Department of State Hospitals

2024-25

May Revision
Proposals and Estimates

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Department of State Hospitals
2024-25 May Revision
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DEPARTMENT OF STATE HOSPITALS
PROGRAM OVERVIEW
Informational Only

BACKGROUND

The California Department of State Hospitals (DSH) manages the nation's largest inpatient forensic mental health hospital system. The mission of DSH is to provide evaluation and treatment to patients in a safe and responsible manner, by leading innovation and excellence across a continuum of care and settings. Within the context of the broader mental health system of care, DSH primarily serves individuals who have been committed to the Department through the superior courts or Board of Parole Hearings. Additionally, DSH serves a smaller contingent of conserved individuals referred by the counties and inmates from the California Department of Corrections and Rehabilitation. DSH is responsible for the daily care and provision of mental health treatment of its patients. Upon discharge from a DSH commitment, individuals typically return to their community, and the county behavioral health system serves to provide additional services and linkages to treatment.

DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton). In addition to state hospital treatment, DSH provides services in contracted Jail-Based Competency Treatment (JBCT), Community-Inpatient Facilities (CIF), Conditional Release Program (CONREP), Community-Based Restoration (CBR), and pre-trial felony mental health Diversion programs. DSH is responsible for the daily care of over 7,000 patients. In fiscal year (FY) 2022-23, DSH served over 13,000 patients, with 9,140 served across the state hospitals, 1,912 in JBCT, 207 in CIF, 620 in CBR contracted programs, and 794 in CONREP programs. 11,259 individuals were treated within a DSH inpatient program and 1,875 were served through DSH's outpatient programs**.** Through Early Access Stabilization Services (EASS) and Re-evaluation services, during FY 2022-23, DSH initiated services for 1,427 patients in EASS, and off ramped 546 through DSH's Re-Evaluation program. In addition, during FY 2022-23, 477 individuals were diverted from jail into county diversion programs funded by DSH.

With nearly 13,000 employees located across its Sacramento headquarters and five state hospitals throughout the state, every team member's effort at DSH focuses on the provision of mental health treatment in a continuum of treatment settings while maintaining the safety of patients, employees, and the public. Approximately half of the Department's employees are in nursing classifications, including psychiatric technicians and registered nurses that provide care for patients in DSH's state hospitals.

DSH is funded through the General Fund and reimbursements from counties for the care of Lanterman-Petris-Short (LPS) patients. All DSH facilities are licensed through the California Department of Public Health (CDPH) and four of the five facilities

(Atascadero, Metropolitan, Napa, and Patton) are accredited by The Joint Commission, an independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States.

STATE HOSPITALS

DSH-Atascadero

Opened in 1954, DSH-Atascadero is located on the Central Coast of California in Atascadero (San Luis Obispo County). The hospital is a forensic mental health hospital and is a self-contained psychiatric hospital constructed within a security perimeter. The majority of the all-male patient population is remanded for treatment by county superior courts or by the California Department of Corrections and Rehabilitation (CDCR) pursuant to various sections of the California Penal Code (PC) and the Welfare and Institutions Code (WIC). DSH-Atascadero primarily serves the following four patient commitment types: Offender with a Mental Health Disorder (OMD), *Coleman* patients (inmates with serious mental illness) from CDCR, Incompetent to Stand Trial (IST), and Not Guilty by Reason of Insanity (NGI).

DSH-Coalinga

Opened in 2005, DSH-Coalinga is located on the western edge of Fresno County. DSH-Coalinga is a forensic mental health hospital and primarily treats Sexually Violent Predators (SVP). It is a self-contained psychiatric hospital constructed with a security perimeter. CDCR provides perimeter security as well as transportation of patients to outside medical services and court proceedings. The majority of the all-male patient population is remanded for treatment by county superior courts or CDCR pursuant to various sections of the California PC and the WIC. DSH-Coalinga primarily serves the following three patient commitment types: OMD, *Coleman* patients from CDCR, and Sexually Violent Predators (SVP).

DSH-Metropolitan

Opened in 1916, DSH-Metropolitan is located in Norwalk (Los Angeles County). The hospital is an open style campus within a security perimeter. Due to concerns raised by the community, DSH-Metropolitan maintains a formal agreement with the City of Norwalk and the Los Angeles County Sheriff not to accept patients charged with murder or a sex crime, or at high risk for escape. This agreement has limited the total number of patients that DSH-Metropolitan can treat below the licensed bed capacity. Until 2019, DSH-Metropolitan's operational bed capacity was restricted due to multiple units that were located outside of the hospital's secured treatment area (STA). The units outside of the STA were unable to house forensic patients. To provide additional capacity to serve forensic patients, a secured fence was constructed to surround the housing units located next to the existing secure

treatment area. To provide additional capacity to address an ongoing system-wide forensic waitlist, the Budget Act of 2016 included the capital outlay construction funding for the Increased Secure Bed Capacity project, which was recently completed. DSH-Metropolitan primarily serves the following four patient commitment types: LPS, IST, OMD and NGI.

DSH-Napa

Opened in 1875, DSH-Napa is located in Napa County. Most of the hospital is a forensic mental health hospital and the first State Hospital. DSH-Napa is the oldest California state hospital still in operation and has an open style campus with a security perimeter. DSH-Napa primarily serves the following four patient commitment types: LPS, IST, OMD, and NGI.

DSH-Patton

Opened in 1893, DSH-Patton is located in the town of Highland in San Bernardino County. Most of the hospital is a forensic mental health hospital and has an open style campus with a security perimeter. Due to concerns from the community about the risk of a patient escape, CDCR correctional officers provide perimeter security and transportation at DSH-Patton. DSH-Patton primarily serves the following four patient commitment types: LPS, IST, OMD, and NGI.

For additional information on the specific state hospitals, please reference the DSH Hospital Profiles located within Section F2.

Community Based and Jail-Based Treatment

Since 1986, with the implementation of CONREP, community-based treatment has been part of the program options for forensically committed individuals. In 1996, SVPs were added to the CONREP population, thereby expanding the number of patients served in the community. In response to the *Stiavetti v Clendenin* ruling and significant growth in the IST waitlist, in 2021, DSH convened an IST Solutions Workgroup. Many of the suggestions developed by the IST Solutions Workgroup were included in the IST Solutions budget package in the Budget Act of 2022[1] with an emphasis on community-based treatment options including Felony Mental Health Diversion, Community Based Restoration (CBR) and Community Inpatient Facility (CIF) programs. Further, the IST Solutions Budget Package provided support to implement jail-based treatment through the Early Access Stabilization Services (EASS)program, recognizing the need for treatment intervention at the earliest point possible to support stabilization and increase opportunities for eligibility and placement to Diversion and CBR programs. These new programs, together with foundational IST treatment programs available through the state hospitals and JBCT programs,

[1] See IST Solutions (Section C9) for more information

establish a robust continuum of care for DSH patients. Lastly, the Budget Act of 2022 amended PC Section 1370 to statutorily prioritize community outpatient treatment effective July 1, 2023, increasing consideration for placement of IST patients in Diversion, CBR, or other community IST facilities. DSH continues to focus efforts on the expansion of community-based treatment to reduce the forensic waitlist and to encourage diversified treatment to reverse the cycle of criminalization for individuals with serious mental illness and increase community transitions for state hospital patients.

DEPARTMENT OF STATE HOSPITALS
FUNCTIONAL VACANCY DISPLAY
Informational Only

This item is updated annually.

Please see the 2024-25 Governor's Budget for the most recent version.

DEPARTMENT OF STATE HOSPITALS POPULATION

	CURRENT YEAR 2023-24					
	July 1, 2023 Actual Census	Previously Approved Adjustments CY 2023-24	2024-25 November Adjustment CY 2023-24	Mid Year Census Adjustment	2024-25 May Revision Adjustment CY 2023-24	June 30, 2024 Projected Census
POPULATION BY HOSPITAL						
ATASCADERO	1,067	0	0	-24	0	1,043
COALINGA	1,341	0	0	0	0	1,341
METROPOLITAN	762	48	0	81	0	891
NAPA	1,103	0	0	0	0	1,103
PATTON	1,416	0	0	-50	0	1,366
TOTAL BY HOSPITAL	**5,689**	**48**	**0**	**7**	**0**	**5,744**
POPULATION BY COMMITMENT - SH						
Coleman - PC 2684[1]	112	0	0	63	0	175
IST - PC 1370	1,768	48	0	-17	0	1,799
LPS & PC 2974	585	0	0	-29	0	556
NGI - PC 1026	1,225	0	0	-22	0	1,203
OMD - PC 2962	334	0	0	12	0	346
OMD - PC 2972	711	0	0	0	0	711
SVP - WIC 6602/6604	954	0	0	0	0	954
TOTAL BY COMMITMENT	**5,689**	**48**	**0**	**7**	**0**	**5,744**
CONTRACTED PROGRAMS						
JAIL BASED COMPETENCY TREATMENT	362	62	0	0	0	424
COMMUNITY BASED RESTORATION/ DIVERSION	648	177	0	0	0	825
COMMUNITY INPATIENT FACILITIES	70	113	0	0	0	183
TOTAL - CONTRACTED PROGRAMS	**1,080**	**352**	**0**	**0**	**0**	**1,432**
CONREP PROGRAMS[2]						
CONREP SVP	20	7	0	0	0	27
CONREP NON-SVP	614	71	0	0	0	685
CONREP FACT PROGRAM	56	124	-90	0	0	90
CONREP STEP DOWN FACILITIES	43	142	0	0	0	185
TOTAL - CONREP PROGRAMS	**733**	**344**	**-90**	**0**	**0**	**987**
CY POPULATION AND CONTRACTED TOTAL	**7,502**	**744**	**-90**	**7**	**0**	**8,163**

Total IST Population - State Hospitals, JBCT, CBR, and CIF (excludes CONREP)

July 1, 2023 Actual: 2,848

June 30, 2024 Projected: 3,231

Projected census will be adjusted as contracts are entered into as a result of the IST Solutions program implementation.

[1] *Coleman* - Reflects current census; pursuant to *Coleman v. Brown* 336 beds are available to *Coleman* patients.

[2] The projected census for CONREP is based on the contracted caseload. Actual census may vary based on activation delays.

DEPARTMENT OF STATE HOSPITALS POPULATION

	BUDGET YEAR 2024-25				
	July 1, 2024 Projected Census	Previously Approved Adjustments BY 2024-25	2024-25 November Adjustment BY 2024-25	2024-25 May Revision Adjustment BY 2024-25	June 30, 2025 Projected Census
POPULATION BY HOSPITAL					
ATASCADERO	1,043	0	0	0	1,043
COALINGA	1,341	0	0	0	1,341
METROPOLITAN	891	48	0	0	939
NAPA	1,103	0	0	0	1,103
PATTON	1,366	10	0	0	1,376
TOTAL BY HOSPITAL	**5,744**	**58**	**0**	**0**	**5,802**
POPULATION BY COMMITMENT - SH					
Coleman - PC 2684[1]	175	0	0	0	175
IST - PC 1370	1,799	52	0	0	1,851
LPS & PC 2974	556	0	0	0	556
NGI - PC 1026	1,203	0	0	0	1,203
OMD - PC 2962	346	3	0	0	349
OMD - PC 2972	711	3	0	0	714
SVP - WIC 6602/6604	954	0	0	0	954
TOTAL BY COMMITMENT	**5,744**	**58**	**0**	**0**	**5,802**
CONTRACTED PROGRAMS					
JAIL BASED COMPETENCY TREATMENT	424	93	18	-18	517
COMMUNITY BASED RESTORATION/ DIVERSION	825	931	0	0	1,756
COMMUNITY INPATIENT FACILITIES	183	40	0	0	223
TOTAL - CONTRACTED PROGRAMS	**1,432**	**1,064**	**18**	**-18**	**2,496**
CONREP PROGRAMS[2]					
CONREP SVP	27	4	0	0	31
CONREP NON-SVP	685	0	0	0	685
CONREP FACT PROGRAM	90	0	0	0	90
CONREP STEP DOWN FACILITIES	185	-22	0	0	163
TOTAL - CONREP PROGRAMS	**987**	**-18**	**0**	**0**	**969**
BY POPULATION AND CONTRACTED TOTAL	**8,163**	**1,104**	**18**	**-18**	**9,267**

Total IST Population - State Hospitals, JBCT, CBR, and CIF (excludes CONREP)

July 1, 2024 Projected: 3,231

June 30, 2025 Projected: 4,347

Projected census will be adjusted as contracts are entered into as a result of the IST Solutions program implementation.

[1] *Coleman* - Reflects current census; pursuant to *Coleman v. Brown* 336 beds are available to *Coleman* patients.

[2] The projected census for CONREP is based on the contracted caseload. Actual census may vary based on activation delays.

POPULATION DATA
STATE HOSPITALS
POPULATION AND PERSONAL SERVICES ADJUSTMENTS
Informational Only

BACKGROUND

A change in position and expenditure authority in fiscal year (FY) 2023-24 and FY 2024-25 is based on a broad range of factors and variables specific to the delivery of patient treatment. These variables may include treatment categories, patient legal classifications, capacity and facility adjustments impacting safety and security. Changes amongst these variables drive clinical and non-clinical staffing needs within state hospitals to meet staff-to-patient ratios, clinical caseloads, and other staffing methodologies adopted in the Budget Acts of 2019 and 2020.

To address treatment, population and facility changes, and the subsequent impact to hospital staffing, the Department of State Hospitals (DSH) conducts biannual assessments including census and population projections to identify significant fluctuations in hospital bed capacity and population growth as seen in the pending placement list, and adjustments within treatment categories, facilities, and treatment capacity.

POPULATION PROJECTIONS

Census and Pending Placement List Projections

DSH utilizes the July 1, 2023, actual census as the baseline census for both FY 2023-24 and FY 2024-25. For the 2024-25 Governor's Budget and May Revision, the methodologies to project future census figures are applied as described below.

Methodology[1]

In the 2016-17 Governor's Budget, DSH implemented a methodology to project the pending placement list, which has since been enhanced and expanded to include additional commitments through collaborative efforts with the University of California, Irvine's (UCI) Department of Criminology, Law, and Society research team. DSH continues to use this as the standard forecasting tool to project the pending placement list for the Incompetent to Stand Trial (IST), Lanterman–Petris–Short (LPS), Offender with a Mental Health Disorder (OMD), Not Guilty by Reason of Insanity (NGI), and Sexually Violent Predator (SVP) populations.

[1] This methodology does not project for the *Coleman* patients. The Department of Corrections and Rehabilitation (CDCR) determines the bed need and produces projections for the *Coleman* population.

This methodology utilizes four primary measures, as well as expected systemwide capacity expansions[2], to forecast the pending placement list. These measures include pending admissions, average referrals, average admissions, and average length of stay (ALOS). A projected pending placement list is generated by adding a point-in-time pending placement list value to an average of monthly new patient referrals. This value is then reduced by the correlating average of monthly admissions, which are offset to incorporate any bed decreases. Expected systemwide capacity increases, augmented by the appropriate ALOS, are then subtracted from the projected pending placement list to yield a modified pending placement list projection for future months.

The projected pending placement list for FY 2023-24 and FY 2024-25 is based on the modified pending placement list value calculated for June 30, 2024, and June 30, 2025. Variables are specific to patient legal class and are calculated based on trends observed in the 12-month period ending February 29, 2024.

Table 1 below provides the DSH pending placement list projections for the IST, LPS, NGI, OMD, and SVP populations. The table also presents the actual census for July 1, 2023, as well as the projected census for FY 2023-24 and FY 2024-25 for all DSH populations. The projected census for June 30, 2024 (for FY 2023-24) and June 30, 2025 (for FY 2024-25) reflects the actual census as well as the approved and proposed census adjustments.

[2] Systemwide capacity expansions include state hospitals, jail-based competency treatment programs, community inpatient facility programs, and community-based restoration programs.

Table 1: Census and Pending Placement List Projections

CURRENT YEAR			
Legal Class	**July 1, 2023 Actual Census**	**June 30, 2024 Projected Census**	**June 30, 2024 Projected Pending Placement List**
IST	2,848	3,231	326
LPS	585	556	287
NGI	1,225	1,203	17
OMD2962	334	346	38
OMD2972	711	711	4
SVP	954	954	7
Coleman[1]	112	175	N/A
Subtotal	*6,769*	*7,176*	679
CONREP[2]	733	987	N/A
Total	**7,502**	**8,163**	**679**
BUDGET YEAR			
Legal Class	**July 1, 2024 Projected Census**	**June 30, 2025 Projected Census**	**June 30, 2025 Projected Pending Placement List**
IST	3,231	4,347	284
LPS	556	556	327
NGI	1,203	1,203	14
OMD2962	346	349	41
OMD2972	711	714	4
SVP	954	954	2
Coleman[1]	175	175	N/A
Subtotal	*7,176*	8,298	672
CONREP[2]	987	969	N/A
Total	**8,163**	**9,267**	**672**

[1] The projected pending place list is not calculated for the Coleman population within the DSH forecasting model. Projections for the Coleman population is developed by CDCR.
[2] The projected census for CONREP is based on the contracted caseload. Actual census may vary based on activation delays.

Referral[3] and Census Trends

Over the span of the last six years, DSH has seen an increase of almost 45% in IST referrals when comparing annual referral rates from FY 2017-18 through FY 2022-23. Notably, during FY 2019-20 and FY 2020-21, DSH observed declines in IST referrals, which were attributed to the COVID-19 pandemic and disruption of court proceedings. However, county courts have since resumed their activities, subsequently leading to surges in IST referral rates that show a consistent year over year increase. In FY 2022-23, DSH experienced another unprecedented growth in referrals, with an increase of 18% in IST referrals as compared to the preceding year. In the current fiscal year DSH is experiencing referrals rates comparable to that of the prior year. The data displayed in Table 2 below highlights a significant and sustained trend in IST referral growth.

Table 2: Average Monthly Referrals[4]

Fiscal Year	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24[1]	% Change
IST	383	343	346	415	488	486	0%
LPS	16	<11	12	<11	11	17	53%
NGI	11	<11	<11	<11	<11	<11	-2%
OMD 2962	46	43	26	27	30	31	2%
OMD 2972	<11	<11	<11	<11	<11	<11	-13%
SVP	<11	<11	<11	<11	<11	<11	-22%
Coleman	*35*	46	16	16	17	26	57%
Total	**498**	**456**	**416**	**483**	**559**	**572**	**2%**

[1]FY 2023-24 referral data reflects averages from July 2023 through February 2024.

Following the onset of COVID-19, DSH experienced a reduction in its patient census. As DSH began its post-pandemic recovery, there was a substantial increase in admissions, leading to an increase in state hospital census. Along with increased hospital admission rates, DSH has been rapidly implementing an array of innovative IST solutions to address the increasing IST referrals and pending placement list. These include expansion of community-based treatment and diversion options for felony ISTs, activation of community inpatient facility programs, expansion of existing Jail Based Community Treatment (JBCT) programs, and the addition of new JBCT programs to serve the IST population. All these efforts have resulted in an increase of 36% in IST census between June 2022 and June 2023.

[3] Referrals include all ISTs initially committed to DSH or a DSH-funded program. Excludes any administrative errors, duplicate records, transfers, and court returns.

[4] Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or "less than 11" within the narrative. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

Table 3: Patient Census

	6/30/2020	6/30/2021	6/30/2022	6/30/2023	2/29/2024	% Change
IST*	2,108	1,951	2,096	2,843	2,869	1%
LPS	747	789	707	584	543	-7%
NGI	1,415	1,338	1,244	1,225	1,200	-2%
OMD 2962	508	415	383	334	346	4%
OMD 2972	760	716	685	710	706	-1%
SVP	943	939	956	954	952	0%
Coleman	296	169	114	112	134	20%
Subtotal	*6,777*	*6,317*	*6,185*	*6,762*	*6,750*	*0%*
CONREP	661	647	714	733	724	-1%
Total	**7,438**	**6,964**	**6,899**	**7,495**	**7,474**	**0%**

* IST census includes the following facilities and programs: state hospitals, community-based restoration program, IST diversion, jail-based competency treatment program, and community inpatient facilities.

Post COVID-19 Impact

Throughout the pandemic, DSH followed the guidance issued by the Centers for Disease Control and Prevention (CDC), California Public Health (CDPH), epidemiologists and medical Subject Matter Experts (SMEs), and by the local county public health director for each DSH facility. As COVID-19 guidance has changed and eased requirements for health care entities from earlier phases of the pandemic, the impacts to DSH operations and census lessened. While DSH continues to take the necessary steps to mitigate the spread of infection, such as exposure testing and isolation of COVID-19 positive patients; some interventions such as Admission Observation Units (AOUs), for patients entering state hospitals, are no longer required. As a result, DSH has been able to increase admissions, leading to an increase of census and a decrease in the pending placement list. DSH reached a high of 1,953 IST patients on the pending placement list as of January 2022 and is now down to 397 as of May 6, 2024. This significant reduction is due to rapid implementation of the IST solutions authorized in the budget, easing of CDC and CDPH requirements on healthcare facilities in response to the pandemic, no longer having to cohort admissions, and shorter quarantine timelines associated with exposures.

STAFFING ANNUAL ASSESSMENT

In 2013, DSH initiated a comprehensive effort to evaluate staffing practices amongst the five state hospitals. This study, identified as DSH's Clinical Staffing Study, was assembled to perform a thorough analysis of past practices and staffing methodologies, and ensure they continue to be adequate and appropriate for the department's growing and evolving populations across all DSH facilities. The

standardized staffing methodologies, supported through the Department of Finance (DOF) Mission-Based Review (MBR) and adopted in the Budget Acts of 2019 and 2020, provide data driven and data informed methods to calculate hospital staffing across the following areas:

- Hospital Forensic Departments
- 24-Hour Care Nursing Services
- Treatment Planning and Delivery
- Protective Services

These four components each provide critical and required services to DSH patients through statutorily required forensic evaluations for the courts, 24-hour housing and nursing care, delivery of psychiatric and medical treatment, and safety and security to patients and staff.

Staffing Adjustments

Using the methodologies and unit categorization system established in the staffing studies, DSH will examine fluctuations to treatment categories, population and facilities and identify necessary staffing adjustments that impact position and expenditure authority.

FY 2023-24

DSH is not currently requesting a change in position and expenditure authority in accordance with the standard staffing and funding methodology outlined above.

FY 2024-25

DSH-Coalinga

DSH must regularly assess the level of care needs for its patient population, specifically as it relates to DSH-Coalinga's aging patient population. In FY 2022-23, DSH Coalinga converted an SVP Residential Recovery Unit (RRU) to an SVP intermediate care facility (ICF) level of care unit to begin addressing this need. The 2024-25 Governor's Budget Estimate item, DSH-Coalinga Intermediate Care Facility Conversion, addresses this continued need to support the patient population.

DSH-Metropolitan

Changes to DSH-Metropolitan's population and treatment categories may necessitate a staffing assessment based on DSH's staffing standards. This assessment will apply described staffing methodologies across DSH-Metropolitan's population and treatment units to determine if these changes impact position authority and

expenditure resources. The primary factors requiring this assessment include the following changes at DSH-Metropolitan:

- Increase in total capacity unaccounted for in the Hospital Forensic Services Department staffing standard implementation due to the timing of implementation and the subsequent increase in capacity associated with expansion of the secure treatment area.
- The high workload associated with the increased capacity anticipated to treat IST designated patients.
- Changes in treatment categories, including:
    - Conversion of moderate workload longer-term forensic legal classifications (NGI and OMD) units to higher workload legal classifications (IST) units.
    - Shift in legal classifications, reflecting an increased treatment focus for IST patients and decreased capacity across other legal classifications, such as LPS.

DSH-Atascadero

Changes to DSH-Atascadero's population and treatment categories may necessitate a staffing assessment based on DSH's staffing standards. This assessment will apply described staffing methodologies across DSH-Atascadero's population and treatment units to determine if these changes impact position authority and expenditure resources. The primary factors requiring this assessment include the following changes at DSH-Atascadero:

- Changes in treatment categories, including shift in legal classifications, reflecting an increased treatment focus for IST patients and decreased capacity across other legal classifications, such as OMD PC2962.
- Changes in workload associated with the changes in legal classifications unaccounted for in the staffing study staffing standards due to timing.

Findings from this assessment impacting position and expenditure authority may be presented in the 2025-26 Governor's Budget.

DSH Staffing Standards

Unit-Based Nursing, Treatment Team, and Primary Care Staffing

Treatment Category & Unit Type Sub-Category	Nursing			Treatment Team		Primary Care	
	AM Shift Ratios	PM Shift Ratios	NOC Shift Ratios	Workload Designation	Caseload Ratios	Workload Designation	Caseload Ratios
Admissions							
PC Standard Admissions	1: 4.5	1: 5	1: 8	High	1:15	Standard	1:45
Hybrid Admissions	1: 5.5	1: 5.5	1: 9.5	High	1:15	Standard	1:45
Medical Treatment							
Medical Unit	1: 2	1: 2	1: 2.5	Moderate	1:30	High	1:15
Skilled Nursing Facility	1: 2.5	1: 2.5	1: 4	Moderate	1:30	High	1:15
Medically Fragile/Geropsych	1: 4.5	1: 5	1: 7.5	Moderate	1:30	Moderate	1:30
Specialized Services Treatment							
High Aggression/Enhanced Treatment Unit (ETU)	1: 1.5	1: 1.5	1: 3	High	1:15	Standard	1:45
Enhanced Treatment Program (ETP)	1: 1.5	1: 1.5	1: 3	High	1:13*	Standard	1:45
PC Specialized Services: Intermediate Care High Behavior Acuity	1: 4.5	1: 4.5	1: 7.5	High	1:15	Standard	1:45
PC Specialized Services: Polydipsia	1: 5.5	1: 5.5	1: 9	High	1:15	Standard	1:45
PC Specialized Services: DBT	1: 5.5	1: 5.5	1: 9	High	1:15	Standard	1:45
LPS Specialized Services: Polydipsia	1: 3	1: 3	1: 4.5	High	1:15	Standard	1:45
LPS Specialized Services: DBT	1: 3	1: 3	1: 4.5	High	1:15	Standard	1:45
LPS Specialized Services: Acute Psychiatric/Pre-DBT	1: 3	1: 3	1: 4.5	High	1:15	Standard	1:45
Specialized Services: Deaf, Hard of Hearing	1: 3	1: 3	1: 6	High	1:15	Standard	1:45
PC Specialized Services: Substance Abuse	1: 5.5	1: 5.5	1: 9	Moderate	1:30	Standard	1:45
PC Specialized Services: Psychologically Fragile	1: 5.5	1: 5.5	1: 9	Moderate	1:30	Standard	1:45
Specialized Services: Sex Offender Treatment	1: 7.5	1: 7.5	1: 14	Moderate	1:30	Standard	1:45
Specialized Services: Monolingual	1: 5	1: 5.5	1: 8	Moderate	1:30	Standard	1:45

Incompetent to Stand Trial (IST) Treatment							
IST Admission to Discharge	1:5.5	1:5.5	1:9.5	High	1:15	Standard	1:45
IST Permanent Housing-Single Rooms	1:5.5	1:6.5	1:9.5	Moderate	1:30	Standard	1:45
IST Permanent Housing-Dorm, Mixed Rooms	1:6.5	1:6.5	1:12	Moderate	1:30	Standard	1:45
Offender with a Mental Disorder (OMD) Treatment							
OMD Permanent Housing-Single, Mixed Rooms	1:5	1:5	1:10	Moderate	1:30	Standard	1:45
Multi-Commitment Treatment							
OMD, NGI, LPS Permanent Housing-Dorm, Mixed Rooms	1:6.5	1:6.5	1:12	Moderate	1:30	Standard	1:45
OMD, NGI Permanent Housing-Single Rooms	1:5.5	1:6.5	1:11	Moderate	1:30	Standard	1:45
CDCR/OMD Permanent Housing	1:7.5	1:8	1:13	Moderate	1:30	Standard	1:45
CDCR (Coleman) Treatment							
CDCR Permanent Housing	1:5.5	1:6	1:12	Moderate	1:30	Standard	1:45
Sexually Violent Predator (SVP) Treatment							
SVP Permanent Housing	1:6	1:6.5	1:14	Moderate	1:30	Standard	1:45
SVP Residential Recovery Unit	1:13	1:17	1:33	Low	1:50	Standard	1:45
Lanterman-Petris Short (LPS) Treatment							
LPS Permanent Housing	1:5	1:5	1:9	High	1:15	Standard	1:45
Discharge Preparation Units							
Discharge Ready	1:7	1:7.5	1:13	Low	1:35	Standard	1:45

* ETP units are designated as a high treatment team workload units, but staffing is set in statute at one team per unit that consists of one psychiatrist, two psychologists, one clinical social worker, and two rehabilitation therapists.

STATE HOSPITALS AND PSYCHIATRIC PROGRAMS
COMMITMENT CODES

Legal Category	Legal Class Text	Code Section	Description
NGI	NGI PC1026	PC 1026	Not Guilty by Reason of Insanity
Other NGI*	RONGI, RO1026	PC 1610	Temporary Admission while waiting for Court Revocation of a PC 1026 (NGI)
Other NGI	MNGI	WIC 702.3	Minor Not Guilty by Reason of Insanity
IST	IST PC1370	PC 1370 or TITLE 18 USC 4244	Incompetent to Stand Trial
Other IST	MIST	PC 1370.01	Misdemeanant Incompetent to Stand Trial
Other IST	EIST	PC 1372(e)	Restored (IST) on Court Hold
Other IST	ROIST, RO1370	PC 1610	Temporary Admission while waiting for Court Revocation of a PC 1370 (IST)
Other IST*	DDIST	PC 1370.1	Commitment as Incompetent to Stand Trial because of Developmental Disability (up to 6 months) and Mental Disorder
OMD	PC2962	PC 2962	Parolee Referred from the Department of Corrections
OMD	PC2964a	PC 2964(a)	Parolee Rehospitalized from CONREP after DSH hearing
OMD	PC2972	PC 2972	Former Parolee Referred from Superior Court
OMD*	RO2972	PC 1610	Temporary admission while waiting for court revocation of PC 2972
MDSO*	MDSO	WIC 6316	Mentally Disordered Sex Offender--Observation
MDSO*	MDSOI	WIC 6316	1. MDSO Observation Indeterminate; 2. MDSO Return by Court
MDSO*	ROMDSO	PC 1610	Temporary Admission while waiting for Court Revocation of MDSO
Other SVP	SVPH	WIC 6601.3	Sexually Violent Predator Board of Parole Hearings (BPH) Hold
Other SVP	SVPE	WIC 6600	Sexually Violent Predator Court Hold
SVP	SVP	WIC 6604	Sexually Violent Predator
SVP	SVPP	WIC 6602	Sexually Violent Predator Probable Cause
PC 2684	PC2684	PC 2684	Prisoner from the Department of Corrections
PC 2685	PC2684A	PC 2684A	Prisoner from the Department of Corrections
DJJ W&I 1756	YAC	WIC 1756	Youth Authority Certification/Youth Authority Referral through Regional Office
LPS	T.Cons	WIC 5353	Temporary Conservatorship
LPS	CONS	WIC 5358	Conservatorship

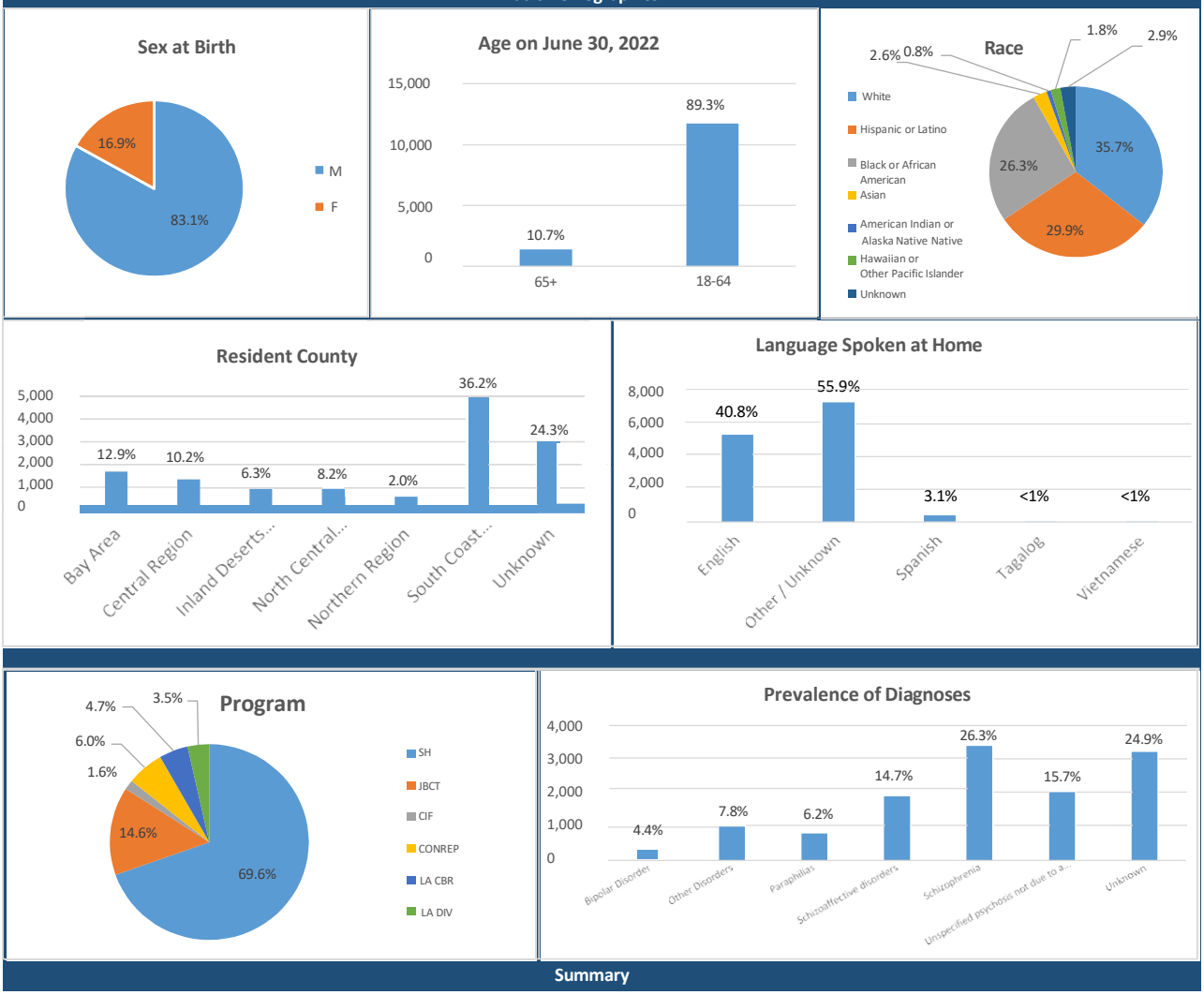
LPS	VOL	WIC 6000	Voluntary
LPS	DET	WIC 5150	72-Hour Detention
LPS	CERT	WIC 5250	14-Day Certification
LPS	SUIC	WIC 5260	Additional 14-Day Certification for Suicidal Persons
LPS	POST	WIC 5304(a)	180-Day Post Certification--ONLY (until 6/91 used for pending cases also, see 37)
LPS	ADD	WIC 5304(b)	Additional 180-Day Post Certification
LPS	A-CERT	WIC 5270.15	30-Day Certification
LPS	PCD	WIC 5303	Pending Court Decision on 180-Day Post Certification
LPS	MURCON	WIC 5008(h)(1)(B)	Murphy's Conservatorship
LPS	DMR	WIC 6500, 6509	Dangerous Person with Developmental Disability Committed by Court
LPS	CAMR	WIC 4825, 6000(a)	Voluntary Person with Developmental Disability Under Own Signature by Regional Center
LPS	VJCW	WIC 6552	Voluntary Juvenile Court Ward
LPS	DMRH	WIC 6506	Hold Pending Hearing on W&I 6509 Petition
LPS*	PC 2974	PC 2974	Recommitment after expiration of prison term (must have concurrent W&I commitment)

***** Items marked with an asterisk were previously captured in the "Other PC" category

Demographic Snapshot: All Commitment Types

Patients Served from July 1, 2022 to June 30, 2023 is 13,134

Basic Demographics



Summary

The data shown above is a combination of State Hospital (SH), Jail-Based Competency Treatment (JBCT), Conditional Release Program (CONREP), Community Inpatient Facility (CIF), LA Community Based Resoration (LA CBR), and LA Diversion (LA DIV) information. The DSH population is composed of 83% males and 17% females; a majority of this population is between the ages of 18 and 64. The age of all patients is calculated as of June 30, 2023. Approximately 36% identify as White, 26% Black, and 30% Hispanic with mostly English spoken at home. The majority of the DSH population are residents of South Coast and Bay Area counties. During this time period, approximately 70% of DSH patients were treated at a State Hospital (excluding transfers from other Programs) and 15% at a JBCT facility. Schizophrenia, Schizoaffective, and Bipolar-type disorders are the three most common diagnoses for the DSH population, accounting for approximately 61% of the population with known diagnoses.

DIVISION OF HOSPITAL STRATEGIC PLANNING AND IMPLEMENTATION
RESEARCH, EVALUATION AND DATA

Patients Served by Race

Fiscal Year 2022-2023

		CDCR	IST	LPS	NGI	OMD[4]	SVP	Grand Total
DSH Inpatient and Outpatient Program's Patients Served by Count[1]	*White*	114	2,303	245	849	570	607	4,688
	Hispanic or Latino	98	2,566	231	424	457	147	3,923
	Black or African American	76	2,129	190	366	457	236	3,454
	Asian	<11	199	36	61	28	<11	338
	Unknown	<11	257	***	40	40	***	383
	Native Hawaiian or Other Pacific Islander	<11	106	***	75	29	<11	232
	American Indian or Alaska Native	<11	64	-	12	16	***	111
	TOTAL	313	7,624	736	1,827	1,597	1,032	**13,129**

		CDCR	IST	LPS	NGI	OMD[4]	SVP	Grand Total	2021 State of California[2]	2022 State of California[3]
DSH Inpatient and Outpatient Program's Patients Served by Percentage[1]	*White*	36.4%	30.2%	33.3%	46.5%	35.7%	58.8%	35.7%	35.8%	33.7%
	Hispanic or Latino	31.3%	33.7%	31.4%	23.2%	28.6%	14.2%	29.9%	39.5%	40.3%
	Black or African American	24.3%	27.9%	25.8%	20.0%	28.6%	22.9%	26.3%	5.4%	5.2%
	Asian	***%	2.6%	4.9%	3.3%	1.8%	***%	2.6%	14.7%	15.3%
	Unknown	***%	3.4%	***%	2.2%	2.5%	***%	2.9%	0.4%	0.6%
	Native Hawaiian or Other Pacific Islander	***%	1.4%	***%	4.1%	1.8%	***%	1.8%	0.3%	0.3%
	American Indian or Alaska Native	***%	0.8%	0.0%	0.7%	1.0%	***%	0.8%	0.3%	0.3%
	TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	**100.0%**		

[1] Total counts of Patients Served do not include patient transfers from other facilites.

[2] Taken from U.S. Census Bureau 2021 American Community Survey (ACS 5-Year Estimates). Does not include 3.6% labeled "two or more races".

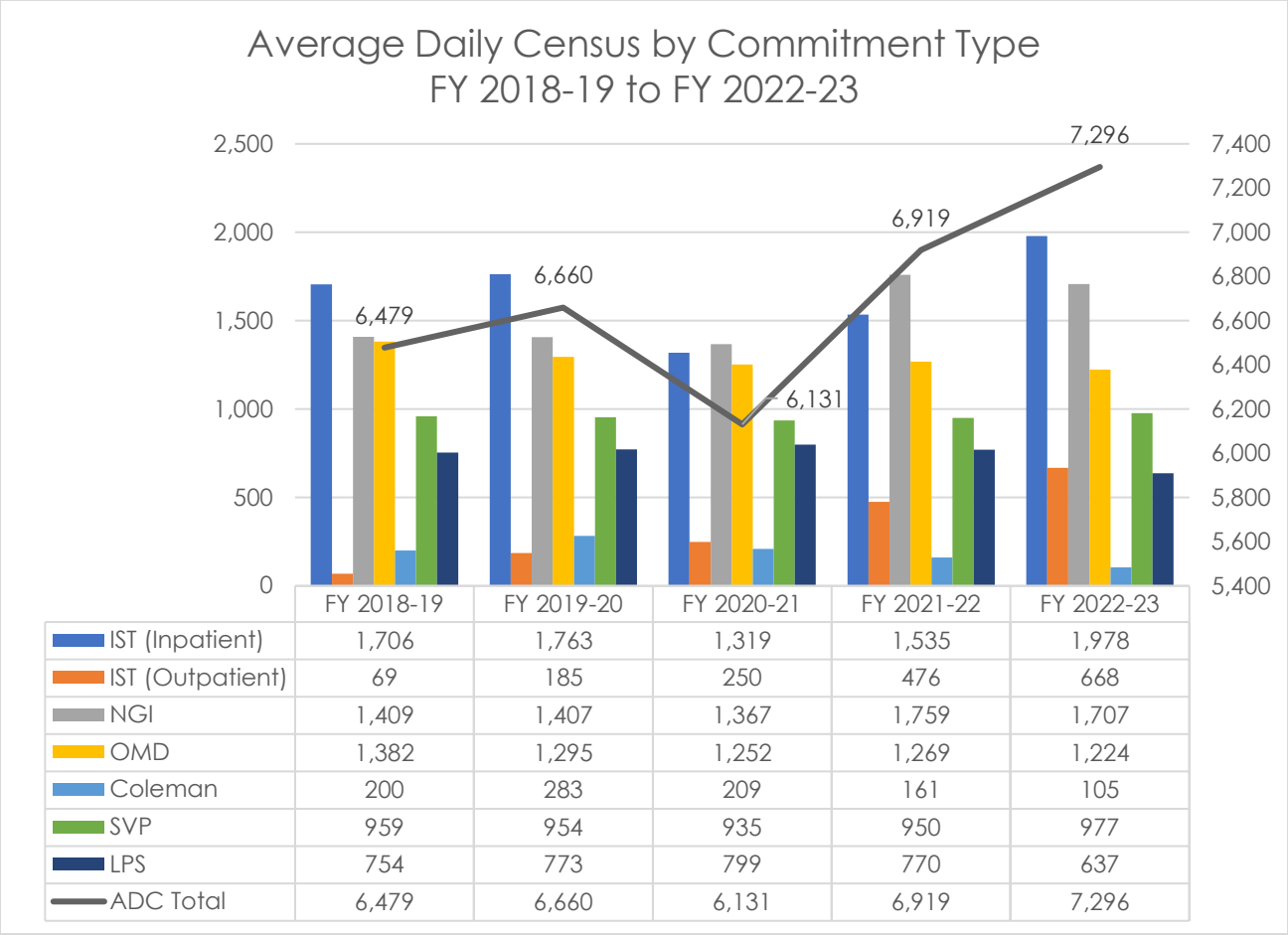
[3] Taken from U.S. Census Bureau 2022 American Community Survey (ACS 1-Year Estimates). Does not include 4.3% labeled "two or more races".

[4] Includes MDSO.

[5] Division of Juvenile Justice patients are excluded and account for less than 11 total patients served (20% White, 20% Hispanic or Latino, 40% Black or African American and 20% Native Hawaiian or Other Pacific Islander). Effective July 1, 2023, DSH no longer serves individuals from the Division of Juvenile Justice.

*Headers represent the following commitments: California Department of Correction and Rehabilitation (CDCR), Incompetent to Stand Trial (IST), Lanterman-Petris Short (LPS), Not Guilty by Reason of Insanity (NGI), Offenders with a Mental Health Disorder (OMD), and Sexually Violent Predator (SVP).

Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or “less than 11” within the narrative. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.



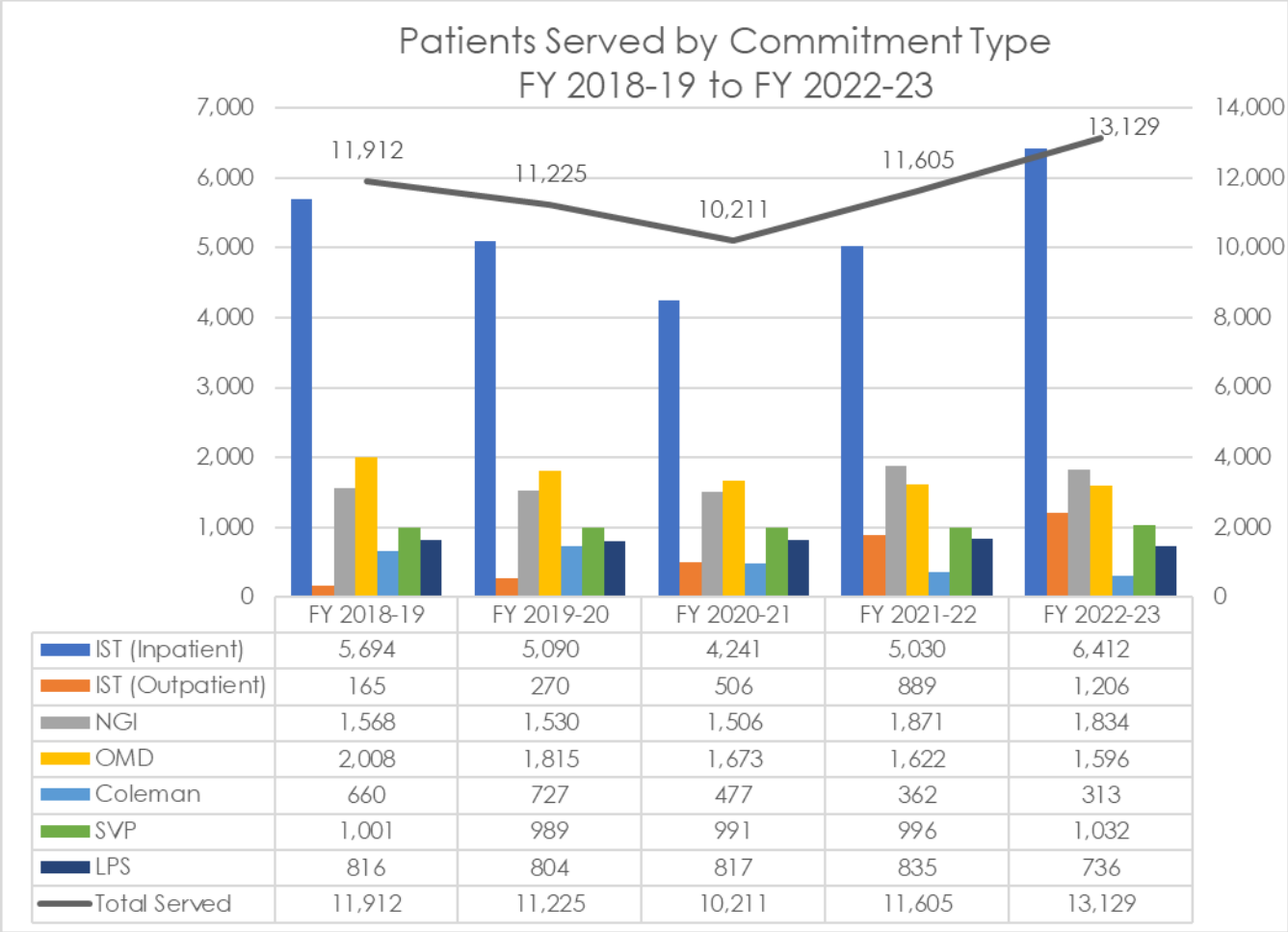
	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
IST (Inpatient)	1,706	1,763	1,319	1,535	1,978
IST (Outpatient)	69	185	250	476	668
NGI	1,409	1,407	1,367	1,759	1,707
OMD	1,382	1,295	1,252	1,269	1,224
Coleman	200	283	209	161	105
SVP	959	954	935	950	977
LPS	754	773	799	770	637
ADC Total	6,479	6,660	6,131	6,919	7,296

Data includes State Hospitals data in all years and for all committments. IST (Inpatient) also includes Community Inpatient Facilities (CIF) and Jail-Based Competency Treatment Programs (JBCT) Community. IST Outpatient includes Community Based Restoration all years. Conditional Release Program (CONREP), CONREP-Sexually Violent Predators (SVP) and CONREP- Forensic Assertive Community Treatment Program are included within IST (Outpatient), NGI, OMD, and SVP beginning FY 2021-22. Data excludes less than 11 Division of Juvenile Justice (DJJ) Patients in FY 2018-19 through FY 2022-23.

During fiscal year (FY) 2022-23, following the cessation of various COVID-19 pandemic protocols and a return to normal admissions, the Department of State Hospitals (DSH) had an average daily census of 7,298 patients; a 16% growth in average daily census over FY 2021-22.

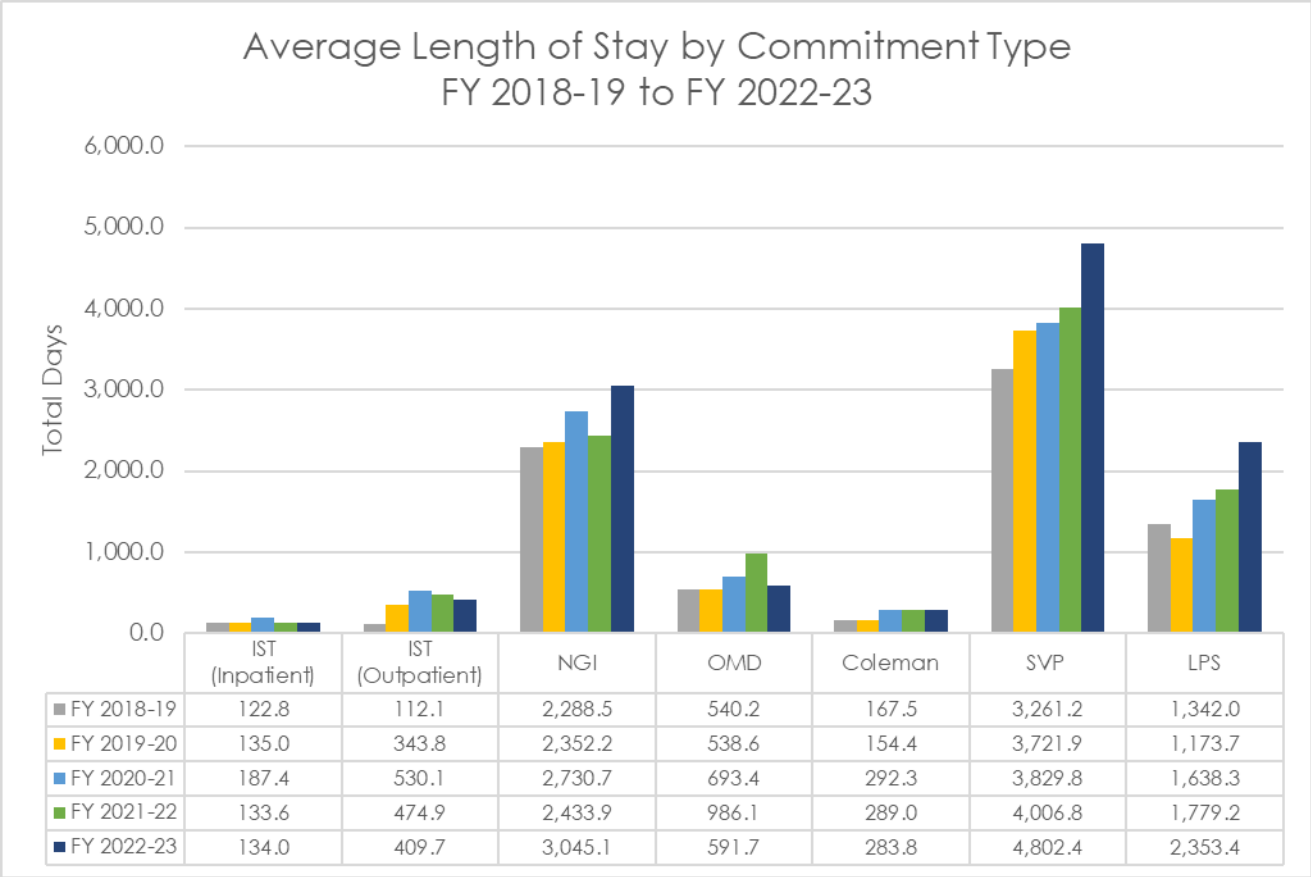
In FYs 2020-21 and 2021-22, COVID-19 impacted both admission rates and inpatient census. Admission rates decreased due to the implementaiton of a 10-day isolation period prior to transfer to a treatment unit, as well as continuous COVID-19 outbreaks requiring quarintines. Inpatient census was further impacted by the need to create Admission Observation Units (AOUs) and other spaces dedicated to isolating patients. The 16% growth from FY 2021-22 to FY 2022-23 reflects DSH's continuum of care and expansion of inpatient and outpatient programs, and a focus of growing

census while balancing continued health and safety measures associated with COVID-19.



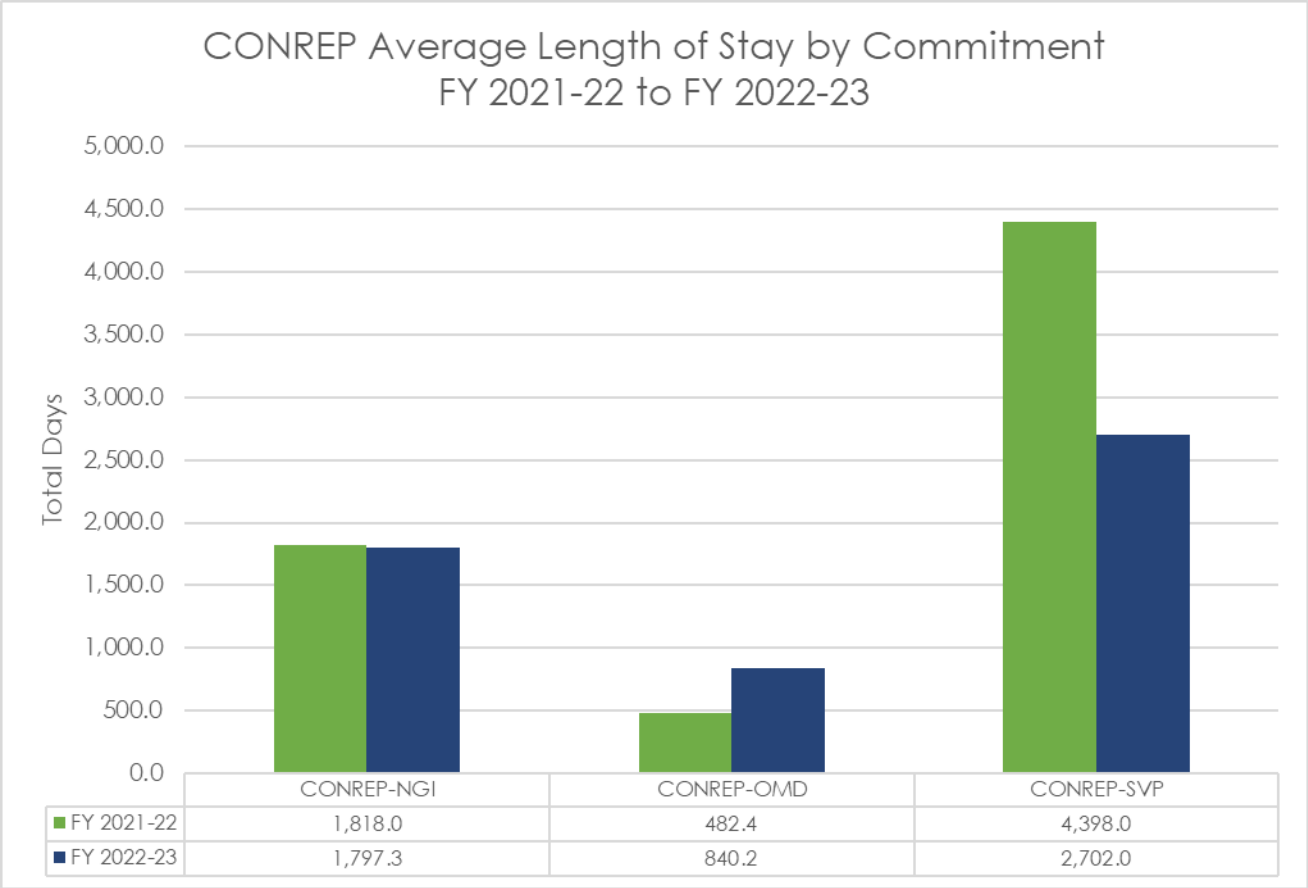
	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
IST (Inpatient)	5,694	5,090	4,241	5,030	6,412
IST (Outpatient)	165	270	506	889	1,206
NGI	1,568	1,530	1,506	1,871	1,834
OMD	2,008	1,815	1,673	1,622	1,596
Coleman	660	727	477	362	313
SVP	1,001	989	991	996	1,032
LPS	816	804	817	835	736
Total Served	11,912	11,225	10,211	11,605	13,129

Data includes State Hospitals data in all years and for all committments. IST (Inpatient) also includes Community Inpatient Facilities (CIF) and Jail-Based Competency Treatment Programs (JBCT) Community. IST Outpatient includes Community Based Restoration all years. Conditional Release Program (CONREP), CONREP-Sexually Violent Predators (SVP) and CONREP- Forensic Assertive Community Treatment Program are included within IST (Outpatient), NGI, OMD, and SVP beginning FY 2021-22. Data excludes less than 11 Division of Juvenile Justice (DJJ) Patients in FY 2018-19 through FY 2022-23.



	IST (Inpatient)	IST (Outpatient)	NGI	OMD	Coleman	SVP	LPS
FY 2018-19	122.8	112.1	2,288.5	540.2	167.5	3,261.2	1,342.0
FY 2019-20	135.0	343.8	2,352.2	538.6	154.4	3,721.9	1,173.7
FY 2020-21	187.4	530.1	2,730.7	693.4	292.3	3,829.8	1,638.3
FY 2021-22	133.6	474.9	2,433.9	986.1	289.0	4,006.8	1,779.2
FY 2022-23	134.0	409.7	3,045.1	591.7	283.8	4,802.4	2,353.4

Data includes State Hospitals data in all years. Data includes State Hospitals data in all years and for all committments. IST (Inpatient) also includes Community Inpatient Facilities (CIF) and Jail-Based Competency Treatment Programs (JBCT). IST Outpatient includes Community Based Restoration all years. Conditional Release Program (CONREP), CONREP-Sexually Violent Predators (SVP) and CONREP- Forensic Assertive Community Treatment Program are included within IST (Outpatient), NGI, OMD, and SVP beginning FY 2021-22.



IST patients treated in CONREP are reflected in the IST (Outpatient) graph above.

STATE HOSPITALS
BUDGET CHANGE PROPOSALS

Please see the Department of Finance (DOF) website for all Budget Change Proposals (BCPs).

STATE HOSPITAL
DSH – METROPOLITAN INCREASED SECURE BED CAPACITY
Program Update

SUMMARY

The Department of State Hospitals (DSH)-Metropolitan Increased Secure Bed Capacity (ISBC) project continues to experience delays in the activation of the remaining units for Incompetent to Stand Trial (IST) forensic patients. DSH anticipates completion of the Skilled Nursing Facility (SNF) building repairs will be in October 2024, resulting in an additional one-time savings of $3.9 million in fiscal year (FY) 2023-24.

BACKGROUND

To provide additional capacity to address the ongoing system-wide forensic waitlist, particularly focusing on the IST patient waitlist, the Budget Act of 2016 included capital outlay construction funding for the ISBC project at DSH-Metropolitan. This project added security fencing and infrastructure for existing patient buildings at the hospital, which had primarily been used to house civilly committed Lanterman-Petris-Short (LPS) patients.

Construction of all five ISBC units is complete; however, as of the Budget Act of 2022, DSH had activated two of five units for the treatment of IST patients. The remaining three units were utilized to accommodate various operational needs related to DSH's COVID-19 response, the Continuing Treatment East (CTE) Fire Alarm Project, and to provide temporary housing to DSH-Metropolitan SNF patients while their building remains under construction/repairs.

As of the Budget Act of 2023, Unit 3, previously utilized for COVID-19 isolation space, was activated for treatment of IST patients. Units 4 and 5 continued to be utilized as temporary housing for SNF patients. DSH and Department of General Services (DGS) anticipated repairs to the DSH-Metropolitan SNF Building to be completed in July 2023, allowing Units 4 and 5 to be utilized for IST forensic patients as originally intended.

In the 2024-25 Governor's Budget, DSH reported continued construction delays due to difficulties in acquiring personnel and construction materials necessary for project completion. Due to these delays, DSH-Metropolitan continued to utilize Units 4 and 5 to house SNF patients, resulting in a one-time savings of $9.6 million in FY 2023-24. DSH and DGS anticipated the SNF building roof repairs to be completed in March 2024.

JUSTIFICATION

Although construction on the roof portion of the SNF building is complete, it is currently awaiting final regulatory approval. Construction on the interior portion began in November 2023, which was needed due to the extensive water intrusion previously experienced impacting the inside of the building and all of its contents. There have been numerous change order requests due to electrical infrastructure and code compliance issues. Electrical repairs to reestablish damaged electrical systems such as Personal Duress Alarm Systems (PDAS), fire alarms, and a new nursing call system are in progress. Currently, DGS Project Management is requesting that the general contractor provide an accelerated schedule to expedite completion of this project.

As of the 2024-25 May Revision, DSH and DGS anticipate internal restorations of the SNF building will be completed in October 2024. This will allow the SNF building patients to be relocated and DSH-Metropolitan to proceed with Unit 4 and 5 activation for IST forensic patients in December 2024. Due to the continued interior construction on the SNF building, DSH is projecting an additional one-time savings of $3.9 million in FY 2023-24.

Activation Timeline Adjustment

Unit	# of Beds	Scheduled Activation as of 2024-25 Governor's Budget	Scheduled Activation as of 2024-25 May Revision	Change from the 2024-25 Governor's Budget
Unit 1	46	September 23, 2019	September 23, 2019	No change - Activated
Unit 2	46	January 29, 2020	January 29, 2020	No change - Activated
Unit 3	46	November 1, 2022	November 1, 2022	No change - Activated
Unit 4	48	May 2024	October 2024	5-month delay
Unit 5	48	May 2024	October 2024	5-month delay

Resource Table

Description	CY	BY	BY+
Current Service Level	$74,857	$74,857	$74,857
Governor's Budget Request	($9,552)	$0	$0
May Revision Request	($3,901)	$0	$0
TOTAL	**$61,404**	**$74,857**	**$74,857**

*Dollars in thousands

BCP Fiscal Detail Sheet

BCP Title: DSH-Metropolitan Increased Secure Bed Capacity **BR Name: 4440-086-ECP-2024-MR**

Budget Request Summary

	FY24					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Salaries and Wages						
Earnings - Permanent	-2,346	0	0	0	0	0
Total Salaries and Wages	**$-2,346**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-1,203	0	0	0	0	0
Total Personal Services	**$-3,549**	**$0**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-176	0	0	0	0	0
5304 - Communications	-22	0	0	0	0	0
5320 - Travel: In-State	-22	0	0	0	0	0
5324 - Facilities Operation	-110	0	0	0	0	0
5346 - Information Technology	-22	0	0	0	0	0
Total Operating Expenses and Equipment	**$-352**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-3,901**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-3,901	0	0	0	0	0
Total State Operations Expenditures	**$-3,901**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-3,901**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4400020 - Hospital Administration	-22	0	0	0	0	0
4410030 - Metropolitan	-3,879	0	0	0	0	0
Total All Programs	**$-3,901**	**$0**	**$0**	**$0**	**$0**	**$0**

Personal Services Details

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
2011 - Custodian I	-30	0	0	0	0	0
7552 - Physician & Surgeon (Safety)	-82	0	0	0	0	0
7619 - Staff Psychiatrist (Safety)	-366	0	0	0	0	0
8094 - Registered Nurse (Safety)	-600	0	0	0	0	0
8104 - Unit Supvr (Safety)	-33	0	0	0	0	0
8252 - Sr Psych Techn (Safety)	-158	0	0	0	0	0
8253 - Psych Techn (Safety)	-668	0	0	0	0	0
8420 - Rehab Therapist (Art-Safety)	-129	0	0	0	0	0
9872 - Clinical Soc Worker (Hlth/CF)-Safety	-127	0	0	0	0	0
9873 - Psychologist (Hlth Facility-Clinical-Safety)	-153	0	0	0	0	0
Total Salaries and Wages	**$-2,346**	**$0**	**$0**	**$0**	**$0**	**$0**
Staff Benefits						
5150200 - Disability Leave - Industrial	-31	0	0	0	0	0
5150210 - Disability Leave - Nonindustrial	-9	0	0	0	0	0
5150350 - Health Insurance	-108	0	0	0	0	0
5150450 - Medicare Taxation	-35	0	0	0	0	0
5150600 - Retirement - General	-534	0	0	0	0	0
5150700 - Unemployment Insurance	-2	0	0	0	0	0
5150800 - Workers' Compensation	-108	0	0	0	0	0
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	-66	0	0	0	0	0
5150900 - Staff Benefits - Other	-310	0	0	0	0	0
Total Staff Benefits	**$-1,203**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$-3,549**	**$0**	**$0**	**$0**	**$0**	**$0**

STATE HOSPITALS
ENHANCED TREATMENT PROGRAM (ETP) STAFFING
Program Update

SUMMARY

The Department of State Hospitals (DSH) anticipates DSH-Patton construction for the Enhanced Treatment Program (ETP) Unit 06 to be completed in July 2024; a four-month delay from what was reported at the 2024-25 Governor's Budget, resulting in a one-time savings of $281,000 in fiscal year (FY) 2023-24.

BACKGROUND

The ETP was developed to accept patients who are at the highest risk of violence and cannot be safely treated in a standard treatment environment. The Budget Act of 2018 authorized DSH to construct four ETP units; three 13-bed units at DSH-Atascadero and one 10-bed unit at DSH-Patton. ETP Unit 29 at DSH-Atascadero was activated in September 2021, while construction for Units 33 and 34 were postponed due to bed capacity pressures associated with Incompetent to Stand Trial (IST) referrals. The Budget Act of 2023 reflected a one-time savings of $3.2 million in FY 2023-24 associated with personal services savings due to delays resulting from continued challenges with the fire sprinkler redesign and regulatory approval at DSH-Patton. Unit construction was scheduled to be completed in March 2024 with unit activation in May 2024.

In the 2024-25 Governor's Budget, DSH reported the project timeline remained unchanged, with construction completion anticipated in March 2024 and unit activation in May 2024.

JUSTIFICATION

Demolition and ETP construction in the North wing began in March 2023. DSH anticipates a four-month delay in the activation of DSH-Patton Unit 06 due to continued challenges with the fire sprinkler redesign and regulatory approvals. Construction is now estimated for completion July 2024, followed by unit activation in September 2024.

Please see the table below for a complete activation timeline.

ETP Activation Timeline			
Units/Hospital	**Scheduled Initiation**	**Scheduled Completion**	**Delay from 2024-25 Governor's Budget**
DSH-Atascadero Unit 29	September 24, 2018 (Actual)	July 2021 (Actual)	N/A
DSH-Patton Unit U-06	December 2023	September 2024	4-month delay

Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$11,936	$15,129	$15,129
Governor's Budget Request	$0	$0	$0
May Revision Request	($281)	$0	$0
TOTAL	**$11,655**	**$0**	**$0**

*Dollars in thousands

BCP Fiscal Detail Sheet

BCP Title: Enhanced Treatment Program Staffing **BR Name: 4440-063-ECP-2024-MR**

Budget Request Summary

	FY24					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Salaries and Wages						
Earnings - Permanent	-171	0	0	0	0	0
Total Salaries and Wages	**$-171**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-89	0	0	0	0	0
Total Personal Services	**$-260**	**$0**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-11	0	0	0	0	0
5304 - Communications	-1	0	0	0	0	0
5320 - Travel: In-State	-1	0	0	0	0	0
5324 - Facilities Operation	-7	0	0	0	0	0
5346 - Information Technology	-1	0	0	0	0	0
Total Operating Expenses and Equipment	**$-21**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-281**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-281	0	0	0	0	0
Total State Operations Expenditures	**$-281**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-281**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4400020 - Hospital Administration	-1	0	0	0	0	0
4410050 - Patton	-280	0	0	0	0	0
Total All Programs	**$-281**	**$0**	**$0**	**$0**	**$0**	**$0**

BCP Title: Enhanced Treatment Program Staffing **BR Name: 4440-063-ECP-2024-MR**

Personal Services Details

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
1138 - Office Techn (Gen)	-14	0	0	0	0	0
4588 - Assoc Accounting Analyst	-8	0	0	0	0	0
5393 - Assoc Govtl Program Analyst	-23	0	0	0	0	0
7619 - Staff Psychiatrist (Safety)	31	0	0	0	0	0
8094 - Registered Nurse (Safety)	-166	0	0	0	0	0
8253 - Psych Techn (Safety)	106	0	0	0	0	0
8324 - Rehab Therapist (Recr-Safety)	-30	0	0	0	0	0
9699 - Hlth Svcs Spec (Safety)	-39	0	0	0	0	0
9872 - Clinical Soc Worker (Hlth/CF)-Safety	10	0	0	0	0	0
9873 - Psychologist (Hlth Facility-Clinical-Safety)	-38	0	0	0	0	0
Total Salaries and Wages	**$-171**	**$0**	**$0**	**$0**	**$0**	**$0**
Staff Benefits						
5150200 - Disability Leave - Industrial	-2	0	0	0	0	0
5150210 - Disability Leave - Nonindustrial	-1	0	0	0	0	0
5150350 - Health Insurance	-8	0	0	0	0	0
5150450 - Medicare Taxation	-3	0	0	0	0	0
5150600 - Retirement - General	-39	0	0	0	0	0
5150800 - Workers' Compensation	-8	0	0	0	0	0
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	-5	0	0	0	0	0
5150900 - Staff Benefits - Other	-23	0	0	0	0	0
Total Staff Benefits	**$-89**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$-260**	**$0**	**$0**	**$0**	**$0**	**$0**

STATE HOSPITALS
MISSION-BASED REVIEW – DIRECT CARE NURSING
Program Update

SUMMARY

The Department of State Hospitals (DSH) has phased-in all positions as part of the Mission-Based Review (MBR) Staffing Study. As of the 2024-25 May Revision, DSH reflects an additional one-time savings of $3.6 million in fiscal year (FY) 2023-24 due to delays in hiring.

BACKGROUND

In 2013, DSH initiated a comprehensive effort to evaluate staffing practices amongst the five state hospitals. As part of the Direct Care Nursing component of the study, the Clinical Staffing Study reviewed current staffing standards and practices, proposed new data-driven staffing methodologies to adequately support the current populations served, assessed relief factor coverage needs, and reviewed current staffing levels within core clinical and safety functions.

A staffing standard was developed through research conducted within DSH's Clinical Staffing Study and in collaboration with the Department of Finance (DOF) Research and Analysis Unit through a Mission-Based Review. The proposal examined nurse-to-patient ratios for providing 24-hour nursing care and the components available to achieve these ratios including internal registries, overtime, temporary help, and position movements among facilities. The proposal additionally presented staffing methodologies for the administration of medication and the afterhours nursing supervisory structure.

The Budget Act of 2019 included a total of 379.5 positions and $46 million, phased in across a three-year period, to support the workload of providing 24-hour care nursing services within DSH.

In the Budget Act of 2021, all recruitment efforts were paused, and resources were shifted to focus on managing COVID-19 priorities and minimizing staff and patient exposure, delaying some position phase-ins.

In the Budget Act of 2023, DSH projected a one-time savings of $4.8 million in FY 2023-24 due to delays in hiring.

In the 2024-25 Governor's Budget, DSH reported an additional one-time savings in FY 2023-24 of $10.3 million due to delays in hiring Medication Pass Psychiatric Technicians. To address recruitment challenges, DSH contracted with CPS HR Consulting for marketing and outreach and collaborated with various Psychiatric

Technician educational programs to increase overall admissions thereby attempting to increase the pipeline to DSH employment. Additionally, DSH hosted rapid hiring events at each hospital, which focused on providing same-day contingent offers. DSH-Napa was able to make 25 conditional job offers to level-of-care nursing positions and 74 conditional offers to psychiatric technicians at DSH-Patton's rapid hiring event.

JUSTIFICATION

Medication Pass Psychiatric Technicians (PT)

A total of 335.0 positions were allocated to Medication Pass PTs to be phased-in over four years.

As of February 29, 2024, all 335.0 positions have been phased-in, and 187.1 positions have been filled. DSH continues to actively recruit to fill these positions, however not all positions have been filled. As a result, DSH is projecting an additional one-time savings in FY 2023-24 of $3.6 million.

Afterhours Supervising Registered Nurses (SRN)

A total of 44.5 positions were allocated to Afterhours Supervising Registered Nurses to be phased in over two years.

As of February 29, 2024, all position phase-ins are complete.

Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$42,287	$47,068	$47,068
Governor's Budget Request	($10,290)	$0	$0
May Revision Request	($3,584)	$0	$0
TOTAL	**$28,413**	**$47,068**	**$47,068**

*Dollars in thousands

BCP Fiscal Detail Sheet

BCP Title: Mission Based Review: Direct Care Nursing **BR Name: 4440-065-ECP-2024-MR**

Budget Request Summary

	FY24					
	CY	BY	BY+1	BY+2	BY+3	BY+4
Salaries and Wages						
Earnings - Permanent	-2,100	0	0	0	0	0
Total Salaries and Wages	**$-2,100**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-1,018	0	0	0	0	0
Total Personal Services	**$-3,118**	**$0**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-233	0	0	0	0	0
5304 - Communications	-29	0	0	0	0	0
5320 - Travel: In-State	-29	0	0	0	0	0
5324 - Facilities Operation	-146	0	0	0	0	0
5346 - Information Technology	-29	0	0	0	0	0
Total Operating Expenses and Equipment	**$-466**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-3,584**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-3,584	0	0	0	0	0
Total State Operations Expenditures	**$-3,584**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-3,584**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4400020 - Hospital Administration	-29	0	0	0	0	0
4410010 - Atascadero	-993	0	0	0	0	0
4410020 - Coalinga	-1,178	0	0	0	0	0
4410030 - Metropolitan	-661	0	0	0	0	0
4410040 - Napa	-723	0	0	0	0	0
Total All Programs	**$-3,584**	**$0**	**$0**	**$0**	**$0**	**$0**

Personal Services Details

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
8253 - Psych Techn (Safety)	-2,100	0	0	0	0	0
Total Salaries and Wages	**$-2,100**	**$0**	**$0**	**$0**	**$0**	**$0**
Staff Benefits						
5150200 - Disability Leave - Industrial	-28	0	0	0	0	0
5150210 - Disability Leave - Nonindustrial	-9	0	0	0	0	0
5150350 - Health Insurance	-97	0	0	0	0	0
5150450 - Medicare Taxation	-31	0	0	0	0	0
5150600 - Retirement - General	-419	0	0	0	0	0
5150700 - Unemployment Insurance	-2	0	0	0	0	0
5150800 - Workers' Compensation	-97	0	0	0	0	0
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	-58	0	0	0	0	0
5150900 - Staff Benefits - Other	-277	0	0	0	0	0
Total Staff Benefits	**$-1,018**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$-3,118**	**$0**	**$0**	**$0**	**$0**	**$0**

STATE HOSPITALS
MISSION-BASED REVIEW – TREATMENT TEAM AND PRIMARY CARE
Program Update

SUMMARY

The Department of State Hospitals (DSH) continues to phase in Treatment Team and Primary Care positions received as part of the Mission-Based Review (MBR) Staffing Study but continues to experience challenges with hiring the newly authorized positions. As of the 2024-25 May Revision, DSH reflects an additional one-time savings of $3.1 million in fiscal year (FY) 2023-24 due to delays in hiring phased-in positions. DSH further requests to delay 31.4 positions that were scheduled to phase-in in FY 2024-25 until July 1, 2027. This provides an additional $8.2 million in savings per year until phase-in resumes.

BACKGROUND

In 2013, DSH initiated a comprehensive effort to evaluate staffing practices amongst the five State Hospitals. As part of the Treatment Team component of the study, the Clinical Staffing Study reviewed current staffing standards and practices, proposed new data-driven staffing methodologies to adequately support the current populations served, assessed relief factor coverage needs, and reviewed current staffing levels within core clinical and safety functions. As part of DSH's staffing study efforts, and in collaboration with the Department of Finance (DOF) Research and Analysis Unit through a Mission-Based Review, the four core areas of Treatment Planning and Delivery were examined:

- Interdisciplinary treatment team caseload ratios and categorization of treatment and treatment units
- Primary care delivery and physician caseload
- Clinical leadership structure
- Clinical programs and best practices

The Budget Act of 2021 included a total request of 250.2 positions and $64.2 million, phased in across a five-year period, to support the workload of providing psychiatric and medical care treatment to patients committed to DSH.

In the Budget Act of 2022, due to the delays and challenges in hiring, DSH shifted 29.5 of positions that were scheduled to be authorized in FY 2022-23 to January 1, 2026 (FY 2025-26) to allow time to recruit for positions already authorized.

In the Budget Act of 2023, DSH shifted 46.5 positions scheduled to be phased-in FY 2023-24 to FY 2026-27. This provided $10.9 million in savings per year until the phase-

ins resume. Furthermore, DSH projected a one-time savings of $8.4 million in FY 2023-24 due to delays in hiring.

In the 2024-25 Governor's Budget, DSH reported an additional one-time savings of $5.3 million in FY 2023-24 due to delays in hiring phased-in positions. To address ongoing recruitment challenges, DSH contracted with CPS HR Consulting and participated in multiple job fairs and recruitment events as well as expanded psychiatry residency and fellowship opportunities across all five state hospitals. Additionally, various bargaining unit agreements were approved to increase compensation levels for multiple treatment team classifications.

JUSTIFICATION

Interdisciplinary Treatment Team

A total of 180.4 positions were allocated to support the Interdisciplinary Treatment Team to be phased in over five years.

As of February 28, 2024, a total of 52.8 positions have been established.

DSH continues to actively recruit to fill these positions, however, has experienced challenges in hiring phased-in positions. As a result, DSH reflects a one-time savings of $355,000 in FY 2023-24.

Due to the delays and challenges in hiring, DSH is requesting to shift 31.4 positions back to allow time to recruit for positions already authorized. By pushing these positions back, DSH will be able to focus on current recruitment and be better positioned for future hires. This shift will not adjust the length of the phase-in. DSH is proposing to shift 31.4 positions that are scheduled to be authorized in FY 2024-25 to July 1, 2027 (FY 2027-28). This shift will result in a budget reduction of $8.2 million in FY 2024-25, $8.2 million in FY 2025-26 and $8.2 million in FY 2026-27.

Primary Medical Care

A total of 31.9 positions were allocated to support Primary Medical Care to be phased in over three years.

As of February 29, 2024, all positions have been established and 10.5 positions have been filled. DSH is actively recruiting to fill these positions, despite continuous hiring challenges. As a result, DSH reflects an additional one-time savings in FY 2023-24 of $1.9 million.

Primary Medical Care	Total	Filled
Chief Physician & Surgeon	6.1	4.0
Physician & Surgeon	25.9	6.5
TOTAL	**31.9**	**10.5**

Trauma-Informed Care

A total of 6.0 positions were allocated to support Trauma-Informed Care to be fully phased in beginning of FY 2021-22.

As of February 29, 2024, all position phase-ins are complete.

Clinical Executive Structure

The Clinical Executive Structure is needed to establish standard practices and procedures, provide leadership to staff and supervisors, and engage in administrative tasks such as focused efforts on recruitment and retention.

Administrative Support Positions

A total of 6.0 positions were allocated to support Administrative Services to be fully phased in beginning of FY 2021-22.

As of February 29, 2024, all position phase-ins are complete.

Clinical Executive Leadership

A total of 12.0 positions were allocated to support Clinical Executive Leadership to be fully phased in beginning FY 2021-22.

As of February 29, 2024, all 12.0 positions have been established and 8.0 have been filled. As a result, DSH is projecting an additional one-time savings in FY 2023-24 of $847,000.

Clinical Executive Leadership	Total	Filled
Medical Director	6.0	4.0
Assistant Medical Director	1.0	0.0
Chief of Primary Care Services	5.0	4.0
TOTAL	**12.0**	**8.0**

Discharge Strike Team

A total of 6.0 positions were allocated to support the Discharge Strike Team to be fully phased in beginning FY 2021-22.

As of February 29, 2024, all position phase-ins are complete.

Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$22,254	$38,421	$49,698
Governor's Budget Request	($5,285)	$0	$0
May Revision Request	($3,118)	($8,156)	($8,156)
TOTAL	**$13,851**	**$30,265**	**$41,542**

*Dollars in thousands

BCP Fiscal Detail Sheet

BCP Title: Mission Based Review: Treatment Team **BR Name: 4440-064-ECP-2024-MR**

Budget Request Summary

	FY24					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Salaries and Wages						
Earnings - Permanent	-2,006	-5,174	-5,174	-5,174	0	0
Total Salaries and Wages	**$-2,006**	**$-5,174**	**$-5,174**	**$-5,174**	**$0**	**$0**
Total Staff Benefits	-971	-2,480	-2,480	-2,480	0	0
Total Personal Services	**$-2,977**	**$-7,654**	**$-7,654**	**$-7,654**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-69	-252	-252	-252	0	0
5304 - Communications	-9	-31	-31	-31	0	0
5320 - Travel: In-State	-10	-31	-31	-31	0	0
5324 - Facilities Operation	-44	-157	-157	-157	0	0
5346 - Information Technology	-9	-31	-31	-31	0	0
Total Operating Expenses and Equipment	**$-141**	**$-502**	**$-502**	**$-502**	**$0**	**$0**
Total Budget Request	**$-3,118**	**$-8,156**	**$-8,156**	**$-8,156**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-3,118	-8,156	-8,156	-8,156	0	0
Total State Operations Expenditures	**$-3,118**	**$-8,156**	**$-8,156**	**$-8,156**	**$0**	**$0**
Total All Funds	**$-3,118**	**$-8,156**	**$-8,156**	**$-8,156**	**$0**	**$0**

Program Summary

Program Funding						
4400020 - Hospital Administration	-9	-31	-31	-31	0	0
4410010 - Atascadero	-609	-1,334	-1,334	-1,334	0	0
4410020 - Coalinga	-1,613	-1,510	-1,510	-1,510	0	0
4410030 - Metropolitan	-259	-1,593	-1,593	-1,593	0	0
4410040 - Napa	-234	-3,012	-3,012	-3,012	0	0
4410050 - Patton	-394	-676	-676	-676	0	0
Total All Programs	**$-3,118**	**$-8,156**	**$-8,156**	**$-8,156**	**$0**	**$0**

BCP Title: Mission Based Review: Treatment Team **BR Name: 4440-064-ECP-2024-MR**

Personal Services Details

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
7552 - Physician & Surgeon (Safety)	-1,072	0	0	0	0	0
7561 - Chief Physician & Surgeon	-166	0	0	0	0	0
7619 - Staff Psychiatrist (Safety)	0	-3,196	-3,196	-3,196	0	0
8323 - Rehab Therapist (Occ-Safety)	-44	-522	-522	-522	0	0
9872 - Clinical Soc Worker (Hlth/CF)-Safety	-205	-260	-260	-260	0	0
9873 - Psychologist (Hlth Facility-Clinical-Safety)	35	-1,196	-1,196	-1,196	0	0
VR00 - Various	-554	0	0	0	0	0
Total Salaries and Wages	**$-2,006**	**$-5,174**	**$-5,174**	**$-5,174**	**$0**	**$0**
Staff Benefits						
5150200 - Disability Leave - Industrial	-27	-67	-67	-67	0	0
5150210 - Disability Leave - Nonindustrial	-8	-21	-21	-21	0	0
5150350 - Health Insurance	-93	-238	-238	-238	0	0
5150450 - Medicare Taxation	-30	-77	-77	-77	0	0
5150600 - Retirement - General	-398	-1,007	-1,007	-1,007	0	0
5150700 - Unemployment Insurance	-1	-5	-5	-5	0	0
5150800 - Workers' Compensation	-93	-238	-238	-238	0	0
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	-56	-144	-144	-144	0	0
5150900 - Staff Benefits - Other	-265	-683	-683	-683	0	0
Total Staff Benefits	**$-971**	**$-2,480**	**$-2,480**	**$-2,480**	**$0**	**$0**
Total Personal Services	**$-2,977**	**$-7,654**	**$-7,654**	**$-7,654**	**$0**	**$0**

STATE HOSPITALS
PATIENT-DRIVEN OPERATING EXPENSES & EQUIPMENT
Program Update

SUMMARY

As of the 2024-25 May Revision, the Department of State Hospitals (DSH) reports a reduction in the amount of patient-related operating expenses and equipment (OE&E) funding requested in the 2024-25 Governor's Budget, with a decrease of $1.6 million in fiscal year (FY) 2023-24 and $632,000 in FY 2024-25 and ongoing, due to lower patient census projections.

BACKGROUND

The Budget Act of 2019 adopted a standardized methodology to provide funding for patient-related OE&E items such as outside medical care, pharmaceuticals, patient clothing, foodstuffs, etc. based on updated census estimates for each fiscal year and an estimated cost per patient, derived from past year actual expenditures. Throughout the COVID-19 pandemic and subsequent rising inflation[1], DSH has closely monitored these expenditures. The Budget Act of 2023 allotted $26.6 million for FY 2023-24 and ongoing based on FY 2021-22 actuals and projected patient census.

In the 2024-25 Governor's Budget, inflation and rising costs continued to impact patient-driven OE&E. DSH requested $10.8 million in FY 2023-24 and ongoing for Utilities, Foodstuff, and Pharmaceuticals based on updated per patient cost, derived from FY 2022-23 actual expenditures, and census projections.

JUSTIFICATION

As of the 2024-25 May Revision, the projected patient census for both FY 2023-24 and FY 2024-25 has decreased from the 2024-25 Governor's Budget projection of 5,839 for each fiscal year. Hospital patient census is now assumed to be 5,744 for FY 2023-24, and 5,802 for FY 2024-25. The per patient cost for Utilities, Foodstuffs, and Pharmaceuticals remains at $17,076[2] as stated in the 2024-25 Governor's Budget.

Allotment Adjustment for FY 2023-24

The 2024-25 Governor's Budget calculated a per patient cost of $17,076 for Utilities, Foodstuffs, and Pharmaceuticals, and projected a patient census of 5,839. Since that time, the projected patient census has decreased by 95 patients to 5,744, requiring a reduction in funding requested.

[1] Please see Department of Finance Budget Letters (BL) 22-22, 2023-24 Price Letter and BL 23-22, 2024-25 Price Letter, reflecting the impacts of inflation on rising costs.
[2] Total per patient cost includes Utilities ($4,987), Foodstuffs ($4,469), and Pharmaceuticals ($7,620)

To calculate the reduction in funding for the aforementioned areas, the adopted methodology follows a two-step process:

- Step One: The first step requires calculating the difference in funding resulting from a change in per patient cost. Given there is no change to the per patient cost from the 2024-25 Governor's Budget, no cost adjustment is needed.
- Step Two: The second step calculates the reduction of funds requested resulting from the decrease in patient census. The per patient cost for Utilities, Foodstuffs, and Pharmaceuticals ($17,076) is multiplied by the decrease in patient census (-95), resulting in a reduction of $1.6 million.

The total cost adjustment is determined by adding the results of steps one and two above. The table below displays the funding reduction for FY 2023-24 resulting from the updated census projection.

FY 2023-24 Updated Cost Adjustment	
2024-25 Governor's Budget Request	$10,784,000
Cost Adjustment for reduced May Revision Census	($1,622,208)
Updated Request for FY 2023-24	**$9,161,792**

Allotment Adjustment for FY 2024-25

The updated projected patient census for FY 2024-25 is 5,802; a decrease of 37 patients from the census of 5,839 projected at the 2024-25 Governor's Budget. To calculate the reduction in funding requested for FY 2024-25, step two of the process is repeated. The per patient cost for Utilities, Foodstuffs, and Pharmaceuticals ($17,076) is multiplied by the decrease in patient census (-37), resulting in a reduction of $632,000

As was performed above to identify the FY 2023-24 total cost adjustment, the results of steps one and two were added to determine the total FY 2024-25 adjustment. The table below displays the funding reduction for FY 2024-25 resulting from the updated census projection.

FY 2024-25 Updated Cost Adjustment	
2024-25 Governor's Budget Request	$10,784,000
Cost Adjustment for reduced May Revision Census	($631,807)
Updated Request for FY 2024-25	**$10,152,193**

As of the 2024-25 May Revision, based on the updated census projections, DSH reports a $1.6 million reduction in FY 2023-24 and a $632,000 reduction in FY 2024-25 and ongoing, resulting in an adjusted total request of $9.2 million for FY 2023-24 and

$10.2 million in FY 2024-25 and ongoing to provide support for patient driven OE&E. DSH will continue to monitor costs and patient census and provide an update in the 2025-26 Governor's Budget.

Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$135,891	$135,891	$135,891
Governor's Budget Request	$10,784	$10,784	$10,784
May Revision Request	($1,622)	($632)	($632)
TOTAL	**$145,053**	**$146,043**	**$146,043**

*Dollars in thousands

BCP Fiscal Detail Sheet

BCP Title: Patient Driven Operating Funding

BR Name: 4440-067-ECP-2024-MR

Budget Request Summary

	FY24					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5326 - Utilities	-473	-184	-184	-184	-184	-184
539X - Other	-1,149	-448	-448	-448	-448	-448
Total Operating Expenses and Equipment	**$-1,622**	**$-632**	**$-632**	**$-632**	**$-632**	**$-632**
Total Budget Request	**$-1,622**	**$-632**	**$-632**	**$-632**	**$-632**	**$-632**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-1,622	-632	-632	-632	-632	-632
Total State Operations Expenditures	**$-1,622**	**$-632**	**$-632**	**$-632**	**$-632**	**$-632**
Total All Funds	**$-1,622**	**$-632**	**$-632**	**$-632**	**$-632**	**$-632**

Program Summary

Program Funding						
4410010 - Atascadero	-426	-426	-426	-426	-426	-426
4410020 - Coalinga	-15	-15	-15	-15	-15	-15
4410030 - Metropolitan	-303	517	517	517	517	517
4410040 - Napa	-65	-65	-65	-65	-65	-65
4410050 - Patton	-813	-643	-643	-643	-643	-643
Total All Programs	**$-1,622**	**$-632**	**$-632**	**$-632**	**$-632**	**$-632**

STATE HOSPITALS
INFECTIOUS DISEASE PREVENTION (COVID-19) UPDATE
Program Update

SUMMARY

In the 2024-25 Governor's Budget, the Department of State Hospitals (DSH) requested $25.9 million in fiscal year (FY) 2024-25, and $7.7 million in FY 2025-26 and ongoing for expenditures related to infection control measures in order to continue to protect the health and safety of DSH staff and patients. As of the 2024-25 May Revision, DSH reports no changes to the 2024-25 Governor's Budget request.

BACKGROUND

DSH executed a COVID-19 response plan across its system to follow guidance from the California Department of Public Health (CDPH), the Centers for Disease Control and Prevention (CDC), and other state and local partners. Under these circumstances, DSH took the necessary steps to mitigate the spread of COVID-19 at all facilities, including implementation of policies and procedures for infection control, respiratory protection, COVID-19 testing, personal protective equipment (PPE), and established isolation units.

Although the California State of Emergency ended on February 28, 2023, and the Federal State of Emergency ended on May 11, 2023, DSH has an ongoing responsibility to protect the health and safety of staff and patients from aerosol transmissible diseases (ATD). Based on the changes in operations made by DSH in accordance with the CDC, CDPH, Cal/OSHA, and local public health guidance, DSH has continued to prioritize the safety of its employees and patients through infection control measures, thereby mitigating the spread of COVID-19 and other infectious diseases throughout DSH facilities. This request ensures DSH will continue to be able to maintain the health and safety of staff and patients in the event of any disease outbreak, mitigate the impact to our aging population during seasonal infectious disease outbreaks or peak seasons, and maintain safe working conditions to foster a therapeutic environment free from emotional and physical harm for all patients and employees.

In the 2024-25 Governor's Budget, DSH requested $25.9 million in FY 2024-25 and $7.7 million ongoing to continue to support infection control measures to protect the health and safety of its employees and patients in compliance with CDPH, Cal/OSHA, and CDC guidance.

JUSTIFICATION

As of the 2024-25 May Revision, there is no change from Governor's Budget and DSH continues to request $25.9 million in FY 2024-25 and $7.7 million in FY 2025-26 and ongoing for testing, vaccinations, commodity goods, and surge resources to support infection control measures implemented for infectious diseases mitigation, in accordance with CDPH, Cal/OSHA, and CDC guidance, as well as permanent funding and position authority for 10.0 limited term Public Health Nurse (PHN) positions, in FY 2024-25 and ongoing, to ensure compliance with public health guidelines and regulations. DSH will continue to monitor infectious disease control measures and provide an update in the 2025-26 Governor's Budget.

Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$42,062	$0	$0
Governor's Budget Request	$0	$25,900	$7,700
May Revision Request	$0	$0	$0
TOTAL	**$42,062**	**$25,900**	**$7,700**

*Dollars in thousands

FORENSIC CONDITIONAL RELEASE PROGRAM (CONREP) GENERAL/NON-SEXUALLY VIOLENT PREDATOR (NON-SVP) PROGRAM

Program Update

SUMMARY

In the 2024-25 Governor's Budget, the Department of State Hospitals (DSH) anticipated a total contracted caseload of 1,038 in FY 2023-24 and 945 in FY 2024-25 and reported a one-time savings of $599,000 in fiscal year (FY) 2023-24 due to delays in admissions at the Northern CA Statewide Transitional Residential Program (STRP) facility. As of the 2024-25 May Revision, DSH anticipates a total contracted caseload of 960 CONREP clients in FY 2023-24 and 938 in FY 2024-25 and reports an additional one-time savings of $2.6 million in FY 2023-24 due to ongoing challenges with hiring clinical staff for the programs.

BACKGROUND

CONREP is DSH's statewide system of community-based services for specified court-ordered forensic individuals. CONREP aims to promote greater public protection in California's communities via an effective and standardized community outpatient treatment system. The CONREP Non-SVP population includes clients deemed Not Guilty by Reason of Insanity (NGI), Offender with a Mental Health Disorder (OMD), and felony Incompetent to Stand Trial (IST)[1] patients who have been court-approved for outpatient placement in lieu of state hospital placement. Individuals suitable[2] for CONREP may be recommended to the courts by the state hospital Medical Director.

Currently, DSH contracts with six county-operated and seven private organizations to provide outpatient treatment services to non-SVP clients in all 58 counties of the state. Contractors complete regular treatment evaluations and assessments in conjunction with the court-approved treatment plan and provide forensic mental health treatment in individual and group therapy settings, in additional to various services needed to support community reintegration including:

- Life skills training
- Residential placement
- Collateral contacts (e.g., other individuals/agencies)
- Home visits
- Substance abuse screenings
- Psychiatric services
- Case management
- Court reports
- Psychological assessments

[1] The Budget Act of 2022 amended PC Section 1370 to statutorily prioritize community outpatient treatment effective July 1, 2023, increasing consideration for placement of IST patients in community IST facilities.

[2] As specified in PC 1600-1615 and 2960-2972, the CONREP Community Program Director (CPD), with the Court's approval (or in the case of OMDs, the Board of Parole Hearings (BPH) approval), assesses and makes the recommendation for individuals' placement in CONREP.

When a DSH patient is discharged to CONREP, the goal is to provide an independent living environment in the least restrictive setting. Historically, CONREP's model of care is a centralized outpatient clinic where most treatment services are delivered. In this treatment model, clients must seek transportation or walk to access these services, requiring them to live close to the outpatient clinic or along a major bus route to access timely treatment regularly. As it is impractical to place individuals in areas which require a client to navigate multiple bus routes or obtain a costly taxi ride, the current type of service model limits the inventory of housing secured for the placement of CONREP clients.

Step-Down Transitional Program

CONREP-eligible clients who may not need a locked setting but have not demonstrated the ability to live in the community without direct staff supervision, may participate in the Statewide Transitional Residential Program (STRP). STRP is an interim housing environment with 24 hours-per-day, seven days-per-week (24/7) supervision, which allows clients to learn appropriate community living skills while transitioning from a state hospital setting. Client stays are based on availability, and typically limited to 90 to 120 days but may be extended due to medical necessity. Once clients are ready to live in the community without structured 24/7 services, they are eligible for transfer to a Board & Care, Room & Board, or other community living arrangement without ongoing direct supervision.

CONREP Forensic Assertive Community Treatment (FACT) Regional Program (CFRP)

The CONREP FACT Regional Program (CFRP) is a 24/7 mobile treatment team providing onsite individual and group treatment to clients at their residence. In addition to providing treatment, CFRP's mobility allows them to respond quickly to provide de-escalation and crisis intervention practices, reducing the likelihood of rehospitalization. DSH has contracted with a provider for up to 180 dedicated beds and staff resources for this new treatment option in CONREP across three regions of the state: Northern California, Bay Area, and Southern California.

In addition to increasing the placement options available for NGI and OMD patients transitioning from the state hospitals, the FACT model of care can be used to treat IST clients ordered to CONREP when other community-based restoration programs are not available.

Independent Placement Panel (IPP)

The Budget Act of 2022 included resources to pilot a new Independent Placement-Determination Panel (IPP), which sought to increase participation in the Conditional Release Program (CONREP) by individuals found Not Guilty by Reason of Insanity

(NGI) or Offenders with a Mental Health Disorder (OMD), thereby increasing state hospital bed capacity for those on the IST waitlist.

In November 2022, DSH formed a stakeholder workgroup consisting of several county CONREP Community Program Directors (CPDs), DSH CONREP clinical staff, and state hospital discharge-planning teams to develop the IPP and establish an implementation plan, with a specific focus on determining assessment and referral protocols, justice partner engagement, CONREP program training, technical assistance, and streamlining the referral process and patient records database. In December 2022, DSH held an information session for all CONREP Community Program Directors (CPDs), leading to the finalization of all CONREP programs designated for phase one implementation (see below):

- Gateways – LA CONREP
- Orange County CONREP
- Harper Medical Group – Central Valley CONREP
    - Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Lassen, Mariposa, Merced, Modoc, Nevada, Plumas, Sacramento, Shasta, Sierra, Siskiyou, Stanislaus, Tehama, Trinity, Tuolumne, Yolo
- Harper Medical Group – South Bay CONREP
    - Monterey, San Benito, Santa Clara, Santa Cruz
- MHM – Central California CONREP
    - Fresno, Kings, Madera, Tulare
- Kern CONREP
    - Kern, Inyo, Mono

The IPP policies and procedures manual was completed and finalized in June 2023 and implementation of the IPP began on July 1, 2023.

Placement Presumption

The Budget Act of 2022 amended PC Section 1370 to statutorily prioritize community outpatient treatment effective July 1, 2023[3], increasing consideration for placement of IST patients in Diversion, CBR, or other community IST facilities. In the 2023-24 May Revision, DSH reported CONREP CPDs completed training in March 2023, emphasizing recommendations for Diversion consideration.

In the Budget Act of 2023, DSH received $2.6 million and 2.0 positions to build out its continuum of care and respond to the increase in the CONREP non-SVP census and associated workload. In the 2024-25 Governor's Budget, DSH reported a one-time

[3] Unless a court, based on the recommendation of the Community Program Director or designee, finds the clinical needs or community safety risk warrants placement in a more secure setting, such as a state hospital or JBCT program.

savings of $599,000 in fiscal year (FY) 2023-24 due to delays in admissions at the Northern CA Statewide Transitional Residential Program (STRP) facility.

JUSTIFICATION

As of the 2024-25 May Revision, DSH anticipates a total contracted caseload of 960 CONREP clients in FY 2023-24 and 938 in FY 2024-25. This contracted caseload includes 685 regular CONREP clients currently placed in settings which do not offer dedicated beds to the program. In addition, CONREP's contracted caseload includes the following current and planned specialized beds dedicated to the program:

- 55 STRP beds in FY 2023-24
  - 35-bed activated Southern CA STRP
  - 20-bed activated Northern CA STRP
- 90 FACT beds
  - 30 activated beds in Central CA in FY 2022-23
  - 60 beds activated in Northern CA and Southern CA in FY 2021-22
- 132 Institute for Mental Disorder (IMD) beds in FY 2023-24
  - 78-bed Southern CA IMD activation (45 beds in October 2023, and 43 remaining beds anticipated in April 2024)
  - 24-bed activated Southern CA IMD (transitioned to Community Inpatient Facility in October 2023)
  - 30-bed activated Northern CA IMD

This contracted caseload reflects the total number of clients and beds available by the end of FY 2023-24 and FY 2024-25, which may vary based on activation delays. Reflecting the projected client phase-in, DSH estimates an average census of 822 in FY 2023-24 and 864 in FY 2024-25.

CONREP community program providers continue to experience challenges in hiring and retention for clinical and administrative staff. This is consistent across all programs and is affecting census and contract costs. DSH continues to support its community providers' efforts to fill positions, while monitoring impacts to contract costs and client admissions.

78-Bed Southern CA IMD Facility (Golden Legacy)

In the 2024-25 Governor's Budget, DSH reported that Golden Legacy's Phase II activation was anticipated for late December 2023 pending the California Department of Public Health's (CDPH) survey and approval. The CDPH Phase II survey was initiated in early March 2024 and is currently underway. DSH now anticipates the remaining 43 beds in Phase II to activate in April 2024 dependent on CDPH approval. Golden Legacy continues to review patient admissions and the referral waitlist in

anticipation of the full program activation. As of the 2024-25 May Revision, DSH reports a one-time savings of $1.6 million in FY 2023-24 from the delayed Phase II activation.

30-Bed Northern CA IMD Facility (Canyon Manor)

In the 2024-25 Governor's Budget, DSH reported that all 30 beds were filled or reserved for clients ready for placement pending a court-ordered release from the state hospital. As of March 2024, 20 of the 30 beds are filled. The provider is experiencing insufficient clinical staffing, which has resulted in reduced client admissions. DSH is working with the provider to implement strategies for hiring and retention. DSH projects the provider will reach adequate staffing levels in April 2024, and the remaining 10 beds will be filled by May 2024. As such, in the 2024-25 May Revision, DSH anticipates an additional one-time savings of $448,000 in FY 2023-24.

20-Bed Northern CA STRP Facility (A&A Health Services)

In the 2023-24 May Revision, DSH and the provider reduced the bed capacity of the 30-bed STRP facility, while maintaining current staffing levels, resulting in a total caseload of 20 in FY 2023-24. In an effort to allow for further development and refinement of the STRP program, the provider paused admissions at the end of May 2023. In October 2023, the provider had resumed reviewing client referrals and was reviewing the waitlist for admissions.

As of March 2024, seven beds are filled. The provider continues to experience challenges with hiring adequate clinical staffing levels and admissions have been affected by this. DSH is working with the provider on strategizing and supporting hiring and retention efforts in order to fill more beds. The provider continues to evaluate additional clients for admission, with DSH anticipating the remaining beds will be filled by July 2024. In the 2024-25 Governor's Budget, DSH reported a one-time savings of $599,000 in FY 2023-24 as a result of the unfilled beds. As of the 2024-25 May Revision, DSH anticipates an additional savings of $592,000 in FY 2023-24.

<u>CONREP FACT Regional Program (CFRP)</u>

In the 2024-25 Governor's Budget, DSH reported a bed reduction for all active CFRP programs, resulting from significant concerns around secured housing locations and the level of staffing required to appropriately meet the clinical needs.

DSH initially contracted with a single FACT provider for up to 180 beds - 60 within each region - but experienced significant concerns with the housing locations secured by the provider and their level of staffing to appropriately meet the clinical needs and satisfy court report requirements of the patients treated within the FACT programs. DSH clinical and operational staff evaluated the program's operations over the

course of nearly a year of providing close on-site supervision, outcomes monitoring, training, and technical assistance. Following this, DSH determined the provider needed to increase staffing levels to provide the requisite services, ensure a dedicated 24/7 clinical on-site presence, maintain service documentation, and complete and submit court reports timely. In addition, to ensure the safety of the clients and staff, two of the three regional programs relocated to alternate areas.

The increase in provider staffing and securing of more suitable housing in safer locations with appropriate on-site supports, has improved services for CFRP patients, but has also increased costs to maintain the program. Further, while DSH continues to monitor these changes to ensure the best patient care and outcomes, each regional program will maintain a maximum of 30 beds, for a total of 90 FACT beds statewide. This reduction in contracted beds is offset by the increased costs to support increased staffing levels and housing with onsite clinical supports and supervision capable of appropriately responding to the treatment needs of patients 24/7. The Budget Act of 2022 provided $14.3 million in ongoing funding to support the CFRP and, when initially designed and implemented, was significantly understaffed to support the 24/7 nature of each regional program, spread across multiple homes within each region, especially as the programs serve more IST patients that typically need a higher level of services based on acuity. Reducing each program's capacity, coupled with increased staffing to support the populations, results in a ratio of approximately 7:1, whereas the previous staffing was a ratio of 12:1. As such, there are no anticipated savings.

The contracted CFRP provider has secured program housing in Sacramento, San Diego, and Alameda counties; all of which support a regional model of FACT programs to serve CONREP clients from across the state. As of March 2024, CFRP-Alameda has paused admissions at a current census of 13 to allow for further program development and refinement of the program. Savings are not anticipated with the reduced census due to the need to maintain staffing and housing to resume admissions in the current year. CFRP-San Diego census is at 26 and CFRP-Sacramento is at 30. The provider continues to evaluate additional clients for admission. The provider continues to evaluate additional clients for admission.

<u>CONREP Supervised Release File (SRF) and Agency California Law Enforcement Telecommunications System (CLETS) Coordinator (ACC)</u>

The expansions of the CONREP continuum of care programs within recent years, and corresponding increases in new patient admissions, discharges, and transfers between programs, have significantly magnified the workload of CONREP Operations administrative staff. The IST patient population treated within CONREP has doubled in the span of only one year, and due to the shorter lengths of stays, the program has experienced a greater level of patient movement through the system. Additionally, as CONREP continues to refine its programming options to offer varying

levels of care to meet the needs of NGI and OMD patients in the state hospitals who are ready to step down, DSH estimates the number of patients and rate of movement will continue to increase across the various CONREP treatment settings. Staff have specifically seen an increase in the time required for managing and updating the SRF due to an increase in volume in critical updates pertaining to admissions, discharges, Absent Without Leaves (AWOLs) and transfers, as well as ensuring DSH staff and contracted program staff have access to CLETS certification training, adhering to the Department of Justice's (DOJs) policies and procedures pertaining to sensitive criminal data information obtained via the SRF, and ensuring compliance with the DOJ's policies, procedures, and audits as the ACC. For context, DSH supported just under 350 SRF entries in 2022 as compared to more than 1,047 SRF entries in 2023 and 148 entries as of March 2024.

Currently, CONREP Operations does not have dedicated law enforcement staff, or the resources required to provide needed operational and administrative program support to the SRF, directly impacting client care. CONREP has had a significant increase in admissions, discharges, and AWOLs due to the increased numbers of ISTs being served across the programs. The required SRF updates are critical to client care in the community and to providing necessary information to law enforcement, in the event they have contact with a client being treated in the community. Dedicated staff are needed for the Agency CLETS Coordinator (ACC) role and SRF updates, to track all patient movement in accordance with CA DOJ and FBI policies and regulations to ensure public safety. DSH will continue to monitor this workload.

Independent Placement Panel (IPP)

The IPP policies and procedures manual was completed and finalized in June 2023 and implementation of the IPP began on July 1, 2023. As of the 2024-25 May Revision, IPP received a total of 43 referrals, 39 of which had completed evaluations submitted to the courts, with approximately 79% resulting in a recommendation from IPP for community outpatient treatment or stepdown into a lower setting within CONREP. DSH will provide an update on the number of total evaluations conducted in the 2025-26 Governor's Budget.

Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$48,047	$48,508	$48,508
Governor's Budget Request	($599)	$0	$0
May Revision Request	($2,647)	$0	$0
TOTAL	**$44,801**	**$48,508**	**$48,508**

*Dollars in thousands

BCP Fiscal Detail Sheet

BCP Title: CONREP Non-SVP **BR Name: 4440-066-ECP-2024-MR**

Budget Request Summary

	FY24					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	-2,647	0	0	0	0	0
Total Operating Expenses and Equipment	**$-2,647**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-2,647**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-2,647	0	0	0	0	0
Total State Operations Expenditures	**$-2,647**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-2,647**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4420010 - Conditional Release Program	-2,647	0	0	0	0	0
Total All Programs	**$-2,647**	**$0**	**$0**	**$0**	**$0**	**$0**

FORENSIC CONDITIONAL RELEASE PROGRAM (CONREP)
SEXUALLY VIOLENT PREDATOR (SVP) PROGRAM
Program Update

SUMMARY

As of the 2024-25 May Revision, DSH continues to project a caseload of 31 SVPs conditionally released into the community as of June 30, 2025.

BACKGROUND

The CONREP program is DSH's statewide system of community-based services for specified court-ordered forensic individuals. The SVP Act (Welfare and Institutions Code (WIC) section 6600, et. seq) went into effect January 1, 1996, with the first SVP client being placed in the CONREP-SVP program in 2003. Prior to 2003, existing CONREP providers did not have SVP-specific services to treat SVP clients, requiring DSH to contract with a single private provider serving all 58 counties.

When an SVP client is conditionally released into the community by court order, existing law requires they be released to their county of domicile, and that sufficient funding be available to provide treatment and supervision services. Clients in CONREP SVP are provided the same array of mental health services as general non-SVP program clients are afforded. Additional required services for SVP clients in CONREP include regularly scheduled sex offender risk assessments, objective measures of sexual interests, polygraph testing, a Community Safety Team (CST), and Global Positioning System (GPS) data and surveillance.

In recent years, DSH has experienced significant community opposition in securing housing for SVP clients to be released into CONREP. Since the SVP law was enacted, the average timeframe is slightly less than 12 months from approved petition to placement in the community but in recent years, this average time to placement has been increasing. Effective January 1, 2023, new statutes resulting from the passage of Senate Bill (SB) 1034 (Atkins), Ch. 880, Statutes of 2022, requires DSH to convene a committee of specified county representatives to obtain relevant assistance and consultation regarding securing suitable housing for each client approved for conditional release. This committee is in effect from the date of the initial order approving placement in CONREP to the date of actual transition from the state hospital to the community through CONREP.

These new requirements provided for the establishment of county-specific Housing Committee Meetings (HCMs) that are open to the public, pursuant to the Bagley-Keene Open Meeting Act. This change has resulted in an increased number of court hearings, task and criteria tracking, reporting requirements, housing status reports to

the court, and inter-agency coordination across multiple counties throughout the state.

Additionally, a recent court decision related to homeschools has further increased the complexity and challenges for the housing search process. WIC 6608.5 (f) requires that "*Placements may not occur within ¼ mile of any public or private school (K-12) for persons with improper sexual conduct with children*." In January 2023, the Court of Appeals found that the definition of a "private school" is inclusive of homeschools regardless of when the home school is established. This means that every homeschool within the state creates a new area where an SVP individual cannot be housed. Moreover, it is not only the homeschools that exist at the time DSH submits a residence for consideration to the court, but homeschools can be created any time after a property has been vetted and submitted to the court, which could then render the property ineligible to be used.

As a result of these new requirements, the current average wait time for individuals who are approved for CONREP but pending a court-approved placement location is 21.2 months. As these new processes are refined and evolve, DSH will monitor for any potential impacts to the average placement waiting period that could result from implementation of the HCMs.

PROGRAM UPDATE

As of the 2024-25 May Revision, 21 court-ordered clients are participating in CONREP-SVP, however, a small number of these individuals have been re-hospitalized and are pending potential re-release to the community in the current year. Additionally, 21 individuals with court-approved petitions are awaiting placement into the community and ten more have filed petitions and are proceeding through the court process. With the dynamic nature of the court process and timelines, challenges surrounding housing availability, as well as other factors, DSH projects a caseload of 31 clients conditionally released in CONREP at the end of fiscal year (FY) 2024-25. Please refer to the table below which displays the total projected caseload for FY 2023-24 and FY 2024-25.

CONREP-SVP Projected Caseload for 2024-25 May Revision		
Description	Projected Caseload as of FY 2023-24	Projected Caseload as of FY 2024-25
Individuals currently in CONREP	21	21
Adjusted Caseload	6	10
Total	**27**	**31**

DSH calculates the estimated projected caseload using the average number of months from the court-approved petition to CONREP placement, and considers

other factors such as revocations, unconditional release from CONREP, and delays to court proceedings and/or community placement.

Although DSH doesn't anticipate a change to the projected caseload of 31, pre-placement and housing costs continue to increase beyond what DSH was previously funded for. While no funding is requested at this time, DSH will monitor these costs closely and may request resources in the 2025-26 Governor's Budget.

Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$12,680	$12,680	$12,680
Governor's Budget Request	$0	$0	$0
May Revision Request	$0	$0	$0
TOTAL	**$12,680**	**$12,680**	**$12,680**

*Dollars in thousands

CONTRACTED PATIENT SERVICES
INCOMPETENT TO STAND TRIAL SOLUTIONS
Program Update

SUMMARY

The Department of State Hospitals (DSH) continues its efforts to provide timely access to treatment for individuals who are found Incompetent to Stand Trial (IST) on a felony charge. In the 2024-25 Governor's Budget, DSH requested position authority for 2.0 positions, while reporting a net savings of $58.6 million in fiscal year (FY) 2023-24 due to changes in implementation of various IST Solutions such as Jail-Based Competency Treatment (JBCT) programs, Community Inpatient Facilities (CIF) programs, and Early Access and Stabilization Services (EASS) programs. As of the 2024-25 May Revision, DSH reports an additional one-time savings of $118.3 million in FY 2023-24 ($45.0 million re-appropriated from the Budget Act of 2022), and a one-time savings of $49.9 million in FY 2024-25, due to activation delays in JBCT and Community Based Restoration (CBR)/Diversion programs, and for county stakeholder workgroup grant contracts not yet executed. Additionally, DSH proposes to shift $129.5 million in from FY 2025-26 to FY 2026-27 to better align with program implementation timelines.

BACKGROUND

For over a decade, the State of California observed significant growth in the number of individuals found IST on felony charges and referred to DSH for competency restoration, with the growth in IST referrals outpacing the department's ability to create sufficient additional capacity. Prior efforts, including increased inpatient bed capacity, systems efficiencies resulting in decreased average length of stays (ALOS), and implementation of community-based treatment programs, were insufficient to respond to the ever-growing demand, resulting in a waitlist and extended wait times for IST defendants pending placement into a DSH treatment program. Further compounding the issue, the COVID-19 pandemic and the adopted infection control measures required at DSH facilities contributed to significantly slower admissions and a reduction in the capacity to treat felony ISTs at DSH for the duration of the state of emergency, causing the IST waitlist and corresponding wait times to grow substantially.

In 2021, the Alameda Superior Court ruled in *Stiavetti v Clendenin*[1] that DSH must commence substantive treatment services to restore IST defendants to competency within 28 days from the transfer of responsibility to DSH[2], providing a specified timeline to meet that standard over three years, with February 27, 2024, as the target date for

[1] In 2015, the American Civil Liberties Union filed a lawsuit against DSH (*Stiavetti v. Clendenin*), alleging the time IST defendants were waiting for admission into a DSH treatment program violated the IST defendant's constitutional right to due process.
[2] Date of service of the commitment packet to DSH for felony IST patients.

ultimately providing substantive treatment services for felony ISTs within 28 days of the transfer of responsibility. On October 6, 2023, the Alameda Superior Court modified the interim benchmarks and final deadline for compliance with the 28 days as follows:

- March 1, 2024 – provide substantive treatment services within 60 days
- July 1, 2024 – within 45 days
- November 1, 2024 – within 33 days
- March 1, 2025 – within 28 days

The Budget Act of 2022 (and subsequent adjustments authorized in the Budget Act of 2023) appropriated funding to implement many of the IST Solutions identified by the statewide IST Solutions Workgroup[3]. These included providing early stabilization to increase diversion opportunities and care coordination, expanding community-based treatment and diversion options for felony ISTs, improving IST discharge planning and coordination, implementing a pilot for Independent Placement Panels (IPP), and improving alienist training. These resources were combined with previously funded IST programs, including IST re-evaluation services, JBCT, and CIF, expanding the DSH continuum of care for IST individuals. Additionally, statutory changes aimed at solving the IST crisis have been implemented to streamline and improve IST processes, target the growth in IST determinations (felony IST growth cap), and establish a comprehensive set of strategies and solutions, ensuring felony IST individuals have timely access to appropriate treatment and services. Collectively, these strategies and solutions assist the state in meeting the court-ordered treatment timelines outlined in *Stiavetti v. Clendenin*.

IST Waitlist

As DSH expanded its continuum of care, the number of individuals found IST on felony charges and referred by the superior courts to DSH continued to increase. During the COVID-19 pandemic, operational impacts slowed admissions and treatment capacity, further impacting the waitlist.

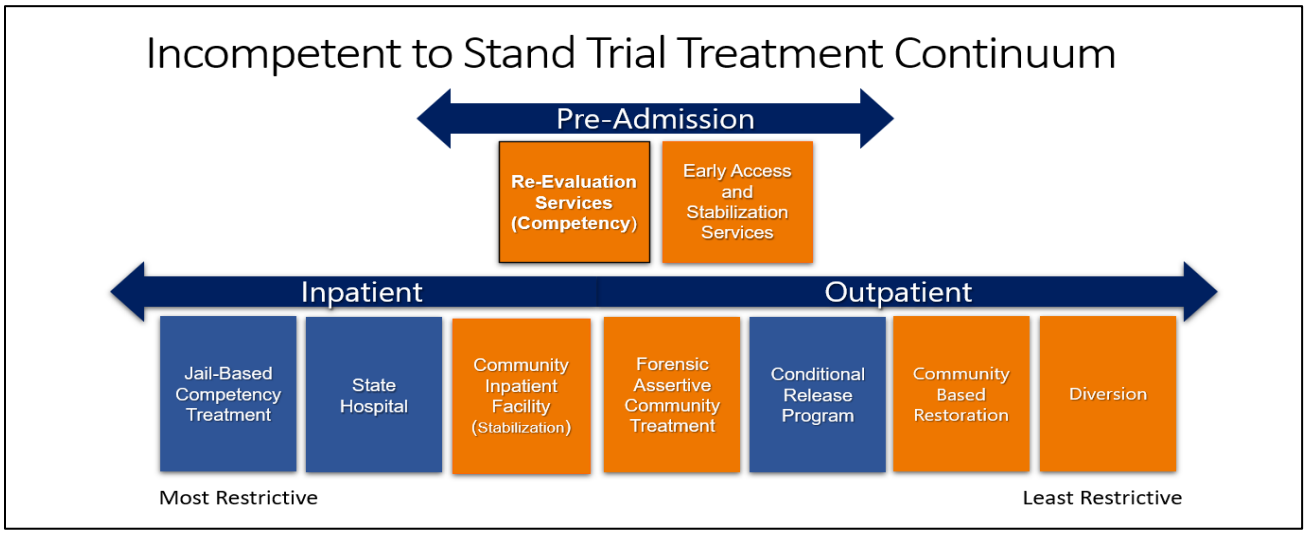
Prior to the declared State of Emergency, in February 2020, DSH had 850 individuals pending placement into a DSH IST treatment program. Throughout the pandemic, DSH observed seasonal fluctuations in the waitlist, with increases in winter and summer, and decreases in the spring and fall, as DSH recovered from COVID-19 surges. In January 2022, resulting from a COVID-19 surge, the IST waitlist reached a

[3] In 2021, the Legislature enacted Welfare & Institutions Code (WIC) section 4147 through the passage of Assembly Bill 133 (Chapter 143, Statutes of 2021) and the Budget Act of 2021 (Chapter 69, Statutes of 2021), which charged the California Health & Human Services Agency (CalHHS) and DSH to convene an IST Solutions Workgroup. Following a series of stakeholder meetings between August 2021 and November 2021, the Workgroup identified over 40 strategies and solutions to advance alternatives to placement in DSH competency restoration programs for those deemed felony IST.

high of 1,953. In the 2024-25 Governor's Budget, DSH reported the waitlist had declined to 501, inclusive of individuals receiving Early Access and Stabilization Services (EASS), which represented a reduction of 38 percent from the total waitlist of 804 reflected in the 2023-24 May Revision.

IST Treatment Continuum

The following chart depicts the comprehensive continuum of IST services DSH has established and is continuing to build with the recent Budget Act investments. Blue boxes indicate DSH legacy programs which have been part of DSH's continuum for a decade or more, while orange boxes represent newer service options which began implementation in recent years.



Historically, restoration treatment options for individuals deemed IST on felony charges were provided in state hospitals, and over the last decade, in JBCT programs. Beginning in 2018, DSH expanded its continuum to include the pilot Felony Mental Health Diversion (Diversion) and partnered with Los Angeles (LA) County to establish the first felony IST community-based restoration program. More recently, in 2021, additional investments were made to expand the continuum of IST services with the implementation of pre-admission programs including IST re-evaluation services, early access and stabilization, and the establishment of additional levels of care and treatment settings to broaden the placement options available for all IST individuals. The information below describes the relevant programs within the IST treatment continuum addressed by this estimate.

IST Re-Evaluation Services

The Budget Act of 2021 authorized DSH to implement the IST Re-Evaluation Services Program as a 4-year limited-term solution to help address the IST waitlist. Under this program, DSH Psychologists re-evaluate individuals who have been deemed IST

pending transfer to a DSH treatment program. By performing these Re-Evaluations, DSH reduces the IST waitlist by identifying individuals who have already been restored to competency while receiving treatment in jail, or by identifying individuals who may be candidates for Diversion or other outpatient treatment programs. The evaluations also identify individuals who may be candidates for involuntary medication orders (IMOs), those who may warrant an acuity review, and those who may be unlikely to restore.

Since its inception, the IST Re-Evaluation Program has successfully implemented re-evaluation services in all eligible jails[4]. In addition to the re-evaluations, this team provides competency evaluations for newly emerging community IST treatment programs which currently do not or will not have forensic evaluator capacity available. DSH plans to deploy forensic evaluation resources flexibly and strategically to areas of IST forensic evaluation need as they become evident. In the 2024-25 Governor's Budget, DSH reported a total of 4,817 evaluations had been completed since program inception, with 1,518 individuals found competent, returned to court, and removed from the IST waitlist due to Re-Evaluation Services.

Early Access and Stabilization Services (EASS)

The EASS program was established in FY 2022-23 as part of IST Solutions to provide treatment and stabilization to individuals deemed IST on felony charges in jail, pending placement into a bed in the IST treatment continuum. EASS seeks to increase community-based treatment placements by facilitating IST patients' stabilization and medication compliance, increasing eligibility for placement into a Diversion or other outpatient treatment programs. In the 2024-25 Governor's Budget, DSH reported the activation of 14 additional EASS counties programs, bringing the total number of operating EASS programs to 44.

Jail-Based Competency Treatment (JBCT)

DSH contracts with California county sheriffs' departments to provide restoration of competency treatment services to lower acuity patients committed as IST while they are housed in county jail facilities using one of the following four JBCT program models:

1. Single-county model – Serves IST patients from one specific county with an established number of dedicated program beds
2. Regional model - Serves IST patients from surrounding counties with an established number of dedicated program beds
3. Statewide model - Serves IST patients from multiple counties statewide with an established number of dedicated program beds

[4] Two counties (Alpine and Sierra) do not house IST patients.

4. Small-county model – Services are delivered individually to a small number of IST patients, generally 12 to 15 annually, and do not have dedicated treatment beds

Providing lower acuity patients with restoration of competency services, generally within 90 days, JBCT programs provide local treatment to individuals deemed IST. IST patients unable to quickly restore to trial competency can be subsequently referred to a state hospital for longer-term IST treatment. As of the 2024-25 Governor's Budget DSH reported the operation of 424 JBCT beds across 24 counties, with plans for further expansions.

Community Inpatient Facilities (CIF)

Originally introduced under the title "Institute for Mental Disease (IMD) and Sub-Acute Bed Capacity program", the CIF program authorized DSH to contract with counties or private providers to develop new, or renovate existing, community inpatient facilities to provide alternative treatment options to state hospitals, including IMDs, Mental Health Rehabilitation Centers (MHRCs), Skilled Nursing Facilities (SNFs), and other types of facilities appropriate for felony IST patients. With the objective of supporting county-operated community-based IST treatment programs where higher levels of care and/or security may be needed, individuals transitioning from jail are able to stabilize prior to stepping up, or down, into a treatment setting with different restrictions.

DSH activated its first 78-bed facility in Sacramento County in April 2022 at the Sacramento Behavioral Health Hospital (SBHH). As an acute psychiatric hospital, SBHH facilitates psychiatric stabilization of felony IST patients, primarily through administering medications to support restoration of competency, or via pathways to participation in Diversion or other outpatient treatment programs. In the 2024-25 Governor's Budget, DSH reported two new contracted CIF programs in southern California for the treatment of the felony IST population along with contracts for two facilities to provide full competency restoration services.

Expanding Felony IST Community Programing via Community-Based Restoration (CBR) and Mental Health Diversion (Diversion)

The Budget Act of 2022 provided one-time infrastructure funding in FY 2022-23 and FY 2023-24 to develop residential housing settings to support felony IST individuals participating in either CBR or felony Diversion programs. Expansions of the CBR and Diversion programs aim to provide care in the most appropriate community-based setting as an alternative to placement in a DSH inpatient beds, using an estimation that 60-70% of annual IST commitments would be eligible for services in a community-based program. In 2022-23, DSH began to develop community-based capacity for

a total of approximately 3,000 annual felony IST admissions, expanding the number of available patient beds through a CBR or Diversion program over a 4-year period[5].

In the 2024-25 Governor's Budget, DSH reported four counties have submitted proposals to Advocates for Human Potential (AHP), and contract negotiations are underway to develop up to 412 beds to house felony IST defendants participating in Diversion or CBR programs. Additionally, 26 counties have expressed interest in submitting applications in the future.

CBR and Diversion[6] Program Implementation

CBR and Diversion programs are community-based IST treatment options provided in the least restrictive, typically residential, settings. Access to locked acute and sub-acute settings may also be offered in response to the acuity needs of the individuals. Both programs offer intensive mental health treatment services with wraparound supports and housing.

The primary goal of CBR is restoration of competency and to that end, competency education is offered in addition to traditional mental treatment and supports. DSH can contract directly with counties or private providers to establish CBR programs statewide and implemented the first CBR program for felony ISTs in 2018-19 in partnership with the LA County Office of Diversion and Re-entry.

The DSH Diversion program has been designed to target a portion of the IST population most likely to succeed in an outpatient setting when provided the appropriate treatment, supports, and housing. Established as a pilot in the Budget Act of 2018, and in partnership with 29 counties, the pilot Diversion program serves individuals with SMI diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder with the potential to be found IST or determined IST on felony charges. Individuals who are successful in Diversion may have their charges dropped at the completion of the Diversion program. The Budget Act of 2022 allocated ongoing funding to establish Diversion as a permanent program which has been modified to serve only those who are determined to be IST across an expanded list of qualifying diagnoses.

In the 2024-25 Governor's Budget, DSH reported partnering with Capstone Solutions Consulting Group to advise DSH on the development of the permanent statewide

[5] Dependent upon securing available housing.
[6] Permanent Diversion program updates will be included in this proposal as part of IST Solutions, while data gathered and analyzed from the pilot will continue to be reported under the Diversion pilot narrative (Section D4) until its conclusion in FY 2024-25, as DSH works to transition counties already participating in the Diversion pilot into new agreements following completion of their pilot program contracts.

program structure and informed stakeholders of the permanent program requirements at a Diversion Quarterly County meeting held on November 9, 2023.

County Stakeholder Workgroup Grants to Support IST Community Programs

In support of expanding IST community programming, DSH was allocated resources to aid behavioral health and criminal justice workgroups across the state, tasked with developing interventions in their communities to reduce the overall number of residents with SMI who enter the criminal justice system, many of whom may be found IST on felony charges, with a focus on improving outcomes of those with a SMI who have fallen into cycles of incarceration and homelessness. Information about this opportunity was originally released to the counties on December 5, 2022, and in the 2023-24 May Revision, DSH reported 32 counties had submitted Letters of Intent (LOI) to contract with DSH for these annual resources. As of the 2024-25 Governor's Budget, 29 of the 32 counties had executed contracts with DSH, while the remaining three contracts were in the process of being executed. Additional interested counties could submit an LOI by September 1, 2023, to enter into a contract effective January 1, 2024, or submit an LOI by December 1, 2023, to enter into a contract with an effective date of July 1, 2024.

Care Coordination & Waitlist Management

The Patient Management Unit (PMU) centralized patient pre-admission processes in June 2017 to ensure the placement of patients in the most appropriate setting based on clinical and safety needs. Prior to this, courts could order commitments to any DSH hospital, creating admission backlogs and inefficiencies.

The Budget Act of 2022 implemented a vertical case management model for IST patient placement, using small teams comprised of clinical and analytical staff dedicated to specific counties, with the goal of building relationships with county stakeholders and using a patient-centered approach to place patients in the most appropriate level of care based on bed availability. Under this new model, PMU clinical staff complete patient intake upon receipt of commitment. Along with clinical and medical intakes[7], placement decisions are based on patient eligibility, charging, medical exclusions, and each individual's position on the waitlist, in addition to availability of DSH placement options in the hospitals and outpatient programs (i.e., EASS, Diversion, and CBR).

In the 2023-24 May Revision, DSH reported a new monthly average of 488 referrals were received in FY 2022-23: an 18% increase from prior year. The Budget Act of 2023 authorized 5.0 positions using IST Solutions savings to support Care Coordination

[7] Penal Code (PC) 1370 requires the courts and county sheriffs to remit health record information, commitment orders, and other relevant documents as specified for each IST committed to DSH to the PMU to facilitate admission.

teams with increased referrals. In the 2024-25 Governor's Budget, DSH reported that Care Coordination had been implemented to serve all 58 counties.

Discharge Planning and Coordination with Counties

DSH undertakes comprehensive discharge planning to support continued patient success when releasing patients from a DSH facility, be it into the community with or without supervision, via transfer to other DSH facilities, or return to court, prison, or jail. Discharge efforts are myriad, including developing treatment goals and objectives with interdisciplinary treatment teams and patients, coordinating community resources (including family and social supports), and partnering with local stakeholders and agencies for further treatment options. Local treatment stakeholders coordinate with DSH to obtain IST patient information in preparation for return to their county, including but not limited to the following[8]:

- CONREP
- County Behavioral Health
- County jails
- Other inpatient or subacute facilities
- Board and Care facilities
- Office of the Public Guardian
- Private conservators
- California Department of Corrections and Rehabilitation (CDCR)

To establish a standardized packet of discharge documents and facilitate a warm handoff of IST patients to their transition location from a state hospital, DSH held a workgroup session in August 2022, with representatives from the County Behavioral Health Directors Association of California (CBHDA) and California State Association of Counties (CSAC).

In the 2024-25 Governor's Budget, DSH reported the creation of a comprehensive four volume training series to enhance the CONREP Discharge Referral process. Discharge and Community Integration (DCI) Specialists are currently providing discipline-specific discharge referral process trainings across all hospitals and serve as points of contact for questions and problem-solving for identified barriers to the successful implementation of the standardized CONREP referral process.

Alienist Training

Through a partnership formed with the Judicial Council in 2022, DSH has sought to develop statewide court-appointed IST evaluator training and workforce development programs, with the objective of improving the quality of IST evaluations performed by court-appointed evaluators. These forensic evaluations determine defendant competency status and serve as the basis for IST commitment to DSH.

[8] Individuals may also be diverted from jail because of dropped or reduced charges and provided supervised release back to the community.

In the 2024-25 Governor's Budget, DSH reported Judicial Council had contracted with the Groundswell Group to develop statewide court-appointed IST evaluator training and workforce development programs, with the objective of improving the quality of IST evaluations performed by court-appointed evaluators.

Felony IST Referral Growth Cap and Penalties

To address the growing IST waitlist, the Budget Act of 2022 enacted WIC section 4336 to establish a growth cap on the number of annual felony IST determinations per county, and implemented a redirection of county funds to be assessed if annual caps are exceeded.

In the 2024-25 Governor's Budget, DSH reported updates to the methodology and rate for the growth cap and implemented a dispute process for potential data discrepancies after discussions with a coalition of county associations representing key IST stakeholders. DSH also released reconciled FY 2022-23 IST Growth Cap data to counties to review, compare to their FY 2021-22 baseline count of IST determinations, and submit any disputes to DSH. DSH anticipated sending final invoices to counties in spring 2024. DSH also requested 2.0 Research Data Specialist (RDS) Is (position authority only) to successfully administer the Felony IST Growth Cap program.

JUSTIFICATION

IST Waitlist

In the 2024-25 Governor's Budget, DSH reported the IST waitlist had declined to 501[9] due to the implementation and expansion of existing IST programs. As of the 2024-25 May Revision, there are 397[10] individuals on the waitlist. This change represents a reduction of 21% from the total waitlist reported in the 2024-25 Governor's Budget. Furthermore, of the 397 individuals on the waitlist pending admission to a treatment bed, 127 are receiving substantive treatment services through EASS or other treatment programs. Only 270 individuals on the waitlist are individuals who are not yet receiving treatment services from a DSH program.

Based on the Alameda Superior Court decision on October 6, 2023, which modified the benchmark deadlines in *Stiavetti v Clendenin,* DSH is required to provide substantive treatment services to IST patients within 60 days as of March 1, 2024. On March 24, 2024, DSH filed a report to the court reflecting its progress in meeting the 60-day benchmark. The report reflected that in February 2024 DSH provided access to substantive treatment services for IST defendants in an average of 12 days with

[9] Data as of January 1, 2024.
[10] Data as of May 6, 2024.

98.2% of individuals receiving substantive services within 60 days. The court's next ordered benchmark is for DSH to provide substantive services within 45-days by July 1, 2024, and the next report to the court showing progress towards this benchmark is due by August 1, 2024.

IST Re-Evaluation Services

In the 2024-25 Governor's Budget, DSH reported a total of 4,817 completed evaluations, of which:

- 3,273 (68%) were found not competent and continued competency restoration treatment
- 1,518 (32%) were found restored to competency
- 26 (<1.0%) were found unlikely to be restored to competency

As of the 2024-25 May Revision, DSH has completed 6,250 evaluations, of which:

- 4,279 (68.5%) were found not competent and continued competency restoration treatment
- 1,943 (31.1%) were found restored to competency
- 28 (<1.0%) were found unlikely to be restored to competency

For individuals found competent following re-evaluation services, DSH has submitted reports to the court regarding restored competency status, allowing those individuals to continue their court proceedings and be removed from the waitlist. Through earlier identification of individuals who are competent, and enabling court proceedings to resume, wait times for individuals still requiring treatment have significantly reduced. Re-evaluation reports also allow the courts to consider different treatment options. The services provided identified approximately 20% of participants as needing IMOs, and approximately 55% as being potentially eligible for Diversion.

With progress in meeting *Stiavetti* substantive treatment timelines, and the expansion of EASS in county jails and community-based programs, the demand for in-jail re-evaluation has slowed. As such, DSH is repurposing IST Re-Evaluation resources to meet increasing demand for IST evaluations in an array of DSH programs. This repurposing accelerates admissions and discharges, which reduces wait times and increases access to care. In the 2024-25 May Revision, DSH continues to deploy these forensic evaluation resources flexibly and strategically to meet IST forensic evaluation needs across its system. DSH will continue to monitor the IST evaluation needs across its programs and services to determine future need for these resources and provide an update in the FY 2025-26 Governor's Budget.

Early Access and Stabilization Services (EASS)

In the 2024-25 Governor's Budget, DSH reported the successful activation of 44 EASS programs, with additional activations planned across the state. In the 2024-25 May Revision, DSH has activated an additional four county programs, bringing the total amount of EASS programs to 48 as of March 15, 2024.

Please see Attachment A for a display of all counties with EASS programs and their activation dates.

As of the 2024-25 May Revision[11], DSH reports the following updates for EASS programs:

- Total patients served: 3,320
- Total patients unenrolled[12]: 3,182
- Total restored while in EASS: 520 (16.3% of those who received services)

DSH continues to pursue standalone EASS county models for those counties preferring to use their county behavioral staff or currently contracted providers; however, operational costs for standalone EASS county models are higher than EASS Programs operated by DSH's contracted clinical providers. Standalone EASS county programs do not utilize DSH's current EASS contracted providers as was originally intended in a regional model, resulting in higher costs. Currently, DSH is in discussions with four counties to develop standalone EASS programs. Final budget negotiations are underway with these counties and DSH estimates these counties will activate in spring 2024. Depending upon final budget negotiations, DSH may need to monitor implementation timelines and assess whether current ongoing funding levels are sufficient to support EASS programs in all other counties and provide an update in the 2025-26 Governor's Budget.

Jail-Based Competency Treatment (JBCT)

DSH continues its efforts to expand the JBCT program and reports the operation of 424 JBCT beds across 24 counties, and in the 2024-25 May Revision, reflects a one-time net savings of $3 million in FY 2023-24, a one-time net savings of $11.1 million in FY 2024-25. The savings are due to activation delays for six counties that were originally planned for phase in by 2024-25 and are now anticipated in FY 2025-26.

[11] Data as of March 14, 2024.
[12] Unenrolled refers to patients no longer receiving EASS services due to competency reached or transfer to another DSH program to continue IST treatment services. Patients who are not restored maintain their place on the waitlist and are admitted to a DSH facility in accordance with their commitment date.

DSH anticipates contract negotiations will be finalized by the 2025-26 Governor's Budget, and will provide an update, including any anticipated savings, at that time.

Please see Attachment B for details on all JBCT program updates, including total capacity and bed rate increases.

Community Inpatient Facilities (CIF)

DSH continues to partner with five different CIF programs for a total of 183 beds throughout California, including: Sacramento Behavioral Healthcare Hospital (SBHH) in Sacramento County; Bakersfield Behavioral Healthcare Hospital (BBHH) in Kern County; Anaheim Community Hospital (ACH) in Orange County; Priorities, Inc. in Sutter County; and Sylmar Health and Rehabilitation Center, Inc. in Los Angeles County. BBHH and ACH are acute inpatient psychiatric facilities while Priorities, Inc. and Sylmar Health and Rehabilitation Center are intermediate care programs that provide full competency restoration services for IST patients.

The following table shows DSH's activated CIF programs and total beds available in each program:

Activated Community Inpatient Facilities			
Facility Name	**Activation Date**	**Total Beds**	**Census as of 3/7/24**
Sylmar	10/30/2023	24	18
BBHH	7/3/2023	29	24
ACH	7/3/2023	36	36
Priorities, Inc.	7/3/2023	16	14
SBHH	4/20/2022	78	55

While the Department continues negotiations with multiple providers interested in partnering with the department to develop new CIFs across the state and continues to seek new potential projects, DSH reported a one-time current year savings of $30 million in the 2024-25 Governor's Budget due to the lengthy negotiation process required to secure the additional contracts in time for a FY 2023-24 program activation.

As of the 2024-25 May Revision, DSH has executed a construction contract with Crestwood Behavioral Health, Inc. for the development of a 36-40-bed MHRC located in Fresno County. The project will remodel an existing building, and activation of the program is expected in early fall 2024.

Due to updated project implementation timelines, DSH proposes to shift $129.5 million from FY 2025-26 to FY 2026-27. DSH continues to work with providers to establish new CIFs across the state and will provide an update in the 2025-26 Governor's Budget.

Expanding Felony IST Community Programing via Community Based Restoration (CBR) and Diversion

DSH was allocated one-time infrastructure funding to expand the number of beds available to patients receiving services through a CBR or Diversion program and support the creation of statewide residential beds to house IST patients. In June 2023, DSH executed a contract with the Advocates for Human Potential (AHP) public consulting firm, and in March 2023, an application portal was opened for counties to submit their requests for proposals (RFPs) for the funding to develop residential housing. To accompany the portal, AHP developed a website which included responses to frequently asked questions, as well as AHP's contact for further information assistance.

In October 2022, January 2023, and June 2023, DSH and AHP hosted three webinars to inform county stakeholders applications would be accepted on a rolling basis through June 30, 2024. As of March 7, 2024, four counties' proposals have been approved, and contract negotiations are underway to develop up to 350 beds to house felony IST defendants participating in Diversion or CBR programs. Additionally, as of March 7, 2024, 29 counties have expressed interest in submitting applications in the future.

AHP has implemented a robust communication plan to reach all counties, respond to questions, remind counties of the funding opportunity, and encourage counties to apply. In March 2024, AHP started hosting bi-monthly "Office Hours" to provide technical assistance to counties and answer questions about the housing opportunity. Counties accepting funding from AHP for this project are required to contract with DSH for a Diversion or CBR program (or both). DSH will provide an update on continued progress in the 2025-26 Governor's Budget.

Los Angeles County CBR and Diversion Program

DSH and the Los Angeles County Office of Diversion and Re-entry executed a contract in Summer 2023 to significantly expand the county's CBR and Diversion program. The new agreement with LA County will expand the program from 515 beds previously designated for its CBR up to a total of 1,344 beds, to be phased in over a 5-year period. The beds will be established at various locations throughout the county across a continuum of settings, including a locked acute psychiatric hospital, a locked IMD or MHRC, and residential facilities with onsite clinical and supportive services. At full activation of all beds, the program will admit up to 840 new (unique) felony IST patients per year in addition to patients residing in beds who may have been admitted in the prior year. The following table shows LA County CBR and Diversion program census from October 2022 through February 2024, and total patients served.

LA County Program	10/31/22 Census	Admissions (11/1/22 – 2/26/24)	Total Patients Served
CBR	450	348	798
Diversion	159	305	464

As of February 26, 2024, LA County has 329 IST patients enrolled in CBR and 291 in Diversion. LA County anticipates it will activate 200 new beds in FY 2023-24, bringing the total beds available in LA County to 825, which will support up to 572 new IST admissions over the course of the year.

Other Permanent Diversion and CBR Program Implementation

Beyond LA County, DSH assumed a number of counties would have secured permanent ongoing contracts beginning in 2022-23 with a phase in of beds and services over a four-year period. As of the 2024-25 Governor's Budget, many of the original 30 counties piloting DSH Diversion programs are still active and planning transition to permanent programs. As part of this planning process DSH partnered with Capstone Solutions Consulting Group to advise DSH on the development of the permanent statewide program structure and assist DSH with better understanding the position of counties in the development of these programs. Capstone is also serving as a liaison between DSH, and counties interested in participating in the permanent program.

On November 9, 2023, DSH informed stakeholders of the permanent program requirements at a Diversion Quarterly County meeting. Counties were provided with fiscal details during this webinar, including information about funding for wraparound treatment services, county overhead costs, risk assessments, court liaison positions, justice partners, and other funding. Counties were also informed of new Diversion and CBR statutory and program requirements and recommendations, and the process and timelines for reporting data to DSH.

A variety of resources were shared with counties during the webinar, including information about three CIFs for ISTs, the DSH IST Re-Evaluation Team which may re-evaluate ISTs in CBR programs, the AHP grant opportunity and the process for applying for the permanent infrastructure funding through June 2024, the Psychopharmacology Resource Network (PRN), and the DSH Diversion and CBR team of psychologists and program staff assigned to each county once a Letter of Intent (LOI) is submitted to DSH and the county enters into a contract with the Department.

As of the 2024-25 May Revision, 24[13] counties have submitted LOIs to execute contracts with DSH to establish a permanent program and serve up to 1,271 IST patients per year. Due to the longer timeline for the permanent diversion program implementation and contract execution, DSH has identified one-time savings in FY 2023-24 of $112.7 million ($45.0 million re-appropriated from the Budget Act of 2022). This assumes an annual patient cost of $125,000 plus an administrative overhead rate of 15% and justice partner costs. Additionally, based upon updated implementation timelines DSH projects an additional one-time savings of $38.8 million in FY 2024-25.

County Stakeholder Workgroup Grants

In December 2022, DSH released information to counties about supporting behavioral health and criminal justice workgroups by offering annual resources. A total of 32 counties submitted Letters of Intent (LOI) to enter into contracts with DSH. As of the 2024-25 May Revision, 32[14] counties have executed contracts with DSH. The 32 counties contracting with DSH for the stakeholder workgroup grants are listed below:

- Butte
- Contra Costa
- Del Norte
- Fresno
- Kern
- Madera
- Mendocino
- Merced
- Mono
- Monterey
- Nevada
- Riverside
- Sacramento
- San Bernardino
- San Diego
- San Joaquin
- San Luis Obispo
- San Mateo
- Santa Barbra
- Santa Clara
- Santa Cruz
- Shasta
- Siskiyou
- Solano
- Sonoma
- Stanislaus
- Sutter
- Tulare
- Tuolumne
- Ventura
- Yolo
- Yuba

Information was re-released to counties by DSH on June 30, 2023, to provide another opportunity for counties to apply for funding. Counties were informed they could submit an LOI by September 1, 2023, to enter into a contract effective January 1, 2024, or submit an LOI by December 1, 2023, to enter into a contract with an effective date of July 1, 2024. As of March 6, 2024, seven additional counties have pending contracts with DSH, as listed below:

- Amador
- Humboldt
- Kings
- Marin
- Mariposa
- Modoc
- Placer

[13] Data as of March 29, 2024.
[14] Data as of March 6, 2024.

As of the May Revision, DSH assumes a one-time savings of $2.6 million in FY 2023-24 for county stakeholder contracts not yet executed. DSH will provide additional updates on new county participation in the 2025-26 Governor's Budget.

Care Coordination & Waitlist Management

In the 2024-25 Governor's Budget, DSH reported Care Coordination had been implemented to serve all 58 counties. In addition to implementing a patient-centered approach to patient placement, for counties with an active EASS program, PMU clinicians are actively liaising with EASS care providers to provide active case management. PMU also convenes a weekly workgroup with stakeholders in LA County to address challenges specific to that county. The LA Care Coordination team has centralized not only pre-admission processing, but transportation scheduling to better troubleshoot issues with county partners. This approach has significantly reduced missed admissions from LA County, lowering wait times and decreasing the number of individuals pending placement specifically from LA County.

In addition to county focused teams, the PMU facilitates and assists with coordinating re-evaluations and schedules transportation to and from all CIFs. DSH will continue to monitor the Care Coordination program activity and provide an update in the 2025-26 Governor's Budget.

Alienist Training

In June 2023, the Judicial Council contracted with the Groundswell Group to develop statewide court-appointed IST evaluator training and workforce development programs, with the objective of improving the quality of IST evaluations performed by court-appointed evaluators. The contractor developed training materials and conducted pilot training utilizing these materials in November 2023. The Judicial Council will conduct advanced training at the Forensic Mental Health Association of California in March 2024. The Judicial Council and DSH established a steering committee to facilitate communication and resolution IST-related topics between DSH and the courts. The Groundswell Group will facilitate these meetings, which will be held quarterly. An update regarding additional training goals will be provided in the 2025-26 Governor's Budget.

IST Solutions Total Request

As of the 2024-25 May Revision, DSH reports an additional one-time savings of $118.3 million in FY 2023-24 ($45.0 million re-appropriated from the Budget Act of 2022), and a one-time savings of $49.9 million in FY 2024-25, due to activation delays in JBCT and Community Based Restoration (CBR)/Diversion programs, and for county stakeholder workgroup grant contracts not yet executed. Additionally, DSH requests to shift

$129.5 million from FY 2025-26 to FY 2026-27 to allow additional time for Community Inpatient Facility infrastructure projects. This will also provide for unforeseen or increased costs to implement solutions or the potential need for additional capacity to respond to the growing referrals. DSH will continue to monitor all IST related programs and provide an update in the 2025-26 Governor's Budget.

Resource Table[15]

Description	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26	FY 2026-27	Ongoing
IST Solutions Current Service Level[16]	$75,000	$489,336	$345,808	$423,939	$591,933	$591,933	$591,933
JBCT Current Service Level	$82,834	$92,573	$106,644	$109,253	$120,353	$120,353	$120,353
CBR Current Service Level	$48,383	$78,358	$74,983	$73,483	$73,483	$73,483	$73,483
Community Inpatient Facilities Current Service Level	$137,609	$88,540	$116,006	$145,526	$274,999	$145,526	$145,526
Re-Evaluation Current Service Level[17]	$13,729	$12,000	$10,176	$10,176	$1,000	$1,000	$1,000
Governor's Budget Request	$0	$0	($58,573)	$0	$0	$0	$0
May Revision Request	$0	($45,000)	($73,300)	($49,900)	($129,473)	$129,473	$0
TOTAL	$357,555	$715,807	$653,617	$771,377	$932,295	$1,061,768	$932,295

[15] Dollars in thousands.
[16] FY 2022-23 One-time of $328,750,000; FY 2023-24 One-time of $160,000,000; FY 2024-25 One-time of $5,000,000.
[17] Pilot program ends June 30, 2025, however, DSH is currently evaluating the future need for resources.

Attachment A

Early Access and Stabilization Services (EASS) Updates	
County	**Activation Date**
Placer	03/11/24
Marin	02/01/24
Siskiyou	12/13/23
Alpine	12/06/23
San Mateo	10/23/23
Yolo	10/18/23
Tehama	10/18/23
San Joaquin	10/16/23
Butte	09/27/23
Inyo	09/15/23
Sacramento	09/01/23
San Luis Obispo	08/23/23
San Diego	08/16/23
Modoc	06/01/23
Mono	04/19/23
Tulare	04/17/23
Colusa	04/12/23
Mariposa	04/01/23
Glenn	03/29/23
El Dorado	02/21/23
Solano	02/01/23
Plumas	01/12/23
Amador	12/19/22
Tuolumne	12/14/22
Lake	12/07/22
San Benito	12/07/22
Riverside	12/05/22
Sutter	12/01/22
Napa	11/16/22
Santa Cruz	11/09/22
Imperial	10/26/22
Del Norte	10/19/22
Humboldt	10/19/22
Lassen	10/17/22

Sonoma	10/17/22
Madera	10/06/22
San Bernadino	09/26/22
Merced	09/19/22
Santa Barbara	09/16/22
Shasta	09/12/22
Nevada	08/31/22
Sierra	08/31/22
Stanislaus	08/29/22
Yuba	08/29/22
Calaveras	08/25/22
Fresno	08/22/22
Ventura	08/03/22
Monterey	07/25/22
Kings	07/18/22

Attachment B

Change from 2024-25 Governor's Budget Total JBCT Capacity and Projected Funding								
JBCT Capacity and Projected Funding								
Program	**Bed Capacity FY 2023-24**	**Bed Capacity FY 2024-25**	**FY24-25 GB Activation/ Expansion**	**FY24-25 MR Activation/ Expansion**	**24-25 GB Per Diem Rate**	**24-25 MR Per Diem Rate**	**2023-24**	**2024-25**
Butte JBCT	10	10	-	-	$491	$491	-	-
Calaveras JBCT	18	18	-	-	$514	$514	-	-
Humboldt	8	8	-	-	$519	$519	-	-
Kern AES	60	60	-	-	$480	$480	-	-
Kings JBCT	8	8	-	-	$546	$546	-	-
Mariposa JBCT	N/A	N/A	-	-	-	-	-	-
Mendocino JBCT	6	6	-	-	$491	$491	-	-
Merced JBCT	9	9	-	-	$566	$566	-	-
Monterey JBCT	13	13	-	-	$491	$491	-	-
Placer JBCT	15	15	-	-	$592	$592	-	-
Riverside JBCT	25	36	Jan-24	Jun-24	$491	$491	($464)	$717
Sacramento JBCT	44	44	-	-	$562	$562	-	-
San Bernardino JBCT	64	64	-	-	$640	$640	-	-
San Diego JBCT	30	40	Jul-24	Jan-25	$491	$491	-	($903)
San Joaquin JBCT	12	12	-	-	$446	$446	-	-
San Luis Obispo JBCT	8	8	-	-	$486	$486	-	-
Santa Barbara JBCT	10	15	Jul-24	Jul-25	$516	$516	-	($942)

Shasta JBCT	8	8	-	-	$474	$474	-	-
Solano JBCT	12	12	Mar-24	R/D	$491	$504	($120)	($301)
Sonoma JBCT	14	14	-	-	$574	$574	-	-
Stanislaus JBCT	18	18	-	-	$490	$490	-	-
Tulare JBCT	15	30	Jan-24	Oct-24	$489	$489	($1,115)	($675)
Ventura JBCT	10	10	-	-	$491	$491	-	-
Yolo JBCT	7	7	-	-	$542	$542	-	-
New Counties Pending Activation	-	104	-	-	-	-	($1,309)	($8,957)
Patients' Rights Advocate Funding	-	-	-	-	-	-	$8	($39)
TOTAL	**424**	**569**					**($3,000)**	**($11,100)**

BCP Fiscal Detail Sheet

BCP Title: Incompetent to Stand Trial (IST) Solutions **BR Name: 4440-068-ECP-2024-MR**

Budget Request Summary

	FY24					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	-73,300	-49,900	0	0	0	0
Total Operating Expenses and Equipment	**$-73,300**	**$-49,900**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-73,300**	**$-49,900**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-73,300	-49,900	0	0	0	0
Total State Operations Expenditures	**$-73,300**	**$-49,900**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-73,300**	**$-49,900**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4430050 - Jail Based Treatment Programs	-3,000	-11,100	0	0	0	0
4430060 - Community Based IST Programs	-70,300	-38,800	0	0	0	0
Total All Programs	**$-73,300**	**$-49,900**	**$0**	**$0**	**$0**	**$0**

BCP Fiscal Detail Sheet

BCP Title: IST Solutions Adjustments **BR Name: 4440-085-ECP-2024-MR**

Budget Request Summary

	FY24					
	CY	BY	BY+1	BY+2	BY+3	BY+4
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	-45,000	0	-129,473	129,473	0	0
Total Operating Expenses and Equipment	**$-45,000**	**$0**	**$-129,473**	**$129,473**	**$0**	**$0**
Total Budget Request	**$-45,000**	**$0**	**$-129,473**	**$129,473**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-45,000	0	-129,473	129,473	0	0
Total State Operations Expenditures	**$-45,000**	**$0**	**$-129,473**	**$129,473**	**$0**	**$0**
Total All Funds	**$-45,000**	**$0**	**$-129,473**	**$129,473**	**$0**	**$0**

Program Summary

Program Funding						
4430060 - Community Based IST Programs	-45,000	0	-129,473	129,473	0	0
Total All Programs	**$-45,000**	**$0**	**$-129,473**	**$129,473**	**$0**	**$0**

STATE HOSPITALS
COUNTY BED BILLING REIMBURSEMENT AUTHORITY
Informational Only

SUMMARY

The Department of State Hospitals (DSH) continues to project no adjustment to its current County Bed Billing Reimbursement Authority.

BACKGROUND

The County Bed Billing Reimbursement Authority is comprised of two main components pertaining to county financial responsibility. These include billings for the Lanterman-Petris-Short (LPS) population and Non-Restorable (NR)/Maximum-Term (MT) Incompetent to Stand Trial (IST) defendants who are not timely transported by and returned to the committing county under specific statutory circumstances.

LPS Population

The LPS population includes civilly committed patients who have been admitted to DSH under the LPS Act (Welfare and Institutions Code (WIC) § 5000 et seq.). The LPS population is referred to DSH by county behavioral health organizations through involuntary civil commitment procedures pursuant to the LPS Act. WIC § 4330 requires counties to reimburse DSH for their use of hospital beds and services provided pursuant to the LPS Act.

IST Non-Restorable (NR) and IST Maximum Term (MT) Population

Pursuant to penal code (PC) §1370, when a state hospital issues a progress report stating there is no substantial likelihood a defendant will recover mental competence, the defendant shall be returned to the committing court, and custody of the defendant shall be transferred without delay to the committing county and shall remain with the county until further order of the court. Pursuant to PC §1370 (b)(1) and §1370 (c)(1), if a county does not take custody of a defendant committed to DSH within 10 calendar days following notification, DSH is authorized to charge counties the daily rate for a state hospital bed. Assembly Bill 133 (Chapter 143, Statutes of 2021) authorizes DSH to charge a county the daily bed rate for each day that a defendant is not transported back to the county and remains in DSH custody.

In the 2024-25 Governor's Budget, DSH reported no adjustments to the current reimbursement authority for fiscal year (FY) 2023-24 or FY 2024-25.

JUSTIFICATION

As of the 2024-25 May Revision, DSH assumes no adjustments to the current reimbursement authority for FY 2023-24 or FY 2024-25.

DSH continues to collaborate with the California Mental Health Services Authority (CalMHSA) to identify opportunities to improve county utilization of the 556 beds made available for treatment of the LPS population through a Memorandum of Understanding (MOU) with the counties. As of the 2024-25 May Revision, the LPS census is 556, as contracted in the MOU, 136[1] of which were ready to transition to a lower level of care, and the LPS referral list currently stands at 285[2] patients referred by the counties.

[1] Data as of February 1, 2024.
[2] Data as of April 8, 2024.

STATE HOSPITALS
WORKFORCE DEVELOPMENT
Informational Only

SUMMARY

As of the 2024-25 May Revision, the Department of State Hospitals (DSH) continues to implement various efforts to address workforce challenges and strategies funded in the 2023 Budget Act to expand and develop psychiatric fellowship and residency rotations.

BACKGROUND

Historically, recruitment and retention have posed a challenge for DSH and have been further exacerbated during the COVID-19 pandemic. While DSH is not alone in its staffing challenges for its healthcare workforce, DSH does present unique challenges for recruitment and retention due to multiple factors. The individuals DSH serves have some of the most difficult to treat behavioral health conditions, many with a significant violence risk level. This, coupled with the geographic locations of DSH facilities and nationwide shortages for the healthcare workforce DSH employs, makes recruitment and retention challenging. Due to these factors, DSH has implemented a multi-faceted approach to recruit and retain staff.

Psychiatric Technician (PT) Programs

The Budget Act of 2019 included ongoing resources to work in conjunction with the Mission-Based Review – Direct Care Nursing proposal to attract and retain a sufficient workforce of trained medical professionals. While nursing level of care classifications vary at DSH, this initiative was focused primarily on recruitment for registered nurses (RNs) and psychiatric technicians (PTs). These two nursing classifications reflect most of the authorized nursing positions at DSH.

DSH's long-term solution to fill vacancies for nursing level-of-care staff is to continue and/or expand partnerships with local community colleges to increase class sizes and/or number of available cohorts, with the goal of producing more RN and PT candidates available to work at DSH hospitals. DSH-Atascadero was approved by the Board of Vocational Nursing & Psychiatric Technicians in March 2020, and in collaboration with Cuesta College, increased the program class size from 30 to 45 students, with two cohorts per year. However, plans to expand these cohorts were significantly impacted during the COVID-19 pandemic. Class sizes were reduced to accommodate spacing restrictions, the number of applications received for these programs dropped, and clinical training sites were limited. DSH-Napa contracts with Napa Valley College which includes the existing two cohorts per year and added an additional six students each, for a total size of 36 students per cohort.

DSH-Napa Psychiatric Residency Program - St. Joseph's Medical Center (SJMC)

The psychiatric Residency Program at St. Joseph's Medical Center (SJMC) was approved for ongoing accreditation in February 2023, and the first cohort of seven residents began their training in July 2021. The program is now in its third year and has three cohorts for a total of 20 residents annually participating. Based on data for Years 1 and 2 Residents, each resident in Year 1 provides two blocks of 160 hours each, totaling 320 hours of care, and each resident in Year 2 provides four blocks of 160 hours each, totaling 640 hours. Over the course of these two years, residents worked a total of 6,720 hours, equivalent to 3.8 personnel years (PYs).

As of the 2024-25 Governor's Budget, DSH had reviewed almost 600 applications and scheduled interviews for the fourth cohort, starting September 2023. DSH was also discussing a possible expansion of the residency program with SJMC.

DSH-Patton Psychiatric Residency Program

DSH received resources in the Budget Act of 2023 to add a second residency program at DSH-Patton based on the successes of the DSH-Napa Psychiatric Residency Program by leveraging established DSH partnerships with community colleges for PT programs.

In the 2024-25 Governor's Budget, DSH reported that the potential partnership with Eisenhower Medical Center to create the new on-site psychiatry training program had dissolved, and DSH has begun to assess alternative options for community partnerships and program accreditation.

Psychiatric Fellowships

The Budget Act of 2023 additionally included resources to expand or develop fellowship programs across all five State Hospitals, with the objective of providing new psychiatrists with specialized training focused on the unique needs of state hospital patients. These forensic fellowships will provide clinicians invaluable opportunities to gain experience and familiarity with forensic populations and provide the Department an opportunity for future recruitment. DSH currently partners with University of California, Davis (UC Davis) to provide training to four forensic fellows a year at DSH-Napa.

Resources received in the Budget Act of 2023 were allocated to expand upon DSH's current forensic fellowships by establishing geriatric psychiatry fellowships, designed to provide the specialized training needed to serve the aging population of DSH patients. These fellowships would establish training sites at DSH-Napa and eventually DSH-Metropolitan; the two facilities currently operating on-site skilled nursing facilities (SNF).

Finally, given a significant percentage of the patient population has a co-occurring substance use disorder, the Budget Act of 2023 provided resources to develop an addiction psychiatry fellowship at DSH-Napa to establish a pipeline of psychiatrists prepared to treat dual diagnoses.

As of the 2024-25 Governor's Budget, DSH was developing various forensic psychiatry fellowship rotation agreements and was discussing rotation opportunities with prospective schools.

Office of Continuing Education and Medical Advancement (CEMA)

The Budget Act of 2023 provided DSH the authority to establish the Office of Continuing Education and Medical Advancement (CEMA), which would oversee Continuing Medical Education (CME) at DSH. CME is an educational requirement for psychiatrists to maintain licensure. Additionally, CME is now a critical component of maintaining board certification for psychiatrists because the American Board of Psychiatry and Neurology (ABPN) recently changed the Maintenance of Certification (MOC) requirement from testing to focus it on CME. DSH has managed a statewide CME program for several years focused on psychopharmacology and forensic topics.

In the 2024-25 Governor's Budget, DSH reported the successful establishment of CEMA, and their work on coordinating with various stakeholders to negotiate agreements for the psychiatric fellowship and resident rotation sites.

Resident Rotations

In the Budget Act of 2023, DSH received resources to increase the amount of rotation opportunities to post-graduate residents. Providing physicians opportunities to gain exposure to the Department and DSH patient populations increases the possibility of attracting future physicians with DSH population experience and affords experience applying that subspecialty knowledge in a large public sector health system.

As of the 2024-25 Governor's Budget, DSH was securing an agreement with Kaiser Foundation Hospital and The Permanente Medical Group, Inc (KP) at DSH-Napa, which was anticipated to be executed by December 2023. Additionally, other agreements with prospective schools were in the early stages of development to expand resident rotations in the new academic year, beginning July 2024.

PROGRAM UPDATE

Psychiatric Technician (PT) Graduation Rates

DSH continues to partner with local community colleges to offer education and training programs to provide an adequate supply of PTs for the state hospitals. The below table displays actual graduation rates from cohorts conducted from calendar year 2020 through Spring 2024 at DSH-Atascadero and DSH-Napa.

DSH-Atascadero

Cohorts	Number of Attendees	Number of Graduates	DSH Hires[1]
2020	60	44	32
2021	60	53	10
Spring 2022	26	17	10
Summer 2022	30	18	15
Fall 2022	33	17	11
Spring 2023	28	22	11
Summer 2023	32	22	22
Fall 2023	30	22	14
Spring 2024	26	16	4

[1] DSH Hires column is subject to change with PT licensure

DSH-Napa

Cohorts[1]	Number of Attendees	Number of Graduates	DSH Hires
Spring 2020	24	16	2
Fall 2020[2]	N/A	N/A	N/A
Spring 2021	30	19	11
Fall 2021	N/A	N/A	N/A
Spring 2022	26	17	4
Fall 2022	17	14	9
Spring 2023[3]	N/A	N/A	N/A
Fall 2023[4]	12	TBD	TBD
Spring 2024	N/A	N/A	N/A

[1] Cohorts with no new students are displayed as N/A
[2] No cohort held due to COVID-19 Restrictions
[3] In the 2024-25 Governor's Budget, number of attendees was erroneously reported as 12 due to point in time issue
[4] Data expected October 2024

DSH-Napa Residency Program Update

The DSH-Napa Residency Program currently has 3 cohorts with 20 residents. As of 2024-25 May Revision, conversations have continued between DSH and SJMC regarding the expansion of the DSH-Napa residency program. DSH-Napa participated in the March 2024/25 match cycle and has matched 10 additional residents into the program starting July 1, 2024, which is an expansion by three residents for this program year from the original planned 7 residents per year.

Residency Program at DSH-Patton

As of the 2024-25 May Revision, discussions have started with DSH-Patton and a prospective university partner to have residency students start in July 2025. The Continuing Education and Medical Advancement (CEMA) is gathering all necessary program information such as number of residents, scope of work, and budget details.

In March 2024, the Accreditation Council for Graduate Medical Education (ACGME) conducted an onsite visit of DSH-Patton as part of their accreditation process. Following the successful meeting, DSH-Patton is now awaiting formal approval of accreditation for the DSH-Patton residency program. DSH will provide an update in the 2025-26 Governor's Budget.

Psychiatric Fellowships

As of the 2024-25 May Revision, DSH has been continuing its work to implement fellowship expansions and fellowship rotation offerings with three universities:

- The Stanford forensic psychiatry fellowship rotation is a statewide contract through June 2026 with DSH-Atascadero as the primary location. Fellows are currently rotating at DSH-Atascadero as an elective.
- The UCLA forensic psychiatry fellowship rotation is a statewide contract in development through June 2026 with DSH-Metropolitan as the primary location.
- The UCSF public psychiatry fellowship rotation is a statewide contract in development through June 2026 with DSH-Napa as the primary location.

While expansions are being finalized, DSH continues with fellowship and resident rotations on existing contracts. Agreement requests at DSH-Patton and DSH-Napa have been submitted, with anticipated completion in FY 2024-25. Additionally, DSH is exploring prospective partners for a DSH Fellowship Program at DSH-Coalinga, while the fellowship program for DSH-Patton has since been converted to a psychiatry fellowship rotation agreement request that is currently in progress with San Mateo County as the prospective partner.

Resident Rotations

As of the 2024-25 May Revision, the agreement with Kaiser Foundation Hospital and the Permanente Medical Group, Inc. (KP) for resident rotations is now anticipated to be executed in Summer 2024. DSH continues with rotations on an existing contract until this contract agreement is finalized.

STATE HOSPITALS
SKILLED NURSING FACILITY (SNF) LEVEL OF CARE NEEDS
Informational Only

SUMMARY

The Department of State Hospitals (DSH) continues to evaluate options to meet the Skilled Nursing Facility (SNF) needs of DSH's aging and high acuity patient population, as the current number of SNF beds remains insufficient to meet the needs of existing and future patients. DSH is anticipating further construction delays of the DSH-Metropolitan SNF building, with completion expected in October 2024. An updated study detailing estimated costs of developing a SNF Unit at DSH-Coalinga is estimated to be completed in July 2024.

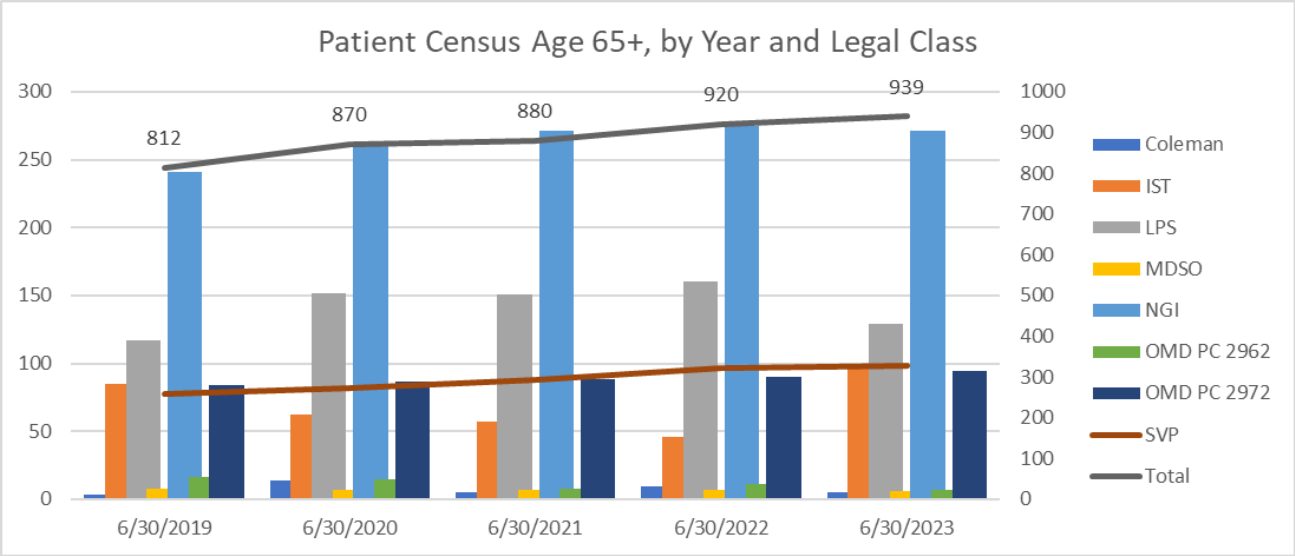
BACKGROUND

As the administrator of the nation's largest inpatient forensic mental health state hospital system, DSH is responsible for the daily care of over 7,000 patients; some of whom, due to either the severity of their mental illness or the crimes they have committed, have long lengths of stay. The following provides by commitment type, the average number of patient days for patients in census at the end of fiscal year (FY) 2022-23.

Commitment Type	Average Patient Days
Coleman/CDCR	107.6
Incompetent to Stand Trial (IST)	131.4
Lanterman-Petris Short (LPS)	2,500.7
Mentally Disordered Sex Offender (MDSO)	4,524.4
Not Guilty by Reason of Insanity (NGI)	4,043.7
Offender with Mental Health Disorder (OMD) PC 2962	310.2
OMD PC 2972	2,580.4
Sexually Violent Predators (SVP)	3,938.5

Mental, physical, and dental health care are provided for patients over the course of their stay at DSH. Depending on a patient's length of stay, their health care may include geriatric, end-of-life care, chronic illnesses, or recuperation from major illnesses or surgery requiring either interim or long-term skilled nursing care.

In recent years, the number of DSH patients aged 65 and over has continued to increase. As illustrated in the graph and table below, DSH has observed an increase of 16% over the last five years in the number of patients aged 65 and over.



While older patients already experience a higher level of prevalence for multiple medical conditions, current research reveals patients with schizophrenia experience accelerated aging and development of age-related illnesses 20 years earlier than expected and suffer from a dramatically decreased life expectancy. As of June 30, 2023, 51% of DSH's population had a diagnosis of schizophrenia. Moreover, mental illness, particularly psychotic spectrum disorders, bipolar disorders, and depressive disorders, are associated with increased prevalence of chronic diseases including asthma, arthritis, cardiovascular disease, cancer, diabetes, and obesity. As of June 30, 2023, 22% of DSH's population had a diagnosis of schizoaffective disorder and 4% had a diagnosis of bipolar disorder.

DSH currently operates three licensed[1] SNF units; two located at DSH-Metropolitan and one at DSH-Napa. As of June 30, 2023, there were 96 active SNF beds at DSH-Metropolitan and 29 at DSH-Napa, for a combined total of 125 active SNF beds. This limited capacity must also accommodate SNF patients transferred from DSH-Atascadero and DSH-Patton. However, due to system limitations, DSH-Metropolitan and DSH-Napa are not able to serve SNF patients committed to DSH-Coalinga as Sexually Violent Predators (SVP).

For DSH-Coalinga, and any other facilities unable to place their SNF patients into one of the three existing DSH SNF units, DSH contracts out with community facilities when possible. However, community options pose challenges which often make placement difficult, including the limited availability of community beds, in addition to the challenge that even when an available bed is identified, many community options are unwilling to accept forensic commitments, particularly those with sexual

[1] SNF beds are licensed and regulated by the California Department of Public Health (CDPH) pursuant to California Code of Regulations (CCR) Title 22, Division 5, Chapter 3. DSH SNF beds are also federally certified by Centers for Medicare and Medicaid Services (CMS) and therefore must also comply with CMS regulations and reporting requirements.

offenses. DSH has taken steps to convert existing Residential Recovery Units (RRU) to meet the increased medical needs of patients with a higher level of acuity. As of May 2023, an additional RRU at DSH-Coalinga was converted to an Intermediate Care Facility (ICF) to accommodate their increasingly geriatric population.

In the Budget Act of 2023, DSH reported three state hospitals were exploring both internal and external options to increase SNF bed capacity, with DSH in collaboration with the Department of General Services (DGS) to develop a study detailing options to operationalize a SNF Unit at DSH-Coalinga.

In the 2024-25 Governor's Budget, DSH finalized and evaluated the study detailing estimated costs of developing a SNF Unit at DSH-Coalinga, recommendations, and alternatives for potential inclusion in future budget requests. Construction progress on the DSH-Metropolitan SNF building roof continued to be impacted by difficulties in acquiring personnel and materials to complete the project. Due to these delays, DSH and DGS expected the SNF building to be completed in March 2024.

PROGRAM UPDATE

As of the 2024-25 May Revision, DSH is continuing to explore solutions to meet the SNF needs of DSH's aging and high-acuity patient population.

An updated study detailing estimated costs of developing a SNF Unit at DSH-Coalinga is currently underway, which will reflect additional options for increasing SNF capacity. The estimated completion date of the updated study is July 2024.

Additionally, construction of the DSH-Metropolitan SNF building interior began in November 2023. As of the 2024-25 May Revision, DSH and DGS anticipate internal restorations to be completed in October 2024, with planned activation in December 2024.

CONTRACTED PATIENT SERVICES
FELONY MENTAL HEALTH DIVERSION PROGRAM (PILOT)
Informational Only

SUMMARY

The Department of State Hospitals (DSH) continues efforts to fully expend the resources allocated as part of the Diversion pilot program by funding and expanding the 28 existing county Diversion programs. As of September 30, 2023, 124 additional individuals have been diverted to county-run programs, bringing the total number of diverted participants to 1,663 DSH will continue to provide status updates on the Diversion pilot program through its completion on June 30, 2025[1].

BACKGROUND

The Budget Act of 2018 provided pilot funding for DSH to develop new Diversion programs by contracting with various counties throughout California to serve individuals with serious mental illness diagnoses, such as schizophrenia, schizoaffective disorder, or bipolar disorder, who have been found or have the potential to be found Incompetent to Stand Trial (IST) on felony charges. In the following years, additional investments in the pilot program have been made to expand its footprint in the state and allow for additional treatment slots.

Funding for Existing County Programs

Of the original funding provided in the Budget Act of 2018, 99.5% was allocated by November 15, 2022, securing contracts with the following 24 counties:

- Alameda
- Contra Costa
- Del Norte
- Fresno
- Humboldt
- Kern
- Los Angeles
- Marin
- Placer
- Riverside
- Sacramento
- San Bernardino
- San Diego
- San Francisco
- San Luis Obispo
- San Mateo
- Santa Barbara
- Santa Clara
- Santa Cruz[2]
- Siskiyou
- Solano
- Sonoma
- Ventura
- Yolo

Diversion Pilot Funding Reappropriation

In the 2023-24 May Revision, DSH requested to reappropriate any remaining contract funds provided in the Budget Act of 2018 to allow counties time to expend the

[1] The Department of State Hospitals (DSH) continues to provide status updates on the Diversion Pilot program, while providing permanent Diversion program updates in IST Solutions (see Section C9).
[2] Santa Cruz program ended October 2022.

remaining balances of their diversion program funding and meet their contracted number of individuals to be diverted under their contracts. This extension was needed due to activation delays of county diversion programs resulting from the COVID-19 pandemic.

FY 2021-22 Pilot County Program Funding

Following the successes of initial efforts, the Budget Act of 2021 provided DSH additional resources to expand the Diversion pilot program to new, currently non-participating counties. In fall 2021, DSH provided intensive technical assistance to aid counties in developing their programs, resulting in five new participating county Diversion programs in Madera, Nevada, San Joaquin, Tulare, and Tuolumne counties. Following the full execution of the contracts, implementation check-in meetings with each of the counties began in fall 2022 to assist county stakeholders with the activation of their Diversion programs.

In the 2024-25 Governor's Budget, DSH reported the five new Diversion programs (Madera, Nevada, San Joaquin, Tulare, and Tuolumne counties) have all activated and begun client enrollment. As of September 30, 2023, Nevada County has enrolled three of eight contracted Diversion clients, while San Joaquin County has enrolled 16 of 26 contracted Diversion clients. Tulare County reported three enrolled Diversion clients out of 13 county spots, and Tuolumne County has reported one out of 15. Madera County has not enrolled any Diversion clients but continues to work through barriers to begin successfully enrolling clients. All programs continue to work actively to identify eligible candidates for program participation.

Expanding Existing County Programs

Also provided in the Budget Act of 2021 were resources to allow participating counties to expand their existing Diversion programs by up to 20% if they met the following criteria:

- Defendants diverted must be found felony IST.
- Diagnostic criteria for entry must include any mental health diagnosis allowed under Penal Code (PC) 1001.36.
- Clients must not pose an unreasonable safety risk to the community.
- A connection exists between the alleged crime and the defendant's symptoms of mental illness or conditions of homelessness.

In the 2024-25 Governor's Budget, DSH reported 20 counties had elected to participate, accounting for 294 new Diversion slots.

Supplemental County Housing Funding

DSH received funds in the Budget Act of 2021 to expand Community Based Restoration (CBR) and Felony Mental Health Diversion (Diversion) programs. As part of the expansion, DSH provided counties with an opportunity to establish new or expand their existing diversion programs by offering Supplemental County Housing funds for diverting and providing housing services to clients found incompetent to Stand Trial (IST) per Penal Code §1370 and on the DSH waitlist. As of the Budget Act of 2023, 17 counties participated in the program and received Supplemental Housing funds for diverting and providing housing services to clients on the DSH waitlist.

In the 2024-25 Governor's Budget, DSH reported that 17 counties participating in the program have billed for a total of $5.8 million in Supplemental Housing. As of March 8, 2024, the 17 counties have billed for a total of $10.8 million in Supplemental Housing.

PROGRAM UPDATE

Ongoing Technical Assistance and Support

In July 2023, DSH began holding monthly meetings with all pilot counties to hear about any barriers they may be facing and to provide support and technical assistance. DSH is currently assisting geographically smaller counties, who have expressed difficulties with receiving referrals and placement, due to the assignment of new judges or public defenders lacking knowledge of the requirements for IST placement. DSH continues to navigate these barriers by educating judicial officials on the referral process for IST Diversion. DSH continues to provide technical assistance to the counties and coordinates monthly meetings with them to assist with any barriers they may be experiencing.

DSH also continues to work with all counties to improve the quality of reported data, by analyzing the data submitted from all 28 participating Diversion counties. Currently, DSH collects Diversion data from participating counties every quarter. Counties who struggle to complete reports timely and accurately are provided with additional support to help with any barriers they may be facing.

DSH is in the process of developing the permanent Diversion program funded through the IST Solutions in the Budget Act of 2022 and the contract language will include updated requirements regarding counties' data reporting, including providing data to DSH monthly rather than quarterly as it currently occurs in the Diversion Pilot program. This change will allow DSH to conduct a well-timed review of data submitted to DSH and provide DSH with an opportunity to reach out to counties to resolve discrepancies sooner.

Diversion Pilot Program Data Collection Efforts and Research

As of September 30, 2023, 1,663 eligible individuals have been diverted to a county-run program. DSH continues to work with all counties to ensure the quality of data collected. The following table provides a high-level snapshot of Diversion program participants:

Diversion Program Participant Descriptive Data		
Program Information	**Total Number**	**Percentage**
Total Enrolled as of 9/30/2023	1,720	100%
Total Ineligible	57	3.3%
Total Eligible	1,663	96.7%
At Risk vs. IST	**Total Number**	**Percentage**
At risk of IST	625	37.6%
IST	1,038	62.4%
Waitlist	**Total Number**	**Percentage**
Removed from DSH Waitlist	724	43.5%
Diagnosis	**Total Number**	**Percentage**
Schizophrenia	674	40.5%
Schizoaffective Disorder	537	32.3%
Bipolar Disorder	331	19.9%
Unspecified Schizophrenia Spectrum and Other Psychotic Disorder (OPD)	96	5.8%
Other	25	1.5%
Ethnicity	**Total Number**	**Percentage**
White	432	26.0%
People of Color	1,231	74.0%
Gender	**Total Number**	**Percentage**
Male	1,094	65.8%
Female	557	33.5%
Other	12	0.7%
Living Situation at Arrest[3]	**Total Number**	**Percentage**
Homeless	1,333	80.6%
Not Homeless	322	19.4%
Felony Charges	**Total Number**	**Percentage**
Assault/ Battery	545	32.8%
Theft	289	17.4%
Robbery	218	13.1%
Miscellaneous (primarily Vandalism)	175	10.5%
Criminal Threats	133	8.0%
Arson	124	7.5%

[3] Seven participants in San Francisco and one in Santa Clara County did not provide all data for this section in their quarterly reports.

Other (primarily weapons, drugs, FTR)	104	6.3%
Obstruction of Justice	46	2.8%
Kidnapping	29	1.7%

Diversion Pilot Program Outcome & Predictive Data (As of 9/30/2023)

Since the launch of the pilot in 2018, enrollment in Diversion has steadily increased. Using data collected throughout the pilot, DSH can analyze and share participant predictor data outcomes and assess program impacts. Using data as of September 30, 2023, from all participating counties, DSH was able to analyze the outcomes of the 1,663 eligible Diversion participants. Of these participants, only 1,621 were included for analysis in the data tables due to several factors. The 42 clients that were not included met eligibility criteria and started their respective Diversion programs but were terminated for a variety of reasons such as: the client being transferred to another program, judicial reasons unrelated to Diversion, or the occurrence of death prior to the completion of the program.

The following tables use the dataset described above to display predictors of status in the program:

Current Status		
	Total Number	**Percent**
Still In	758	46.8%
Revoked/AWOL/Re-incarcerated	483	29.8%
Successful Completion	380	23.4%
Total	**1,621**	**100%**
Length of Stay by Current Status		
	Average	
Still In (as of 9/30/2023)	339.56	
Revoked/AWOL/Re-incarcerated	204.10	
Successful Completion	627.08	
Risk Assessment[4] Conducted		
	Total Number	**Percent**
Yes	546	70.0%
No	234	30.0%
Total	**780**	**100%**
Development of Treatment Plan[5]		
	Total Number	**Percent**
Intensive evaluation[6]	655	86.3%

[4] Clinical assessment designed to evaluate an individual's risk of violence.
[5] Individualized course of treatment and interventions based on specific patient needs.
[6] The use of various disciplines, including psychiatry, to evaluate a patient's needs and the best course of treatment to meet those needs.

Formal RNR assessment[7]	82	10.8%
Both	22	2.9%
Total	**759**	**100%**

Diversion Program Participant Outcome Data		
Incompetent to Stand Trial	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
IST	162 (35.9%)	289 (64.1%)
At risk of IST	218 (52.9%)	194 (47.1%)
Homeless	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
Yes	286 (40.8%)	415 (59.2%)
No	94 (58.4%)	67 (41.6%)
Abuse of Substances	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
Yes	306 (41.9%)	425 (58.1%)
No	68 (59.6%)	46 (40.4%)
Methamphetamine Use	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
Methamphetamine	160 (33.5%)	317 (66.5%)
No drug use/Other drugs	212 (57.9%)	154 (42.1%)

DSH's Diversion program participant outcome data is dynamic and unpredictable. Throughout the pilot, tracking indicators and data in various subgroups (e.g., 'IST' versus 'at risk of IST') have changed over time. Even modest changes within the dataset of smaller numbers can have a high impact on results and determined conclusions. Additionally, data collected from the 28 participating counties, each from very disparate areas of the state with their own diverse populations, have expanded the characteristics of the sample data collected; a trend which continues as additional counties pursue Diversion programs.

As additional counties begin Diversion participation, the sample data from various subgroups may change proportionately to previous data. These observed fluctuations are likely to continue through the end of the pilot phase of the DSH Diversion program, resulting in dynamic changes in the outcomes when compared to previous quarters. DSH strives to improve upon the operational definitions of the

[7] Structured assessment to determine what factors elevate a patient's risk of reoffending or responding poorly to treatment, how to minimize those risk factors for the patient through a treatment plan, and how to adjust the treatment plan over time as a patient's risk factors change.

data and refine data collection prior to the permanent program implementation to account for these dynamic fluctuations. FY 2024-25 will be the final year of the DSH Diversion pilot.

FORENSIC EVALUATION SERVICES
SEX OFFENDER COMMITMENT PROGRAM AND OFFENDERS WITH A MENTAL HEALTH DISORDER (SOCP/OMD) PRE-COMMITMENT PROGRAM
Informational Only

SUMMARY

The Department of State Hospitals (DSH) continues to monitor the Sexually Violent Predator (SVP) and Offenders with a Mental Health Disorder (OMD) referral trends. In the 2024-25 Governor's Budget, DSH projected to receive 410 SVP and 1,924 OMD referrals in fiscal year (FY) 2023-24. As of the 2024-25 May Revision, DSH now projects to receive 580 SVP and 2,018 OMD referrals in FY 2023-24.

BACKGROUND

Prior to an individual's release from California Department of Corrections and Rehabilitation (CDCR), statute requires DSH to provide forensic evaluation services[1] to determine if the individual needs treatment in a state hospital as an SVP or OMD upon release from prison. DSH administers these services through the Sex Offender Commitment Program (SOCP) and the OMD Program. DSH employs a team of Consulting Psychologists, SVP Evaluators, and contracted forensic psychologists to provide the forensic evaluations. The forensic evaluator staffing allows DSH to complete the volume of interviews, evaluations, forensic report development, and expert witness and court testimony services required. The number of CDCR referrals for potential SVP and OMD commitments to DSH is the primary driver of the workload. Additional workload may include, but is not limited to the following:

- Completing update and replacement evaluations and report addendums, as required by the court.
- Completing recommitment evaluations in accordance with WIC 6604.
- Completing independent evaluations to resolve differences of opinion (DOP) for SVP evaluations, as required by statute.
- Developing and maintaining a robust quality assurance program, including data analytics, to target evaluators' training and/or support needs.
- Developing and implementing standardized assessment protocols, policies, and regulations.
- Preparing for, and participating in, expert witness and court testimony.

[1] DSH continues to rely on the existing video conferencing infrastructure throughout the state. This has allowed DSH to conduct most forensic evaluations and provide much court testimony virtually, significantly reducing travel costs for SVP and OMD evaluations.

SOCP Program

In accordance with WIC 6601(b), CDCR and the Board of Parole Hearings (BPH) are responsible for screening CDCR inmates to determine whether an individual is likely to be an SVP. If CDCR and BPH determine an individual is likely to be an SVP, BPH refers the individual to DSH for forensic psychological evaluation. For those referred, statue requires DSH to complete two forensic psychological evaluations to determine if the individual meets the statutory criteria for civil commitment as an SVP. In addition, the statute requires DSH to refer cases in which evaluations indicate an individual meets criterion to the county District Attorney's Office no less than 20 days prior to the individual's release from prison. In the 2024-25 Governor's Budget, DSH reported that between August and November 2023, DSH had averaged 57 referrals per month, nearly doubling the 30 average referrals per month received between January and July 2023.

OMD Program

Pursuant to Penal Code (PC) 2960–2981, CDCR evaluators conduct a forensic evaluation of inmates who have been in CDCR mental health programs and who have a violent commitment offense prior to the individual's release on parole. If the CDCR evaluator determines the inmate has a severe mental health disorder and could meet the criteria for OMD commitment, CDCR refers the inmate to DSH for an additional forensic evaluation. The CDCR Chief Psychiatrist then reviews the reports to determine if the inmate meets the criteria for commitment as an OMD. If the Chief Psychiatrist certifies the criteria are met, BPH transfers the inmate to a state hospital for treatment as a special condition of parole. In the 2024-25 Governor's Budget, DSH reported OMD referrals had slightly declined and projected a total of 1,924 OMD referrals for FY 2023-24.

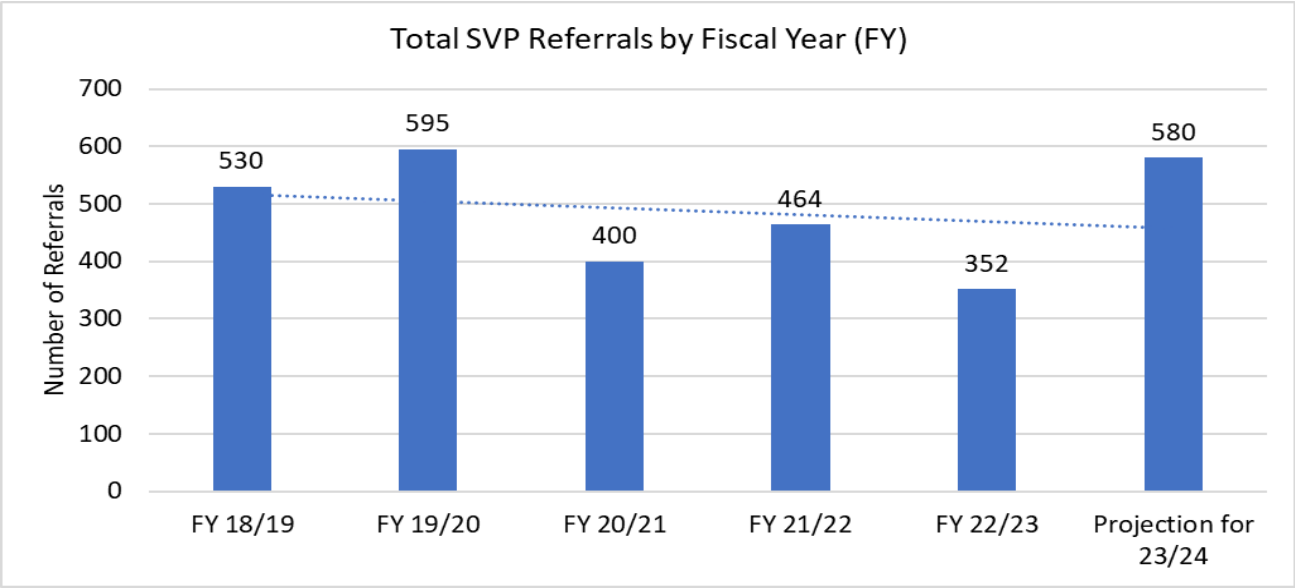
PROGRAM UPDATE

SOCP Program

In the 2024-25 Governor's Budget, DSH reported that FY 2023-24 had seen a dramatic increase over FY 2022-23 SOCP referral rates, nearly doubling in the amount received per month.

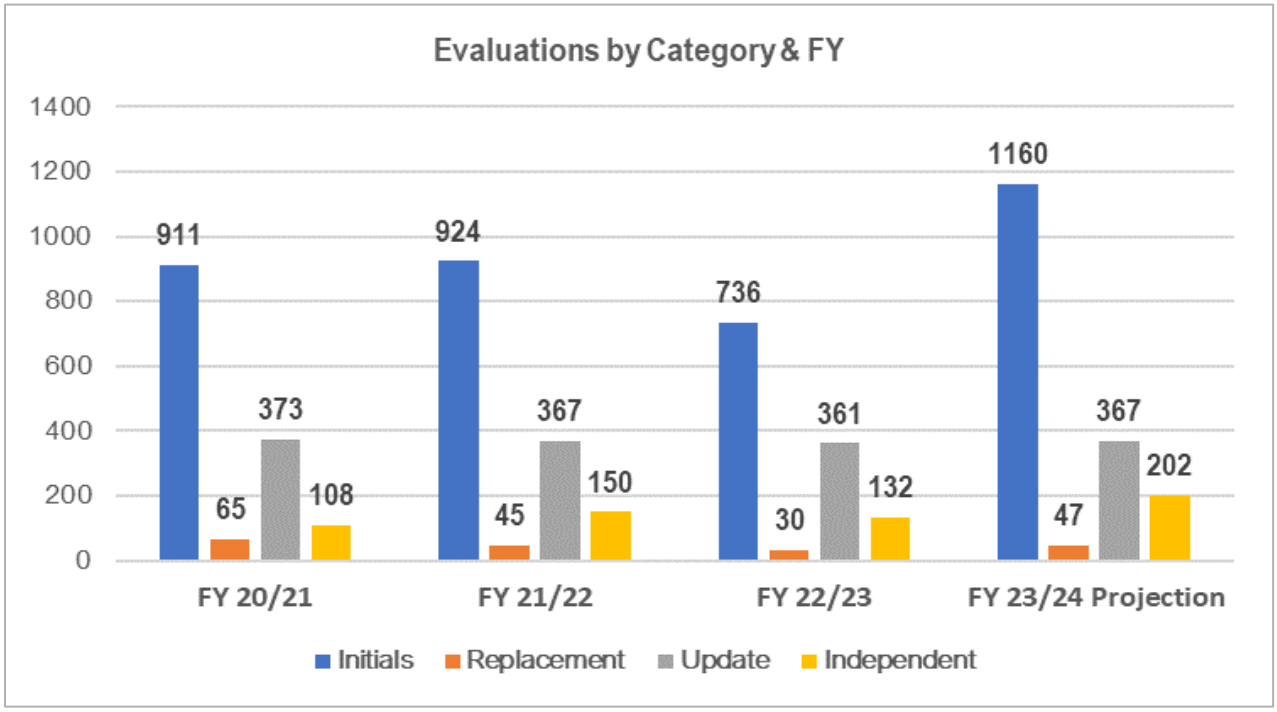
As of the 2024-25 May Revision, DSH can report that between July 2023 and February 2024, DSH received an average of 48 referrals per month, which is 65.5% higher than the average 29 referrals per month received between January and June 2023. Based on these trends, DSH now projects a total of 580 SVP Evaluation referrals for FY 2023-24. Each referral requires two evaluations further increasing the workload for each referral received.

Please see the chart below for the total SVP referrals received by fiscal year, from FY 2018-19 through FY 2023-24.



DSH continues to monitor potential for surges of SVP referrals on a weekly basis in collaboration with CDCR and Board of Parole Hearings (BPH). The increase of SVP referrals is due to changes in sentencing laws. These statute changes are resulting in the resentencing of eligible individuals serving prison terms, yielding in the earlier release of an increased number of individuals from prison who meet the criteria to be evaluated in accordance with the SVP Act. Since SVP referrals continue to vary, DSH must maintain sufficient resources until the trend stabilizes to ensure enough resources are available to meet statutory requirements. DSH will continue to monitor SVP referral trends and provide an update in the 2025-26 Governor's Budget.

Please refer to the chart below which displays the total number of evaluations by category, from FY 2020-21 to the projection for FY 2023-24.

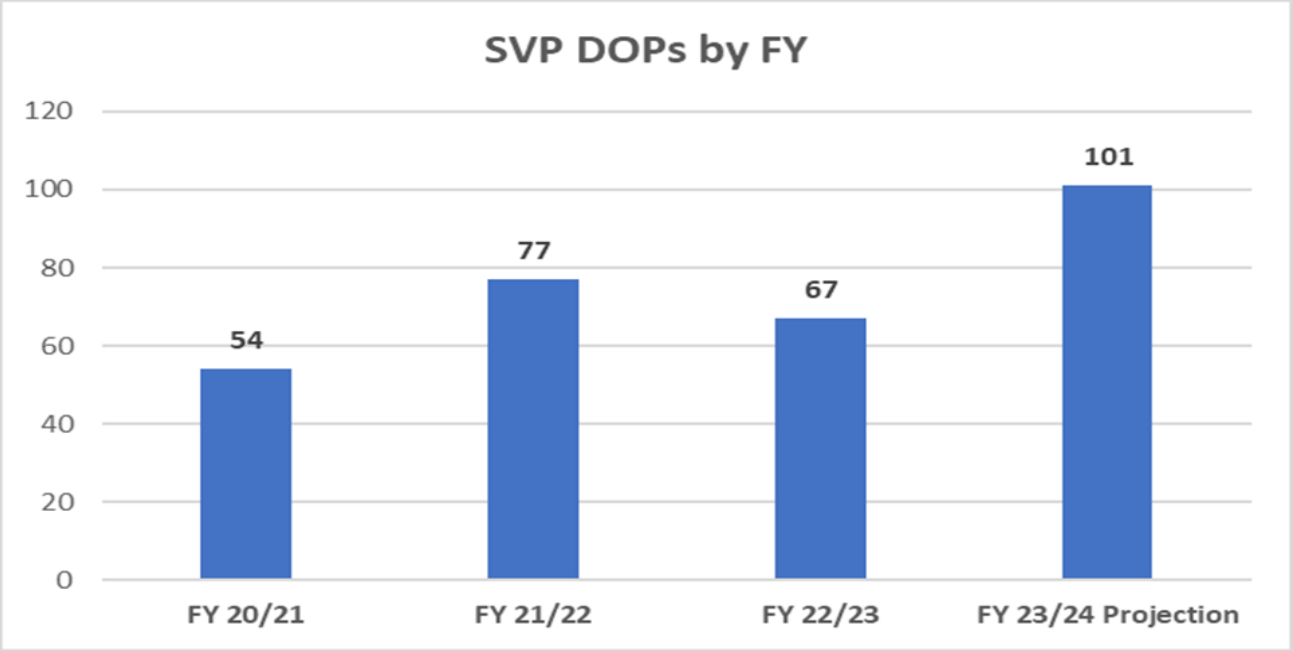


For FY 2022-23, there was a decrease in initial evaluations due to the lower amount of SVP referrals received. However, based on the projected increase of SVP referrals for FY 2023-24, initial evaluations are projected to increase.

Update evaluations are also likely to rise for FY 2023-24 due to an increase in the number and backlog of SVP cases awaiting trial requiring an updated evaluation. DSH will continue to monitor the rate of update referrals requested by justice partners and provide an update in the next caseload estimate. Additionally, in FY 2022-23 DSH evaluators testified in 385 SVP court cases. The workload involved in providing testimony for probable cause hearings and jury trials is equal to approximately two SVP evaluations as each court case includes at least two evaluators and requires four in the case of a difference of opinion (DOP).

For each SVP referral received, DSH performs a minimum of two initial evaluations. When there is a DOP between two forensic civil service evaluators initially assigned by DSH to perform SVP evaluations, DSH is statutorily required to assign two additional independent evaluators (who are not state government employees) to assess the individual. In addition, the Forensic Services Division (FSD) performs update evaluations (assigned when a court requests an update of an evaluation on an SVP patient pending trial) and replacement evaluations (assigned when an evaluator is not available to perform an update of an evaluation they performed earlier).

The chart below shows the number of SVP DOP referrals for FY 2020-21 to FY 2023-24 projections.



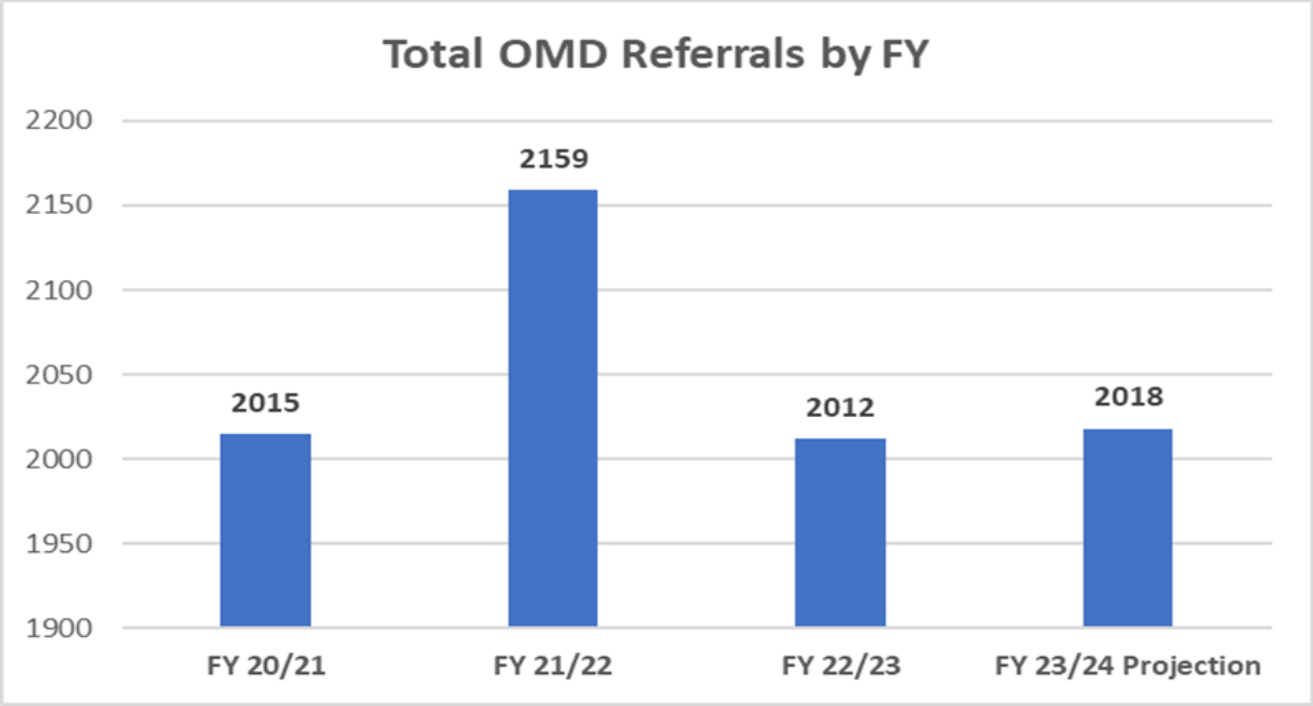
For FY 2022-23, DSH previously projected 80 DOP cases and the actual total received was 67[2]. Based on the average DOP rate of the two prior FYs (17.5% of referrals received) and the total number of 580 projected SVP referrals for FY 2023-24, as of the 2024-25 May Revision, DSH projects a total of 101 SVP DOP cases for FY 2023-2024, up from 72 as projected in the 2024-25 Governor's Budget.

Since FY 2022-23, 132 SVP referrals were received with fewer than 75 days from referral to release date. Of these referrals, 28 became DOPs (resulting in 56 additional evaluations). Referrals received with 75 days or less to release date that become DOPs do not provide adequate time to process the required independent evaluations, which significantly impacts operations resulting in reprioritization of the caseload and overtime in order to meet statutory timelines. DSH is continuing to develop efficiencies to reduce the impact of rush referrals, while coordinating with BPH to send referrals 180 days before the release date, in accordance with statutory requirements.

[2] Revised from 60 as reported in the 2024-25 Governor's Budget.

OMD Program

The following chart provides the total OMD referrals from FY 2020-21 to the projection for FY 2023-24.



In the 2024-25 Governor's Budget, DSH reported that OMD referrals trends were declining, and projected a total of 1,924 for FY 2023-24. As of the 2024-25 May Revision, based on the OMD referrals received between July and December 2023, DSH now projects 2,018 OMD referrals for FY 2023-24, bringing the projection more in line with prior year trends. DSH will continue to closely monitor to determine if the trend changes.

DSH will also continue to work closely with the CDCR and BPH to determine any workload impacts to the SOCP and OMD program and provide an update in the 2025-26 Governor's Budget.

STATE HOSPITALS
CAPITAL OUTLAY BUDGET CHANGE PROPOSALS

Please see the Department of Finance (DOF) website for all Capital Outlay Budget Change Proposals (COBCPs).

POPULATION PROFILE
Penal Code 2684 (*Coleman*) Patients

Description of Legal Class

The Department of State Hospitals (DSH) admits *Coleman* patients pursuant to Penal Code (PC) 2684: Treatment of Prisoners. The *Coleman* patients are California Department of Corrections and Rehabilitation (CDCR) patients, who are transferred from CDCR for inpatient mental health care with the expectation that they will return to CDCR (pursuant to PC 2685) when they have reached maximum benefit from treatment. If they are still mentally ill at the end of their prison term, they may receive further state hospital treatment as an Offender with a Mental Health Disorder (OMD) if they meet the criteria under PC 2962. Additionally, patients who do not meet the criteria pursuant to PC 2962 may be treated at DSH either as a parolee with a mental health disorder pursuant to PC 2974, or as a Lanterman-Petris-Short (LPS) civil commitment.

Legal Statutes and Commitments

- PC 2684 – Coleman Prisoner from CDCR

Requirements for Discharge

The goal of DSH is to provide each *Coleman* patient with the appropriate treatment to stabilize their mental health symptoms and gain the necessary skills to safely transition and reintegrate into the appropriate environment within CDCR. A patient may be eligible for discharge from DSH when the Interdisciplinary Treatment Team determines that the patient has met the requested treatment outcome expectations, the current treatment goals and objectives, and the appropriate continuation of care has been arranged. A patient may be discharged directly into the community when they are institutionally released from CDCR.

DSH Treatment Continuum & Services

The focus of treatment for the *Coleman* population is on psychiatric stabilization. A number of *Coleman* patients are sent to DSH because of complicated presentations, such as complex medical diagnoses, cognitive issues, or developmental disabilities along with mental illness. In addition to psychiatric and medical services, psychosocial treatments are provided with a focus on helping the patient manage their mental illness symptoms and reintegrate back into a prison environment when discharged from the state hospital.

Programs

DSH provides treatment to *Coleman* patients through inpatient care within State Hospitals at DSH-Atascadero, DSH-Coalinga, and DSH-Patton.

DSH Coleman Treatment Programs	
State Hospitals (SH)	DSH's inpatient mental health hospital system provides psychiatric, medical, and psychosocial treatment services to forensic and civil patients housed at Atascadero, Coalinga, and Patton State Hospitals.

Population Data

In fiscal year (FY) 2022-23, the *Coleman* patient population remained relatively stable with an average census of 116 patients in July 2022 and ending with an average census of 114 in June 2023.

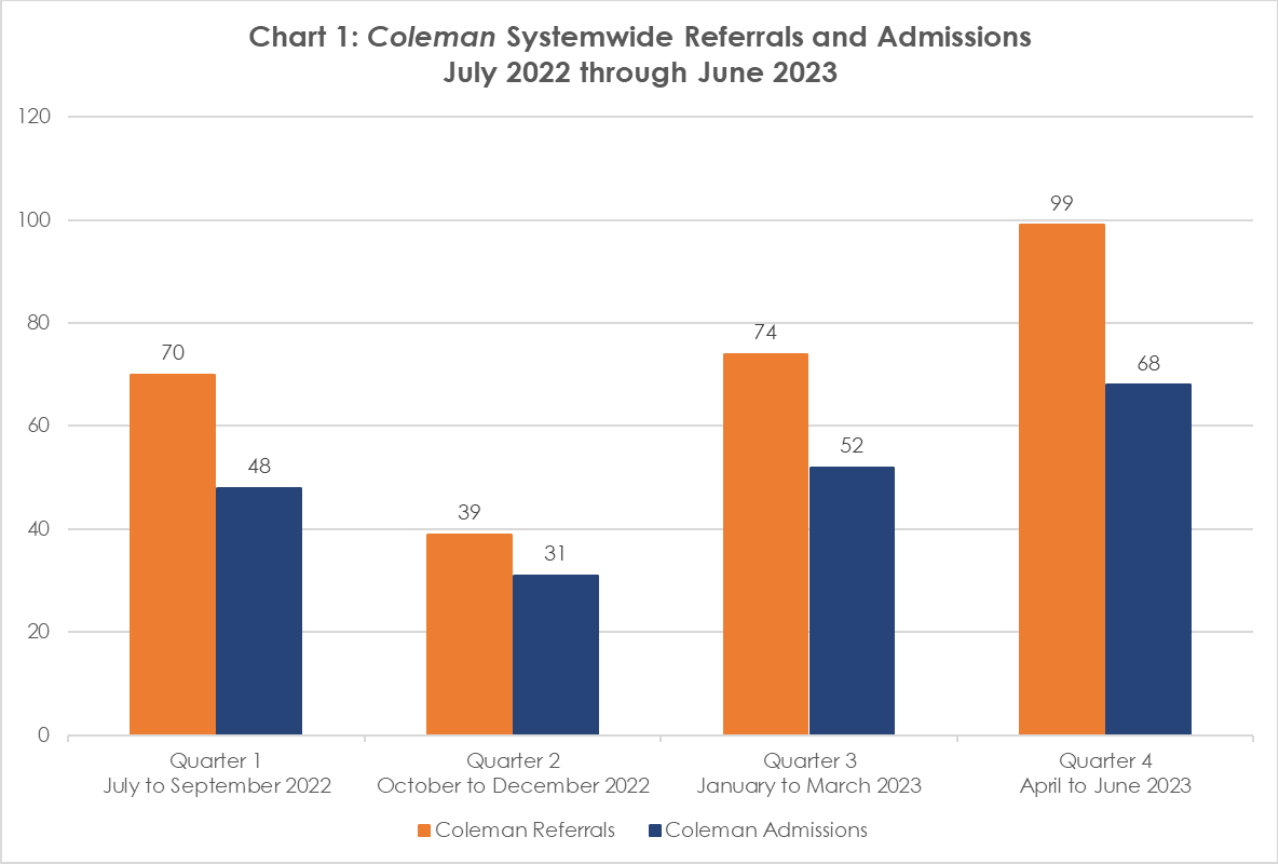
As referenced in Table 1, there were noticeable declines in comparison to prior FY 2021-22 as noted through patients served, average daily census, average length of stay and discharges. Prior FY 2021-22 is an outlier year as there were a number of patients who carried over from FY 2020-21 as a result of the COVID-19 pandemic, which resulted in increased discharges and average length of stays. COVID-19 outbreaks at the State Hospitals and the CDCR prisons in caused *Coleman* patients, who were otherwise ready to discharge, to remain at DSH hospitals until DSH or CDCR quarantines could be lifted. FY 2022-23 data reflects operations that continued to experience COVID-19 outbreaks throughout the year.

The table on the following page summarizes key statistics across the *Coleman* population.

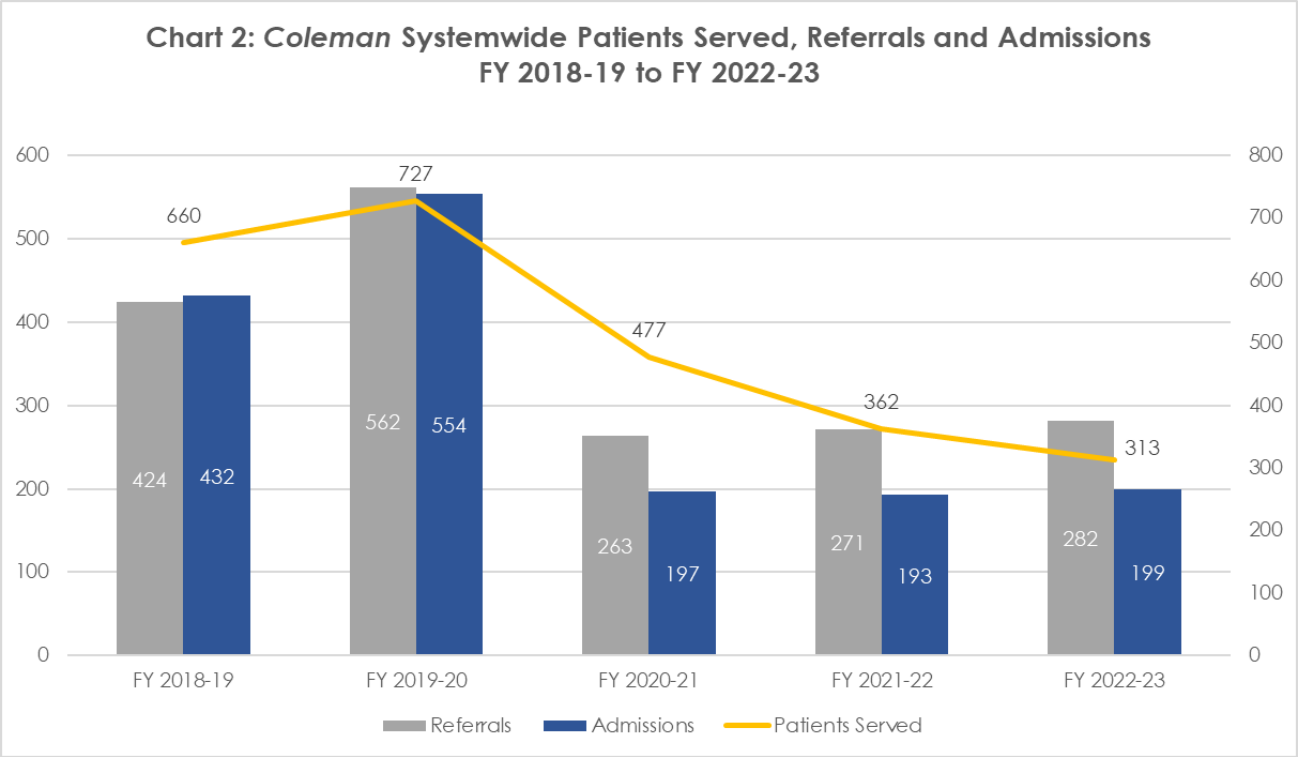
Table 1: *Coleman* Patient Data Summary[1]

***Coleman* Patient Data**	**FY 2021-22**	**FY 2022-23**	**Percent Change from Prior FY**
Patients Referrals	271	282	4%
Admissions	193	199	3%
Patients Served	362	313	-14%
Average Daily Census	160.5	105.0	-35%
Average Length of Stay	288.8	283.8	-2%
Discharges	233	189	-19%

In FY 2022-23, 282 *Coleman* patients were referred to DSH for psychiatric stabilization treatment, an increase of 4% from FY 2021-22. Chart 1 displays *Coleman* systemwide referrals and admissions for FY 2022-23. Chart 2 displays a five-year period of referrals and admissions with a trend line of patients served over the years.



[1] Patient referrals excludes other inpatient program transfers and court returns. Rescinded, rejected, and other cancelled referrals are included. Patient admissions include other inpatient program transfers. Patients served excludes other inpatient program transfers.



The chart above (Chart 2), displays 199 total admissions in FY 2022-23, a 3% growth in admissions from the prior FY. During this time, the Pending Placement List has remained steady with minor fluctuations based on the number of patients referred by CDCR at any given time. All patients referred for intermediate care treatment are subjected to court mandated timelines and must be admitted within 30 days for intermediate care facility referrals and 10 days for acute care referrals, barring any medical holds.

As a result of the CDCR referrals accepted, DSH admitted 199 *Coleman* patients in FY 2022-23 with an average of 17 admissions per month. Chart 3 displays *Coleman* admissions by quarter and the average monthly admissions rate.

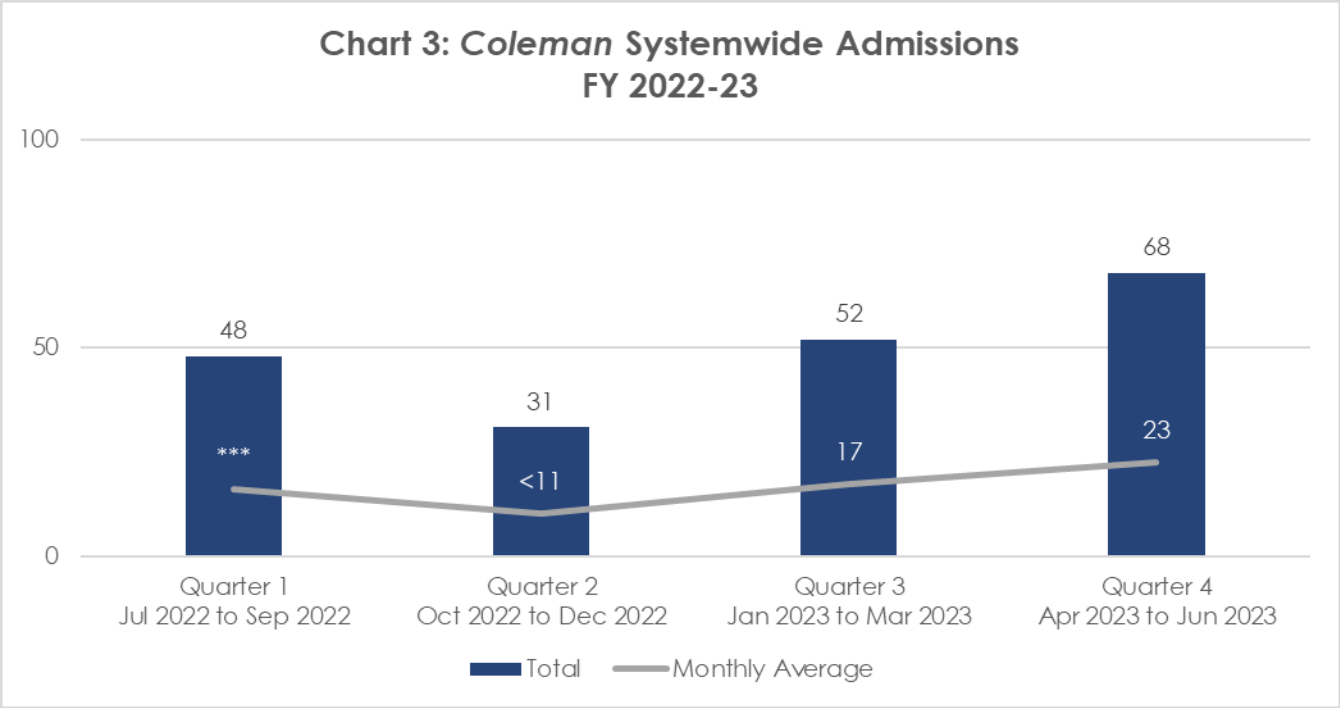


Table 2 below displays the number of patients treated across the year.

Table 2: *Coleman* Patients Served[2]

Patients Treated/ Served	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
	660	727	477	362	313

Discharge Data

DSH discharged 189 *Coleman* patients with an average length of stay of 283.8 days and a median length of stay of 221 days. 16% of *Coleman* patients discharged within the first 90 days of their stay, 40% of the *Coleman* patients discharged within the first 180 days of their stay and 74% of the *Coleman* patients discharged within the first year of their stay. Table 3 displays length of stay by quarter.

Table 3: *Coleman* Patient Length of Stay by Quarter – FY 2022-23

Coleman Length of Stay	Quarter 1 July 2022 to Sept. 2022	Quarter 2 Oct. 2022 to Dec. 2022	Quarter 3 Jan. 2023 to March 2023	Quarter 4 April 2023 to June 2023	Total FY 2022-23
Average Length of Stay	306.6	296.3	298.7	238.4	283.8
Median Length of Stay	220.5	229.0	236.0	220.5	221.0
Discharged Count	45	43	50	51	189

[2] Patients served excludes other inpatient program transfers.

POPULATION PROFILE
Incompetent to Stand Trial Patients

Description of Legal Class

The Department of State Hospitals (DSH) admits individuals found Incompetent to Stand Trial (IST) under Penal Code (PC) section 1370: Inquiry into the Competence of the Defendant Before Trial or After Conviction. Individuals found IST have been accused of felony crimes and are referred to DSH after a court has determined that they are unable to understand the nature of the criminal proceedings or assist counsel in the conduct of a defense. The court commits these defendants to DSH for treatment specifically designed to enable the defendant to proceed with the trial. DSH provides treatment across a continuum of care, which includes inpatient and outpatient settings. Patients receive competency-based treatment and return to county custody once they have regained competency and can effectively assist in their trial proceedings, are determined to be unlikely to be restored to competency in the foreseeable future or are within 90-days of their maximum commitment for competency treatment.

Legal Statutes and Commitments

- PC 1370- Incompetent to Stand Trial
- PC 1370, subdivision (b)(1) – Unlikely to Regain Competency
- PC 1370, subdivision (c)(1) – Maximum Commitment
- PC 1372 – Certificate of Restoration
- PC 1372, subdivision (e) – Continued Treatment Until Trial Commencement

Requirements for Discharge

An IST patient cannot be confined for longer than is reasonably necessary for restoration of competency or determination that competency cannot be restored. The maximum IST commitment time is two years[1]. An IST commitment ends when either: (1) the defendant obtains certification that he or she has regained competency, pursuant to PC section 1372; (2) the maximum time for confinement runs out, pursuant to PC 1370 (c)(1); or (3) DSH determines there is no substantial likelihood a patient will regain competency in the foreseeable future, pursuant to PC 1370 (b)(1). If a patient has not regained competency to stand trial by the end of their IST commitment term or is determined there is no substantial likelihood, he or she will regain competency in the foreseeable future, the patient must be returned to the committing county. Patients may return for further hospitalization under a civil

[1] Effective January 1, 2019, the maximum term for ISTs was reduced from three years to two years, pursuant to SB 1187.

commitment once civil proceedings pursuant to the Lanterman-Petris-Short (LPS) Act have concluded.

As defined in PC 1370(b)(1), a patient may be deemed by their treatment team as unlikely to regain competency. Upon notification to the Sheriff of the county of commitment, the patient must be picked up within ten days and returned to county custody. Often, the county will pursue other means to ensure the patient receives treatment and care, including securing a conservatorship and referring the individual back to the state hospital under a conservatorship commitment.

In the event a patient is nearing their maximum term of commitment, the state hospital, pursuant to PC 1370(c)(1) must notify the Sheriff, who must pick up the patient who is within 90 days prior to the expiration of the commitment term within ten days of notice by DSH. In prior years, DSH noted counties did not consistently retrieve their patients promptly, requiring patients to remain on the census for extended periods. In FY 2022-23, when applying the average length of stay for an IST patient, this practice resulted in a loss of 14 IST patients served between PC 1370 (b)(1) and PC 1370(c)(1) individuals. Assembly Bill 133 amended PC 1372 (a)(3)(C)[2] which specifies that counties will be billed for the costs of care for any patients remaining in a facility beyond ten days from notice to the Sheriff.

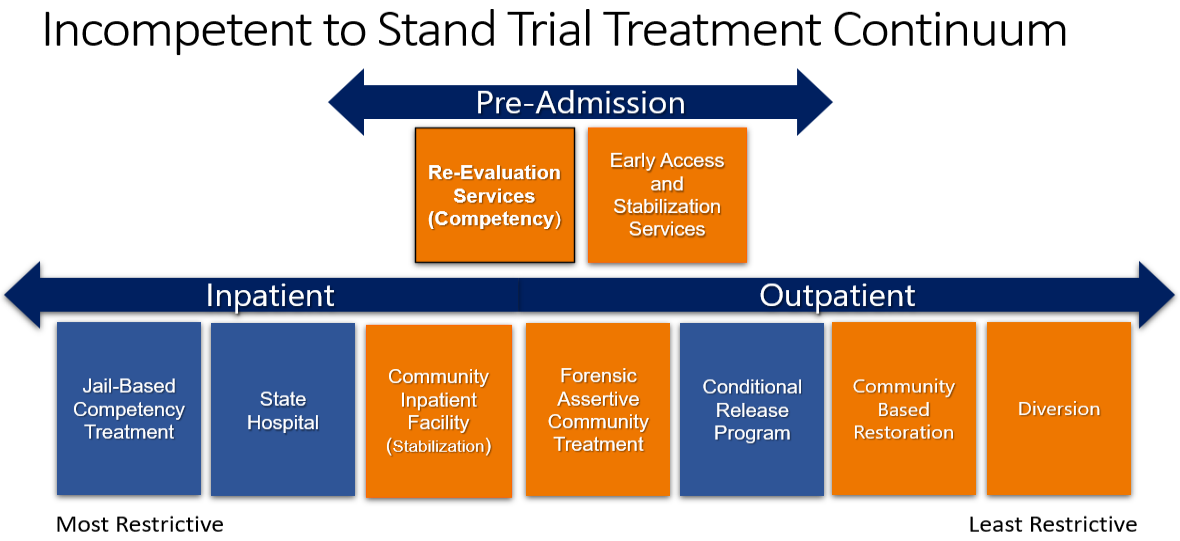
DSH Treatment Continuum & Services

The diagram on the following page depicts the comprehensive continuum of IST services DSH has established and is continuing to build with the recent Budget Act investments. Blue boxes indicate DSH legacy programs which have been part of DSH's continuum for a decade or more, while orange boxes represent newer service options which began implementation in recent years.

Historically, restoration treatment options for individuals deemed IST on felony charges were primarily provided in State Hospitals and Jail Based Competency Treatment (JBCT) programs. In 2018, DSH was authorized to partner with counties to pilot Felony Mental Health Diversion (Diversion) opportunities for individuals deemed IST on felony charges or who were likely to be found IST on felony charges. Additionally, in 2018 DSH was authorized to partner with Los Angeles (LA) County to establish the first community-based restoration of competency program for individuals from LA County who were determined to be IST on felony charges. Utilizing

[2] PC 1372 (a)(3)(C) states, "In all cases, the patient shall be returned to the committing court no later than 10 days following the filing of a certificate of restoration. The state shall only pay for 10 hospital days for patients following the filing of a certificate of restoration of competency. The State Department of State Hospitals shall report to the fiscal and appropriate policy committees of the Legislature on an annual basis in February, on the number of days that exceed the 10-day limit prescribed in this subparagraph. This report shall include, but not be limited to, a data sheet that itemizes by county the number of days that exceed this 10-day limit during the preceding year."

the recent investments made in the Budget Acts of 2021 and 2022, DSH is building upon these initial community-based programs to expand the treatment continuum serving ISTs in the least restrictive community treatment options.



Programs

The following are DSH's IST programs and services, and their corresponding descriptions:

DSH IST Treatment Programs	
Jail Based Competency Program (JBCT)	DSH contracts with a number of California counties, through the local Sheriffs' Offices, to provide restoration of competency services to felony IST patients housed in county jail facilities. These services are provided by the county's chosen mental health provider. The JBCTs are responsible for assessment for competency and malingering, cognitive screenings, re-assessment of competency, and completion and submission of all court reports. Services provided to IST patients include daily clinical contact, group and individual therapy, competency education materials, and clinical support through interdisciplinary teams.
State Hospitals (SH)	DSH's inpatient mental health hospital system provides clinical, medical, and competency restoration treatment services to IST defendants housed at Atascadero, Metropolitan, Napa, and Patton State Hospitals.

Community Inpatient Facility (CIF)	DSH's Institutions for Mental Diseases (IMDs)/Sub-Acute program contracts with community-based locked, inpatient facilities including IMDs, Mental Health Rehabilitation Centers, and acute psychiatric hospitals where individuals deemed incompetent to stand trial receive substantive services in lieu of admission to a State Hospital or JBCT program.
Forensic Assertive Community Treatment (FACT)	FACT Program services are available 24/7 through a mobile treatment team who provides onsite intensive wrap-around services, where the clients live, including psychiatry/medication management, individual and group treatment, as well as case management services and also respond to clients as needed to reduce the likelihood of rehospitalization through de-escalation and crisis intervention practices. DSH has contracted with a provider for minimum of 90 dedicated beds and staff resources for this new treatment option.
Forensic Conditional Release Program (CONREP)	CONREP is DSH's statewide system of community-based services for specified court-ordered forensic individuals. DSH contracts with county and private providers to provide community-based treatment services for individuals committed to DSH, under various commitment types, who have been approved by the court for outpatient treatment in lieu of state hospital placement or for individuals approved by the courts to step down from state hospital treatment to the community. CONREP serves felony incompetent to stand trial patients who have been court-approved for outpatient placement in lieu of State Hospital placement.
Community Based Restoration (CBR)	DSH contracts with counties to operate Community Based Restoration programs where felony IST defendants from the contracted county can receive competency restoration services in a community treatment setting in lieu of a State Hospital or JBCT program.
Diversion	DSH Mental Health Diversion contracts with county-operated programs that allow felony IST defendants with certain serious mental illnesses to participate in intensive community-based mental health treatment. Services include housing, wrap-around support services, and medical evaluation and management with the goal of

	long-term mental health treatment engagement and connection to services. Criminal charges may bedropped for individuals who successfully complete the program. Participating counties are required to connect individuals who successfully complete this program into ongoing community mental health care programs.
DSH IST Services	
DSH Re-Evaluation Services	DSH's Re-Evaluation Program (WIC 4335.2) utilizes expert forensic evaluators to re-evaluate an IST defendant's competency status after the individual has been ordered to DSH while they are pending admission to a DSH IST Program and to determine if the individual needs to continue into an IST treatment program or is competent or has no substantial likelihood to be restored and should be returned to court. If at the time of the evaluation the individual appears to be a candidate for Diversion or outpatient treatment, it makes the recommendation for this consideration.
Early Access and Stabilization Services (EASS)	DSH contracts with county and private providers to provide substantive services including mental health services, psychiatric stabilization, and competency restoration services to felony IST defendants while the individual is in jail pending placement to a State Hospital, Jail Based Competency Program, Diversion or Community Based Program or facility.

The focus of treatment for the IST population is stabilization and restoration of competency.

- Stabilization: Stabilization focuses on medication evaluation and management, including a minimum of monthly visits with program psychiatrists, support with long-acting injectable medication, and daily contact with program staff.

- Restoration of Competence: Restoration treatment includes group psychoeducation, individual therapy, medication evaluation and management, and statutorily required competency to stand trial progress reports that can include a 90-Day, 180-day, etc. status update as well as PC1372 or unlikely to restore court reports.

Throughout treatment, patients are regularly evaluated and, if there is concurrence that a patient is competent, a forensic report (certificate of restoration) is sent to the

court, identifying that the patient is competent and ready to be discharged to the county of commitment where they can resume trial proceedings. Patients must be discharged and returned to the custody of the county of commitment within 10 days of the certificate of restoration filing.

Population Data

System-wide Metrics

In fiscal year (FY) 2022-23, DSH treated 7,618 patients designated as IST. This growth of 29% from prior year, reflects DSH's continuum of care expansion of inpatient and outpatient programs, and a focus of growing census while balancing continued health and safety measures associated with COVID-19. DSH had an average daily census of 2,647 IST patients during FY 2022-23 with a 32% growth from 2,219 IST designated patients in July 2022, to 2,938 in June 2023. In addition, compared to prior fiscal year, average daily census increased overall by 32% in FY 2022-23. The table below summarizes key statistics across the IST population.

Table 1: System-wide IST Patient Data Summary[3]

IST Patient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Referrals	4,979	5,850	17%
Patient Admissions	3,946	5,874	49%
Patients Served	5,919	7,618	29%
Average Daily Census	2,011	2,647	32%

In FY 2022-23 5,850 IST patients were committed to DSH for competency treatment, an increase of 17% from FY 2021-22. Chart 1 displays IST system-wide referrals and admissions for FY 2022-23. Chart 2 displays a five-year period of referrals and admissions, also identifying DSH's increasing number of patients treated annually over the past few years.

[3] Patient referrals excludes other inpatient program transfers and court returns. Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

Chart 1: IST Systemwide Referrals and Admissions
July 2022 through June 2023

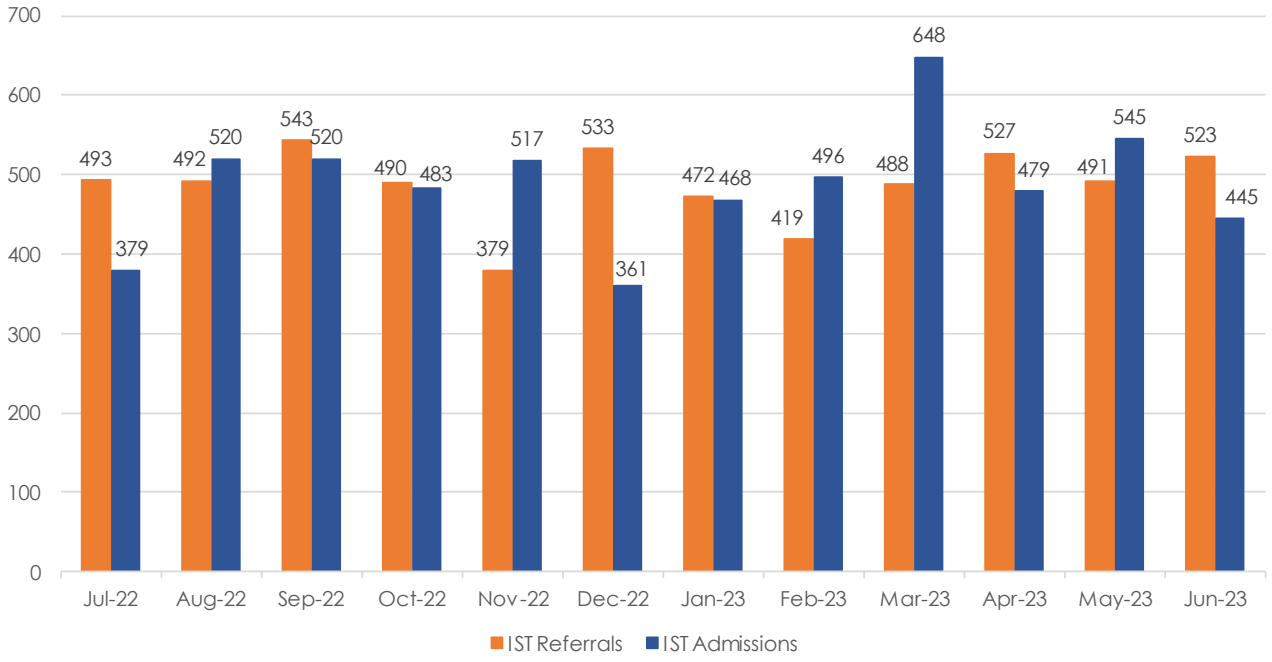
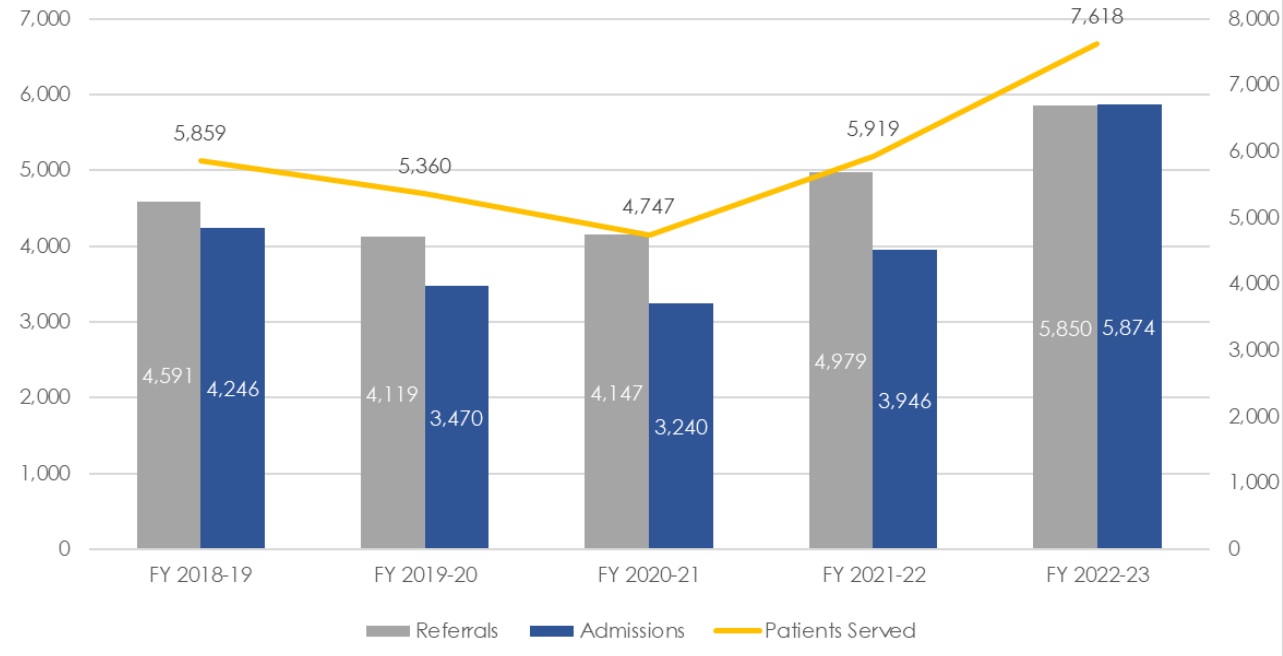


Chart 2: IST Systemwide Patients Served, Referrals and Admissions
FY 2018-19 to FY 2022-23



In FY 2022-23, the IST PPL decreased by 48% from 1,718 patients in July 2022 to 894 patients in June 2023. The primary drivers in reducing the IST PPL have included, expansion of bed capacity, admission rates to inpatient and outpatient programs and patients found competent prior to admission through a re-evaluation of competency while in county jail. The table below, Table 2, identifies the IST pending placement list as of June 30 of the corresponding year.

Table 2: IST System-wide Pending Placement List

IST Patients Pending Placement	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
	849	1,212	1,454	1,779	894

Inpatient Program Metrics

DSH inpatient treatment programs include State Hospitals, JBCT, and Community Inpatient Facilities (CIF). During FY 2022-23 DSH inpatient programs treated on average 1,978 IST patients. July 2022 IST patient average census was 1,603 with a 38% growth to 2,209 IST patients in June 2023.

Table 3: IST Inpatient Data Summary[4]

IST Inpatient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Admissions	3,449	5,253	52%
Patients Served	5,030	6,412	27%
Average Daily Census	1,534	1,978	29%

DSH inpatient programs admitted 5,253 IST patients in FY 2022-23 with an average of 438 admissions per month. Chart 3 displays inpatient program IST admissions by quarter and the average monthly admissions rate.

[4] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

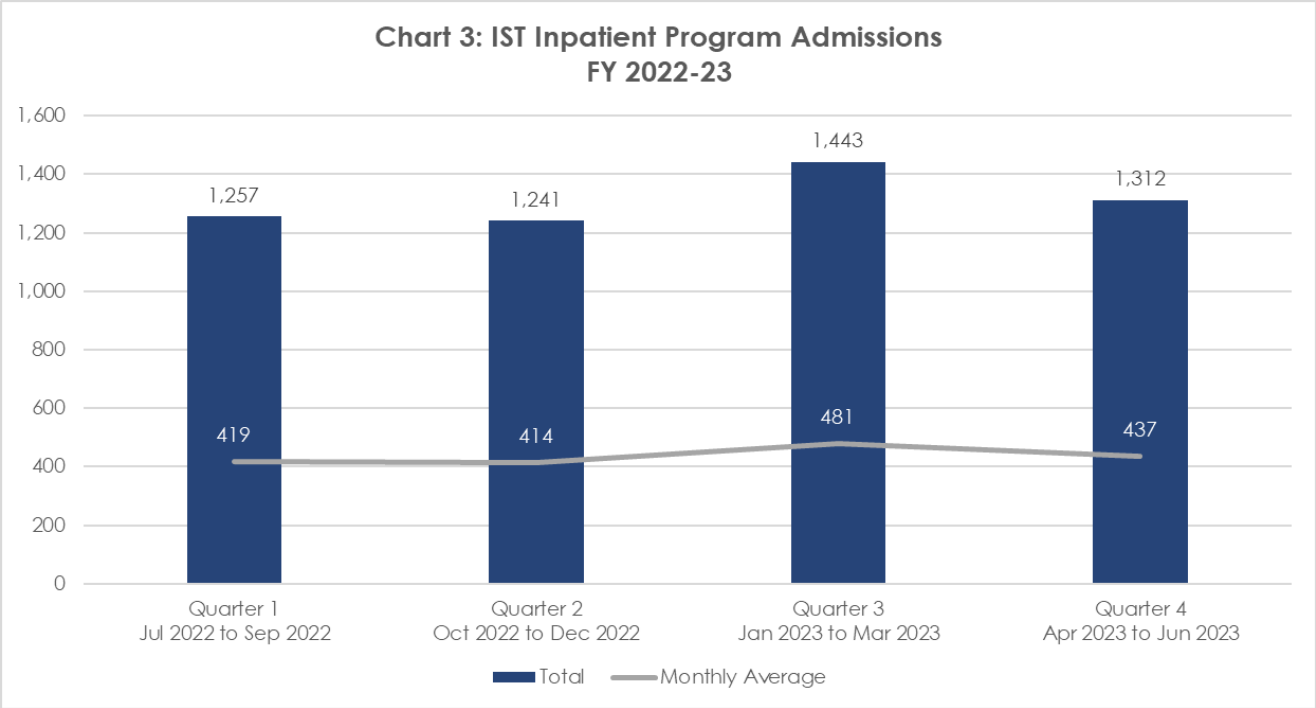


Table 4, below, displays the number of IST patients treated across the year in inpatient programs for the past five years.

Table 4: IST Patients Served – Inpatient Programs[5]

Patients Treated/ Served	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
	5,694	5,090	4,241	5,030	6,412

Inpatient Discharge Data

DSH discharged 4,628 IST patients from inpatient programs with an average length of stay of 134 days and a median length of stay of 107 days across all programs. 40% of IST patients discharged within the first 90 days of their stay, 77% of the IST patients discharged within the first 180 days of their stay, and 95% of the IST patients discharged within the first year of their stay.

[5] Patients served excludes other inpatient and outpatient program transfers.

Table 5: IST Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 90 Days	40%
91 - 180 Days	37%
181 - 365 days	18%
366 - 730 days (1 - 2 years)	5%
731+ days (2+ years)	0%

For patients yet to discharge the average days in treatment is 131.4 days and the median days in treatment is 106 days. Table 6 displays Inpatient programs length of stay by quarter.

Table 6: IST Inpatient Length of Stay by Quarter – FY 2022-23

IST Inpatient Programs: Length of Stay	Quarter 1 July 2022 to Sept. 2022	Quarter 2 Oct. 2022 to Dec. 2022	Quarter 3 Jan. 2023 to March 2023	Quarter 4 April 2023 to June 2023	Total FY 2022-23
Average Length of Stay	132.1	135.1	138.6	130.8	134.0
Median Length of Stay	101.0	106.0	119.0	104.0	107.0
Discharged Count	1,097	1,000	1,184	1,347	4,628

Outpatient Program Metrics

DSH outpatient treatment programs include CONREP, Community Based Restoration (CBR), and Diversion. During FY 2022-23, DSH outpatient programs treated on average 668 IST patients. In July 2022 the IST patient average census was 615 with an 18% growth to 729 IST patients by the end of the FY in June 2023.

Table 7: IST Outpatient Data Summary[6]

IST Outpatient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Admissions	497	621	25%
Patients Served	889	1,206	36%
Average Daily Census	476	668	40%

DSH outpatient programs admitted 621 IST patients in FY 2022-23 with an average of 52 admissions per month. Chart 4 displays IST outpatient program admissions by quarter.

[6] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

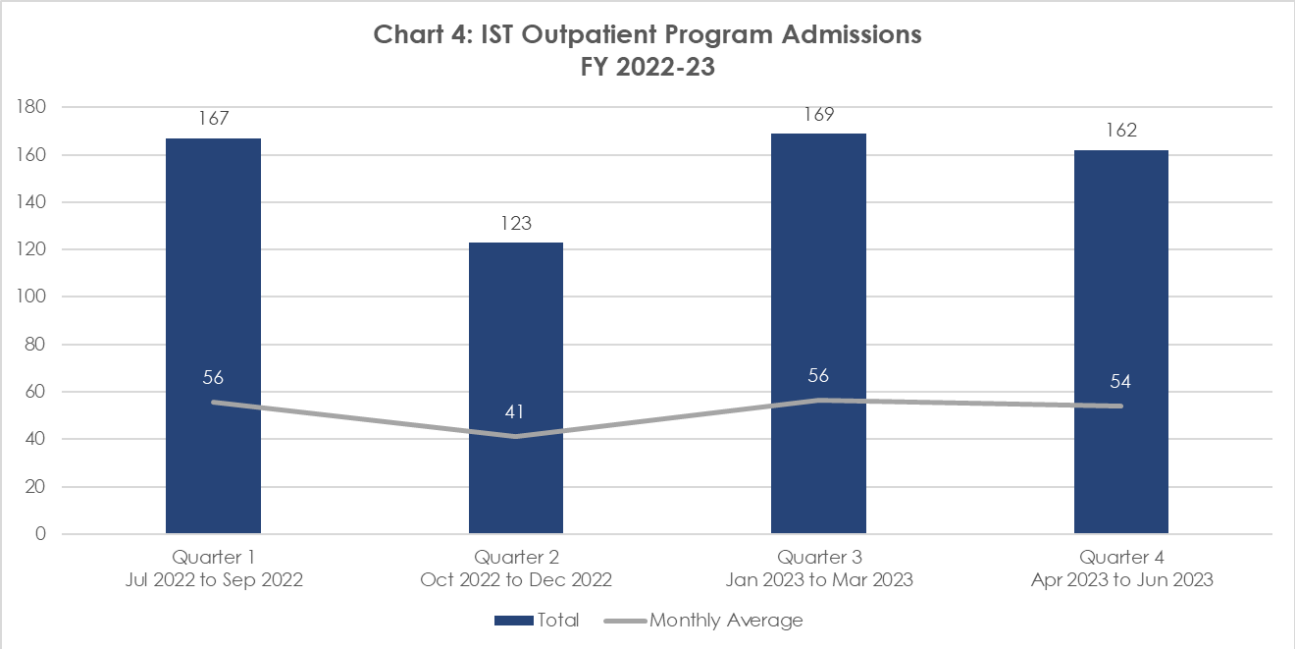


Table 8, below, displays the number of patients treated in outpatient programs within each FY for the past five years.

Table 8: IST Patients Served – Outpatient Programs[7]

Patients Treated/Served	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
	165	270	506	889	1,206

Outpatient Discharge Data

DSH discharged 455 IST patients from outpatient programs with an average length of stay of 409.7 days and a median length of stay of 466 days across all programs. 16% of IST patients discharged within the first 90 days of their stay, 30% of the IST patients discharged within the first 180 days of their stay, and 45% of the IST patients discharged within the first year of their stay.

Table 9: IST Outpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 90 Days	16%
91 - 180 Days	14%
181 - 365 days	15%
366 - 730 days (1 - 2 years)	52%
731+ days (2+ years)	3%

[7] Patients served excludes other inpatient and outpatient program transfers.

Table 10 displays outpatient length of stay by quarter.

Table 10: IST Outpatient Length of Stay by Quarter – FY 2022-23

IST Outpatient Programs: Length of Stay	**Quarter 1** July 2022 to Sept. 2022	**Quarter 2** Oct. 2022 to Dec. 2022	**Quarter 3** Jan. 2023 to March 2023	**Quarter 4** April 2023 to June 2023	**Total** FY 2022-23
Average Length of Stay	354.8	409.8	432.4	418.7	409.7
Median Length of Stay	227.0	508.0	494.0	480.0	466.0
Discharged Count	77	110	129	139	455

IST Services Metrics

Early Access Stabilization Services

During FY 2022-23, DSH's Early Access Stabilization Services (EASS) Program enrolled over 1,400 IST patients with 36 counties actively participating in EASS. The EASS program provided IST services to 1,427 patients during the FY.

Table 11: IST Early Access Stabilization Services Summary by Quarter

IST Early Access Stabilization Services	**Quarter 1** July 2022 to Sept. 2022	**Quarter 2** Oct. 2022 to Dec. 2022	**Quarter 3** Jan. 2023 to March 2023	**Quarter 4** April 2023 to June 2023	**Total** FY 2022-23
IST Substantive Services Initiated	115	392	466	454	1,427
Newly Participating Counties	12	14	5	5	36

Re-Evaluation Services

IST Re-Evaluation Services completed 2,143 evaluations during FY 2022-23. Outcomes resulted in 25% ISTs found competent prior to admission, 74% retain and treat, and less than 1% IST unlikely to restore.

Table 12: IST Re-Evaluation Services Summary by Quarter[8]

IST Re-Evaluation Services	Quarter 1 July 2022 to Sept. 2022	Quarter 2 Oct. 2022 to Dec. 2022	Quarter 3 Jan. 2023 to March 2023	Quarter 4 April 2023 to June 2023	Total FY 2022-23
IST Evaluations Completed	**568**	**607**	**537**	**431**	**2,143**
IST Found Competent	28%	25%	26%	21%	25%
IST Retain and Treat	***%	75%	***%	79%	74%
IST Unlikely to Restore	***%	0.0%	***%	0.0%	<1%

[8] Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. Counts between 1-10 are masked with "<11". Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

POPULATION PROFILE
Lanterman-Petris-Short Patients

Description of Legal Class

The Lanterman-Petris-Short (LPS) population includes multiple civil commitment types of patients who have been admitted under the LPS Act. These patients require physically secure 24-hour care and are committed through civil court proceedings if legal criteria concerning a danger to themselves or others, or grave disability, are met. Certain current parolees or former parolees may also be conserved under LPS commitments. It is also possible for other forensic commitments to convert to LPS commitments, such as if a patient committed as Incompetent to Stand Trial (IST) is found substantially unlikely to regain competence in the foreseeable future but requires ongoing mental health inpatient treatment and the respective county pursues legal conservatorship.

Legal Statutes and Commitments[1]

- PC 2974 – Parolee from CDCR
- WIC 5353 – Temporary Conservatorship
- WIC 5358 – Conservatorship
- WIC 5008(h)(1)(B) – Murphy Conservatee
- WIC 5304(a) – 180-Day Post Certification
- WIC 6000 – Voluntary
- WIC 4825, 6000(a) – Admission to a state hospital of a developmentally disabled individual by their conservator
- WIC 6500, 6509 – A person with a developmental disability committed to a state hospital

Requirements for Discharge

LPS conservatees have not been charged with a crime but are instead referred by local community mental health programs through involuntary civil commitment procedures pursuant to the LPS Act. Those whose psychiatric conditions require a higher level of care and cannot be treated in locked facilities or board and care homes are sent to DSH for treatment. A patient's LPS conservatorship lasts for one year and can be renewed by the court on an annual basis. A new petition for renewal is filed with the court prior to the current conservatorship's expiration.

LPS patients are discharged from DSH when (1) their county of residence places them in a different facility, (2) their county of residence places them in independent living

[1] Legal Statute and Commitments List only includes those applicable to patients treated by DSH in the past five years. Other LPS Act related legal statutes and commitments not typically treated by DSH include WIC 5304(b), WIC 5150, WIC 5250, WIC 5260, WIC 5270.15, WIC 5303, WIC 6506, and WIC 6552.

or with family, or (3) they have successfully petitioned the court to remove the conservatorship.

DSH Treatment Continuum & Services

Under Welfare and Institutions Code (WIC) section 5150, an individual, on probable cause, can be taken into custody for mental health treatment for 72 hours. The individual can then be evaluated for an additional 14-day period of treatment pursuant to WIC 5250. After further evaluation and judicial review, the individual can then be placed on hold or temporarily conserved (T.Cons) for up to 30 days pending a full commitment hearing under WIC 5353 or WIC 5270. If the individual is gravely disabled, they can be placed under conservatorship pursuant to WIC 5350 for one year.

Over the past five years, 85% of all LPS patients treated in DSH were committed under a WIC 5353 or 5358 conservatorship. Table 1 below displays the percent of LPS patients treated in DSH over the past five years by commitment type.

Table 1: LPS Patients Treated by Commitment Type

Commitment Type	Percent of LPS Patients Treated (Past 5 years)
WIC 5353 - Temporary Conservatorship WIC 5358 - Conservatorship	85%
WIC 5008(h)(1)(B) - Murphy Conservatorship	14%
WIC 6000 - Voluntary	0.25%
PC 2974 - Parolee from CDCR	0.25%
Other LPS	0.17%

The focus of treatment for the LPS population is on psychiatric stabilization and psychosocial treatments to reduce the risk of danger to themselves or others and develop basic life skills to function optimally in a lower level of care in the community. Because of the wide diversity of patients under the LPS commitment, discharge criteria differ for each legal statute. Most LPS patients can be treated in the community once the DSH treatment team believes the patient is no longer a danger to themselves or others and the patient's county of residence pursues alternative placement options.

Programs

DSH provides inpatient treatment to LPS patients within the State Hospitals.

DSH LPS Treatment Programs	
State Hospitals (SH)	DSH's inpatient mental health hospital system provides psychiatric, medical, and psychosocial treatment services to forensic and civil patients housed at Atascadero, Coalinga, Metropolitan, Napa, and Patton State Hospitals.

Population Data

System-wide Metrics

In fiscal year (FY) 2022-23, DSH experienced a decrease in the total number of LPS patients treated and in the LPS average daily census, but an increase in LPS referrals and admissions as compared to the prior year. These statistics are summarized in Table 2 below.

Table 2: LPS Patient Data Summary[2]

LPS Patient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Referrals	112	135	21%
Patient Admissions	36	94	161%
Patients Served	835	736	-12%
Average Daily Census	770	637	-17%
Average Length of Stay	1,779	2,353	32%
Patient Discharges	228	245	7%

Even with the increase in admissions, the LPS census decreased by 17% within FY 2022-23 from 707 patients in July 2022 to 590 patients in June 2023[3].

Chart 1 displays LPS system-wide referrals and admissions by quarter for FY 2022-23, and Chart 2 displays a five-year period of referrals and admissions for a broader historical view.

[2] Patient referrals excludes other inpatient program transfers and court returns. Patient admissions include other inpatient program transfers. Patients served excludes other inpatient program transfers.
[3] DSH provides treatment to patients pursuant to the LPS Act through a Memorandum of Understanding (MOU) with California Counties via the California Mental Health Services Authority (CalMHSA), to provide a maximum of 556 treatment beds.

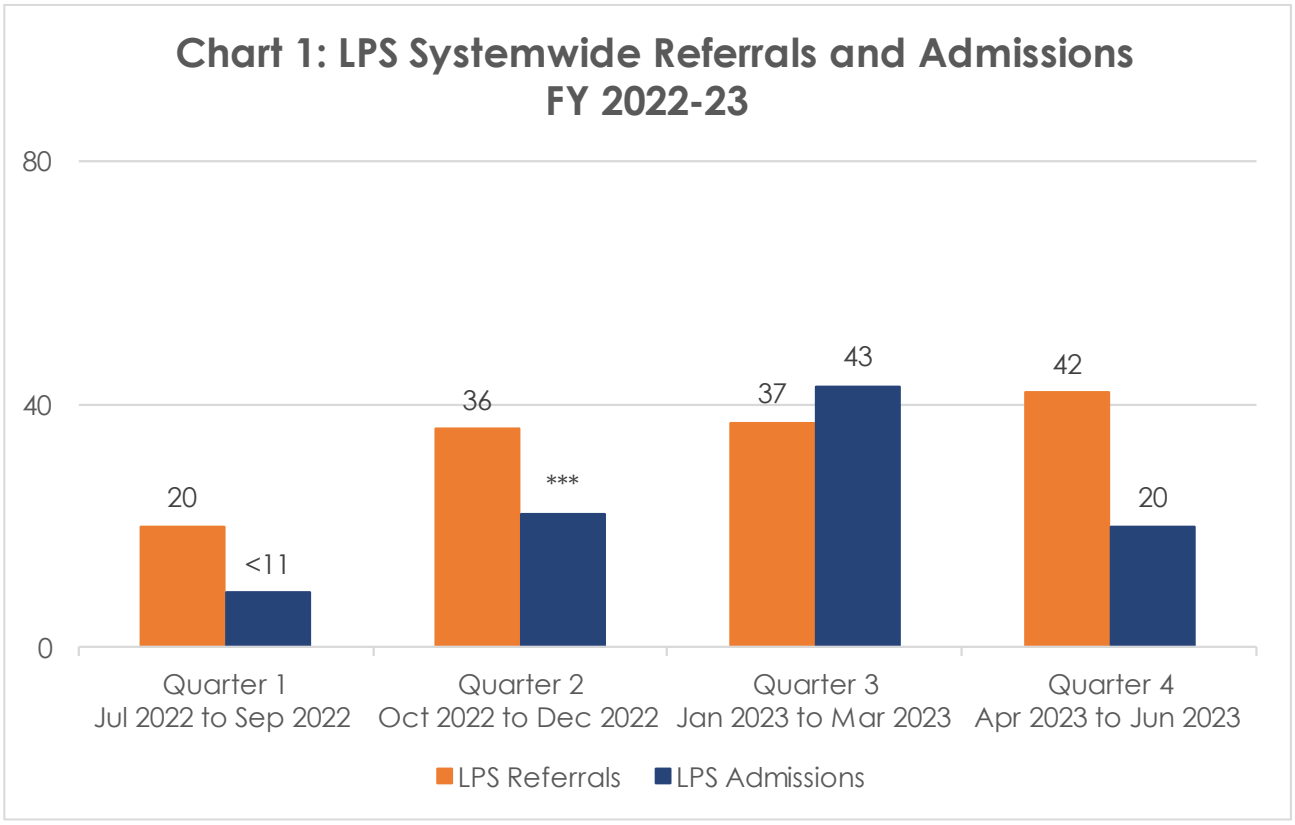


Chart 1: LPS Systemwide Referrals and Admissions
FY 2022-23
80
40
0
20
<11
36
***
37
43
42
20
Quarter 1
Jul 2022 to Sep 2022
Quarter 2
Oct 2022 to Dec 2022
Quarter 3
Jan 2023 to Mar 2023
Quarter 4
Apr 2023 to Jun 2023
LPS Referrals
LPS Admissions

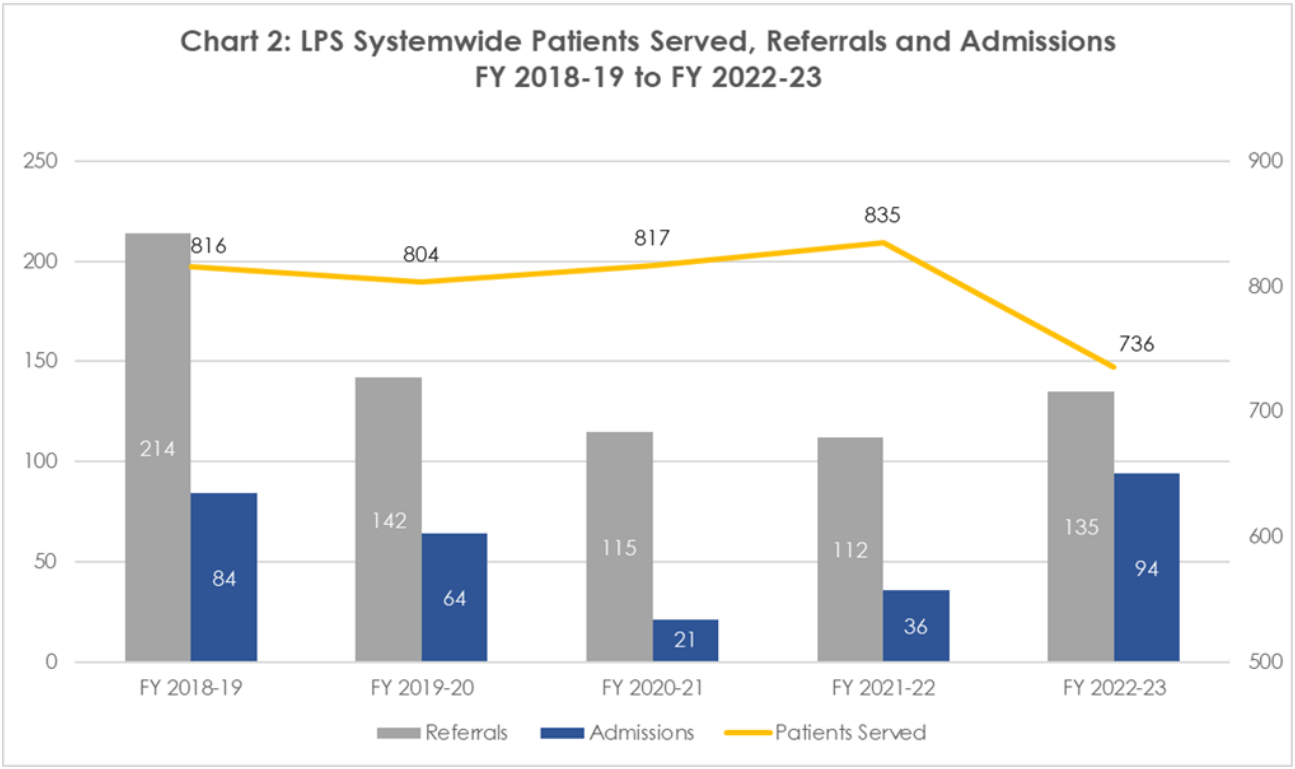


Chart 2: LPS Systemwide Patients Served, Referrals and Admissions
FY 2018-19 to FY 2022-23
250
200
150
100
50
0
900
800
700
600
500
816
804
817
835
736
214
84
142
64
115
21
112
36
135
94
FY 2018-19
FY 2019-20
FY 2020-21
FY 2021-22
FY 2022-23
Referrals
Admissions
Patients Served

DSH is not statutorily required to admit LPS patients as is the case with other legal classifications but complies with a Memorandum of Understanding (MOU) agreed upon with the counties for 556 LPS beds. All conservatorships under the LPS Act must designate a least restrictive placement based on the individual's treatment needs. DSH is one of many placement options designated in the statute. Therefore, admission of an LPS conservatee to a state hospital is reserved for those that are deemed to require a DSH setting for treatment. LPS patients referred and committed to DSH are added to the DSH System-wide LPS Pending Placement List until a bed becomes available or a DSH bed is no longer needed. Table 3 below identifies the number of LPS patients pending placement into a DSH bed as of June 30 of the corresponding year. The number of LPS patients pending placement remained relatively consistent at a 2% decrease from FY 2021-22 to FY 2022-23.

Table 3: LPS System-wide Pending Placement List

LPS Patients Pending Placement	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
	216	201	297	317	311

Discharge Data

DSH discharged 245 LPS patients in FY 2022-23 with an average length of stay of 2,353.4 days (6.4 years) and a median length of stay of 1,650 days (4.5 years). Only 6% of LPS patients discharged within one year, 55% discharged within five years, and 46% had a length of stay longer than five years. Table 4 below depicts the distribution of LPS patients discharged in FY 2022-23 by length of stay.

Table 4: LPS Patient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	6%
366 - 1,460 Days (2 - 4 years)	39%
1,461 - 1,825 days (4 - 5 years)	10%
1,826 - 3,650 days (5 - 10 years)	28%
3,651+ days (10+ years)	18%

For patients yet to discharge the average days in treatment is 588 days and median days in treatment is 1,844.5 (5.1 years).

Table 5 on the following page displays length of stay by quarter for FY 2022-23.

Table 5: LPS Patient Length of Stay by Quarter – FY 2022-23

LPS Patient Length of Stay Days (Years)	**Quarter 1** July 2022 to Sept. 2022	**Quarter 2** Oct. 2022 to Dec. 2022	**Quarter 3** Jan. 2023 to March 2023	**Quarter 4** April 2023 to June 2023	**Total** FY 2022-23
Average Length of Stay	2,156.4 (5.9 yrs.)	2,123.7 (5.8 yrs.)	2,928.5 (8.0 yrs.)	1,948.9 (5.3 yrs.)	2,353.4 (6.4 yrs.)
Median Length of Stay	1,721.0 (4.7 yrs.)	1,577.0 (4.3 yrs.)	2,042.0 (5.6 yrs.)	1,268.5 (3.5 yrs.)	1,650.0 (4.5 yrs.)
Discharged Count	61	63	77	44	245

LPS patients can be discharged to a variety of locations. For the 245 LPS patients discharged in FY 2022-23 those locations are displayed in the table below.

Table 6: LPS Patient Discharges by Location[4]

Discharge Location	**LPS** FY 2022-23	**MURCON** FY 2022-23	**Total** FY 2022-23	**Percent to Total**
Community Outpatient Treatment	<11	0	**<11**	***%
Deceased	23	0	**23**	9%
Discharged to Community	***	<11	**85**	35%
Locked Facility: CDCR, DJJ, Jail, Court, Other State Hospitals	***	***	**73**	30%
Locked Medical Facility	***	<11	**48**	20%
Other/Unknown	<11	0	**<11**	***%
Total Discharges	**229**	**16**	**245**	**100%**

[4] Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. Counts between 1-10 are masked with "<11". Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

POPULATION PROFILE
Not Guilty by Reason of Insanity Patients

Description of Legal Class

The Department of State Hospitals (DSH) admits individuals found Not Guilty by Reason of Insanity (NGI) under Penal Code (PC) 1026: Pleadings and Proceedings before Trial-Plea. Once a court determines that an individual (defendant) is found guilty but was insane at the time the crime was committed, the court commits the defendant to DSH for a maximum term of commitment equal to the longest sentence which could have been imposed for the crime. Based on the criminal conviction, the patient is found not guilty by reason of insanity. A patient may be placed immediately in outpatient treatment in the community under supervision rather than going directly to a state hospital. The court can recommit the patient to DSH beyond the maximum term of the original commitment if the patient is found, based on his or her mental illness, to represent a substantial danger of physical harm to others. A recommitment lasts for two years from the date of the recommitment order.

Legal Statutes and Commitments

- PC 1026 – Not Guilty by Reason of Insanity
- PC 1026.5 – Not Guilty by Reason of Insanity, Extension of term
- PC 1610 – Temporary admission while waiting for court revocation of PC 1026, RONGI
- WIC 702.3 - Minor Not Guilty by Reason of Insanity, MNGI

Requirements for Discharge

Restoration of sanity is a two-step process in which evidence is presented and reviewed that would determine if a patient is a danger to the health and safety of others, due to his or her mental illness, if released under supervision and treatment in the community. The two-step process requires (1) an outpatient placement hearing and (2) a restoration hearing following a year in outpatient care. During the first step of the process the court must find that the patient is no longer a danger to the health and safety of others due to his or her illness if released under supervision and treatment in the community. During the second step of the process, the court must determine whether the patient has been fully restored to sanity. The court's finding of restoration will result in the patient's unconditional release from supervision. A patient may bypass the mandatory one-year of outpatient commitment and have an early restoration hearing in the event the conditional release program director recommends an early release. Outpatient status may not exceed one year, after

which time the Court must either discharge the patient, order the patient confined to a facility, or renew the outpatient status.[1]

DSH Treatment Continuum & Services

Because NGI patients tend to have severe mental illnesses and their crimes may involve severe violence, their length of treatment in a state hospital may be longer. The treatment team must demonstrate to the court that the NGI patient has achieved long-term stabilization and no longer poses a danger due to their mental illness. Thus, the patient needs to demonstrate long-term symptom stability, long-term adherence to psychiatric treatments, and an understanding of the factors that exacerbate their mental illness. Each NGI patient's progress in treatment is assessed by a forensic evaluator every six months with progress reports submitted to the court. In the event that the individual's maximum term of commitment approaches and DSH does not believe the individual is safe to discharge, DSH can pursue an extension of the NGI commitment to extend the individual's stay in the DSH hospital, pursuant to PC 1026.5. In fiscal year (FY) 2022-23, 379 patients were served at the state hospitals under this extension option.

To assess dangerousness and develop effective treatments to reduce violence risk, specialized violence risk assessments must be conducted. Based on the individual NGI patient's mental illness factors and violence risk, individualized treatments must be developed. Additionally, scenarios that could realistically provoke similar violent responses must be evaluated and worked through with the patient. Furthermore, the patient must understand their violence risk factors and be able to demonstrate that they would take preventive actions to mitigate any factors that would heighten their violence risk.

Although NGI patients are admitted to DSH because of a severe mental illness and dangerousness, NGI patients have the right to refuse treatment unless that right is removed by case law or regulation, as guided by the *Greenshields* involuntary medication order process. This can effectively lengthen the patient stay at the state hospital if they choose not to fully participate in the treatments recommended by their treatment team.

Programs

DSH provides treatment to NGI patients through inpatient care within the State Hospitals and on an outpatient basis through the Forensic Conditional Release Program (CONREP).

[1] Penal Code section 1606

DSH NGI Treatment Programs	
State Hospitals (SH)	DSH's inpatient mental health hospital system provides psychiatric, medical, and psychosocial treatment services to forensic and civil patients housed at Atascadero, Coalinga, Metropolitan, Napa, and Patton State Hospitals.
Forensic Conditional Release Program (CONREP)	CONREP is DSH's statewide system of community-based services for specified court-ordered forensic individuals. DSH contracts with county and private providers to provide community-based treatment services for individuals committed to DSH, under various commitment types, who have been approved by the court for outpatient treatment in lieu of state hospital placement or for individuals approved by the courts to step down from state hospital treatment to the community.

Population Data

System-wide Metrics

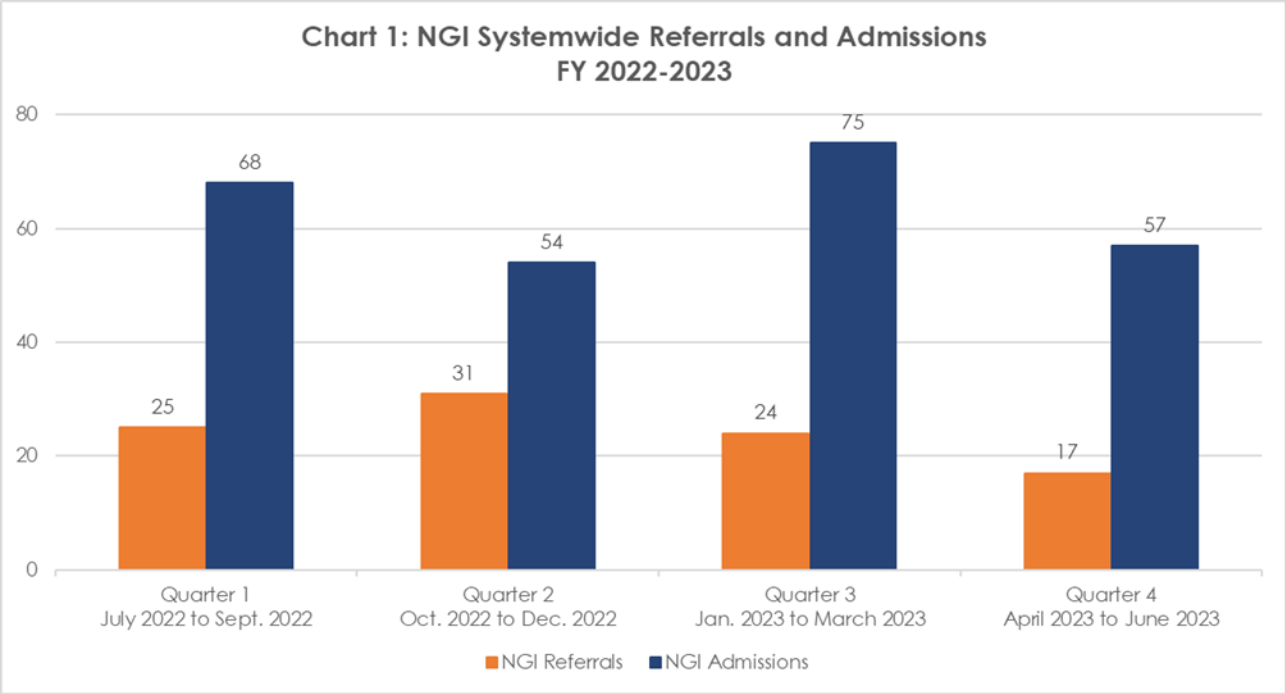
Across inpatient and outpatient programs, DSH treated 1,832 patients designated as NGI in FY 2022-23. The table below summarizes key statistics across the NGI population.

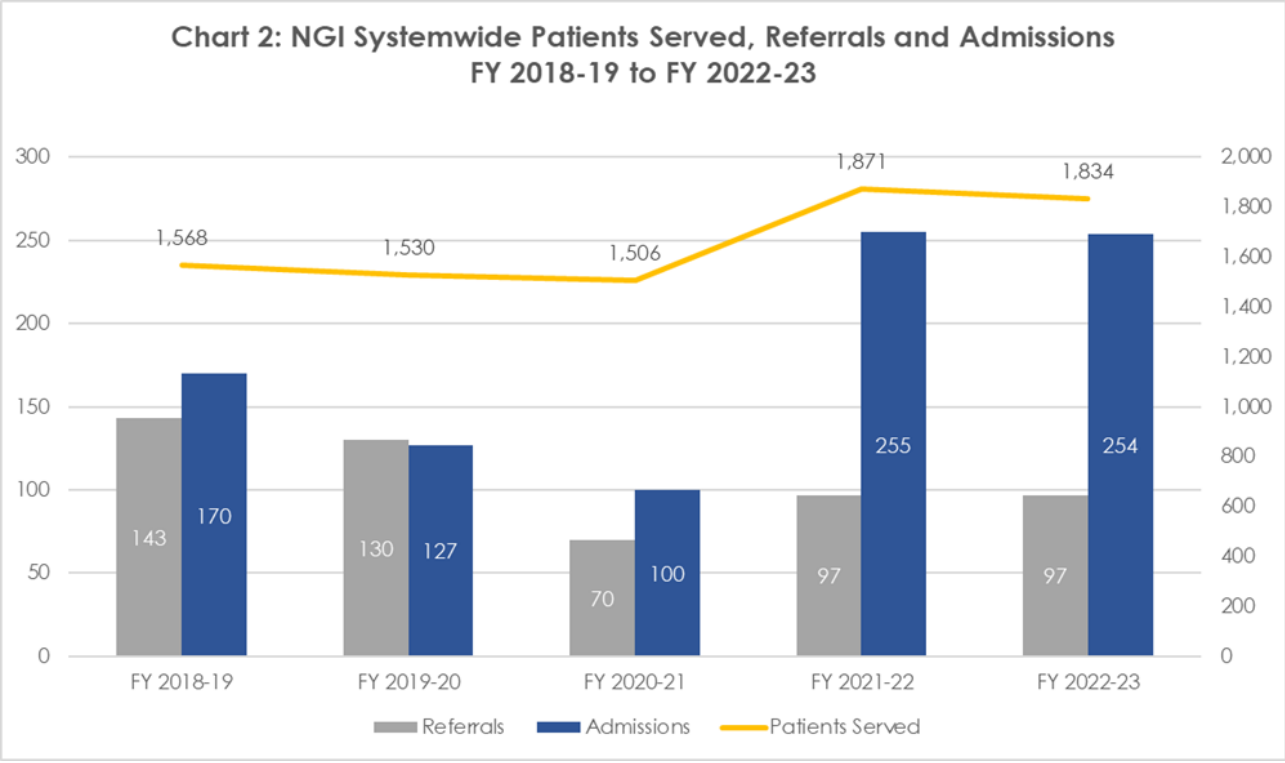
Table 1: System-wide NGI Patient Data Summary[2]

NGI Patient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Referrals	97	97	0%
Patient Admissions	255	254	0%
Patients Served	1,869	1,832	-2%
Average Daily Census	1,759	1,705	-3%

Chart 1 displays NGI system-wide referrals and admissions by quarter for FY 2022-23 and Chart 2 displays a five-year period of referrals and admissions for a broader historical view[3].

[2] Patient referrals excludes other inpatient program transfers and court returns. Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.
[3] Outpatient data is only included in FY 2021-22 and FY 2022-23 (Chart 2).





NGI patients are individuals committed to a state hospital for treatment by the courts and transfer directly from jail. The table below, Table 2, identifies the NGI pending placement list (PPL) as of June 30 of the corresponding year.

Table 2: NGI System-wide Pending Placement List[4]

NGI Patients Pending Placement	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
	29	34	14	44	11

Inpatient Program Metrics

Patients committed to DSH as NGI receive inpatient treatment within four of DSH's state hospitals: DSH-Atascadero, DSH-Metropolitan, DSH-Napa and DSH-Patton. During FY 2022-23, DSH inpatient programs treated on average 1,228 NGI patients daily, with an average census of 1,241 in July 2022, with a slight decrease of 1% across the year ending with an average census of 1,228 NGI patients in June 2023.

Table 3: NGI Inpatient Data Summary[5]

NGI Inpatient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Admissions	149	149	0%
Patients Served	1,406	1,348	-4%
Average Daily Census	1,290	1,228	-5%

DSH Inpatient programs admitted 149 NGI Patients in FY 2022-23 with an average of 12 admissions per month. Chart 3 displays Inpatient program NGI admissions by quarter and the average monthly admissions rate.

[4] The pending placement list reflects patients pending inpatient treatment.
[5] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

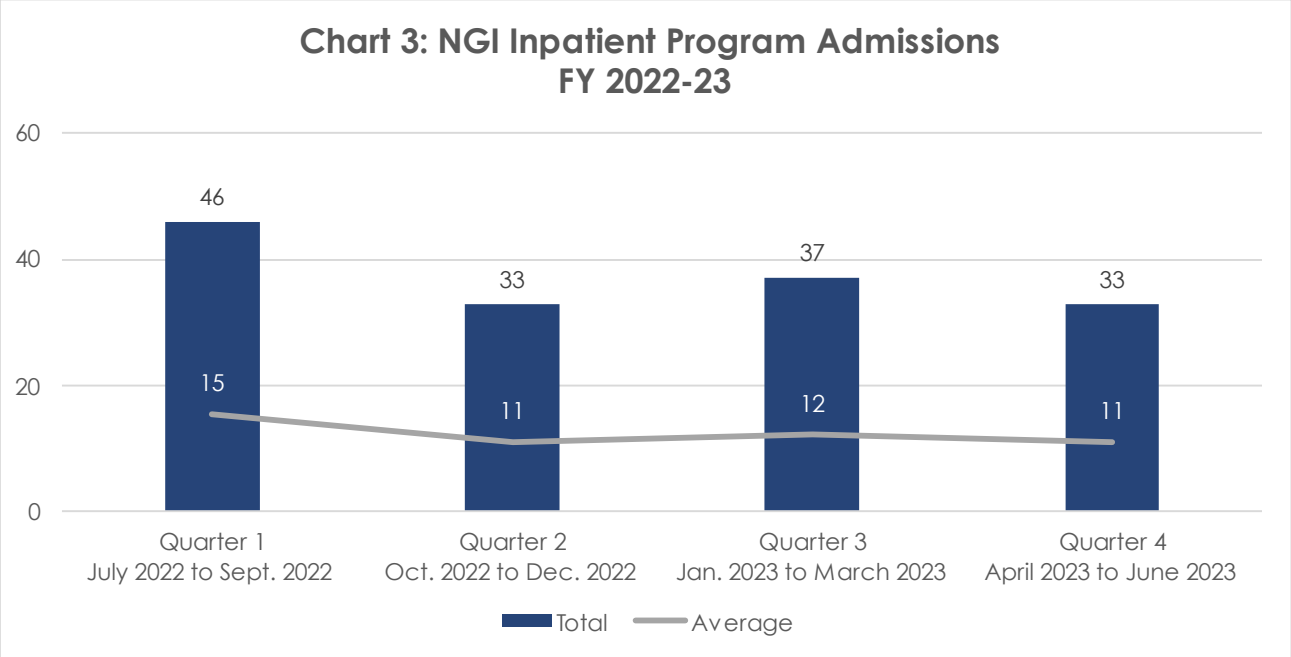


Table 4, below, displays the number of NGI patients treated in inpatient programs within each FY for the past five years.

Table 4: NGI Patients Served – Inpatient Programs[6]

Patients Treated/ Served	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
	1,568	1,530	1,506	1,406	1,348

Inpatient Discharge Data

DSH discharged 165 NGI patients from inpatient programs with an average length of stay of 3,045.1 days (over 8 years) and a median length of stay of 2,122.0 days (over 5 years) across all programs. Only 12% of the NGI patients discharged within the first year of their stay, 44% of the NGI patients discharged within the first five years of their stay, and 56% of the NGI patients discharged with a length of stay of more than five years. Table 5 on the following page depicts the distribution of NGI patients discharged from inpatient programs in FY 2022-23 by length of stay.

[6] Patients served excludes other inpatient and outpatient program transfers.

Table 5: NGI Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	12%
366 - 1,460 Days (2 - 4 years)	21%
1,461 - 1,825 days (4 - 5 years)	11%
1,826 - 3,650 days (5 - 10 years)	27%
3,651+ days (10+ years)	28%

For patients yet to discharge the average days in treatment is 4,043.7 days (11.1 years) and median days in treatment is 2,668.0 days (7.3 years).

Table 6 displays Inpatient programs length of stay by quarter.

Table 6: NGI Inpatient Length of Stay by Quarter – FY 2022-23

NGI Inpatient Length of Stay Days (Years)	**Quarter 1** July 2022 to Sept. 2022	**Quarter 2** Oct. 2022 to Dec. 2022	**Quarter 3** Jan. 2023 to March 2023	**Quarter 4** April 2023 to June 2023	**Total** FY 2022-23
Average Length of Stay	3,426.7 (9.4 yrs.)	3,545.0 (9.7 yrs.)	2,744.3 (7.5 yrs.)	2,116.0 (5.8 yrs.)	3,045.1 (8.3 yrs.)
Median Length of Stay	2,285.0 (6.3 yrs.)	2,670.0 (7.3 yrs.)	1,944.0 (5.3 yrs.)	1,695.0 (4.6 yrs.)	2,122.0 (5.8 yrs.)
Discharged Count	52	42	40	31	165

NGI patients can be discharged to a variety of locations including outpatient treatment programs. The table below displays the discharge locations for the 165 patients discharged in FY 2022-23.

Table 7: NGI Inpatient Discharges by Location

NGI Inpatient Discharge Location	**NGI** FY 2022-23	**Percent to Total**
Community Outpatient Treatment	69	42%
Locked Facility: CDCR, DJJ, Jail, Court, Other State Hospitals	52	32%
Discharged to Community	25	15%
Deceased	19	12%
Total Discharges	**165**	**100%**

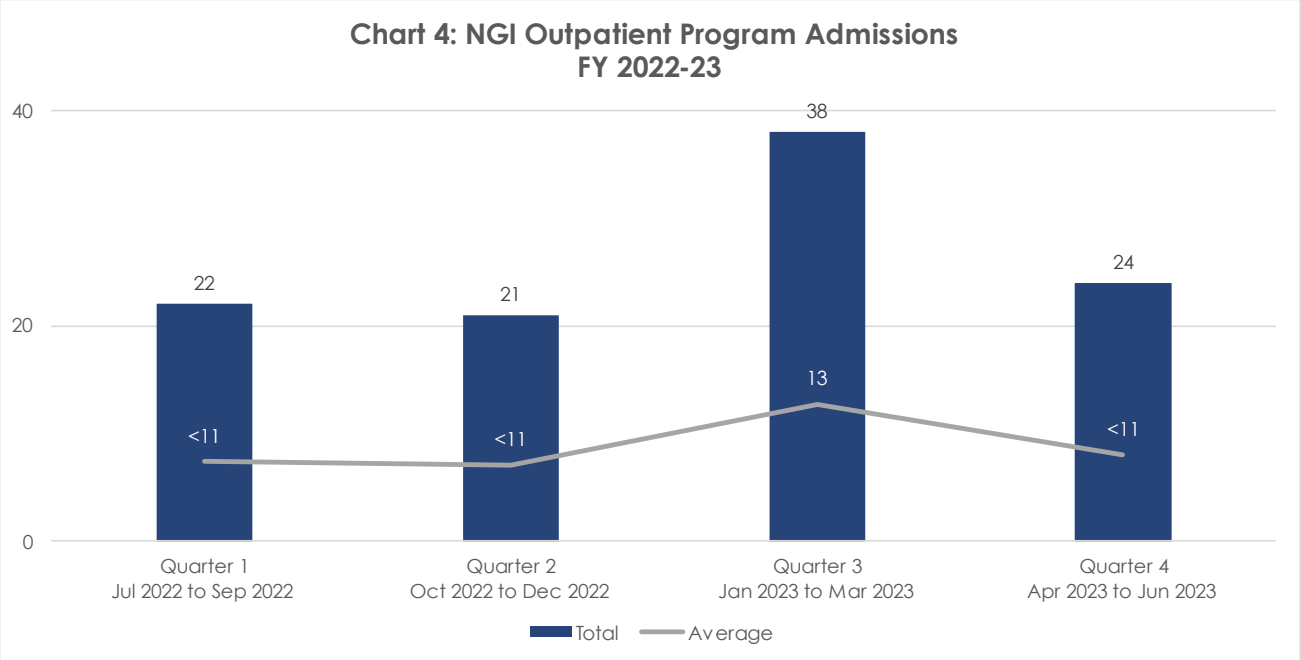
Outpatient Program Metrics

CONREP is the DSH outpatient treatment program for patients committed as NGI. During FY 2022-23, DSH CONREP treated on average 478 NGI patients daily, with an average census of 483 in July 2022 and an ending average census of 469 patients in June 2023.

Table 8: NGI Outpatient Data Summary[7]

NGI Outpatient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Admissions	106	105	-1%
Patients Served	463	484	5%
Average Daily Census	468	478	2%

DSH outpatient programs admitted 105 NGI patients in FY 2022-23 with an average of nine admissions per month. Chart 4 displays outpatient program NGI admissions by quarter.



[7] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

The table below displays the number of patients treated across the year in outpatient programs.

Table 9: NGI Patients Served – Outpatient Programs[8]

Patients Treated/Served	FY 2021-22	FY 2022-23
	465	486

Outpatient Discharge Data

DSH discharged 121 NGI patients from outpatient programs with an average length of stay of 1,797.3 days (approximately 5 years) and a median length of stay of 918.0 days (over 2 years) across all programs. 27% of NGI patients discharged within the first year of their stay, 50% of the NGI patients discharged within the first five years of their stay and 50% of the NGI patients discharged with a length of stay of more than five years. Table 10 below depicts the distribution of NGI patients discharged from outpatient programs in FY 2022-23 by length of stay.

Table 10: NGI Outpatient Length of Stay Distribution

NGI Outpatient Length of Stay	% of Patients
0 - 365 Days (1 year)	27%
366 - 1,460 Days (2 - 4 years)	8%
1,461 - 1,825 days (4 - 5 years)	14%
1,826 - 3,650 days (5 - 10 years)	14%
3,651+ days (10+ years)	36%

Table 11 displays outpatient length of stay by quarter for FY 2022-23.

Table 11: NGI Outpatient Length of Stay by Quarter – FY 2022-23

NGI Outpatient Length of Stay	Quarter 1 July 2022 to Sept. 2022	Quarter 2 Oct. 2022 to Dec. 2022	Quarter 3 Jan. 2023 to March 2023	Quarter 4 April 2023 to June 2023	Total FY 2022-23
Average Length of Stay	2,176.9 (6 yrs.)	2,499.8 (6.8 yrs.)	1,523.6 (4.2 yrs.)	1,126.2 (3.1 yrs.)	1,797.3 (4.9 yrs.)
Median Length of Stay	1,718.0 (4.7 yrs.)	1,157.0 (3.2 yrs.)	672.0 (1.8 yrs.)	643.0 (1.8 yrs.)	918.0 (2.5 yrs.)
Discharged Count	22	31	39	29	121

[8] Patients served excludes other inpatient and outpatient program transfers.

POPULATION PROFILE
Offenders with a Mental Health Disorder

Description of Legal Class

The Department of State Hospitals (DSH) admits Offenders with a Mental Health Disorder (OMD) patients under Penal Code (PC) 2962: Disposition of Mentally Disordered Prisoners upon Discharge. OMD commitments are patients who are parolees (or former parolees), referred by the California Department of Corrections and Rehabilitation (CDCR), who meet the six criteria for OMD classification. The criteria include (1) the presence of a severe mental disorder, (2) the mental disorder is not in remission or requires treatment to be kept in remission, (3) the mental disorder was a factor in the commitment offense, (4) the prisoner has been in treatment for at least 90 days in the year prior to release, (5) the commitment offense involved force or violence or serious bodily injury and (6) the prisoner continues to be dangerous due to the severe mental disorder. The individual is evaluated by both the treating CDCR psychologist/psychiatrist and a DSH psychologist/psychiatrist. If the evaluators agree the individual meets all the conditions above, the Board of Parole Hearings (BPH) can commit that individual to a state hospital as a condition of parole. The individual then receives treatment at DSH unless they can be certified for outpatient treatment or the individual challenges the commitment.

Parolees who committed one of a specified list of crimes and who were treated for a severe mental disorder connected to their original crime can be committed to a state hospital as a condition of parole for a period not to exceed the length of their parole term; these patients are committed under PC 2962. If the person still requires treatment at the end of their parole term, they can be committed under PC 2972 if it is determined that the patient has a severe mental disorder, that the patient's severe mental disorder is not in remission or cannot be kept in remission without treatment, and that by reason of their severe mental disorder, the patient represents a substantial danger of physical harm to others. A person committed under PC 2972 is committed for one year and re-evaluated annually.

Legal Statutes and Commitments

- PC 2962 – Parolee referred from CDCR
- PC 2964(a) – OMD Admission from Outpatient
- PC 2972 – OMD, commitment for further treatment
- PC 1610 – Temporary admission while waiting for court revocation of PC 2972
- PC 1610 – Temporary admission while waiting for court revocation of MDSO
- WIC 6316 – Person convicted of a sex offense ordered to treatment (former MDSO statute now repealed)

Requirements for Discharge

After one year, a parolee is entitled to an annual review hearing conducted by the BPH to determine if (1) the parolee still meets the six criteria for OMD classification and (2) whether the parolee can be treated on an outpatient basis. The length of a parole period is determined by statute and depends on the type of sentence imposed. Parole terms can extend beyond the maximum parole period due to revocation or escape attempts. A parole period can be waived at the discretion of BPH. Most parolees have a maximum parole period of three years, with a four-year maximum if parole was suspended due to revocation. The parole period may exceed four years for more serious offenses.

An OMD patient (or parolee) may be placed into outpatient treatment in the Forensic Conditional Release Program (CONREP) if the Court believes that the OMD patient can be safely and effectively treated on an outpatient basis. Outpatient status may not exceed one year, after which time the Court must either discharge the patient, order the patient confined to a facility, or renew the outpatient status.[1]

DSH Treatment Continuum & Services

The focus of treatment for the OMD population involves helping patients increase their ability to safely and effectively manage symptoms associated with their mental illness and prepare them for eventual transfer to outpatient treatment in CONREP. Another area of focus is substance abuse treatment since a history of substance abuse is prevalent in most OMD patients. Other goals are to motivate patients for treatment, develop greater self-autonomy and independence, and the mastery of self-discipline and Activities of Daily Living (ADL) skills such as practicing good hygiene, grooming, and feeding.

Programs

DSH provides treatment to OMD patients through inpatient care within State Hospitals and on an outpatient basis in CONREP.

DSH OMD Treatment Programs	
State Hospitals (SH)	DSH's inpatient mental health hospital system provides psychiatric, medical, and psychosocial treatment services to forensic and civil patients housed at Atascadero, Coalinga, Metropolitan, Napa, and Patton State Hospitals.

[1] Penal Code section 1606

Forensic Conditional Release Program (CONREP)	CONREP is DSH's statewide system of community-based services for specified court-ordered forensic individuals. DSH contracts with county and private providers to provide community-based treatment services for individuals committed to DSH, under various commitment types, who have been approved by the court for outpatient treatment in lieu of state hospital placement or for individuals approved by the courts to step down from state hospital treatment to the community.

Population Data

State-wide Metrics

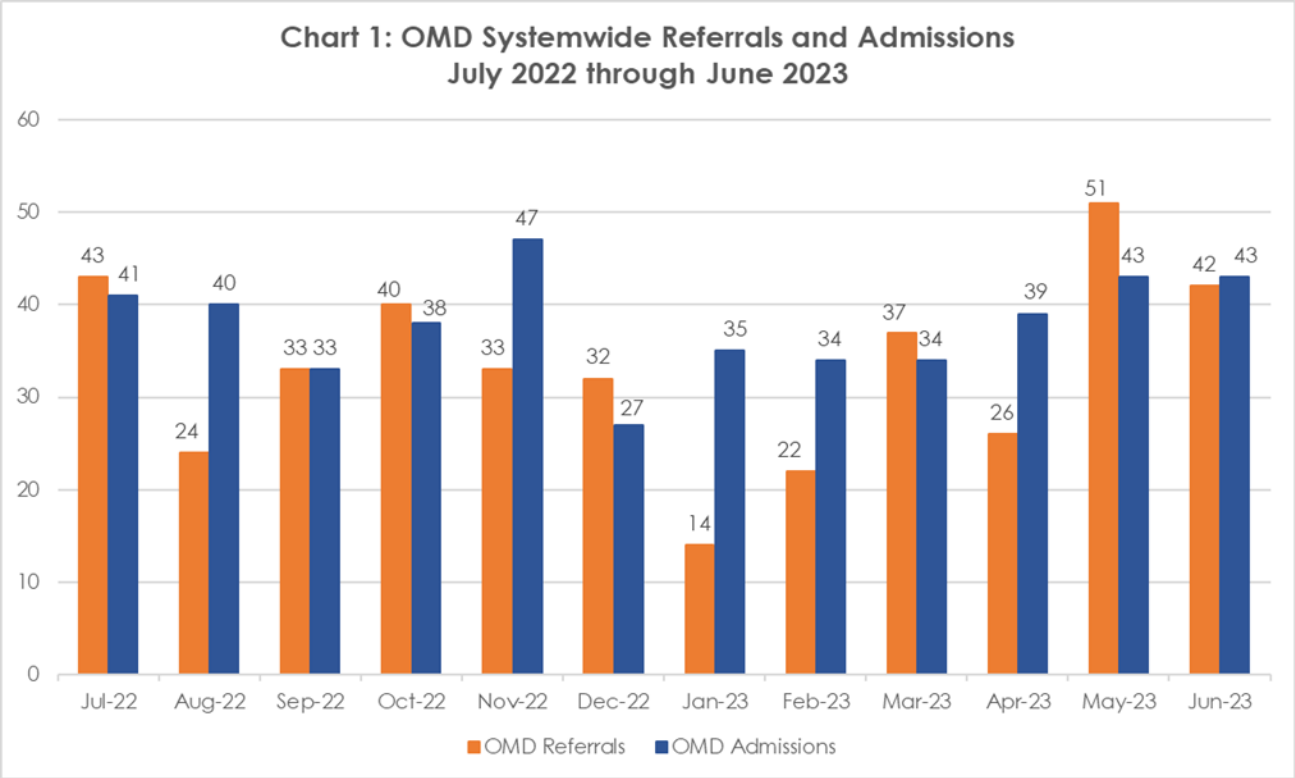
Across inpatient and outpatient programs, DSH treated 1,596 patients committed as OMD in fiscal year (FY) 2022-23. The table below summarizes key statistics across the OMD population.

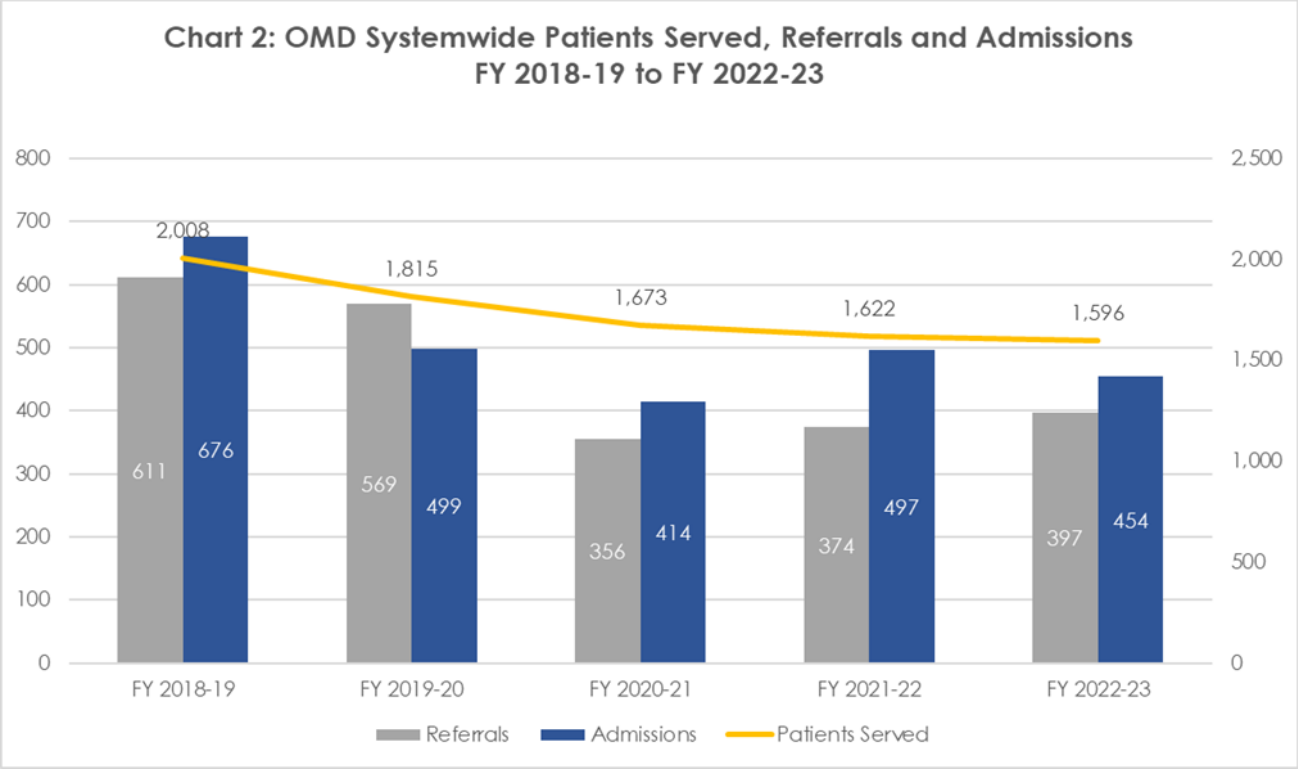
Table 1: System-wide OMD Patient Data Summary[2]

OMD Patient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Referrals	374	397	6%
Patient Admissions	497	454	-9%
Patients Served	1,622	1,596	-2%
Average Daily Census	1,269	1,224	-4%

Chart 1 displays OMD system-wide referrals and admissions by month for FY 2022-23, and Chart 2 displays a five-year period of referrals and admissions for a broader historical view[3].

[2] Patient referrals excludes other inpatient program transfers and court returns. Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.
[3] Outpatient data is only included in FY 2021-22 and FY 2022-23 (Chart 2).





DSH is statutorily required to admit OMD patients upon completion of their prison sentence since these individuals are not able to safely serve their parole in the community until their severe mental health disorder is in remission and can be kept

in remission. To ensure continuity of care and public safety individuals are discharged from prison directly to a state hospital.

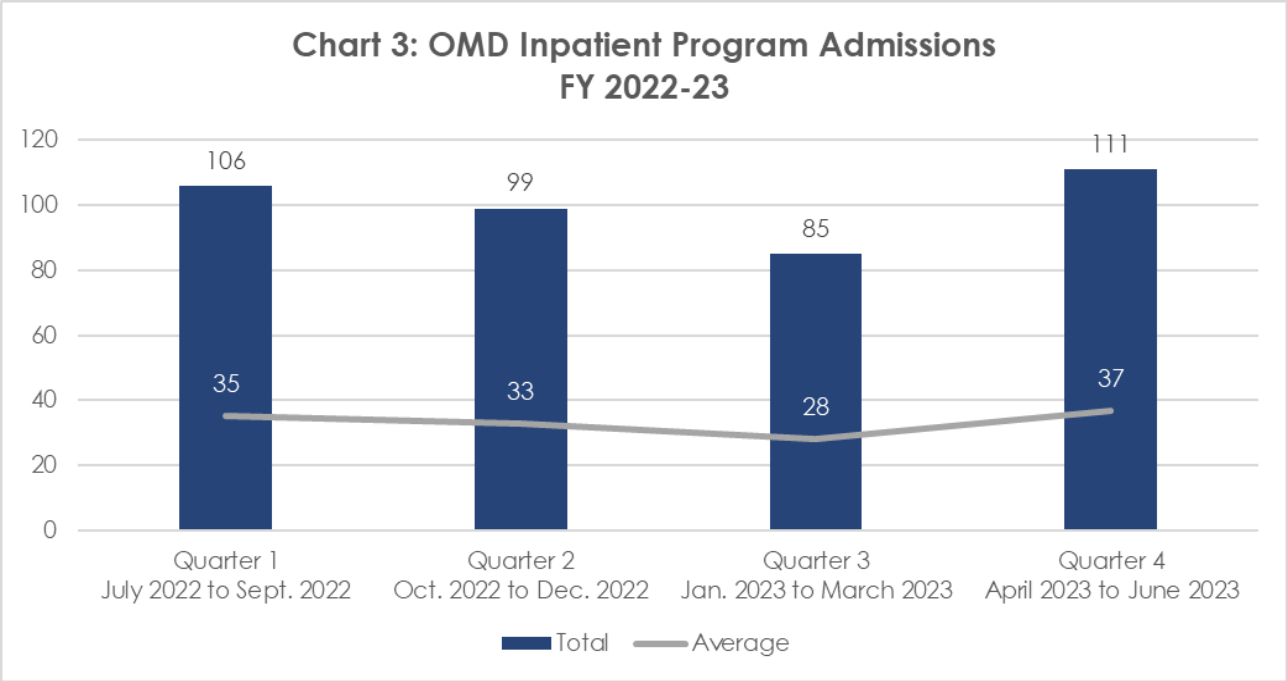
Inpatient Program Metrics

Patients committed to DSH as OMD can receive inpatient treatment within DSH's five state hospitals, with PC 2962 commitment treatment only at DSH-Atascadero (male patients) and DSH-Patton (female patients). Patients who are committed pursuant to PC 2972 may receive treatment across all five state hospitals. In FY 2022-23, the state hospitals treated an average of 1,051 OMD patients daily, with an average census of 1,058 in July 2022 and 1,043 in June 2023.

Table 2: OMD Inpatient Data Summary[4]

OMD Inpatient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Admissions	421	401	-5%
Patients Served	1,478	1,432	-3%
Average Daily Census	1,112	1,051	-5%

DSH inpatient programs admitted 401 OMD patients in FY 2022-23 with an average of 33 admissions per month. Chart 3 displays Inpatient Program OMD admissions by quarter and the average monthly admissions rate.



[4] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

Table 3 displays the number of OMD patients treated in inpatient programs within each FY for the past five years.

Table 3: OMD Patients Served – Inpatient Programs[5]

Patients Treated/ Served	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
	2,008	1,815	1,673	1,478	1,430

PC 2962 Inpatient Data

Patients committed as PC 2962 make up 50% of the OMD patients treated within inpatient programs.

Table 4: PC 2962 Inpatient Data Summary[6]

PC 2962 Inpatient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Admissions	337	348	3%
Patients Served	724	719	-1%
Average Daily Census	406	350	-14%

DSH discharged 318 PC 2962 patients from inpatient programs with an average length of stay of 329.9 days, and a median length of stay of 150.5 days. 67% of PC 2962 patients discharged within one year, 86% of OMD patients discharged within two years, and only 14% had a length of stay longer than two years. The table below depicts the distribution of PC 2962 patients discharged from inpatient treatment in FY 2022-23 by length of stay.

Table 5: PC 2962 Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	67%
366 - 1,460 Days (2 - 4 years)	32.7%
1,461 - 1,825 days (4 - 5 years)	0.3%
1,826 - 3,650 days (5 - 10 years)	0%
3,651+ days (10+ years)	0%

Table 6, on the following page, displays inpatient programs length of stay for PC 2962 patients by quarter for FY 2022-23.

[5] Patients served excludes other inpatient and outpatient program transfers.
[6] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

Table 6: PC 2962 Inpatient Length of Stay by Quarter – FY 2022-23

PC 2962 Inpatient Programs: Length of Stay	Quarter 1 July 2022 to Sept. 2022	Quarter 2 Oct. 2022 to Dec. 2022	Quarter 3 Jan. 2023 to March 2023	Quarter 4 April 2023 to June 2023	Total FY 2022-23
Average Length of Stay	358.7	289.4	301.9	370.7	329.9
Median Length of Stay	161.0	136.0	143.0	261.0	150.5
Discharged Count	89	82	76	71	318

For PC 2962 patients yet to discharge the average days in treatment is 310.2 and median days in treatment is 225.

PC 2962 patients can be discharged to a variety of locations including outpatient treatment programs. The table below displays the discharge locations for the 318 patients discharged in FY 2022-23.

Table 7: PC 2962 Inpatient Discharges by Location[7]

PC 2962 OMD Inpatient Discharge Location	Total FY 2022-23	Percent to Total
Community Outpatient Treatment	<11	***%
Discharged to Community	50	16%
Discharged to Parole	232	73%
Locked Facility: CDCR, DJJ, Jail, Court, Other State Hospitals	25	8%
Locked Medical Facility	<11	***%
Total Discharges	**318**	**100%**

PC 2972 Inpatient Data

Patients committed as PC 2972 make up 50% of the OMD patients treated within inpatient programs.

[7] Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. Counts between 1-10 are masked with "<11". Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

Table 8: PC 2972 Inpatient Data Summary[8]

PC 2972 Inpatient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Admissions	84	53	-37%
Patients Served	754	713	-5%
Average Daily Census	705	701	-1%

DSH discharged 102 PC 2972 patients from inpatient programs with an average length of stay of 1,397 days (3.8 years), and a median length of stay of 730 days (2.0 years). A little over 35% of PC 2972 patients discharged within one year, 65.7% of PC 2972 patients discharged within four years, and 34.3% had a length of stay longer than four years. The table below depicts the distribution of PC 2972 patients discharged from inpatient treatment in FY 2022-23 by length of stay.

Table 9: PC 2972 Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	35.3%
366 - 1,460 Days (2 - 4 years)	30.4%
1,461 - 1,825 days (4 - 5 years)	4.9%
1,826 - 3,650 days (5 - 10 years)	19.6%
3,651+ days (10+ years)	9.8%

Table 10 displays inpatient programs length of stay by quarter for FY 2022-23.

Table 10: PC 2972 Inpatient Length of Stay by Quarter – FY 2022-23

PC 2972 Inpatient Programs: Length of Stay Days (Years)	**Quarter 1** July 2022 to Sept. 2022	**Quarter 2** Oct. 2022 to Dec. 2022	**Quarter 3** Jan. 2023 to March 2023	**Quarter 4** April 2023 to June 2023	**Total** FY 2022-23
Average Length of Stay	1,525.2 (4.2 yrs.)	1,698.8 (4.7 yrs.)	1,402.2 (3.8 yrs.)	1,071.1 (2.9 yrs.)	1,397.0 (3.8 yrs.)
Median Length of Stay	757.0 (2.1 yrs.)	1,491.5 (4.1 yrs.)	608.0 (1.7 yrs.)	652.0 (1.8 yrs.)	730.0 (2.0 yrs.)
Discharged Count	17	28	24	33	102

For PC 2972 patients yet to discharge the average days in treatment is 2,579.6 (7.1 years) and median days in treatment is 1,982 (5.4 years).

PC 2972 patients can be discharged to a variety of locations including outpatient treatment programs. Table 11 displays the discharge locations for the 102 patients discharged in FY 2022-23.

[8] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

Table 11: PC 2972 Inpatient Discharges by Location

PC 2972 OMD Inpatient Discharge Location	Total FY 2022-23	Percent to Total
Community Outpatient Treatment	32	31%
Deceased	<11	***%
Discharged to Community	36	35%
Locked Facility: CDCR, DJJ, Jail, Court, Other State Hospitals	***	***%
Other/Unknown	<11	***%
Total Discharges	**102**	**100%**

Outpatient Program Metrics

CONREP is the DSH outpatient treatment program for patients committed as OMD. Both PC 2962 and PC 2972 OMD patients can be committed to CONREP. During FY 2022-23, DSH CONREP treated on average 173 OMD patients daily, with an average census of 178 in July 2022 and an ending average census of 162 patients in June 2023.

Table 12: OMD Outpatient Data Summary[9]

OMD Outpatient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Admissions	76	53	-30%
Patients Served	144	164	14%
Average Daily Census	158	173	9%

DSH outpatient programs admitted 53 OMD patients in FY 2022-23 with an average of four admissions per month. Chart 4 displays outpatient program OMD admissions by quarter.

[9] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

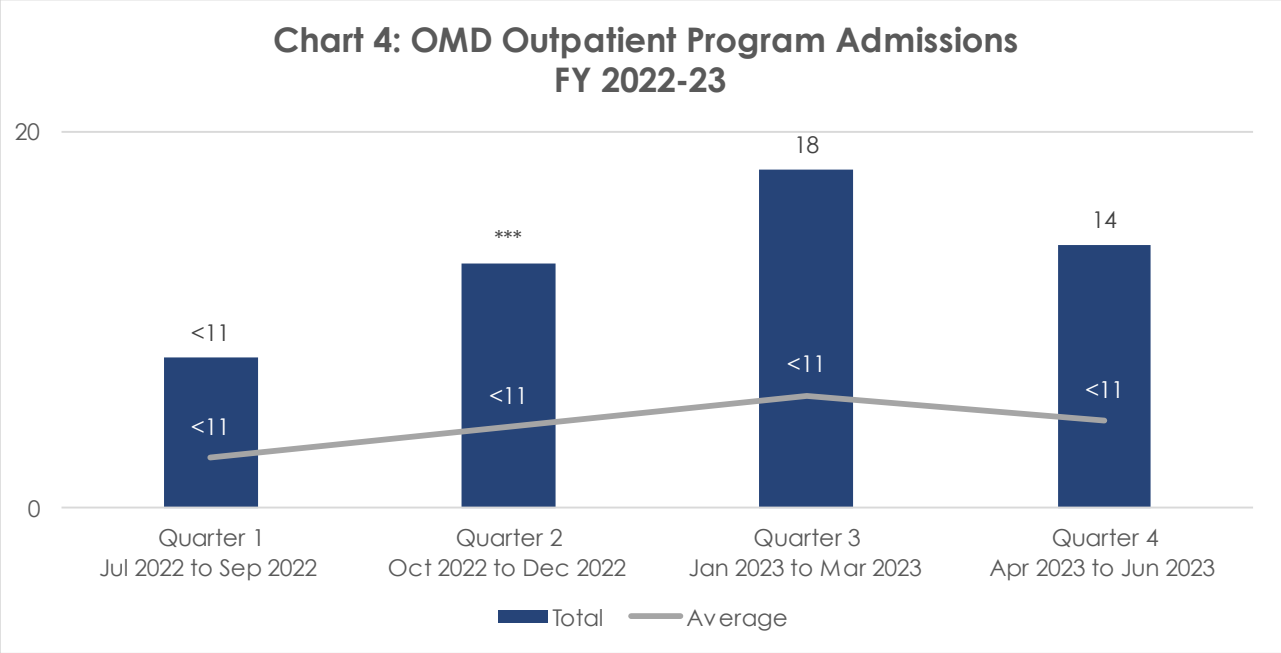


Table 13, below, displays the number of OMD patients treated in outpatient programs within each FY for the past two years.

Table 13: OMD Patients Served – Outpatient Programs[10]

Patients Treated/Served	FY 2021-22	FY 2022-23
	144	164

DSH discharged 65 OMD patients from outpatient programs with an average length of stay of 840.2 days (3.2 years) and a median length of stay of 333 days (0.91 years) across all outpatient programs. 55% of OMD patients discharged within one year, 86% of OMD patients discharged within four years, and only 14% had a length of stay longer than four years. The table below depicts the distribution of OMD patients discharged from outpatient treatment in FY 2022-23 by length of stay.

Table 14: OMD Outpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	55%
366 - 1,460 Days (2 - 4 years)	31%
1,461 - 1,825 days (4 - 5 years)	2%
1,826 - 3,650 days (5 - 10 years)	8%
3,651+ days (10+ years)	5%

[10] Patients served excludes other inpatient and outpatient program transfers.

Table 15 displays outpatient length of stay by quarter for FY 2022-23.

Table 15: OMD Outpatient Length of Stay by Quarter – FY 2022-23

OMD Outpatient Programs: Length of Stay Days (Years)	**Quarter 1** July 2022 to Sept. 2022	**Quarter 2** Oct. 2022 to Dec. 2022	**Quarter 3** Jan. 2023 to March 2023	**Quarter 4** April 2023 to June 2023	**Total** FY 2022-23
Average Length of Stay	1,075.5 (2.9 yrs.)	1,455.7 (4.0 yrs.)	568.5 (1.6 yrs.)	697.2 (1.9 yrs.)	840.2 (2.3 yrs.)
Median Length of Stay	175.5 (0.5 yrs.)	507.5 (1.4 yrs.)	350.5 (0.96 yrs.)	314.0 (0.86 yrs.)	333.0 (0.91 yrs.)
Discharged Count	***	<11	22	21	65

POPULATION PROFILE
Sexually Violent Predator Patients

Description of Legal Class

The Department of State Hospitals (DSH) admits Sexually Violent Predator (SVP) patients under Welfare and Institutions Codes (WIC) 6602 and 6604: Sexually Violent Predator. SVP commitments are civil commitments of individuals released from prison who meet criteria under the Sexually Violent Predator Act, including being convicted of certain sex offenses against one or more victims, and who have a diagnosed mental disorder that makes the person a danger to the health and safety of others in that it is likely that they will engage in sexually violent criminal behavior.

Potential SVP patients/inmates are screened by CDCR and Board of Parole Hearings (BPH) and referred to DSH for full evaluation to determine whether the individuals meet the criteria of an SVP before the completion of their prison term. DSH refers the SVP petition to the county of commitment no less than 20 days prior to the prisoner's release date. If or when the District Attorney (DA) files an SVP petition, the patient/inmate is transferred to county jail pending the WIC section 6602 probable cause hearing. DSH admits patients committed as SVP once there is a WIC section 6602 finding of probable cause. After a WIC 6602 probable cause finding, then a commitment trial is held and, if adjudged to be an SVP under WIC section 6604, the individual is committed to a state hospital for an indeterminate period of time. SVP patients can petition for release, be recommended for outpatient status by DSH, or be found to no longer meet the SVP criteria by DSH.

Legal Statutes and Commitments

- WIC 6602 – Sexually Violent Predator Probable Cause
- WIC 6604 – Sexually Violent Predator
- WIC 6601.3 – Sexually Violent Predator BPH Hold
- WIC 6600 – Sexually Violent Predator Court Hold
- PC 1610 – Temporary admission while waiting for court revocation of outpatient status

Requirements for Discharge

Once a court determines an individual meets the criteria for an SVP commitment, the individual is admitted to a DSH hospital. These patients undergo an annual review process where the patient's SVP status is evaluated by a DSH forensic evaluator, and an update is provided to the court. If DSH provides the court with the opinion that the individual no longer meets SVP criteria, or that the individual can be treated in a less restrictive setting, DSH will then authorize the patient to petition the court for release, and a court hearing is then held to consider the petition. The hearing set as

a result of the patient's petition is to determine whether the status of their mental disorder in that they can be safely treated in the community while under supervision and treatment and should be released from the hospital under conditional release to the community; or whether their condition has so changed that they no longer meet the criteria to be designated an SVP and should be unconditionally released from their SVP commitment to DSH.

If the court agrees that the patient will not pose a public safety threat if conditionally released into a supervised program, it will order the patient be conditionally released. If the patient is conditionally released, DSH's Forensic Conditional Release Program (CONREP) provides treatment, monitoring and supervision of the patient while they are in the community. Alternatively, the court may decide that the patient no longer meets the statutory criteria to be designated as an SVP and order their unconditional release from DSH. If a patient is unconditionally released, a CDCR parole agent takes over the monitoring and supervision of that individual in the community while they are on parole.

DSH Treatment Continuum & Services

Patients committed as SVP have been determined to have committed a sexually violent offense that involve predatory elements, and many have mental disorders that are not amenable to standard medication treatments, as such, treatment for SVP patients typically requires long-term treatment. Psychosocial treatments, relapse prevention/wellness, and recovery action planning are emphasized and reinforced across all clinical disciplines and treatment modalities. To assess dangerousness and develop effective treatments to reduce violence risk, specialized violence risk assessments must be conducted to both guide treatment and measure progress in treatment.

DSH must submit an annual report to the court of the SVP patient's mental condition, including a review of whether they still meet the SVP criteria, whether conditional release to a less restrictive environment or unrestricted discharge would be in the best interest of the individual, and whether conditions could be imposed upon release that would adequately protect the community. Before being recommended for release, the SVP patient must demonstrate long-term stability and adherence to treatment, as well as demonstrate an understanding of their sexual violence risk factors and patterns of thinking that relates to their criminal activity patterns. Furthermore, the SVP patient must be able to demonstrate that they would take preventive actions to avoid or mitigate any factors that would increase their sexual violence risk.

Although SVP patients are admitted to DSH because of mental illness and dangerousness, all patients (including SVP patients) have the right to refuse treatment, unless individually directed by a court to comply. This can effectively

lengthen the patient's stay at the state hospital if a patient chooses not to actively engage or fully participate in the treatments recommended by their treatment team.

Programs

DSH provides sex offense treatment to SVP patients through inpatient care within State Hospitals, at DSH-Coalinga (males) and DSH-Patton (females), and on an outpatient basis in the Forensic Conditional Release Program (CONREP). In addition to the core sex offense treatment program, other supplemental treatment is offered to meet the individualized needs of patients such as but not limited to substance abuse treatment, life skills and vocational training and anger management. CONREP is considered the final phase of the sex offense treatment program which is about applying all the skills learned while in the hospital to a supervised outpatient setting and ultimately supporting a safe reintegration of the individual back to the community.

DSH Treatment Programs	
State Hospitals (SH)	DSH's inpatient mental health hospital system provides psychiatric, medical, and psychosocial treatment services to forensic and civil patients housed at Atascadero, Coalinga, Metropolitan, Napa, and Patton State Hospitals.
Forensic Conditional Release Program (CONREP)	CONREP is DSH's statewide system of community-based services for specified court-ordered forensic individuals. DSH contracts with county and private providers to provide community-based treatment services for individuals committed to DSH, under various commitment types, who have been approved by the court for outpatient treatment in lieu of state hospital placement or for individuals approved by the courts to step down from state hospital treatment to the community.

Population Data

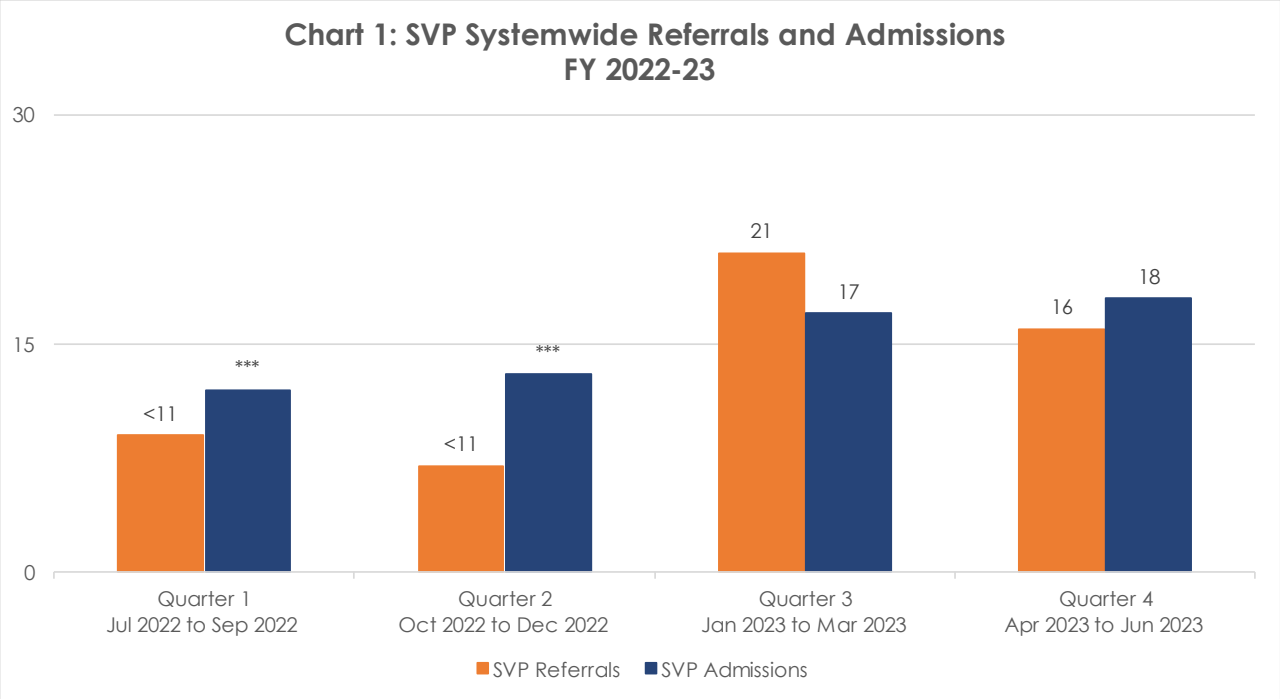
System-wide Metrics

Across inpatient and outpatient programs, DSH treated 1,032 patients designated as SVP, an increase of 4% from prior year. DSH had an average daily census of 977 SVP patients during fiscal year (FY) 2022-23 with no significant change from 976 SVP designated patients in July 2022, to 973 in June 2023. The table below summarizes key statistics across the SVP population.

Table 1: System-wide SVP Patient Data Summary[1]

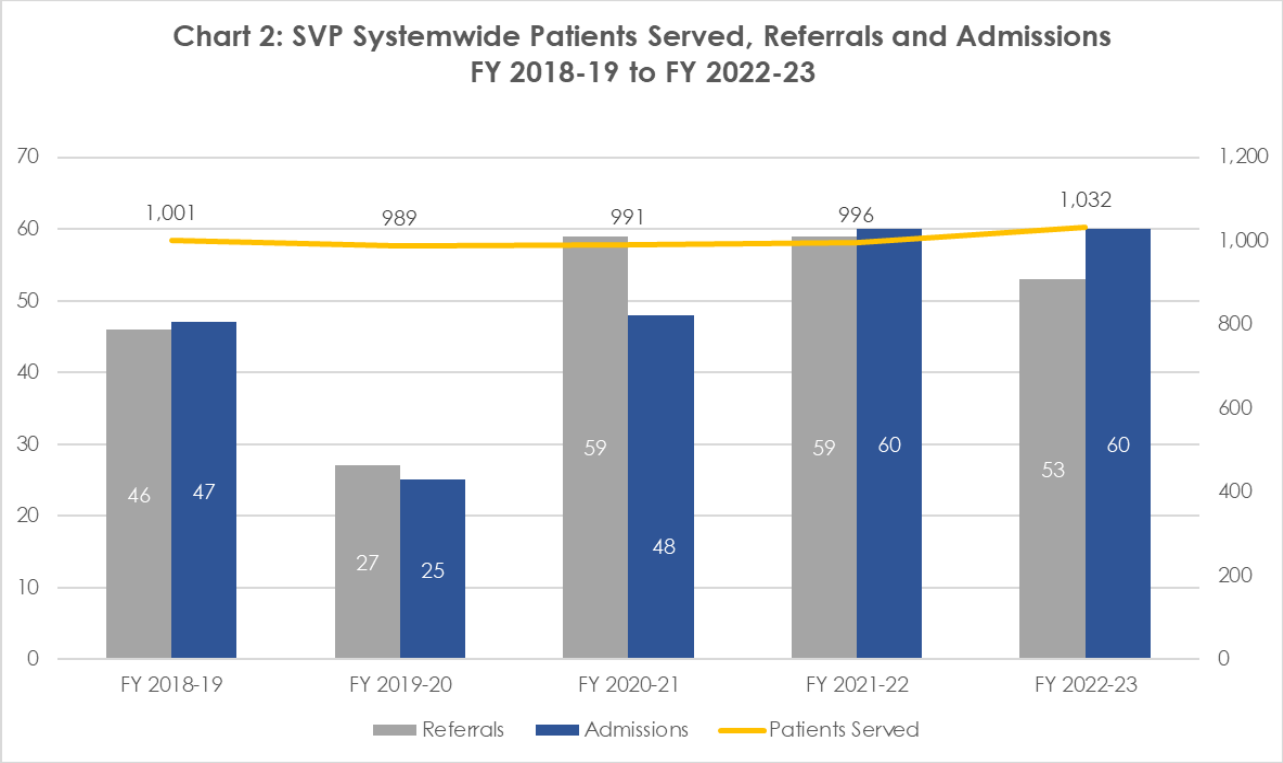
SVP Patient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Referrals	59	53	-10%
Patient Admissions	60	60	0%
Patients Served	996	1,032	4%
Average Daily Census	950	977	3%

Chart 1 displays SVP system-wide referrals and admissions for FY 2022-23.



[1] Referral counts do not reflect referrals for SVP evaluation. Referrals reflect the number of patients committed as SVP once there is a WIC section 6602 finding of probable cause. Patient referrals excludes other inpatient program transfers and court returns. Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

Chart 2 displays a five-year period of referrals and admissions for a broader historic view.[2]



The DSH system-wide SVP Pending Placement List (PPL) decreased 45% from the prior FY. FY 2022-23 began with 24 SVP patients pending placement in July 2022 and decreased by 54% to 11 patients pending placement in June 2023. The table below identifies the SVP PPL as of June 30 of the corresponding year.

Table 2: System-wide SVP Pending Placement List[3]

SVP Patients Pending Placement[4]	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
	<11	<11	11	20	11

Inpatient Program Metrics

Patients committed to DSH as SVP receive inpatient treatment at DSH-Coalinga. During FY 2022-23, DSH-Coalinga treated on average 956 SVP patients daily,

[2] Outpatient data is only included in FY 2021-22 and FY 2022-23 (Chart 2).
[3] The pending placement list reflects patients pending inpatient treatment.
[4] Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. Counts between 1-10 are masked with "<11". Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

maintaining a stable census across the FY. In July 2022, the average census was 957, decreasing slightly to 953 SVP patients in June 2023.

Table 3: SVP Inpatient Data Summary[5]

SVP Inpatient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Admissions	55	57	4%
Patients Served	981	1,013	3%
Average Daily Census	933	956	2%

DSH inpatient programs admitted 57 SVP patients in FY 2022-23 with an average of five admissions per month. Chart 3 displays inpatient program SVP admissions by quarter and the average monthly admissions rate.

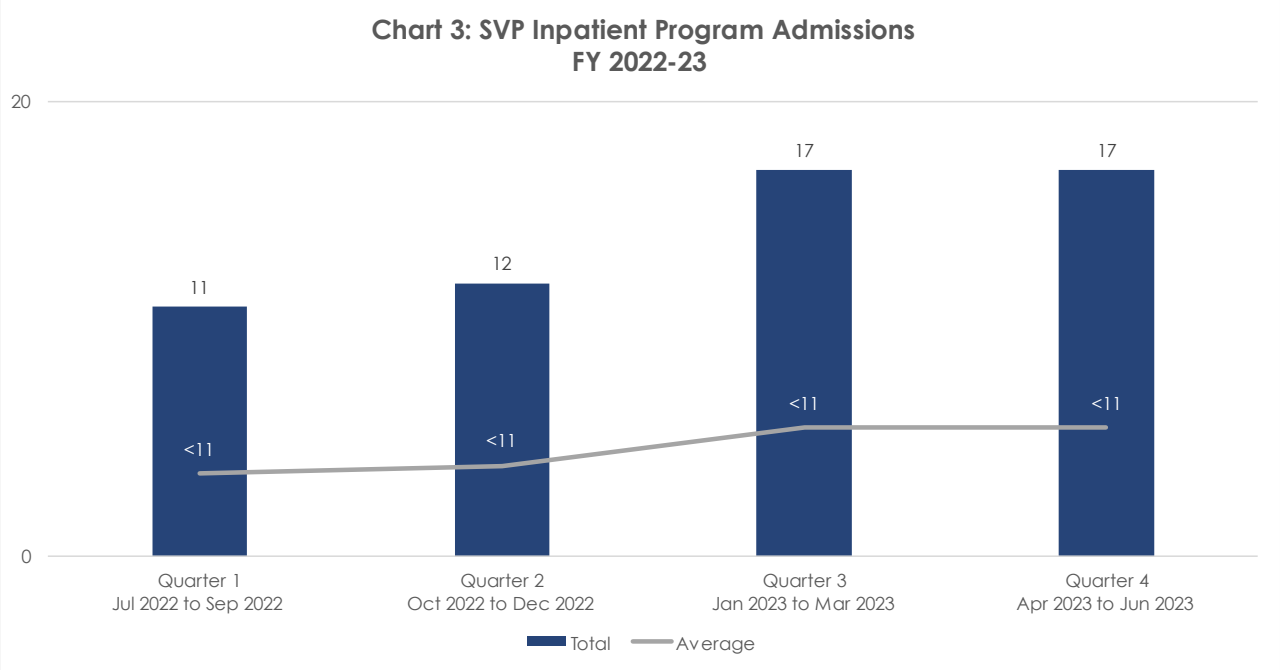


Table 4, below, displays the number of patients treated across the year.

Table 4: SVP Patients Served – Inpatient Programs[6]

Patients Treated/ Served	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
	1,001	989	991	981	1,013

[5] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.
[6] Patients served excludes other inpatient and outpatient program transfers.

WIC 6602 Inpatient Data

Patients committed pursuant to WIC 6602 make up 44% of the SVP patients treated within inpatient programs.

Table 5: WIC 6602 Inpatient Data Summary[7]

WIC 6602 Inpatient Data	FY 2021-22	FY 2022-23	Percent Change from Prior FY
Patient Admissions	50	39	-22%
Patients Served	451	449	-0.4%
Average Daily Census	398	400	0.3%

DSH discharged 36 WIC 6602 patients from inpatient programs with an average length of stay of 4,474.7 days (approximately 12 years) and a median length of stay of 4,755 days (approximately 13 years). 0% of WIC 6602 patients discharged within the first year of their stay, 6% discharged within the first five years of their stay, 31% discharged within ten years of their stay, and 69% had a length of stay longer than 10 years. The table below depicts the distribution of WIC 6602 patients discharged from inpatient treatment in FY 2022-23 by length of stay.

Table 6: WIC 6602 Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	0%
366 - 1,460 Days (2 - 4 years)	6%
1,461 - 1,825 days (4 - 5 years)	0%
1,826 - 3,650 days (5 - 10 years)	25%
3,651+ days (10+ years)	69%

Table 7, on the following page, displays inpatient programs length of stay for WIC 6602 patients by quarter for FY 2022-23.

[7] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

Table 7: WIC 6602 Inpatient Length of Stay by Quarter – FY 2022-23

6602 Inpatient Programs: Length of Stay Days (Years)	**Quarter 1** July 2022 to Sept. 2022	**Quarter 2** Oct. 2022 to Dec. 2022	**Quarter 3** Jan. 2023 to March 2023	**Quarter 4** April 2023 to June 2023	**Total** FY 2022-23
Average Length of Stay	4,967.4 (13.6 yrs.)	4,125.1 (11.3 yrs.)	4,389.9 (12.0 yrs.)	4,774.6 (13.1 yrs.)	4,474.7 (12.3 yrs.)
Median Length of Stay	5,222.0 (14.3 yrs.)	3,711.0 (10.2 yrs.)	4,981.0 (13.6 yrs.)	5,046.5 (13.8 yrs.)	4,755.0 (13.0 yrs.)
Discharged Count	<11	11	12	<11	36

For WIC 6602 patients yet to discharge the average days in treatment is 2,880.3 (7.9 years) and median days in treatment is 2,338.0 (6.4 years).

Table 8 displays the discharge locations for the 36 WIC 6602 patients discharged in FY 2022-23.

Table 8: WIC 6602 Inpatient Discharges by Location

6602 Inpatient Programs: Discharge Location	**Total** FY 2022-23	**Percent to Total**
Deceased	<11	***%
Discharged to Community[8]	30	83%
Locked Facility: CDCR, DJJ, Jail, Court, Other State Hospitals	<11	***%
Total Discharges	**36**	**100%**

WIC 6604 Inpatient Data

Patients committed pursuant to WIC 6604 make up 56% of the SVP patients treated within inpatient programs.

Table 9: WIC 6604 Inpatient Data Summary[9]

WIC 6604 Inpatient Data	**FY 2021-22**	**FY 2022-23**	**Percent Change from Prior FY**
Patient Admissions	<11	18	260%
Patients Served	530	564	6.4%
Average Daily Census	535	557	4.1%

DSH discharged 20 WIC 6604 patients from inpatient programs with an average length of stay of 5,392.2 days (approximately 15 years) and a median length of stay

[8] Less than 11 patients were conditionally discharged, the remaining were unconditional discharges.
[9] Patient admissions include other inpatient and outpatient program transfers. Patients served excludes other inpatient and outpatient program transfers.

of 5,724.5 days (approximately 16 years). 0% of WIC 6604 patients discharged within the first year of their stay, 5% discharged within the first five years of their stay, 15% discharged within ten years of their stay, and 85% had a length of stay longer than 10 years. The table below depicts the distribution of WIC 6604 patients discharged from inpatient treatment in FY 2022-23 by length of stay.

Table 10: WIC 6604 Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	0%
366 - 1,460 Days (2 - 4 years)	5%
1,461 - 1,825 days (4 - 5 years)	0%
1,826 - 3,650 days (5 - 10 years)	10%
3,651+ days (10+ years)	85%

The table below displays the FY 2022-23 length of stay by quarter for WIC 6604 commitments discharged from inpatient programs in FY 2022-23.

Table 11: WIC 6604 Inpatient Length of Stay by Quarter – FY 2022-23

6604 Inpatient Programs: Length of Stay Days (Years)	**Quarter 1** July 2022 to Sept. 2022	**Quarter 2** Oct. 2022 to Dec. 2022	**Quarter 3** Jan. 2023 to March 2023	**Quarter 4** April 2023 to June 2023	**Total** FY 2022-23
Average Length of Stay	5,157.3 (14.1 yrs.)	5,582.0 (15.3 yrs.)	5,215.0 (14.3 yrs.)	5,439.7 (14.9 yrs.)	5,392.2 (14.8 yrs.)
Median Length of Stay	5,426.0 (14.9 yrs.)	6,030.0 (16.5 yrs.)	5,898.0 (16.2 yrs.)	5,651.0 (15.5 yrs.)	5,724.5 (15.7 yrs.)
Discharged Count	<11	<11	<11	<11	20

For WIC 6604 patients yet to discharge the average days in treatment is 4,663.9 days (12.8 years) and the median days in treatment is 5,327.0 days (14.6 years).

The table below displays the discharge locations for the 20 WIC 6604 patients discharged in FY 2022-23.

Table 12: WIC 6604 Inpatient Discharges by Location

6604 Inpatient Programs: Discharge Location	**Total** FY 2022-23	**Percent to Total**
Community Outpatient Treatment	<11	***%
Deceased	***	***%
Total Discharges	**20**	**100%**

Outpatient Program Metrics

DSH SVP outpatient treatment programs are provided by CONREP. During FY 2022-23, DSH outpatient programs treated on average 21 SVP patients. In July 2022, the SVP patient average census was 19 with a 9% growth to 21 SVP patients in June 2023.

DSH outpatient programs admitted less than 11 SVP patients in FY 2022-23 with an average of less than 1% admissions per month. Chart 4 displays outpatient program SVP admissions by quarter.

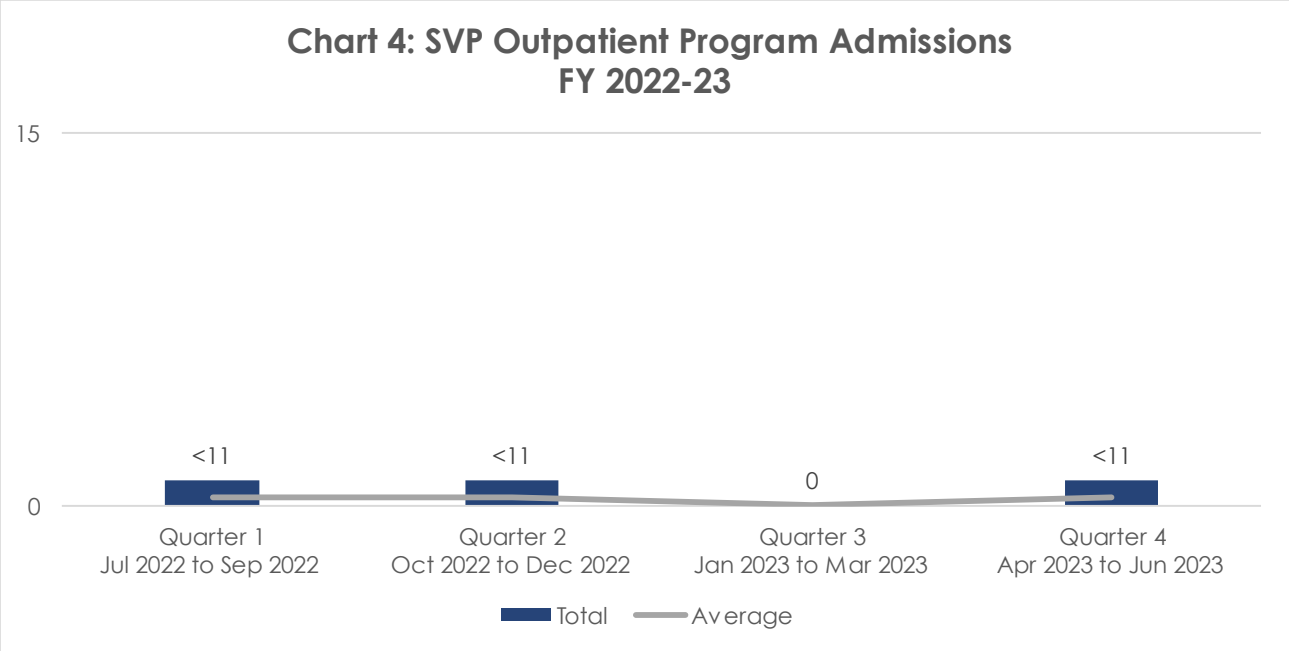


Table 13, below, displays the number of patients treated across the year in outpatient programs.

Table 13: SVP Patients Served – Outpatient Programs[10]

Patients Treated/Served	FY 2021-22	FY 2022-23
	15	19

DSH discharged less than 11 SVP patients from outpatient programs with an average length of stay and a median length of stay of 2,702.0 days (over 7 years) across all programs. 0% of SVP patients discharged within the first five years of their stay and 100% of the SVP patients discharged within ten years of their stay. Table 14, on the following page, displays outpatient length of stay by quarter.

[10] Patients served excludes other inpatient and outpatient program transfers.

Table 14: SVP Outpatient Length of Stay by Quarter – FY 2022-23

SVP Outpatient Programs: Length of Stay Days (Years)	**Quarter 1** July 2022 to Sept. 2022	**Quarter 2** Oct. 2022 to Dec. 2022	**Quarter 3** Jan. 2023 to March 2023	**Quarter 4** April 2023 to June 2023	**Total** FY 2022-23
Average Length of Stay	0.0	2,231.0 (6.1 yrs.)	0.0	3,173.0 (8.7 yrs.)	2,702.0 (7.4 yrs.)
Median Length of Stay	0.0	2,231.0 (6.1 yrs.)	0.0	3,173.0 (8.7 yrs.)	2,702.0 (7.4 yrs.)
Discharged Count	0	<11	0	<11	<11

DEPARTMENT OF STATE HOSPITALS - ATASCADERO

HISTORY

The Department of State Hospitals (DSH)-Atascadero is a secure forensic hospital located on the Central Coast of California, in San Luis Obispo County. It opened in 1954 and is a psychiatric hospital constructed within a secure perimeter. DSH-Atascadero treats only male patients, the majority of which are remanded for treatment by county superior courts or by the California Department of Corrections and Rehabilitation (CDCR). The hospital does not accept voluntary admissions.

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,275 beds. In fiscal year (FY) 2022-23, DSH-Atascadero served 1,067 patients. The commitment categories of patients treated at DSH-Atascadero are as follows:

Patient Commitments	Penal Code
Incompetent to Stand Trial	1370
Lanterman-Petris-Short	WIC 5000 Sec.
Offender with a Mental Health Disorder	2962 / 2972
Coleman/CDCR	2684
Not Guilty by Reason of Insanity	1026

HOSPITAL STAFF

Approximately 2,280 employees work at DSH-Atascadero providing 24/7 care, including psychologists, psychiatrists, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, and other clinical staff. In addition, there are various non-level of care staff at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, and other administrative staff.

TREATMENT AND PROGRAMS

The residential treatment programs, in conjunction with Recovery and Mall Services (defined below), provide a variety of patient, group, and unit-wide skills training, rehabilitative and enrichment activities. These activities are prescribed by the treatment team according to the patient's identified interests and assessed needs. Included in these activities is a vocational rehabilitation program which provides the patients with the opportunity to learn an increasing number of vocational and work skills under the direction of trained vocational counselors and a variety of school-based classes where patients can improve academic achievement, receive a General Education Diploma, or pursue advanced independent studies.

Program management is responsible for ensuring a safe and therapeutic environment through the appropriate management of resources and the delivery of group psychotherapy, psychoeducational and rehabilitation treatment specific to the patients' needs. When indicated, individual patient psychotherapy, vocational training, and educational training are also provided.

Treatment Plan

Treatment planning is directed toward the goal of helping patients to recover from psychiatric disability, which includes the reduction of symptoms, acquisition of skills for coping with the effects of mental illness, successful fulfillment of constructive adult roles, and the development of supports, which in combination, will permit maximum independence and quality of life. The planning process offers the patient, family members, relatives, significant others, and authorized representatives the full opportunity to participate meaningfully in the recovery and discharge process.

Each patient will have a comprehensive, individualized treatment plan based on the integrated assessments of mental health professionals. Therapeutic and rehabilitation services are designed to address each patient's needs and to assist

the patient in meeting specific treatment goals, consistent with generally accepted professional standards of care. Such plans are developed and reviewed on a regular basis in collaboration with the patient.

Treatment Team

The treatment team consists of an interdisciplinary core of members, including at least the patient, treating psychiatrist, psychologist, rehabilitation therapist, social worker, registered nurse, and psychiatric technician, and may include the patient's family, guardian, advocates, and attorneys as appropriate. Based on the patient's needs, other members may also include, but are not limited to registered dietitian, pharmacist, teacher, physical therapist, speech-language pathologist, occupational therapist, vocational services staff, and psychiatric nurse practitioner.

Families and officials (i.e., conservators) may be included as active participants with the team and may be of considerable assistance in assessment, planning, treatment, and post-hospital care of the patients. At the time of admission, families shall be notified so that they may meet with the team, provided the patient gives consent for notification.

Provision of Treatment, Rehabilitation, and Supplemental Activities

DSH's goal is to provide individualized active recovery services that focus on maximizing the functioning of persons with psychiatric disabilities. DSH endeavors to identify, support, and build upon each recovering patient's strengths to achieve maximum potential towards his or her hopes, dreams, and life goals.

Recovery and Mall Services (RMS)

RMS is a clinical treatment program that utilizes Recovery oriented Psychosocial Rehabilitation philosophy to provide quality, evidence based, recovery focused, therapeutic and rehabilitation services, as well as supplemental leisure activities designed to facilitate the psychiatric rehabilitation of patients at DSH-Atascadero. All services provided through RMS promote increased wellness and independent functioning. RMS provides centralized campus locations for treatment where facilitators from throughout the hospital may provide approved, scheduled treatment groups. These areas include the Phoenix Campus, Gymnasium, Community Center, Music Center, Main Courtyard and Art Center.

The RMS department offers Interfaith Services, Volunteer Services, Library Services through the Logan Library Patient and Professional Libraries, Aztec Adult School, Graphic Arts Services, Barbershop Services and Substance Use Recovery

Services. In addition, RMS also offers Vocational Training Programs that include Printing/Graphic Arts and Landscape Gardening. Furthermore, RMS offers scheduled hospital-wide supplemental activities, events and meetings including but not limited to: Phoenix Club, Incentive Bingo and Community Center, Evening Open Gym, Monthly Birthday Party, and the Hospital Advisory Council meetings.

Central Medical Services (CMS)

CMS provides medical care and evaluation to all patients in the hospital. These services include radiology, public health, laboratory, physical therapy, dentistry, pharmacy, medical clinics, unit sick call, contractual services inside and outside the hospital, and review of community-based consultations. Services are available to patients on referral from general physicians and psychiatrists who have primary responsibility for the care of patients on residential treatment units.

Enhanced Treatment Program (ETP)

The ETP is designed to provide enhanced treatment in a secure setting for patients at the highest risk of most dangerous behavior. The ETP is intended to provide increased therapy opportunities within a structured, least restrictive environment. The ETP is to be utilized when safe treatment is not possible in a standard treatment environment. The pilot is driven by Assembly Bill 1340. Unit 29 opened in September 2021 and the Budget Act of 2022 postponed the activation of Units 33 and 34 due to the ongoing bed capacity pressures within the DSH system.

The ETP model allows for enhanced staffing which includes a complement of Clinical, Nursing and Hospital Police Officer (HPO) staff. Classifications utilized include Staff Psychiatrist, Clinical Psychologist, Clinical Social Worker, Rehabilitation Therapist, Registered Nurse, and Psychiatric Technician.

ACCREDITATION AND LICENSURE

DSH-Atascadero is accredited by The Joint Commission (TJC) an independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States. TJC conducts unannounced surveys of this hospital at least every three years. The purpose of the survey is to evaluate the hospital's compliance with nationally established TJC standards. The survey results are used to determine whether accreditation should be awarded and whether certain conditions or reporting requirements should be implemented to maintain accreditation status. TJC standards deal with subject matter such as organization quality, patient safety, provision of care, treatment, and services, as well as the environment in which care is provided.

DSH-Atascadero is licensed by the California Department of Public Health and has eight units licensed as acute psychiatric. An acute psychiatric facility means having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy and dietary services. DSH-Atascadero also has 26 units licensed as Intermediate Care Facility (ICF). An ICF means a health facility that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care.

TRAINING AND INTERNSHIPS

DSH-Atascadero offers various training and internship opportunities across many clinical disciplines. Please see the table below for a brief description of DSH-Atascadero's training programs.

DSH-Atascadero Training Programs

DISCIPLINE	PROGRAM TYPE
Nursing	•Registered Nursing Programs Clinical Rotation •Nursing Students Preceptorship
Pharmacy [1]	•Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools.
Physician and Surgeon [2]	•Accepts Contracted Students
Psychiatric Technicians [3]	•Psychiatric Technician Trainee •Pre-Licensed Psychiatric Technician •20/20 Psychiatric Technician Training Program
Psychology	•American Psychological Association Approved Pre-Doctoral Internship
Registered Dietitians	•Accredited Dietetic Internship •Contracted Cal-Poly San Luis Obispo Dietetic Internship
Rehabilitation Therapy	•Recreation Therapy (Student Assistants) •Music Therapy (Student Assistants)
Social Work	•Paid MSW Internship (Graduate Student Assistant) •Social Work Intern (Student Assistant)

[1] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools. The preceptor at each of the hospitals will communicate with the schools to determine when to send students for their clinical rotations. The contracted schools are University of Southern California (USC), University of California-San Francisco (UCSF), Touro University California College of Pharmacy, California North State University, California Health Sciences University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (UOP), Western University of Health Science, Chapman University.

[2] **Physician and Surgeon:** Accepts Family Nurse Practitioner students who need clinical hours. They can execute contracts with the school to formalize these rotations.

[3] **Psychiatric Technicians:** 1. Psychiatric Technician Trainees are currently enrolled in a Psychiatric Technician School and work part time inside DSH hospitals (up to 20 hours/week). 2. Pre-Licensed Psychiatric Technicians are graduates from Psychiatric Technician School but have not yet passed the state licensing exam. They are limited to 9 months in that role (test must be passed within the 9 months) and work full time with some limitations on their job responsibilities. 3. 20/20 Psychiatric Technician training programs are open to current employees that have been accepted into a Psychiatric Technician School. The modified work hours shall be a maximum of twelve (12) months in length and the amount of the 20/20 time utilized by each selected employee will depend on the type of education/training programs available.

DEPARTMENT OF STATE HOSPITALS – COALINGA

HISTORY

The Department of State Hospitals (DSH)-Coalinga is located at the edge of the Coastal Mountain Range on the western side of Fresno County. Coalinga is halfway between Los Angeles and San Francisco and 60 miles southwest of Fresno.

DSH-Coalinga opened in 2005 and began treating forensically committed patients, most of which are sexually violent predators (SVPs). It is a self-contained psychiatric hospital constructed with a security perimeter. California Department of Corrections and Rehabilitation (CDCR) provides perimeter security as well as transportation of patients to outside medical services and court proceedings. The hospital does not accept voluntary admissions.

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,500 beds. In fiscal year (FY) 2022-23, DSH-Coalinga served 1,341patients. The commitment categories of patients treated at DSH-Coalinga are as follows:

Patient Commitments	Code Section
Lanterman-Petris-Short	WIC 5000 Sec.
Offender with a Mental Health Disorder	2972
Coleman/CDCR	2684
Not Guilty by Reason of Insanity	1026
Mentally Disordered Sex Offenders	6316 (WIC)
Sexually Violent Predators	6602/6604

HOSPITAL STAFF

Approximately 2,490 employees work at DSH-Coalinga providing 24/7 care, including psychologists, psychiatrists, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, and other clinical staff. In addition,

there are various non-level of care job classifications at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, and other administrative staff.

TREATMENT AND PROGRAMS

The fundamental goal of the DSH-Coalinga Sex Offenders Treatment Program is for the patient to acquire pro-social skills and to prevent recurrence of sexual offending. The program combines components of the Self-Regulation/Better Life models with the principles of Risk-Need-Responsivity (RNR). This combined approach strengthens the patient's self-regulation skills to prepare for a life free of sexual offending. The three principals of the RNR model are explained here in more detail.

The risk principle involves matching the intensity of treatment to the patient's risk level of reoffending, with high-risk offenders receiving more intensive and extensive treatment than low-risk offenders. Offense risk is determined by the combination of static and dynamic risk factors.

The need principle focuses on assessing dynamic risk factors and targeting them in treatment. Dynamic Risk Factors are defined as enduring but changeable features of an offender; they are amenable to interventions, and when successfully addressed, result in a decrease in recidivism risk.

The responsivity principle states that services should be delivered in a manner that is engaging and consistent with the learning style of the individual. Examples include fostering strengths; establishing meaningful relationships; and attending to relevant characteristics such as age, cognitive skills, cultural factors, and emotional regulation issues. It also states that the primary treatment components should use social learning and cognitive-behavioral approaches. Empirical studies indicate that adhering to RNR principles can maximize treatment effects and reduce recidivism.

The Self-Regulation/Better Life model also provides some educational opportunities, vocational services, and recreational activities. Individuals with intellectual disabilities or severe psychiatric disorders participate in programs adapted for their treatment needs.

LICENSURE

DSH-Coalinga is licensed by the California Department of Public Health. DSH-Coalinga has two units designated as acute psychiatric. An acute psychiatric

facility means having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy and dietary services. In addition, DSH-Coalinga currently has 24 units licensed as an Intermediate Care Facility (ICF). An ICF is defined as a health facility that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care. In May of 2023, DSH-Coalinga converted an additional Residential Recovery Units (RRU) to an ICF, bringing the total number of licensed units to 24. In addition, DSH-Coalinga has six unlicensed RRUs, which provides inpatient care to patients who are required to reside at DSH but have a lesser need for supervision.

TRAINING AND INTERNSHIPS

DSH-Coalinga offers various training and internship opportunities across many clinical disciplines. Please see the table below for a brief description of DSH-Coalinga's training programs.

DSH-Coalinga Training Programs

DISCIPLINE	PROGRAM TYPE
Nursing	• Registered Nursing Programs Clinical Rotation • Nursing Students Preceptorship
Pharmacy [1]	•Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools.
Psychiatric Technicians [2]	•Psychiatric Technician Trainee •Pre-Licensed Psychiatric Technicians •20/20 Psychiatric Technician Training Program
Psychology	•American Psychological Association Approved Pre-Doctoral Internship
Rehabilitation Therapy [3]	•Recreation Therapy (Student Assistants) •Recreation Therapy Internship Program •Music Therapy (coming soon)
Social Work [4]	•Masters of Social Work Internships (Graduate Student Assistants)

[1] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools. The preceptor at each of the hospitals will communicate with the schools to determine when to send students for their clinical rotations. The contracted schools are University of Southern California (USC), University of California-San Francisco (UCSF), Touro University California College of Pharmacy, California North State University, California Health Sciences University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (UOP), Western University of Health Science, Chapman University.

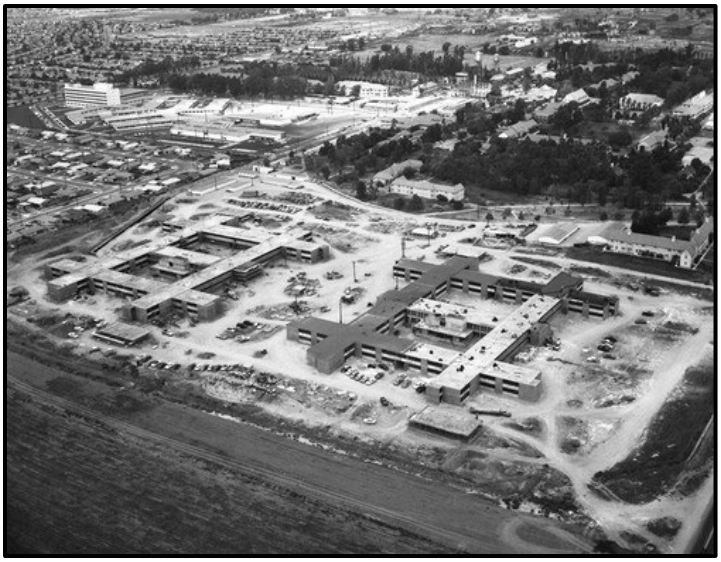
[2] **Psychiatric Technicians:** 1. Psychiatric Technician Trainees are currently enrolled in a Psychiatric Technician School and work part time inside DSH hospitals (up to 20 hours/week). 2. Pre-Licensed Psychiatric Technicians are graduates from Psychiatric Technician School but have not yet passed the state licensing exam. They are limited to 9 months in that role (test must be passed within the 9 months) and work full time with some limitations on their job responsibilities. 3. 20/20 Psychiatric Technician training programs are open to current employees that have been accepted into a Psychiatric Technician School. The modified work hours shall be a maximum of twelve (12) months in length and the amount of the 20/20 time utilized by each selected employee will depend on the type of education/training programs available.

[3] **Recreational Therapy Internship:** Recreational Therapy Internship Candidates are in their final semester of their degree and are required to complete a minimum of a 14-week 560-hour internship. Partners can be made with any accredited school in the country with a Recreational

Therapy or Therapeutic Recreation program. The specific DSH-C Recreation Therapy Internship Program lasts for a minimum of 17-weeks due to New Employee Orientation. Once completed, students are eligible for national certification with National Council for Therapeutic Recreation Certification (NCTRC). To ensure the safety and well-being of students, patients, and staff, the internship is designed to follow the guidelines outlined in the American Therapeutic Recreation Association (ATRA) Code of Ethics. DSH-Coalinga can provide current opportunities for skill growth and professional development in accordance with American Music Therapy Association (AMATA) guidelines.

[4] **Social Work:** The Master of Social Work Internship program accepts six Graduate Student Assistants per academic program year. Graduate students are currently enrolled in a Master of Social Work program at an accredited university and complete at least 20 internship hours at DSH-C each week. The Field Instructor and Preceptor for each student will communicate with one another throughout the internship to assess progress and determine appropriate rotation throughout the hospital. The Social Work Department is currently contracted with nine Master of Social Work universities. The contracted schools include University of California (USC), California State University Fresno (CSUF), California State University Bakersfield (CSUB), California State University Monterey Bay (CSUMB), San Jose State University (SJSU), Arizona State University (ASU), Campbellsville University (CU), UMASS Global, and Simmons University.

DEPARTMENT OF STATE HOSPITALS – METROPOLITAN



HISTORY

The Department of State Hospitals (DSH)-Metropolitan opened in 1916 as a self-sufficient facility with its own dairy cows, pigs, chickens, and farmland. Located in Norwalk in Los Angeles (LA) County, today it serves as a modern-day psychiatric facility providing state of the art psychiatric care. The hospital is an open style campus within a security perimeter. Due to concerns raised by the community, DSH-Metropolitan maintains a formal agreement with the City of Norwalk and the LA County Sheriff not to accept patients charged with murder or a sex crime, or at high risk for escape. The hospital does not accept voluntary admissions.

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,106 beds. In fiscal year (FY) 2022-23, DSH-Metropolitan served 762 patients. The commitment categories of patients treated at DSH-Metropolitan are as follows:

Patient Commitments	Penal Code
Incompetent to Stand Trial	1370
Lanterman-Petris-Short	WIC 5000 Sec.
Offender with a Mental Health Disorder	2972
Not Guilty by Reason of Insanity	1026

HOSPITAL STAFF

Approximately 2,270 employees work at DSH-Metropolitan providing 24/7 care, including psychiatrists, psychologists, social workers, rehabilitation therapists, registered nurses, psychiatric technicians, and other clinical staff. In addition, there are various non-level of care staff at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, teachers, and other administrative staff.

TREATMENT AND PROGRAMS

DSH-Metropolitan is the first state hospital to have a specialized unit dedicated to Dialectical Behavior Therapy (DBT). DBT is a systematic cognitive-behavioral approach founded in the late 1970s by psychologist Marsha Linehan. It balances principles of acceptance (mindfulness) and change (behaviorism) and is effective for treating complex, difficult-to-treat mental disorders. Research indicates DBT to be effective in reducing:

- Suicidal and self-injurious behaviors
- Treatment resistant depression
- Intense anger or difficulty with controlling emotions
- Impulsive behaviors that are potentially self-damaging (e.g., substance abuse, eating disorders)
- Treatment dropout
- Psychiatric hospitalizations

DSH-Metropolitan has a specialized unit dedicated to DBT as a treatment modality for patients who are diagnosed with a serious mental illness and who typically have a complex response to trauma that directly influenced their attachment styles, coping mechanisms, and interpersonal relationships. Each patient in the DBT Program participates in the following activities:

- DBT Skills Groups which include four modules: Mindfulness, Emotional Regulation, Distress Tolerance, and Interpersonal Relationships
- Homework and Review Group
- Weekly Individual Therapy
- Bi-Weekly Outings
- Groups focused on practicing and applying skills

Other treatment programs include:

Trial Competency Program

The Trial Competency Program is for patients admitted to the hospital pursuant to Penal Code (PC) 1370, Incompetent to Stand Trial (IST). The IST patients are trial defendants determined by the court to be unable to participate in their trial because they are not able to understand the nature of the criminal proceedings or assist counsel in the conduct of their defense due to psychiatric symptoms associated with a mental illness. These patients receive a specialized program of treatment which is specifically designed to help the patient gain the knowledge and skills necessary to return to court. The goal is for the patient to understand court proceedings and effectively participate in their defense. Treating the defendant as IST and returning to court for trial is sometimes followed by a court determination that the defendant is Not Guilty by Reason of Insanity (NGI) and requires further treatment under PC 1026.

Offender with a Mental Health Disorder (OMD) Program

The OMD Program is for patients paroled to the hospital by authority of the Board of Paroles under provisions of PC 2962. Patients may be released to parole, placed in a Conditional Release Program (CONREP), or become civilly committed.

Lanterman-Petris-Short (LPS) Program

The LPS Program provides treatment for civilly committed patients who suffer from severe symptoms of mental illness, who engage in the behaviors that are dangerous to themselves or others, or who are gravely disabled by their mental illness and thereby unable to formulate a viable plan for self-care. The program provides a highly structured treatment environment for re-socialization in preparation for community placement.

Skilled Nursing Facility (SNF)

The fully licensed SNF provides continuous nursing treatment and care for both Penal Code (PC) and civilly committed patients whose primary need is availability of skilled nursing care on an extended basis. Program objectives include the provision of interventions that are person-appropriate, foster hope and caring, and honor the resident's individual rights, cultural differences, spirituality and dignity.

ACCREDITATION AND LICENSURE

DSH-Metropolitan is accredited by The Joint Commission (TJC) an independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States. TJC conducts unannounced surveys of this hospital at least every three years. The purpose of the survey is to evaluate the hospital's compliance with nationally established TJC standards. The survey results are used to determine whether accreditation should be awarded and under what conditions that happens. TJC standards evaluate organization quality, safety of care issues and the safety of the environment in which care is provided.

DSH-Metropolitan is licensed by the California Department of Public Health and has 23 units designated as acute psychiatric. An acute psychiatric facility means having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary services. DSH-Metropolitan also has three units designated as a Skilled Nursing Facility (SNF). A SNF means a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis.

TRAINING AND PARTNERSHIPS

DSH-Metropolitan offers various training and internship opportunities across many clinical disciplines. Please see the table below for a brief description of those training programs.

DSH-Metropolitan Training Programs

DISCIPLINE	PROGRAM TYPE
Nursing [1]	• Registered Nursing Clinical Rotation Programs • Nursing Students Preceptorship
Pharmacy [2]	•Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools.
Physician and Surgeon	•Student Volunteer Opportunities
Psychiatric Technicians [3]	•20/20 Psychiatric Technician Training Programs
Psychiatry	•Pacific Northwest University – Psychiatry Clerkship •Western University of Health Sciences – Psychiatry Clerkship •Psychiatric Fellowship Program for Child Psychiatry
Psychology	•Association of Psychology Postdoctoral and Internship Center – Affiliated Internship Program
Registered Dietitians	•Accredited Dietetic Internship
Rehabilitation Therapy	•Art Therapy (Loyola Marymount University/ Practicum Students) •Music Therapy (American Music Therapy Association National Roster Internship Program /Volunteer Positions) •Recreation Therapy (Volunteer Positions)
Social Work	•Masters of Social Work Internships (Volunteer Positions)

[1] **Nursing:** Preceptorship for Bachelor of Science in Nursing (BSN) and Master of Science in Nursing (MSN) programs available on an individual basis.

[2] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools. The preceptor at each of the hospitals will communicate with the schools to determine when to send students for their clinical rotations. The contracted schools are University of Southern California (USC), University of California-San Francisco (UCSF), Touro University California College of Pharmacy, California North State University, California Health Sciences University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (UOP), Western University of Health Science, Chapman University.

[3] **Psychiatric Technicians:** DSH-Metropolitan offers 20/20 Psychiatric Technician training program for only Psychiatric Technician Assistants to become a Psychiatric Technician. The modified work

hours shall be a maximum of twelve (12) months in length and the amount of the 20/20 time utilized by each selected employee will depend on the type of education/training programs available.

DEPARTMENT OF STATE HOSPITALS – NAPA

HISTORY

In 1872, a site was selected, and work began for the erection of the 500-bed, four-story, Gothic Style Hospital building. The Hospital originated in response to overcrowding at Stockton Asylum, the first State Hospital. The Department of State Hospitals (DSH)-Napa opened on Monday, November 15, 1875, and is the oldest State Hospital still in operation. DSH-Napa was once self-sufficient, with its own dairy and poultry ranches, vegetable gardens, orchards, and other farming operations. The hospital does not accept voluntary admissions.

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,418 beds, but current maximum capacity is 1,374 beds. In fiscal year (FY) 2022-23, DSH-Napa served 1,103 patients. The commitment categories of patients treated at DSH-Napa are as follows:

Patient Commitments	Code Section
Incompetent to Stand Trial	1370
Lanterman-Petris-Short	WIC 5000 Sec.
Offender with a Mental Health Disorder	2972
Not Guilty by Reason of Insanity	1026
Recommitment After Expiration of Prison Term (Must have concurrent W&I commitment)	2974
Department of Juvenile Justice	-

HOSPITAL STAFF

Approximately 2,670 employees work at DSH-Napa, providing 24/7 care, including psychologists, psychiatrists, physicians, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, and other clinical staff. In addition, there are various non-level of care job classifications at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, and other administrative staff.

TREATMENT PROGRAMS

Patients are screened prior to being scheduled for admission to ensure that DSH-Napa is the appropriate treatment setting. One treatment program is located outside the Secure Treatment Area (STA) for primarily civil commitments and four programs are located inside the STA for forensic commitments. Within these treatment programs there are residential units, each having a focus on a particular population and treatment. Staff orients the patient to the unit on arrival. Members of the Treatment Team meet with patients and continue the assessment process and develop treatment plans. Once developed, the plan is reviewed regularly by the Treatment Team and updated as the patient progresses, and treatment objectives change. Family, significant others, conservators, Conditional Release Program (CONREP) and the courts may play a role as the patient moves through the continuum of care from admission to discharge.

In addition to the living units there are other service sites. For instance, Mall Services provides a variety of off unit services for patients. Mall Services is a centralized approach to delivering services where the patients and staff from throughout the hospital come together to participate in services. Mall Services represents more of a centralized system of programming rather than a reference to a specific building or certain location. The services are provided, as much as possible, in the context of real-life functioning and in the rhythm of life of the patient. Thus, Mall Services extends beyond the context of a "building or place," and its services are based on the needs of the patient, not the needs of the program, the staff members, or the institution. Vocational Services provides opportunities for patients to develop job skills and habits, as well as earn funds. Educational Services enables patients to continue their education, high school, or college, and provide skills groups for anger management and development of interpersonal skills. Rehabilitation Therapy Services, facilitated by music, dance, art, occupational and recreation therapists, provide treatment groups to engage the patient in wellness and improved quality of life. Rehabilitation Therapy Services also provides physical, occupational, and speech therapies.

Department of Medicine and Ancillary Services provides clinics that deliver various medical services, including, but not limited to primary care, dental, podiatry, neurology, cardiac and obstetrics and gynecology clinics.

The goal of treatment services is to assist patients to recognize and manage psychiatric symptoms. Patients also work on developing socially responsible behaviors, independent living skills, and coping skills to address their mental illness and forensic issues.

Specialty units include:

- Admission units- focused on completion of initial assessments and initiation of behavioral stabilization.
- Incompetent to Stand Trial (Penal Code (PC) 1370) treatment, focuses on trial competency treatment, attainment of competency and return them to court for adjudication of pending charges. Patients participate in a wide range of mental health groups and therapeutic activities to assist in addressing symptoms and behaviors that may interfere with their ability to understand the court proceedings and to cooperate with their attorney in preparing a defense.
- Other commitments proceed from admission units through the continuum of care from stabilization to discharge. During a patient's stay some patients may receive specialized treatment.
    - Dialectic Behavior Therapy (DBT) involves individualized treatment and unit milieu management that focuses on supporting patient's use of DBT skills to minimize harm to self and others
    - Treatment for polydipsia (intoxication resulting from excessive consumption of fluids)
    - Sex offender treatment
    - Intensive Substance Abuse Recovery
    - Geropsychiatric
- Discharge units focus on skills development for community living and on relapse prevention. Each patient prepares a personalized relapse prevention plan. The Treatment Teams work closely with CONREP towards returning patients to the community under CONREP supervision.

ACCREDITATION AND LICENSURE

DSH-Napa is accredited by The Joint Commission (TJC) and independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States. TJC conducts unannounced surveys of this hospital at least every three years. The purpose of the survey is to evaluate the hospital's compliance with nationally established TJC standards. The

survey results are used to determine whether accreditation should be awarded and whether certain conditions or reporting requirements should be implemented to maintain accreditation status. TJC standards deal with subject matter such as organization quality, patient safety, provision of care, treatment, and services, as well as the environment in which care is provided.

DSH-Napa is licensed by the California Department of Public Health and has two units designated as acute psychiatric. An acute psychiatric facility means having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy and dietary services. DSH-Napa has one unit designated as a Skilled Nursing Facility (SNF). A SNF is a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. Additionally, DSH-Napa has 33 units designated as an Intermediate Care Facility (ICF). An ICF means a health facility that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care.

TRAINING AND PARTNERSHIPS

DSH-Napa offers various training and internship opportunities across many clinical disciplines. Please see the table below for a brief description of DSH-Napa's training programs.

DSH-Napa Training Programs

DISCIPLINE	PROGRAM TYPE
Nursing	• Registered Nursing Programs Clinical Rotation
Pharmacy [1]	•Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools.
Psychiatric Technicians [2]	•Psychiatric Technician Apprentice •Pre-Licensed Psychiatric Technicians •Psychiatric Technician Prorams Clinical Rotation
Psychiatry	•UC Davis, Psychiatry and Law •Touro University •Clinical Clerkships for Medical School Graduates •Residency Program with St. Joseph Medical Center
Psychology	•American Psychological Association Approved Pre-Doctoral Internship
Registered Dietitians	•Accredited Dietetic Internship
Rehabilitation Therapy	•Recreation Therapy Internship •Occupational Therapy •Music Therapy •Dance Movement Therapy •Art Therapy
Social Work	•Masters of Social Work Internships (Open to 2nd year MSW students)

[1] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools. The preceptor at each of the hospitals will communicate with the schools to determine when to send students for their clinical rotations. The contracted schools are University of Southern California (USC), University of California-San Francisco (UCSF), Touro University California College of Pharmacy, California Health Sciences University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (UOP), Western University of Health Science, Chapman University. University of Southern California (USC), University of California-San Francisco (UCSF), Touro University California College of Pharmacy, California Health Sciences

University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (UOP), Western University of Health Science, Chapman University.

[2] **Psychiatric Technicians:** 1. Psychiatric Technician Apprentice - This class is limited term and designed for entrance and performance in an apprentice program leading to status as a licensed Psychiatric Technician. Persons in this class receive training under the provisions of apprenticeship standards and written apprentice agreements under Chapter 4, Division 3, California Labor Code. 2. Pre-Licensed Psychiatric Technicians are graduates from Psychiatric Technician School but have not yet passed the state licensing exam. They are limited to 9 months in that role (test must be passed within the 9 months) and work full time with some limitations on their job responsibilities.

DEPARTMENT OF STATE HOSPITALS – PATTON

HISTORY

The Department of State Hospitals (DSH)-Patton is a secure forensic psychiatric hospital located in San Bernardino County. DSH-Patton was established in 1890 and opened in 1893. DSH-Patton provides treatment to forensically and civilly committed patients within secure treatment areas (STA's). The hospital does not accept voluntary admissions.

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,287 beds. In fiscal year (FY) 2022-23, DSH-Patton served 1,416 patients. The commitment categories of patients treated at DSH-Patton are as follows:

Patient Commitments	Penal Code
Incompetent to Stand Trial	1370
Lanterman-Petris-Short	WIC 5000 Sec.
Offender with a Mental Health Disorder	2962 / 2972
Coleman/CDCR	2684
Not Guilty by Reason of Insanity	1026

HOSPITAL STAFF

Approximately 2,570 employees work at DSH-Patton providing 24/7 care, including psychiatrists, psychologists, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, registered dieticians, and other clinical staff. In addition, there are various non-level-of-care staff at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, information technology staff, plant operations staff, spiritual leaders, and other administrative staff.

TREATMENT AND PROGRAMS

The Trial Competency treatment along with the Court Preparation Project is for patients admitted to the hospital under Penal Code (PC) 1370 as Incompetent to Stand Trial. These patients receive a specialized constellation of treatment which is designed to specifically help the patient gain the knowledge and skills necessary to return to court. The goal is for the patient to understand court proceedings and effectively participate in their defense.

The focus of treatment for Offenders with a Mental Disorder (OMD) and Not Guilty by Reason of Insanity (NGI) population emphasizes the potential for each patient to learn new skills and adaptive coping mechanisms to manage symptoms of a mental illness, while also enhance the patient's awareness and insight into symptoms that led to dangerousness in the past. Other goals include motivation for treatment, development of social skills, understanding co-occurring disorders, independence in Activities of Daily Living (ADL), and helping patients to create an overall lifestyle of recovery from mental illness, addiction, and other co-morbid conditions. Treatment also focuses on improving patients' quality of life for preparation and eventual successful and effective transition to Community Outpatient Treatment (COT) or a less restrictive setting.

All treatment programs at DSH-Patton utilize the recovery philosophy as well as a Trauma-Informed Care approach, offering a broad spectrum of treatment, while fully endorsing the hospital's mission to provide comprehensive clinical services within the context of a biopsychosocial rehabilitation model within an environment of safety and security for all patients, staff, and the community in an atmosphere of dignity and respect.

Enhanced Treatment Program (ETP)

The ETP is designed to provide enhanced treatment in a secure setting for patients at the highest risk of most dangerous behavior. The ETP is intended to provide increased therapy opportunities within a structured, least restrictive environment. The ETP is to be utilized when safe treatment is not possible in a standard treatment environment. The pilot is driven by Assembly Bill 1340. The Budget Act of 2023 reported the project had been rephased while fire sprinkler redesign and State Fire Marshal approvals continue in other areas of the building.

The ETP model allows for enhanced staffing which includes a complement of Clinical, Nursing and Hospital Police Officer (HPO) staff. Classifications utilized include Staff Psychiatrist, Clinical Psychologist, Clinical Social Worker, Rehabilitation Therapist, Registered Nurse, and Psychiatric Technician.

ACCREDITATION AND LICENSURE

DSH-Patton is awarded the *Gold Seal of Approval* for achieving accreditation under the Hospital Accreditation Program (HAP) by The Joint Commission (TJC) recognized as an independent, not-for-profit organization and the largest standards-setting and accrediting body in healthcare. The HAP accreditation program is achieved upon successful completion of an on-site triennial survey attained by meeting rigorous performance standards, delivering the best quality care, and exhibiting a culture of excellence that inspires to continually improve performance. The hospital sustains accreditation with a mutual belief in patient and employee safety, effective care processes, patient outcomes using evidence-based practices, maintenance in environmental engineering controls, and, performance analysis studies, which are collectively woven into the fabric of our healthcare organization's operation. The hospital recognizes accreditation does not begin and end with an on-site survey, it is a continuous process of monitoring, communication, transparency, education and evaluating sustainability.

DSH-Patton is licensed as an Acute Psychiatric Hospital (APH) by the California Department of Public Health – Licensing and Certification Unit governed by the provisions of the Health and Safety Code of California and its rules and regulations to operate and maintain Acute Psychiatric Care and Intermediate Care bed classifications. Patton hospital meets the APH definition by demonstrating a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients the following basic services: medical, nursing, rehabilitative, pharmacy and dietary services. DSH-Patton is licensed to provide services for 1,287 patients and with additional housing not to exceed total 1,530 patient beds in adherence to the Welfare and Institutions Code, Section 4107 (c) defining the joint plan between the California Department of Corrections and Rehabilitation and the State Department of Mental Health. DSH-Patton's licensing operation also includes Physical Therapy, Radiological Services, Social Services and Speech Pathology. The hospital maintains licensure through frequent on-site surveys that includes a robust review on the hospitals' safety, environment, effectiveness, and quality of healthcare, every three years for Acute units and two years for Intermediate Care units. Communication, education, performance improvement studies, quality improvement analysis and risk management awareness and interventions are additional priorities to the hospital's continued emphasis for optimal patient care and treatment.

DSH-PATTON MUSEUM

On April 17, 2015, the DSH-Patton Museum opened its doors for the first time to the public. The on-site museum examines the history of psychiatric treatment in California state-run facilities and offers a glimpse of the evolution of mental health treatment during the last 127 years.

Patton accepted its first patients on August 1, 1893. The museum, only the second of its kind west of the Mississippi River, features more than 140 artifacts. Among the artifacts found in the museum are original medical and surgical equipment, firefighting equipment from the early part of the last century and nursing uniforms from the 1950s. It explores the complex and extensive history of Patton State Hospital, including its history as a general psychiatric hospital and the transition to a forensic facility. It avoids reinforcing stigma and attempts to be inclusive of the various individuals whose experiences are reflected in the hospital's past.

The museum itself is located on the grounds of the hospital in a 1920s cottage home that once was inhabited by hospital staff and their families. Since the museum's opening, numerous Southern Californians have visited for tours and researchers from as far away as South Africa have presented to experience the museum. The DSH-Patton Museum remains a valuable resource for state employees and members of the public by providing insight and information about an institution with deep local roots and a history that exemplifies the progression of mental health treatment in America.

TRAINING AND PARTNERSHIPS

DSH-Patton offers various training and internship opportunities across many clinical disciplines. Please see the table below for a brief description of DSH-Patton's training programs.

DSH-Patton Training Programs

DISCIPLINE	PROGRAM TYPE
Nursing	• Registered Nursing Programs Clinical Rotation
Pharmacy [1]	•Systemwide, DSH's pharmacy discipline is currently contracted with 13 pharmacy schools.
Psychiatric Technicians [2]	•20/20 Psychiatric Technician Program
Psychiatry	•Loma Linda University Clerkship •Loma Linda University Forensic Psychiatry Residency •UC Riverside •Western University of Health Sciences •CA University of Science and Medicine
Psychology	•Practicum •American Psychological Association •Approved Pre-Doctoral Internship •Post-Doctoral Fellowship
Registered Dietitians	•Accredited Dietetic Internship
Rehabilitation Therapy	•Recreation Therapy (Student Assistants)
Social Work	•Master of Social Work Graduate Students (GSA Paid Internship) •Bachelor of Social Work Students (Volunteer Status)

[1] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with 13 pharmacy schools. The preceptor at each of the hospitals will communicate with the schools to determine when to send students for their clinical rotations. The contracted schools are University of Southern California (USC), University of California-San Francisco (UCSF), Touro University California College of Pharmacy, California North state University, California Health Sciences University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (Stockton), Western University of Health Science, Chapman University, American University of Health Sciences School of Pharmacy, and Marshal B Ketchum College of Pharmacy.

[2] **Psychiatric Technicians:** 1. 20/20 Psychiatric Technician training programs are open to current employees that have been accepted into a Psychiatric Technician School. The modified work hours shall be a maximum of twelve (12) months in length and the amount of the 20/20 time utilized by each selected employee will depend on the type of education/training programs available.

CALIFORNIA DEPARTMENT OF STATE HOSPITALS

REPORT ON STATE HOSPITAL FINANCIAL ACTIVITY

California Department of State Hospitals

FISCAL YEAR 2023-24

May 14, 2024






DIRECTOR
Stephanie Clendenin

EXECUTIVE SUMMARY

Pursuant of the Budget Act of 2023, the Department of State Hospitals (DSH) submits this report to the California State Legislature on the financial activity of the state hospitals. This report is prepared in accordance with Item 4440-011-0001, Provision 9 of the Budget Act of 2023 which requires DSH to provide a year-end summary and an operating budget for each state hospital with the fiscal year (FY) 2024-25 Governor's Budget and May Revision estimate. Specifically, this report includes the following information for each state hospital:

- The number of authorized and vacant positions for each institution
- The number of authorized and vacant positions for each institution, broken out by key classifications
- The number of authorized positions utilized in the temporary help blanket for each institution
- The 2022-23 year-end budget and expenditures by line-item detail for each institution
- The budgeted allocations for each institution for current and budget year
- The projected expenditures for current and budget years

DEPARTMENT OF STATE HOSPITALS OVERVIEW

DSH manages the nation's largest inpatient forensic mental health hospital system. The mission of DSH is to provide evaluation and treatment to patients in a safe and responsible manner, by leading innovation and excellence across a continuum of care and settings. DSH is responsible for the daily care and provision of mental health treatment of its patients. DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton) and employs nearly 13,000 staff. In addition to state hospital treatment, DSH provides services in contracted Jail-Based Competency Treatment (JBCT), Community-Inpatient Facilities (CIF), Conditional Release Program (CONREP), Community-Based Restoration (CBR), and pre-trial felony mental health Diversion programs. DSH is responsible for the daily care to over 7,000 patients. In FY 2022-23, DSH served over 13,000 patients, with 9,140 served across the state hospitals, 1,912 in JBCT, 207 in CIF, 620 in CBR contracted programs, and 794 in CONREP programs. 11,259 individuals were treated within a DSH inpatient program and 1,875 served through DSH's outpatient programs. Through Early Access Stabilization Services (EASS) and Re-Evaluation services, during FY 2022-23, DSH initiated services for 1,427 patients in EASS, and off ramped 546 through DSH's Re-Evaluation program. In addition, during FY 2022-23, 477 individuals were diverted from jail into county diversion programs funded by DSH.

SUMMARY OF AUTHORIZED AND VACANT POSITIONS

The following table provides a summary of the authorized and vacant positions for the state hospital system as of April 1, 2024.

State Hospital	Authorized Positions[1]	Vacant as of 4/1/2024	Vacancy Percent
Atascadero	2,344.6	565.6	24.1%
Coalinga	2,540.5	522.1	20.6%
Metropolitan	2,399.3	516.1	21.5%
Napa	2,754.5	712.2	25.9%
Patton	2,705.1	269.2	10.0%
Totals	**12,744.0**	**2,687.4**	**20.3%**

[1] Includes positions approved for Estimate Items Enhanced Treatment Program (21.0 in Patton) that will not be filled due to delays in activation and Metropolitan State Hospital Increased Secure Bed Capacity (51.1 in Metropolitan) that will not be filled due to SNF roof repairs as described in the 2024-25 Governor's Budget Estimate.

AUTHORIZED VERSUS VACANT POSITIONS BY CLASSIFICATION

As of April 1, 2024, DSH's vacancy rate is 20.3%. Item 4440-011-0001, Provision 9 requires DSH to provide the number of authorized and vacant classifications, including psychiatric technicians, nurses, physicians, psychiatrists, social workers, and rehabilitation therapists. The following table provides a summary of the authorized and vacant positions for those classifications.

		Atascadero		Coalinga		Metropolitan		Napa		Patton	
Class Title	Class Code	Authorized	Vacant	Authorized	Vacant	Authorized[1]	Vacant	Authorized	Vacant	Authorized[1]	Vacant
Staff Psychiatrist	7619	36.2	26.2	34.3	21.3	67.3	37.3	55.4	9.7	66.5	35.0
Psychologist	9873	45.0	14.0	35.7	23.7	42.0	8.0	51.4	11.9	65.3	10.7
Sr. Psychiatric Technician	8252	104.2	22.2	95.0	10.0	85.8	30.8	83.0	26.0	93.0	0.0
Rehabilitation Therapist	Various	53.4	12.4	46.0	12.0	60.0	17.8	66.1	9.1	76.3	15.3
Registered Nurse	8094	248.5	63.5	236.9	21.1	304.1	45.1	461.2	93.8	363.1	17.1
Clinical Social Worker	9872	50.3	20.3	46.8	19.8	64.7	23.7	63.2	10.5	77.0	14.0
Psychiatric Technician	8253	674.8	209.8	719.7	205.9	487.4	123.4	466.8	169.4	750.3	25.3
Physician/Surgeon	7552	17.5	0.0	25.2	16.2	26.4	1.0	26.8	0.0	31.0	6.0

[1] Includes positions approved for Estimate Items Enhanced Treatment Program (21.0 in Patton) that will not be filled due to delays in activation and Metropolitan State Hospital Increased Secure Bed Capacity (51.1 in Metropolitan) that will not be filled due to SNF roof repairs as described in the 2024-25 Governor's Budget Estimate.

TEMPORARY HELP BLANKET POSITIONS

Temporary help blanket positions are utilized to offset vacancies and overtime. The following table provides a summary of authorized temporary help blanket positions for the state hospitals as of April 1, 2024.

Authorized Blanket Positions	
Atascadero	30.1
Coalinga	28.0
Metropolitan	67.2
Napa	47.5
Patton	81.2
Total	**254.0**

STATE HOSPITAL ALLOCATIONS AND EXPENDITURES

Exhibit I (attached) provides detail on the budget and expenditures for all five state hospitals and each facility individually, listed by FI$Cal account code for FY 2022-23. For FY 2023-24 and FY 2024-25, Exhibit II (attached) displays the projected budget and expenditures for all five hospitals and each facility individually. Any anticipated savings due to delayed projects or unit activations have been reflected in these allocations and projected expenditures.

Exhibit I—All Hospitals[1]

		2022-23 Budget	2022-23 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$748,981,000	$739,340,000
	5100150-Earnings - Temporary Civil Service Employees	$31,986,000	$31,503,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$107,874,000	$106,430,000
Salaries and Wages Total		**$888,841,000**	**$877,273,000**
Staff Benefits	5150150-Dental Insurance	$992,000	$980,000
	5150200-Disability Leave - Industrial	$14,840,000	$14,666,000
	5150210-Disability Leave - Nonindustrial	$3,306,000	$3,261,000
	5150350-Health Insurance	$21,774,000	$21,505,000
	5150400-Life Insurance	$61,000	$61,000
	5150450-Medicare Taxation	$12,986,000	$12,821,000
	5150500-OASDI	$8,277,000	$8,173,000
	5150600-Retirement - General	$202,948,000	$200,347,000
	5150620-Retirement - Public Employees - Safety	$1,000	$1,000
	5150700-Unemployment Insurance	$357,000	$352,000
	5150750-Vision Care	$190,000	$187,000
	5150800-Workers' Compensation	$65,427,000	$64,581,000
	5150900-Staff Benefits - Other	$151,850,000	$149,966,000
Staff Benefits Total		**$483,009,000**	**$476,901,000**
Operating Expenses and Equipment	5301400-Goods - Other	$4,300,000	$4,243,000
	5302900-Printing - Other	$918,000	$908,000
	5304800-Communications - Other	$2,296,000	$2,266,000
	5306700-Postage - Other	$205,000	$202,000
	5308900-Insurance - Other	$687,000	$679,000
	5320490-Travel - In State - Other	$1,710,000	$1,688,000
	5320890-Travel - Out of State - Other	$3,000	$3,000
	5322400-Training - Tuition and Registration	$1,069,000	$1,056,000
	5324350-Rents and Leases	$53,797,000	$53,018,000
	5326900-Utilities - Other	$29,553,000	$29,202,000
	5340330-Consulting and Professional Services – Inter - Other	$3,799,000	$3,748,000
	5340580-Consulting and Professional Services - External - Other	$117,941,000	$116,429,000
	5344000-Consolidated Data Centers	$46,000	$46,000
	5346900-Information Technology - Other	$396,000	$392,000
	5368115-Office Equipment	$17,352,000	$17,114,000
	5390900-Other Items of Expense - Miscellaneous	$87,676,000	$86,544,000
	5415000-Claims Against the State	$16,000	$16,000
	5490000-Other Special Items of Expense	$2,144,000	$2,111,000
Operating Expenses and Equipment Total		**$323,908,000**	**$319,665,000**
Grand Total		**$1,695,758,000**	**$1,673,839,000**

[1] Budget and expenditure do not include reimbursements or reappropriations.

Exhibit I—Atascadero State Hospital[2&3]

		2022-23 Budget	2022-23 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$149,069,000	$146,612,000
	5100150-Earnings - Temporary Civil Service Employees	$4,891,000	$4,810,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$18,435,000	$18,131,000
Salaries and Wages Total		**$172,395,000**	**$169,553,000**
Staff Benefits	5150150-Dental Insurance	$165,000	$162,000
	5150200-Disability Leave - Industrial	$2,703,000	$2,658,000
	5150210-Disability Leave - Nonindustrial	$1,262,000	$1,241,000
	5150350-Health Insurance	$4,296,000	$4,225,000
	5150400-Life Insurance	$12,000	$12,000
	5150450-Medicare Taxation	$2,442,000	$2,402,000
	5150500-OASDI	$1,736,000	$1,707,000
	5150600-Retirement - General	$40,436,000	$39,769,000
	5150700-Unemployment Insurance	$63,000	$62,000
	5150750-Vision Care	$38,000	$37,000
	5150800-Workers' Compensation	$16,637,000	$16,363,000
	5150900-Staff Benefits - Other	$25,281,000	$24,864,000
Staff Benefits Total		**$95,071,000**	**$93,502,000**
Operating Expenses and Equipment	5301400-Goods - Other	$1,276,000	$1,255,000
	5302900-Printing - Other	$140,000	$138,000
	5304800-Communications - Other	$505,000	$497,000
	5306700-Postage - Other	$36,000	$35,000
	5308900-Insurance - Other	$31,000	$30,000
	5320490-Travel - In State - Other	$376,000	$370,000
	5322400-Training - Tuition and Registration	$205,000	$202,000
	5324350-Rents and Leases	$33,022,000	$32,478,000
	5326900-Utilities - Other	$3,798,000	$3,735,000
	5340330-Consulting and Professional Services – Inter - Other	$1,083,000	$1,065,000
	5340580-Consulting and Professional Services - External - Other	$24,463,000	$24,060,000
	5344000-Consolidated Data Centers	$14,000	$14,000
	5346900-Information Technology - Other	$68,000	$67,000
	5368115-Office Equipment	$1,928,000	$1,896,000
	5390900-Other Items of Expense - Miscellaneous	$14,972,000	$14,725,000
	5490000-Other Special Items of Expense	$22,000	$22,000
Operating Expenses and Equipment Total		**$81,939,000**	**$80,589,000**
Grand Total		**$349,405,000**	**$343,644,000**

[2] Budget and expenditure do not include reimbursements or reappropriations.
[3] Includes Hospital Police Academy.

Exhibit I—Coalinga State Hospital[4]

		2022-23 Budget	2022-23 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$164,704,000	$163,339,000
	5100150-Earnings - Temporary Civil Service Employees	$824,000	$817,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$24,787,000	$24,582,000
Salaries and Wages Total		**$190,315,000**	**$188,738,000**
Staff Benefits	5150150-Dental Insurance	$229,000	$227,000
	5150200-Disability Leave - Industrial	$4,152,000	$4,118,000
	5150210-Disability Leave - Nonindustrial	$803,000	$796,000
	5150350-Health Insurance	$4,927,000	$4,886,000
	5150400-Life Insurance	$15,000	$15,000
	5150450-Medicare Taxation	$2,696,000	$2,674,000
	5150500-OASDI	$2,049,000	$2,032,000
	5150600-Retirement - General	$47,315,000	$46,923,000
	5150620-Retirement - Public Employees - Safety	$1,000	$1,000
	5150700-Unemployment Insurance	$101,000	$100,000
	5150750-Vision Care	$42,000	$42,000
	5150800-Workers' Compensation	$13,011,000	$12,903,000
	5150900-Staff Benefits - Other	$31,623,000	$31,361,000
Staff Benefits Total		**$106,964,000**	**$106,078,000**
Operating Expenses and Equipment	5301400-Goods - Other	$744,000	$738,000
	5302900-Printing - Other	$312,000	$309,000
	5304800-Communications - Other	$669,000	$663,000
	5306700-Postage - Other	$51,000	$51,000
	5308900-Insurance - Other	$74,000	$73,000
	5320490-Travel - In State - Other	$471,000	$467,000
	5320890-Travel - Out of State - Other	$3,000	$3,000
	5322400-Training - Tuition and Registration	$176,000	$175,000
	5324350-Rents and Leases	$3,590,000	$3,560,000
	5326900-Utilities - Other	$6,924,000	$6,867,000
	5340330-Consulting and Professional Services – Inter - Other	$300,000	$298,000
	5340580-Consulting and Professional Services - External - Other	$40,387,000	$40,052,000
	5344000-Consolidated Data Centers	$2,000	$2,000
	5346900-Information Technology - Other	$37,000	$37,000
	5368115-Office Equipment	$4,025,000	$3,992,000
	5390900-Other Items of Expense - Miscellaneous	$24,230,000	$24,029,000
	5415000-Claims Against the State	$15,000	$15,000
	5490000-Other Special Items of Expense	$46,000	$46,000
Operating Expenses and Equipment Total		**$82,056,000**	**$81,377,000**
Grand Total		**$379,335,000**	**$376,193,000**

[4] Budget and expenditure do not include reimbursements or reappropriations.

Exhibit I—Metropolitan State Hospital[5]

		2022-23 Budget	2022-23 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$95,594,000	$95,475,000
	5100150-Earnings - Temporary Civil Service Employees	$4,791,000	$4,785,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$9,443,000	$9,431,000
Salaries and Wages Total		**$109,828,000**	**$109,691,000**
Staff Benefits	5150150-Dental Insurance	$163,000	$163,000
	5150200-Disability Leave - Industrial	$1,491,000	$1,489,000
	5150210-Disability Leave - Nonindustrial	$236,000	$236,000
	5150350-Health Insurance	$3,236,000	$3,232,000
	5150400-Life Insurance	$9,000	$9,000
	5150450-Medicare Taxation	$1,798,000	$1,796,000
	5150500-OASDI	$1,103,000	$1,102,000
	5150600-Retirement - General	$25,134,000	$25,103,000
	5150700-Unemployment Insurance	$38,000	$38,000
	5150750-Vision Care	$27,000	$27,000
	5150800-Workers' Compensation	$8,588,000	$8,577,000
	5150900-Staff Benefits - Other	$24,529,000	$24,499,000
Staff Benefits Total		**$66,352,000**	**$66,271,000**
Operating Expenses and Equipment	5301400-Goods - Other	$471,000	$470,000
	5302900-Printing - Other	$141,000	$141,000
	5304800-Communications - Other	$54,000	$54,000
	5306700-Postage - Other	$31,000	$31,000
	5308900-Insurance - Other	$135,000	$135,000
	5320490-Travel - In State - Other	$209,000	$209,000
	5322400-Training - Tuition and Registration	$161,000	$161,000
	5324350-Rents and Leases	$3,012,000	$3,008,000
	5326900-Utilities - Other	$4,380,000	$4,375,000
	5340330-Consulting and Professional Services – Inter - Other	$437,000	$436,000
	5340580-Consulting and Professional Services - External - Other	$8,735,000	$8,724,000
	5344000-Consolidated Data Centers	$8,000	$8,000
	5346900-Information Technology - Other	$11,000	$11,000
	5368115-Office Equipment	$1,102,000	$1,101,000
	5390900-Other Items of Expense - Miscellaneous	$8,536,000	$8,525,000
	5415000-Claims Against the State	$1,000	$1,000
	5490000-Other Special Items of Expense	$93,000	$93,000
Operating Expenses and Equipment Total		**$27,517,000**	**$27,483,000**
Grand Total		**$203,697,000**	**$203,445,000**

[5] Budget and expenditure do not include reimbursements or reappropriations.

Exhibit I—Napa State Hospital[6]

		2022-23 Budget	2022-23 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$162,969,000	$160,904,000
	5100150-Earnings - Temporary Civil Service Employees	$6,747,000	$6,661,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$27,022,000	$26,679,000
Salaries and Wages Total		**$196,738,000**	**$194,244,000**
Staff Benefits	5150150-Dental Insurance	$235,000	$232,000
	5150200-Disability Leave - Industrial	$5,124,000	$5,059,000
	5150210-Disability Leave - Nonindustrial	$459,000	$453,000
	5150350-Health Insurance	$4,893,000	$4,831,000
	5150400-Life Insurance	$12,000	$12,000
	5150450-Medicare Taxation	$2,871,000	$2,835,000
	5150500-OASDI	$1,604,000	$1,584,000
	5150600-Retirement - General	$43,423,000	$42,872,000
	5150700-Unemployment Insurance	$81,000	$80,000
	5150750-Vision Care	$42,000	$41,000
	5150800-Workers' Compensation	$13,539,000	$13,367,000
	5150900-Staff Benefits - Other	$34,760,000	$34,319,000
Staff Benefits Total		**$107,043,000**	**$105,685,000**
Operating Expenses and Equipment	5301400-Goods - Other	$1,035,000	$1,022,000
	5302900-Printing - Other	$109,000	$108,000
	5304800-Communications - Other	$829,000	$818,000
	5306700-Postage - Other	$40,000	$39,000
	5308900-Insurance - Other	$380,000	$375,000
	5320490-Travel - In State - Other	$234,000	$231,000
	5322400-Training - Tuition and Registration	$283,000	$279,000
	5324350-Rents and Leases	$11,512,000	$11,366,000
	5326900-Utilities - Other	$8,991,000	$8,877,000
	5340330-Consulting and Professional Services – Inter - Other	$1,347,000	$1,330,000
	5340580-Consulting and Professional Services - External - Other	$18,971,000	$18,730,000
	5346900-Information Technology - Other	$265,000	$262,000
	5368115-Office Equipment	$5,005,000	$4,942,000
	5390900-Other Items of Expense - Miscellaneous	$18,791,000	$18,553,000
	5490000-Other Special Items of Expense	$976,000	$964,000
Operating Expenses and Equipment Total		**$68,768,000**	**$67,896,000**
Grand Total		**$372,549,000**	**$367,825,000**

[6] Budget and expenditure do not include reimbursements or reappropriations.

Exhibit I—Patton State Hospital[7]

		2022-23 Budget	2022-23 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$176,645,000	$173,010,000
	5100150-Earnings - Temporary Civil Service Employees	$14,733,000	$14,430,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$28,187,000	$27,607,000
Salaries and Wages Total		**$219,565,000**	**$215,047,000**
Staff Benefits	5150150-Dental Insurance	$200,000	$196,000
	5150200-Disability Leave - Industrial	$1,370,000	$1,342,000
	5150210-Disability Leave - Nonindustrial	$546,000	$535,000
	5150350-Health Insurance	$4,422,000	$4,331,000
	5150400-Life Insurance	$13,000	$13,000
	5150450-Medicare Taxation	$3,179,000	$3,114,000
	5150500-OASDI	$1,785,000	$1,748,000
	5150600-Retirement - General	$46,640,000	$45,680,000
	5150700-Unemployment Insurance	$74,000	$72,000
	5150750-Vision Care	$41,000	$40,000
	5150800-Workers' Compensation	$13,652,000	$13,371,000
	5150900-Staff Benefits - Other	$35,657,000	$34,923,000
Staff Benefits Total		**$107,579,000**	**$105,365,000**
Operating Expenses and Equipment	5301400-Goods - Other	$774,000	$758,000
	5302900-Printing - Other	$216,000	$212,000
	5304800-Communications - Other	$239,000	$234,000
	5306700-Postage - Other	$47,000	$46,000
	5308900-Insurance - Other	$67,000	$66,000
	5320490-Travel - In State - Other	$420,000	$411,000
	5322400-Training - Tuition and Registration	$244,000	$239,000
	5324350-Rents and Leases	$2,661,000	$2,606,000
	5326900-Utilities - Other	$5,460,000	$5,348,000
	5340330-Consulting and Professional Services – Inter - Other	$632,000	$619,000
	5340580-Consulting and Professional Services - External - Other	$25,385,000	$24,863,000
	5344000-Consolidated Data Centers	$22,000	$22,000
	5346900-Information Technology - Other	$15,000	$15,000
	5368115-Office Equipment	$5,292,000	$5,183,000
	5390900-Other Items of Expense - Miscellaneous	$21,147,000	$20,712,000
	5490000-Other Special Items of Expense	$1,007,000	$986,000
Operating Expenses and Equipment Total		**$63,628,000**	**$62,320,000**
Grand Total		**$390,772,000**	**$382,732,000**

[7] Budget and expenditure do not include reimbursements or reappropriations.

Exhibit II—All Hospitals[8]

	2023-24 Budget	2024-25 Budget	2023-24 Projected Expenditure	2024-25 Projected Expenditure
4410010-Atascadero	$399,036,000	$398,420,000	$395,046,000	$394,436,000
4410020-Coalinga	$414,860,000	$422,911,000	$410,711,000	$418,682,000
4410030-Metro	$259,069,000	$270,639,000	$256,478,000	$267,933,000
4410040-Napa	$412,235,000	$415,906,000	$408,113,000	$411,747,000
4410050-Patton	$441,891,000	$447,784,000	$437,472,000	$443,306,000
Grand Total	**$1,927,091,000**	**$1,955,660,000**	**$1,907,820,000**	**$1,936,104,000**

[8] Budget and expenditure do not include reimbursements or reappropriations.

STATE HOSPITALS
HOSPITAL POLICE OFFICER/STATE HOSPITAL POLICE ACADEMY
Provisional Language Reporting

BACKGROUND

The Budget Act of 2023 includes provisional language stating:

"The State Department of State Hospitals shall provide a status update on the recruitment and retention of hospital police officers, to be included in the department's 2024–25 Governor's Budget estimate and subsequent May Revision estimate. The update shall include the number of authorized and vacant positions for each hospital, the actual attrition rate for the 2023–24 fiscal year, the projected attrition rate for the 2024–25 fiscal year, and the rate of success pertaining to the number of hospital police officer cadet graduates of the OPS Police Academy."

Hospital Police Officer Positions

The table below displays the status of Hospital Police Officers (HPO) authorized positions as of March 1, 2024:

HPO Authorized Positions[1] as of March 1, 2024				
Hospitals	Filled	Vacant	FTE[2]	Vacancy Rate
Atascadero	109.0	20.0	129.0	15.50%
Coalinga	181.0	40.0	221.0	18.10%
Metropolitan	114.0	22.3	136.3	16.36%
Napa	92.0	66.9	158.9	42.10%
Patton	64.0	2.0	66.0	3.03%
Total	560.0	151.2	711.2	21.26%

Hospital Police Officer Attrition Rate

The table below displays the projected HPO attrition rates as of March 1, 2024, based on actual attrition rates and trends for fiscal years (FYs) 2021-22, 2022-23, and 2023-24:

[1] Only includes classification 1937 – Hospital Police Officer
[2] Authorized Positions as of March 2024

HPO Attrition Rates as of March 1, 2024					
Hospitals	FY 2023-24 FTE[3]	FY 2023-24 Attrition Rate[4]	Average Estimated Monthly Positions	FY 2024-25 Attrition Rate[5]	Average Estimated Monthly Positions
Atascadero	129.0	1.16%	1.5	1.32%	1.7
Coalinga	221.0	0.40%	0.9	0.37%	0.8
Metropolitan	136.3	0.86%	1.2	0.84%	1.2
Napa	158.9	0.78%	1.2	0.57%	0.9
Patton	66.0	1.24%	0.8	1.40%	0.9
Total	**711.2**	**0.89%**	**5.6**	**0.90%**	**5.5**

Cadet Graduation Rates

The table below displays actual graduation rates from cohorts conducted from FY 2017-18 through the present:

OPS Cadet Graduation Rates				
Academy	Academy Dates	Cadets Attended	Cadets Graduated	Graduation Rate
Academy 27	(02/12/18 – 05/18/18)	50	44	88.0%
Academy 28	(08/13/18 – 11/16/18)	49	42	85.7%
Academy 29	(10/01/18 – 01/10/19)	38	32	84.2%
Academy 30	(02/11/19 – 05/31/19)	33	31	93.9%
Academy 31	(08/12/19 – 11/22/19)	43	34	79.1%
Academy 32	(12/02/19 – 03/20/20)	19	17	89.5%

[3] Authorized Positions as of March 2024
[4] Projected attrition rate based on FY 2021-22, 2022-23, and 2023-24 data
[5] Projected attrition rate based on FY 2022-23, 2023-24, and 2024-25 data

Academy 33	(02/10/20 – 05/22/20)	20	16	80.0%
Academy 34	(08/24/20 – 12/10/20)	25	21	84.0%
Academy 35	(12/28/20 – 04/22/21)	19	10	52.6%
Academy 36	(05/03/21 – 08/12/21)	16	9	56.3%
Academy 37	(08/23/21 – 12/09/21)	10	4	40.0%
Academy 38	(12/28/21 – 04/17/22)	15	11	73.3%
Academy 39	(05/02/22 – 08/11/22)	24	18	75.0%
Academy 40	(08/23/22 – 12/08/22)	16	14	87.5%
Academy 41	(12/28/22 – 04/13/23)	22	19	86.4%
Academy 42	(05/01/23 – 08/15/23)	18	15	83.3%
Academy 43	(08/28/23 - 12/12/23)	15	15	100.0%
Academy 44	(12/28/24 – 04/16/24)	9	8	88.9%
Academy 45	(04/29/24 – 08/13/24)	19	TBD	TBD
	Total[6]	**441**	**360**	**81.6%**

HPO Recruitment Efforts

The Office of Protective Services (OPS) started working with vendors in December 2021 to establish contracts for assistance with HPO recruitment efforts and increase the total number of HPO applications received. In November 2023, DSH partnered with AllStar Talent for these services. As part of a digital marketing campaign, both Facebook and Google advertisements are utilized to increase awareness and leads for DSH to engage with prospective candidates. In addition, DSH continues to conduct online virtual Career Fairs and create videos and other media

[6] Not including Academy 45, scheduled to end August 13, 2024

advertisements to broadcast and increase awareness of DSH peace officer employment opportunities. Advertisements are frequently refreshed to continue to attract new applicants.

To increase recruitment, DSH also converted their exam process from a proctored, in-person exam to a non-proctored, online exam. The non-proctored, online exam successfully went live on September 28, 2023. As of April 19, 2024, 837 candidates passed the online exam, 555 of which submitted applications for HPO positions. This is a significant increase from 279[7] HPO applications that were received in 2023 prior to the online exam going live. These numbers represent a higher percentage of candidates taking the exam and applying for HPO positions. The goal of the streamlined, continuous online exam is to increase recruitment numbers and accelerate the recruitment process.

[7] Data from January 2, 2023, to August 2, 2023