing and treatment building, with courtyards enclosed by security fencing with razor wire, plus selective use of CCTV, complements the perimeter fencing and patrols. During our visit, our consultant identified preventive security improvements to enhance the hospital's overall level of security.



Although only two escapes occurred in the last five years, unprotected areas of the rooftop and hospital front need security improvements.



First, there is no security fencing protecting portions of the hospital front. Although the windows in this area are welded shut and have metal slats preventing escape from the inside, some housing units lack barriers in front of the windows. Because it is possible for anyone to walk up to the front windows out of the guard tower's view, an outsider could cut through the windows and assist with an escape. At a minimum, our consultant recommends that this area needs a single security fence with razor wire.

Second, there is no effective barrier on the roof of the administration building and adjoining structures. According to hospital staff, the last escapee from Atascadero may have gained access to the roof of a housing unit and, since most of the main structures are connected, moved to the administration building and climbed down to complete his escape. Although the guard tower overlooks the rooftops, the rooftops are crowded with mechanical and electrical equipment that supplies ample hiding places. Consequently, our consultant believes the unprotected areas should have rooftop fencing about eight-feet high, several coils of razor wire, and disturbance sensors. Decorative partitions may hide the fences if aesthetics are a concern.

Estimated costs for the perimeter and rooftop fence, including electronic sensors, are \$370,000.

Conclusion

The approach to perimeter security used at three of the four hospitals is staff-intensive, that is, HPOs or correctional officers observe fences from guard posts. More cost-effective alternatives exist, including CCTV, double-fences, fence disturbance sensors, and dedicated patrols at Napa and Patton hospitals. Consequently, Napa hospital could reduce annual operating costs by \$2.2 million and Patton hospital by \$3.9 million. Capital costs to accomplish these savings would total \$1.4 million for Napa hospital and \$2.5 million for Patton hospital.

In addition, we believe that replacing the CDC's correctional officers with appropriately trained HPOs at Patton hospital would reduce annual personnel costs by \$804,000 without negatively affecting security. We also identified \$470,000 in potential annual savings at Metropolitan hospital through the elimination of two redundant guard posts. Finally, we identified needed security improvements, estimated to cost \$370,000, at Atascadero hospital. By adopting these alternative security measures, the department can adequately protect the public while minimizing annual operating costs.

Recommendations

To increase the cost-effectiveness of its perimeter security operations, and to reduce the State's annual security costs by approximately \$7.4 million, the Department of Mental Health (department) should take the following actions:

- Complete construction of an enhanced double-fence security system at Napa and Patton hospitals, including installation of redundant electronic detection systems.
- Upon completion of the fence projects, initiate dedicated mobile internal and external patrols, thereby permitting reductions in staffing. All patrol units should be equipped with portable alarm receivers for immediate notification when the fence sensors are activated.
- Eliminate two of the four guard posts at Metropolitan hospital.
- Install additional perimeter fencing with disturbance sensors at the front of Atascadero hospital and on roof lines of the administration building.

- Replace the California Department of Corrections (CDC) officers who currently provide perimeter security at Patton hospital with hospital police officers. This would require that the department request the Legislature to modify the Welfare and Institutions Code, Section 4107, to authorize the department to provide perimeter security at Patton hospital, instead of the CDC.

Chapter 2

Internal Security Enhancements Are Needed To Protect Hospital Staff and the Public

Chapter Summary

As discussed in Chapter 1, overall security for the State's mental hospitals involves many elements other than perimeter security and operational staffing issues. Our security consultant assisted us during our visits to each of the four hospitals operated by the Department of Mental Health (department). During our visits, we noted potential for improvements in five main areas of security.

First, at several hospitals, various internal security practices lack vigilance. Specifically, our consultant found weaknesses in physical, procedural, and technological security, as well as lack of concern among staff.

Second, we found escapes and assaults by certain types of forensic patients are currently not considered felonies, thus some forensic patients may commit these acts without fear of punishment. Classifying escapes and staff assaults by forensic patients as felonies may deter patients from attempting an escape or assaulting staff.

Third, training, upgrading, and standardization of the qualifications for hospital police officers (HPOs) is warranted because the population of forensic patients is increasing.

Fourth, we found that when forensic patients are transported to court or medical appointments, hospitals use different procedures. These differences could be resolved by standardizing the number of officers and staff used to guard patients, thereby minimizing security costs. In addition, under certain limited conditions, HPOs would benefit by being armed.

Finally, the hospital system would benefit from centralized coordination of its security efforts. We found that there is an absence of centralized or consistent security management and innovation. Each hospital operates with a significant degree of autonomy. Thus, physical security enhancements at one hospital may not be a priority at another institution. However,

if the department established a headquarters-level position, it could plan, coordinate, and inspect the security operations within the four hospitals.

Background

In addition to perimeter security issues discussed in Chapter 1, there are a range of functions supporting internal security at the state hospitals. Internal security generally includes

physical, procedural, technological security, and staffing. These components must be equally strong because patients will focus on any weak security elements; for example, staff careless about locking doors, or less-secure windows.

At Patton hospital, a unique organizational situation exists. As stated in Chapter 1, since 1982, the California Department of Corrections (CDC) is responsible for perimeter security, visitor control, and off-grounds transportation and guarding of forensic patients. All of the internal security services are provided by “level-of-care staff” (those in direct contact with patients), and there is no hospital police force at this location.

Our consultant noted that another important background factor is that all of the forensic facilities at the department’s hospitals are old. They are not designed to maximize staff sight lines, or use electronic technology or to accomplish other security-related objectives. Changes in these structural conditions would require major architectural and engineering assessments that are not currently under consideration.

Security Consultant Highlights Important Elements of Internal Security

Physical Security includes sufficient coverage for the buildings and grounds used by forensic patients to prevent escape. Walls, doors, windows, elevators, storage areas, and staff work areas all present opportunities for patient escapes or access to contraband materials if not controlled effectively.

Procedural Security encompasses all of the policies and procedures governing handling patient and facility operation. Included here are staffing ratios for escorts, methods of controlling hazardous items such as razors, rules concerning patient counts and observation in recreational areas, and access for each ward and building.

Technological Security refers to the use of electrical, mechanical, or electronic devices that aid security objectives. Examples are door alarm systems, electronic sensors, metal detection equipment, and radio communications.


Security Staffing includes the number, classifications, and qualifications of internal security personnel.

***Internal Security Requirements
Lack Attention and Concern
in Several Locations***

During our audit, our consultant noted a number of weaknesses in the physical security of forensic housing and treatment buildings. For example, he observed windows without metal slats or with slats spaced too far apart to prevent escape. He also noted exterior doors and courtyard fences without alarms and found signs of staff complacency toward security policies.

***Physical and Technological
Security Weaknesses***

Our security consultant accompanied us during visits to all four hospitals and identified security weaknesses in the forensic housing and treatment buildings at Napa, Metropolitan, and Patton hospitals; no significant internal security deficiencies were identified at Atascadero. Examples of deficiencies include extensive use of regular window glass; windows with no metal slats or with slats too far apart to prevent escape; windows that can be opened; exterior doors without alarms; and courtyard fences that can be easily scaled because they lack alarms, are too low, and/or have no razor wire. The prevalence of regular window glass is particularly dangerous because patients can break through the glass to escape, or use broken glass to injure themselves or others.


Napa hospital has enhanced courtyard fencing and exterior lighting, and has installed improved alarm systems.

We did, however, observe that Napa hospital is making improvements. Napa hospital's plant operations staff were authorized to initiate a number of security improvements, including new courtyard fencing, additional exterior lighting, additional metal window slats, and installation of electronic personal alarm equipment that operates off the hospital's paging system. (The personal alarm system is a hand-held device that can be activated by staff when they are in danger.) In addition, Napa hospital has installed an improved, dual-tone system for its personal alarm system. According to staff at Napa hospital, the annual operations and maintenance budget funded these improvements.

While Napa hospital had made progress in improving the physical security within its buildings, our consultant pointed out the need for a systematic upgrade of the physical security at all department hospitals. This is not a crisis-level requirement, but should be ongoing over a period of several years. A detailed

survey of building and equipment needs, including windows, door alarms, personal staff alarms, and metal detection equipment should aid in determining an overall plan.

Our consultant recommends that the following physical security upgrades be made on an ongoing basis:

- Eliminate glass and window spaces large enough to permit escape in all areas frequented by forensic patients and replace with nonbreakable material, such as Lexan.
- Install fence sensors and/or razor wire on courtyard fences.
- Install alarms and locking systems on all exterior doors of buildings used by forensic patients.
- Install improved personal alarm systems.
- Acquire portable metal detection equipment for housing units, and X-ray and metal scanning equipment for sallyports, visiting centers, admissions suites for new patients, and other selected locations.
- Acquire improved alarm systems and/or radio communications for level-of-care staff supervising patients in the courtyards.

This list is intended to be illustrative and not comprehensive. A full survey of all buildings will identify the exact scope of the need. Consequently, we cannot estimate capital costs at this time.

Staff Complacency Toward Security Policies and Needs

Our consultant found doors unlocked, employees without ID badges, and a disengaged door alarm.

Compounding the above internal physical security weaknesses, our consultant found insufficient vigilance by staff during our tours of patient housing and treatment facilities. In particular, he observed problems at Napa, Patton, and Metropolitan hospitals. Examples of these weaknesses include security doors left unlocked; doors to ward offices left open allowing access to sharp instruments, patient records, keys, and other materials; employees without ID badges; and a disengaged alarm on an exterior door. In addition, through document reviews and staff interviews, our consultant learned of security keys left in reach of patients, staff ID badges lost or stolen, and improperly recorded patient counts. All of these violate standing hospital


orders, and result from a lack of attention to routine security precautions. Further, our consultant noted that adherence to hospital security policies seemed to vary considerably among treatment programs (programs) within the same hospital. Each program develops its own organizational culture, thereby creating varying degrees of complacency or attentiveness toward security efforts.

Finally, we noted that each hospital operates with a significant degree of autonomy. Thus, physical security enhancements at Napa hospital, for instance, may not be a priority at another hospital. Additionally, program directors within each hospital may determine the extent to which internal security improvements are implemented.

Inattention to internal security may lead to overreliance on the hospital police force and perimeter security. Therefore, weak internal security will place added pressure on the perimeter security system and vice versa. The best overall security relies on a reasonable balance between the two systems.

To address staff complacency, the department should centralize physical security decision-making at each hospital, standardize operating practices, and routinely audit internal security. Such audits could be conducted by staff from headquarters and hospital staff, and would also serve as a form of training and peer review.

Changes in Crime Classifications May Assist in Improving Security


*To protect the public
and hospital staff, escapes
and assaults by all
forensic patients should
be felonies.*

During our audit, we met informally with staff at each hospital. In our discussions, some staff pointed out two additional weaknesses in security. Specifically, except for those incompetent to stand trial, those not guilty by reason of insanity, and mentally disordered sex-offenders, it is not a crime for forensic patients to escape from a department hospital. In addition, assaults by forensic patients are not considered felonies unless they independently meet existing legal criteria for felony assault (such as assault with a deadly weapon or aggravated assault). As a result, some patients can escape without fear of punishment. In addition, patients may receive only limited punishment for assaulting hospital staff.


We believe that escapes and assaults by all forensic patients should be felonies, to protect the safety of hospital staff and the public. Currently, within the CDC, any prisoner who assaults any non-prisoner, or who escapes, can be charged with a felony. Forensic patients have been legally committed to

receive medical treatment either as a condition of parole, in lieu of serving prison time, or because they are dangerous to the public.

***Hospital Police Officer Qualifications,
Training, and Staffing Need
Upgrading and Standardization***

During our audit, we identified areas where HPOs' qualifications and training should be upgraded and standardized.

Three of the department's hospitals are staffed with an HPO force, and we recommend that the fourth hospital, Patton, also convert from the CDC security contingent to an HPO force. As the forensic population increases, transportation, off-grounds hospital guarding, and related HPO workload will increase. The combined size of the HPO staffing and its critical role in hospital security and public safety support improved standardization and quality.


As the forensic population increases, HPOs will have a critical role in hospital security and public safety.

Insufficient Minimum Qualifications

Currently, the requirements to become an HPO—a designated peace officer position under the California Penal Code, Section 830.4—do not include a driver's license or a personal psychological interview. In addition, the probationary period is only six months and the minimum age is 18 years.

A department task force is revising minimum qualifications for all three existing HPO classifications (i.e., the HPO I or officer level, sergeant, and lieutenant), plus a new HPO "trainee" class. This new entry-level position would receive extensive formal training. The draft requirements we reviewed included a minimum age of 21 years, a valid driver's license, a personal psychological interview, and a one-year probation period. We support these changes. However, one problem we noted with the draft qualifications is that one year of service as a trainee is the minimum qualification for an HPO I. This means that candidates with the required peace officer training cannot be appointed to the HPO I class without first serving as a trainee. This restriction presumably would apply even if a candidate has previously worked for a law enforcement agency. We believe the final qualifications should permit more flexibility. Otherwise, we support the department's efforts and encourage the prompt adoption of improved qualifications for the HPO position.

Insufficient and Non-Standardized Training

New HPO hires at Napa and Metropolitan hospitals receive over 200 hours of formal peace officer training at local community colleges. This training is specified by the State's Commission on Peace Officer Standards and Training (POST). In contrast, Atascadero HPOs are provided 64 hours of POST-certified training plus 78 hours of other training. Our consultant recommends that all HPOs should receive the same level of training as received by the Napa and Metropolitan HPOs because the additional hours include important patrol, legal, and weaponry training. In addition, HPOs should continue to receive supplemental training such as the "managing assaultive behavior" course required of all hospital employees.

Off-Grounds Transportation and Patient Guarding Lack Consistency and Coordination


Many patients, forensic and non-forensic, must travel to court and to medical appointments for specialized services. Forensic patients are guarded at all times they are off-grounds, including around-the-clock supervision when admitted to community hospitals for in-patient care. Our audit determined that the policies governing these services vary considerably among the four hospitals. Furthermore, with the exception of Patton hospital, we found that unarmed officers transport forensic patients.

—◆—
Although they are delivered to hospitals by armed guards, sexually violent predators, gang members, and others are transported by unarmed HPOs.


Unarmed Officers Transport Forensic Patients

Most forensic patients are currently delivered to hospitals under armed guard (by the CDC or local sheriff's officers), and all off-grounds transporting officers at Patton hospital are authorized to carry firearms. In contrast, the HPOs that transport the same kind of patients are not authorized to carry firearms. These patients can include sexually violent predators, gang members, and occasionally, malingers (patients who feign mental illness for transfer out of the more confining prison environment). There is no legal prohibition against HPOs carrying firearms on duty; the decision is internal to the department.

Our consultant believes the safety of everyone involved, and particularly the officers, is better served by permitting firearms. The primary concern is attacks by outsiders who are attempting to free or harm patients (e.g., retaliation for an alleged gang incident). While we found no evidence that such attacks have occurred, it seems prudent to protect the officers in the event of such an attack.



No officers should be permitted to carry weapons until they are screened and fully trained.



While our consultant supports the arming of HPOs when transporting and guarding patients off-grounds, he believes it is imperative that no officers be permitted to carry the weapons until they are screened and fully trained. As noted earlier, minimum qualifications for an HPO do not include a personal psychological interview. Such screening should be a prerequisite for firearms training. Moreover, clear and stringent policies on the use of deadly force are also needed, as well as regular refresher training.

The initial cost to purchase handguns will vary depending on the number of officers designated to carry the weapons and whether the department assumes the security for Patton hospital. Based on \$500 per officer, 20 officers per location, and four hospitals, an estimate of \$40,000 seems reasonable. Thereafter, additional operating and training costs should be manageable within current budgeting processes.

Off-Grounds Transportation and Guarding Policy


We reviewed current transportation practices at each hospital that were based on routine transportation or overnight guarding of one forensic patient. In our comparison, we did not evaluate more unique situations, such as those involving high-risk patients, or multiple-patient transports. We found that the hospitals are inconsistent in the numbers of officers and staff used to transport forensic patients to off-grounds appointments or to guard patients during overnight stays in community hospitals.

For example, Napa and Metropolitan hospitals use one HPO and one staff person to accompany a patient to off-grounds appointments. In contrast, Patton hospital uses two officers and one staff person. Atascadero hospital uses two HPOs, and sometimes, nursing staff. While some patients may represent serious escape risks or threats to the staff and the public and thus warrant extra staff, our consultant believes that most do not. He thinks that the department should standardize the number of officers and staff used to transport patients to adequately protect staff and the public while minimizing costs.

We similarly found that the hospitals are inconsistent in the number of officers and staff guarding patients during overnight stays in community hospitals for patients requiring medical procedures unavailable at the mental health hospitals, such as surgery or acute medical care. HPOs or correctional officers, and in some cases staff, guard the patients. For example, during overnight stays at local hospitals, Metropolitan hospital guards its patients with one HPO. In contrast, Napa and Patton hospitals use one officer and one staff person, while Atascadero hospital uses two officers. As with off-grounds transports, we believe that the department could minimize security costs by standardizing the number of officers and staff used to guard patients.

Hospital Security Needs Leadership and Centralized Coordination and Control

While each hospital has unique characteristics, there is a lack of consistency and standardization in many areas of hospital security that the hospitals' unique characteristics cannot justify. There is also an absence of security management and innovation. Knowledgeable, professional, and independent experts should advise top management on issues affecting security.


While each hospital operates with a certain level of autonomy, we believe that the overall security at each hospital would benefit from standardization.

While each hospital operates with a certain level of autonomy, we believe that the overall security at each hospital would benefit from standardization. Specifically, standardization would improve HPO training, patient transportation, and staff adherence to security policies. The department could plan, coordinate, and inspect the security operations within the four hospitals. Specifically, the key objectives would be to:

- Provide objective advice to the department's top-level managers, including assessments of operating and capital budget requests.
- Coordinate HPO programs, including initial and ongoing training and patient transportation.
- Oversee the department-wide improvements to physical and procedural security measures, as described in this chapter.
- Identify practices that should be standardized, including development of the necessary policies, forms, etc., in conjunction with hospital-based personnel.

- Direct and participate in unannounced security audits.
- Research innovative security technology.

Our consultant estimates that the total annual cost for this position, including necessary clerical support and operating expenses, would be approximately \$150,000.

Conclusion

The overall security for the State's mental hospitals involves many elements other than perimeter security and operational staffing issues, as discussed in Chapter 1. We visited each of the four hospitals operated by the department and noted various physical, procedural, and technological measures that, if improved, would increase the overall security of the hospital system.

At several hospitals, physical and internal security requirements lack attention and concern. For example, our consultant found unlocked doors, an alarm disengaged, and other security shortcomings at several hospitals. Further, the minimum qualifications and training standards for HPOs need to be increased to ensure the quality of hospital security. In addition, under certain limited conditions, HPOs would benefit by being armed. Moreover, when patients are transported to court or medical appointments, each hospital uses different procedures to guard the patient. Finally, the hospital system would benefit from centralized coordination of its security systems, and that forensic patient escapes and assaults against staff should be considered felonies.

Recommendations

To increase the overall physical security at each hospital and to reduce staff complacency toward internal security matters, the Department of Mental Health (department) should:

- Develop and implement a plan to improve the internal physical security at all hospitals. The plan should survey all buildings to identify the specific needs, including glass and window spaces, fences and courtyards, exterior door alarms, personal alarm systems, portable metal detection equipment, X-ray and metal scanning equipment, and alarm systems for courtyards.

- Centralize fundamental physical security decisions at each hospital.
- Increase the standardization of important operating practices, especially daily patient counts, key control, locking and alarming doors, and patient transportation.
- Conduct periodic unannounced audits of internal and perimeter security. Such audits could be conducted by staff from headquarters and other hospitals, as a form of training and peer review.

To increase the overall qualifications, training, and effectiveness of its HPOs, the department should require all new HPOs to complete the same level of POST-certified training that Napa and Metropolitan HPOs receive. In addition, to protect patients and officers, officers who transport patients off grounds should be armed. Prior to arming its officers, the department should ensure that all such officers are fully trained and screened.

To improve overall coordination and control of security at its hospitals, the department should establish a headquarters-based position with the responsibility to coordinate and control hospital security.

Finally, to protect staff and the public from potential assaults by patients, the department should seek legislative change to make certain patient acts a felony. Specifically, any forensic patient who escapes, or who assaults any staff may be charged with a felony.

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Chapter 3

The Population of Forensic Patients Is Increasing

Chapter Summary

The patient population at state hospitals is changing. Five years ago, forensic patients comprised just over half of the total patient population; now they account for 74 percent of all patients. The increasing forensic population is partially due to a new law that took effect in 1996 that allows psychiatric treatment for sexually violent predators (SVPs) at a state hospital. Consequently, we estimate that by June 2006, forensic patients will comprise 85 percent of the patient population.

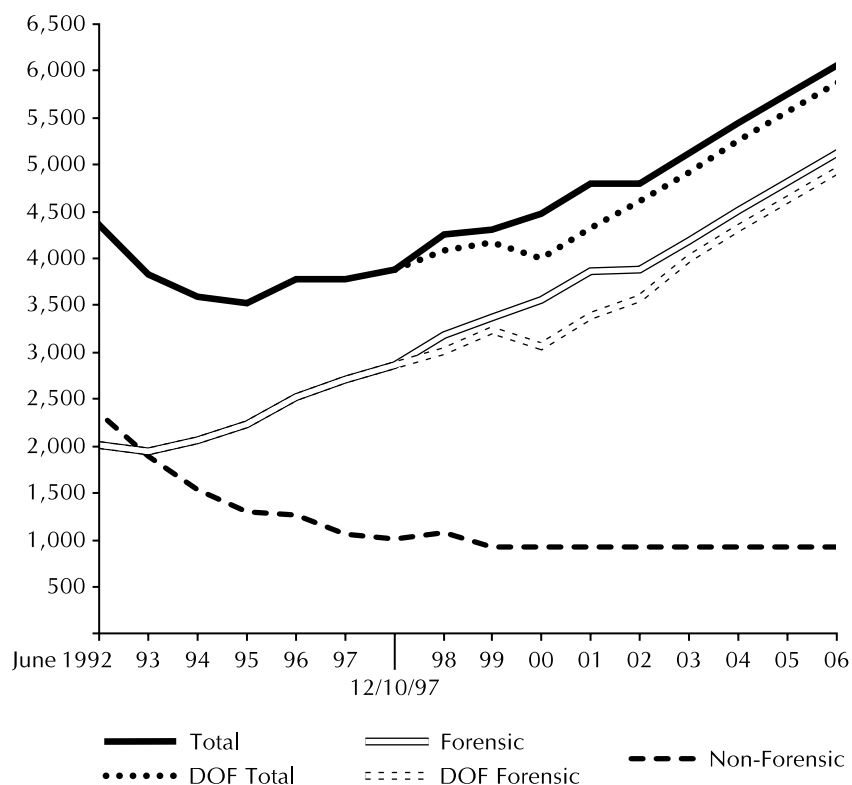
Based on the Department of Mental Health's (department) estimated growth for the population of patients and its current construction plans, the department will have adequate capacity through June 2003. Thereafter, growth will exceed the number of currently available or planned beds. The department states that it is studying ways to obtain a large facility (1,000-plus beds) that may specialize in treating SVPs.

We also noted that because the department's security risk assessments are based on excessively narrow criteria, patients are considered high-security risks solely based on their history of prior escape. Moreover, some patients may be considered low- or medium-security risks even when their behavior may suggest that they represent a threat to the community.

The Forensic Populations Will Comprise 85 Percent of All Patients by 2006

Between 1992 and 1997, forensic patients treated in the State's mental hospitals have increased by 43 percent while non-forensic patients have declined by 57 percent. Based on the department's projections, its forensic population will increase to 85 percent of the total patient population by June 30, 2006. Figure 2 indicates population changes between 1992 and 1997, and population estimates for each year through June 2006.

Figure 2
State Mental Hospital Patient Population 1992 Through 2006



We obtained population figures from the department's computer records for 1992 through 1997. The figures for 1997 and beyond are estimates we obtained from the department and the Department of Finance (DOF). As indicated in Figure 2, we provided a "range" of population estimates rather than a specific number for each year. This is because the DOF disagrees with the department's estimates for SVPs and for referrals from the California Department of Corrections (CDC). As indicated in Table 4, the estimates for SVPs and CDC referrals are slightly different.

For example, by June 30, 2006, the DOF's estimate for SVPs is 1,413, while the department's is 1,545. Similarly, the DOF estimates the number of CDC referrals will be zero beginning in fiscal year 1999-2000, while the department estimates that it will treat up to 346 CDC referrals each year until fiscal year 2000-01, and 65 patients annually in subsequent years.

Table 4
Estimated Patient Population by Commitment Category, 1997 Through 2006

COMMITMENT CATEGORY	DEC. 1997	JUNE 1998	JUNE 1999	JUNE 2000	JUNE 2001	JUNE 2002	JUNE 2003	JUNE 2004	JUNE 2005	JUNE 2006
CDC Referrals	314	467	346	346	346	65	65	65	65	65
<i>DOF estimate</i>	n/a	467	346	0	0	0	0	0	0	0
Sexually Violent Predator	201	297	453	609	765	921	1,077	1,233	1,389	1,545
<i>DOF estimate</i>	n/a	138	321	477	633	789	945	1,101	1,257	1,413
Mentally Disordered Offender	545	560	630	690	770	820	890	970	1,030	1,100
Not Guilty by Reason of Insanity	939	950	1,010	1,060	1,100	1,150	1,200	1,250	1,300	1,350
Incompetent to Stand Trial	661	695	720	750	790	820	860	900	940	980
Other Forensic	204	213	213	98	98	98	98	98	98	98
SUBTOTAL FORENSIC	2,864	3,182	3,372	3,553	3,869	3,874	4,190	4,516	4,822	5,138
<i>DOF estimate</i>	n/a	3,023	3,240	3,075	3,391	3,677	3,993	4,319	4,625	4,941
Non-Forensic	1,015	1,070	932	932	932	932	932	932	932	932
TOTALS	3,879	4,252	4,304	4,485	4,801	4,806	5,122	5,448	5,754	6,070
<i>DOF's Totals</i>	n/a	4,093	4,172	4,007	4,323	4,609	4,925	5,251	5,557	5,873

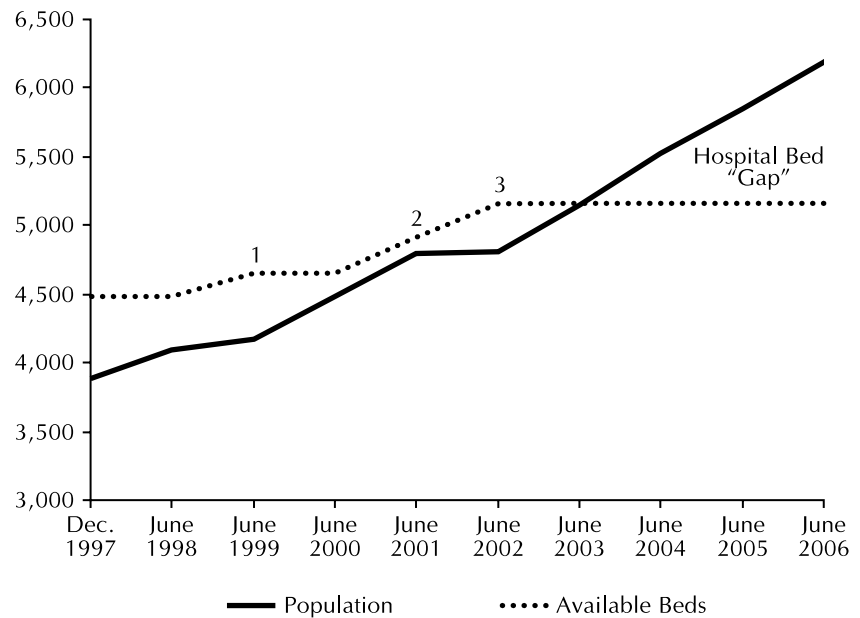
In addition, populations will increase for those not guilty by reason of insanity, those incompetent to stand trial, and mentally disordered offenders. As a result, by June 30, 2006, the forensic population may be between 4,941 and 5,138 patients.

While the population of forensic patients clearly is increasing, we recognize the difficulty in estimating future populations. Given that the SVP law has only been in effect since 1996, not enough historical data exists to accurately project the SVP population. In addition, the law is currently being challenged in the California Supreme Court, and future SVP population estimates may change depending on the outcome.

The department is increasing its bed capacity. It currently has funding to add 160 beds at Patton hospital in fiscal year 1998-99. Further, the governor's fiscal year 1998-99 budget

proposed funding for 250 beds at Atascadero hospital to be completed in fiscal year 2000-01, as well as a second 250-bed addition to be completed later. With these planned increases, we estimate that the department can meet the population projections through June 2003. After 2003, however, hospital bed capacity will remain constant at 5,149 beds while the patient population continues to rise, thereby creating an increasing shortage or “gap” of hospital beds, as illustrated in Figure 3.

Figure 3
Statewide Population Estimates and Available Beds
1997 Through 2006



- 1 - Assumes 160 new beds at Patton hospital by June 1999
- 2 - Assumes 250 new beds at Atascadero hospital by June 2001
- 3 - Assumes 250 more beds at Atascadero hospital by June 2002

The department has contracted for a feasibility study to identify various ways of obtaining a large hospital facility to house and treat additional forensic patients. According to the department’s chief of hospital operations, this new facility will specialize in treating and housing over 1,000 SVPs. Thus, while the department should have the capacity to meet the growth in population through at least June 2003, an increase in forensic patients will consume the available beds. To mitigate this

shortage, the department will need to expedite its plan to obtain the 1,000-plus bed facility, since planning and construction may take at least three to four years.

***The Department Bases Assessment
of Patient Security on
Excessively Narrow Criteria***

The California Welfare and Institutions Code, Section 7228, requires that prior to admission to Napa or Metropolitan hospitals, the department must evaluate each patient committed as incompetent to stand trial or not guilty by reason of insanity. Section 7230 requires that high-risk patients only be placed at Atascadero or Patton hospitals, or at a correctional facility. Napa or Metropolitan hospitals can only treat low- and medium-risk patients.

To meet the mandates of Section 7228, the department developed a security risk assessment for all forensic patients that interprets security risk to mean only the risk of escape. It assigns medium-risk patient scores between 41 and 54 and low-risk patient scores of 17 to 40. The department considers the patient's prior history of escape as the most important factor in its assessment, but also considers age, psychological disorder, number of prior felony convictions, maximum sentence, and physical condition. Department staff who developed the assessment said that because prior history of escape is the most significant indicator of future escape attempts, only patients having a history of escape are classified as high-risk.



Patients can be classified as "high-risk" only if they have a history of prior escapes.



Our consultant believes that these legal requirements, along with the department's risk-assessment process, create several problems. First, the exclusion of all factors other than prior escapes in determining who is a high-risk patient may result in incorrect classifications. For example, a patient with a history of incarceration in a secure prison could be classified as a low- or medium-risk patient because he had no opportunity to escape from prison. On the other hand, patients who "walked away" while on a grounds-pass many years ago could be rated as high-risk. Once a patient is classified as high-risk, there is no way within the current process to lower the classification, despite changed circumstances.

Second, there is no consistent definition of prior escape. Some hospital staff considered a "walk-away" to be an escape, while others did not. As a result, staff may not apply assessment

criteria consistently. Third, the criteria do not adequately consider the community threat represented by some patients, such as those with a history of violent crime or lewd behavior.

While the legislative intent underlying Section 7228 may not be specific as to what high-risk means, we believe that the public would apply this term to more patients than just those with one or more escapes as an adult. Based on these concerns and lack of consistency in the assessments, we recommend that the department revise its current process and develop a more comprehensive risk-assessment process. In addition, because Napa hospital has proposed constructing security features similar to those at Patton hospital once construction is complete, the department should consider requesting the Legislature to modify Section 7228 so that patients could be directly admitted and evaluated at Napa hospital.

Conclusion

Based on estimated growth trends for the population of patients and its current construction plans, the department appears to have adequate capacity for the projected increase in forensic patient population through June 2003. However, after June 2003, the growth in forensic patient population will exceed available beds. The department states that it is studying ways to obtain a large facility (1,000-plus beds) specializing in treating and housing SVPs.

We also noted that because the department's security risk-assessment process is based on excessively narrow criteria, patients are considered high-security risks based solely on their history of prior escape. Moreover, some patients may be considered low- or medium-security risks even when their behavior may suggest that they represent a greater threat to the community.

Recommendations

To meet the expected shortage of hospital beds after June 2003, the Department of Mental Health (department) should develop a plan to build additional housing. In addition, to allow the greatest flexibility to treat and house its growing population of forensic patients, the department should revise its security risk-assessment process. Further, after Napa hospital's security improvements are completed, the department should request

that the Legislature remove the current legal restriction that precludes admitting high-risk forensic patients directly to Napa hospital.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

A handwritten signature in black ink, reading "Kurt R. Sjoberg". The signature is written in a cursive, flowing style.

KURT R. SJOBERG
State Auditor

Date: March 12, 1998

Staff: Elaine Howle, CPA, Audit Principal
Bill Shepherd, CPA
Willie Benson
Christine Berthold, CPA
Claire Hur

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Appendix A

Categories of Forensic Patients

Approximately 74 percent of the patients in state mental hospitals are forensic patients. Following is a description of the six groups of forensic patients discussed in this report.

Incompetent To Stand Trial

A person is considered mentally incompetent if, as a result of mental disorder or developmental disability, the person is unable to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a rational manner. The California Penal Code, Section 1370, states that if a person accused of a crime is found mentally incompetent, their trial or judgment shall be suspended until they become mentally competent. When a superior court finds a defendant mentally incompetent, treatment frequently involves hospitalization at a state mental hospital. The maximum commitment time is either three years or the maximum term of imprisonment for the most serious charge, whichever is less. If the defendant has not regained competence to stand trial by that time, the defendant must be released, or if certain criteria are met, the defendant can be hospitalized further under a "Murphy Conservatorship" under the Lanterman-Petris-Short (LPS) Act.

Not Guilty by Reason of Insanity

When a court finds that a person was guilty of a crime, but was insane at the time, the person may be committed to a state hospital for treatment under the California Penal Code, Section 1026. Treatment lasts for the maximum sentence that could have been imposed for the crime and cannot be reduced for good behavior. If the patient is considered dangerous at the end of the original commitment, and the original crime was a felony involving physical harm or the threat of physical harm, the court can extend the treatment period.

Transfers From the Department of Corrections

The California Penal Code, Section 2684, allows the California Department of Corrections (CDC) to transfer inmates to a state hospital for treatment, if they are found to be mentally ill while in prison. When the inmates have reached maximum benefit from treatment, they are returned to prison. If they are still mentally ill at the end of their prison term, they may receive further state hospital treatment as a Mentally Disordered Offender (see below) or an LPS commitment may be initiated.

Mentally Disordered Offender

As a condition of parole, certain inmates are admitted to a state hospital for treatment. Treatment occurs during parole, and in some cases, beyond parole. Both the CDC and the Department of Mental Health staff must certify that the inmate meets certain criteria: (1) has a severe mental disorder that is not in remission or cannot be kept in remission without treatment; (2) the severe mental disorder was a factor in the crime for the current sentence; (3) the inmate has been in treatment for at least 90 days during the year prior to release; and (4) force, violence, or serious bodily injury was involved in the crime, and the inmate continues to be dangerous because of the severe mental disorder.

Sexually Violent Predator

A program to treat sexually violent predators was established in 1995 under the California Welfare and Institutions Code, Section 6600. Sexually violent predators have been previously convicted of specified sex offenses against two or more victims and have a diagnosed mental disorder that makes it likely that they will engage in sexually violent criminal behavior upon release into the community. The law took effect on January 1, 1996. Commitments last for a maximum of two years, and can be renewed upon petition and approval of the superior court.

Other

There are a few forensic patients who do not fit into the above general categories. For example, wards of the California Youth Authority are sometimes transferred to state hospitals for

treatment. In addition, a few forensic patients were committed as “Mentally Disordered Sex Offenders” under a former state statute that has since been repealed.

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Appendix B

Detailed Specifications and Cost Estimates for Enhanced Double-Fence Security System

As discussed in Chapter 1, we estimate that our consultant's proposed changes to the approved perimeter security plan at Napa hospital and existing security measures at Patton hospital can reduce annual security costs by \$2.2 million at Napa and by \$3.9 million at Patton, while maintaining effective perimeter security. The following is a more detailed description of the proposed changes and cost estimates.

Napa Hospital

The Department of Mental Health (department) intends to implement a perimeter security plan at Napa hospital that has a proposed total budget of \$6.5 million for capital costs. The project calls for a 16-foot fence topped with razor wire, 10 guard posts, one sallyport, a new visitors' center, and other improvements.

In particular, the department's security plan calls for staffing 10 guard posts on a constant basis, requiring about 49 hospital police officers (HPO), plus 5 sergeants, and 2 lieutenants. Based on an average salary of \$33,900 for HPOs, \$37,176 for sergeants, and \$40,788 for lieutenants; plus 25 percent for benefits, we estimate that it would cost about \$2.4 million annually to staff the 10 guard posts.

As an alternative, our consultant proposes constructing a double-fence with enhanced electronic detection and dedicated patrols that will accomplish Napa hospital's security more cheaply and effectively.

Our Proposal for Double-Fencing, Electronic Detection, and Dedicated Patrols

As discussed in Chapter 1, the proposed changes to Napa hospital's external security would require higher initial capital costs but would generate annual operating savings. The proposed changes employ the following perimeter security measures:

- **Double-fence**—Add a second fence to the currently planned single fence. Fourteen-feet high, 7,511 linear feet, with razor wire and anti-climb mesh. Estimated cost: \$124.25 per linear foot. Estimated total cost: \$933,242.
- **Additional Gates**—Add a second vehicle and pedestrian gate to existing sallyports. Also, add second emergency gate. Estimated cost: \$15,044.
- **Electronic detection system**—Add electronic sensors to the second fence and a microwave detection system to the space between the two fences. Estimated cost: \$463,609.
- **Miscellaneous**—Remove existing asphalt and concrete. Estimated cost: \$25,487.

Total estimated costs: \$1,437,382

In return, operating costs would be reduced because, under our consultant's proposal, the 10 guard posts would be unnecessary, thus eliminating the need for 44 HPOs, 5 sergeants, and 2 lieutenants. (Five HPOs would be redirected to the dedicated perimeter patrol.) Based on an average salary of \$33,900 for HPOs, \$37,176 for sergeants, and \$40,788 for lieutenants, plus 25 percent for benefits, our consultant estimates that the total annual savings would be \$2.2 million.

Patton Hospital

The proposed changes to Patton hospital's perimeter security duplicate the enhanced double-fence approach just described for Napa hospital. The only significant differences relate to size, operational characteristics, and cost factors.

Patton hospital operates two completely separate compounds, each with its own perimeter security fence, disturbance sensor system, closed-circuit television (CCTV), and sallyports. A single-security fence topped with razor wire and anti-climb mesh surrounds both compounds. In the west compound, 2 of the 11 guard posts are inactive and 2 others operate only 16 hours a day. The east/central compound has 10 guard posts that are staffed around the clock. Correctional officer staffing for these guard posts requires about 90 full-time equivalent positions. Assuming mid-range salaries and a 28 percent benefit factor, the current annual cost is over \$4.8 million.

Our consultant proposes that a double-fence with electronic detection and dedicated patrols can reduce the relatively high perimeter-security costs at Patton hospital without compromising public safety.

Double-Fencing, Electronic Detection, and Dedicated Patrols

As previously stated, this proposal for Patton hospital is identical to the enhanced double-fencing alternative described for Napa hospital except as noted below:

- **Double-fence**—Add an additional fence to the existing single fence. Fourteen-feet high, 12,100 linear feet with razor wire and anti-climb mesh. Estimated cost: \$1,561,275.
- **Additional gates**—Add additional vehicle gates. Estimated cost: \$46,300.
- **Electronic detection system**—Add electronic sensors to the second fence, microwave detection system to the space between the two fences, and three CCTV cameras. Estimated cost: \$638,093.
- **Miscellaneous**—Remove asphalt, concrete; add paving; demolish partial building. Estimated cost: \$231,227.

Total estimated costs: \$2,476,895

In return, operating costs would be reduced because, under our consultant's proposal, the 19 existing guard posts would be unnecessary, thus eliminating the need for 73 of the 90 correctional officers assigned to guard posts. (Seventeen officers would be reassigned to the dedicated patrols inside and outside the perimeter fence.) Based on an average annual salary of \$41,952, plus 28 percent benefits, the total annual savings would be \$3.9 million.

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Agency's response to the report provided as text only:

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
DEPARTMENT OF MENTAL HEALTH
1600 - 9TH STREET
SACRAMENTO, CA 95814
(916) 654-2309

PETE WILSON, GOVERNOR

March 9, 1998

Mr. Kurt R. Sjoberg
State Auditor
660 "J" Street, Suite 300
Sacramento, California 95814

Dear Mr. Sjoberg:

Thank you for the opportunity to review your report, entitled "*Department of Mental Health: Changes in State Hospital Security Measures Can Reduce Annual Costs While Maintaining Public Safety.*" The Department of Mental Health welcomes the review and suggestions.

I would like to discuss several points regarding the Department and your audit, but first would like to point out that the Department has worked with the local communities and local law enforcement in devising the security systems in use at each of our state hospitals. For example, at Napa State Hospital, the local Sheriff and Chief of Police have been involved in approving the security fence design, the number of observation kiosks needed, and interim security measures needed until construction of the security fence is completed. At Metropolitan, the Sheriff's office has been involved in approving or giving input to the security measures and policies that the hospital has developed and is involved in a review of all forensic patient transfers from other hospitals. Likewise, Atascadero and Patton have good relationships with local law enforcement and use them to get input on items relating to security.

With respect to the draft report, we find that many of your recommendations in Chapter 2 (Internal Security Enhancements) make sense to us, and we will review them in detail to see which ones we can implement and how we can best go about doing this. In addition, in the current years budget, \$1.150 million was appropriated for increased security measures at Napa State Hospital subject to the approval of the Department of Finance and a 30-day notification to the Joint Legislative Budget Committee. Many of the items agreed to in the interim plan are to come from this \$1.150 million allocation. Items include eleven additional Hospital Peace Officers, five dispatch clerks, dispatch equipment, equipment for the additional peace officers, installing lexan and window bars in the major building now housing forensic patients at Napa (this item is approximately \$350,000 for one building), providing security measures on forensic unit porches, cellular communication for staff doing ground escort duty, enhancing or installing personal alarm systems, and installing a security/fire alarm panel for one of the units. The Department intends to continue

the security upgrading and security fence project at Napa, while discussions regarding your report are held. As you point out, we have a growing forensic population, therefore, we need to complete these security improvements so we can house additional forensic patients at Napa State Hospital.

We will also review our risk assessment tool to see if changes are needed, although this tool has been in use for less than one year and was a result of a study of indicators of flight risk of patients at two of our hospitals, comparing those who attempted to escape and those who didn't. Further, the patient risk assessment, by policy, is updated on each patient at least once a year, and in practice more frequently as patient circumstances warrant. Your report seems to indicate that a patient coming from a California Department of Corrections (CDC) institution could be rated as a

①* low or medium security risk and be transferred to one of our hospitals serving low or medium risk patients. This gives the wrong impression of our security risk tool, and more importantly of our treatment system. Patients transferred from CDC to our Department go only to Atascadero (men) or Patton (women) State Hospitals. These patients are never transferred to either Metropolitan or Napa State Hospitals.

As to your major recommendations of double fencing at Napa and Patton State Hospitals, reducing the number of observation kiosks at Metropolitan, Napa, and Patton State Hospitals, taking over the security of Patton from the Department of Corrections, direct admission of patients to Metropolitan and Napa, and arming Hospital Peace Officers when they are performing transportation duties, I believe these issues need further discussion with all the relevant parties, including local legislators, local law enforcement agencies, concerned community groups, hospital neighbors, and other constituency groups. While our objective will continue to be zero incidents, the low escape

② rate at our hospitals points to the success of security systems which employ single fence security compounds with staff observing the fence lines. In the last twelve years, there have been only seven escapes of forensic patients from these hospitals, with only one in the last three years where this system is in place.

A final note is the cost and savings estimates attributed to double fencing. While we have not performed an independent estimate of our own, we do know the estimate for the fence to be constructed at Napa State Hospital. Based on this comparison, your cost estimate for double fencing

③ may be understated. For the fencing alone, our estimate at Napa is \$1,306,445 which would coincide with the estimate contained in your report of \$933,242, thus a difference of \$373,203.

In conclusion, we believe that we have been able to establish safe, secure, and therapeutically appropriate state mental hospitals where public safety, including the safety of the clients and employees, and successful treatment modalities have been successfully blended. We have been most fortunate to have the advice of local law enforcement and community members in achieving this delicate balance.

*California State Auditor's comments on this response begin on page 49.

Kurt R. Sjoberg
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March 9, 1998

Again, I want to thank you for the opportunity to review the report. The Department also appreciated the professionalism of your staff. We found them helpful in keeping us informed as they were doing the audit. If you have any questions, please feel free to call me or John Rodriguez, Deputy Director for Long Term Care Services, at 654-2413.

Sincerely,

John Rodriguez

FOR

STEPHEN W. MAYBERG, Ph.D.
Director

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Comments

California State Auditor's Comments on the Response From the Department of Mental Health

To provide clarity and perspective, we are commenting on the Department of Mental Health's (department) response to our audit report. The numbers correspond to the numbers we have placed in the response.

- ① Text changed.
- ② While we agree that the department's objective should be to ensure that an effective security system exists at all hospitals, as discussed on page 11 of our report, our security consultant believes that significant cost savings can result from double-fencing, electronic sensors, and dedicated patrols, while still protecting the public. Moreover, the California Department of Corrections is considering installing a double-fence at Patton hospital and estimates that 60 staff positions would be saved.
- ③ Our construction consultant, Nacht & Lewis Architects, developed the estimates on a conceptual basis, using existing architectural drawings. The conceptual estimates did not include the costs for complete design drawings, plans, permits, and contingencies. However, even if the department's estimate is more accurate, the one-time cost would still result in a short pay-back period and significant annual savings. Specifically, our estimate of construction costs at Napa hospital would result in a pay-back period of about 8 months, using our annual savings estimate of \$2.2 million. Even using the department's \$373,303 higher estimate, the pay-back period would be about 10 months, followed by \$2.2 million in annual savings.

cc: Members of the Legislature
Office of the Lieutenant Governor
Attorney General
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps