Department of State Hospitals

2025-26

Governor's Budget
Proposals and Estimates

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California Department of Finance
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Department of State Hospitals
2025-26 Governor's Budget
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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 for individuals with complex behavioral health needs in a safe, equitable and responsible manner, by leading innovation and excellence across a continuum of care. 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 contingent of conserved individuals referred by the counties and inmates from the California Department of Corrections and Rehabilitation (CDCR). 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 7,400 patients. In fiscal year (FY) 2023-24, DSH served over 14,000 patients, with 9,510 served across the state hospitals, 1,881 in JBCT, 506 in CIF, 859 in CBR contracted programs, and 897 in CONREP programs. 11,897 individuals were treated within a DSH inpatient program and 2,117 were served through DSH's outpatient programs. Through Early Access Stabilization Services (EASS) and Re-Evaluation services, during FY 2023-24, DSH initiated services for 2,797 patients in EASS, and off ramped 198 through DSH's Re-Evaluation program. In addition, 249 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 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 persons designated as 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 SVP.

DSH-Metropolitan

Opened in 1916, DSH-Metropolitan is located in Norwalk (Los Angeles County). The hospital is an open-style campus within a secure 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 at that time, 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 secure 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, CBR, and CIF programs. Furthermore, the IST Solutions Budget Package provided support to implement jail-based treatment through the 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, establish a robust continuum of care for DSH patients. Lastly, the Budget Act of 2022 amended PC Section 1370 to

[1] See IST Solutions (Section C8) for more information

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 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

BACKGROUND

The Department of State Hospitals (DSH) functional vacancy table displays how major functions within the State Hospitals rely on multiple staffing strategies such as overtime, temporary help, and contracted staff to provide critical patient services. While other functions in the hospitals use some level of overtime, temporary help, or contracted staff, the reliance on these staffing alternatives is highest for treatment teams, primary care, nursing services, and protective services. In the tables below, overtime, temporary help, and contracted staff are converted to full-time equivalents (FTEs) to reflect the true vacancy rate for these classifications. This information is unavailable through other budget documents because the Salaries and Wages galley does not provide information on 1) the specific classifications that use overtime, 2) the classifications that are used in temporary help, and 3) contracted staff, as these are reflected in operating expenditures and equipment (OE&E) in the budget. As a result, the Salaries and Wages galley does not provide a true vacancy rate for these classifications. DSH provides an updated functional vacancy table annually as part of the Governor's Budget update.

The pertinent information in this table can be found in the following columns:

- Departmental Regular/Ongoing Authorized Positions ties to the 4440-fiscal year (FY) 2024-25 Schedule 7A, FY 2023-24 Authorized Positions
- Temporary Help includes employees working second positions, retired annuitants, limited term, and permanent intermittent
- Total Authorized Positions contains the total Regular/Ongoing Authorized Positions and Temporary Help positions for specific classifications
- Contracted FTE and Overtime FTE contain FTE positions which have been converted from contract hours and overtime hours
- Total Filled FTE is the grand total of Total Filled Civil Service Positions, Temp Help Filled, Contracted FTE, and Overtime FTE
- Functional Vacancy FTE is the calculated difference between Total Filled Civil Service Positions and Total Filled FTE
- Functional Vacancy Rate is calculated by dividing Functional Vacancy FTE by Total Authorized Positions

Examining the results of this data allows the following observations about how the hospitals fulfill the need for critical patient services:

- Clinical Services – Treatment Team and Primary Care: For the Staff Psychiatrist positions, state hospitals utilized temporary help and contract employees to staff 21.6% of the total authorized positions. These positions are a hard-to-fill classification at state hospitals, due in part to the nationwide shortage of psychiatrists. DSH was authorized to establish a psychiatry residency program at DSH-Napa in partnership with St. Joseph's Medical Center to assist with training more psychiatrists to work in the DSH system. The first cohort at DSH-Napa started in July 2021 and is now in its fourth year and has three cohorts for a total of 20 residents. Due to the success of the DSH-Napa Psychiatric Residency Program, DSH-Patton has recently been authorized to begin developing its own residency program. Additionally, DSH has been authorized to expand or develop fellowship programs across all five state hospitals to provide training for the unique needs of state hospital patients.

- Clinical Services – Nursing: The high utilization rates for temporary help and overtime reflect a finding from the Clinical Staffing Study for 24-Hour Care Nursing Services, which determined that the state hospitals do not have enough authorized nursing positions to fill all the posts on the units. This finding was discussed in the Direct Care Nursing Budget Change Proposal (BCP) included in the Budget Act of 2019. This BCP provided resources to help close the gap but assumed some temporary help and overtime will continue to be utilized to meet the patient care needs. DSH continues to work to fill the resources authorized by this BCP.

- Protective Services: The Protective Services BCP included in the Budget Act of 2020 states that DSH-Napa does not have sufficient position authority to cover the protective services posts necessary to fulfill essential police functions which is a driver for overtime for protective services classifications. While new positions were authorized by this BCP to provide additional protective services resources, these positions were phased in over several years and are still undergoing recruitment and hiring.

Department of State Hospitals	Hospital Position Report Average of FY 2023-24									
Classifications	**Departmental Regular/ Ongoing Authorized Positions[1]**	**Temp Help**	**Total Authorized Positions**	**Total Filled Civil Service Positions[2]**	**Temp Help Filled**	**Contracted FTE**	**Overtime FTE[3]**	**Total Filled FTE**	**Functional Vacancy FTE[4]**	**Functional Vacancy Rate**
Clinical Services -Treatment Team and Primary Care										
Social Worker (9872, 9874)[5]	294.0	0.0	294.0	210.2	1.8	0.0	0.0	212.0	82.0	27.9%
Rehab Therapist - Safety (8321, 8323, 8324, 8420, 8422)	297.0	0.0	297.0	233.8	1.3	2.2	3.5	240.8	56.2	18.9%
Psychologist-Clinical-Safety (9873)	239.3	0.0	239.3	166.9	4.2	1.5	0.0	172.6	66.7	27.9%
Staff Psychiatrist-Safety (7619)	259.7	0.0	259.7	129.8	3.4	52.8	0.0	186.0	73.8	28.4%
Nurse Practitioner-Safety (9700)	40.0	0.0	40.0	35.5	0.3	0.0	0.3	36.1	3.9	9.8%
Physician & Surgeon-Safety (7552)[6]	126.5	0.0	126.5	102.2	0.8	7.9	0.0	110.9	16.4	13.0%
Total: Clinical Services -Treatment Team and Primary Care	**1,256.5**	**0.0**	**1,256.5**	**878.4**	**11.8**	**64.4**	**3.8**	**958.4**	**299.0**	**23.8%**
Clinical Services - Nursing										
Psychiatric Technician (8236, 8253, 8254, 8274)	3,712.1	137.6	3,849.7	2,646.5	162.2	98.8	539.9	3,447.4	536.6	13.9%
Registered Nurse-Safety (8094)	1,578.5	115.2	1,693.7	1,328.2	71.5	117.7	210.8	1,728.2	53.8	3.2%
Senior Psych Tech-Safety (8252)[7]	358.0	1.3	359.3	374.7	3.9	0.0	99.8	478.4	0.0	0.0%
Total: Clinical Services - Nursing	**5,648.6**	**254.1**	**5,902.7**	**4,349.4**	**237.6**	**216.5**	**850.5**	**5,654.0**	**590.4**	**10.0%**
Protective Services										
Hosp Police Lieut (1935)	30.6	0.0	30.6	22.5	0.9	0.0	5.0	28.3	4.7	15.5%
Hosp Police Sgt (1936)	99.0	0.0	99.0	78.3	1.9	0.0	17.3	97.5	4.4	4.5%
Hosp Police Ofcr (1937)	723.9	0.0	723.9	562.3	6.8	0.0	135.4	704.5	27.7	3.8%
Total: Protective Services	**853.5**	**0.0**	**853.5**	**663.1**	**9.6**	**0.0**	**157.7**	**830.4**	**36.9**	**4.3%**

[1] Total includes Administratively Established positions
[2] Total includes Administratively Established positions
[3] Overtime data per month is "point in time" and monthly updates to this data set may affect previous months' totals.
[4] Functional Vacancy FTE is calculated individually per hospital, then summarized to display a final total.
[5] Includes 16.0 positions established via MBR: Treatment Team.
[6] Includes 25.9 positions established via MBR: Treatment Team.
[7] The Senior Psych Tech-Safety classification is interchangeable with the Psychiatric Technician classification on the 7A, which is a point in time document, and any vacant positions are shown as Psychiatric Technicians on the 7A itself. Filled amount is an average throughout the 12 months of FY 2023-24.

DEPARTMENT OF STATE HOSPITALS POPULATION

	CURRENT YEAR 2024-25					
	July 1, 2024 Actual Census	Previously Approved Adjustments CY 2024-25	2025-26 November Adjustment CY 2024-25	Census Adjustment	2025-26 May Revision Adjustment CY 2024-25	June 30, 2025 Projected Census
POPULATION BY HOSPITAL						
ATASCADERO	1,020	0	0	111	0	1,131
COALINGA	1,300	0	0	0	0	1,300
METROPOLITAN	847	82	0	0	0	929
NAPA	1,069	0	0	9	0	1,078
PATTON	1,314	10	0	0	0	1,324
TOTAL BY HOSPITAL	**5,550**	**92**	**0**	**120**	**0**	**5,762**
POPULATION BY COMMITMENT - SH						
Coleman - PC 2684[1]	159	0	0	111	0	270
IST - PC 1370	1,659	82	0	0	0	1,741
LPS & PC 2974	547	0	0	9	0	556
NGI - PC 1026	1,208	4	0	0	0	1,212
OMD - PC 2962	333	3	0	0	0	336
OMD - PC 2972	694	3	0	0	0	697
SVP - WIC 6602/6604	950	0	0	0	0	950
TOTAL BY COMMITMENT	**5,550**	**92**	**0**	**120**	**0**	**5,762**
CONTRACTED PROGRAMS						
JAIL BASED COMPETENCY TREATMENT	362	79	0	0	0	441
COMMUNITY BASED RESTORATION/ DIVERSION[2]	626	284	0	0	0	910
COMMUNITY INPATIENT FACILITIES	175	19	0	0	0	194
TOTAL - CONTRACTED PROGRAMS	**1,163**	**382**	**0**	**0**	**0**	**1,545**
CONREP PROGRAMS[3]						
CONREP SVP	19	12	0	0	0	31
CONREP NON-SVP	565	127	0	0	0	692
CONREP FACT PROGRAM	54	36	0	0	0	90
CONREP STEP DOWN FACILITIES	63	140	0	0	0	203
TOTAL - CONREP PROGRAMS	**701**	**315**	**0**	**0**	**0**	**1,016**
CY POPULATION AND CONTRACTED TOTAL	**7,414**	**789**	**0**	**120**	**0**	**8,323**

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

July 1, 2024 Actual: 2,822
June 30, 2025 Projected: 3,286

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] Community Based Restoration/ Diversion totals exclude new Diversion programs. Projected census will be adjusted as programs are implemented with Counties.

[3] 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 2025-26				
	July 1, 2025 Projected Census	Previously Approved Adjustments BY 2025-26	2025-26 November Adjustment BY 2025-26	2025-26 May Revision Adjustment BY 2025-26	June 30, 2026 Projected Census
POPULATION BY HOSPITAL					
ATASCADERO	1,131	0	0	0	1,131
COALINGA	1,300	0	0	0	1,300
METROPOLITAN	929	0	0	0	929
NAPA	1,078	0	0	0	1,078
PATTON	1,324	0	0	0	1,324
TOTAL BY HOSPITAL	**5,762**	**0**	**0**	**0**	**5,762**
POPULATION BY COMMITMENT - SH					
Coleman - PC 2684[1]	270	0	0	0	270
IST - PC 1370	1,741	0	0	0	1,741
LPS & PC 2974	556	0	0	0	556
NGI - PC 1026	1,212	0	0	0	1,212
OMD - PC 2962	336	0	0	0	336
OMD - PC 2972	697	0	0	0	697
SVP - WIC 6602/6604	950	0	0	0	950
TOTAL BY COMMITMENT	**5,762**	**0**	**0**	**0**	**5,762**
CONTRACTED PROGRAMS					
JAIL BASED COMPETENCY TREATMENT	441	47	0	0	488
COMMUNITY BASED RESTORATION/ DIVERSION[2]	910	123	0	0	1,033
COMMUNITY INPATIENT FACILITIES	194	34	0	0	228
TOTAL - CONTRACTED PROGRAMS	**1,545**	**204**	**0**	**0**	**1,749**
CONREP PROGRAMS[3]					
CONREP SVP	31	0	0	0	31
CONREP NON-SVP	692	0	0	0	692
CONREP FACT PROGRAM	90	0	0	0	90
CONREP STEP DOWN FACILITIES	203	0	0	0	203
TOTAL - CONREP PROGRAMS	**1,016**	**0**	**0**	**0**	**1,016**
BY POPULATION AND CONTRACTED TOTAL	**8,323**	**204**	**0**	**0**	**8,527**

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

July 1, 2025 Projected: 3,286

June 30, 2026 Projected: 3,490

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] Community Based Restoration/ Diversion totals exclude new Diversion programs. Projected census will be adjusted as programs are implemented with Counties.

[3] 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) 2024-25 and FY 2025-26 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, 2024, actual census as the baseline census for both FY 2024-25 and FY 2025-26. For the 2025-26 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 2024-25 and FY 2025-26 is based on the modified pending placement list value calculated for June 30, 2025, and June 30, 2026. Variables are specific to patient legal class and are calculated based on trends observed in the 12-month period ending August 31, 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, 2024, as well as the projected census for FY 2024-25 and FY 2025-26 for all DSH populations. The projected census for June 30, 2025 (for FY 2024-25) and June 30, 2026 (for FY 2025-26) 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, 2024 Actual Census**	**June 30, 2025 Projected Census**	**June 30, 2025 Projected Pending Placement List**
IST[1]	2,822	3,286	344
LPS	547	556	234
NGI	1,208	1,212	1
OMD2962	333	336	55
OMD2972	694	697	1
SVP	950	950	2
Coleman[2]	159	270	N/A
Subtotal	*6,713*	*7,307*	*637*
CONREP[3]	701	1,016	N/A
Total	**7,414**	**8,323**	**637**
BUDGET YEAR			
Legal Class	**July 1, 2025 Projected Census**	**June 30, 2026 Projected Census**	**June 30, 2026 Projected Pending Placement List**
IST[1]	3,286	3,490	365
LPS	556	556	305
NGI	1,212	1,212	2
OMD2962	336	336	57
OMD2972	697	697	1
SVP	950	950	1
Coleman[2]	270	270	N/A
Subtotal	*7,307*	*7,511*	*731*
CONREP[3]	1,016	1,016	N/A
Total	**8,323**	**8,527**	**731**

[1]The IST projected census excludes new Diversion programs. These programs will be added to projected census as they are implemented with our county partners.
[2]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.
[3] 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 seven years, DSH has seen an increase of 45% in IST referrals when comparing annual referral rates from FY 2017-18 (339 per month) through FY 2023-24 (490 per month). 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 2023-24, DSH experienced a continued growth in referrals, with an increase of 0.4% 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[3,4]

Fiscal Year	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	% Change[5]
IST	383	343	346	415	488	490	0%
LPS	16	<11	***	<11	***	***	57%
NGI	***	<11	<11	<11	<11	<11	30%
OMD 2962	46	43	26	27	30	30	1%
OMD 2972	<11	<11	<11	<11	<11	<11	-30%
SVP	<11	<11	<11	<11	<11	<11	-17%
Coleman	35	46	16	16	17	51	207%
Total	**498**	**456**	**416**	**483**	**559**	**603**	**8%**

Following the onset of COVID-19, DSH experienced a reduction in its patient census due to necessary infection control protocols such as the creation of isolation units, admission observation units, and at times, pausing admissions to protect the health and safety of its patients and staff. 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)

[3]Referrals include all ISTs initially committed to DSH or a DSH-funded program. Excludes any administrative errors, duplicate records, program 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.
[5]Percentage of change from FY 2022-23 is based on raw data, which has been rounded to whole numbers for display purposes.

programs, and the addition of new JBCT programs to serve the IST population. All these efforts have resulted in an overall increase in IST census. DSH did experience a slight dip in census in June 2023 due to an increase of COVID-19 positives. As the system recovered from the temporary COVID-19 surge, IST census increased to over 2,900 by the end of August 2024.

Table 3: Patient Census

	6/30/2020	6/30/2021	6/30/2022	6/30/2023	6/30/2024	% Change
IST[1]	2,108	1,951	2,096	2,843	2,824	-1%
LPS[2]	747	789	707	584	550	-6%
NGI	1,415	1,338	1,244	1,225	1,208	-1%
OMD 2962	508	415	383	334	333	0%
OMD 2972	760	716	685	710	696	-2%
SVP	943	939	956	954	951	0%
Coleman[3]	296	169	114	112	160	43%
Subtotal	*6,777*	*6,317*	*6,185*	*6,762*	*6,722*	*-1%*
CONREP	661	647	714	733	697	-5%
Total	**7,438**	**6,964**	**6,899**	**7,495**	**7,419**	**-1%**

[1]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.
[2]LPS census reductions reflect outcomes of statutory changes pertaining to non-restorable IST and IST individuals who have reached maximum commitment and may undergo a conservatorship investigation as well as efforts to align the LPS census to the number of beds contracted by the counties.
[3]Coleman census was impacted by COVID-19 related infection control measures and transfer protocols between DSH and CDCR

Post COVID-19 Impact

Throughout the pandemic, DSH followed the guidance issued by the Centers for Disease Control and Prevention (CDC), California Department of Public Health (CDPH), epidemiologists and medical Subject Matter Experts (SMEs), and the local county public health director for each DSH facility. As COVID-19 guidance changed, and requirements for health care entities from earlier phases of the pandemic eased, 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, utilized for patients entering into a state hospital, 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 359 as of January 1, 2025. This significant reduction is due to the rapid implementation of the IST solutions authorized in the budget, the 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. Due to the average monthly referrals, it is unlikely this current pending placement list trend will change significantly moving forward. In FY 2023-24, DSH received an average of 490 IST referrals per month. The current waitlist reflects real-time monthly referrals, and the number of patients pending admission to a treatment bed is fewer than the number of referrals received per month.

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 2024-25

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

FY 2025-26

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 2025-26 Governor's Budget Estimate item, DSH-Coalinga Intermediate Care Facility Conversion, addresses this continued need to support its aging 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 NGI and OMD.

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 May Revision.

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/Gero psych	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

DEPARTMENT OF STATE HOSPITALS
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 PC1026 (NGI)
Other NGI	MNGI	WIC 702.3	Minor Not Guilty by Reason of Insanity
Other NGI	TANGI	PC 1610	Rehospitalization, temporary admission not guilty by reason of insanity
IST	IST PC1370	PC 1370.1	Incompetent to Stand Trial
Other IST	EIST	PC 1372(e)	Restored (IST) on Court Hold
Other IST	ROIST, RO1370, TAIST	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	Supervised Persons Referred from the Department of Corrections and Rehabilitation (CDCR)
OMD	PC2964a	PC 2964(a)	Supervised Persons Rehospitalized from Conrep after DSH hearing
OMD	PC2972	PC 2972	Former Supervised Person 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
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	Person Designated as a Sexually Violent Predator BPH Hold
Other SVP	ROSVP	PC 1610	Pending Revocation of a Person Designated as a Sexually Violent Predator
SVP	SVP	WIC 6604	Person Designated as a Sexually Violent Predator
SVP	SVPP	WIC 6602	Person Designated as a Sexually Violent Predator Probable Cause
PC 2684	PC2684	PC 2684	Incarcerated Person from CDCR
LPS	T.Cons	WIC 5353	Temporary Conservatorship
LPS	CONS	WIC 5358	Conservatorship
LPS	VOL	WIC 6000	Voluntary
LPS	MURCON	WIC 5008(h)(1)(B)	Murphy's Conservatorship
LPS*	PC 2974	PC 2974	Recommitment after expiration of prison term (must have concurrent W&I commitment)

*Historical legal codes that are no longer admitted into DSH are excluded from this table.

Demographic Snapshot: All Commitment Types

Patients Served from July 1, 2023 to June 30, 2024 is 14,014

Basic Demographics

Gender

<1%
17%
82%
M
F
U

Age on June 30, 2024

15,000
10,000
5,000
0
10.6%
89.4%
65+
18-64

Race

2.5%
2.0%
2.9%
0.7%
White
Hispanic or Latino
Black or African American
Asian
American Indian or Alaska Native
Native Hawaiian or Other Pacific Islander
Unknown
35.1%
26.4%
30.3%

Resident County

6,000
5,000
4,000
3,000
2,000
1,000
0
12.4%
9.6%
6.6%
7.9%
2.0%
35.3%
26.1%
Bay Area
Central Region
Inland Deserts...
North Central...
Northern Region
South Coast...
Unknown

Language Spoken at Home

10,000
8,000
6,000
4,000
2,000
0
40.5%
55.9%
3.4%
***%
***%
English
Other / Unknown
Spanish
Tagalog
Vietnamese

Program

6.1%
2.6%
6.4%
3.6%
13.4%
67.9%
SH
JBCT
CIF
CONREP
LA CBR
LA DIV

Prevalence of Diagnoses

8,000
6,000
4,000
2,000
0
4.0%
6.4%
5.7%
14.7%
42.1%
0.4%
26.7%
Bipolar Disorder
Other Disorders
Paraphilias
Schizoaffective disorders
Schizophrenia
Unspecified psychosis not due to a...
Unknown

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 approximately 82% 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, 2024. Approximately 35% 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 68% of DSH patients were treated at a State Hospital (excluding transfers from other Programs) and 13% at a JBCT facility. Schizophrenia, Schizoaffective, and Bipolar-type disorders are the three most common diagnoses for the DSH population, accounting for approximately 83% of the population with known diagnoses.

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. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

RESEARCH, EVALUATION AND DATA INSIGHTS
DATA MONITORING AND STATISTICS

Patients Served by Race

Fiscal Year 2023-2024

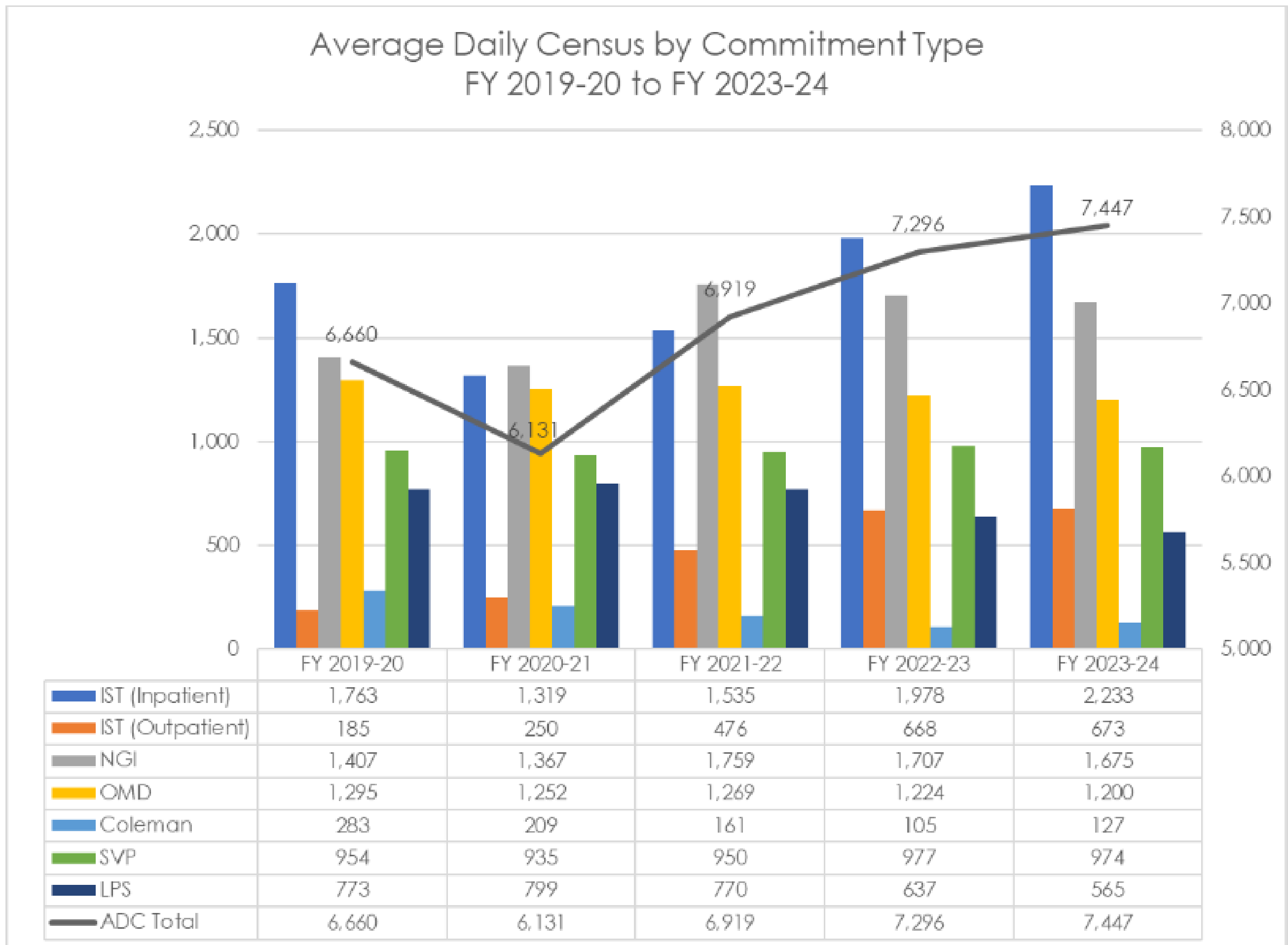
		CDCR	IST	LPS	NGI	OMD[4]	SVP	Grand Total
DSH Inpatient and Outpatient Program's Patients Served by Count[1]	*White*	134	2,584	234	825	557	590	4,924
	Hispanic or Latino	138	2,888	201	418	446	156	4,247
	Black or African American	116	2,400	154	359	444	230	3,703
	Asian	<11	224	***	64	25	<11	356
	Unknown	***	270	18	50	37	***	406
	Native Hawaiian or Other Pacific Islander	<11	143	***	81	25	<11	274
	American Indian or Alaska Native	<11	61	<11	11	16	***	104
	TOTAL	419	8,570	652	1,808	1,550	1,015	**14,014**

		CDCR	IST	LPS	NGI	OMD[4]	SVP	Grand Total	2022 State of California[2]	2023 State of California[3]
DSH Inpatient and Outpatient Program's Patients Served by Percentage[1]	*White*	32.0%	30.2%	35.9%	45.6%	35.9%	58.1%	35.1%	35.2%	33.3%
	Hispanic or Latino	32.9%	33.7%	30.8%	23.1%	28.8%	15.4%	30.3%	39.7%	40.4%
	Black or African American	27.7%	28.0%	23.6%	19.9%	28.6%	22.7%	26.4%	5.3%	5.1%
	Asian	***%	2.6%	***%	3.5%	1.6%	***%	2.5%	14.9%	15.5%
	Unknown	***%	3.2%	2.8%	2.8%	2.4%	***%	2.9%	0.4%	0.7%
	Native Hawaiian or Other Pacific Islander	***%	1.7%	***%	4.5%	1.6%	***%	2.0%	0.3%	0.3%
	American Indian or Alaska Native	***%	0.7%	***%	0.6%	1.0%	***%	0.7%	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 facilities.
2 Taken from U.S. Census Bureau 2022 American Community Survey (ACS 5-Year Estimates). Does not include 3.8% labeled "two or more races".
3 Taken from U.S. Census Bureau 2023 American Community Survey (ACS 1-Year Estimates). Does not include 4.4% labeled "two or more races".
4 Includes MDSO.

*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. 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.



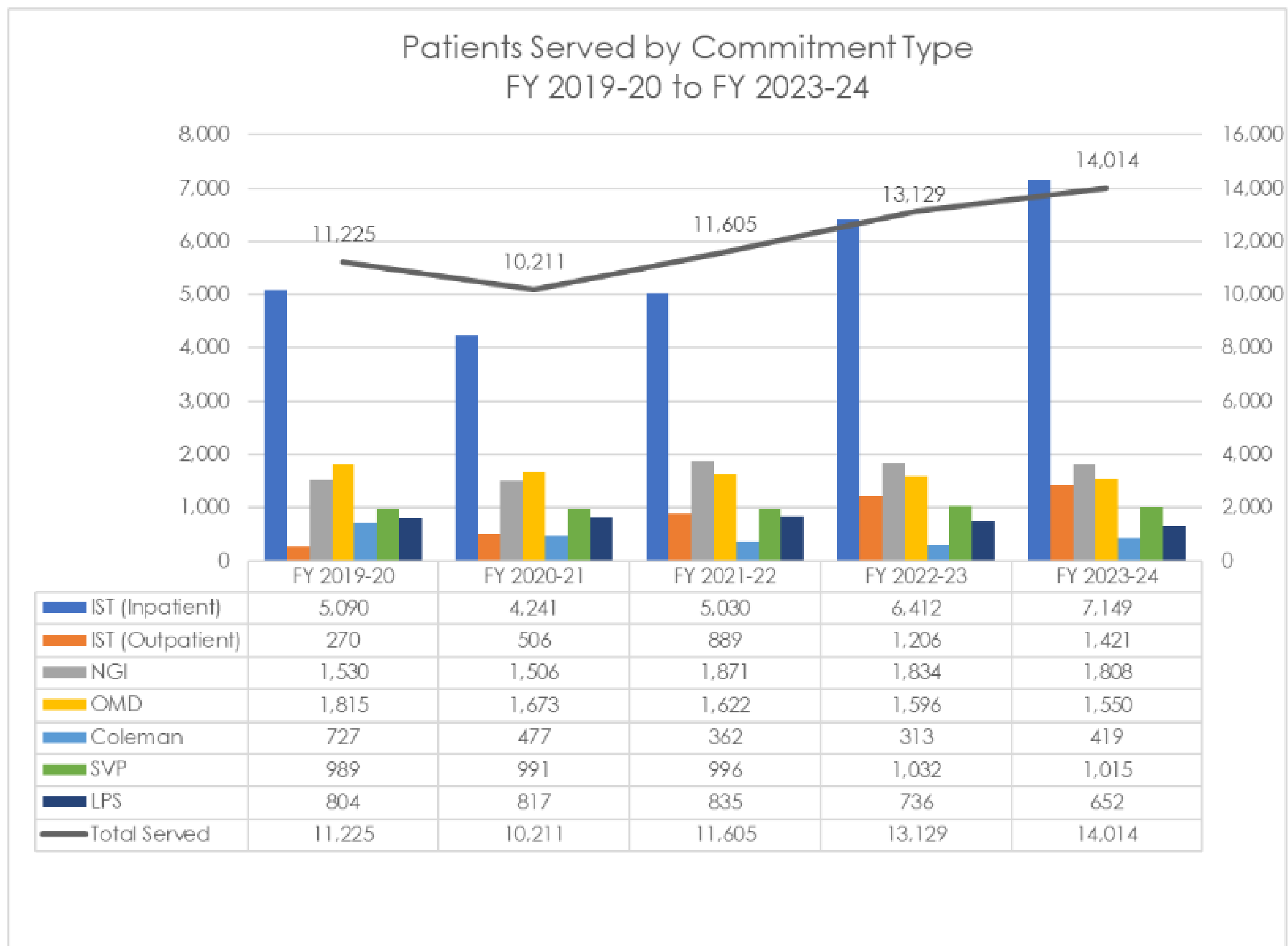
	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
IST (Inpatient)	1,763	1,319	1,535	1,978	2,233
IST (Outpatient)	185	250	476	668	673
NGI	1,407	1,367	1,759	1,707	1,675
OMD	1,295	1,252	1,269	1,224	1,200
Coleman	283	209	161	105	127
SVP	954	935	950	977	974
LPS	773	799	770	637	565
ADC Total	6,660	6,131	6,919	7,296	7,447

Data includes State Hospitals data in all years and for all commitments. IST (Inpatient) also includes Community Inpatient Facilities (CIF) and Jail-Based Competency Treatment Programs (JBCT) Community. IST Outpatient includes Community Based Restoration for all years. LA Diversion beginning in FY 2022-23. Conditional Release Program (CONREP), CONREP-Sexually Violent Predators (SVP) and CONREP- Forensic Assertive Community Treatment (FACT) 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 2019-20 through FY 2022-23.

During fiscal year (FY) 2023-24, 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 7,447 patients; a 2% growth in average daily census over FY 2022-23.

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 2% growth from FY 2022-23 to FY 2023-24 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.

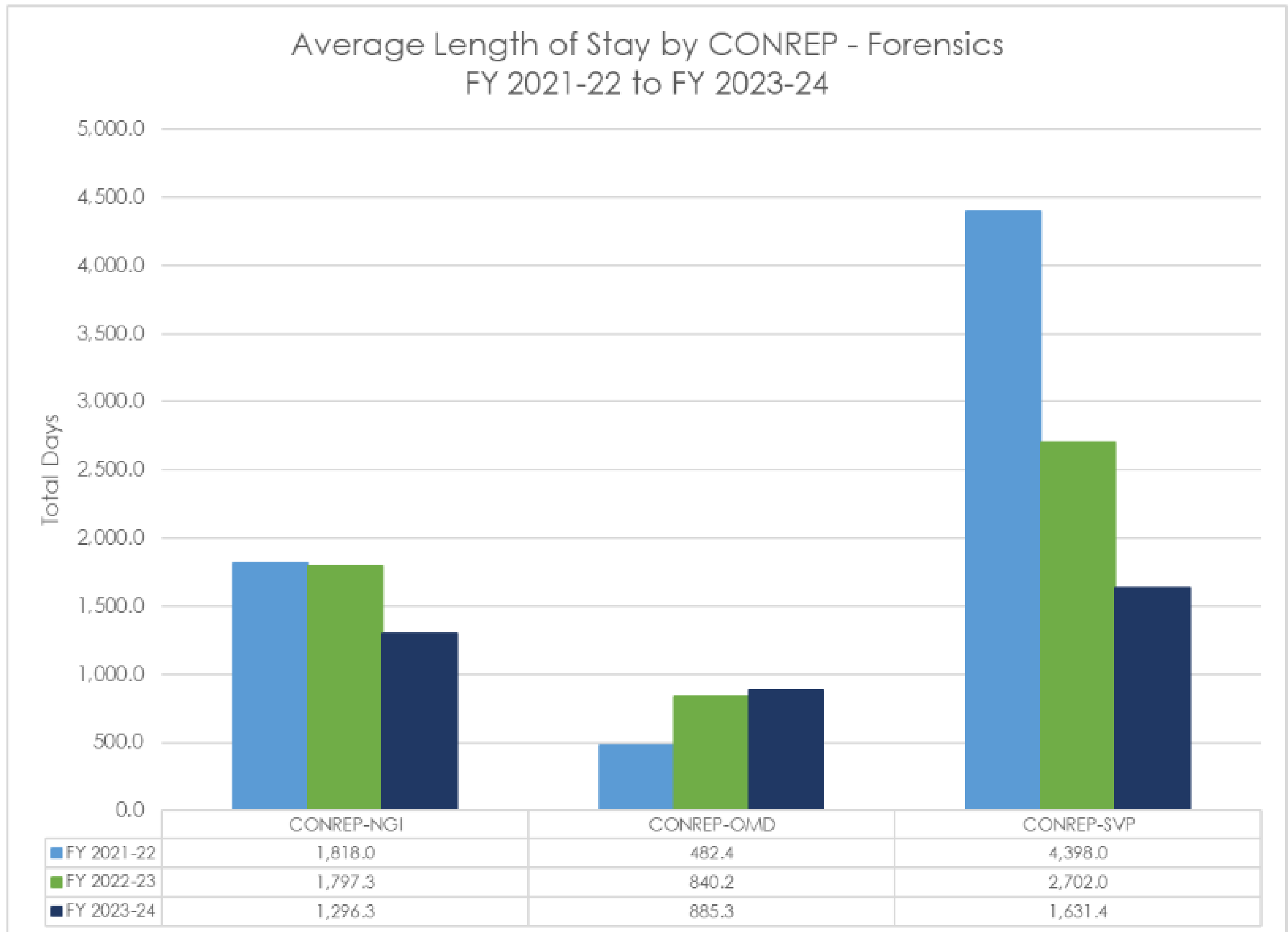


	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
IST (Inpatient)	5,090	4,241	5,030	6,412	7,149
IST (Outpatient)	270	506	889	1,206	1,421
NGI	1,530	1,506	1,871	1,834	1,808
OMD	1,815	1,673	1,622	1,596	1,550
Coleman	727	477	362	313	419
SVP	989	991	996	1,032	1,015
LPS	804	817	835	736	652
Total Served	11,225	10,211	11,605	13,129	14,014

Data includes State Hospitals data in all years and for all commitments. IST (Inpatient) also includes Community Inpatient Facilities (CIF) and Jail-Based Competency Treatment Programs (JBCT) Community. IST Outpatient includes Community Based Restoration. LA Diversion beginning in FY 2022-23. Conditional Release Program (CONREP), CONREP-Sexually Violent Predators (SVP) and CONREP-Forensic Assertive Community Treatment (FACT) 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 2019-20 through FY 2022-23.

	IST (Inpatient)	IST (Outpatient)	NGI	OMD	Coleman	SVP	LPS
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
FY 2023-24	141.5	416.7	3,110.5	711.4	141.0	4,298.4	2,296.2

Data includes State Hospitals data in all years. Data includes State Hospitals data in all years and for all commitments. IST (Inpatient) also includes Community Inpatient Facilities (CIF) and Jail-Based Competency Treatment Programs (JBCT). IST Outpatient includes Community Based Restoration all years. LA Diversion beginning FY 2022-23. Conditional Release Program (CONREP), CONREP-Sexually Violent Predators (SVP) and CONREP-Forensic Assertive Community Treatment (FACT) 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 2019-20 through FY 2022-23.



	CONREP-NGI	CONREP-OMD	CONREP-SVP
FY 2021-22	1,818.0	482.4	4,398.0
FY 2022-23	1,797.3	840.2	2,702.0
FY 2023-24	1,296.3	885.3	1,631.4

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 HOSPITALS
COUNTY BED BILLING REIMBURSEMENT AUTHORITY
Program Update

SUMMARY

As of the 2025-26 Governor's Budget, the Department of State Hospitals (DSH) is currently in negotiations with counties regarding a proposed increase to the daily bed rate based on DSH's actual costs. The Department does not project an adjustment to its County Bed Billing Reimbursement Authority at this time and will provide an update in the 2025-26 May Revision.

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 agencies through involuntary civil commitment procedures pursuant to the LPS Act. Individuals conserved under the LPS Act are to be treated in the least restricted setting to meet their treatment needs. DSH is identified in the LPS Act as a treatment setting for LPS conserved individuals along with other community treatment settings and is the more restrictive placement option under 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 for an IST individual stating there is no substantial likelihood the 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.

The Budget Act of 2024 reported no adjustments.

JUSTIFICATION

As of the 2025-26 Governor's Budget, DSH assumes no adjustments to the current reimbursement authority for fiscal year (FY) 2024-25 or ongoing. LPS and NR/MT daily bed rates are currently under negotiation, and DSH will provide an update as negotiations conclude, and more information becomes available.

DSH also 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, provided through a Memorandum of Understanding (MOU) with the counties. As of the 2025-26 Governor's Budget, the DSH LPS projected census is 556, as contracted in the MOU, with 122[1] patients ready to transition to a lower level of care, and an additional 246[2] LPS patients referred to DSH for admission. DSH will continue to monitor and provide an update on negotiated bed rates in the 2025-26 May Revision.

Resource Table

Description	CY	BY	BY+
Current Service Level	$164,228	$164,228	$164,228
Governor's Budget Request	$0	$0	$0
TOTAL	**$164,228**	**$164,228**	**$164,228**

*Dollars in thousands

[1] Data as of September 30, 2024
[2] Data as of November 25, 2024

STATE HOSPITAL
DSH – METROPOLITAN INCREASED SECURE BED CAPACITY
Program Update

SUMMARY

As of the 2025-26 Governor's Budget, the Department of State Hospitals (DSH)-Metropolitan Increased Secure Bed Capacity (ISBC) project continues to experience delays in the activation of Units 4 and 5 for Incompetent to Stand Trial (IST) forensic patients. DSH anticipates the Skilled Nursing Facility (SNF) building restoration will be completed in early 2025; a three-month delay from the 2024-25 May Revision. This results in a one-time savings of $4.4 million in fiscal year (FY) 2024-25.

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 the 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 Chronic 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.

In the Budget Act of 2024, DSH reported a one-time savings of $3.9 million in FY 2023-24 due to continued construction delays. DSH and the Department of General Services (DGS) anticipated internal restorations of the SNF building to be completed in October 2024, which would allow SNF building patients to be relocated and DSH-Metropolitan Units 4 and 5 to be activated.

JUSTIFICATION

While roof replacement of the SNF building is complete, construction and repairs continue on the interior portion of the SNF building, which began November 2023 following extensive water intrusion. Numerous change order requests arose due to

unanticipated 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, and DSH/DGS Project Management has worked to accelerate the project schedule and final regulatory approval in order to reactivate the SNF building.

As of the 2025-26 Governor's Budget, DSH and DGS anticipate internal restorations of the SNF building will be completed in early 2025. Completion of the SNF building restoration will allow the SNF building patients to be relocated and DSH-Metropolitan to proceed with activation of Units 4 and 5 for IST forensic patients, including patients from the Norwalk Alternate Care Site (ACS), which will be relocated to DSH-Metropolitan Units 4 and 5 upon closure. Due to the continued delays in interior construction on the SNF building, DSH is projecting a one-time savings of $4.4 million in FY 2024-25.

Activation Timeline Adjustment

Unit	# of Beds	Scheduled Activation as of 2024-25 May Revision	Scheduled Activation as of 2025-26 Governor's Budget	Change from the 2024-25 May Revision
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	October 2024	Early 2025	Delayed
Unit 5	48	October 2024	Early 2025	Delayed

Resource Table

Description	CY	BY	BY+
Current Service Level	$74,857	$74,857	$74,857
Governor's Budget Request	($4,372)	$0	$0
TOTAL	**$70,485**	**$74,857**	**$74,857**

*Dollars in thousands

BCP Fiscal Detail Sheet

BCP Title: DSH-Metropolitan Increased Secure Bed Capacity | **BR Name: 4440-034-ECP-2025-GB**

Budget Request Summary

	FY25					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Salaries and Wages						
Earnings - Permanent	-2,700	0	0	0	0	0
Total Salaries and Wages	**$-2,700**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-1,384	0	0	0	0	0
Total Personal Services	**$-4,084**	**$0**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-144	0	0	0	0	0
5304 - Communications	-18	0	0	0	0	0
5320 - Travel: In-State	-18	0	0	0	0	0
5324 - Facilities Operation	-90	0	0	0	0	0
5346 - Information Technology	-18	0	0	0	0	0
Total Operating Expenses and Equipment	**$-288**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-4,372**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	-4,372	0	0	0	0	0
Total State Operations Expenditures	**$-4,372**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-4,372**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4400020 - Hospital Administration	-18	0	0	0	0	0
4410030 - Metropolitan	-4,354	0	0	0	0	0
Total All Programs	**$-4,372**	**$0**	**$0**	**$0**	**$0**	**$0**

Personal Services Details

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
2011 - Custodian I	-74	0	0	0	0	0
7552 - Physician & Surgeon (Safety)	-225	0	0	0	0	0
7619 - Staff Psychiatrist (Safety)	-970	0	0	0	0	0
8094 - Registered Nurse (Safety)	-219	0	0	0	0	0
8104 - Unit Supvr (Safety)	-91	0	0	0	0	0
8252 - Sr Psych Techn (Safety)	-394	0	0	0	0	0
8253 - Psych Techn (Safety)	304	0	0	0	0	0
8420 - Rehab Therapist (Art-Safety)	-315	0	0	0	0	0
9872 - Clinical Soc Worker (Hlth/CF)-Safety	-311	0	0	0	0	0
9873 - Psychologist (Hlth Facility-Clinical-Safety)	-405	0	0	0	0	0
Total Salaries and Wages	**$-2,700**	**$0**	**$0**	**$0**	**$0**	**$0**

Staff Benefits	CY	BY	BY+1	BY+2	BY+3	BY+4
5150200 - Disability Leave - Industrial	-35	0	0	0	0	0
5150210 - Disability Leave - Nonindustrial	-11	0	0	0	0	0
5150350 - Health Insurance	-124	0	0	0	0	0
5150450 - Medicare Taxation	-41	0	0	0	0	0
5150600 - Retirement - General	-614	0	0	0	0	0
5150700 - Unemployment Insurance	-3	0	0	0	0	0
5150800 - Workers' Compensation	-124	0	0	0	0	0
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	-76	0	0	0	0	0
5150900 - Staff Benefits - Other	-356	0	0	0	0	0
Total Staff Benefits	**$-1,384**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$-4,084**	**$0**	**$0**	**$0**	**$0**	**$0**

STATE HOSPITALS
ENHANCED TREATMENT PROGRAM (ETP) STAFFING
Program Update

SUMMARY

As of the 2025-26 Governor's Budget, the Department of State Hospitals (DSH) anticipates construction of the Enhanced Treatment Program (ETP) unit at DSH-Patton (Unit 06) to be completed in April 2025; a nine-month delay from what was reported at the 2024-25 May Revision. This delay results in a one-time savings of $571,000 in fiscal year (FY) 2024-25.

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 2024 reflected a one-time savings of $281,000 in FY 2023-24 due to continued challenges with the fire sprinkler redesign and regulatory approvals. Unit construction completion was anticipated in July 2024, with unit activation in September 2024.

JUSTIFICATION

On July 30, 2024, the State Fire Marshal approved the fire sprinkler system redesign for DSH-Patton Unit 06. Construction on the sprinkler system began shortly after in the ancillary corridor of the U building and the U5 building. Due to continued construction, DSH anticipates an additional nine-month delay in the completion of DSH-Patton Unit 06, with construction now estimated for completion April 2025, followed by unit activation in June 2025.

As a result of the delay, DSH is reporting a one-time savings of $571,000 in FY 2024-25 for the ETP unit in Patton. An update will be provided in the 2025-26 May Revision.

Please see the table below for a complete activation timeline.

ETP Activation Timeline			
Units/Hospital	**Scheduled Initiation**	**Scheduled Completion**	**Delay from 2024-25 May Revision**
DSH-Atascadero Unit 29	September 24, 2018 (Actual)	July 2021 (Actual)	N/A
DSH-Patton Unit U-06	December 2023	April 2025	9-month delay

Resource Table

Description	CY	BY	BY+
Current Service Level	$15,129	$15,129	$15,129
Governor's Budget Request	($571)	$0	$0
TOTAL	**$14,558**	**$15,129**	**$15,129**

*Dollars in thousands

BCP Fiscal Detail Sheet

BCP Title: Enhanced Treatment Program (ETP) Staffing | **BR Name: 4440-035-ECP-2025-GB**

Budget Request Summary

	FY25					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Salaries and Wages						
Earnings - Permanent	-346	0	0	0	0	0
Total Salaries and Wages	**$-346**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-177	0	0	0	0	0
Total Personal Services	**$-523**	**$0**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-24	0	0	0	0	0
5304 - Communications	-3	0	0	0	0	0
5320 - Travel: In-State	-3	0	0	0	0	0
5324 - Facilities Operation	-15	0	0	0	0	0
5346 - Information Technology	-3	0	0	0	0	0
Total Operating Expenses and Equipment	**$-48**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-571**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	-571	0	0	0	0	0
Total State Operations Expenditures	**$-571**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-571**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4400020 - Hospital Administration	-3	0	0	0	0	0
4410050 - Patton	-568	0	0	0	0	0
Total All Programs	**$-571**	**$0**	**$0**	**$0**	**$0**	**$0**

Personal Services Details

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
1138 - Office Techn (Gen)	-38	0	0	0	0	0
5393 - Assoc Govtl Program Analyst	-69	0	0	0	0	0
7619 - Staff Psychiatrist (Safety)	92	0	0	0	0	0
8094 - Registered Nurse (Safety)	-354	0	0	0	0	0
8252 - Sr Psych Techn (Safety)	-9	0	0	0	0	0
8253 - Psych Techn (Safety)	242	0	0	0	0	0
8324 - Rehab Therapist (Recr-Safety)	-59	0	0	0	0	0
9699 - Hlth Svcs Spec (Safety)	-104	0	0	0	0	0
9872 - Clinical Soc Worker (Hlth/CF)-Safety	29	0	0	0	0	0
9873 - Psychologist (Hlth Facility-Clinical-Safety)	-76	0	0	0	0	0
Total Salaries and Wages	**$-346**	**$0**	**$0**	**$0**	**$0**	**$0**

Staff Benefits	CY	BY	BY+1	BY+2	BY+3	BY+4
5150200 - Disability Leave - Industrial	-4	0	0	0	0	0
5150210 - Disability Leave - Nonindustrial	-1	0	0	0	0	0
5150350 - Health Insurance	-16	0	0	0	0	0
5150450 - Medicare Taxation	-5	0	0	0	0	0
5150600 - Retirement - General	-79	0	0	0	0	0
5150800 - Workers' Compensation	-16	0	0	0	0	0
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	-10	0	0	0	0	0
5150900 - Staff Benefits - Other	-46	0	0	0	0	0
Total Staff Benefits	**$-177**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$-523**	**$0**	**$0**	**$0**	**$0**	**$0**

STATE HOSPITALS
PATIENT-DRIVEN OPERATING EXPENSES & EQUIPMENT
Program Update

SUMMARY

Due to rising costs, the Department of State Hospitals (DSH) requests $21.68 million in fiscal year (FY) 2024-25 and ongoing for recognized increases in Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization as part of support for patient-driven operating expenses and equipment (OE&E).

BACKGROUND

DSH provides 24 hour, 7 days a week care and treatment to its patients. In order to ensure DSH received the appropriate amount of funding to care for its patients, and under the recommendation of the Legislative Analyst Office (LAO), the Budget Act of 2019 adopted a standardized methodology to provide funding for patient-related OE&E, based on an updated projected census for each fiscal year and a cost per patient derived from past year actual expenditures. As part of the approved methodology, DSH identified key components of care required to provide adequate care and treat DSH patients. Below is a table displaying those categories:

Budget Categories	Sub-Categories
Utilities	Electricity, Natural Gas, Water, and Sewer
Outside Hospitalization	Includes but is not limited to, Oncology, Dialysis, Surgery, Radiology, Hospice, and Geriatric Specialties
Clothing/Personal Supplies	Clothing, Hygiene products, Footwear
Recreation & Religion	Vocational Services Supplies, Religious materials
Foodstuffs	Food products (recognizing dietary restrictions/needs), Utensils, Kitchen Supplies
Quartering & Housekeeping	Towels, Bedding, Housekeeping Supplies
Laundry	Prison Industry Authority (PIA) contracted services, etc.
Miscellaneous Client Services	Patient Transportation (i.e. ambulance services), Indigent Aid, Discharge Gate Allowance, etc.
Chemicals, Drugs and Lab Supplies	Prosthetics, Eye Services, Dentures
Pharmaceuticals	Medications, Prescriptions
Educational Supplies	Academic and Vocational Education Program Materials and Supplies

Utilizing a per patient cost of $17,076 for Utilities, Foodstuffs, and Pharmaceuticals only, in the Budget Act of 2024, DSH received $9.2 million for FY 2023-24 and $10.2 million in FY 2024-25 and ongoing to support an increase in patient census and rising costs.

JUSTIFICATION

As of the 2025-26 Governor's Budget, DSH requests $21.68 million in FY 2024-25 and ongoing to support the growing costs of Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization. Following an abridged version of the methodology adopted in the Budget Act of 2019, the patient-driven OE&E costs are based on updated hospital census projections and per patient costs derived from FY 2023-24 actual expenditures for Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization only.

Increase in Per Patient Cost

As inflation[1] and costs continue to rise in 2024, so too does the per patient cost for patient-driven OE&E. For the categories of Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization, per patient expenditures from FY 2022-23 to FY 2023-24 increased by $3,936.70 per patient, or 16%, to $29,039.70. The chart below displays the increase in cost per patient for the Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization categories within patient-driven OE&E:

Figure 1: All State Hospitals			
Budget Categories	2022-23 Avg. Cost Per Patient	2023-24 Avg. Cost Per Patient	Percentage Change
State Hospital Census	*5,689*	*5,550*	*-2%*
Utilities	$4,987	$5,132	3%
Outside Hospitalization	$8,027	$11,009	37%
Foodstuffs	$4,469	$4,705	5%
Pharmaceuticals	$7,620	$8,195	8%
Total	**$25,103**	**$29,040**	16%

Allotment Adjustment for FY 2024-25

Between FY 2022-23 and FY 2023-24, the per patient cost for Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization increased by $3,936.70 to $29,039.70. The projected patient census for FY 2024-25 decreased from 5,802 to the current

[1] Please see Department of Finance Budget Letter (BL) 24-26, 2025-26 Price Letter, reflecting the impact of inflation on rising costs.

projection of 5,762; a difference of 40 patients. To calculate the additional funding need, the abridged methodology follows a two-step process:

- Step One: The first step is calculating the additional need resulting from the increased per patient cost for Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization only. The per patient cost difference ($3,936.70) is multiplied by the 2024-25 May Revision projected census (5,802), resulting in $22,840,733.

- Step Two: The second step is calculating the funding adjustment resulting from the decrease in patient census. The updated per patient cost for Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization only ($29,039.70) is multiplied by the difference in patient census (-40), resulting in -$1,161,588**.**

The cost adjustment for Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization in FY 2024-25 is determined by adding steps one and two above, resulting in $21,679,145. The table below displays the cost adjustment.

FY 2024-25 Cost Adjustment for Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization	
Cost Adjustment for Increased Per Patient Cost	$22,840,733
Cost Adjustment for Updated Census	-$1,161,588
Total Cost Adjustment for FY 2024-25	**$21,679,145**

Allotment Adjustment for FY 2025-26

DSH projects the FY 2025-26 patient census to remain at 5,762 patients. Given no projected change to the census in FY 2025-26, DSH requests no additional funding for patient-driven OE&E.

DSH will continue to monitor costs and patient census and provide an update in the 2025-26 May Revision.

Resource Table

Description	CY	BY	BY+
Current Service Level	$146,043	$146,043	$146,043
Governor's Budget Request	$21,679	$21,679	$21,679
TOTAL	**$167,722**	**$167,722**	**$167,722**

*Dollars in thousands

BCP Fiscal Detail Sheet

BCP Title: Patient Driven Operating Expenses & Equipment (OE&E) - Modified Approval **BR Name: 4440-036-ECP-2025-GB**

Budget Request Summary

			FY25			
	CY	BY	BY+1	BY+2	BY+3	BY+4
Operating Expenses and Equipment						
5326 - Utilities	637	637	637	637	637	637
5340 - Consulting and Professional Services - External	16,860	16,860	16,860	16,860	16,860	16,860
539X - Other	4,182	4,182	4,182	4,182	4,182	4,182
Total Operating Expenses and Equipment	**$21,679**	**$21,679**	**$21,679**	**$21,679**	**$21,679**	**$21,679**
Total Budget Request	**$21,679**	**$21,679**	**$21,679**	**$21,679**	**$21,679**	**$21,679**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	21,679	21,679	21,679	21,679	21,679	21,679
Total State Operations Expenditures	**$21,679**	**$21,679**	**$21,679**	**$21,679**	**$21,679**	**$21,679**
Total All Funds	**$21,679**	**$21,679**	**$21,679**	**$21,679**	**$21,679**	**$21,679**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4410010 - Atascadero	6,662	6,662	6,662	6,662	6,662	6,662
4410020 - Coalinga	4,088	4,088	4,088	4,088	4,088	4,088
4410030 - Metropolitan	3,406	3,406	3,406	3,406	3,406	3,406
4410040 - Napa	3,617	3,617	3,617	3,617	3,617	3,617
4410050 - Patton	3,906	3,906	3,906	3,906	3,906	3,906
Total All Programs	**$21,679**	**$21,679**	**$21,679**	**$21,679**	**$21,679**	**$21,679**

STATE HOSPITALS
***COLEMAN* INCREASED REFERRALS**
New Item

SUMMARY

The Department of State Hospitals (DSH), in conjunction with the California Department of Corrections and Rehabilitation (CDCR), developed new methodologies to increase *Coleman* referrals from CDCR to DSH to increase DSH's *Coleman* census. As of the 2025-26 Governor's Budget, DSH requests 3.0 positions (authority only) in fiscal year (FY) 2025-26 and ongoing to address increased workload related to referral intake for *Coleman* patients.

BACKGROUND

Pursuant to Penal Code (PC) 2684: Treatment of Prisoners, DSH *Coleman*[1] patients are CDCR incarcerated individuals who have transferred from CDCR to DSH for inpatient mental health care, with the expectation they will return to CDCR[2] when they have reached maximum benefit from treatment. The *Coleman* Program Guide, agreed to by the court, establishes criteria by which incarcerated individuals are referred to DSH, which includes complicated presentations, (such as complex medical diagnoses), cognitive issues, or developmental disabilities along with mental illness.

In compliance with *Coleman,* DSH has designated beds at three hospitals for individuals referred via PC 2684:

- DSH-Atascadero -256 *Coleman* beds
- DSH-Coalinga - 50 *Coleman* beds
- DSH-Patton - 30 *Coleman* beds (females only)

Treatment focus for the *Coleman* population is psychiatric stabilization. In addition to psychiatric and medical services, psychosocial treatments are provided, with a focus on helping patients manage the symptoms of their mental illness and reintegrate back into a prison environment when discharged from the state hospital.

Prior to 2023, referrals to DSH only occurred if 1) the patient's custodial Least Restrictive Housing (LRH) designation, as determined by California Correctional Health Care Services (CCHCS) was unlocked dorms, and 2) if CDCR's Inpatient Referral Unit (IRU) clinically recommend unlocked dorms. Referrals with a different LRH and/or different IRU clinical recommendations would be referred to a CDCR psychiatric inpatient program. Due to the number of inmate-patients meeting these

[1] For more information on the *Coleman* patient population, please see Section F1.
[2] Pursuant to PC 2685

eligibility limitations, the *Coleman* census at DSH has remained lower than anticipated by the *Coleman* court since the COVID-19 pandemic.

California Welfare and Institutions Code (WIC) Section 7234 established the Patient Management Unit (PMU) as a centralized hub for processing referrals received by DSH, including those committed via PC 1370 (Incompetent to Stand Trial), PC 1026 (Not Guilty by Reason of Insanity), and PC 2684 (*Coleman)*. Referrals for both PC 1370 and *Coleman* patients have court mandated timelines for processing and admitting patients.

Prior to December 2020, PMU processed *Coleman* referrals utilizing 1.0 Associate Governmental Program Analyst (AGPA) and 1.0 Nurse Consultant. Due to the lack of a clinical review process, most Coleman referrals were admitted to DSH with mixed results. A significant number of the inmate-patients admitted were not clinically appropriate for a DSH hospital setting due to violent or disruptive behaviors not suitable for housing in DSH's unlocked dorm settings which put other patients and DSH team members at risk.

During the COVID-19 pandemic, the *Coleman* court and Special Master's Office increased oversight of CDCR's referrals to DSH, requiring DSH to dedicate clinical resources to liaise and manage a new, in-depth clinical referral review process. PMU hired 1.0 Senior Psychologist Specialist who provided in-depth reviews of every CDCR referral to help determine the patient's appropriateness for admission, key areas of concern that could impact treatment, and other salient clinical matters. In addition to providing initial reviews, the Senior Psychologist Specialist was also responsible for coordinating acute discharges from the state hospital, communication with multiple CDCR and DSH entities, and touring different hospitals with the Special Master expert team, as needed. The increase in clinical review led to fewer state hospital admissions when *Coleman* referrals were found not appropriate for admission.

On October 9, 2023, as part of discussions between CDCR, DSH, and the Special Master, a "trial process" was initiated that led to a significant increase in CDCR referrals and reviews. Previously, an endorsement to DSH required the patient to have a LRH of unlocked dorms and IRU clinical recommendation for unlocked dorm. The "trial process" eliminated the requirement for an IRU clinical recommendation and sent all referrals with a LRH of unlocked dorms to DSH, regardless of the clinical housing recommendation. This led to an increase in CDCR referrals from 26 per month to 51; an increase of 96%.

Prior to the "trial process" DSH received approximately 22.2% of all Intermediate Care Facility (ICF) referrals made by CDCR, but since the "trial process" implementation DSH has now received approximately 47.5% of all ICF referrals made by CDCR. Beforehand, CDCR only relied on DSH to review less than a quarter of the ICF referrals

and currently CDCR relies on DSH to review close to half of all ICF referrals, with a trend this reliance on DSH will increase in the near term.

The "trial process" also implemented a procedure for DSH and CDCR to review CDCR patients who are housed in a CDCR inpatient psychiatric program and have not been referred to DSH. Under this process, the CDCR Inmate Referral Unit, in collaboration with DSH, every 30-45 days identifies and reviews a selection of patients who are being treated in CDCR's psychiatric inpatient programs and have the Least Restrictive Housing designation of Unlocked Dorms to determine if it may be clinically appropriate to step the individual down to an unlocked dorm setting based on the patient's current clinical presentation. This utilization review expands the number of patients that may be admitted to DSH and requires additional staff time to complete the reviews. Since implementation of this "trial process" DSH has reviewed approximately 327 patients not referred to DSH and housed within a CDCR inpatient psychiatric program.

In June 2024, in response to concerns from the court regarding the low census of the *Coleman* population within DSH, the DSH and CDCR collaborated to develop three proposals to increase potential utilization of *Coleman* beds:

Long-Term Intermediate Program

The Long-Term Intermediate Program was designed to house patients who have previously been referred to DSH, and who have demonstrated difficulty in reintegrating into CDCR's outpatient level of care due to the severity of their mental illness. This will result in longer lengths of stay than typical for *Coleman* patients. Given the nature of this program, a DSH Consulting Psychologist is required to perform a deeper clinical review to determine whether patients meet criteria and require continued care in such a program. In addition, the Consulting Psychologist will have to regularly coordinate with the treatment team, leadership, and, upon an eventual discharge, will also organize a case conference to ensure the patient is transferred back to CDCR without any significant issues.

Admissions Unit

Traditionally, *Coleman* patients had been admitted directly to their home unit without first being admitted to an Admissions Unit for patient stabilization. This proposal would admit sub-acute individuals referred from CDCR to an Admissions Unit first. Admission Units are single, unlocked rooms, which provide a higher level of support for individuals transitioning from the custodial environment at CDCR, to DSH's standard intermediate care facility (ICF) unlocked dorms. This change will increase both the number of admissions to DSH and the overall *Coleman* census, resulting in an increased workload for PMU.

Review of Close Custody, Single Cell, and Life Without Parole (LWOP)

The final proposal addressed CDCR patient referrals with a Close Custody, Single Cell designation, or LWOP term. Historically, inmate-patients with these custody classifications have been ineligible for placement at DSH. However, it was proposed that DSH clinically review referrals with these custody classifications to make a clinical determination if the patient is clinically indicated for the state hospital setting. In the event the inmate-patient is recommended for admission, CDCR custody leadership will review and determine if the custody classifications can be removed or modified to allow for admission to the state hospital. Based on 2023 data provided by CDCR, this would increase the number of referrals reviewed by 27 per month.

In addition to DSH reviewing referrals for Close Custody, Single Cell and LWOP, to identify if they are clinically indicated for DSH's setting, DSH and CDCR IRU will also periodically review individuals who were not clinically indicated for treatment in an unlocked dorm at the time of initial referral and were ultimately admitted into a CDCR PIP. This utilization review creates additional review workload but will help identify individuals who after treatment at the CDCR PIP may have become clinically appropriate for step down to DSH unlocked dorms.

All three proposals went into effect September 16, 2024.

JUSTIFICATION

Prior to December 2020, PMU was allocated 2.0 positions (1.0 AGPA and 1.0 Nurse Consultant) to review referrals from Coleman. However, since FY 2020-21, *Coleman* referrals received by DSH and *Coleman* admissions have steadily continued to increase, resulting in an increased workload for PMU.

Please see the table below displaying the number of *Coleman* referrals and admissions by fiscal year from FY 2020-21 to projections for FY 2024-25:

Fiscal Year	*Coleman* Referrals Received	Monthly Average (Referrals)	Admissions to State Hospitals	Monthly Average (Admissions)
2020-2021	265	22	195	16
2021-2022	305	25	193	16
2022-2023	308	26	198	17
2023-2024	612	51	307	26
2024-2025 (Projected)	976	81	586	49

Since FY 2022-23, CDCR referrals to DSH have increased by 99% and admissions have increased by 55%. This does not include the additional 300-350 CDCR patient reviews

DSH completes as part of the "trial process" for those CDCR patients out of LRH in a psychiatric inpatient program, so the increase is actually far larger in terms of the number of patients DSH reviews on an annual basis. With the addition of the three DSH proposals (Long-Term Intermediate Program, Admissions Unit, and Review of Close Custody, Single Cell, and LWOP), there is a projected increase of 217% for referrals and 196% for admissions, when compared to FY 2022-23 (prior to the trial process implementation).

In addition, prior to October 2023, DSH only received less than a quarter of all ICF referrals made by CDCR, but now with the "trial process" implementation DSH has received close to half of all ICF referrals made which makes for a 114% increase. This demonstrates an increased reliance on DSH to review a significant portion of the ICF referrals generated within CDCR that will increase in the near future. Current population projections for CDCR suggest a significant population increase with the passage of Proposition 36[3]:

When CDCR overall population increases, the CDCR mental health population increases leading to an increase in ICF referrals, which historically suggests there will be a further increase of referrals sent to DSH starting in the near term given the increased reliance of DSH reviewing approximately half of all CDCR ICF patient referrals.

Staffing Resources – 2.0 Associate Governmental Program Analysts

As a result of the increased workload, PMU has allocated 1.0 AGPA position for *Coleman* referrals and has temporarily redirected resources to address the increase in referrals, causing additional pressure and overtime for existing staff. All staff in PMU are processing referrals that have a court-mandated admission timeline; therefore, none of the workload can be delayed. A typical completed CDCR referral takes 60 minutes to initially process, another 30 minutes for follow-up as needed, and 60 minutes for tracking to make sure the decision and transfer by the hospital is on track, bringing average processing time for a typical CDCR referral approximately 150 minutes to fully process typical completed CDCR referral could take. Quality control and review of the CDCR referrals can add another 90 minutes of workload per referral.

In addition, the PMU area responsible for processing/reviewing CDCR referrals is also tasked with processing WIC 7301 referrals, PC 1026 commitments, CDCR PC 1370 commitments, and tracking a subset of the PC 1370 population admitted to a specialized program within CDCR. As a result, PMU's current staffing of 1.0 AGPA is significantly limited and overloaded.

[3] California may take a big step backwards towards more incarceration with Proposition 36 | Prison Policy Initiative by Sarah Staudt, published October 17, 2024.

DSH requests 2.0 additional AGPAs in order to address the increased ongoing workload due to increased referrals coming from CDCR. This will allow DSH to meet court-mandated admission timelines as well as support enhanced clinical review and hospital admission teams. Please see Attachment A for the Workload Analysis for the requested 2.0 AGPAs.

Staffing Resources – 1.0 Chief Psychologist

The large increase in *Coleman* referrals has resulted in a significant workload increase for the PMU clinical team, resulting in clinical resources being redirected to PMU. Since a clinical review takes approximately 4 hours per CDCR referral, PMU's clinical team required four additional Consulting Psychologists to take on the increased workload. DSH is requesting 1.0 Chief Psychologist to provide oversight and supervision to PMU's clinical team.

The Chief Psychologist ensures reviews are conducted as clinically indicated, timely, accurately, and meet court ordered timelines for when CDCR patients must be admitted to DSH. Missed timelines incur a fine of $1,000 per day per CDCR patient, so meeting timelines is essential. The Chief Psychologist also oversees consultation with clinical leadership internally and at the state hospitals, reviews and updates existing and new policies related to CDCR and DSH, and represents DSH during tours, audits, depositions, and court hearings. This position will also allow DSH to have a peer-to-peer relationship with the Chief Psychologist at CDCR, which will also foster additional collaboration between the two entities. Please see Attachment B for the Workload Analysis for the 1.0 Chief Psychologist.

As of the 2025-26 Governor's Budget, DSH requests position authority only to support 1.0 Chief Psychologist and 2.0 AGPAs responsible for supporting CDCR's increased *Coleman* referrals to DSH.

Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$1,020	$1,020	$1,020
Governor's Budget Request	$0	$0	$0
TOTAL	**$1,020**	**$1,020**	**$1,020**

*Dollars in thousands

Attachment A - Associate Governmental Program Analyst Workload Analysis

	PROJECTED ONGOING WORKLOAD	
ACTIVITY TASK	**Hours per Month**	**Number of Hours Annually**
Specific Task		
Works closely with assigned counties, programs, and facilities to ensure patients are assigned to the most appropriate facility within required timeframes that best suits their treatment needs.	60.0	720.0
Serves in a lead capacity, working independently, and closely with other Care Coordination Teams, to ensure PMU is in receipt of required patient documentation and identify any missing information prior to assigning placement of the patient to a facility.	15.0	180.0
Independently conducts research and performs outreach as necessary to external county partners to request any pertinent documentation or information related to patient treatment.	15.0	180.0
Verifies documents to validate any exclusionary criteria that would preclude a patient from placement at specific facilities within the DSH continuum of care.	5.0	60.0
Monitors patient placement to ensure admission occurs within timelines.	10.0	120.0
Submits patient documentation to appropriate facility once it is determined where the patient should receive treatment.	10.0	120.0
Manages, monitors, and analyzes waitlists for adherence to timelines and other legal and regulatory expectations.	10.0	120.0
Collaborates with county partners, DSH staff across facilities and programs, contractors, and external stakeholders.	15.0	180.0
Independently provides policy, technical support, and program guidance as directed by management.	15.0	180.0
Independently prepares oral or written recommendations on various issues to	15.0	180.0

management, stakeholders, as well as internal and external partners.		
Facilitates and coordinates stakeholder conferences and other meetings as needed to address any questions, concerns, or issues that arise.	15.0	180.0
Provides superior customer service and transparent communication with internal and external entities.	10.0	120.0
Identifies any barriers related to patient admission or treatment and works with assigned programs to develop solutions.	20.0	240.0
Responds to all inquiries in a timely manner and elevates any significant issues or barriers to leadership.	10.0	120.0
Develops PMU related policies and operating procedures, as well as relevant departmental Regulations, Memoranda of Understanding, and collaborates closely with affected divisions and units in DSH.	5.0	60.0
Facilitates and participates in meetings and workgroups related to DSH preadmission as requested; prepares recommendations to management.	5.0	60.0
Leads trainings and demonstrations as requested by management.	5.0	60.0
Independently prepares written, analytical, and/or visual interpretation and impact of legislative proposals, bill analyses, budget change proposals, and other special projects as required.	35.0	420.0
Independently develops and prepares internal reports and analyses as requested by management.	15.0	180.0
Serves as a lead regarding PMU practices and procedures to workgroups and innovation projects as assigned.	5.0	60.0
Provides coverage for patient referral processing and placement, including data entry, as assigned.	15.0	180.0
Participates in Division, Branch, and Unit training program including formal training, on the job training, mentoring, and coaching.	5.0	60.0

Participates in cross-training on other assignments and provides coverage as assigned.	2.0	24.0
Independently develops literacy with DSH datasets, specifically the application of data to court reporting, admissions and discharge data, and IST solutions programs outcomes.	5.0	180.0
TOTAL HOURS PROJECTED ANNUALLY	322	**3,984**
Total New AGPAs Needed		**2.2**

Attachment B - Chief Psychologist Workload Analysis

	PROJECTED ONGOING WORKLOAD	
ACTIVITY TASK	**Hours per Month**	**Number of Hours Annually**
Specific Task		
Provides mental health guidance, leadership, and consultation on all post-trial commitments being admitted, treated, and discharged to and from DSH state hospital or contracted agency	60.00	720.00
Communicate regularly with DSH executive leadership, hospital leadership, other agencies, the court, and as indicated interested parties (i.e. Special Master)	15.00	180.00
Subject matter expert on matters involving post-trial commitments, namely commitments consistent with PC 2684, PC 2685, PC 1026, WIC 7301, PC 2974, and LPS	15.00	180.00
Collaborate with DSH personnel to ensure timely access to care	5.00	60.00
Collaborate with DSH personnel on emergent cases (i.e. acute discharges) from the hospital	3.00	36.00
Maintain all policies, procedures, and court orders are being followed	7.00	84.00
Attend all court hearings, court ordered tours of the hospitals, and all other tours of the hospitals from other agencies	8.00	96.00
Develop and/or modify policies and procedures as needed	20.00	240.00
Provide training to DSH personnel on policies, procedures, and court orders	5.00	60.00
Manages a team of consulting psychologists and one supervising psychiatric social worker, along with providing guidance to analysts as indicated	35.00	420.00
Participates in case conferences, appeals, and utilization management meetings	8.00	96.00
TOTAL HOURS PROJECTED ANNUALLY	**181.00**	**2,172.00**
Total New Chief Psychologist Needed		**1.04**

BCP Fiscal Detail Sheet

BCP Title: Coleman Increased Referrals

BR Name: 4440-038-ECP-2025-GB

Budget Request Summary

	FY25					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	0.0	3.0	3.0	3.0	3.0	3.0
Total Positions	**0.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
Total State Operations Expenditures	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
Total All Programs	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Personal Services Details

Positions	Salary Information: Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
5393 - Assoc Govtl Program Analyst				0.0	2.0	2.0	2.0	2.0	2.0
9859 - Chief Psychologist - CF				0.0	1.0	1.0	1.0	1.0	1.0
Total Positions				**0.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**

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

Program Update

SUMMARY

As of the 2025-26 Governor's Budget, the Department of State Hospitals (DSH) anticipates a total contracted caseload of 985 CONREP clients in fiscal year (FY) 2024-25 and FY 2025-26. DSH reports a one-time savings of $3.6 million in FY 2024-25 as a result of a reduced census.

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 individuals deemed Not Guilty by Reason of Insanity (NGI), Offender with a Mental Health Disorder (OMD), and Incompetent to Stand Trial (IST)[1] for those 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 addition 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

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

[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.

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. In order to address these service model limitations, CONREP has expanded its continuum of care to include Step-Down Transitional Programs and Forensic Assertive Community Treatment (FACT) Programs. Both programs allow for care in an enhanced supportive setting with services delivered on-site where the CONREP clients reside.

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). The 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 are 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 24/7 structured 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)

CFRP is a 24/7 mobile treatment team providing onsite individual and group treatment to clients at their residence. In addition to providing treatment, the CFRP's mobility allows them to respond quickly to provide de-escalation and crisis intervention practices, reducing the likelihood of rehospitalization. DSH contracts with providers for up to 90 dedicated beds, including staff resources, 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 (CBR) programs are not available.

Independent Placement Panel (IPP) & Placement Presumption

The Budget Act of 2022 included resources to pilot a new Independent Placement-Determination Panel (IPP), which sought to increase participation in CONREP by patients found NGI or OMD, thereby increasing state hospital bed capacity for

those on the IST waitlist.

In November 2022, DSH initiated a stakeholder workgroup to develop the IPP, consisting of several county CONREP Community Program Directors (CPDs), DSH CONREP clinical staff, and state hospital discharge-planning teams. This group was tasked with establishing an implementation plan, with specific focus on determining assessment and referral protocols, justice partner engagement, CONREP program training, technical assistance, and streamlining of the referral process and patient records database.

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

Budget Act of 2024

In the Budget Act of 2024, DSH reported a one-time savings of $3.2 million in FY 2023-24 due to delays in admissions at the Northern CA STRP facility and ongoing challenges with hiring clinical staff for programs.

JUSTIFICATION

As of the 2025-26 Governor's Budget, DSH anticipates a total contracted caseload of 985 CONREP clients in FY 2024-25 and FY 2025-26. This contracted caseload includes 692 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, closed in December 2024.
- 90 FACT beds
  - 30 activated beds in Northern CA Region - (Sacramento County)
  - 30 activated beds in Southern CA Region - (San Diego County)
  - 30 beds anticipated to activate in Northern CA Region - (TBD) in Spring 2025
- 168 Institute for Mental Disorder (IMD) beds
  - 78-bed activated Southern CA IMD

[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.

- o 30-bed activated Northern CA IMD
- o 60 beds anticipated to activate in a new Northern CA Mental Health Rehabilitation Center (MHRC) in Spring 2025

This contracted caseload reflects the total number of clients and beds available by the end of FY 2024-25 and FY 2025-26, which may vary based on activation timelines. Reflecting the projected client phase-in, DSH estimates an average census of 743 in FY 2024-25 and 877 in FY 2025-26.

CONREP community program providers have continued to experience challenges in hiring and retention for clinical and administrative staff. This barrier is consistent across all programs and impacts census and contract costs.

78-Bed Southern CA IMD Facility (Golden Legacy)

Using space previously licensed as a skilled nursing facility (SNF), and in partnership with a Southern CA IMD facility, Golden Legacy, DSH developed plans for a 78-bed step-down program for OMD and NGI state hospital patients ready for CONREP within in the next 18 to 24 months of their treatment. Activation of the program was split between Phase I (34 beds) and Phase II (43 beds), with Phase I activating in October 2023 and Phase II in April 2024. Both units are now in full operation.

30-Bed Northern CA IMD Facility (Canyon Manor)

As of November 2024, 20 of the 30 contracted beds are currently filled. The provider continues to experience insufficient clinical evaluator staffing, which has resulted in reduced client admissions. DSH is working with the provider to implement a number of strategies for hiring and retention, in hopes that this position will be filled by January 2025. DSH reports a one-time savings of $450,000 in FY 2024-25 as a result of the unfilled beds. An update will be provided in the 2025-26 May Revision.

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. Admissions have been affected by continued difficulty with maintaining adequate clinical staffing levels. As of November 2024, DSH has decided to discontinue the 20-bed Northern CA STRP facility, with the program officially projected to close in December 2024. DSH is currently exploring alternative providers to fill this need within the CONREP continuum of care in Northern CA. DSH reports a one-time savings of $832,000 in FY 2024-25 as a result of the unfilled beds. An update will be provided in the 2025-26 May Revision.

CONREP FACT Regional Program (CFRP)

In the 2024-25 May Revision, DSH reported that CFRP-Alameda had paused admissions to the contracted provider to allow for further program development and refinement of the 30-bed program. Ultimately, the provider was unable to maintain the staffing to effectively manage the Alameda program and the location has since closed. However, DSH continues to explore options to expand its continuum of care, including additional CFRP beds. To that end, DSH is currently in the process of engaging a new contract provider to operate an additional 30 CFRP beds in Northern California. The new provider is currently in the process of locating the appropriate housing and DSH anticipates activation of this program in late Spring 2025. Of the total 60 CFRP beds currently operating, as of November 2024, CFRP-San Diego's census is at 26 and CFRP-Sacramento's is at 27. Evaluation of additional clients for placement to these beds is ongoing.

As of the Governor's Budget, DSH estimates a one-time savings of $2.3 million in FY 2024-25 as a result of the CFRP-Alameda program closure. An update on the new activation of the new CFRP program will be provided in the 2025-26 May Revision.

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 November 2024, IPP has received a total of 82 referrals, 74 of which had completed evaluations submitted to the courts. Approximately 81% of conventional evaluations resulted in a recommendation from IPP for community outpatient treatment or stepdown into a lower setting within CONREP. Additionally, IPP has a 96% agreement rate with the Courts statewide for these discharge recommendations. On November 1, 2024, the IPP expanded to include three additional CONREP programs. This expansion provides coverage to five additional counties, resulting in 41 counties participating in IPP overall. An update on expansion efforts will be provided in the May Revision.

Future Fiscal Impact of Healthcare Minimum Wage Implementation

DSH is monitoring the implementation of Senate Bill (SB) 525 (Durazo, Chapter 890, Statutes of 2023)[4], which incrementally increases the minimum wage for healthcare workers in certain healthcare settings. DSH's contracted providers have raised to DSH that the healthcare minimum wage will impact their cost of operating the CONREP programs and continuum of care. While DSH is not requesting resources in the 2025-26 Governor's Budget, the potential increased program costs resulting from SB 525 are being tracked as a potential future fiscal pressure. DSH continues to monitor impacts to contract costs and will provide updates in the future.

[4] SB 525 (Durazo, Chapter 890, Statutes of 2023)

Resource Table[1]

Description	CY	BY	BY+
Current Service Level	$48,508	$48,508	$48,508
Governor's Budget Request[2]	($3,558)	$0	$0
TOTAL	**$44,950**	**$48,508**	**$48,508**

[1] Dollars in thousands

[2] The savings amounts for the programs above are rounded to the tenth, resulting in slight differences in the amounts presented in the resource table.

BCP Fiscal Detail Sheet

BCP Title: CONREP Non-SVP | **BR Name: 4440-039-ECP-2025-GB**

Budget Request Summary

	FY25					
	CY	BY	BY+1	BY+2	BY+3	BY+4
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	-3,558	0	0	0	0	0
Total Operating Expenses and Equipment	**$-3,558**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-3,558**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	-3,558	0	0	0	0	0
Total State Operations Expenditures	**$-3,558**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-3,558**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4420010 - Conditional Release Program	-3,558	0	0	0	0	0
Total All Programs	**$-3,558**	**$0**	**$0**	**$0**	**$0**	**$0**

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

Program Update

SUMMARY

As of the 2025-26 Governor's Budget, the Department of State Hospitals (DSH) projects a caseload of 31 persons designated as a Sexually Violent Predator (SVP) to be conditionally released into the community as of June 30, 2026.

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. 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.

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. However, in recent years, this average time to placement has been increasing.

Effective January 1, 2023, implementation of SB 1034[1] required DSH to convene a committee of specified county representatives to obtain assistance and consultation regarding securing suitable housing for each client approved for conditional release. These new requirements resulted in the creation of county-specific Housing Committee Meetings (HCMs), which are open to the public pursuant to the Bagley-Keene Open Meeting Act. Each committee remains in effect from the date of the initial order approving placement into CONREP, to the date of actual transition from the state hospital to the community CONREP program. This change resulted in an increased number of court hearings, task and criteria tracking, reporting

[1] SB 1034 (Atkins, Chapter 880, Statutes of 2022)

requirements, housing status reports to the court, and inter-agency coordination across multiple counties throughout the state.

Additionally, WIC 6608.5 (f) dictates placement shall not occur "within one-quarter mile of *any public or private school providing instruction in kindergarten or any of grades 1 to 12*". 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. As a result, every homeschool within the state creates a new area where an individual designated as a SVP cannot be housed. Furthermore, this finding applies to any homeschools identified following property vetting and submission to the court, potentially rendering the property as ineligible for community placement.

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 22 months. As these new processes evolve, DSH will continue to monitor for potential impacts to the average placement waiting period, including those resulting from implementation of the HCMs.

JUSTIFICATION

As of the 2025-26 Governor's Budget, 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, 20 individuals with court-approved petitions are awaiting placement into the community and 13 more have filed petitions and are proceeding through the court process. With the dynamic nature of court processes and timelines, challenges surrounding housing availability, as well as other factors, DSH projects a caseload of 31 clients conditionally released in CONREP by the end of fiscal year (FY) 2025-26. Please refer to the table below which displays the total projected caseload for FY 2024-25 and FY 2025-26.

CONREP-SVP Projected Caseload for 2025-26 Governor's Budget		
Description	Projected Caseload as of FY 2024-25	Projected Caseload as of FY 2025-26
Individuals currently in CONREP	21	27
Adjusted Caseload	10	4
Total	**31**	**31**

DSH calculates the estimated projected caseload by reviewing the current status of the clients in the community, those with a court-approved petition to CONREP awaiting placement, and those who have filed a petition for CONREP awaiting trial on the petition. Consideration is given to various factors such as revocations, unconditional release from CONREP, and upcoming delays to court proceedings and/or community placement progress.

SB 1034 has resulted in increased costs for DSH and the SVP program contractors. DSH's role to chair, facilitate, and arrange for accommodations of the HCMs comes with increased operating costs, including DSH staff travel costs, a contract with California Highway Patrol (CHP) to provide security services at each HCM, and the ability to provide Americans with Disabilities Act (ADA) accommodations and translation services, if needed.

Additionally, the SVP program provider has realized increased costs related to the HCMs requirements and standard operating practices. Significant areas of increase are in enhanced monitoring services, additional personnel for the housing search process due to the increase in approved petitions and the obstacles in securing suitable housing, and increases in the general operating costs related to salary and benefits, liability and malpractice insurance, and other standard operating expenses. While DSH is not requesting resources in the 2025-26 Governor's Budget, the projected impact is being tracked as a future fiscal issue. An update will be provided in the 2025-26 May Revision.

Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$12,680	$12,680	$12,680
Governor's Budget 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. As of the 2025-26 Governor's Budget, DSH requests 1.0 position (authority only) in fiscal year (FY) 2025-26 and ongoing to support the data collection and outcomes monitoring for the Felony Mental Health Diversion (Diversion) program and proposes to fund the position by utilizing IST Solutions savings. DSH further proposes to utilize savings from IST Solutions to support 22.0 positions (authority only) in FY 2025-26 and ongoing to support Re-Evaluation Services for Felony IST Program on an ongoing basis. Finally, DSH also reports a one-time savings of $237.5 million in FY 2024-25, $82.1 million in FY 2025-26, and $78.9 million in FY 2026-27. These savings reflect updated timelines for various IST program activations, primarily assumptions regarding the build out of new community-based treatment infrastructure and associated programming.

IST WAITLIST

Background

For over a decade, the State of California observed significant growth in the number of individuals found IST on a felony charge and referred to DSH for competency restoration, with 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 growing demand, resulting in a waitlist and extended wait times for IST defendants pending placement into a DSH treatment program. 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

[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.

within 28 days from the transfer of responsibility to DSH[2]. The court provided a specified timeline to meet that standard over three years, setting February 27, 2024, as the target date for fully implementing the requirement. 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 CIFs, to expand the DSH continuum of care for IST individuals. Additionally, statutory changes aimed at solving the IST demand for services have been implemented to streamline and improve IST processes, target growth in IST determinations (felony IST growth cap), and establish a comprehensive set of strategies and solutions, to ensure 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* and expand community-based treatment and diversion options for felony ISTs that will help end the cycle of criminalization by connecting patients to comprehensive behavioral health treatment.

Prior to the COVID-19 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 high of 1,953. In the 2024-25 May Revision, DSH reported the waitlist had declined to 397, inclusive of individuals receiving Early Access and Stabilization Services (EASS),

[2]Date of service of the commitment packet to DSH for felony IST patients.
[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.

which represented a reduction of 21% from the total waitlist of 501 reflected in the 2024-25 Governor's Budget.

Justification

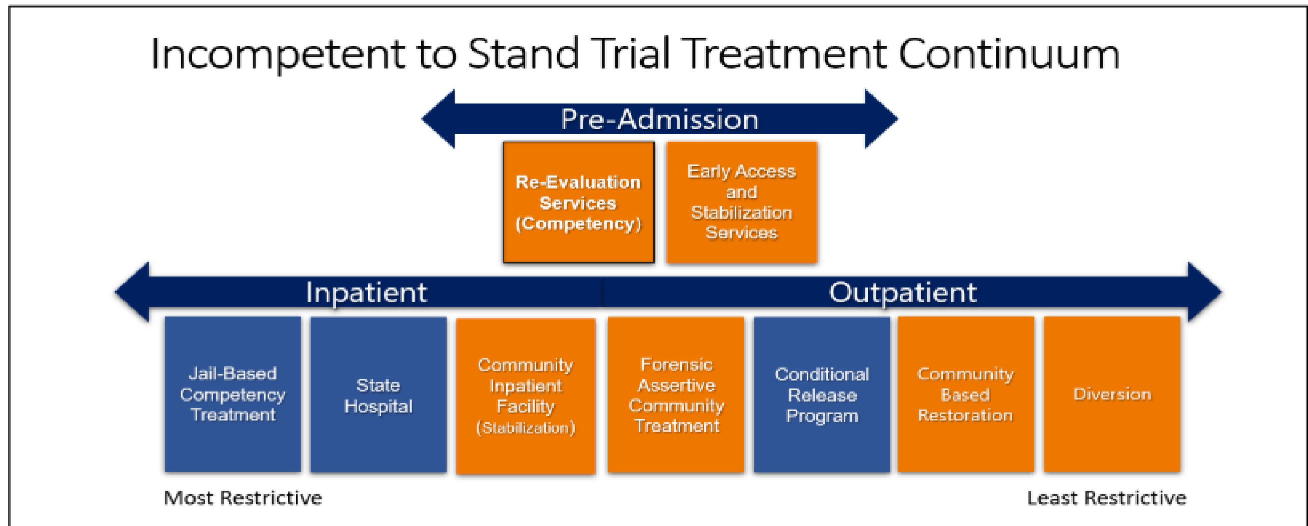
In the 2024-25 May Revision, DSH reported the IST waitlist had declined to 397[4] due to the implementation and expansion of existing IST programs. As of the 2025-26 Governor's Budget, there are 359[5] individuals on the waitlist. This change represents a reduction of 9.6% from the total waitlist reported in the 2024-25 May Revision. Furthermore, of the 359 individuals on the waitlist pending admission to a treatment bed, 125 are receiving substantive treatment services through EASS or other treatment programs. Only 206 individuals on the waitlist are individuals who have not yet began receiving treatment services from a DSH program. While significant progress has been made on reducing the number of individuals on the waitlist, the current waitlist trend is unlikely to change significantly moving forward as average monthly referrals have shown increases in recent years. In FY 2020-21, DSH received an average of 346 IST referrals per month. In FY 2023-24, the average increased by 42% compared to FY 2020-21 to 490 per month. The current waitlist reflects real-time monthly referrals, and the number of patients pending admission to a treatment bed is fewer than the number of referrals received per month.

Based on the Alameda Superior Court decision to modify the benchmark deadlines in *Stiavetti v Clendenin,* DSH was required to provide substantive treatment services to IST patients within 60 days as of March 1, 2024, and within 45 days beginning July 1, 2024. On July 29, 2024, DSH filed a report to the court, including data through June 30, 2024, reflecting its progress in meeting the benchmarks, which reflected that in June 2024 DSH provided access to substantive treatment services for IST defendants in an average of 12 days, with 98% of individuals receiving substantive services within 45 days, ahead of the July 1 45-day benchmark deadline. Effective November 1, the court ordered benchmark is for DSH to provide substantive services within 33 days. DSH filed a report to the court on December 6, 2024 which reflected that in October 2024, DSH provided access to substantive treatment services for IST individuals in an average of 8 days with 99.4% of IST defendants receiving services within 45 days and 95.5% within 33 days. The next court ordered benchmark is for DSH to provide substantive treatment services within 28 days by March 1, 2025. As of October 2024, DSH provided services within 28 days for 94.1% of IST individuals. DSH will provide an update in the 2025-26 May Revision.

[4]Data as of May 6, 2024
[5]Data as of January 1, 2025

IST TREATMENT CONTINUUM

The following chart depicts the comprehensive continuum of IST services DSH has established and is continuing to build with the 2022 and 2023 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 Diversion program and partnered with Los Angeles (LA) County to establish the first felony IST CBR program. In 2021 and 2022, 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.

COMMUNITY INPATIENT FACILITIES (CIF)

Background

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, CIFs to provide alternative treatment options to state hospitals, including IMDs, Mental Health Rehabilitation Centers (MHRC), Skilled Nursing Facilities (SNF), 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 May Revision, DSH reported executing a new construction contract with Crestwood Behavioral Health, Inc. for the development of a 40-bed MHRC in Fresno County.

Justification

DSH continues to partner with five different CIF programs for a total of 197 beds throughout California, including:

- SBHH in Sacramento County
- Bakersfield Behavioral Healthcare Hospital (BBHH) in Kern County
- Anaheim Community Hospital (ACH) in Orange County
- Priorities, Inc. in Sutter County
- Sylmar Health and Rehabilitation Center, Inc. in LA County.

SBHH, BBHH, and ACH are acute inpatient psychiatric facilities while Priorities, Inc. and the Sylmar Health and Rehabilitation Center are intermediate care programs that provide full competency restoration services for IST patients.

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

Activated Community Inpatient Facilities			
Facility Name	**Activation Date**	**Total Beds**	**Average Daily Census for FY 2024-25**
Sylmar	10/30/2023	24	22
BBHH	7/3/2023	29	26
ACH	7/3/2023	50	47
Priorities, Inc.	7/3/2023	16	15
SBHH	4/20/2022	78	68

To further expand upon the above efforts, DSH has executed a construction contract with Crestwood Behavioral Health, Inc. to remodel an existing building for the development of a 40-bed licensed MHRC located in Fresno County. Construction for

this project began in August 2024, with anticipated completion in summer 2025, followed by program activation in fall 2025.

DSH also executed a construction contract with NewGen Health, LLC for the development of a new building in San Bernardino County to establish a 198-bed licensed MHRC to serve IST patients. The Shandin Hills MHRC will be used to facilitate stabilization, through the administration of medications and treatment, to support a pathway to participation in a mental health Diversion or other outpatient treatment program. This facility will also be utilized to serve those who cannot be diverted, by providing competency treatment services to continue legal proceedings. Construction is anticipated for completion in summer 2026, with program activation in fall 2026.

An update on continued progress will be provided in the 2025-26 May Revision.

IST RE-EVALUATION SERVICES

Background

The IST Re-Evaluation Services Program was authorized in the Budget Act of 2021 as a 4-year limited-term solution to address the growing IST waitlist. Under this program, DSH psychologists re-evaluate individuals 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 re-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[6]. 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 May Revision, DSH reported a total of 6,250 evaluations completed since program inception, with 1,943 individuals found competent, returned to court, and removed from the IST waitlist due to Re-Evaluation Services.

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

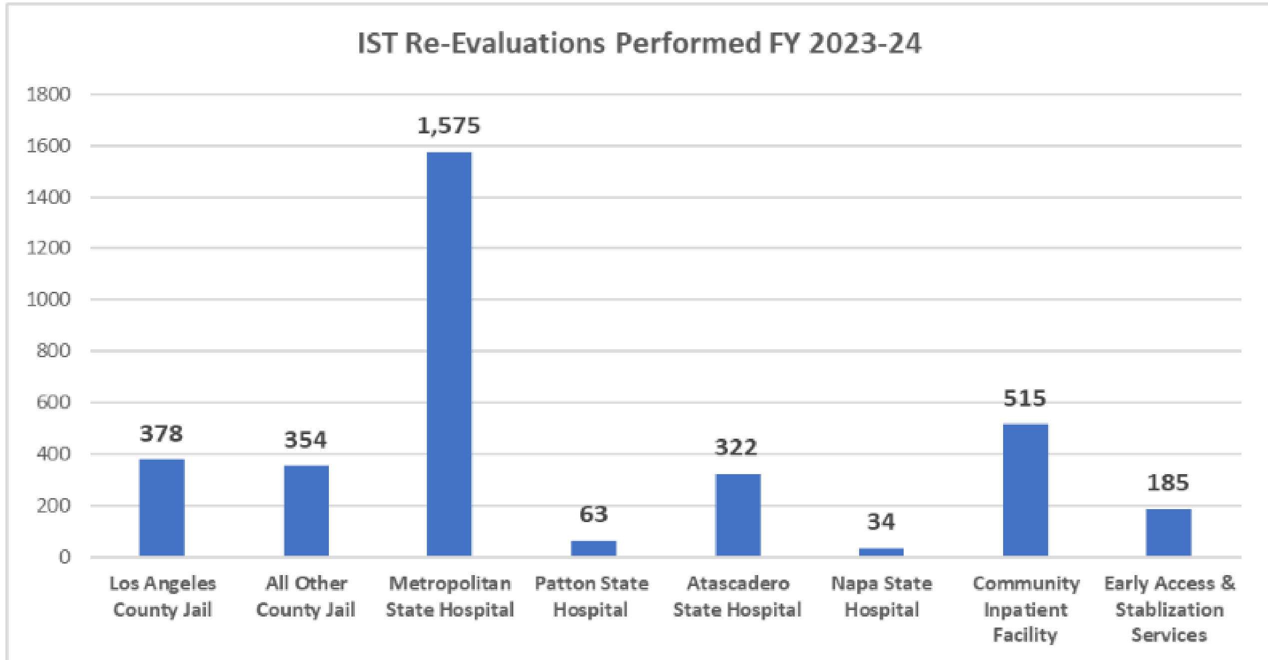
Justification

As of the 2025-26 Governor's Budget, DSH has completed a total of 7,999 evaluations, of which:

- 5,430 (67.9%) were found not competent and continued competency restoration treatment
- 2,536 (31.7%) were found restored to competency
- 33 (<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, court proceedings can resume, significantly reducing wait times for individuals still requiring treatment. Re-Evaluation reports also allow the courts to consider different treatment options. In FY 2023-24, approximately 15% of participants were identified as needing IMOs, and of those screened for Diversion, approximately 82% were referred.

With progress in meeting the *Stiavetti* treatment timelines and the expansion of EASS in county jails and community-based programs, the demand for in-jail re-evaluation has slowed. DSH has leveraged these IST Re-Evaluation resources to meet increasing demand for IST evaluations in an array of DSH programs. This utilization accelerates admissions and discharges, which reduces wait times and increases access to care. For example, of the 3,426 evaluations performed in FY 2023-24, 1,994 (58%), were performed at the hospitals. Due to significantly reduced wait times and other constraints, a substantial number of these evaluations were performed upon an individual's arrival to the treatment facility, rather than in-jail. The chart below shows the distribution of Re-Evaluation services across the state hospitals and community-based programs for FY 2023-24.



As DSH continues to deploy these forensic evaluation resources flexibly and strategically to meet IST forensic evaluation needs across its system, DSH proposes to extend and adapt the Re-Evaluation Services Pilot program, which is due to sunset on June 30, 2025.

As of the 2025-26 Governor's Budget, DSH proposes to redirect savings from IST Solutions to support 22.0 positions (authority only) in FY 2025-26 and ongoing to support the ongoing Re-Evaluation Services for Felony IST Program. Over the last three years, the Re-Evaluation Program has largely met its originally intended goals and has been one of the highly successful strategies resulting in elimination of DSH's backlog of IST referrals, and dramatically reducing wait times. As DSH continues to implement its long-term IST solutions by way of building more CIFs, and residential treatment beds for CBR and Diversion programs, DSH requires a sustained solution to support the ongoing IST evaluation needs of these programs, as well as a backstop to address gaps in forensic evaluation support within existing treatment programs. DSH had an average daily census of 2,906 IST designated patients during FY 2023-24, with a 1% growth from 2,881 patients in July 2023, to 2,908 in June 2024. In addition, as compared to the prior fiscal year, the average daily census increased overall by 10% in FY 2023-24.

The Re-Evaluation Program also provides support to forensic evaluation services within the DSH-operated inpatient and outpatient CBR programs. Due to a shortage of forensic evaluators in the community, DSH was compelled to augment these programs in order to meet statutory and clinical requirements and maximize utilization of these beds. DSH expects the need for this augmentation to increase in the coming years due to planned expansions in these programs.

The list below reflects the number of positions requested for the Re-Evaluation Program:

Classifications	PY
5393 - Associate Governmental Program Analyst	9.0
5795 - Attorney III	1.0
7620 - Consulting Psychologist	3.0
7616 - Sr Psychiatrist (Specialist)	2.0
9831 - Sr Psychologist (Health Facility) (Supervisor)	2.0
4800 – Staff Services Manager I	1.0
4801 - Staff Services Manager II	1.0
1401 - Information Technology Associate	1.0
5237 - Legal Analyst	1.0
5742 - Research Data Specialist I	1.0
Total	**22.0**

DSH proposes to repurpose IST Solutions savings to convert 22.0 limited-term positions to permanent in FY 2025-26 and ongoing. DSH also requests authority to redirect savings from IST Solutions in FY 2025-26 and ongoing for operational costs including contracted forensic evaluators and other support costs associated with the time spent by jail staff to coordinate inmate interviews. Other support costs include IT resources necessary to support telehealth interviews, in addition to the IT hardware, software, interpreter services, evaluation tools and materials, and any travel costs for the forensic evaluators as needed.

IST SOLUTIONS

The Budget Acts of 2022 and 2023 appropriated funding to implement many of the IST Solutions identified by the statewide IST Solutions Workgroup[7] which adjoined or enhanced existing DSH treatment options for those found to be Felony IST. These included providing early stabilization services, increasing diversion opportunities by expanding community-based treatment and diversion options for felony ISTs, improving patient care coordination, improving IST discharge planning and coordination with local counties, and improving alienist training.

Early Access and Stabilization Services (EASS)

Background

[7]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.

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 May Revision, DSH reported the activation of five additional EASS counties programs, bringing the total number of operating EASS programs to 49.

Justification

As of the 2025-26 Governor's Budget, DSH has activated an additional five county programs, bringing the total amount of EASS programs[8] to 55[9], and reports the following updates as a result of EASS implementation:

- Total patients served: 5,620
- Total patients unenrolled[10]: 5,490
- Total restored while in EASS: 633 (11.5% 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 that deliver services across multiple counties. 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. As of the 2025-26 Governor's Budget, DSH has activated three additional standalone EASS programs. Currently, DSH is in discussions and final budget negotiations with two counties to develop standalone EASS programs and estimates these programs will activate this winter. 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. An update will be provided in the 2025-26 May Revision.

<u>Community-Based Restoration (CBR) and Felony Mental Health Diversion (Diversion)</u>

Background

[8]Please see Attachment A for a display of all counties with EASS programs and their activation dates.
[9]Data as of November 21, 2024
[10]Unenrolled refers to patients no longer receiving EASS services due to competency reached or admission to another DSH program to continue IST treatment services. Patients who are not restored while receiving treatment in EASS maintain their place on the waitlist and are admitted to a DSH facility in accordance with their commitment date.

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 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 bed, 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 four-year period[11].

In the 2024-25 May Revision, DSH reported four counties' proposals had been approved, and contract negotiations were underway to develop up to 350 beds to house felony IST defendants participating in Diversion or CBR programs. Additionally, 29 counties had expressed interest in submitting applications in the future.

CBR and Diversion[12] 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 health treatment and support. DSH can contract directly with counties or private providers to establish CBR programs statewide. The first CBR program for felony ISTs was implemented in 2018-19 in partnership with the LA County Office of Diversion and Re-entry.

The DSH Diversion program was designed to target a portion of the IST population most likely to succeed in an outpatient setting when provided the appropriate treatment, support, and housing. Established as a pilot in the Budget Act of 2018, and in partnership with 29 counties, the Diversion program serves individuals with serious mental illness (SMI) diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder with the potential to be found IST or determined IST on felony charges. Individuals who successfully complete the Diversion program may have their charges dropped upon completion. The Budget Act of 2022 allocated ongoing funding to

[11] Dependent upon securing available housing.

[12] 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.

establish Diversion as a permanent program and has been modified to serve only those who are determined to be IST across an expanded list of qualifying diagnoses.

In the 2024-25 May Revision, DSH reported a Diversion Quarterly County meeting was held on November 9, 2023. During this webinar, counties were provided with fiscal details and were informed of new Diversion and CBR statutory and program requirements and recommendations. As of March 2024, 24 counties had submitted Letters of Intent (LOI) to execute contracts with DSH to establish permanent programs to serve up to 1,271 IST patients per year.

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 community interventions 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 LOIs to contract with DSH for these annual resources.

As of the 2024-25 May Revision, all 32 counties had executed contracts with DSH.

Justification

DSH was allocated one-time infrastructure funding to expand the number of beds available to patients receiving services through a CBR or Diversion program, supporting 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 opened for counties to submit their requests for proposals for funding to develop residential housing. To accompany the portal, AHP developed a website which included responses to frequently asked questions, as well as contact information for further assistance.

In October 2022, January 2023, and June 2023, DSH and AHP hosted webinars to inform county stakeholders applications would be accepted on a rolling basis through June 30, 2024. The deadline for submitting applications was ultimately extended to October 31, 2024. AHP 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 began hosting bi-monthly "Office Hours" to provide technical assistance to counties and answer questions about housing opportunities.

Counties accepting funding from AHP for this project are required to contract with DSH for a Diversion and/or CBR program. Many counties have expressed concerns and informed DSH of barriers to applying, such as county staffing shortages, size, and rural location of the county, in addition to competing housing options, difficulty in locating housing sites, and challenges in securing a provider. Smaller and more rural counties have been encouraged to partner with neighboring counties to submit a joint application.

As of the 2025-26 Governor's Budget, nine applications have been approved for Diversion and CBR, providing 932 beds, and are in various stages of finalization.

To support the data collection and outcomes monitoring of the permanent Diversion programs, DSH requests 1.0 Research Data Specialist I (RDS I) position (authority only) in FY 2025-26 and ongoing. The RDS I will provide data management and data quality oversight to the permanent Diversion program, which includes regular data reconciliation and record matching within existing DSH applications, regular development, and maintenance of analytic reports, developing monitoring and oversight tools, such as PowerBI dashboards, and data modeling support to integrate patient data throughout DSH's data infrastructure. This role will be responsible for implementing data best practices across the full data life cycle, ensure accuracy of data models and business logic to support automation, and providing analytic support to the Diversion program team.

DSH will provide an update on continued progress in the 2025-26 May Revision.

Los Angeles County CBR and Diversion Program

DSH and the Los Angeles County Office of Diversion and Re-entry (ODR) 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 1,274 beds, to be phased in over a five-year period. In the 2024-25 May Revision, DSH reported that ODR is contracted to activate a total of 1,344 beds by FY 2026-27. DSH has determined that this total included bed capacity located through the CIF program and overstated the number of beds DSH is directly funding ODR to activate. This technical error impacts reported bed capacity only and not funding for the ODR programs. The following table displays the corrected total bed capacity from FY 2024-25 through FY 2026-27:

Fiscal Year	Original Bed Count	Corrected Bed Count
2024-25	1,025	1,005
2025-26	1,239	1,169
2026-27	1,344	1,274

ODR will establish beds 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 and admissions from November 1, 2022, through November 4, 2024, to reflect the total patients served.

LA County Program	10/31/22 Census	Admissions (11/1/22 – 11/04/2024)	Total Patients Served
CBR	450	753	1,203
Diversion	159	305	464

As of the 2025-26 Governor's Budget, 1,270 IST patients have been served in the CBR program and 464 in Diversion in LA County. In addition, 155 new beds for IST patients are scheduled to be activated in FY 2024-25 bringing the total beds available in LA County to 1,005, which will support up to 709 new IST admissions over the course of the year. DSH will provide an update in the 2025-26 May Revision.

Other Permanent Diversion and CBR Program Implementation

Beyond LA County, DSH assumed a number of counties would secure 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 29 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 the use of CIFs for ISTs, the DSH IST Re-Evaluation Team which may re-evaluate ISTs in CBR programs, the AHP grant opportunity and the application process for the permanent infrastructure funding, recently extended through October 31, 2024. Counties were also informed of the Psychopharmacology Resource Network, and the DSH Diversion and CBR team of psychologists and program staff assigned to each county upon submission of an LOI and execution of a contract with the Department.

DSH is in the final negotiation process to execute permanent Diversion and/or CBR contracts in FY 2024-25 for 19 counties with a combined maximum admission of 1,346 clients per year.

Information was re-released to counties by DSH on July 17, 2024, to provide additional opportunities for counties to submit a LOI for the permanent Diversion and CBR programs by September 20, 2024, to enter into a contract in FY 2025-26. Seven counties submitted an LOI for FY 2025-26 with a combined maximum admission of 251 clients per year. Capstone Solutions and DSH continue to engage in technical assistance discussions and encourage counties that have not already applied to do so.

Update to Welfare and Institutions Code (WIC) 4361, DSH Diversion Program, via Senate Bill (SB)1323

Recently enacted legislation, SB 1323 effective January 1, 2025, modernizes the IST process by providing judges the authority to determine if restoration of competency is in the interest of justice and if not, to provide longer-term more comprehensive treatment options with an emphasis on mental health diversion.

When a court finds restoration is not in the interest of justice, the court must conduct an eligibility hearing within 30 days for placement into a diversion program. If the individual is not eligible and granted diversion, the court may consider referral to the Public Guardian for conservatorship investigation, Assisted Outpatient Treatment (AOT), Community Assistance Recovery and Empowerment (CARE) Court, or to reinstate competency proceedings.

These changes may reduce the rate of felony IST referrals to DSH by diverting individuals to diversion or other community-based treatment options before an IST commitment is ultimately ordered and referred to DSH. Currently, the DSH Diversion Program authorized in WIC 4361 provides funding to counties to support diversion programs for those found IST on a felony charge *and* committed to DSH for restoration of competency. SB 1323 updates WIC 4361 by removing the requirement for a felony IST individual to be committed to DSH for restoration of competency, thereby allowing counties to fund diversion placements earlier in the process in

accordance with the court's interest of justice ruling and order to diversion. To conform with the statutory changes to WIC 4361, DSH is in the process of updating program policies and developing technical assistance to provide guidance to counties. DSH will monitor implementation of the changes outlined in SB 1323 and any impacts to DSH programs and IST referral rates and will provide an update in future caseload estimates.

County Stakeholder Workgroup Grants

In December 2022, DSH released information to counties about supporting behavioral health and criminal justice workgroups by offering annual resources. As of September 2024, 39 counties have executed contracts with DSH:

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

Information was re-released to counties by DSH on August 29, 2024, to provide another opportunity for counties to apply for funding. The deadline for counties to submit an LOI to enter into a contract effective January 1, 2025, is September 30, 2024. To enter into a contract effective July 1, 2024, counties must submit an LOI by December 31, 2024. DSH will monitor progress and provide an update in the 2025-26 May Revision.

Alienist Training

Background

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.

In the 2024-25 May Revision, DSH reported the Judicial Council, in partnership with the Groundswell Group, developed 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 first training was held in November 2023, with an advanced training held at the Forensic Mental Health Association of California in March 2024. The Groundswell Group also conducts quarterly meetings to facilitate communication between DSH and the courts.

Justification

As of the 2025-26 Governor's Budget, the Judicial Council and DSH are developing a three-year extension of their existing interagency agreement to solidify training gains through continued in-person and hybrid trainings and development of web-based on-demand educational resources. This extension will be at a zero cost for DSH as the Judicial Council seeks to reappropriate unspent funds from the current year. For additional information on future trainings and efforts, please refer to the Judicial Council.

Care Coordination and Waitlist Management (CCWM)

Background

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[13], 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).

Justification

Care Coordination has been implemented to serve all 58 counties. In addition to implementing a patient-centered approach to patient placement, for counties with

[13] 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.

an active EASS program, PMU clinicians are actively liaising with EASS care providers to provide active case management. PMU convenes a weekly workgroup with stakeholders in LA County to address specific county challenges. 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.

Starting in 2025, PMU will begin piloting the processing of referrals for IST patients treated within Diversion or CBR needing to step-up for stabilization to CIFs and then back down to the community. DSH will continue to monitor the Care Coordination program activity and the pilot's impact on existing resources and provide an update in the 2025-26 May Revision.

Proposition 36 and IST Referrals

In November 2024, voters passed Proposition 36 that provides for specified drug and retail crimes, that previously were charged as misdemeanors, to be charged as treatment-mandated felonies or receive increased sentences. This increases the range of crimes that can be charged as felony and for which someone may be found incompetent to stand trial and referred to DSH programs for treatment. DSH will monitor the implementation of Proposition 36 and any impact on referral rates and will provide an update in May Revision.

<u>Discharge Planning and County Care Coordination</u>

Background

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, such as[14]:

- CONREP
- County Behavioral Health

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

- 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).

Taking feedback from the workgroup, DSH created a comprehensive four volume training series to enhance the CONREP Discharge Referral process. Discharge and Community Integration (DCI) Specialists provide 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.

Justification

As of the 2025-26 Governor's Budget, DSH continues to enhance the discharge process as patients transition from a state hospital to a community-based setting. Based on the feedback from CBHDA and CSAC, these efforts include standardizing electronic forms and uniform formats to facilitate and improve information exchange between DSH, County Behavioral Health, and county jails. In addition, DSH continues to provide trainings for the CONREP referral process. An update will be provided in the 2025-26 May Revision.

<u>Felony IST Referral Growth Cap</u>

Background

To address the growing IST waitlist, the Budget Act of 2022 enacted WIC section 4336 establishing a growth cap on the number of annual felony IST determinations per county and requiring a redirection of county funds to be assessed if annual caps are exceeded. Following discussions with a coalition of county associations representing key IST stakeholders, DSH made updates to the methodology and rate for the growth cap and implemented a dispute process for potential data discrepancies. 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. In the Budget

Act of 2024, DSH received position authority only for 2.0 RDS I's to successfully administer the Felony IST Growth Cap program.

Justification

In spring 2024, Growth Cap penalties were assessed for eleven counties associated with FY 2022-23 activity which exceeded their FY 2021-22 baseline felony IST determination counts, and in June 2024, invoices totaling $22.6 million were issued to these counties. As of the 2025-26 Governor's Budget, all 11 counties[15] invoiced have remitted their Growth Cap payments in full. Additionally, six county expenditure plans detailing the projected use of the Growth Cap funds have been received.

Growth Cap expenditure plans are required from all counties assessed penalty fees in order to receive reimbursement of said funds back for redirection to upstream efforts aimed at reducing the number of new IST determinations in future years. Of the six plans received, DSH has requested reimbursement be issued back to three of the counties and is working with the remaining three counties to have additional questions answered to obtain clarity on the plans so that reimbursement may be processed. Additionally, DSH is actively engaging counties who have not yet submitted their required expenditure plan to offer support and technical assistance in the preparation of their plan.

On October 31, 2024, the reconciled IST determination data for FY 2023-24 was released to all counties. The release of that information opened the dispute window for counties to submit potential corrections to DSH for consideration before the FY 2023-24 IST determination data is compared to their baseline IST cap and assessment of potential penalty fees. DSH will provide additional updates in the 2025-26 May Revision.

JAIL-BASED COMPETENCY TREATMENT (JBCT)

Background

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

[15] Data as of September 2024

3. Statewide model - Serves IST patients from multiple counties statewide with an established number of dedicated program beds
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 May Revision, DSH reported the operation of 424 JBCT beds across 24 counties, with plans for further expansions.

Justification

As of the 2025-26 Governor’s Budget, DSH continues its efforts to implement a few planned expansions of the JBCT program and reports the operation of 433 JBCT beds across 24 counties, and reflects a one-time savings in FY 2024-25, a one-time savings in FY 2025-26, and a one-time savings in FY 2026-27 due to delayed activations in six new counties and delayed expansions for three existing counties. DSH anticipates one new county to activate and one existing county to expand in FY 2024-25, two new counties to activate and two existing counties to expand in FY 2025-26, and the remaining three new counties to activate in FY 2026-27. DSH anticipates contract negotiations will be finalized by the 2025-26 May Revision, and will provide an update, including any anticipated savings, at that time.

IST SOLUTIONS SAVINGS

DSH was initially authorized significant funding to establish several new IST related programs and expand existing programs to address the growing number of IST referrals, significant IST waitlist, and bring DSH into compliance with the required timelines for treatment as ordered in Stiavetti v Clendenin. Funding was authorized across multiple fiscal years and based upon assumptions of when new programs may be activated, and cost assumptions were based on relevant data available at the time. Initial funding authorized was subsequently reallocated to later fiscal years to provide sufficient funding to implement programs based on updated projections and assumptions. Several programs aimed at reducing the backlog of IST individuals waiting in jail and wait times to accessing competency treatment are now either fully or near fully implemented (e.g. Care Coordination, IPP, EASS, Re-Evaluation, Growth Cap, new and expanded JBCT programs). DSH is now focused on its longer-term IST solutions programs, including the implementation of permanent mental health diversion and other community-based treatment programs. As a budget savings solution in 2025-26 and 2026-27, DSH will maximize the utilization of its prior years IST

funding with multiple fiscal year authority and adjust the funding to align with planned activation timeline of its community-based treatment program. The adjusted timeline is based on updated assumptions regarding the build out of new infrastructure and the readiness of county and private providers. Based on these updated assumptions, DSH reports one time savings of $237.5 million in FY 2024-25, $82.1 million in FY 2025-26, and $78.9 million in FY 2026-27.

Resource Table[16]

Description	FY 2024-25	FY 2025-26	FY 2026-27	FY 2027-28 and Ongoing
Current Service Level Total	**$771,377**	**$933,295**	**$1,061,768**	**$932,295**
Community Inpatient Facilities	$145,526	$145,526	$274,999	$145,526
2025-26 Governor's Budget	($52,104)	$9,738	($39,936)	$59,537
Re-Evaluation	$10,176	$1,000	$1,000	$1,000
2025-26 Governor's Budget	($12,391)	$8,928	$10,800	$10,900
IST Solutions[17,18]	$499,780	$659,774	$658,774	$658,774
2025-26 Governor's Budget	($131,361)	($62,964)	($49,238)	($69,238)
JBCT	$115,895	$126,995	$126,995	$126,995
2025-26 Governor's Budget	($41,661)	($37,935)	($551)	($551)
TOTAL	**$683,343**	**$914,431**	**$982,843**	**$932,943**

[16]Dollars in thousands.
[17]Includes BCP redirections to CONREP SVP and Data Compliance in 2024-25 and ongoing. IST Re-Evaluation (In FY 2025-26, 2026-27, 2027-28 and ongoing) and Coleman in 2025-26 and ongoing.
[18]IST Solutions includes funding for Early Access and Stabilization Services (EASS), Care Coordination and Waitlist Management (CCWM), Community-Based Restoration (CBR) and Diversion, Alienist Training, Increased Conditional Release Program (CONREP) Placements, and Discharge Planning/County Care Coordination.

Attachment A

Early Access and Stabilization Services (EASS) Updates	
County	**Activation Date**
Trinity	10/08/24
Orange	08/28/24
Mendocino	08/08/24
Kern	08/06/24
Contra Costa	08/05/24
Alameda	08/01/24
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

STATE HOSPITALS
WORKFORCE DEVELOPMENT

Informational Only

SUMMARY

As of the 2025-26 Governor's Budget, the Department of State Hospitals (DSH) continues to implement various efforts to address workforce challenges and strategies funded in the Budget Act of 2023, to expand and develop psychiatric fellowship and residency rotations.

BACKGROUND

Historically, recruitment and retention have posed a challenge for DSH. This was further exacerbated by the COVID-19 pandemic, which resulted in nationwide shortages for the healthcare workforce. Additionally, multiple factors present unique challenges for DSH recruitment and retention. Individuals served by DSH have some of the most complex and difficult to treat behavioral health conditions, many with a significant violence risk level. This, coupled with the remote geographic locations of DSH facilities, makes recruitment and retention more challenging. As a result, DSH worked to implement a multi-faceted approach to recruit and retain healthcare workforce 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, primarily focused on recruitment for registered nurses (RNs) and psychiatric technicians (PTs); the two most commonly utilized nursing classifications at DSH.

Long term, DSH's solution to fill vacancies for nursing level-of-care staff is to continue to expand partnerships with local community colleges to increase class sizes or cohort frequency, with the goal of producing more RN and PT candidates available to work at DSH hospitals. In March 2020, DSH-Atascadero, in collaboration with Cuesta College, increased the program class size from 30 to 45 students, with two cohorts per year. However, plans were significantly impacted during the COVID-19 pandemic, with class sizes reduced to accommodate spacing restrictions. DSH-Napa continues to contract with Napa Valley College which holds two cohorts per year, with 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 fourth year and has three cohorts, for a total of 20 residents participating annually. 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 full-time equivalent (FTE).

As of the 2024-25 May Revision, DSH had participated in the March 2024-25 match cycle and matched 10 additional residents into the program starting July 1, 2024. 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 May Revision, DSH reported that 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 was awaiting formal approval of accreditation for the DSH-Patton residency program.

Psychiatric Fellowships

The Budget Act of 2023 included resources to expand or develop psychiatric 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 partnered with University of California, Davis (UC Davis) to provide training to four forensic fellows a year at DSH-Napa.

Resources were also 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 were to establish training sites at DSH-Napa and eventually DSH-Metropolitan, both of which operate on-site skilled nursing facilities (SNF).

Finally, due to the prevalence of co-occurring substance use disorder within the patient population, 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 May Revision, DSH was working to implement fellowship expansions and fellowship rotation offerings with three universities:

- The Stanford forensic psychiatry fellowship rotation contract through June 2026, with DSH-Atascadero as the primary location, had fellows rotating at DSH-Atascadero as an elective.
- The University of California, Los Angeles (UCLA) forensic psychiatry fellowship rotation contract through June 2026 was in development, with DSH-Metropolitan as the primary location.
- The University of California, San Francisco (UCSF) public psychiatry fellowship rotation contract through June 2026 was in development, with DSH-Napa as the primary location.

While expansions were being finalized, DSH continued with fellowship and resident rotations on existing contracts. Agreement requests at DSH-Patton and DSH-Napa were submitted, with anticipated completion in FY 2024-25. Additionally, DSH was 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 which was currently in progress, with San Mateo County as the prospective partner.

Resident Rotations

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

As of the 2024-25 May Revision, DSH was securing an agreement with Kaiser Foundation Hospital and The Permanente Medical Group, Inc (KP) for resident rotations, which was anticipated to be executed by Summer 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 Fall 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
Fall 2024	31	16	10

[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	12	3	TBD
Spring 2024	N/A	N/A	N/A
Fall 2024[4]	23	TBD	TBD

[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 a point in time issue
[4] Data expected for the 2027-28 Governor's Budget

<u>DSH-Napa Residency Program</u>

Effective July 1, 2024, the cohort size for the DSH-Napa Residency Program increased from seven to ten, with ten residents identified in the March 2024-25 match cycle starting in the program. This expansion of three additional residents per year, with

three cohorts, yields a total of 30 residents participating annually. 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 have worked a total of 6,720 hours, equivalent to 3.8 FTE In Year 3 of residency, there are zero residents rotating; however, DSH-Napa is responsible for training and educating all 4 years of cohorts. Year 4 of the residency program included a total of 20 blocks of 160 hours each and therefore, residents worked a total of 3,200 hours. In all 4 years, residents have worked a total of 9,920 hours caring for DSH-Napa patients, equivalent to 5.6 FTE

DSH-Patton Residency Program

Following a successful onsite visit in March 2024 with ACGME as part of their accreditation process, DSH-Patton received a 4-year accreditation for the DSH-Patton residency program, through June 2028.

As of the 2025-26 Governor's Budget, DSH-Patton is in discussions with a prospective university partner to begin a Southern California residency program starting in July 2025. DSH is currently working with the university to develop a Scope of Work, with contract finalization anticipated in Spring 2025. DSH will continue this effort and provide an update in the 2025-26 May Revision.

Psychiatric Fellowships

DSH continues its work to implement and expand fellowship rotation offerings, both in forensic and public psychiatry.

Forensic Psychiatry Fellowship Rotations

- The UCLA Forensic Psychiatry Fellowship rotation agreement was successfully executed as of July 2024, with DSH-Metropolitan as the primary training rotation site.
- The UCSF Forensic Psychiatry Fellowship rotation agreement was successfully executed in July 2024, and provides virtual statewide services.
- The Stanford Health Care Forensic Psychiatry Fellowship rotation agreement, while reported in the 2024-25 May Revision as being effective through June 2026, is still in progress. However, fellows continue to rotate at DSH-Atascadero as an elective.

Public Psychiatry Fellowship Rotations

- The UCSF Public Psychiatry Fellowship (PPF) rotation agreement was executed in June 2024, with DSH-Napa as the primary training location site. In addition,

UCSF shall work in partnership with DSH leaders to select five DSH staff psychiatrists suitable for a remote public psychiatry administrative fellowship (PPAF).

- DSH is in preliminary discussions with a university partnership to offer a statewide PPF program to begin Summer 2025.

In addition to the current partnerships above, the DSH Office of Continuing Education and Medical Advancement (CEMA) is currently developing agreements for a Forensic psychiatry fellowship rotation with DSH-Patton as the primary location, anticipated for implementation in July 2025, as well as a Geriatric psychiatry fellowship rotation agreement, with DSH-Napa as the primary location, anticipated to be executed by early 2025. Lastly, DSH is also exploring prospective partners to begin a fellowship program at DSH-Coalinga.

Resident Rotations

DSH has continued to seek additional opportunities for resident rotations. In May 2024, DSH executed an agreement with KP for resident rotations. The program has been well received by the rotating residents and DSH-Napa faculty, with interest being expressed to increase this rotation from once-a-week to two consecutive full-weeks.

As of the 2025-26 Governor's Budget, a contract for a psychiatry resident rotation through June 2027 is in development, with DSH-Patton as the primary location. Additionally, a statewide psychiatry residency rotation contract through June 2027, with DSH-Atascadero as the primary location, has an anticipated execution date of early 2025. An update will be provided in the 2025-26 May Revision.

Continuing Medical Education and Training Expansion

A primary objective of CEMA is to increase continuing medical education (CME) offerings as a retention tool for current DSH psychiatrists. Prior to the establishment of CEMA in the Budget Act of 2023, DSH had established a contract for continuing medical education with University of California, Irvine (UCI) in 2017. In the spring of 2024, this agreement was expanded to now provide CME credits for professional events and conferences (i.e. Psychopharmacology Resource Network (PRN) providing an annual DSH Prescribers Summit), in addition to DSH's regularly scheduled series. This expansion of course offerings allow DSH providers and county partners the opportunity to refine their skills, and to stay current on the latest developments in psychiatry, ultimately improving patient care. DSH will continue to coordinate with specialty experts to provide CME for DSH psychiatrists and county partners, including topics in psychopharmacology, perinatal care, and neurology, and will provide an update in the 2025-26 May Revision.

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 medically fragile patient population, as current SNF bed capacity remains insufficient to meet the needs of existing and future patients. Completion of the DSH-Metropolitan SNF internal restorations and repairs is expected in early 2025 and two of the three units will be reopened to SNF patients, with the activation date for the third SNF unit yet to be determined. Additionally, DSH completed the study estimating costs of developing a SNF Unit at DSH-Coalinga.

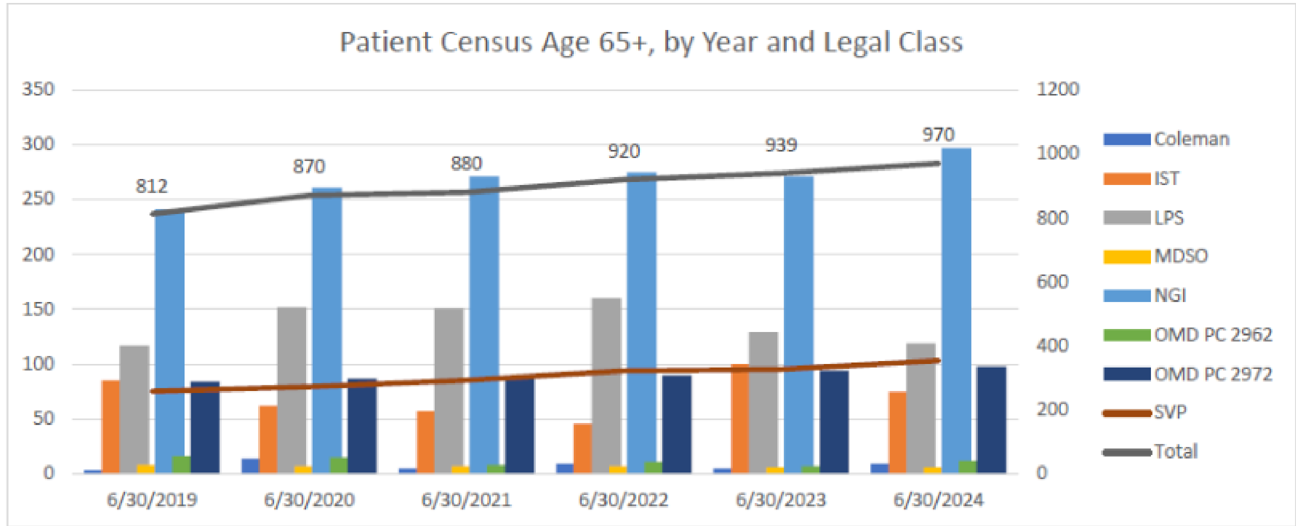
BACKGROUND

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) 2023-24.

Commitment Type	Average Patient Days
Coleman/CDCR	138.4
Incompetent to Stand Trial (IST)	154.1
Lanterman-Petris Short (LPS)	2,514.0
Mentally Disordered Sex Offender (MDSO)	4,841.6
Not Guilty by Reason of Insanity (NGI)	3,896.1
Offender with Mental Health Disorder (OMD) PC 2962	295.4
OMD PC 2972	2656.2
Sexually Violent Predators (SVP)	4,107.7

Patients are provided mental, physical, and dental health care 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 below, DSH has observed an increase of 19% over the last five years in the number of patients aged 65 and over.



Patients over the age of 65 are increasingly representative of DSH's population, composing 17% of FY 2023-24 DSH patients, up from 13% in FY 2019-20.

Age Range	Patient Census Age 65+ as of June 30											
	2019		2020		2021		2022		2023		2024	
	Count of Patients	% to Total Census	Count of Patients	% to Total Census	Count of Patients	% to Total Census	Count of Patients	% to Total Census	Count of Patients	% to Total Census	Count of Patients	% to Total Census
65-74	670	11%	715	13%	710	13%	736	14%	747	13%	760	14%
75-84	126	2%	142	2%	156	3%	172	3%	179	3%	192	3%
85-94	***	***%	***	***%	***	***%	***	***%	***	***%	***	***%
Systemwide	**6,129**	**100%**	**5,718**	**100%**	**5,557**	**100%**	**5,316**	**100%**	**5,688**	**100%**	**5,559**	**100%**

* 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.

Older patients already experience a higher level of prevalence for multiple medical conditions, but 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, 2024, 50% 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, 2024, 23% 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, 2024, there were 64 active SNF beds at DSH-

[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.

Metropolitan and 27 at DSH-Napa, for a combined total of 94 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. Additionally, even when an available bed is identified, many community options are unwilling to accept forensic commitments, particularly those with sexual 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. The last RRU conversion was completed in May 2023, when DSH-Coalinga repurposed an existing RRU space into an Intermediate Care Facility (ICF) to accommodate the increasingly geriatric and high-acuity population.

In the 2024-25 May Revision, DSH reported on the progress of the DSH-Metropolitan SNF building roof replacement project, which was estimated to be completed in October 2024, with activation planned for December 2024. DSH also projected the study detailing estimated costs of developing a SNF Unit at DSH-Coalinga would be completed by July 2024.

PROGRAM UPDATE

As of the 2025-26 Governor's Budget, DSH projects internal restorations and repairs of the DSH-Metropolitan SNF building will be completed in early 2025, with planned activation shortly after. At which time, the SNF patients will be transferred to these units and the emptied units will be returned to utilization for forensic patients.

DSH can also report that the DGS study conducted at DSH-Coalinga to assess additional SNF capacity options was completed. DSH continues to evaluate options and next steps.

DSH continues to explore options to meet the SNF needs of DSH's aging and high-acuity patient population, including a potential partnership to establish a community-based SNF unit, and will provide an update in the 2025-26 May Revision.

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 June 30, 2024, 264 additional individuals have been diverted to county-run programs, bringing the total number of diverted participants to 1,803. 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[2]

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
- 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 C8).
[2] Santa Cruz contract ended in October 2022. Del Norte, Kern, Los Angeles, Sacramento, San Francisco, Santa Clara, and Sonoma contracts ended in June 2024.

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.

Fiscal Year (FY) 2021-22 Pilot County Program Funding

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 five new participating counties in developing their Diversion programs, resulting in programs in Madera, Nevada, San Joaquin, Tulare, and Tuolumne counties.

The 2024-25 May Revision reported all five of the new DSH Diversion programs (Madera, Nevada, San Joaquin, Tulare, and Tuolumne counties) had activated and begun client enrollment. As of June 30, 2024, Nevada County had enrolled four of eight contracted Diversion clients, while San Joaquin County had enrolled 22 of 26. Tulare County reported four of 13 enrolled Diversion clients, and Tuolumne County reported two of 15 spots filled. Madera County had not yet enrolled any Diversion clients into its program but continued 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.
- An existing connection between the alleged crime and the defendant's symptoms of mental illness or conditions of homelessness.

In the 2024-25 May Revision, 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 existing diversion programs by offering Supplemental County Housing funds for diverting and providing housing services to clients found IST per PC 1370, and on the DSH waitlist.

In the 2024-25 May Revision, DSH reported the 17 counties participating in the program had billed for a total of $15.7 million in Supplemental Housing.

Ongoing Technical Assistance and Support

In July 2023, DSH began holding monthly meetings with all pilot counties to discuss any local barriers to diversion, and to provide support and technical assistance. DSH continues to navigate barriers by educating judicial officials on the referral process for IST Diversion and providing state-wide virtual and in-person trainings. DSH also continues to provide technical assistance to the counties by coordinating monthly all-county meetings where counties can connect to collaborate on lessons learned and share resources.

DSH 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 quarterly from participating counties. Counties who struggle to complete reports timely and accurately are provided with additional support to help with any barriers they may be facing.

The Budget Act of 2022 established Diversion as a permanent DSH program, and the Department is executing permanent program contracts, including a provision to provide data to DSH monthly rather than quarterly. This increase in frequency will allow DSH to resolve any data discrepancies with counties in a timely manner, to align the collection and reporting of Diversion data with other DSH program reporting, and to identify potential programmatic issues at the county level earlier than DSH was able to under the quarterly collection schedule.

PROGRAM UPDATE

Diversion Pilot Program Data Collection Efforts and Research

As of June 30, 2024, 1,803 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[3]		
Program Information	**Total Number**	**Percentage**
Total Enrolled as of 6/30/2024	1,864	100%
Total Ineligible	61	3.3%
Total Eligible	1,803	96.7%
At Risk vs. IST	**Total Number**	**Percentage**
At risk of IST	678	37.6%
IST	1,125	62.4%
Waitlist	**Total Number**	**Percentage**
Removed from DSH Waitlist	763	42.3%
Diagnosis	**Total Number**	**Percentage**
Schizophrenia	719	39.9%
Schizoaffective Disorder	591	32.8%
Bipolar Disorder	357	19.8%
Unspecified Schizophrenia Spectrum and Other Psychotic Disorder (OPD)	103	5.7%
Other	33	1.8%
Ethnicity	**Total Number**	**Percentage**
White	486	27.0%
People of Color	1,317	73.0%
Gender	**Total Number**	**Percentage**
Male	1,194	66.2%
Female	595	33.0%
Other	14	0.8%
Living Situation at Arrest[4]	**Total Number**	**Percentage**
Homeless	1,427	79.5%
Not Homeless	368	20.5%
Felony Charges	**Total Number**	**Percentage**
Assault/ Battery	586	32.5%
Theft	319	17.7%
Robbery	233	12.9%
Miscellaneous (primarily Vandalism)	188	10.4%
Criminal Threats	147	8.1%
Arson	133	7.4%
Other (primarily weapons, drugs, FTR)	113	6.3%
Obstruction of Justice	54	3.0%

[3] Two counties did not submit Q4 data to DSH.
[4] San Francisco and Santa Clara County did not provide data for all participants for this section in their quarterly reports.

Kidnapping	30	1.7%

Diversion Pilot Program Outcome & Predictive Data

Since the launch of the pilot in 2018, enrollment in Diversion has steadily increased. Using data collected throughout the pilot, DSH can now analyze and share participant predictor data outcomes and assess program impacts. Using data as of June 30, 2024, from all participating counties, DSH analyzed the outcomes of the 1,803 eligible Diversion participants. Of these participants, 52 were not included for analysis because they had met eligibility criteria and started their respective Diversion programs, but were terminated for a variety of reasons including: client transfer to another program, judicial reasons unrelated to Diversion, or the occurrence of death prior to program completion. The following tables use the dataset described above to display predictors of status in the program:

Current Status		
	Total Number	**Percent**
Still In	564	32.2%
Revoked/AWOL/Re-incarcerated	562	32.1%
Successful Completion	625	35.7%
Total	**1,751**	**100%**
Length of Stay by Current Status		
	Average	
Still In	469.69	
Revoked/AWOL/Re-incarcerated	223.40	
Successful Completion	614.34	
Risk Assessment[5] Conducted		
	Total Number	**Percent**
Yes	642	69.8%
No	278	30.2%
Total	**920**	**100%**
Development of Treatment Plan[6]		
	Total Number	**Percent**
Intensive evaluation[7]	765	85.5%
Formal RNR assessment[8]	106	11.8%
Both	24	2.7%

[5] Clinical assessment designed to evaluate an individual's risk of violence
[6] Individualized course of treatment and interventions based on specific patient needs
[7] The use of various disciplines, including psychiatry, to evaluate a patient's needs and the best course of treatment to meet those needs
[8] 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

Total	895	100%

Diversion Program Participant Outcome Data[9]		
Incompetent to Stand Trial	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
IST	335 (49.7%)	339 (50.3%)
At risk of IST	290 (56.5%)	223 (43.5%)
Homeless	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
Yes	496 (51.1%)	474 (48.9%)
No	129 (60.0%)	86 (40.0%)
Abuse of Substances	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
Yes	507(50.6%)	494 (49.4%)
No	103 (65.2%)	55 (34.8%)
Methamphetamine Use	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
Methamphetamine	280 (43.4%)	365 (56.6%)
No drug use/Other drugs	328 (64.2%)	183 (35.8%)

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 significant 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 data and refine data collection prior to the permanent program implementation to account for these dynamic fluctuations. The Diversion pilot program will run through its completion on June 30, 2025.

[9] Totals may not equal the Current Status Total as information regarding living situation and substance use are not required for eligibility, and when not provided, is not captured in the reported data.

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 May Revision, DSH projected to receive 580 SVP and 2,018 OMD referrals in fiscal year (FY) 2023-24. As of the 2025-26 Governor's Budget, DSH projects to receive 538 SVP and 2,205 OMD referrals in FY 2024-25.

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 incarcerated persons to determine if 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 May Revision, DSH reported that between July 2023 and February 2024, DSH had averaged 48 referrals per month, which is 65.5% higher than the average 29 referrals per month received between January and June 2023.

OMD Program

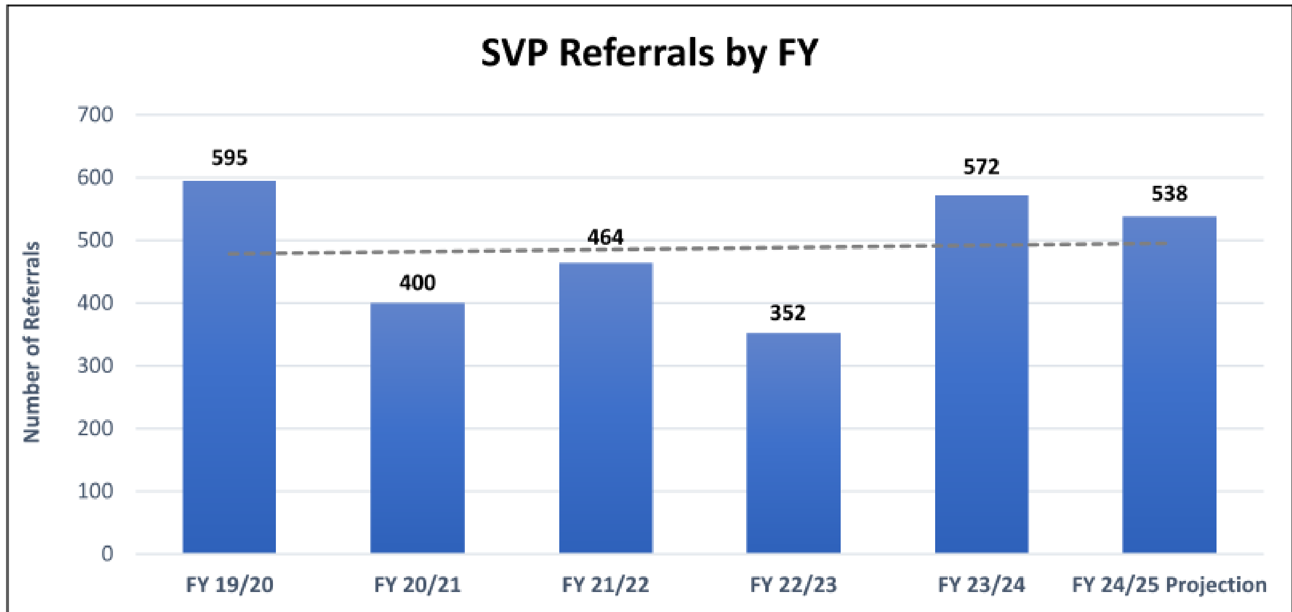
Pursuant to Penal Code (PC) 2960–2981, CDCR evaluators conduct a forensic evaluation of incarcerated persons who have a) been in CDCR mental health programs, and b) have a violent commitment offense, prior to the individual's release on parole. If the CDCR evaluator determines the inmate has a severe 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 May Revision, DSH reported a 7% decline in OMD referrals in FY 2022-23 compared to prior FY 2021-22, and projected a total of 2,018 OMD referrals for FY 2023-24.

PROGRAM UPDATE

SOCP Program

DSH received 572 SVP evaluation referrals in FY 2023-24. This was a 38% increase in referrals compared to FY 2022-23. In FY 2024-25, DSH projects 538 SVP referrals, which is a decrease from the FY 2023-24 referrals. The projection is based on the most recent 12 months of actual referrals received between November 2023 to October 2024.

The chart below shows the total SVP referrals received by fiscal year from FY 2019-20 through the projection for FY 2024-25.

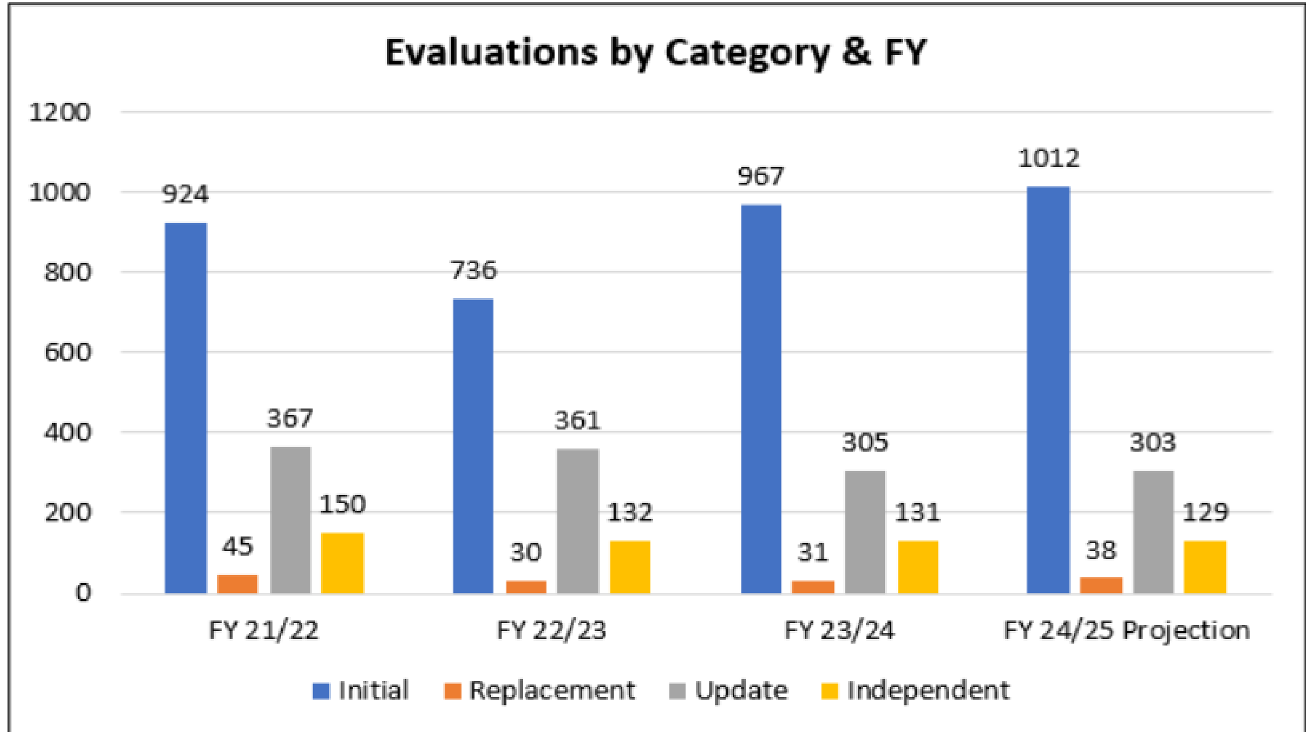


Note: The above actual referral totals are provided based on the FY the referral was received from CDCR/BPH.

The increase of SVP referrals recognized in FY 2023-24, and now projected for FY 2024-25, is due to changes in California sentencing laws. These statute changes have resulted in the resentencing of eligible individuals serving prison terms, yielding earlier release dates to an increased number of incarcerated individuals who meet the criteria for evaluation under the SVP Act. DSH will continue to monitor SVP referral trends and provide an update in the 2025-26 May Revision.

For each SVP referral received, DSH performs a minimum of two initial evaluations. When there is a difference of opinion (DOP) between the 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).

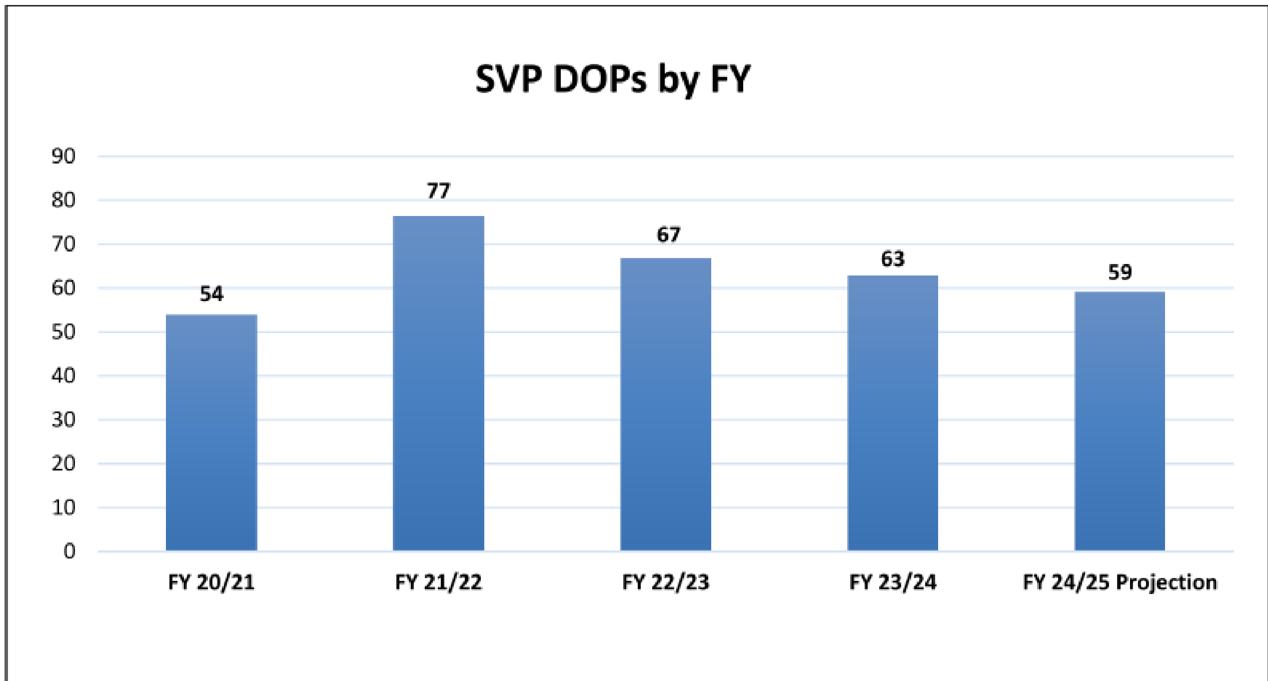
The chart below displays the total number of evaluations conducted by type of SVP evaluation, from FY 2021-22 to the projection for FY 2024-25 which is based on the most recent 12 months of actual referrals received between November 2023 to October 2024.



Note: The above actuals are determined by the number of evaluations completed by 6/30 of each FY.

FY 2022-23 experienced a decrease in initial evaluations due to the lower amount of SVP referrals received. However, in FY 2023-24, initial evaluation referral rates rebounded to those observed in FY 2021-22. The rates are projected to remain at this higher rate in FY 2024-25.

The chart below shows the number of SVP DOP referrals from FY 2021-22 to the projection for FY 2024-25.



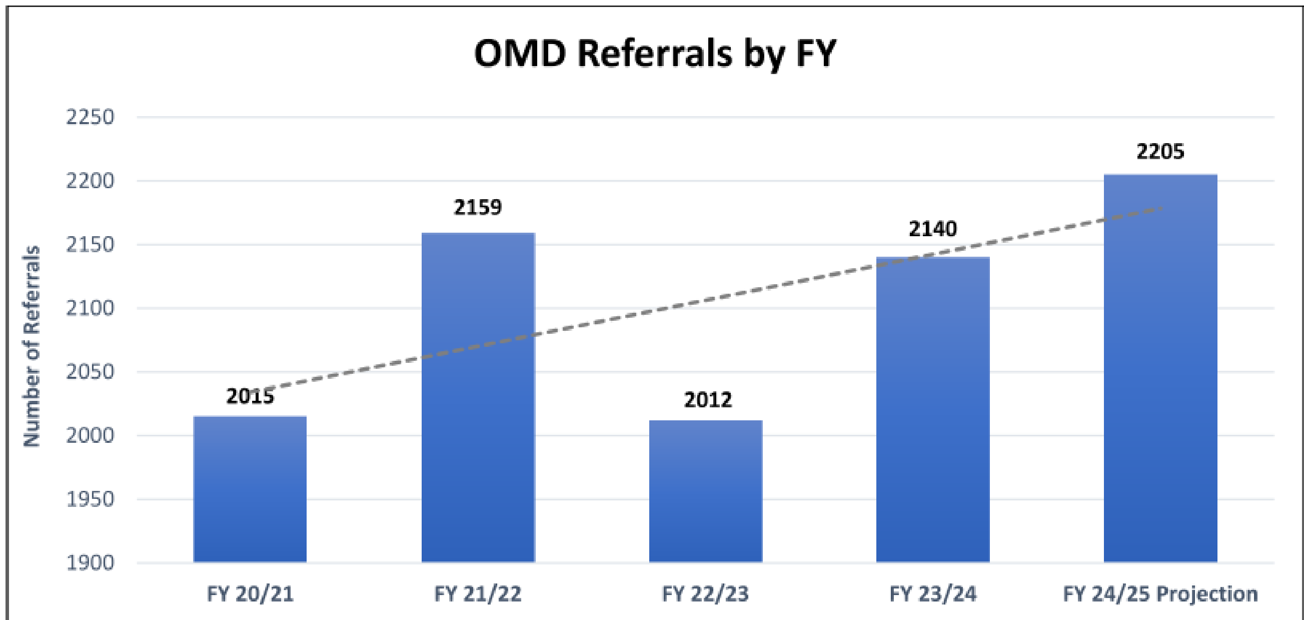
In FY 2023-24, DSH received a total of 63 DOP cases. This equates to approximately 11% of the total SVP referrals received that fiscal year. Applying this same percentage to the projected 538 SVP referrals in FY 2024-25, DSH assumes a total of 59 DOP cases in FY 2024-25.

Additionally, DSH evaluators testified in 206 SVP court cases during FY 2023-24. The workload involved in preparing and providing testimony for probable cause hearings and jury trials is significant, equal to approximately two SVP evaluations per evaluator. This translates to an approximate workload equivalent of 824 evaluations, as each court case includes at least two evaluators and requires four in the case of a difference of opinion. This approximation does not include independent court preparation and testimony.

OMD Program

In FY 2023-24, DSH received 2,140 OMD referrals for evaluation. This is approximately 6% higher than actual referral rates in FY 2022-23. Using the most recent 12 months of actual referrals received between November 2023 to October 2024, DSH projects 2,205 OMD referrals for FY 2024-25; an increase from FY 2023-24.

The following chart provides the total OMD referrals from FY 2020-21 to the projection for FY 2024-25.



DSH will continue to work closely with CDCR and BPH to determine potential workload impacts to the SOCP and OMD program and provide an update in the 2025-26 May Revision.

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 they will return to CDCR (pursuant to PC 2685) when they have reached maximum benefit from treatment. If the individuals 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 – Incarcerated Person 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 psychiatric stabilization. A number of *Coleman* patients are sent to DSH due to complicated presentations, such as complex medical diagnoses, cognitive issues, or developmental disabilities in addition to mental illness. In addition to psychiatric and medical services, psychosocial treatments are provided with a focus on helping the patients 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 the 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, Metropolitan, Napa, and Patton State Hospitals. Coleman patients are treated at Atascadero, Coalinga, and Patton State Hospitals.

Population Data

In fiscal year (FY) 2023-24, the *Coleman* patient population increased 40%, with an average census of 112 patients in July 2023, and ending with an average census of 156 in June 2024. Table 1 below summarizes key statistics across the *Coleman* population.

Table 1: *Coleman* Patient Data Summary

Coleman Patient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY[1]
Patients Referrals[2]	282	611	117%
Admissions[3]	199	307	54%
Patients Served[4]	313	419	34%
Average Daily Census	105	127	21%
Average Length of Stay	284	141	-50%
Discharges	189	251	33%

In FY 2023-24, 611 *Coleman* patients were referred to DSH for psychiatric stabilization treatment; an increase of 117% from FY 2022-23. Below, Chart 1 displays *Coleman* systemwide referrals and admissions for FY 2023-24. Chart 2 displays a five-year period of referrals and admissions with a trend line of patients served over the years.

[1] Totals are based on raw data, which have been rounded for display purposes.
[2] Patient referrals excludes other inpatient program transfers and court returns.
[3] Patient admissions include other inpatient program transfers.
[4] Patients served excludes other inpatient program transfers.

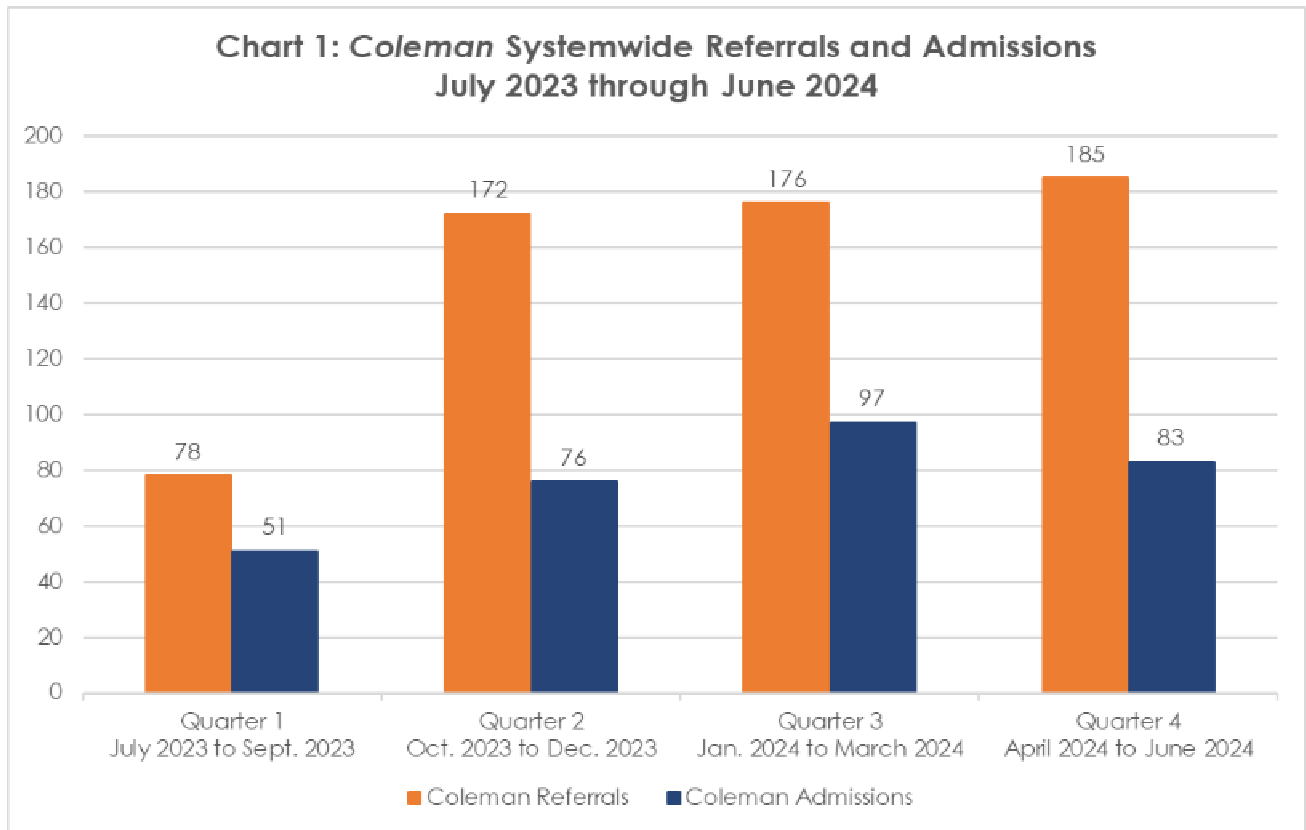


Chart 1: *Coleman* Systemwide Referrals and Admissions
July 2023 through June 2024
200
180
160
140
120
100
80
60
40
20
0
78
51
172
76
176
97
185
83
Quarter 1
July 2023 to Sept. 2023
Quarter 2
Oct. 2023 to Dec. 2023
Quarter 3
Jan. 2024 to March 2024
Quarter 4
April 2024 to June 2024
Coleman Referrals
Coleman Admissions

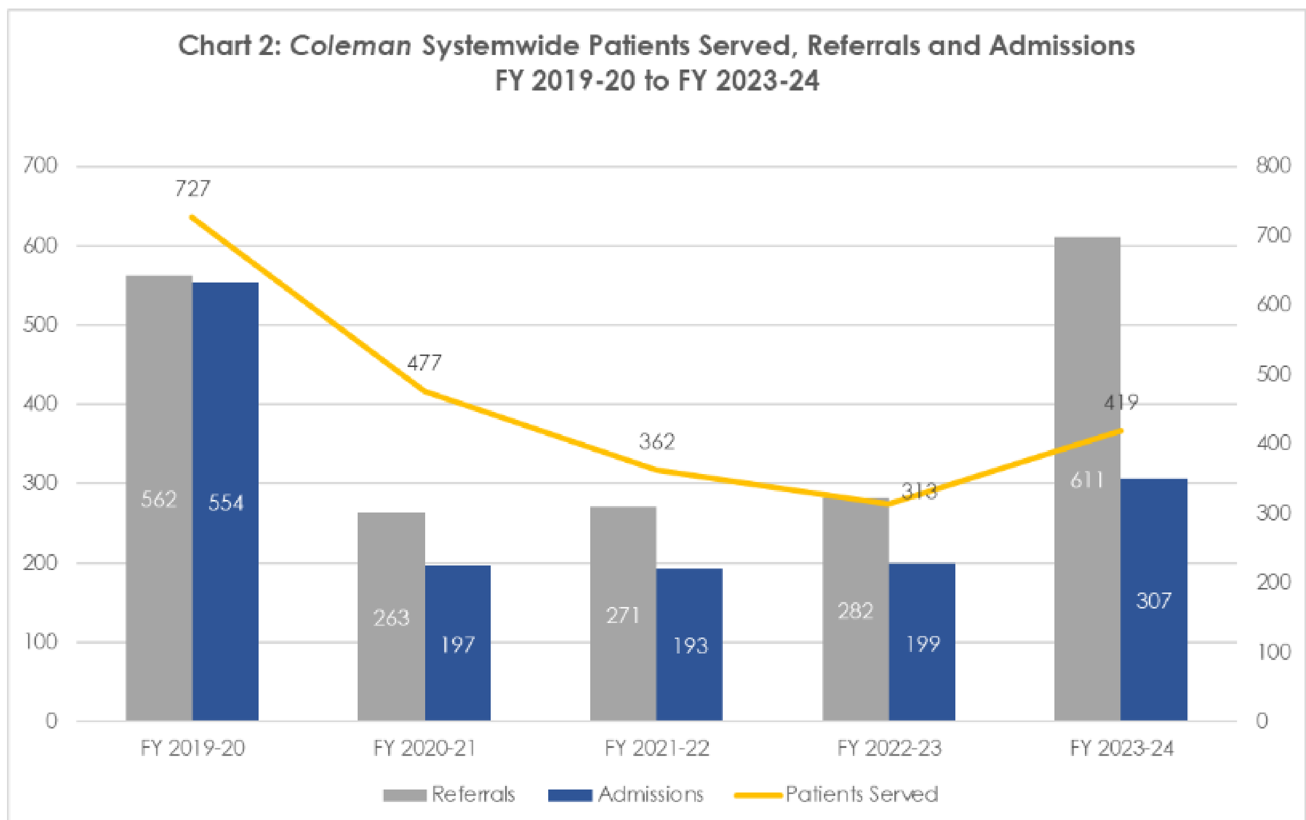


Chart 2: *Coleman* Systemwide Patients Served, Referrals and Admissions
FY 2019-20 to FY 2023-24
700
600
500
400
300
200
100
0
800
700
600
500
400
300
200
100
0
727
477
362
313
419
562
554
263
197
271
193
282
199
611
307
FY 2019-20
FY 2020-21
FY 2021-22
FY 2022-23
FY 2023-24
Referrals
Admissions
Patients Served

The chart above (Chart 2), displays 307 total admissions in FY 2023-24; a 54% growth in admissions from the prior FY. During this time, the Pending Placement List (PPL) has increased ***%[5] in the FY, with fewer than 11 in July 2023 and ending at 23 patients in June 2024. All patients referred for intermediate care treatment are subjected to court mandated timelines and must be admitted within 30 days, barring any medical holds.

As a result of the CDCR referrals accepted, DSH admitted 307 *Coleman* Patients in FY 2023-24 with an average of 26 admissions per month. Chart 3 displays *Coleman* admissions by quarter and the average monthly admissions rate.

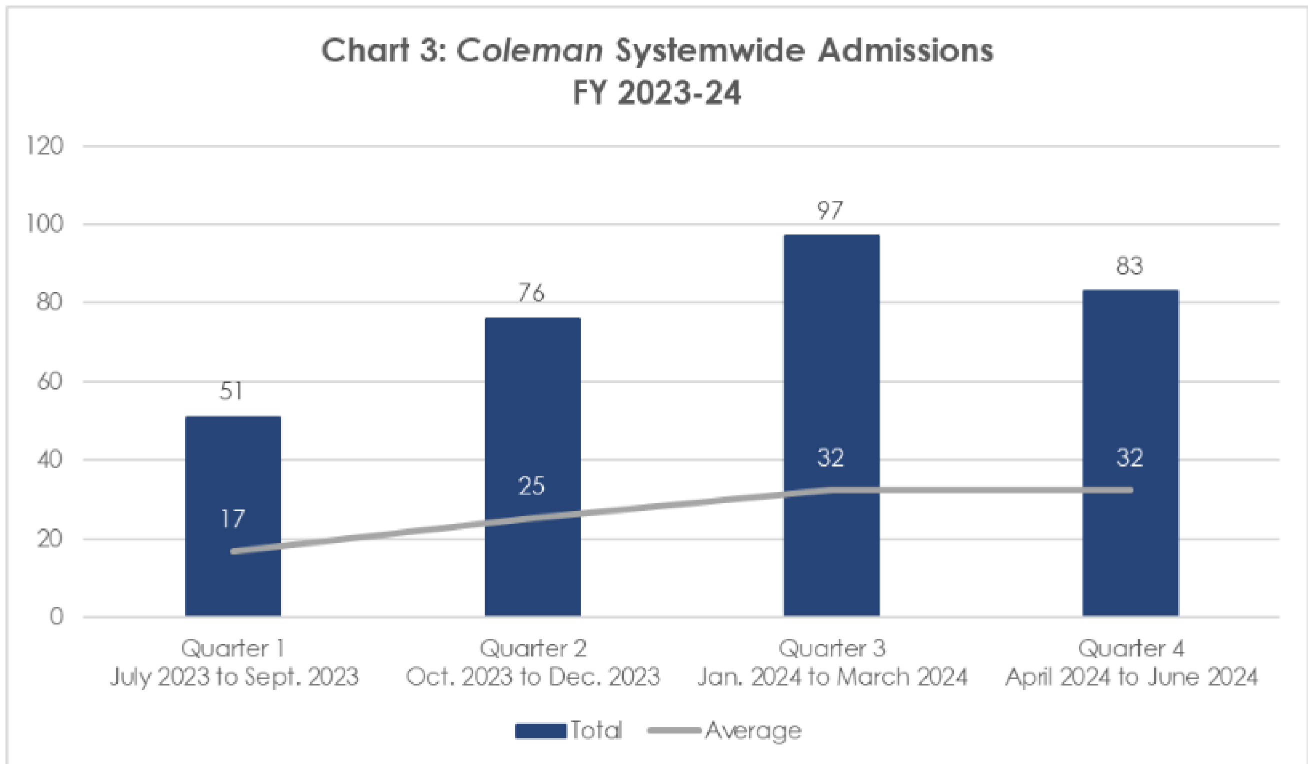


Table 2 below displays the number of patients treated across the year.

Table 2: *Coleman* Patients Served[6]

Patients Treated/ Served	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
	727	477	362	313	419

[5] 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.
[6] Patients served excludes other inpatient program transfers.

Discharge Data

In FY 2023-24, DSH discharged 251 *Coleman* patients with an average length of stay of 141 days and a median length of stay of 123 days. 40% of *Coleman* patients discharged within the first 90 days of their stay; 71% of the *Coleman* patients discharged within the first 180 days of their stay and 96% 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 2023-24

***Coleman* Length of Stay**	**Quarter 1** July 2023 to Sept. 2023	**Quarter 2** Oct. 2023 to Dec. 2023	**Quarter 3** Jan. 2024 to March 2024	**Quarter 4** April 2024 to June 2024	**Total**[7] FY 2023-24
Average Length of Stay	148.2	157.7	138.4	121.4	141.0
Median Length of Stay	144.5	146.0	106.0	97.0	123.0
Discharged Count	58	62	65	66	251

[7] Totals are based on raw data, which have been rounded for display purposes.

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

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

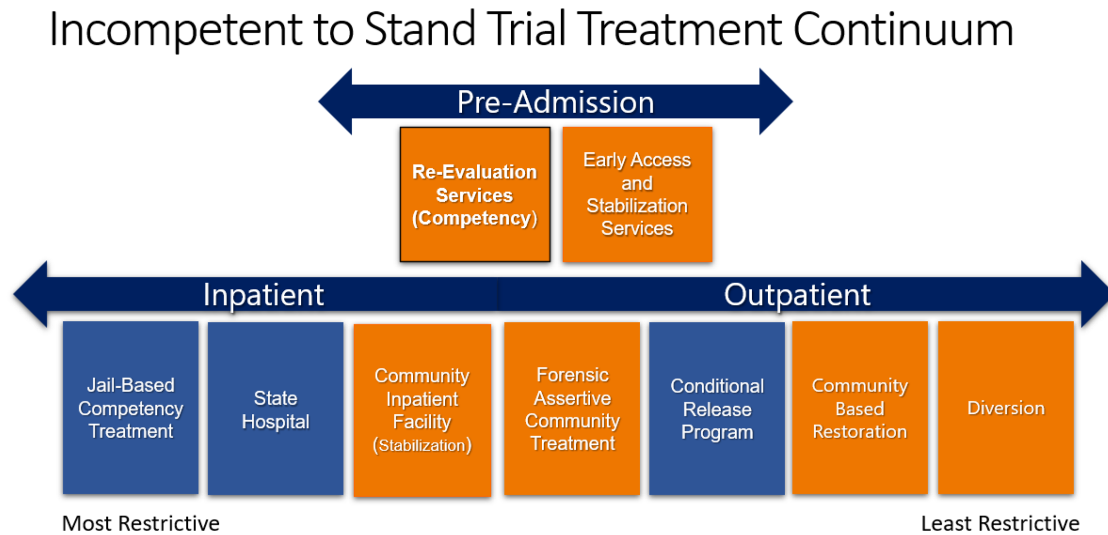
As defined in PC 1370(b)(1), a patient may be designated by their treatment team as unlikely to regain competency. Upon notification to the Sheriff of the county of commitment, the patient must be picked up within ten days and returned to county custody. Often, the county will pursue other means to ensure the patient receives treatment and care, including securing a conservatorship or 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 to pick up a patient who is within 90 days of expiration of their commitment term. The Sheriff must then pick up the patient within ten days of notice by DSH. Counties are billed for the continued costs of care for any patients remaining in a facility beyond the ten-day 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 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 patients housed at Atascadero, Metropolitan, Napa, and Patton State Hospitals.
Community Inpatient Facility (CIF)	DSH's Community Inpatient Facility (CIF) program (formerly the Institutions for Mental Diseases (IMDs)/Sub-Acute program) contracts with community-based locked, inpatient facilities including Mental Health Rehabilitation

	Centers, Skilled Nursing Facilities and acute psychiatric hospitals where IST patients receive medication management, mental health therapy and support services, and when clinically indicated, competency education and evaluation services. Additionally, individuals deemed suitable for diversion receive mental health treatment and medication to facilitate psychiatric stabilization to support their participation in and transition to a DSH Diversion or CBR program in a lesser restrictive environment.
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 respond to clients as needed to reduce the likelihood of rehospitalization through de-escalation and crisis intervention practices.
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 IST 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 are dropped 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 and is pending admission to a DSH IST program, 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, this program 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 Competency: Restoration treatment includes group psychoeducation, individual therapy, medication evaluation and management, and statutorily required competency to stand trial evaluations and court reports.

Throughout treatment, patients are regularly evaluated and, if there is concurrence a patient is competent, a forensic report (certificate of restoration) is sent to the court, identifying the patient as 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 ten days of the certificate of restoration filing.

Population Data

System-wide Metrics

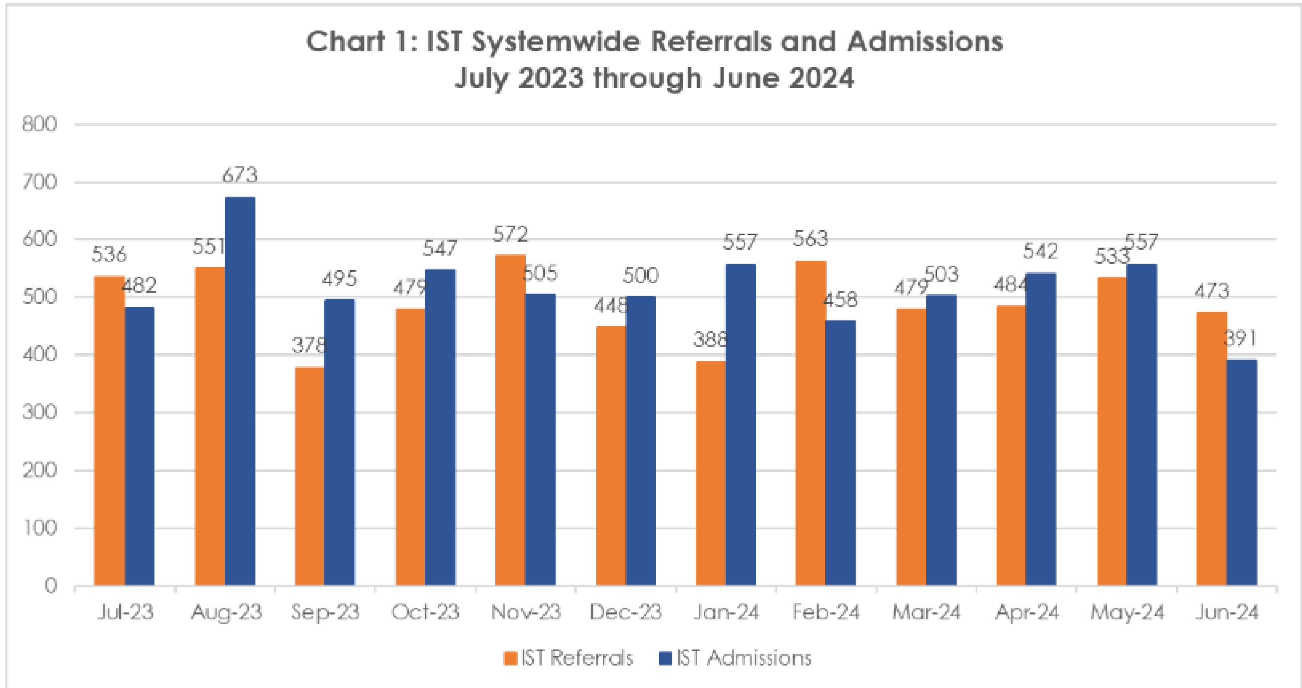
In FY 2023-24, DSH treated 8,570 patients designated as IST. This growth of 12% from prior year, reflects DSH's continuum of care expansion of inpatient and outpatient programs, and a focus of growing census while balancing continued health and safety measures associated with COVID-19. DSH had an average daily census of 2,906 IST designated patients during FY 2023-24, with a 1% growth from 2,881 patients in July 2023, to 2,908 in June 2024. In addition, as compared to the prior fiscal year, the average daily census increased overall by 10% in FY 2023-24. The table below summarizes key statistics across the IST population.

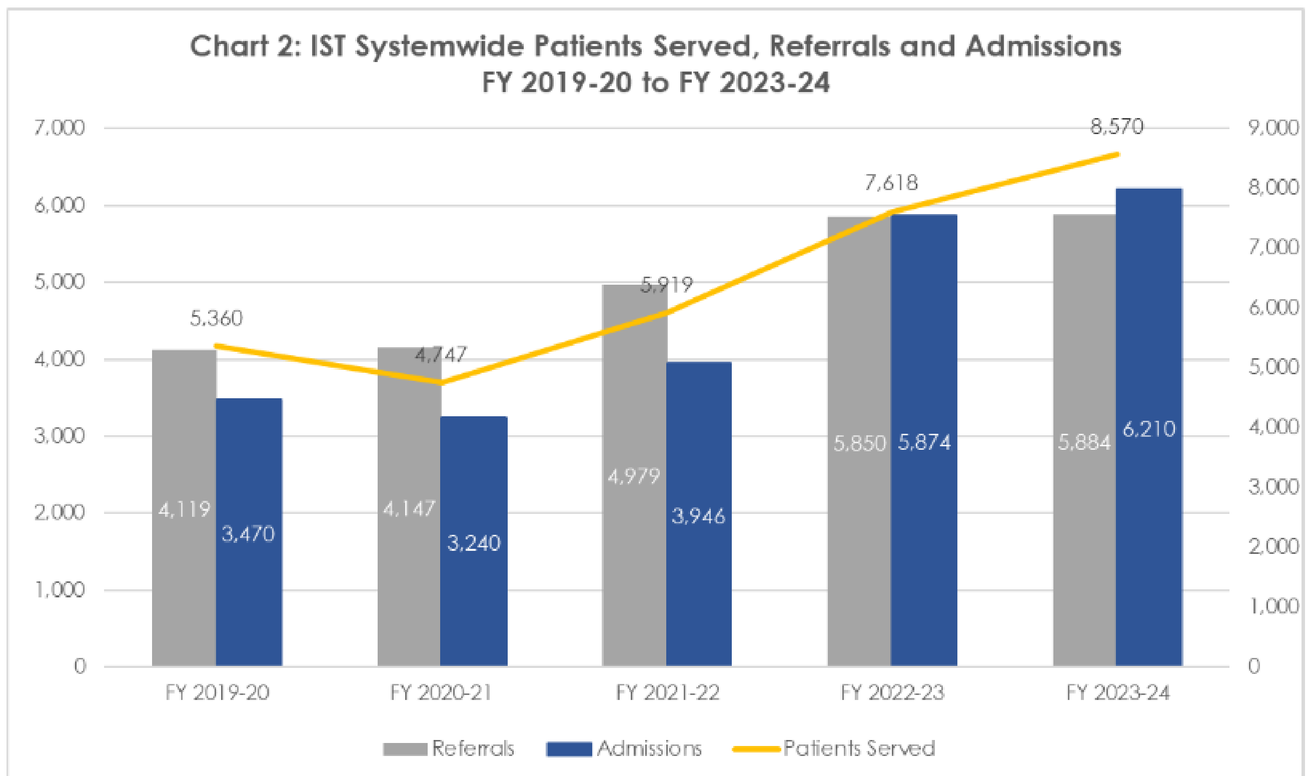
Table 1: System-wide IST Patient Data Summary

IST Patient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Referrals[2]	5,850	5,884	1%
Patient Admissions[3]	5,874	6,210	6%
Patients Served[4]	7,618	8,570	12%
Average Daily Census	2,647	2,906	10%

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

In FY 2023-24, 5,884 IST designated patients were committed to DSH for competency treatment; an increase of 1% from FY 2022-23. Chart 1 below displays IST system-wide referrals and admissions for FY 2023-24. Chart 2 displays a five-year period of referrals and admissions, while also identifying DSH's increasing number of patients treated annually over the past few years.





In FY 2023-24, the IST Pending Placement List (PPL) decreased by 53% from 910 patients in July 2023 to 425 patients in June 2024. The PPL has continued to decrease with 384 patients pending placement as of September 30, 2024. Due to the average monthly referrals, it is unlikely this current pending placement list trend will change significantly moving forward. The primary drivers in reducing the IST PPL have included higher 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 PPL as of June 30 of the corresponding year.

Table 2: IST System-wide Pending Placement List

IST Patients Pending Placement	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
	1,212	1,454	1,779	894	425

Inpatient Program Metrics

DSH inpatient treatment programs include State Hospitals, JBCT, and Community Inpatient Facilities (CIF). During FY 2023-24, DSH inpatient programs treated on average 2,233 IST designated patients daily. In July 2023, the average daily census was 2,176 with a 3% growth as compared to June 2024, with an average daily census of 2,233 patients. Table 3 (below) shows the IST Inpatient Data Summary for FY 2022-23 and FY 2023-24.

Table 3: IST Inpatient Data Summary

IST Inpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Admissions[5]	5,253	5,492	5%
Patients Served[6]	6,412	7,149	11%
Average Daily Census	1,978	2,233	13%

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

DSH inpatient programs admitted 5,492 IST designated patients in FY 2023-24 with an average of 458 admissions per month. Chart 3 displays inpatient program IST admissions by quarter and the average monthly admissions rate.

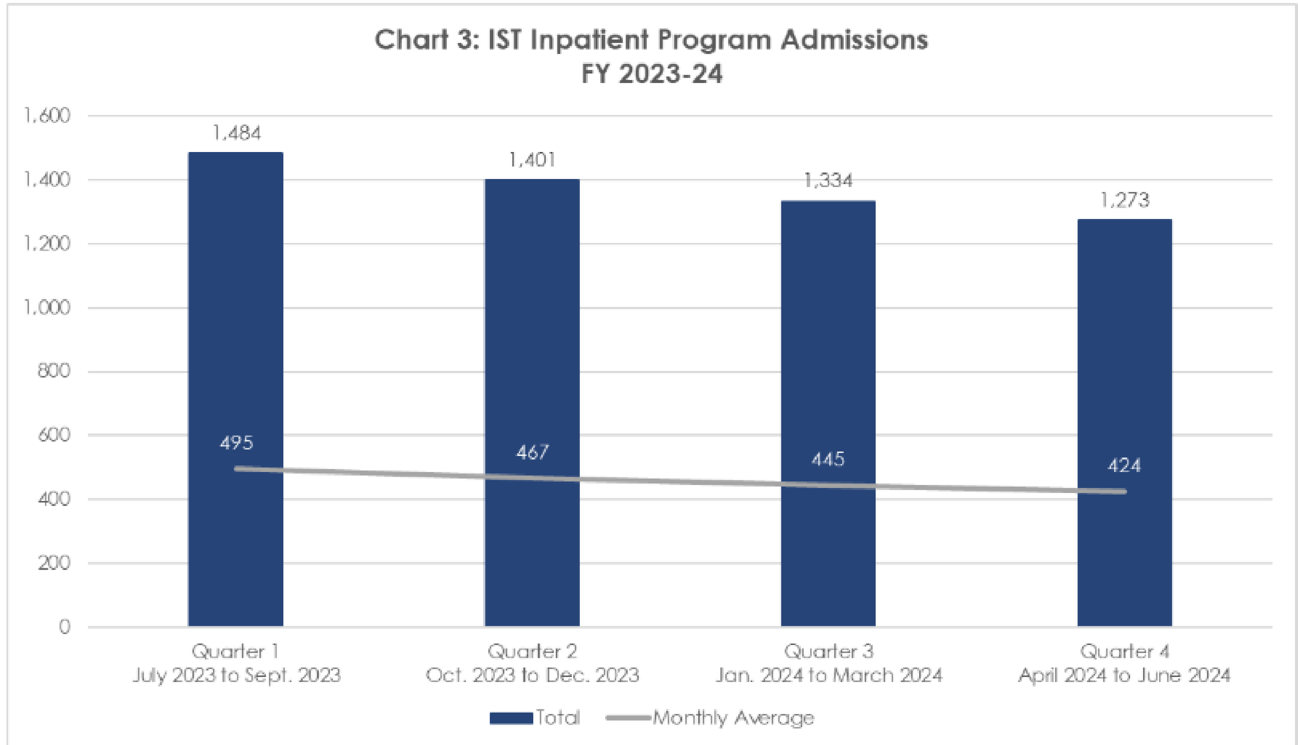


Table 4 below, displays the number of IST designated patients treated across the year in inpatient programs for the past five years.

Table 4: IST Patients Served – Inpatient Programs[7]

Patients Treated/ Served	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
	5,090	4,241	5,030	6,412	7,149

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

Inpatient Discharge Data

DSH discharged 5,462 IST designated patients from inpatient programs with an average length of stay of 141 days and a median length of stay of 111 days across all programs. 42% of patients discharged within the first 90 days of their stay, 73% discharged within the first 180 days of their stay and 94% of patients discharged within the first year of their stay.

Table 5: IST Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 90 Days	42%
91 - 180 Days	32%
181 - 365 days	21%
366 - 730 days (1 - 2 years)	6%
731+ days (2+ years)	0%

For patients yet to discharge as of June 30, 2024, the average days in treatment is 132.7 days and the median days in treatment is 96 days. Table 6 displays Inpatient programs length of stay by quarter.

Table 6: IST Inpatient Length of Stay by Quarter – FY 2023-24

IST Inpatient Programs: Length of Stay	Quarter 1 July 2023 to Sept. 2023	Quarter 2 Oct. 2023 to Dec. 2023	Quarter 3 Jan. 2024 to March 2024	Quarter 4 April 2024 to June 2024	Total[8] FY 2023-24
Average Length of Stay	142.4	128.6	145.4	149.5	141.4
Median Length of Stay	114.0	103.0	111.0	113.0	111.0
Discharged Count	1,408	1,379	1,365	1,310	5,462

[8] Totals are based on raw data, which have been rounded for display purposes.

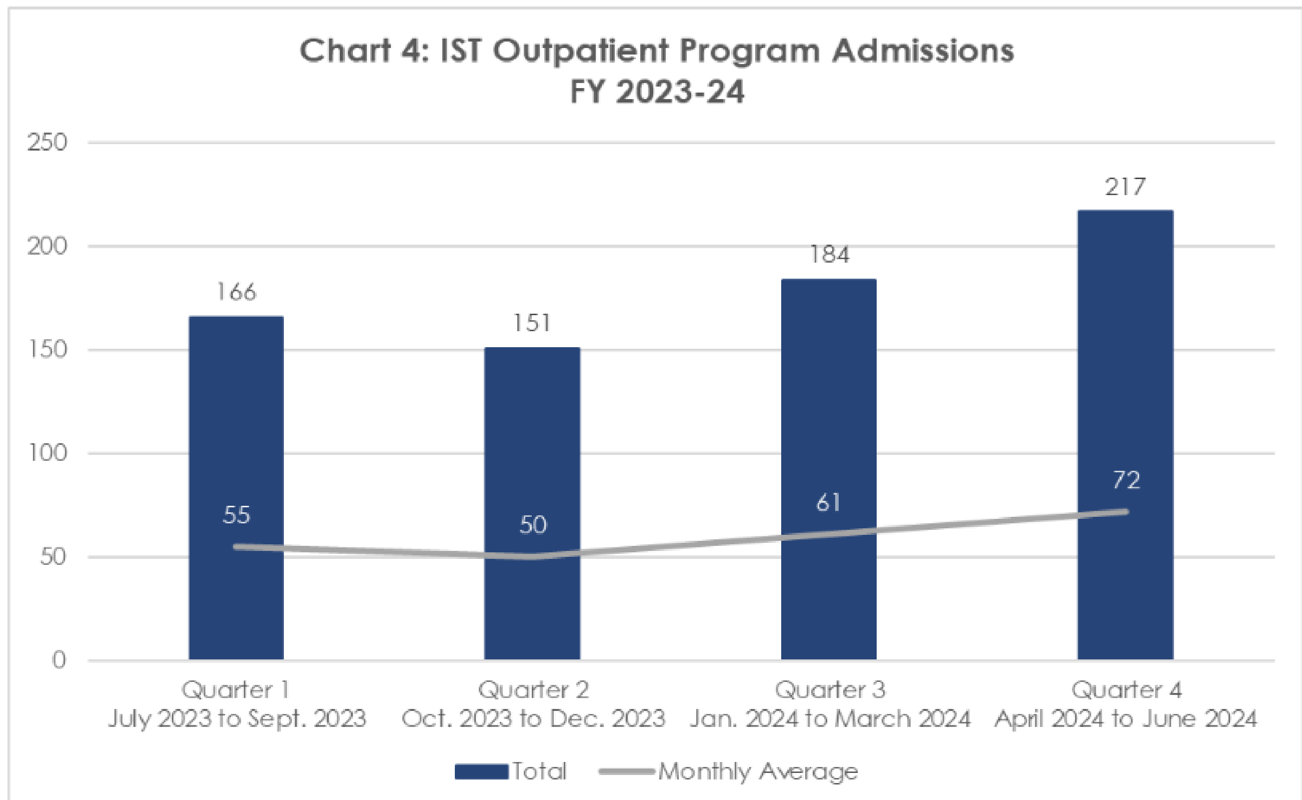
Outpatient Program Metrics

DSH outpatient treatment programs include CONREP, Community Based Restoration (CBR), and Diversion. During FY 2023-24 DSH outpatient programs treated on average 673 IST designated patients. In July 2023, the average census was 706 with a 4% decrease to 676 patients by the end of the FY in June 2024.

Table 7: IST Outpatient Data Summary

IST Outpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Admissions[9]	621	718	16%
Patients Served[10]	1,206	1,421	18%
Average Daily Census	668	673	1%

DSH outpatient programs admitted 718 IST designated patients in FY 2023-24, with an average of 60 admissions per month. Chart 4 displays IST outpatient program admissions by quarter.



[9] Patient admissions include inpatient and outpatient program transfers.
[10] Patients served excludes 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[11]

Patients Treated/Served	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
	270	506	889	1,206	1,421

Outpatient Discharge Data

DSH discharged 659 IST patients from outpatient programs, with an average length of stay of 418.5 days, and a median length of stay of 589 days, across all programs. 26% of patients discharged within the first 90 days of their stay, 34% discharged within the first 180 days of their stay, and 40% of 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	26%
91 - 180 Days	8%
181 - 365 days	7%
366 - 730 days (1 - 2 years)	53%
731+ days (2+ years)	7%

Table 10 displays outpatient length of stay by quarter.

Table 10: IST Outpatient Length of Stay by Quarter – FY 2023-24

IST Outpatient Programs: Length of Stay	Quarter 1 July 2023 to Sept. 2023	Quarter 2 Oct. 2023 to Dec. 2023	Quarter 3 Jan. 2024 to March 2024	Quarter 4 April 2024 to June 2024	Total[12] FY 2023-24
Average Length of Stay	478.9	377.0	394.0	418.2	418.5
Median Length of Stay	620.0	535.0	577.0	598.0	589.0
Discharged Count	174	138	193	154	659

[11] Patients served excludes inpatient and outpatient program transfers.
[12] Totals are based on raw data, which have been rounded for display purposes.

IST Services Metrics

Early Access Stabilization Services

During FY 2023-24 DSH's Early Access Stabilization Services (EASS) Program provided IST services to 2,797 patients with 13 newly participating counties and a total of 49 counties actively participating in EASS during the FY.

Table 11: IST Early Access Stabilization Services Summary by Quarter

IST Early Access Stabilization Services	**Quarter 1** July 2023 to Sept. 2023	**Quarter 2** Oct. 2023 to Dec. 2023	**Quarter 3** Jan. 2024 to March 2024	**Quarter 4** April 2024 to June 2024	**Total** FY 2023-24
IST Services Initiated	569	736	748	744	2,797
Newly Participating Counties	5	6	2	0	13
Total Participating Counties	41	47	49	49	49

Re-Evaluation Services

IST Re-Evaluation Services completed 834 evaluations during FY 2023-24. Outcomes resulted in 24% IST patients found competent prior to admission, and 76% found retain and treat.

Table 12: IST Re-Evaluation Services Summary by Quarter[13]

IST Re-Evaluation Services	**Quarter 1** July 2023 to Sept. 2023	**Quarter 2** Oct. 2023 to Dec. 2023	**Quarter 3** Jan. 2024 to March 2024	**Quarter 4** April 2024 to June 2024	**Total** FY 2023-24
IST Evaluations Completed	**380**	**201**	**142**	**111**	**834**
IST Found Competent	23%	***%	23%	***%	24%
IST Retain and Treat	77%	70%	77%	82%	76%
IST Unlikely to Restore	0.0%	***%	0.0%	***%	***%

[13] 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.

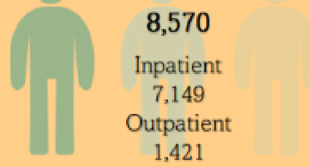
IST POPULATION DATA HIGHLIGHTS

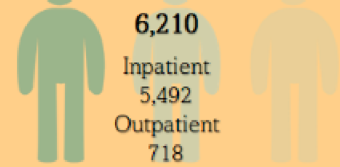
Referral Growth

DSH has experienced a 28 percent growth in IST county referrals from FY 2018-19 through FY 2023-24.

Average Monthly Referrals	
FY 2018-19	383
FY 2019-20	343
FY 2020-21	346
FY 2021-22	415
FY 2022-23	488
FY 2023-24	490
6-Year ↑	**28% ↑**

KEY STATISTICS





Increased by **12%** from FY 2022-23

Increased by **6%** from FY 2022-23

Expansion of and new IST Treatment and Services

- DSH increased IST treatment capacity by 1,231 beds since FY 2017-18 across State Hospitals, JBCT, CIF and CBR programs.
- DSH county funded Diversion program diverted 207 individuals.
- EASS and Re-evaluation Services provide increased access to competence evaluations and early access services. EASS has initiated services to 2,797 patients and Re-evaluation Services have conducted 834 re-evaluations finding 24% patients competent.

IST Waitlist & COVID-19 Impact

The DSH IST waitlist grew during the years of COVID-19 response, due to proactive public health measures aimed to protect the health and safety of patients and staff.

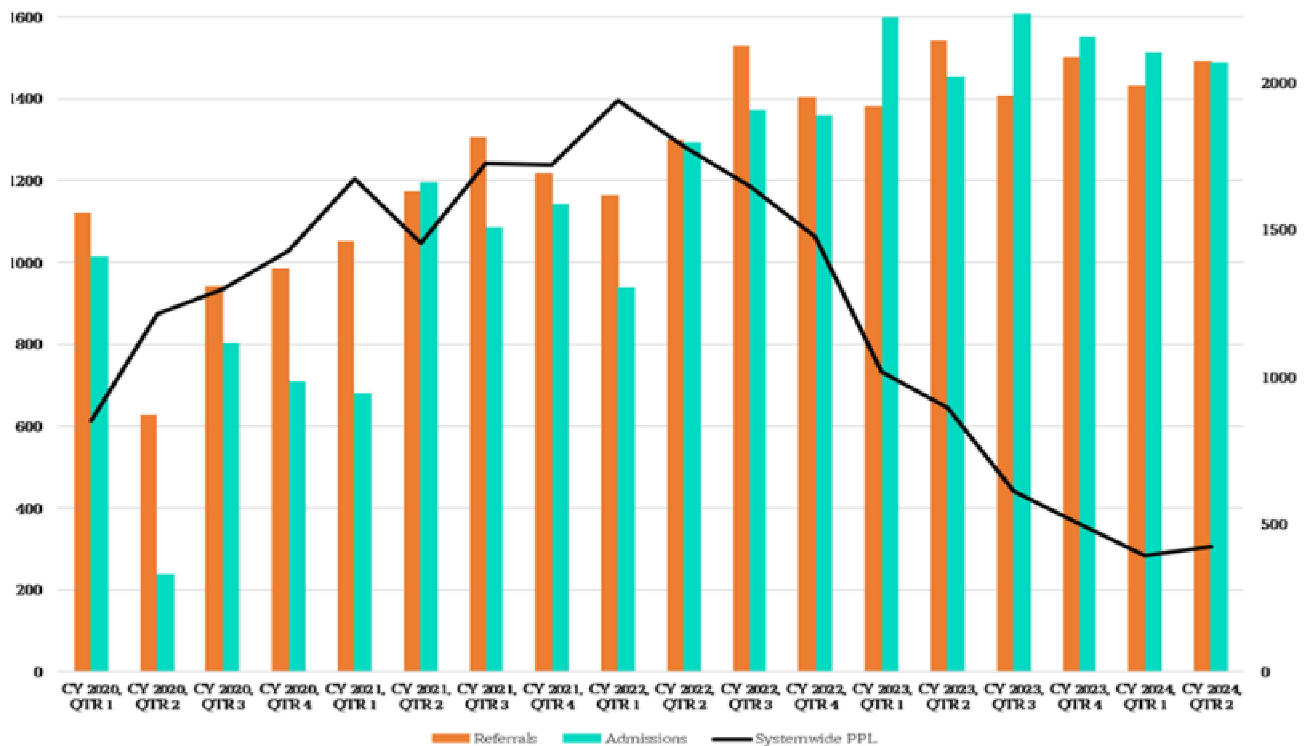
System Recovery & Decreased Waitlist

As the COVID-19 infection rate reduced, DSH has been able to increase admissions. Increased admissions, paired with new services and programs, has led to a significant reduction in the IST waitlist.

PPL Trends

February 2020: 848
PPL High: 1,953
September 2024 : 384
80% Decrease

IST Waitlist, Referrals and Admission Trends



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 hospitals 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, 84% of all LPS patients treated in DSH were committed under WIC 5353 or 5358 as conservatees. 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[2]

Commitment Type	Percent of LPS Patients Treated[3] (Past 5 years)
WIC 5353 - Temporary Conservatorship WIC 5358 - Conservatorship	84%
WIC 5008(h)(1)(B) - Murphy Conservatorship	16%
Other LPS	***%

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 to 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.

[2] 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.
[3] Totals are based on raw data, which have been rounded for display purposes.

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.

<u>Population Data</u>

System-wide Metrics

Although DSH is not statutorily required to admit LPS patients as is the case with other legal classifications, 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. In fiscal year (FY) 2023-24, 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 decrease in admissions as compared to the prior year. These statistics are summarized in Table 2 below.

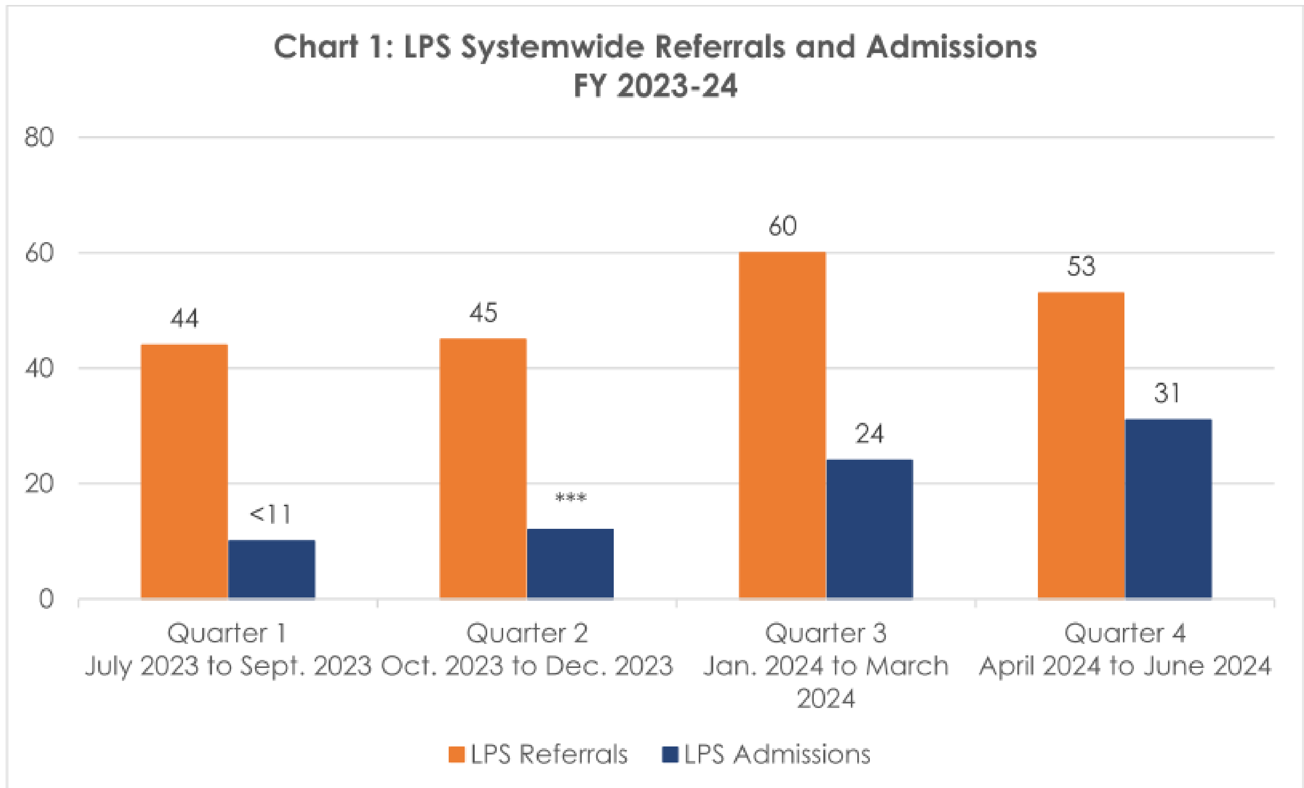
Table 2: LPS Patient Data Summary

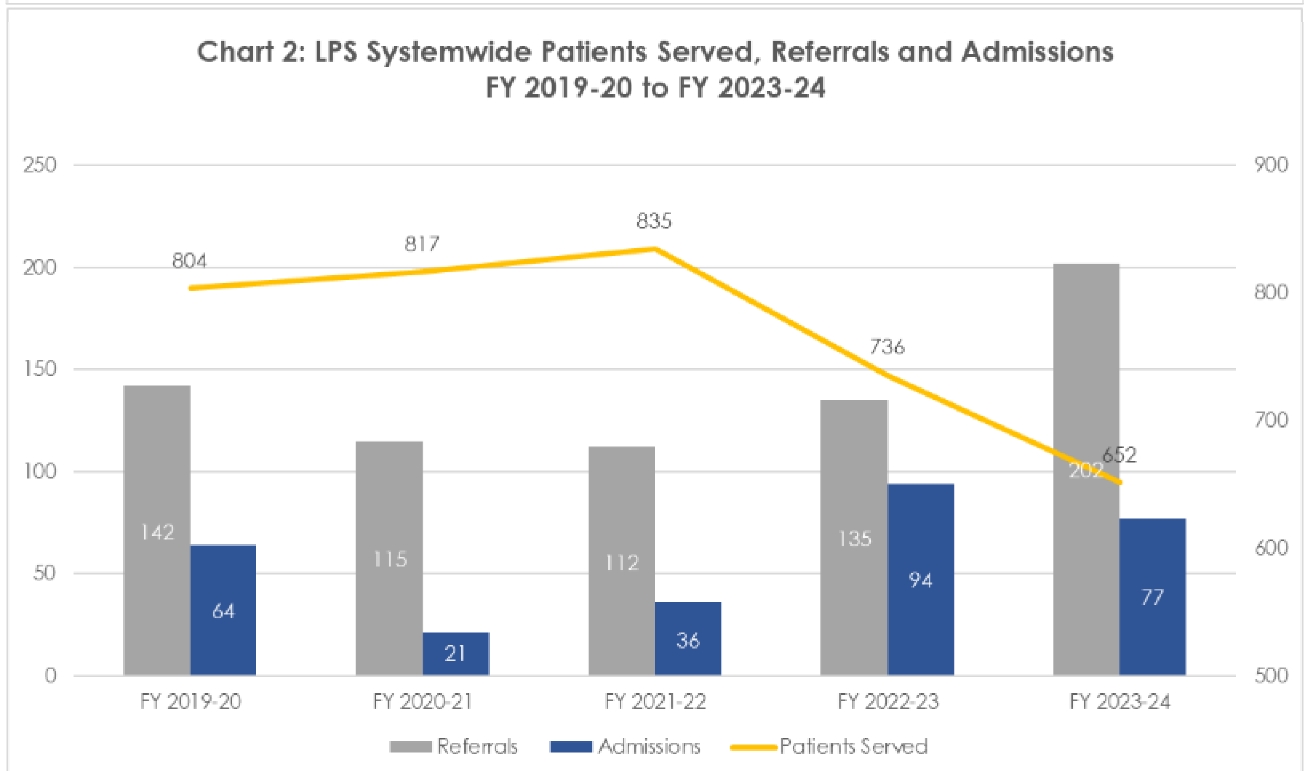
LPS Patient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Referrals[4]	135	202	50%
Patient Admissions[5]	94	77	-18%
Patients Served[6]	736	652	-11%
Average Daily Census	637	565	-11%
Average Length of Stay	2,353	2,296	-2%
Patient Discharges	245	140	-43%

The LPS patient referrals increased by 50% from FY 2022-23 to FY 2023-24. Even with the increase in referrals, the LPS patient admissions decreased by 18% and census decreased by 6% within FY 2023-24 from 589 patients in July 2023 to 554 patients in June 2024[7].

[4] Patient referrals excludes inpatient program transfers and court returns.
[5] Patient admissions include inpatient program transfers.
[6] Patients served excludes inpatient program transfers.
[7] 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 displays LPS system-wide referrals and admissions by quarter for FY 2023-24, and Chart 2 displays a five-year period of referrals and admissions for a broader historical view.





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 30th of the corresponding year. The number of LPS patients pending placement decreased 22% from FY 2022-23 to FY 2023-24.

Table 3: LPS System-wide Pending Placement List

LPS Patients Pending Placement	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
	201	297	317	311	244

Discharge Data

DSH discharged 140 LPS patients in FY 2023-24 with an average length of stay of 2,296.2 days (6.3 years) and a median length of stay of 1,984 days (5.4 years). Only 14% of LPS patients discharged within one year, 50% discharged within five years, and 50% had a length of stay longer than five years. Table 4 below depicts the distribution of LPS patients discharged in FY 2023-24 by length of stay.

Table 4: LPS Patient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	14%
366 - 1,460 Days (2 - 4 years)	25%
1,461 - 1,825 days (4 - 5 years)	11%
1,826 - 3,650 days (5 - 10 years)	31%
3,651+ days (10+ years)	19%

For patients yet to discharge the average days in treatment is 2,514 days, approx. 7 years and median days in treatment is 1,984, 5.4 years.

Table 5 below displays length of stay by quarter for FY 2023-24.

Table 5: LPS Patient Length of Stay by Quarter – FY 2023-24

LPS Patient Length of Stay Days (Years)	Quarter 1 July 2023 to Sept. 2023	Quarter 2 Oct. 2023 to Dec. 2023	Quarter 3 Jan. 2024 to March 2024	Quarter 4 April 2024 to June 2024	Total[8] FY 2023-24
Average Length of Stay	2,207.7 (6.0 yrs.)	2,329.6 (6.34 yrs.)	2,083.0 (5.7 yrs.)	2,529.1 (6.9 yrs.)	2,296.2 (6.3 yrs.)
Median Length of Stay	1,561.0 (4.3 yrs.)	1,778.0 (4.9 yrs.)	1,695.5 (4.6 yrs.)	2,068.5 (5.7 yrs.)	1,984.0 (5.4 yrs.)

[8] Totals are based on raw data, which have been rounded for display purposes.

Discharged Count	31	33	36	40	140

LPS patients can be discharged to a variety of locations. For the 140 LPS patients discharged in FY 2023-24 those locations are displayed in the table below.

Table 6: LPS Patient Discharges by Location[9]

Discharge Location	LPS FY 2023-24	MURCON FY 2023-24	Total FY 2023-24	Percent to Total
Community Outpatient Treatment	<11	<11	*******	***%
Deceased	13	0	**13**	9%
Discharged to Community	***	<11	**64**	46%
Locked Facility: CDCR, DJJ, Jail, Court, Other State Hospitals	***	<11	**21**	15%
Locked Medical Facility	25	0	**25**	18%
Other/Unknown	***	<11	*******	***%
Total Discharges	**124**	**16**	**140**	**100%**

[9] 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.

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 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 to determine whether a patient is a danger to the health and safety of others, due to their 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 their 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]

[1] Penal Code section 1606

DSH Treatment Continuum & Services

Because NGI patients tend to be severely mentally ill and their crimes involve severe violence, treatment requires substantial time resources. 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 the maximum term approaches and DSH does not feel discharge would be appropriate, the hospital can pursue an extension of the NGI sentence to extend the stay of the individual, pursuant to PC 1026.5. In fiscal year (FY) 2023-24, 367 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 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 designated patients are admitted to DSH due to severe mental illness and increased risk of violence, patients have the right to refuse treatment unless the Court finds the individual lacks capacity to make the decision; 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).

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

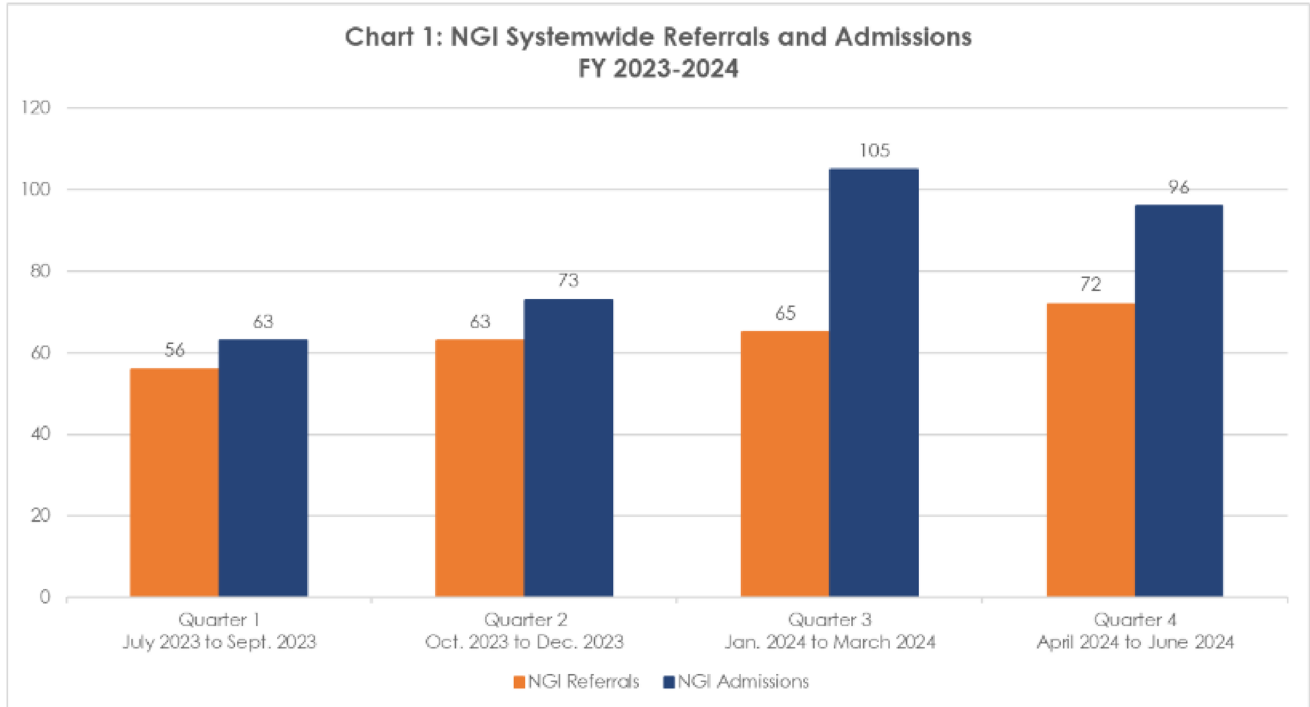
Across inpatient and outpatient programs, DSH treated 1,808 patients designated as NGI in FY 2023-24. The table below summarizes key statistics across the NGI population.

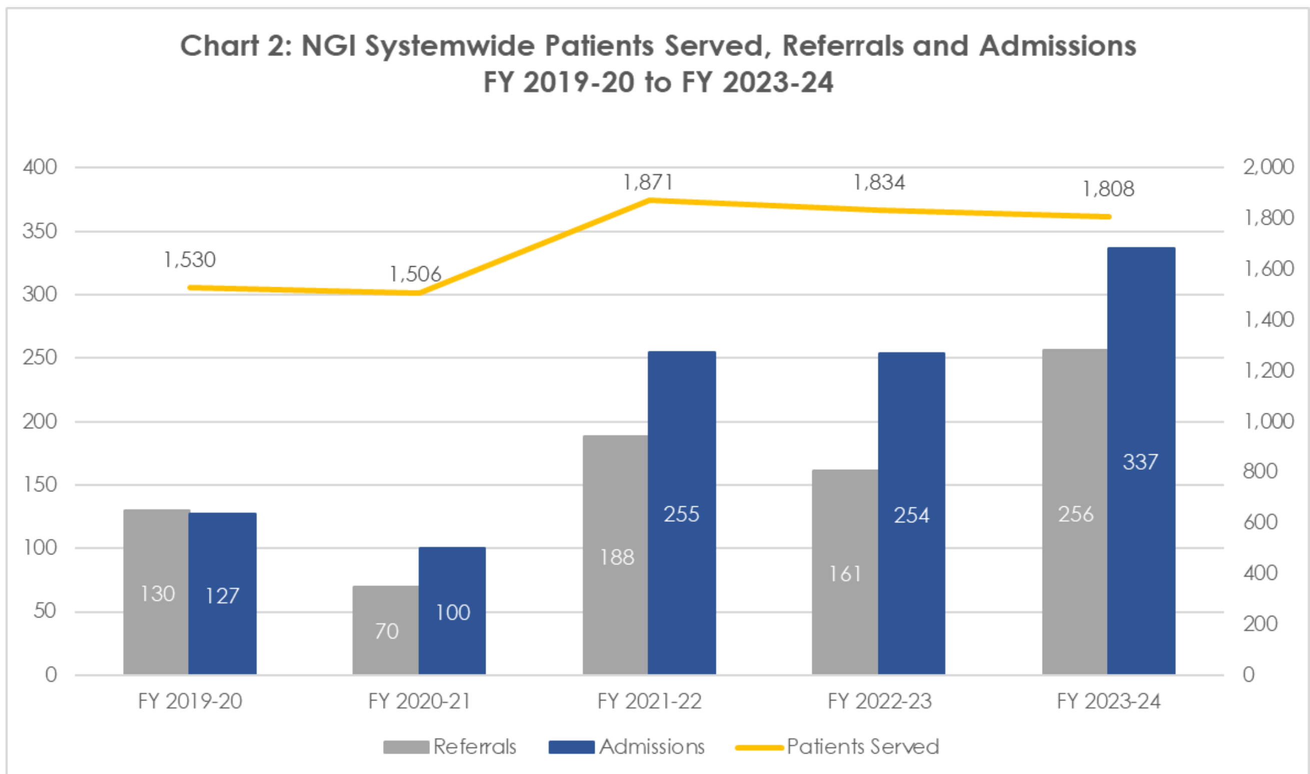
Table 1: System-wide NGI Patient Data Summary

NGI Patient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Referrals[2]	161	167	4%
Patient Admissions[3]	254	337	33%
Patients Served[4]	1,832	1,808	-1%
Average Daily Census	1,705	1,675	-2%

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

Chart 1 displays NGI system-wide referrals and admissions by quarter for FY 2023-24 and Chart 2 displays a five-year period of referrals and admissions for a broader historical view[5].





[5] Outpatient data is included beginning FY 2021-22 (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[6,7]

NGI Patients Pending Placement	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
	34	14	44	11	<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 2023-24, DSH inpatient programs treated on average 1,209 NGI designated patients daily, with an average census of 1,229 in July 2023, including a slight decrease of 1% across the year, ending with an average census of 1,211 patients in June 2024.

Table 3: NGI Inpatient Data Summary

NGI Inpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Admissions[8]	149	202	36%
Patients Served[9]	1,348	1,297	-4%
Average Daily Census	1,228	1,209	-2%

[6] The pending placement list reflects patients pending inpatient treatment.
[7] 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.
[8] Patient admissions include other inpatient and outpatient program transfers.
[9] Patients served excludes other inpatient and outpatient program transfers.

DSH Inpatient programs admitted 202 patients in FY 2023-24 with an average of 17 admissions per month. Chart 3 displays Inpatient program NGI admissions by quarter and the average monthly admissions rate.

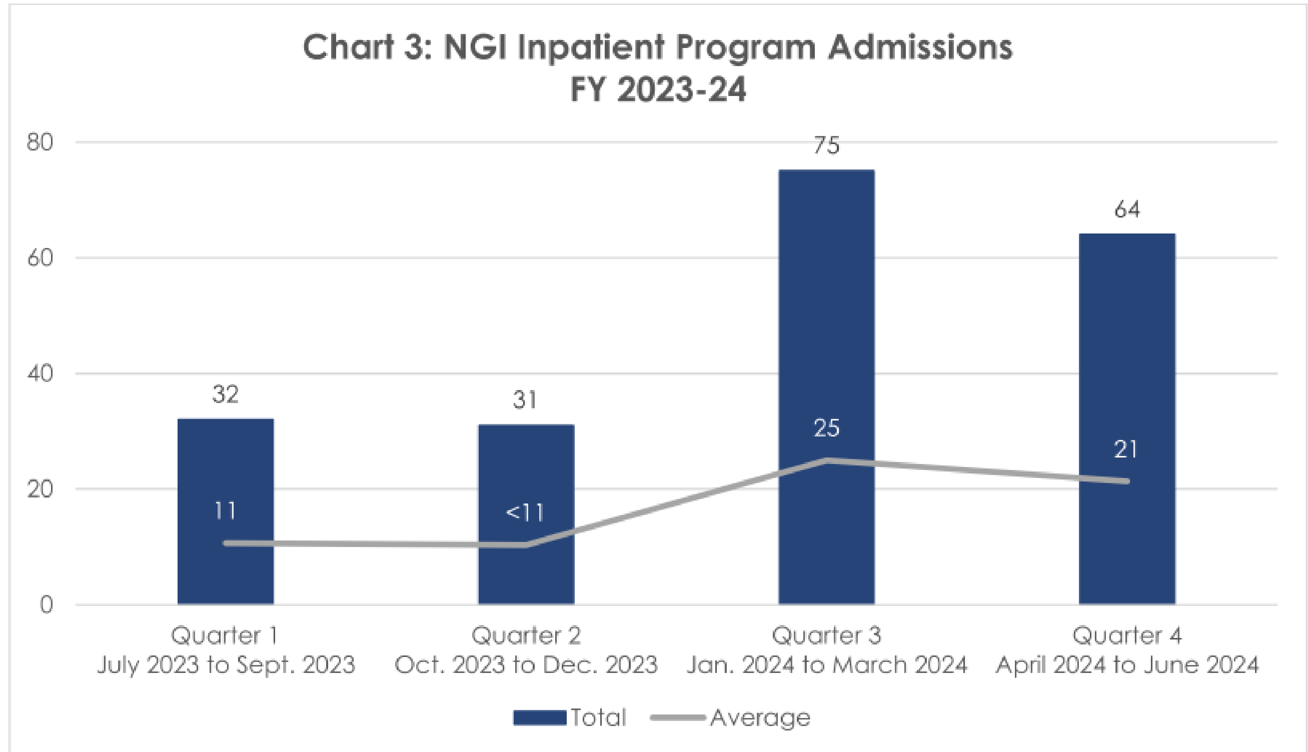


Table 4, below, displays the number of NGI patients treated in inpatient programs within each FY for the past five years.

Table 4: NGI Patients Served – Inpatient Programs[10]

Patients Treated/ Served	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
	1,530	1,506	1,406	1,348	1,297

Inpatient Discharge Data

DSH discharged 227 NGI designated patients from inpatient programs with an average length of stay of 3,110.5 days, 8.5 years, and a median length of stay of 2,120.0 days, over 5.5 years across all programs. Only 15% of the patients discharged within the first year of their stay, 43% discharged within the first five years of their stay, and 57% of the 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 2023-24 by length of stay.

[10] 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)	15%
366 - 1,460 Days (2 - 4 years)	22%
1,461 - 1,825 days (4 - 5 years)	6%
1,826 - 3,650 days (5 - 10 years)	26%
3,651+ days (10+ years)	31%

For patients yet to discharge the average days in treatment is 3,896.1 days, 10.7 years and median days in treatment is 2,421.0 days, 6.6 years.

Table 6 displays Inpatient programs length of stay by quarter.

Table 6: NGI Inpatient Length of Stay by Quarter – FY 2023-24

NGI Inpatient Length of Stay Days (Years)	Quarter 1 July 2023 to Sept. 2023	Quarter 2 Oct. 2023 to Dec. 2023	Quarter 3 Jan. 2024 to March 2024	Quarter 4 April 2024 to June 2024	Total[11] FY 2023-24
Average Length of Stay	3,001.1 (8.2 yrs.)	2,635.3 (7.2 yrs.)	3,859.2 (10.6 yrs.)	2,581.3 (7.1 yrs.)	3,110.5 (8.5 yrs.)
Median Length of Stay	2,319.0 (6.4 yrs.)	1,952.0 (5.3 yrs.)	2,931.0 (8.0 yrs.)	1,725.0 (4.7 yrs.)	2,120.0 (5.8 yrs.)
Discharged Count	46	45	77	59	227

NGI designated patients can be discharged to a variety of locations including outpatient treatment programs. The table below displays the discharge locations for the 227 patients discharged in FY 2023-24.

Table 7: NGI Inpatient Discharges by Location[12]

NGI Inpatient Discharge Location	NGI FY 2023-24	Percent to Total
Community Outpatient Treatment	67	30%
Locked Facility: CDCR, DJJ, Jail, Court, Other State Hospitals	97	43%
Discharged to Community	36	16%
Deceased	***	***%
Other/Unknown	<11	***%

[11] Totals are based on raw data, which have been rounded for display purposes.

[12] 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.

Total Discharges	**227**	**100%**

Outpatient Program Metrics

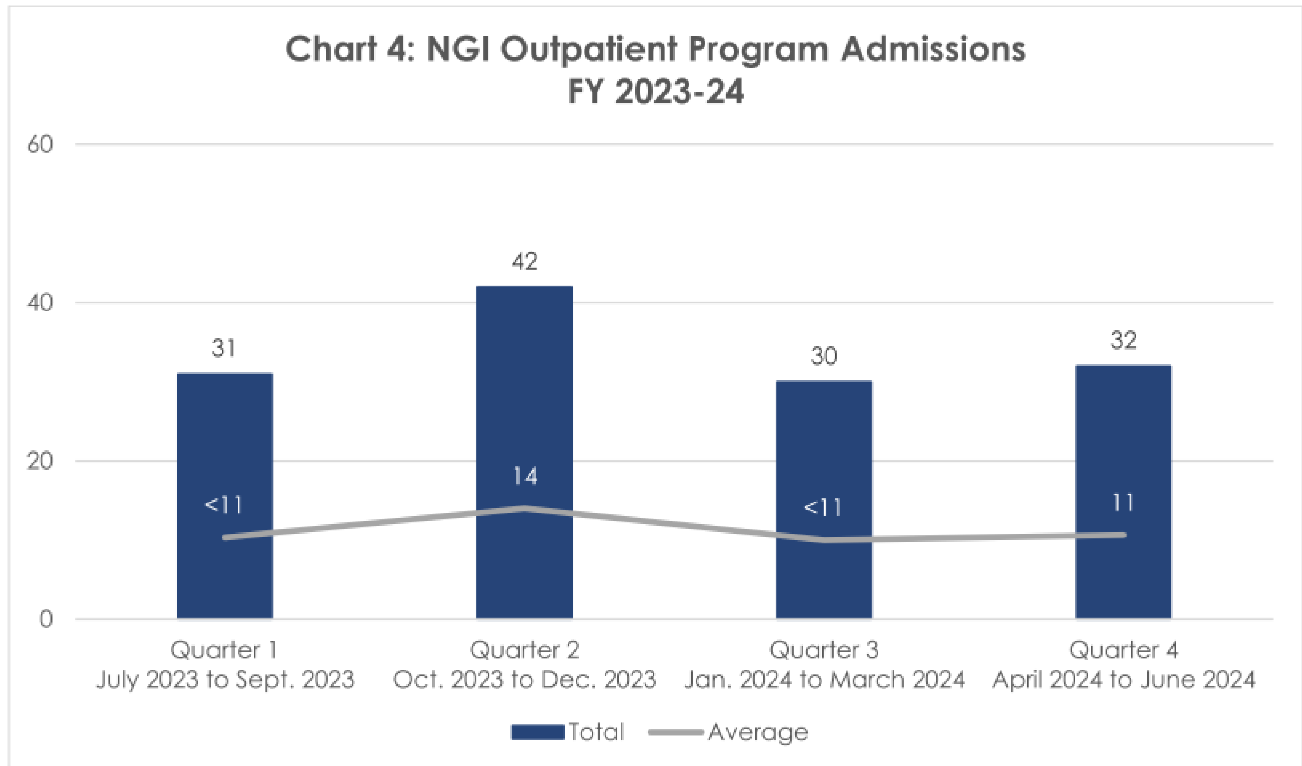
CONREP is the DSH outpatient treatment program for patients committed as NGI. During FY 2023-24, DSH CONREP treated on average 466 NGI designated patients daily, with an average census of 462 in July 2023, and an ending average census of 460 patients in June 2024.

Table 8: NGI Outpatient Data Summary

NGI Outpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY[13]
Patient Admissions[14]	105	135	29%
Patients Served[15]	484	511	6%
Average Daily Census	478	466	-2%

DSH outpatient programs admitted 135 NGI patients in FY 2023-24 with an average of 11 admissions per month. Chart 4 displays outpatient program NGI admissions by quarter.

[13] Percent change from prior fiscal year is based on raw data, which has been rounded to whole numbers for display purposes.
[14] Patient admissions include inpatient and outpatient program transfers.
[15] Patients served excludes inpatient and outpatient program transfers.



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

Table 9: NGI Patients Served – Outpatient Programs[16]

Patients Treated/Served	FY 2021-22	FY 2022-23	FY 2023-24
	465	486	511

Outpatient Discharge Data

DSH discharged 130 NGI patients from outpatient programs with an average length of stay of 1,296.3 days, approximately 4 years, and a median length of stay of 531.0 days, 1.5 years across all programs. 32% of NGI patients discharged within the first year of their stay, 82% of the NGI patients discharged within the first five years of their stay, and 18% 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 2023-24 by length of stay.

Table 10: NGI Outpatient Length of Stay Distribution

NGI Outpatient Length of Stay	% of Patients
0 - 365 Days (1 year)	32%
366 - 1,825 Days (2 - 5 years)	50%

[16] Patients served excludes inpatient and outpatient program transfers.

1,826 - 3,650 days (5 - 10 years)	9%
3,651+ days (10+ years)	9%

Table 11 displays outpatient length of stay by quarter for FY 2023-24.

Table 11: NGI Outpatient Length of Stay by Quarter – FY 2023-24

NGI Outpatient Length of Stay	**Quarter 1** July 2023 to Sept. 2023	**Quarter 2** Oct. 2023 to Dec. 2023	**Quarter 3** Jan. 2024 to March 2024	**Quarter 4** April 2024 to June 2024	**Total**[17] FY 2023-24
Average Length of Stay	1,335.6 (3.7 yrs.)	1,111.1 (3.0 yrs.)	1,161.7 (3.2 yrs.)	1,638.2 (4.5 yrs.)	1,296.3 (3.6 yrs.)
Median Length of Stay	938.0 (2.6 yrs.)	515.0 (1.4 yrs.)	387.0 (1.1 yrs.)	603.0 (1.7 yrs.)	531.0 (1.5 yrs.)
Discharged Count	27	39	33	31	130

[17] Totals are based on raw data, which have been rounded for display purposes.

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 the patient has a severe mental disorder, 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 – Supervised Persons Referred from CDCR
- PC 2964(a) – Supervised Persons Rehospitalized from Conrep after DSH hearing
- PC 2972 – Former Supervised Person Referred from Superior Court
- 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 two 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 supervised person) 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, as 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

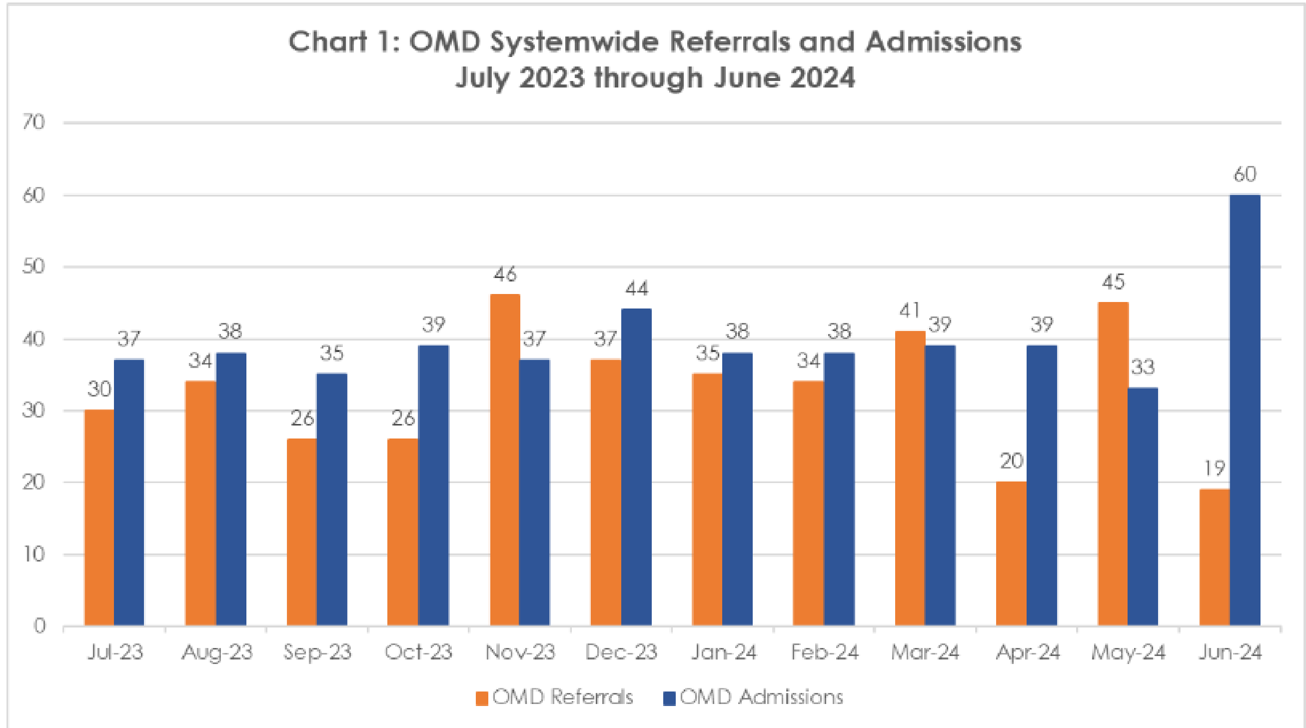
Across inpatient and outpatient programs, DSH treated 1,514 patients committed as OMD in fiscal year (FY) 2023-24. The table below summarizes key statistics across the OMD population.

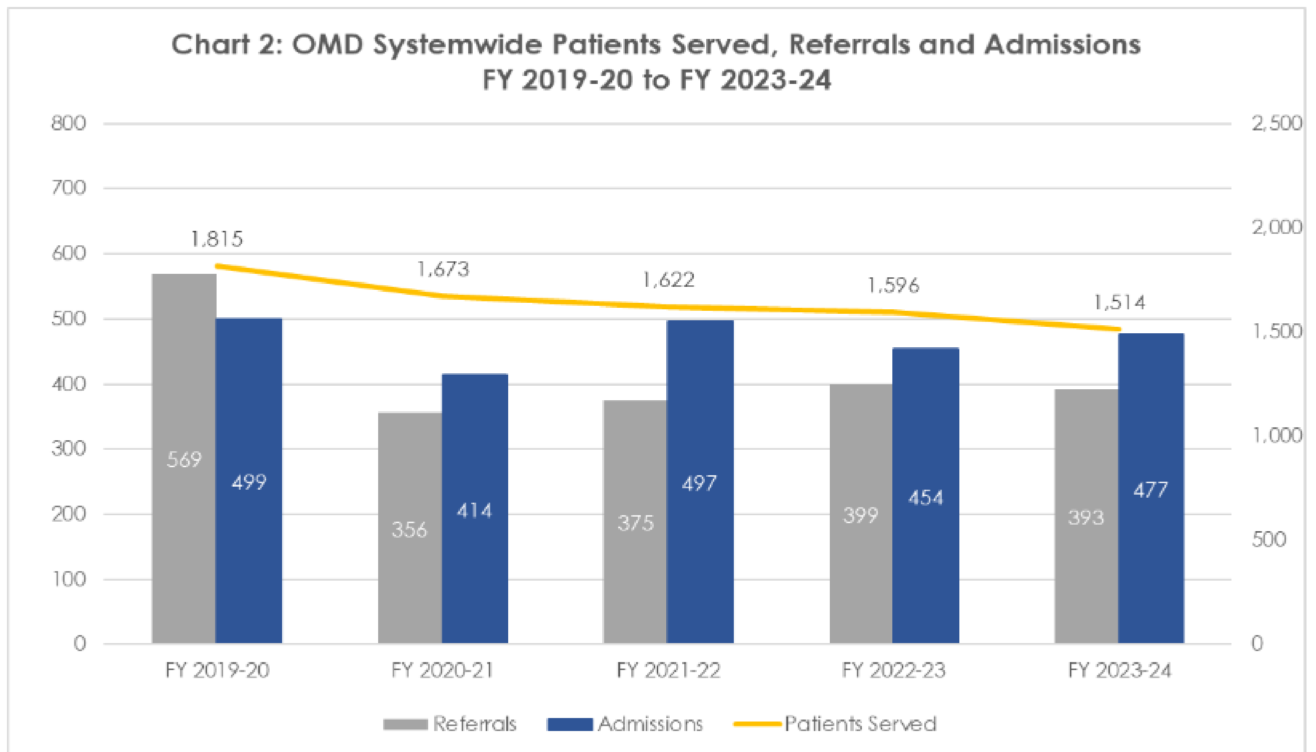
Table 1: System-wide OMD Patient Data Summary

OMD Patient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Referrals[2]	397	393	-1%
Patient Admissions[3]	454	477	5%
Patients Served[4]	1,596	1,514	-5%
Average Daily Census	1,224	1,272	4%

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

Chart 1 displays OMD system-wide referrals and admissions by month for FY 2023-24, and Chart 2 displays a five-year period of referrals and admissions for a broader historical view[5].





[5] 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 2023-24, the state hospitals treated an average of 1,112 OMD patients daily, with an average census of 1,138 in July 2023, and 1,076 in June 2024.

Table 2: OMD Inpatient Data Summary

OMD Inpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Admissions[6]	401	427	6%
Patients Served[7]	1,432	1,383	-3%
Average Daily Census	1,051	1,112	6%

DSH inpatient programs admitted 427 OMD patients in FY 2023-24 with an average of 36 admissions per month. Chart 3 displays Inpatient Program OMD admissions by quarter and the average monthly admissions rate.

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

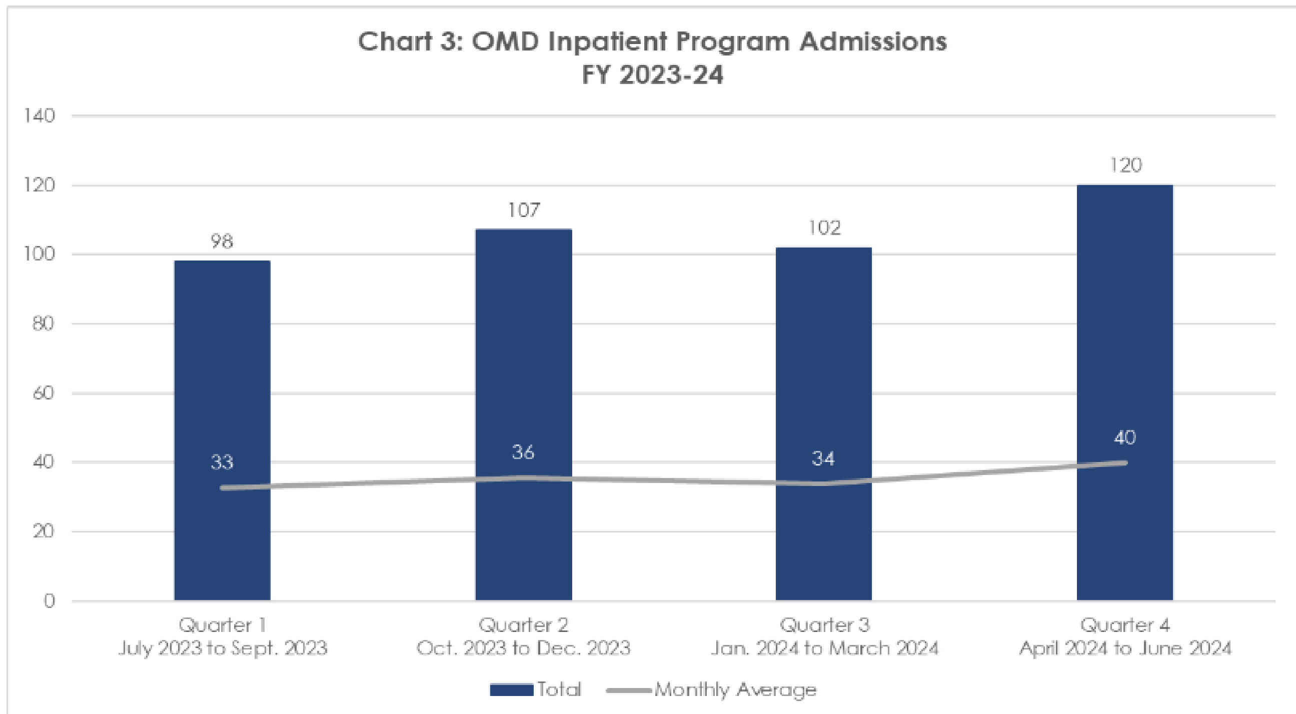


Table 3 displays the number of OMD patients treated in inpatient programs within each FY for the past five years.

Table 3: OMD Patients Served – Inpatient Programs[8]

Patients Treated/ Served	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
	1,815	1,673	1,478	1,430	1,383

PC 2962 Inpatient Data

Patients committed as PC 2962 make up 48% of the OMD patients treated within inpatient programs.

Table 4: PC 2962 Inpatient Data Summary

PC 2962 Inpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY[9]
Patient Admissions[10]	348	361	4%
Patients Served[11]	719	663	-8%
Average Daily Census	350	327	-6%

[8] Patients served excludes inpatient and outpatient program transfers.
[9] Percent change from prior fiscal year is based on raw data, which has been rounded to whole numbers for display purposes.
[10] Patient admissions include inpatient and outpatient program transfers.
[11] Patients served excludes inpatient and outpatient program transfers.

DSH discharged 318 PC 2962 patients from inpatient programs with an average length of stay of 276.1 days and a median length of stay of 144.5 days. 60% of PC 2962 patients discharged within the first 180 days of their stay, 72% of OMD patients discharged within the first year of their stay, 22% of the OMD patients discharged within the first two years of their stay, and only 7% 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 2023-24 by length of stay.

Table 5: PC 2962 Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 180 Days	60%
181 - 365 Days	12%
366 - 730 (1-2 yrs.)	22%
731 + (2+ yrs.)	7%

Table 6 displays inpatient programs length of stay for PC 2962 patients by quarter for FY 2023-24.

Table 6: PC 2962 Inpatient Length of Stay by Quarter – FY 2023-24

PC 2962 Inpatient Programs: Length of Stay	Quarter 1 July 2023 to Sept. 2023	Quarter 2 Oct. 2023 to Dec. 2023	Quarter 3 Jan. 2024 to March 2024	Quarter 4 April 2024 to June 2024	Total[12] FY 2023-24
Average Length of Stay	264.3	343.9	262.1	240.6	276.1
Median Length of Stay	140.0	181.0	147.0	141.5	144.5
Discharged Count	83	76	69	90	318

For PC 2962 patients yet to discharge the average days in treatment is 295.4 and median days in treatment is 208.

[12] Totals are based on raw data, which have been rounded for display purposes.

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 2023-24.

Table 7: PC 2962 Inpatient Discharges by Location[13]

PC 2962 OMD Inpatient Discharge Location	Total FY 2023-24	Percent to Total
Community Outpatient Treatment	<11	***%
Discharged to Community	276	87%
Locked Facility: CDCR, DJJ, Jail, Court, Other State Hospitals	18	6%
Deceased	<11	***%
Other/Unknown	***	***%
Total Discharges	**318**	**100%**

PC 2972 Inpatient Data

Patients committed as PC 2972 make up 52% of the OMD patients treated within inpatient programs.

Table 8: PC 2972 Inpatient Data Summary

PC 2972 Inpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Admissions[14]	53	66	25%
Patients Served[15]	713	720	1%
Average Daily Census	701	712	2%

DSH discharged 119 PC 2972 patients from inpatient programs with an average length of stay of 1,879.6 days (5.1 years) and a median length of stay of 1,261 days (3.5 years). 19% of PC 2972 patients discharged within one year, 60% of PC 2972 patients discharged within five years, 88% had a length of stay longer within ten years, and 12% of PC 2972 patients discharged has a length of stay ten years or longer. The table below depicts the distribution of PC 2972 patients discharged from inpatient treatment in FY 2023-24 by length of stay.

[13] 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.
[14] Patient admissions include inpatient and outpatient program transfers.
[15] Patients served excludes inpatient and outpatient program transfers.

Table 9: PC 2972 Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	19%
366 - 1,825 Days (2 - 5 years)	40%
1,826 - 3,650 days (5 - 10 years)	29%
3,651+ days (10+ years)	12%

Table 10 displays inpatient programs length of stay by quarter for FY 2023-24.

Table 10: PC 2972 Inpatient Length of Stay by Quarter – FY 2023-24

PC 2972 Inpatient Programs: Length of Stay Days (Years)	**Quarter 1** July 2023 to Sept. 2023	**Quarter 2** Oct. 2023 to Dec. 2023	**Quarter 3** Jan. 2024 to March 2024	**Quarter 4** April 2024 to June 2024	**Total**[16] FY 2023-24
Average Length of Stay	1,174.9 (3.2 yrs.)	1,342.4 (3.7 yrs.)	2,496.5 (6.8 yrs.)	2,079.7 (5.7 yrs.)	1,879.6 (5.1 yrs.)
Median Length of Stay	419.0 (1.1 yrs.)	1,079.0 (3.0 yrs.)	1,587.5 (4.3 yrs.)	1,952.0 (5.3 yrs.)	1,261.0 (3.5 yrs.)
Discharged Count	17	25	24	53	119

For PC 2972 patients yet to discharge the average days in treatment is 2,681.3 (7.3 years) and median days in treatment is 2,049.0 (5.6 years).

PC 2972 patients can be discharged to a variety of locations including outpatient treatment programs. Table 11 displays the discharge locations for the 119 patients discharged in FY 2023-24.

Table 11: PC 2972 Inpatient Discharges by Location[17]

PC 2972 OMD Inpatient Discharge Location	**Total** FY 2023-24	**Percent to Total**
Community Outpatient Treatment	***	***%
Deceased	<11	***%
Discharged to Community	32	27%
Locked Facility: CDCR, DJJ, Jail, Court, Other State Hospitals	56	47%
Other/Unknown	<11	***%
Total Discharges	**119**	**100%**

[16] Totals are based on raw data, which have been rounded for display purposes.
[17] 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.

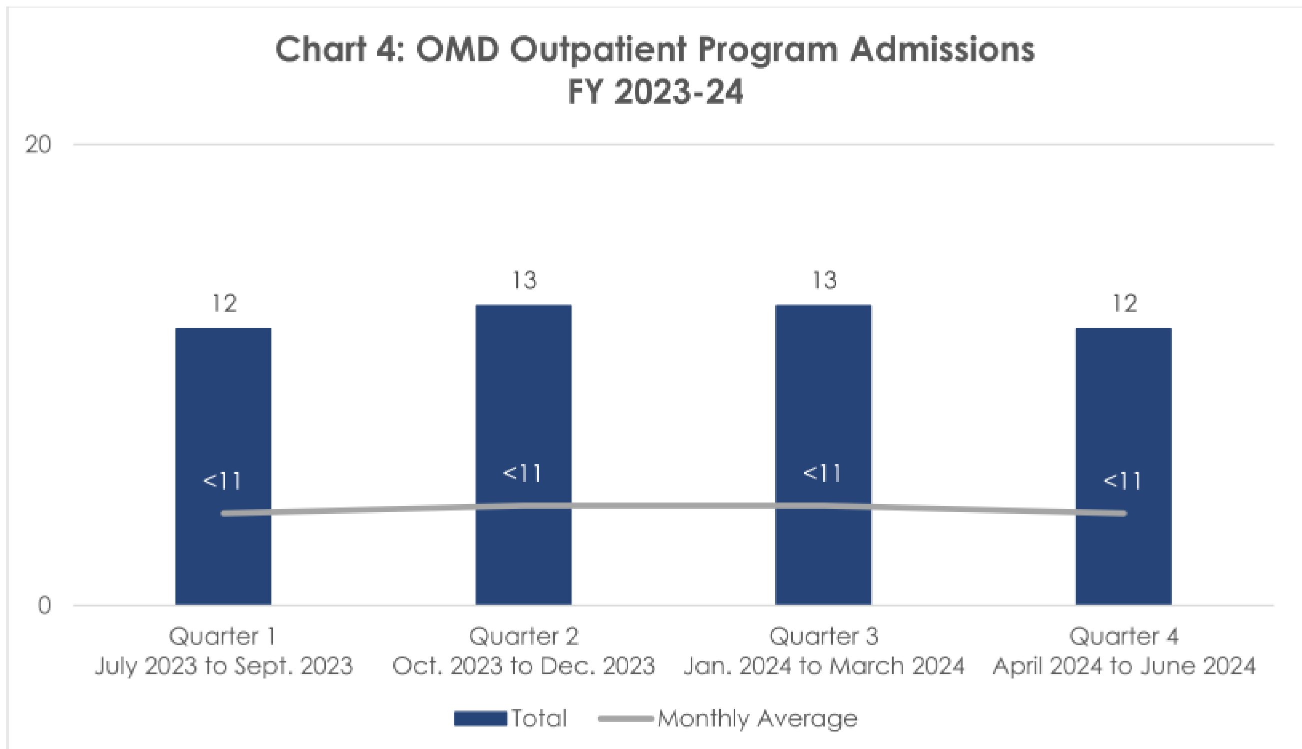
Outpatient Program Metrics

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 2023-24, DSH CONREP treated on average 160 OMD patients daily, with an average census of 161 in July 2023 and an ending average census of 159 patients in June 2024.

Table 12: OMD Outpatient Data Summary

OMD Outpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY[18]
Patient Admissions[19]	53	50	-6%
Patients Served[20]	164	131	-20%
Average Daily Census	173	160	-7%

DSH outpatient programs admitted 50 OMD patients in FY 2023-24 with an average of fewer than 11 admissions per month. Chart 4 displays outpatient program OMD admissions by quarter.



[18] Percent change from prior fiscal year is based on raw data, which has been rounded to whole numbers for display purposes.
[19] Patient admissions include inpatient and outpatient program transfers.
[20] Patient admissions include inpatient and outpatient program transfers. Patients served excludes 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[21]

	FY 2021-22	FY 2022-23	FY 2023-24
Patients Treated/Served	144	164	131

DSH discharged 48 OMD patients from outpatient programs with an average length of stay of 885.3 days (2.4 years) and a median length of stay of 406.5 days (1.1 years) across all outpatient programs. 35% of OMD patients discharged within one year, 75% of OMD patients discharged within 2.5 years, and 25% had a length of stay longer than 2.5 years. The table below depicts the distribution of OMD patients discharged from outpatient treatment in FY 2023-24 by length of stay.

Table 14: OMD Outpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	35%
366 - 913 Days (1 – 2.5 years)	40%
914+ Days (2.5+ years)	25%

Table 15 displays outpatient length of stay by quarter for FY 2023-24.

Table 15: OMD Outpatient Length of Stay by Quarter – FY 2023-24[22]

OMD Outpatient Programs: Length of Stay Days (Years)	**Quarter 1** July 2023 to Sept. 2023	**Quarter 2** Oct. 2023 to Dec. 2023	**Quarter 3** Jan. 2024 to March 2024	**Quarter 4** April 2024 to June 2024	**Total[23]** FY 2023-24
Average Length of Stay	458.2 (1.3 yrs.)	1,066.2 (2.9 yrs.)	512.9 (1.4 yrs.)	1,631.7 (4.5 yrs.)	885.3 (2.4 yrs.)
Median Length of Stay	517.0 (1.4 yrs.)	479.0 (1.3 yrs.)	384.0 (1.1 yrs.)	1,131.0 (3.1 yrs.)	406.5 (1.1 yrs.)
Discharged Count	<11	15	***	<11	48

[21] Patients served excludes inpatient and outpatient program transfers.
[22] 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.
[23] Totals are based on raw data, which have been rounded for display purposes.

POPULATION PROFILE
Sexually Violent Predator Patients

Description of Legal Class

The Department of State Hospitals (DSH) admits persons designated as Sexually Violent Predator (SVP) under Welfare and Institutions Codes (WIC) 6602 and 6604: Sexually Violent Predator. SVP commitments are civil commitments of prisoners 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.

SVP patients/inmates are screened by the California Department of Corrections and Rehabilitation (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 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 probably cause finding, a commitment trial is held and, if adjudged to be a SVP under WIC section 6604, the individual is committed to a state hospital for an indeterminate period of time. SVPs can petition for release; WIC 6604 SVP can be recommended for outpatient status by DSH or be found to no longer meet the SVP criteria by DSH.

Legal Statutes and Commitments

- WIC 6601.3 – Person designated as a Sexually Violent Predator BPH Hold
- WIC 6602 – Person designated as a Sexually Violent Predator Probable Cause
- WIC 6604 – Person designated as a Sexually Violent Predator
- PC 1610 – Pending revocation of a person designated as Sexually Violent Predator

Requirements for Discharge

Once a court determines a patient meets the criteria for an WIC 6604 SVP commitment, these patients undergo an annual review process where the patient's SVP status is evaluated. At that point, DSH may decide the patient is ready to be released into the community on a conditional release basis. A patient may have a hearing to determine whether they should be released from the hospital under

conditional release to the community or unconditional release to the community without supervision.

Unconditional releases occur when a court determines an individual no longer meets the legal criteria for SVP commitment. Conditional releases occur when a court determines the individual would not be a danger to the health and safety of others in that it is not likely that the person will engage in sexually violent criminal behavior due to the person's diagnosed mental disorder if under supervision and treatment in the community. If the patient is conditionally released, DSH's Forensic Conditional Release Program (CONREP) takes over the monitoring and supervision of the patient.

DSH Treatment Continuum & Services

Patients committed as SVP typically involve crimes with severe sexual violence and many have mental disorders not amenable to standard medication treatments, as such, treatment for SVP patients typically requires substantial time resources. Because of the risk to the community if an SVP patient is not treated effectively, 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 of the SVP patient's mental condition to the court 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. If the state hospital 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, a court hearing is held. SVP patients can also petition for a hearing.

Before being recommended for release, the SVP patient must demonstrate long-term stability and adherence to treatments, as well as demonstrate an understanding of their sexual violence risk factors and patterns of thinking that relate 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 might increase their sexual violence risk.

Programs

DSH provides treatment to SVP patients through inpatient care within state hospitals, at DSH-Coalinga (males) and DSH-Patton (females), and on an outpatient basis in CONREP.

DSH SVP 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. SVP patients are treated at Coalinga 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

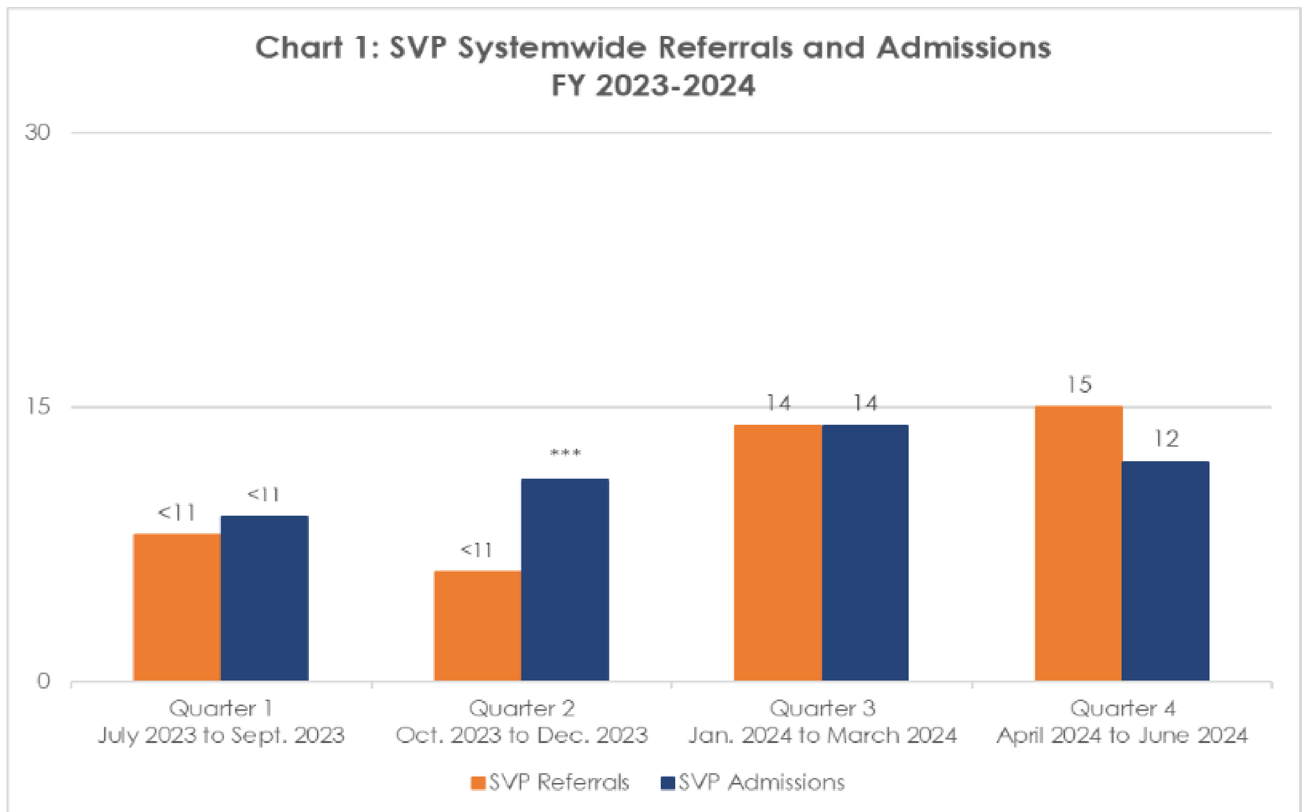
System-wide Metrics

In FY 2023-24, across inpatient and outpatient programs, DSH treated 1,015 patients designated as SVP; a decrease of 2% from prior year. DSH had an average daily census of 974 SVP patients during FY 2023-24 with no significant change from 976 SVP designated patients in July 2023, to 973 in June 2024. The table below summarizes key statistics across the SVP population.

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

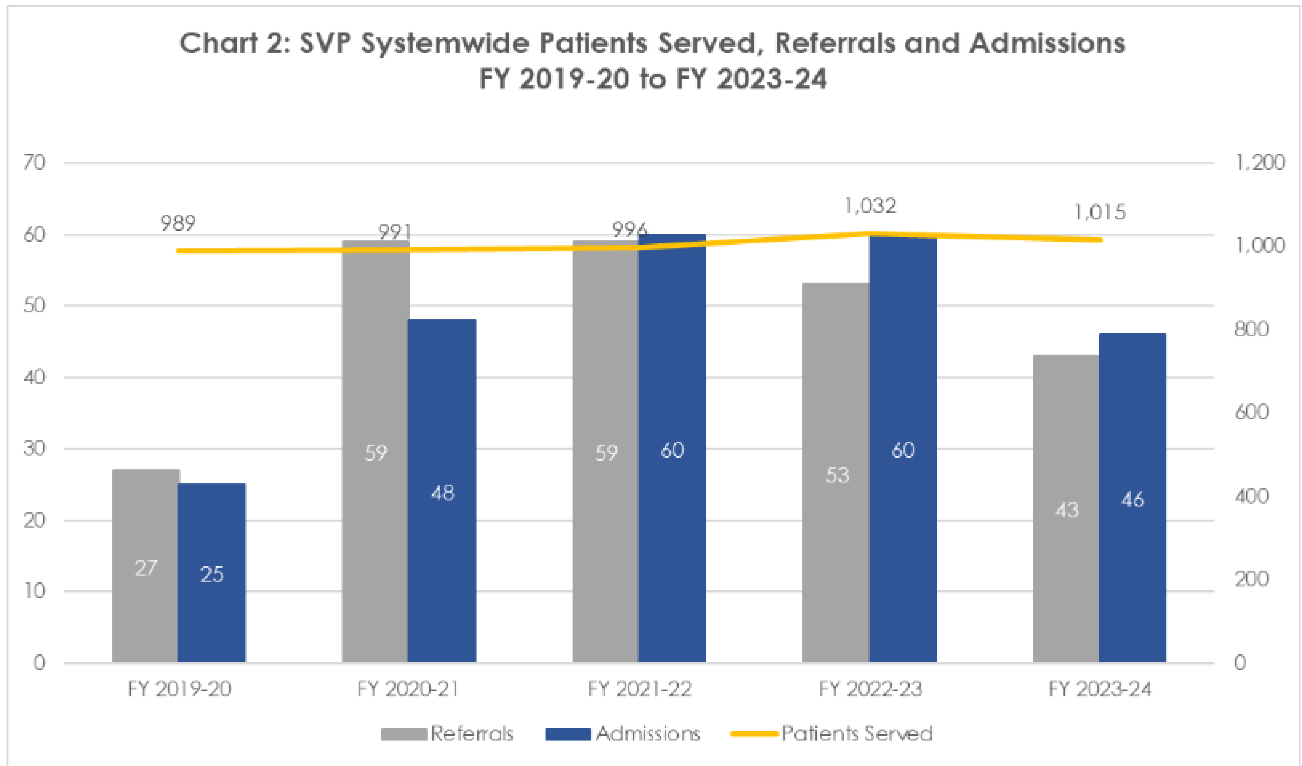
SVP Patient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Referrals[2]	53	40	-25%
Patient Admissions[3]	60	46	-23%
Patients Served[4]	1,032	1,015	-2%
Average Daily Census	977	974	0%

Chart 1[5] displays SVP system-wide referrals and admissions for FY 2023-24.



[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. Patients served excludes inpatient and outpatient program transfers.
[2] Patient referrals excludes inpatient program transfers and court returns.
[3] Patient admissions include inpatient and outpatient program transfers.
[4] Patients served excludes inpatient and outpatient program transfers.
[5] 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.

Chart 2 displays a five-year period of referrals and admissions for a broader historic view[6].



The DSH system-wide SVP Pending Placement List (PPL) decreased 36% from the prior FY. FY 2023-24 began with fewer than 11 SVP patients pending placement in July 2023 and a slight increase to fewer than 11 patients pending placement in June 2024. The table below identifies the SVP PPL as of June 30th of the corresponding year.

Table 2: System-wide SVP Pending Placement List[7]

SVP Patients Pending Placement	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
	<11	11	20	11	<11

Inpatient Program Metrics

Patients committed to DSH as SVP receive inpatient treatment at DSH-Coalinga. During FY 2023-24 DSH-Coalinga treated on average 955 SVP patients daily, maintaining a stable census across the FY. In July 2023 the average census was 956, decreasing slightly to 953 SVP patients in June 2024.

[6] Outpatient data is only included in FY 2021-22 and FY 2022-23 (Chart 2).
[7] The pending placement list reflects patients pending inpatient treatment.

Table 3: SVP Inpatient Data Summary[8]

SVP Inpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Admissions	57	43	-25%
Patients Served	1,013	997	-2%
Average Daily Census	956	955	0%

DSH Inpatient programs admitted 43 SVP patients in FY 2023-24. Chart 3 displays inpatient program SVP admissions by quarter and the average monthly admissions rate.

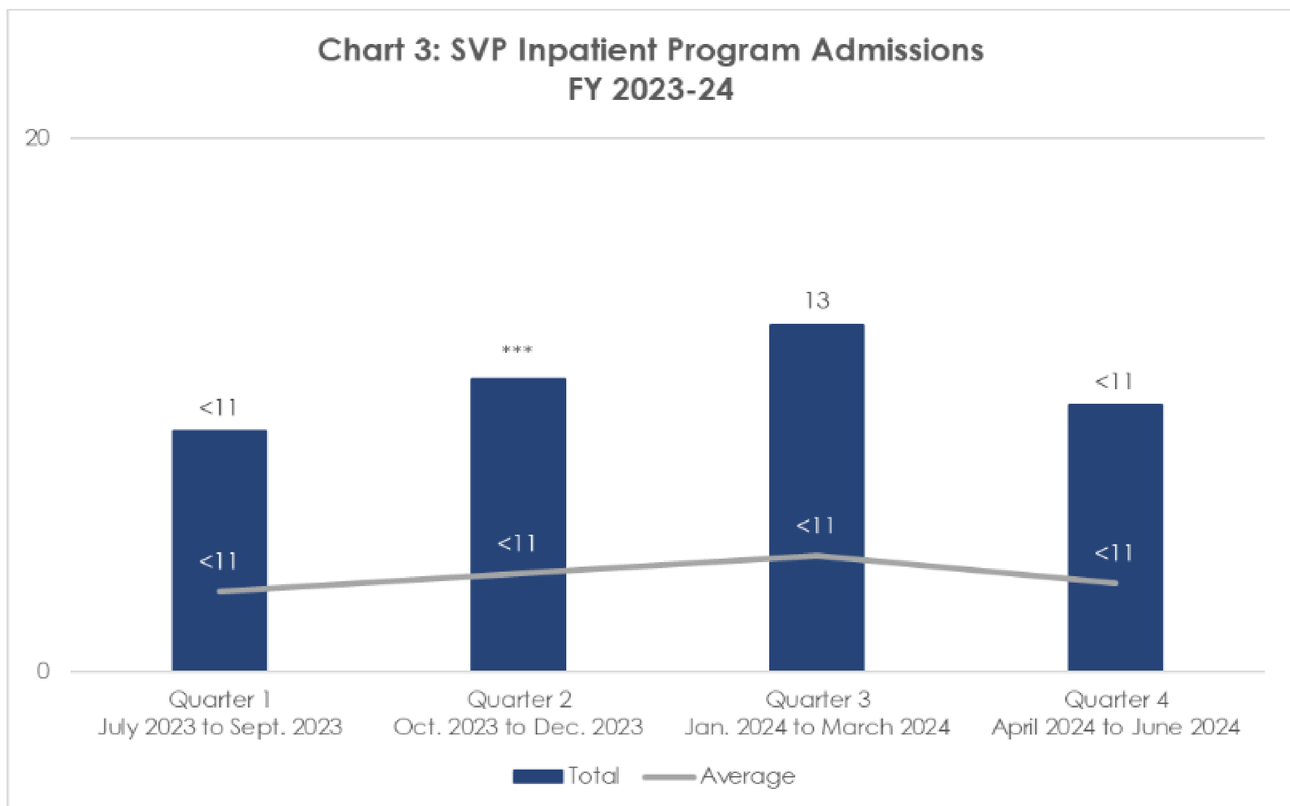


Table 4, below, displays the number of patients treated across the year.

Table 4: SVP Patients Served – Inpatient Programs[9]

Patients Treated/ Served	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
	989	991	981	1,013	997

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

WIC 6602 Inpatient Data

Patients committed pursuant to WIC 6602 make up 42% of the SVP patients treated within inpatient programs.

Table 5: WIC 6602 Inpatient Data Summary

WIC 6602 Inpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Admissions[10]	39	31	-21%
Patients Served[11]	449	418	-7%
Average Daily Census	400	382	-5%

DSH discharged 25 WIC 6602 patients from inpatient programs with an average length of stay of 4,315 days, approximately 12 years, and a median length of stay of 4,298 days, 11.8 years. 44% of WIC 6602 patients discharged within the fifteen and half years of their stay, and 56% had a length of stay longer than 15.5 years. The table below depicts the distribution of WIC 6602 patients discharged from inpatient treatment in FY 2023-24 by length of stay.

Table 6: WIC 6602 Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 – 5,658 Days (0 – 15.5 years)	44%
5,659+ Days (15.5+ years)	56%

Table 7 displays inpatient programs length of stay for WIC 6602 patients by quarter for FY 2023-24.

Table 7: WIC 6602 Inpatient Length of Stay by Quarter – FY 2023-24

6602 Inpatient Programs: Length of Stay Days (Years)	Quarter 1 July 2023 to Sept. 2023	Quarter 2 Oct. 2023 to Dec. 2023	Quarter 3 Jan. 2024 to March 2024	Quarter 4 April 2024 to June 2024	Total[12] FY 2023-24
Average Length of Stay	4,083.6 (11.2 yrs.)	4,134.4 (11.3 yrs.)	1,224.0 (3.4 yrs.)	4,902.4 (13.4 yrs.)	4,315.0 (11.8 yrs.)
Median Length of Stay	4,287.0 (14.3 yrs.)	4,239.0 (10.2 yrs.)	1,224.0 (13.6 yrs.)	5,302.0 (13.8 yrs.)	4,298.0 (13.0 yrs.)
Discharged Count	<11	<11	<11	<11	25

For WIC 6602 patients yet to discharge the average days in treatment is 2,906.7, 8 years and median days in treatment is 2,271.0, 6.2 years.

[10] Patient admissions include inpatient and outpatient program transfers.
[11] Patients served excludes inpatient and outpatient program transfers.
[12] Totals are based on raw data, which have been rounded for display purposes.

Table 8 displays the discharge locations for the 25 WIC 6602 patients discharged in FY 2022-23.

Table 8: WIC 6602 Inpatient Discharges by Location

6602 Inpatient Programs: Discharge Location	Total FY 2023-24	Percent to Total
Deceased	<11	***%
Discharged to Community[13]	15	60%
Other/Unknown	<11	***%
Total Discharges	**25**	**100%**

WIC 6604 Inpatient Data

Patients committed pursuant to WIC 6604 make up 58% of the SVP patients treated within inpatient programs.

Table 9: WIC 6604 Inpatient Data Summary

WIC 6604 Inpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Admissions[14]	18	12	-33%
Patients Served[15]	564	579	3%
Average Daily Census	557	573	3%

DSH discharged 21 WIC 6604 patients from inpatient programs with an average length of stay of 4,278.7 days, approximately 12 years, and a median length of stay of 5,189 days, 14.5 years. 67% 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 2023-24 by length of stay.

Table 10: WIC 6604 Inpatient Length of Stay Distribution[16]

Length of Stay	% of Patients
0 - 365 Days (1 year)	***%
366 - 1,460 Days (2 - 4 years)	***%
1,461 - 1,825 days (4 - 5 years)	0%

[13] Fewer than 11 patients were conditionally discharged, and the remaining were unconditional discharges.

[14] Patient admissions include inpatient and outpatient program transfers.

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

[16] NOTE: 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.

1,826 - 3,650 days (5 - 10 years)	***%
3,651+ days (10+ years)	67%

The table below displays the FY 2023-24 length of stay by quarter for WIC 6604 commitments discharged from inpatient programs in FY 2023-24.

Table 11: WIC 6604 Inpatient Length of Stay by Quarter – FY 2023-24[17]

6604 Inpatient Programs: Length of Stay Days (Years)	**Quarter 1** July 2023 to Sept. 2023	**Quarter 2** Oct. 2023 to Dec. 2023	**Quarter 3** Jan. 2024 to March 2024	**Quarter 4** April 2024 to June 2024	**Total[18]** FY 2023-24
Average Length of Stay	3,464.0 (9.5 yrs.)	5,394.2 (14.8 yrs.)	3,303.5 (9.1 yrs.)	5,729.5 (15.7 yrs.)	4,278.7 (11.7 yrs.)
Median Length of Stay	3,464.0 (9.5 yrs.)	6,446.0 (17.7 yrs.)	4,147.5 (11.4 yrs.)	6,400.0 (17.5 yrs.)	5,289.0 (14.5 yrs.)
Discharged Count	<11	<11	<11	<11	21

For WIC 6604 patients yet to discharge the average days in treatment is 4,896.5 days, or 13.4 years and the median days in treatment is 5,583.0 days, or 15.3 years.

The table below displays the discharge locations for the 21 WIC 6604 patients discharged in FY 2023-24.

Table 12: WIC 6604 Inpatient Discharges by Location[16]

6604 Inpatient Programs: Discharge Location	**Total** FY 2023-24	**Percent to Total**
Community Outpatient Treatment	<11	***%
Discharged to Community[19]	<11	***%
Deceased	***	***%
Total Discharges	**21**	**100%**

Outpatient Program Metrics

DSH SVP outpatient treatment programs are provided by CONREP. During FY 2023-24, DSH outpatient programs treated on average 19 SVP patients. In July 2023, the SVP patient average census was 20 with no change in June 2024.

[17] 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.
[18] Totals are based on raw data, which have been rounded for display purposes.
[19] Fewer than 11 patients were conditionally discharged to the community.

DSH outpatient programs admitted fewer than 11 SVP patients in FY 2023-24. Chart 4 displays outpatient program SVP admissions by quarter.

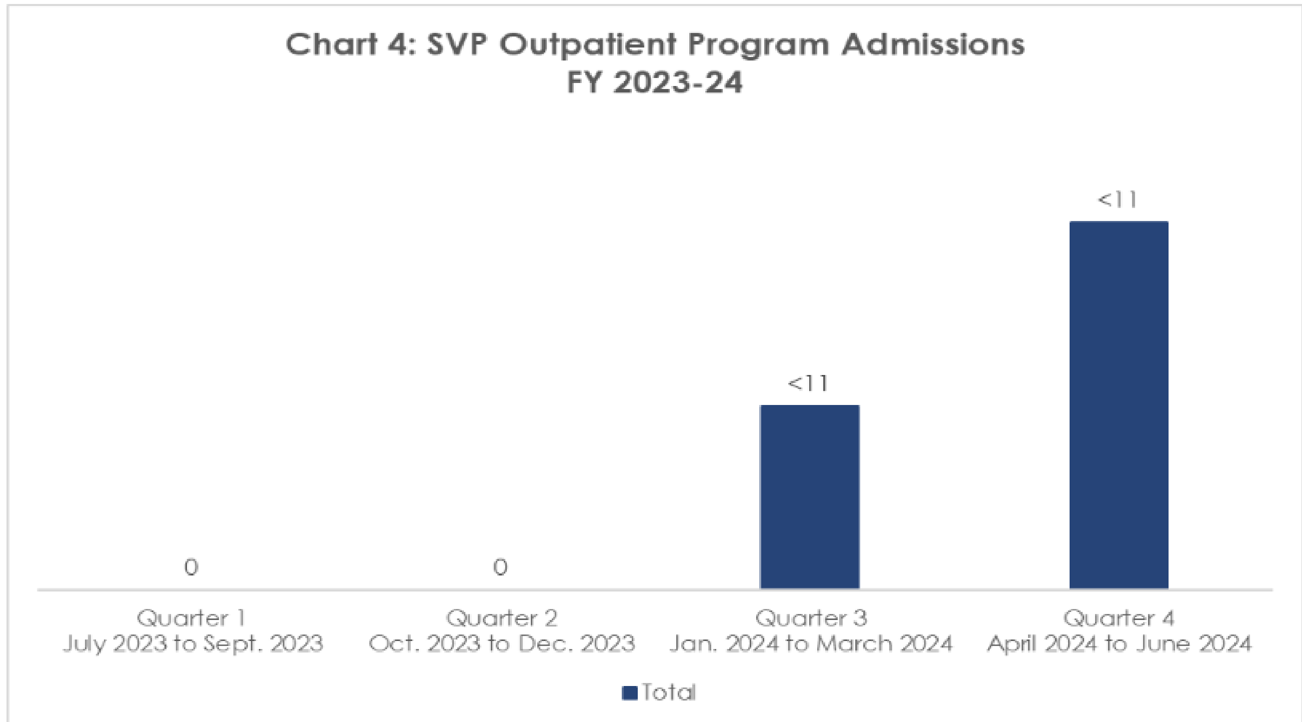


Table 13, below, displays the number of patients treated across the year in outpatient programs.

Table 13: SVP Patients Served – Outpatient Programs[20]

	FY 2021-22	FY 2022-23	FY 2023-24
Patients Treated/Served	15	19	18

DSH discharged fewer than 11 SVP patients from outpatient programs with an average length of stay of 1,631.4 days, 4.5 years and a median length of stay of 1,472 days, 4 years, across all programs. 100% of SVP patients discharged within the first five years of their stay. Table 14 displays outpatient length of stay by quarter.

Table 14: SVP Outpatient Length of Stay by Quarter – FY 2023-24

SVP Outpatient Programs: Length of Stay Days (Years)	**Quarter 1** July 2023 to Sept. 2023	**Quarter 2** Oct. 2023 to Dec. 2023	**Quarter 3** Jan. 2024 to March 2024	**Quarter 4** April 2024 to June 2024	**Total[21]** FY 2023-24
Average Length of Stay	0.0	1,266.0 (3.5 yrs.)	1,325.5 (3.6 yrs.)	2,120.0 (5.8 yrs.)	1,631.4 (4.5 yrs.)

[20] Patients served excludes inpatient and outpatient program transfers.
[21] Totals are based on raw data, which have been rounded for display purposes.

Median Length of Stay	0.0	1,266.0 (3.5 yrs.)	1,325.5 (3.6 yrs.)	2,120.0 (5.8 yrs.)	1,472.0 (4.0 yrs.)
Discharged Count	0	<11	<11	<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) 2023-24, DSH-Atascadero served 1,876 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 2,279 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 violence. 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 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 which 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 persons designated as sexually violent predators (SVP). 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) 2023-24, DSH-Coalinga served 1,466 patients. 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)
Persons Designated as 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 [1]	• Registered Nursing Programs Clinical Rotation • Nursing Students Preceptorship • 20/20 Registered Nurse Training Program
Pharmacy [2]	• Systemwide, DSH's pharmacy discipline is currently contracted with 10 pharmacy schools.
Psychiatric Technicians [3]	• Psychiatric Technician Trainee • Pre-Licensed Psychiatric Technicians • 20/20 Psychiatric Technician Training Program
Psychology	• American Psychological Association Approved Pre-Doctoral Internship
Rehabilitation Therapy [4]	• Recreation Therapy (Student Assistants) • Recreation Therapy Internship Program • Music Therapy (coming soon)
Social Work [5]	• Masters of Social Work Internships (Graduate Student Assistants)

[1] **Nursing:** Preceptorship for Bachelor of Science in Nursing (BSN) and Master of Science in Nursing (MSN) programs available on an individual basis. 20/20 Registered Nurse Training Program 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:** 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.

[4] **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.

[5] **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) 2023-24, DSH-Metropolitan served 2,268 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 2,255 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 one of the state hospitals offering 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

At DSH-Metropolitan, DBT is used 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 influences their attachment styles, coping mechanisms, and interpersonal relationships. Each patient who received individualized DBT 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
- 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.

Offender with a Mental Health Disorder (OMD) Program

The OMD Program is for patients paroled to the hospital by authority of the Board of Parole Hearings under 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 forensic 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 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.

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
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) 2023-24, DSH-Napa served 1,697 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

HOSPITAL STAFF

Approximately 2,663 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, 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 are 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 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, such as:
    - Dialectic Behavior Therapy (DBT) which 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 treatment
- 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 is 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 10 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 10 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.

[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). 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) 2023-24, DSH-Patton served 2,203 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 2,560 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, facility 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 (IST). These patients receive a specialized 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.

The focus of treatment for Offenders with a Mental Health Disorder (OMD) and Not Guilty by Reason of Insanity (NGI) populations emphasizes the potential for each patient to learn new skills and adaptive coping mechanisms to manage symptoms of a mental illness and enhance the patient's awareness and insight into symptoms that led to dangerousness in the past. Additional goals of treatment include enhancing the patient's motivation to actively engage in treatment, development of social skills, understanding co-occurring disorders, relapse prevention, increasing independence in Activities of Daily Living (ADL), targeting criminogenic risk factors to reduce recidivism, 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 safe, 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 in 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 violence. 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 for those patients that pose the highest risk of aggression. The pilot program was authorized by Assembly Bill 1340, which has been incorporated into California Health & Safety Code 1265.9. DSH-Patton's 10-bed unit is estimated for construction completion in April 2025.

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.

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 since 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 experienced the museum. The DSH-Patton Museum remains a valuable resource for state employees and members of the public by providing insight and information about a local institution with a history that exemplifies the progression of mental health treatment in America. As understanding evolves with ongoing reflection on the past, staff will continue to develop the museum and its exhibits. Future plans include a monument to acknowledge individuals who were sterilized while at, or living in, state-run hospitals, homes, and institutions.

Since its inception in 2015, the museum has been visited by thousands of people such as authors, historians, students, community members and mental health professionals.

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 has 12 units designated as acute. 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-Patton also has 21 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-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 10 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 10 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 2024-25

January 10, 2025

DIRECTOR
Stephanie Clendenin

EXECUTIVE SUMMARY

Pursuant of the Budget Act of 2024, 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 2024 which requires DSH to provide a year-end summary and an operating budget for each state hospital with the fiscal year (FY) 2025-26 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 2023-24 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 for individuals with complex behavioral health needs in a safe, equitable and responsible manner, by leading innovation and excellence across a continuum of care. 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 employees. 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 7,400 patients. In FY 2023-24, DSH served over 14,000 patients, with 9,510 served across the state hospitals, 1,881 in JBCT, 506 in CIF, 859 in CBR contracted programs, and 897 in CONREP programs. 11,897 individuals were treated within a DSH inpatient program and 2,117 were served through DSH's outpatient programs. Through Early Access Stabilization Services (EASS) and Re-Evaluation services, during FY 2023-24, DSH initiated services for 2,797 patients in EASS, and off ramped 198 through DSH's Re-Evaluation program. In addition, 249 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 November 1, 2024.

State Hospital	Authorized Positions[1]	Vacant as of 11/1/2024	Vacancy Percent[2]
Atascadero	2,285.90	557.00	24.4%
Coalinga	2,491.50	534.90	21.5%
Metropolitan	2,231.30	405.10	18.2%
Napa	2,651.20	693.00	26.1%
Patton	2,551.20	263.40	10.3%
Totals	**12,211.10**	**2,453.4**	**20.1%**

[1] Includes positions approved for Estimate Items Enhanced Treatment Program (21.0 in Patton) that will not be filled due to delays, which move the unit activation to June 2025. 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 2025-26 Governor's Budget Estimate.
[2] This report addresses authorized and temporary help positions only. The department also utilizes contracted registry positions to support patient care, when needed. For details regarding the utilization of contracted registry, please refer to the Functional Vacancy Report in Section A2 of the DSH 2025-26 Governor's Budget Estimate.

AUTHORIZED VERSUS VACANT POSITIONS BY CLASSIFICATION

As of November 1, 2024, DSH's vacancy rate is 20.1 percent. 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**	**Vacant**	**Authorized**	**Vacant**	**Authorized**	**Vacant**
Staff Psychiatrist	7619	33.0	21.0	26.3	18.3	50.3	23.3	55.4	4.7	66.5	19.3
Psychologist	9873	45.5	13.5	35.7	22.7	42.0	5.0	51.4	15.0	61.3	8.7
Senior Psychiatric Technician	8252	105.4	23.4	95.0	3.0	83.4	23.4	84.0	27.0	86.5	1.0
Rehabilitation Therapist	Various	54.4	14.4	46.0	9.0	60.0	17.8	69.1	9.1	73.3	12.3
Registered Nurse	8094	246.4	49.4	236.9	24.3	300.7	35.7	460.2	68.3	366.1	25.1
Clinical Social Worker	9872	50.3	20.3	46.8	20.8	64.7	19.7	62.2	8.7	74.0	9.0
Psychiatric Technician	8253	683.0	215.0	718.5	225.3	485.9	110.9	468.8	180.4	755.8	45.3
Physician/Surgeon	7552	17.5	1.0	25.2	17.2	25.4	2.0	26.8	0.1	31.0	1.0

[1] 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 2025-26 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 November 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 2023-24. For FY 2024-25 and FY 2025-26, 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]

		2023-24 Budget	2023-24 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$926,527,000	$906,658,000
	5100150-Earnings - Temporary Civil Service Employees	$35,497,000	$34,879,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$160,079,000	$157,198,000
Salaries and Wages Total		**$1,122,103,000**	**$1,098,735,000**
Staff Benefits	5150150-Dental Insurance	$1,127,000	$1,104,000
	5150200-Disability Leave – Industrial	$14,628,000	$14,341,000
	5150210-Disability Leave - Nonindustrial	$2,775,000	$2,694,000
	5150350-Health Insurance	$28,487,000	$27,851,000
	5150400-Life Insurance	$70,000	$70,000
	5150450-Medicare Taxation	$15,707,000	$15,376,000
	5150500-OASDI	$9,016,000	$8,808,000
	5150600-Retirement – General	$230,482,000	$225,284,000
	5150620-Retirement - Public Employees - Safety	$1,000	$1,000
	5150700-Unemployment Insurance	$506,000	$493,000
	5150750-Vision Care	$227,000	$222,000
	5150800-Workers' Compensation	$74,975,000	$73,285,000
	5150900-Staff Benefits – Other	$155,119,000	$151,759,000
Staff Benefits Total		**$533,120,000**	**$521,288,000**
Operating Expenses and Equipment	5301400-Goods – Other	$4,711,000	$4,608,000
	5302900-Printing – Other	$656,000	$644,000
	5304800-Communications – Other	$6,306,000	$6,216,000
	5306700-Postage – Other	$232,000	$227,000
	5308900-Insurance – Other	$1,112,000	$1,091,000
	5320490-Travel - In State – Other	$2,071,000	$2,028,000
	5320890-Travel - Out of State - Other	$3,000	$3,000
	5322400-Training - Tuition and Registration	$1,170,000	$1,148,000
	5324350-Rents and Leases	$34,939,000	$34,169,000
	5326900-Utilities – Other	$29,036,000	$28,472,000
	5340330-Consulting and Professional Services – Inter - Other	$4,769,000	$4,646,000
	5340580-Consulting and Professional Services - Ext - Other	$88,770,000	$85,923,000
	5344000-Consolidated Data Centers	$144,000	$136,000
	5346900-Information Technology - Other	$2,568,000	$2,541,000
	5368115-Office Equipment	$18,638,000	$18,339,000
	5390900-Other Items of Expense - Miscellaneous	$86,012,000	$83,958,000
	5415000-Claims Against the State	$142,000	$139,000
	5490000-Other Special Items of Expense	$3,089,000	$3,034,000
Operating Expenses and Equipment Total		**$284,368,000**	**$277,322,000**
Grand Total		**$1,939,591,000**	**$1,897,345,000**

[1]Budget and expenditure do not include reimbursements or reappropriations.

Exhibit I—Atascadero State Hospital[2&3]

		2023-24 Budget	2023-24 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$171,173,000	$159,640,000
	5100150-Earnings - Temporary Civil Service Employees	$5,128,000	$4,782,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$19,948,000	$18,604,000
Salaries and Wages Total		**$196,249,000**	**$183,026,000**
Staff Benefits	5150150-Dental Insurance	$180,000	$168,000
	5150200-Disability Leave - Industrial	$1,505,000	$1,404,000
	5150210-Disability Leave - Nonindustrial	$864,000	$806,000
	5150350-Health Insurance	$5,439,000	$5,073,000
	5150400-Life Insurance	$13,000	$13,000
	5150450-Medicare Taxation	$2,779,000	$2,591,000
	5150500-OASDI	$1,881,000	$1,754,000
	5150600-Retirement - General	$45,699,000	$42,620,000
	5150700-Unemployment Insurance	$102,000	$95,000
	5150750-Vision Care	$44,000	$41,000
	5150800-Workers' Compensation	$15,070,000	$14,054,000
	5150900-Staff Benefits - Other	$28,516,000	$26,594,000
Staff Benefits Total		**$102,092,000**	**$95,213,000**
Operating Expenses and Equipment	5301400-Goods - Other	$897,000	$836,000
	5302900-Printing - Other	$123,000	$115,000
	5304800-Communications - Other	$565,000	$527,000
	5306700-Postage - Other	$43,000	$40,000
	5308900-Insurance - Other	$120,000	$112,000
	5320490-Travel - In State - Other	$364,000	$339,000
	5322400-Training - Tuition and Registration	$159,000	$149,000
	5324350-Rents and Leases	$5,074,000	$4,732,000
	5326900-Utilities - Other	$3,417,000	$3,187,000
	5340330-Consulting and Professional Services – Inter - Other	$1,044,000	$973,000
	5340580-Consulting and Professional Services - Ext - Other	$32,094,000	$29,931,000
	5344000-Consolidated Data Centers	$113,000	$105,000
	5346900-Information Technology - Other	$167,000	$156,000
	5368115-Office Equipment	$1,432,000	$1,336,000
	5390900-Other Items of Expense - Miscellaneous	$17,284,000	$16,120,000
	5490000-Other Special Items of Expense	$268,000	$250,000
Operating Expenses and Equipment Total		**$63,164,000**	**$58,908,000**
Grand Total		**$361,505,000**	**$337,147,000**

[2]Budget and expenditure do not include reimbursements or reappropriations.
[3]Includes Hospital Police Academy.

Exhibit I—Coalinga State Hospital[4]

		2023-24 Budget	2023-24 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$173,535,000	$171,446,000
	5100150-Earnings - Temporary Civil Service Employees	$1,000,000	$990,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$31,198,000	$30,822,000
Salaries and Wages Total		**$205,735,000**	**$203,258,000**
Staff Benefits	5150150-Dental Insurance	$241,000	$238,000
	5150200-Disability Leave - Industrial	$4,230,000	$4,179,000
	5150210-Disability Leave - Nonindustrial	$732,000	$723,000
	5150350-Health Insurance	$5,747,000	$5,678,000
	5150400-Life Insurance	$16,000	$16,000
	5150450-Medicare Taxation	$2,870,000	$2,835,000
	5150500-OASDI	$2,037,000	$2,012,000
	5150600-Retirement - General	$49,758,000	$49,158,000
	5150620-Retirement - Public Employees - Safety	$1,000	$1,000
	5150700-Unemployment Insurance	$153,000	$151,000
	5150750-Vision Care	$45,000	$44,000
	5150800-Workers' Compensation	$13,692,000	$13,527,000
	5150900-Staff Benefits - Other	$29,848,000	$29,488,000
Staff Benefits Total		**$109,370,000**	**$108,050,000**
Operating Expenses and Equipment	5301400-Goods - Other	$682,000	$674,000
	5302900-Printing - Other	$87,000	$86,000
	5304800-Communications - Other	$1,759,000	$1,738,000
	5306700-Postage - Other	$39,000	$39,000
	5308900-Insurance - Other	$66,000	$65,000
	5320490-Travel - In State - Other	$473,000	$467,000
	5320890-Travel - Out of State - Other	$2,000	$2,000
	5322400-Training - Tuition and Registration	$171,000	$169,000
	5324350-Rents and Leases	$5,227,000	$5,164,000
	5326900-Utilities - Other	$6,366,000	$6,289,000
	5340330-Consulting and Professional Services – Inter - Other	$310,000	$306,000
	5340580-Consulting and Professional Services - Extl - Other	$56,517,000	$55,836,000
	5344000-Consolidated Data Centers	$1,000	$1,000
	5346900-Information Technology - Other	$15,000	$15,000
	5368115-Office Equipment	$3,147,000	$3,109,000
	5390900-Other Items of Expense - Miscellaneous	$26,584,000	$26,264,000
	5415000-Claims Against the State	$69,000	$68,000
	5490000-Other Special Items of Expense	$709,000	$700,000
Operating Expenses and Equipment Total		**$102,224,000**	**$100,992,000**
Grand Total		**$417,329,000**	**$412,300,000**

[4]Budget and expenditure do not include reimbursements or reappropriations.

Exhibit I—Metropolitan State Hospital[5]

		2023-24 Budget	2023-24 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$166,383,000	$165,206,000
	5100150-Earnings - Temporary Civil Service Employees	$6,345,000	$6,300,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$29,550,000	$29,341,000
Salaries and Wages Total		**$202,278,000**	**$200,847,000**
Staff Benefits	5150150-Dental Insurance	$229,000	$228,000
	5150200-Disability Leave - Industrial	$1,921,000	$1,907,000
	5150210-Disability Leave - Nonindustrial	$299,000	$296,000
	5150350-Health Insurance	$5,334,000	$5,296,000
	5150400-Life Insurance	$13,000	$13,000
	5150450-Medicare Taxation	$2,800,000	$2,780,000
	5150500-OASDI	$1,574,000	$1,562,000
	5150600-Retirement - General	$26,934,000	$26,743,000
	5150700-Unemployment Insurance	$22,000	$22,000
	5150750-Vision Care	$41,000	$41,000
	5150800-Workers' Compensation	$11,892,000	$11,807,000
	5150900-Staff Benefits - Other	$25,926,000	$25,743,000
Staff Benefits Total		**$76,985,000**	**$76,438,000**
Operating Expenses and Equipment	5301400-Goods - Other	$1,066,000	$1,059,000
	5302900-Printing - Other	$119,000	$118,000
	5304800-Communications - Other	$3,517,000	$3,493,000
	5306700-Postage - Other	$43,000	$42,000
	5308900-Insurance – Other	$471,000	$468,000
	5320490-Travel - In State – Other	$368,000	$365,000
	5322400-Training - Tuition and Registration	$261,000	$259,000
	5324350-Rents and Leases	$40,000	$40,000
	5326900-Utilities – Other	$5,304,000	$5,267,000
	5340330-Consulting and Professional Services – Inter - Other	$718,000	$713,000
	5340580-Consulting and Professional Services - Ext - Other	$75,000	$74,000
	5344000-Consolidated Data Centers	$11,000	$11,000
	5346900-Information Technology – Other	$2,250,000	$2,235,000
	5368115-Office Equipment	$7,932,000	$7,876,000
	5490000-Other Special Items of Expense	$255,000	$253,000
Operating Expenses and Equipment Total		**$22,430,000**	**$22,273,000**
Grand Total		**$301,693,000**	**$299,558,000**

[5]Budget and expenditure do not include reimbursements or reappropriations.

Exhibit I—Napa State Hospital[6]

		2023-24 Budget	2023-24 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$194,866,000	$190,388,000
	5100150-Earnings - Temporary Civil Service Employees	$7,547,000	$7,374,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$36,384,000	$35,548,000
Salaries and Wages Total		**$238,797,000**	**$233,310,000**
Staff Benefits	5150150-Dental Insurance	$260,000	$254,000
	5150200-Disability Leave - Industrial	$5,051,000	$4,935,000
	5150210-Disability Leave - Nonindustrial	$423,000	$413,000
	5150350-Health Insurance	$6,439,000	$6,291,000
	5150400-Life Insurance	$13,000	$13,000
	5150450-Medicare Taxation	$3,382,000	$3,304,000
	5150500-OASDI	$1,692,000	$1,653,000
	5150600-Retirement - General	$51,137,000	$49,962,000
	5150700-Unemployment Insurance	$165,000	$161,000
	5150750-Vision Care	$49,000	$48,000
	5150800-Workers' Compensation	$16,349,000	$15,973,000
	5150900-Staff Benefits - Other	$34,727,000	$33,929,000
Staff Benefits Total		**$119,687,000**	**$116,936,000**
Operating Expenses and Equipment	5301400-Goods - Other	$1,044,000	$1,020,000
	5302900-Printing - Other	$64,000	$63,000
	5304800-Communications - Other	$263,000	$257,000
	5306700-Postage - Other	$44,000	$43,000
	5308900-Insurance - Other	$395,000	$386,000
	5320490-Travel - In State - Other	$285,000	$278,000
	5322400-Training - Tuition and Registration	$319,000	$312,000
	5324350-Rents and Leases	$14,716,000	$14,378,000
	5326900-Utilities - Other	$9,005,000	$8,798,000
	5340330-Consulting and Professional Services – Inter - Other	$1,785,000	$1,744,000
	5340580-Consulting and Professional Services - External - Other	$84,000	$82,000
	5346900-Information Technology - Other	$33,000	$32,000
	5368115-Office Equipment	$4,554,000	$4,449,000
	5390900-Other Items of Expense - Miscellaneous	$22,507,000	$21,990,000
	5415000-Claims Against the State	$72,000	$70,000
	5490000-Other Special Items of Expense	$1,050,000	$1,026,000
Operating Expenses and Equipment Total		**$56,220,000**	**$54,928,000**
Grand Total		**$414,704,000**	**$405,174,000**

[6]Budget and expenditure do not include reimbursements or reappropriations.

Exhibit I—Patton State Hospital[7]

		2023-24 Budget	2023-24 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$220,570,000	$219,978,000
	5100150-Earnings - Temporary Civil Service Employees	$15,475,000	$15,433,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$42,999,000	$42,883,000
Salaries and Wages Total		**$279,044,000**	**$278,294,000**
Staff Benefits	5150150-Dental Insurance	$217,000	$216,000
	5150200-Disability Leave - Industrial	$1,921,000	$1,916,000
	5150210-Disability Leave - Nonindustrial	$457,000	$456,000
	5150350-Health Insurance	$5,528,000	$5,513,000
	5150400-Life Insurance	$15,000	$15,000
	5150450-Medicare Taxation	$3,876,000	$3,866,000
	5150500-OASDI	$1,832,000	$1,827,000
	5150600-Retirement - General	$56,954,000	$56,801,000
	5150700-Unemployment Insurance	$64,000	$64,000
	5150750-Vision Care	$48,000	$48,000
	5150800-Workers' Compensation	$17,972,000	$17,924,000
	5150900-Staff Benefits - Other	$36,102,000	$36,005,000
Staff Benefits Total		**$124,986,000**	**$124,651,000**
Operating Expenses and Equipment	5301400-Goods - Other	$1,022,000	$1,019,000
	5302900-Printing - Other	$263,000	$262,000
	5304800-Communications - Other	$202,000	$201,000
	5306700-Postage - Other	$63,000	$63,000
	5308900-Insurance - Other	$60,000	$60,000
	5320490-Travel - In State - Other	$581,000	$579,000
	5320890-Travel - Out of State – Other	$1,000	$1,000
	5322400-Training - Tuition and Registration	$260,000	$259,000
	5324350-Rents and Leases	$9,882,000	$9,855,000
	5326900-Utilities - Other	$4,944,000	$4,931,000
	5340330-Consulting and Professional Services – Inter - Other	$912,000	$910,000
	5344000-Consolidated Data Centers	$19,000	$19,000
	5346900-Information Technology - Other	$103,000	$103,000
	5368115-Office Equipment	$1,573,000	$1,569,000
	5390900-Other Items of Expense - Miscellaneous	$19,637,000	$19,584,000
	5415000-Claims Against the State	$1,000	$1,000
	5490000-Other Special Items of Expense	$807,000	$805,000
Operating Expenses and Equipment Total		**$40,330,000**	**$40,221,000**
Grand Total		**$444,360,000**	**$443,166,000**

[7]Budget and expenditure do not include reimbursements or reappropriations.

Exhibit II—All Hospitals[8]

	2024-25 Budget	2025-26 Budget	2024-25 Projected Expenditure	2025-26 Projected Expenditure
4410010-Atascadero	$402,547,000	$386,531,000	$398,522,000	$382,666,000
4410020-Coalinga	$423,195,000	$422,777,000	$418,963,000	$418,549,000
4410030-Metro	$268,006,000	$268,482,000	$265,326,000	$265,797,000
4410040-Napa	$417,592,000	$417,763,000	$413,416,000	$413,585,000
4410050-Patton	$451,044,000	$449,814,000	$446,534,000	$445,316,000
Grand Total	**$1,962,384,000**	**$1,945,367,000**	**$1,942,761,000**	**$1,925,913,000**

[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 2024 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 2025–26 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 2024–25 fiscal year, the projected attrition rate for the 2025–26 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 November 1, 2024:

HPO Authorized Positions[1] as of November 1, 2024				
Hospitals	Filled	Vacant	FTE[2]	Vacancy Rate
Atascadero	99.0	30.9	129.9	23.79%
Coalinga	185.0	36.0	221.0	16.29%
Metropolitan	112.0	24.3	136.3	17.83%
Napa	93.0	66.9	159.9	41.84%
Patton	66.0	3.0	69.0	4.35%
Total	**555.0**	**161.1**	**716.1**	**22.50%**

Hospital Police Officer Attrition Rate

The table below displays the projected HPO attrition rates as of November 1, 2024, based on actual attrition rates and trends for fiscal years (FYs) 2022-23, 2023-24, and 2024-25:

[1] Only includes classification 1937 – Hospital Police Officer
[2] Authorized Positions as of November 2024

HPO Attrition Rates as of November 1, 2024					
Hospitals	FY 2024-25 FTE[3]	FY 2024-25 Attrition Rate[4]	Average Estimated Monthly Positions	FY 2025-26 Attrition Rate[5]	Average Estimated Monthly Positions
Atascadero	129.9	1.57%	2.0	1.44%	1.9
Coalinga	221.0	0.41%	0.9	0.42%	0.9
Metropolitan	136.3	0.85%	1.2	0.75%	1.0
Napa	159.9	0.39%	0.6	0.62%	1.0
Patton	69.0	1.44%	1.0	1.24%	0.9
Total	**716.1**	**0.80%**	**5.7**	**0.80%**	**5.7**

Cadet Graduation Rates

The table below displays actual graduation rates from cohorts conducted from FY 2021-22 through the present:

OPS Cadet Graduation Rates				
Academy	Academy Dates	Cadets Attended	Cadets Graduated	Graduation Rate
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%

[3] Authorized Positions as of November 2024
[4] Projected attrition rate based on FY 2022-23, 2023-24, and 2024-25 data
[5] Projected attrition rate based on FY 2023-24, 2024-25, and 2025-26 data

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	(12/28/23 – 04/16/24)	9	8	88.9%
Academy 45	(04/29/24 – 08/13/24)	19	16	84.2%
Academy 46	(08/26/24 – 12/11/24)	14	10[6]	71.4%
	Total	**178**	**139**	**78.1%**

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 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 December 1, 2024, 3,850 candidates have taken and completed the online exam, and 3,195 have 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 significantly 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.

[6] Reflects cadets scheduled to graduate
[7] Data from January 2, 2023, to August 2, 2023

STATE HOSPITALS
ENHANCED TREATMENT PROGRAM (ETP) STAFFING
An Annual Report to the Fiscal and Policy Committees of the Legislature in Accordance with Section 4145(a) of the Welfare and Institutions Code (WIC)
Informational Only

EXECUTIVE SUMMARY

The Department of State Hospitals (DSH) was authorized by Assembly Bill 1340 (Achadjian, Statutes of 2014) to establish pilot Enhanced Treatment Programs (ETP) for patients determined to be at the highest risk for dangerous behavior against other patients and hospital staff and who cannot be safely treated in a standard treatment environment. The ETP provides treatment with the intent to return patients to a standard treatment environment with supports to prevent future aggression, increase safety, and protect patients and staff from harm.

DSH was originally authorized to establish four ETP units, totaling 49 beds. Three 13-bed units were to be provided at DSH-Atascadero, and one 10-bed treatment unit would be at DSH-Patton. One unit at DSH-Atascadero began admitting patients on September 14, 2021. As the remaining three units are not yet completed or activated, this report covers activity for the operation of the first activated ETP unit at DSH-Atascadero, in accordance with reporting requirements established in AB 1340.[1]

The current reporting period ranges from October 1, 2023, to September 30, 2024. For comparison, the report also presents cumulative data from activation of the ETP on September 14, 2021, up to the end of end current reporting period. The data reflects patient characteristics including gender, ethnicity, age on admission, legal group, and years at DSH. Data also includes information on staffing requirements, staff-to-patient ratios, as well as staff turnover. Data on restraint and seclusion use and serious injuries is also provided. The report also includes information regarding patients' rights complaints received as provided by the Disability Rights California, California Office of Patients' Rights, and the resolution to these issues. Finally, the report includes information regarding training provided to ETP staff, as well as the training offered to staff who are primarily assigned to other units but could be asked to provide support in the ETP.

Recommendations based on the findings are outlined at the conclusion of this report.

[1] Status updates on the construction and activation of each unit is provided in DSH's annual Governor's Budget and May Revision Population and Caseload Estimates (see Section C3).

BACKGROUND

Assembly Bill 1340 (Achadjian, Statutes of 2014) authorized DSH to establish a pilot ETP for those patients determined to be at highest risk for dangerous behavior against other patients and hospital staff, and who cannot be safely treated in a standard treatment environment. The ETP provides treatment and support intended to return patients to a standard treatment environment and prevent future aggression, while increasing safety in the facility and protecting patients and staff from harm. As such, the ETP provides enhanced treatment, staffing, security, and implements admissions and treatment planning processes to identify and address patients' violence risk factors.

This report covers program activity since activation of the first activated ETP unit at DSH-Atascadero, in accordance with reporting criteria established in AB 1340. Specifically, Section 4145 of the Welfare and Institutions Code reads:

> *4145. (a) The State Department of State Hospitals shall monitor the pilot enhanced treatment programs (ETP), evaluate outcomes, and report on its findings and recommendations. This report shall be provided to the fiscal and policy committees of the Legislature annually, beginning on January 10 of the first year after which the first ETP is opened and services have commenced, and shall be in compliance with Section 9795 of the Government Code. The evaluation shall include, but is not limited to, all of the following:*
>
> *(1) Comparative summary information regarding the characteristics of the patients served.*
> *(2) Compliance with staffing requirements.*
> *(3) Staff classification to patient ratio.*
> *(4) Average monthly occupancy.*
> *(5) Average length of stay.*
> *(6) The number of residents whose length of stay exceeds 90 days.*
> *(7) The number of patients with multiple stays.*
> *(8) The number of patients whose discharge was delayed due to lack of available beds in a standard treatment environment.*
> *(9) Restraint and seclusion use, including the number of incidents and duration, consistent with paragraph (3) of subdivision (d) of Section 1180.2 of the Health and Safety Code.*
> *(10) Serious injuries to staff and residents.*
> *(11) Serious injuries to staff and residents related to the use of seclusion and restraints as defined under Section 1180 of the Health and Safety Code.*
> *(12) Staff turnover.*
> *(13) The number of patients' rights complaints, including the subject of the complaint and its resolution.*
> *(14) Type and number of trainings provided for ETP staff.*

(15) Staffing levels for ETPs.

In response to the reporting requirements as identified in Section 4145, DSH has established data tracking and collection methodologies to capture the information required. This report details the methodology used and describes the data captured for the collection period ending on September 30, 2024. The data contained in this report is limited to what is permitted under the Health Insurance Portability and Accountability Act (HIPAA), and state privacy laws, when disclosure of health information is required by law.

I. Methodology

This current reporting period ranges from October 1, 2023, to September 30, 2024. Data from the current reporting period will be presented alongside cumulative data collected throughout activation of the ETP, beginning September 14, 2021, through September 30, 2024. The data included in this report 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.

Existing DSH enterprise data collection practices were relied upon for reporting of items identified in Section 4145(a) (1-12) and (14-15). The requested information was operationalized considering current DSH policy and procedures related to data collection and verification. Data was collected using existing software and was independently verified using tracking sheets developed specifically for this reporting requirement.

Data related to Section 4145(a)(13) was provided by the Disability Rights California, California Office of Patients' Rights. DSH contracts with the California Office of Patients' Rights, a Disability Rights California unit, to provide patients' rights advocacy services at the state hospitals.

II. Summary of Data

Patient Characteristics

Gender	Reporting Period 10/1/23 to 9/30/24	Cumulative 09/13/21 to 9/30/24
Male	<11 (100%)[a]	28 (100%)[b]
Female[c]	0 (0%)	0 (0%)

[a] Admissions during this reporting period.
[b] Total patients served on the ETP.

[c] The DSH-Patton ETP unit designed to serve female patients is under construction.

Ethnicity	Reporting Period 10/1/23 to 9/30/24	Cumulative 9/13/21 to 9/30/24	DSH[a]	CA[b]
	N (%)	N (%)	%	%
Asian	0 (%)	<11 (***%)	4%	17%
Black or African American	<11 (***%)	<11 (***%)	25%	7%
Hispanic or Latino	<11 (***%)	<11 (***%)	28%	40%
White	0 (0%)	<11 (***%)	40%	34%
Other/Unknown	<11 (***%)	<11 (***%)	3%	3%

[a] DSH resident census as of 9/30/2024.
[b] CA census population estimates as of July 1, 2023. DP05: ACS Demographic - Census Bureau Table

Age	Reporting Period 10/1/23 to 9/30/24	Cumulative 9/13/21 to 9/30/24	DSH[a]
	N (%)	N (%)	N (%)
18-29	<11 (***%)	<11(***%)	474 (9%)
30-41	<11 (***%)	*** (***%)	1520 (27%)
42-53	<11 (***%)	13 (49%)	1339 (24%)
54-65	0 (0%)	0 (0%)	1366 (25%)
66-77	0 (0%)	0 (0%)	758 (14%)
78-90	0 (0%)	0 (0%)	*** (***%)
91+	0 (0%)	0 (0%)	<11 (***%)
Mean Age (years)	37.22	39.68	49.15

[a] DSH patient census as of 9/30/2024.

Legal Group	Reporting Period 10/1/23 to 9/30/24	Cumulative 9/13/21 to 9/30/24	DSH[a]
	N (%)	N (%)	N (%)
Incompetent to Stand Trial	<11 (***%)	<11 (***%)	1682 (30%)
Not Guilty by Reason of Insanity	<11 (***%)	<11 (***%)	1210 (22%)
Offender with a Mental Disorder	<11 (***%)	<11 (***%)	1019 (18%)
Lanterman-Petris- Short Act	<11 (***%)	13 (46%)	553 (10%)
Sexually Violent Predator	0 (0%)	<11 (***%)	949 (17%)
Coleman[b]	0 (0%)	0 (0%)	157 (3%)

[a] DSH patients' information on census as of 9/30/2024.
[b] Per Enhanced Treatment Program Emergency Regulations (California Code of Regulations, Title 9, Division 1, Chapter 17, Article 2, Section 4900), a patient may be referred to the Enhanced Treatment Program if there is no existing contract or memorandum of understanding that provides alternative and clinically appropriate treatment outside of DSH. *Coleman* patients are eligible for treatment in the CDCR Psychiatric Inpatient Programs.

Years at DSH – Current Admission[a,b]	Reporting Period 10/1/23 to 9/30/24	Cumulative 9/13/21 to 9/30/24	DSH[c]
	N (%)	N (%)	N (%)
0-5	14 (67%)	19 (68%)	3647 (65%)
6-10	<11 (***%)	<11 (***%)	700 (13%)
11-15	<11 (***%)	<11 (***%)	480 (9%)
16-20	<11 (***%)	<11 (***%)	435 (8%)
21-24	<11 (***%)	<11 (***%)	121 (2%)
25+	0 (0%)	0 (0%)	187 (3%)
Mean:	5.21	5.52	5.97

[a] This data captures years at DSH *prior* to ETP Admission.
[b] "Current Admission" includes hospital years during most recent commitment that did not result in a discharge from DSH.
[c] DSH patients' information on census as of 9/30/2024.

Years at DSH – Overall[a,b]	Reporting Period 10/1/23 to 9/30/24	Cumulative 9/13/21 to 9/30/24
	N (%)	N (%)
0-5	11 (52%)	13 (46%)
6-10	<11 (***%)	<11 (***%)
11-15	<11 (***%)	<11 (***%)
16-20	<11 (***%)	<11 (***%)
21-24	<11 (***%)	<11 (***%)
25+	0 (0%)	0 (0%)
Mean:	7.81	8.53

[a] This data captures years at DSH *prior* to ETP Admission.
[b] "Overall" includes hospital years during all DSH commitments. Individuals committed to DSH may have had multiple commitment periods during their lifetime.

All patients (residents) currently or formerly admitted to the ETP are male. A unit that can accommodate female patients is currently under construction with an estimated activation in mid-2025. ETP patients' (residents) mean age is 39.68 years, which is about 8.5 years below the DSH wide age average. ETP patients (residents) come from Asian, Black or African American, Hispanic or Latino, White, and Other or Unknown ethnic backgrounds. The ethnic distribution of the total ETP patients served (residents) generally aligns with DSH patient mix in general, except for a slighter larger segment of White patients (residence) receiving care in the standard treatment environment compared to the ETP. The ethnic distribution of ETP patients differs from the overall CA population with a lower representation of Hispanic or Latino individuals on the ETP. The primary legal commitment for patients (residents) in the ETP are: Not Guilty by Reason of Insanity (NGI), Offenders with Mental Disorders (OMD), Incompetent to Stand Trial (IST), Sexually Violent Predators (SVP), and Lanterman-Petris-Short (LPS) Act Conservatees. Compared to the overall DSH population, the ETP serves a significantly higher percentage of LPS patients (residents) and a lower percentage of IST and SVP patients (residents). Since their

most recent DSH admission, ETP patients (residents) have spent an average of 5.52 years at DSH, which is equitable to the average length of stay throughout DSH at 5.97 years. However, as some ETP patients (residents) have been admitted to DSH on multiple occasions, their combined average time spent in DSH is 8.53 years. There is no DSH systemwide comparison statistic available for length of stay across different admissions.

Compliance with Staffing Requirements

According to Health and Safety Code 1265.9(d)(1), the ETP shall maintain a staff-to-patient ratio of one to five. Health and Safety Code 1265.9(g) defines staff as licensed nurses and psychiatric technicians providing direct patient care.

During the reporting period from September 14, 2021, through September 30, 2023, the ETP maintained a staff-to-patient ratio of one to five or lower. This ratio was maintained during the current reporting period from October 1, 2023, to September 30, 2024.

Staff Classification to Patient Ratio

Section 4144(e)(3) of the Welfare and Institutions Code defines a multidisciplinary treatment team as "*consisting of a psychologist, a psychiatrist, a nurse, a psychiatric technician, a clinical social worker, a rehabilitation therapist and any other necessary staff…*". The ETP staff also includes Hospital Police Officers to assist with movement of patients to and from treatment within and outside the ETP Unit.

Section 4144(l)(3) of the Welfare and Institutions Code defines an FNAT Psychologist as "*Forensic Needs Assessment Team" or "FNAT" means a panel of psychologists with expertise in forensic assessment or violence risk assessment, each of whom are assigned an ETP case or group of cases*."

Staff Classification	Staff-to-Patient Ratio[a]
Level-of-Care Staff[b]	
AM Shift	1 : 1.5
PM Shift	1 : 1.5
NOC Shift	1 : 3.0
Hospital Police Officer	1 : 6.5
Rehabilitation Therapist	1 : 6.5
Psychologist	1 : 6.5
Psychiatrist	1 : 13.0
Social Worker	1 : 13.0
FNAT Psychologist	1 : 6.5

[a] This ratio stayed consistent from September 14, 2021 through September 30, 2024

[b] Level of Care staff include Psychiatric Technicians and Registered Nurses.

Occupancy

Average Monthly Occupancy	N
October 2023	***
November 2023	<11
December 2023	***
January 2024	<11
February 2024	<11
March 2024	***
April 2024	12.80
May 2024	13.00
June 2024	13.00
July 2024	12.52
August 2024	13.00
September 2024	12.27
Average October 1, 2023 – September 30, 2024	11.63
Average September 14, 2021 – September 30, 2024	11.76

Average Length of Stay[a]	Reporting Period 10/1/23 to 9/30/24	Cumulative 9/13/21 to 9/30/24
	Days	Days
DSH-Atascadero ETP Current Patients	274.67 ± 103.29	290.76 ± 107.86
DSH-Atascadero ETP Discharged Patients	106.56 ± 73.83	145.81 ± 96.62
Total	202.62 ± 123.76	247.00 ± 123.53

[a] Days are full days and Standard Deviation.

Other Occupancy	Reporting Period 10/1/23 to 9/30/24	Cumulative 9/13/21 to 9/30/24
The number of patients (residents) whose length of stay exceeds 90 days.	17	25
The number of patients (residents) with multiple ETP stays.	<11	<11
The number of patients (residents) whose discharge was delayed due to lack of available beds in a standard treatment environment.	0	0

The ETP began accepting patients on September 14, 2021. Since then, there have been a total of 28 admissions and 16 discharges of individual patients (residents). Between October 1, 2023, and September 30, 2024, there were fewer than 11

admissions and fewer than 11 discharges. At the end of this reporting period on September 30, 2024, there were 12 patients (residents) on the unit.

17 patients' (residents') length of stay exceeded 90 days during this reporting period. Less than 11 patients (residents) were discharged and re-admitted to the ETP during this current reporting period. None of the ETP discharges were delayed due to lack of available beds in a standard treatment environment.

Restraint and Seclusion Use

Patients (residents) may be placed in seclusion or restraint for being an imminent danger to themselves or to others and after less restrictive interventions have been exhausted or were unsuccessful.

Cumulatively, since activating the ETP on September 14, 2021, to the end of this reporting period on September 30, 2024, there were fewer than 11 incidents of seclusion and 120 incidents of both ambulatory and non-ambulatory (5-point bed restraint) restraints, for a total of *** seclusion and restraint episodes. 40 (36%) incidents of non-ambulatory restraints used during the cumulative period were related to patients (residents) being deemed an imminent danger to others, while 72 (64%) incidents of non-ambulatory restraint use were related to imminent danger to self. A total of fewer than 11 incidents of seclusion involved fewer than 11 patients for a total of 9.13 hours. These incidents occurred prior to September 30, 2022, and there have been no episodes of seclusion use since.

Since activation, 112 incidents of non-ambulatory restraints occurred in the ETP. 5-point restraint usage lasted for a combined 1416.59 hours. These 112 restraint incidents involved fewer than 11 of the total 28 patients admitted to the ETP. 40% of the patients involved in the restraint incidents accounted for 86 (77%) of these incidents and 1227.24 (86%) of the total restraint hours. There were also fewer than 11 incidents of ambulatory restraint use which lasted for a combined total of 6.56 hours. There have been no ambulatory restraint hours since the end of the September 2022 reporting period.

During the current reporting period from October 1, 2023, to September 30, 2024, there were fewer than 11 incidents of non-ambulatory restraints. Fewer than 11 incidents of these non-ambulatory restraint use were related to patients (residents) being deemed an imminent danger to others, and incidents of non-ambulatory restraint use related to imminent danger to self were also fewer than 11. The total time of non-ambulatory restraint use during this reporting period was 78.41 hours. There were no incidents of ambulatory restraint usage or seclusion during this period.

Restraint and Seclusion Use	Reporting Period 10/1/23 to 9/30/24		Cumulative 9/13/21 to 9/30/24	
	N[a]	Duration[b]	N[a]	Duration[b]
Seclusion	0	0.00	<11	9.13
Ambulatory Restraint	0	0.00	<11	6.56
Non-Ambulatory Restraint	<11	78.41	112	1416.59
Total	<11	78.41	***	1432.28

[a] Number of distinct incidents that required seclusion or restraint of a patient.
[b] Total time in hours.

Non-Ambulatory Restraint Frequency and Duration[a]						
	Reporting Period 10/1/23 to 9/30/24			Cumulative 09/13/21 to 9/30/24		
	N[b]	%	Duration[c]	N	%	Duration
Danger to Others	<11	***%	0.33	40	36%	489.52
Danger to Self	<11	***%	78.08	72	64%	927.07

[a] Non-ambulatory Restraint while patient is located on the ETP Unit.
[b] Number of distinct incidents requiring non-ambulatory restraint of a patient.
[c] Time in hours.

Rates of ETP patient (resident) non-ambulatory restraint use per month were obtained for the six months prior to ETP admission and were compared to non-ambulatory restraint use during ETP placement.

During the reporting period from October 1, 2023, to September 30, 2024, rates for frequency and duration of non-ambulatory restraint use significantly decreased following admission to the ETP. Rates in the frequency of non-ambulatory restraint use decreased by 97.26% for patients receiving treatment during this reporting period, compared to the six months prior to admission. Furthermore, patients who received treatment on the ETP during this reporting period, spent a total of 4389.52 hours in non-ambulatory restraints within six months prior to their admission. During the twelve months captured in this reporting period these same patients spent 78.4 hours in non-ambulatory restraints.

Findings are similar for changes in duration and frequency of non-ambulatory restraint use throughout the length of the program's existence. From September 14, 2021, to September 30, 2024, frequency rates of non-ambulatory restraint use decreased by 87%, while the rate for duration of non-ambulatory restraint use decreased by 88% These findings align with the goal of the ETP to provide less restrictive care by reducing the frequency and duration of non-ambulatory restraint use.

Non-Ambulatory Restraint Rate and Duration Prior to ETP vs. During ETP Placement											
Reporting Period 10/1/23 to 9/30/24						Cumulative 09/13/21 to 9/30/24					
Prior to ETP Admission			During ETP Placement			Prior to ETP Admission			During ETP Placement		
N[a]	Rate[b]	Duration[c]	N	Rate	Duration	N	Rate	Duration	N	Rate	Duration
202	***	4389.52	<11	***	78.41	304	0.0659	5323.88	112	0.0086	1416.59

[a] Number of distinct incidents requiring non-ambulatory restraint of a patient.
[b] Rates of aggression are calculated per 1 patient day.
[c] Time in hours.

Serious Injuries to Staff and Patients (Residents)

Serious injuries to staff and patients (residents) were defined based on DSH Policy Directive #9500, Incident Management System. Injuries that met the following criteria are reported in the data below:

> *"Medical Treatment Required: The injury received is severe enough to require medical treatment (medical treatment beyond first aid and other than diagnostic of assessment; i.e. sutures, broken bones, may include new prescriptions specific to the treatment related to the injury sustained in the incident, beyond over-the-counter medication) by a licensed medical physician, osteopath, podiatrist, dentist, physician's assistant, or nurse practitioner, but the treatment required is not serious enough to warrant or require hospitalization; further, the treatment received may be provided within the facility or provided outside the facility where it may range from treatment at a doctor's private office through treatment at the emergency room of a general acute care hospital."*

> *"Hospitalization Required: The injury received is so severe that it requires medical intervention and treatment as well as care of the injured patient at a general acute care hospital outside the facility; this severity level requires that the injured patient be formally admitted to the hospital and assigned to a bed on a unit outside of the emergency room."*

Serious injury to staff and patients (residents) related to the use of seclusion and restraint was defined per Health and Safety Code 1180.1 (g), "*Serious injury" means significant impairment of the physical condition as determined by qualified medical personnel, and includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, or injuries to internal organs*."

Based on this definition, there were fewer than 11 aggressive incidents that resulted in serious injuries to staff between October 1, 2023, and September 30, 2024. None of these incidents resulted in injuries requiring hospitalization. There were no additional injuries to staff related to the use of seclusion and restraint. During this review period,

there were no serious injuries to patients (residents) because of either, aggression, use of seclusion or restraint, or self-injury.

Cumulatively, since activation of the ETP on September 14, 2021, through September 30, 2024, there were *** aggressive incidents resulting in serious injury to staff. Fewer than 11 of these injuries were due to physical aggression by a patient; and fewer than 11 of these injuries was related to the use of seclusion or restraint. None of these injuries required hospitalization. There were a total of fewer than 11 serious injuries to patients (residents). Fewer than 11 of these injuries were the result of patient aggression to self; and fewer than 11 injuries occurred related to the use of seclusion and restraint. None of these injuries required hospitalization.

The injuries resulting from use of restraint and seclusion occurred within the October 2022 to September 2023 reporting period. These injuries occurred during the stabilization process.

To summarize, there were a total of 28 serious injuries to either staff or patients (residents) that occurred since activation of the ETP on September 14, 2021, to September 30, 2024. There were *** aggressive incidents resulting in serious injury to staff (as defined by Policy Directive #9500) during that period. There were fewer than 11 serious injuries to staff (as defined by Health and Safety Code 1180.1(g)) related to the use of seclusion or restraint. There were fewer than 11 incidents of patient aggression to self that resulted in serious injuries to patients (residents) (as defined by Policy Directive #9500.). Fewer than 11 incidents of serious patient injury (defined by Health and Safety Code 1180.1(g)) occurred during stabilization of patients (residents). None of these 28 incidents required hospitalization. There were no aggressive acts to other patients (residents) resulting in serious injury during the review period.

Serious Injuries	Reporting Period 10/1/23 to 9/30/24	Cumulative 9/13/21 to 9/30/24
	N	N
All Serious Injuries to Staff[a]	<11	***
All Serious Injuries to Patients (Residents)[a]	0	<11
Serious injuries to Staff related to the use of seclusion and restraints[b,c]	0	<11
Serious injuries to Patients (Residents) related to the use of seclusion and restraints[b,c]	0	<11
Serious Injuries to Patients (Residents) as a result of self-injurious behavior[a,d]	0	<11
Total[e]:	<11	28

[a] Serious injury is defined as requiring medical care beyond first aid or overnight stay in a hospital as defined by Policy Directive #9500.
[b] Serious injury as defined by Health and Safety Code 1180.1(g).
[c] These injuries occurred during stabilization and containment. The patient was not placed in full-bed restraints following this incident. These numbers are also accounted for in Rows 1&2.
[d] Injuries due to self-harm behaviors are not included in the total, as they are accounted for in the overall frequency count for serious injuries to patients (residents).
[e] Total number of serious injuries includes all serious injuries to staff and patients Rows 1&2.

For each reporting period, rates of patient aggression toward self and others, as well as resulting injuries were calculated. These variables were also calculated for each patient in the six months prior to ETP admission. This allowed for calculation of rates of change in aggression and injuries following admission to the ETP.

Rates of Aggression and Injury Prior to ETP vs. During ETP Admission[a]

	Reporting Period 10/1/23 to 9/30/24					Cumulative 09/13/21 to 9/30/24				
	Prior to ETP Admission		During ETP Admission			Prior to ETP Admission		During ETP Admission		
	N	Rate	N	Rate	Change	N	Rate	N	Rate	Change
Physical Aggression towards Staff	135	0.0389	32	0.0075	-81%	236	0.0511	197	0.0150	-71%
Physical Aggression towards Peers	***	***	<11	***	-95%	129	0.0279	22	0.0017	-94%
Serious Injuries to Staff[b]	***	***	<11	***	-88%	21	0.0045	19	0.0015	-68%
Serious Injuries to Peers[b]	<11	***	0	0.0000	-100%	<11	***	0	0.0000	-100%
Physical Aggression towards Self	13	0.0037	13	0.0031	-18%	22	0.0048	94	0.0072	+51%
Serious Injuries towards Self[c]	<11	***	0	0.0000	-100%	<11	***	<11	***	+182%

[a] Rates of aggression are calculated per 1 patient day.
[b] Serious injury is defined as requiring medical care beyond first aid or overnight stay in a hospital as defined by Policy Directive #9500.
[c] Percent change is calculated from non-rounded values.

Compared to the six months prior to admission, patients receiving treatment on the ETP between October 1, 2023, to September 30, 2024, had an 81% decrease in rate of aggression towards staff, and a 95% decrease of aggression towards peers. Cumulative results covering the period from September 14, 2021, to September 30, 2024, show a 71% reduction in rate of aggression towards staff and a 94% reduction in rate of aggression towards peers. Furthermore, the severity of injuries resulting from these aggressive acts decreased by 100% for patient to patient (resident) aggression. The severity of injuries to staff decreased by 68%.

This data highlights that the ETP is meeting its goal for reduction of severe physical aggression towards both staff and patients, and that rates of injury severity correspond accordingly.

Rates of physical aggression towards self increased while patients were on the ETP, as did the injuries that occurred as a result. Since activation of the ETP on September 14, 2021, there have been fewer than 11 self-harm incidents resulting in serious injuries. Fewer than 11 (***%) of the 28 ETP patients were responsible for all of the self-harm incidents.

The ETP was established as a treatment program addressing physical violence towards others. As such the program was not designed to address the unique treatment needs of patients with significant self-harm behaviors. Due to the observed increase in self-harm behaviors following placement in the ETP, the selection process for admission was adjusted The ETP initially accepted referrals for patients who in addition to high levels of physical aggression towards others also engaged in self-harm behaviors. Over time, data showed that patients who had a significant history of self-harm in the standard treatment environment experienced an increase in those behaviors following ETP placement. Patients who did not have a significant history of self-harm did not experience an increase in self-harm behaviors following admission to the ETP and derive a benefit from ETP placement.

Currently, patients with a severe pre-existing history of self-harm do not appear to gain maximum benefit from treatment on the ETP and are not considered suitable for regular ETP referrals. Efforts to establish treatment programming to accommodate the needs of patients who are both at risk for danger to others and to self are underway.

Staff Turnover

During the current reporting period of October 1, 2023, through September 30, 2024, 2.0 registered nurses left the ETP, and both left employment with DSH. During this same time period 5.0 psychiatric technicians left the ETP; 1.0 promoted to a position outside the ETP, 3.0 left employment with the facility and 1.0 transferred to another unit within the facility.

During this reporting period, 2.0 registered nurses and 1.0 psychiatric technician were hired into the ETP. 2.0 registered nurses and 5.0 psychiatric technicians transferred into the ETP from other units within the facility.

Cumulatively, from activation of the ETP on September 14, 2021, through the end of this most recent reporting period on September 30, 2024, 10.0 registered nurses left the ETP; 7.0 registered nurses left employment with DSH, 1.0 transferred to another DSH facility, and 2.0 registered nurses transferred to other units within the facility. During this same time, 27.0 psychiatric technicians left the ETP; 4.0 promoted to a position outside the ETP, 11.0 left employment with DSH, 2.0 transferred to another DSH facility, and 10.0 transferred to other units within the facility.

During the reporting period from September 14, 2021, through September 30, 2024, 6.0 registered nurses were hired to the ETP as well as 7.0 psychiatric technicians. An additional, 2.0 registered nurses and 22.0 psychiatric technicians transferred into the ETP from other units within the facility.

Changes in clinical staff first occurred within the period of October 1, 2022, to September 30, 2023. 1.0 social worker left the ETP to transfer to another unit, and 0.75 social worker transferred into the ETP. That social worker was re-assigned to another unit and replaced by another social worker who also provided 0.75 coverage. In September 2024, one of the original social workers returned to the unit and continues to provide 0.75 coverage. The staffing changes related to social work were due to re-assignments to meet operational need. Recruitment is in process for additional social work resources.

In July 2023 1.0 Psychologist retired from state service, and 0.9 Senior Supervising Psychologist provided coverage for 13 months until 1.0 Psychologist transferred to the ETP from another unit. Since activation of the ETP in 2021, 2.0 FNAT psychologists left the ETP. In December 2022 1.0 FNAT psychologist left state service, 1.0 FNAT psychologist transferred to another division within DSH on a limited term assignment. 1.0 FNAT psychologist was hired. One remaining FNAT psychologist position provided temporary relief (filling behind another psychologist on family leave) and was not refilled.

During this reporting period specifically, .75 social worker left the ETP to transfer to another unit, and 0.75 social worker transferred into the ETP. (Note: This occurred in March 2024 and the new social worker is providing 0.25 coverage on another unit temporarily. 0.9 Senior Psychologist covered the unit from the beginning of this reporting period until August 1st, 2024, when 1.0 Psychologist was transferred from another unit. On July 1, 2024, 1.0 Psychiatrist went on extended leave. During the period from July 1, 2024 to September 30, 2024, 0.5 psychiatric coverage was

provided by various psychiatrists within the facility. Ongoing recruitment is in process for additional clinical staff resources.

Patients' Rights Complaints

The Disability Rights California, California Office of Patients' Rights provided information pertaining to patients' rights complaints received from October 1, 2023, to September 30, 2024. During this period fewer than 11 patients made a total of twenty-one complaints.

Complaint Category	Patients	Complaints
Access and Use of Personal Possessions/ Keep and Spend Reasonable Sum of Money	<11	6
Daily Living	<11	2
Dignity / Privacy / Respect / Humane Care	<11	7
Free from Harm	<11	1
Medical Care and Treatment	<11	2
Advocacy Services/ Legal/ Mental Health Treatment	<11	3
Totals [a]	**<11**	**21**

[a] Patients are counted once for the total; the same patient may have submitted multiple complaints for different problem codes.

Access / Use of Personal Possessions

- Complaints were regarding not receiving funds and/or being able to communicate with staff due to malfunctioning intercoms, not being able to purchase items from the Canteen, and lost property.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved most complaints by reviewing trust account records, addressing the functioning of the unit intercoms with staff, and assisting the patient with completing a patient request for missing property and/or informing the patient about available funds in their account.

Advocacy Services/ Legal/ Mental Health Treatment

- Complaints were regarding legal information missing from the chart, being dissatisfied with the outcome of a recent hearing, and asking for information about an upcoming hearing as well as contact information for legal counsel.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved complaints by speaking with the patient and speaking with members of the treatment team. The patient was provided with requested information about legal counsel, upcoming hearings and steps to take following placement hearings, and were directed towards the appropriate processes for retrieving missing documentation/ records.

Daily Living

- Complaints were regarding food and toothpaste, and missing utensils and menu items from meals.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved the complaints by speaking with staff on the unit regarding these concerns. The PRA encouraged patients to reach out to staff for any missing items during meals, and if they are in any distress or feel unsafe.

Dignity / Privacy / Respect / Humane Care

- Complaints were regarding staff disrespecting the patient, not answering the call button/intercom, providing harmful items, and creating an unsafe environment.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved this complaint by visiting the unit and discussing concerns with the patient. Patients were advised to continue to communicate their concerns with staff and their treatment team, and if they feel unsafe, they can continue to communicate with hospital police. The PRA spoke with unit staff, and they will be addressing the concerns on the unit.

Free from Harm

- Complaint was regarding staff behavior making the patient feel unsafe.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved this complaint by encouraging the patient to speak to staff and hospital police if other staff make them feel uncomfortable or unsafe.

Medical Care and Treatment

- Complaints were regarding pain management, and an incident of falling.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved this complaint by encouraging the patient to continue to report any pain or discomfort with staff. PRA visited the unit and investigated the incident of falling, reported their findings back to the patient, and encouraged the patient to talk with staff.

ETP Staff Training

In addition to mandated training provided to all hospital staff, those providing care on the ETP receive specialized training. Employees whose primary work assignment is elsewhere in the hospital, but who may be asked to provide treatment coverage on the ETP also receive an orientation to working on the ETP.

In anticipation of ETP activation, 57 ETP staff participated in a six-week in-person training academy in April and May 2019 aimed at providing specialized skills to address the needs of the patient populations served through the ETP. Training was offered with a focus on evidence-based treatments to address common risk factors

for violence. Due to delays in activation and the COVID-19 pandemic, another abbreviated two-week training academy was held virtually in April 2021 for 57 staff. The data below details the training topics presented during the most recent training academy, held April 13, 2021, through April 30, 2021.

- ETP Background, Philosophy & Culture
- ETP Positive Psychology
- ETP Trauma Informed Care
- ETP Motivational Interviewing
- ETP Sensory Modulation
- ETP Admission and Discharge Process
- ETP New Admission Orientation Process
- ETP Cognitive Remediation
- ETP Milieu Management Skills (DBT)
- ETP Treatment of Criminogenic Risk
- ETP Transdisciplinary Approach
- ETP Discipline Specific Duties
- ETP Writing a Behavior Plan
- ETP Coping Skills and Unit Privileges
- ETP Specific Charting Requirements
- ETP Incident Management Overview
- ETP Risk Assessment Process & Application
- ETP Patient's Rights
- ETP Therapeutic Options
- ETP Therapeutic Strategies and Interventions Theory
- ETP Social Skills Training for Schizophrenia
- ETP Operational Processes

In addition, an abbreviated videotaped training was created for staff whose primary work assignment is the ETP, but who did not have the opportunity to attend the full ETP academy. Eleven staff completed this training during the reporting period of October 1, 2023, through September 30, 2024.Cumulatively, 39 staff completed this video training during the reporting period of September 14, 2021, through September 30, 2024. Courses recorded and provided to staff included:

- ETP Positive Psychology
- ETP Trauma Informed Care
- ETP Motivational Interviewing
- ETP Therapeutic Options
- ETP Transdisciplinary Approach
- ETP Social Skills Training for Schizophrenia
- ETP Risk Assessment Process & Application
- ETP Specific Charting Requirements
- ETP Operational Processes

Lastly, a one-hour orientation to working on the ETP was developed for those whose primary work assignment is elsewhere, but who may be asked to provide treatment coverage on the ETP. 565 staff completed this training prior to the activation of the ETP. 1052 level-of-care (e.g., licensed nurses and psychiatric technicians) and clinical (e.g., psychiatrists, psychologists, social workers, rehabilitation therapists) staff

completed this training during the reporting period of September 14, 2021, through September 30, 2023. This video included:

- ETP Positive Philosophy
- ETP Trauma Informed Care
- ETP Sensory Modulation
- ETP Milieu Management Plan
- ETP Structure and Processes

On November 23, 2023, a revised version of this video was created. Since then, 585 level-of-care (e.g., licensed nurses and psychiatric technicians) and clinical (e.g., psychiatrists, psychologists, social workers, rehabilitation therapists) staff have completed this training. Courses provided in the updated video are:

- ETP Trauma Informed Care
- ETP Milieu Management Plan
- ETP Structure and Processes

In addition to the formalized training outlined above, ETP team members received informal consultation from subject matter experts outside of DSH. Department of Development Services as well as consults under contract with DSH assisted ETP team members with honing their skills in the treatment of complex psychopathology and behavioral issues. Consultations provided included advanced psycho pharmacology, Dialectical Behavior Therapy, Cognitive Behavioral Therapy for Psychosis, Behavioral Analysis, and Cognitive Remediation. 14 level-of-care and 7 clinical staff members participated in a half-day resiliency training aimed at providing coping skills while working in a highly acute environment.

Staffing Levels for ETPs

The table below summarizes the number of staff permanently assigned to provide direct patient care on the ETP and their classifications. Included are positions currently filled, as well as those being actively recruited as of September 30, 2024.

ETP Permanent Staff[a]	Filled	Vacant
Registered Nurse	11	6
Psychiatric Technician (includes Senior Psychiatric Technician)	21	5
Licensed Vocational Nurse	1	0
Psychiatrist	1[b]	0
Psychologist	1	0
Social Worker	.75[c]	.25
Rehabilitation Therapist	2	0
FNAT Psychologist	2	0
Hospital Police Officers	9	0

Unit Supervisor	1	0

[a] Staff permanently assigned to the ETP, not including coverage to meet required staff-to-patient ratios.
[b] Providing temporary coverage for staff on leave.
[c] Staff are also assigned duties/coverage outside of the ETP.

FINDINGS AND RECOMMENDATIONS

The ETP was conceived of as an environment to manage aggression, with units designed and constructed with environmental controls to allow for management of aggression using least restrictive practices. The foremost goals of the ETP are to reduce episodes of aggression and associated injury severity, and to reduce the use of restraints.

Patients (residents) engage in significantly less aggression towards others after being admitted to the ETP compared to when they received care in the standard treatment environment. Since activation of the ETP in September 2021 our data shows that following ETP admission, the rates of aggressive incidents towards staff decreased by 71%, while aggressive acts towards other patients decreased by 94%. Serious injuries to staff decreased by 68%, and serious injuries to patients due to aggression by peers were altogether eliminated.

Patients (residents) also are placed in non-ambulatory restraints less frequently and for shorter periods of time after being placed in the ETP. Since activation of the ETP on September 14, 2021, through September 30, 2024, there have been a total of 112 episodes of non-ambulatory restraint use. 40 (36%) of these were related to aggressive acts towards others, and 72 (64%) of restraint use was related to self-injurious behavior.

Of note is that 50 (47%) of the 112 non-ambulatory restraint incidents occurred within the first three months of activation. During the first three months of activation, staff were still getting accustomed to utilizing the unique features and treatment enhancements of the ETP. Consequently, staff were educated about ETP-specific procedures of locking the patient room door as a less restrictive alternative to manage aggressive behavior.

Since the first year of ETP operations, DSH has noticed a significant decrease in the use of non-ambulatory restraints. While there were 84 non-ambulatory restraint episodes between September 14, 2021, to September 30, 2022, there were 21 non-ambulatory restraint episodes between October 1, 2022, to September 30, 2023 and only fewer than 11 non-ambulatory restraint episodes from October 1, 2023, and September 30, 2024. These data highlight that, since ETP activation, clinicians and staff have become more proficient in using their skills to reduce the incidents of severe physical violence and limit their reliance on restraint use.

DSH learned that around 70% of non-ambulatory restraint use was due to patients (residents) engaging in self-harm behaviors. The ETP referral process was adjusted to increase screening for self-injurious behavior. While this approach has significantly reduced the need for non-ambulatory restraints, the aim is to further develop staff skills in treating patients who are at risk for self-injurious behavior to reduce the need for restraints and utilize the unique features of the ETP environment instead.

Overall, data supports that compared to the standard treatment environment, the ETP is successful in meeting its goals for reduction of severe physical aggression towards others, reducing the frequency of resulting serious injuries, and also reducing the frequency on non-ambulatory restraint use.

An additional goal is to continue to address ongoing staff recruitment and retention. This objective is addressed within the DSH statewide strategic plan goal towards establishing a great workplace to align with the goals and mission of the Department. While not specific to the ETP, this concentrated focus to recruit a talented workforce and create centers of professional training and excellence at the state hospitals will broaden the potential applicant pool for ETP positions.

CONTRACTED PATIENT SERVICES
INCOMPETENT TO STAND TRIAL (IST) DIVERSION PROGRAM
SUPPLEMENTAL REPORTING LANGUAGE

Informational Only

BACKGROUND

The Budget Act of 2019 added the following Provisional Language:

> *Item 4440-011-0001—Department of State Hospitals 1. Incompetent to Stand Trial Diversion Program. Trial courts shall work with the Judicial Council to provide data pursuant to mental health diversion programs set forth in Penal Code section 1001.36 including the number of petitions that were granted. When possible, the courts shall also report the (1) number of petitions that were denied, (2) number of petitions denied because the defendant did not meet the statutory requirements for eligibility, (3) number of individuals who successfully completed the diversion program, and (4) number of individuals that were terminated from the program. The Judicial Council will make this data available to the Legislature and the Department of State Hospitals on an annual basis commencing July 1, 2020. The Department of State Hospitals shall include this report in the data elements it receives from counties that have contracted with the department for mental health diversion programs funded pursuant to Chapter 6.5 (commencing with Section 4361) of the Welfare and Institutions Code.*

In response to the Provisional Language, the Department of State Hospitals (DSH) and the Judicial Council worked to ensure the Superior Courts of California data related to Penal Code (PC) section 1001.36 is transmitted and incorporated into the county data sets collected from the pre-trial diversion program (per Welfare and Institutions Code (WIC) 4361). This report describes the methodologies employed by both departments to collect the data required by WIC 4361 and the Provisional Language, as well as challenges encountered. Additionally, a high-level summary of the data collected as of June 30, 2024, is provided.

2025-26 GOVERNOR'S BUDGET REPORT

<u>Judicial Council Data Collection Methodology</u>

Pursuant to the Supplemental Report of the 2019 Budget Act regarding Assembly Bill 1810 (Stats. 2018, Ch. 34), trial courts are required to work with the Judicial Council of California to provide data pursuant to mental health diversion programs set forth in PC 1001.36. The Judicial Council is to make this data available to the Legislature and DSH on an annual basis, beginning January 1,

2020. In response to those requirements, the Judicial Council amended its quarterly superior court data surveys to include requests for totals of petitions for mental health diversion, petition outcomes, and program outcomes. These items were further amended to distinguish between petitions and diversions for cases including at least one felony charge and total petitions and diversions.

Below is a list of mental health diversion data requested by Judicial Council:

- Number of petitions received for pretrial mental health diversion pursuant to PC 1001.36
- Number of petitions received for pretrial mental health diversion pursuant to PC 1001.36 for individuals charged with at least one felony
- Number of pretrial mental health diversion petitions granted
- Number of pretrial mental health diversion petitions granted for individuals charged with at least one felony
- Number of pretrial mental health diversion petitions denied
- Number of pretrial mental health diversion petitions denied for individuals charged with at least one felony
- Number of petitions for mental health diversion denied because defendant does not meet the statutory requirements for eligibility under PC 1001.36(b)
- Number of petitions for mental health diversion denied because defendant does not meet the statutory requirements for eligibility under PC 1001.36(b) for individuals charged with at least one felony
- Number of pretrial mental health diversion petitions in which the individual successfully completed diversion
- Number of pretrial mental health diversion petitions in which the individual successfully completed diversion for individuals charged with at least one felony

Judicial Council Data Collection Challenges

Data collected during the first quarter of 2020 (the first period for which the reporting of this data was mandatory for courts) reflected activity which corresponded with the initial weeks of the COVID-19 shelter-in-place order in California. This, in addition to subsequent orders of similar suit and the closure of many court buildings, meant superior court staff across much of the state may not have had the opportunity to access the data systems or set up the queries required to report these data to the Judicial Council. The data for these petitions and programs reported therefore should not be interpreted as a comprehensive count of statewide totals but rather a subset of them. Finally, this data may not have been as thoroughly validated as it would have been given the usual circumstances and as such may be subject to future changes.

DSH Data Collection Methodology

Pursuant to WIC 4361, counties funded by DSH for a felony mental health Diversion program are required to submit quarterly data reports that capture the following information:

- The number of individuals court ordered to post-booking diversion and the length of time for which the defendant has been ordered to diversion
- The number of individuals originally declared incompetent to stand trial on felony charges ultimately ordered to diversion
- The number of individuals participating in diversion
- The name, social security number, date of birth, and demographics of each individual participating in the program[1]
- The length of time in diversion for each participating individual
- The types of services and supports provided to each individual participating in diversion
- The number of days each individual was in jail prior to placement in diversion[1]
- The number of days that each individual spent in each level of care facility[1]
- The diagnoses of each individual participating in diversion[1]
- The nature of the charges for each individual participating in diversion[1]
- The number of individuals who completed diversion
- The name, social security number, and birthdate of each individual who did not complete diversion and the reasons for not completing

DSH operationalized the collection of these data points via a master data dictionary and workbook. As counties complete the contracting process with DSH, the DSH data team collaborates with the county data teams to individualize the master data dictionary and workbook for each county. Typically, adjustments to the data dictionary occur in the section capturing services provided as each program has a different combination of available treatment opportunities.

Once counties begin to send defendants to Diversion, they have 90 days after the end of each quarter to submit data reports to DSH. DSH provides each county with access to a secure online file transfer system to upload reports. DSH established reporting quarters in alignment with the state fiscal year (FY):

- Quarter 1 – July 1 through September 30
- Quarter 2 – October 1 through December 31
- Quarter 3 – January 1 through March 31
- Quarter 4 – April 1 through June 30

[1] This information shall be confidential and shall not be open to public inspection

Data Collection Challenges

DSH has encountered two main issues related to the collection of data for this project to date. The first issue is challenges to DSH's authority to collect patient-level data from various County Councils and county information security departments. DSH released a Department Letter (DL 19-001) in October 2019 establishing its authority to collect this information as a "health oversight agency" as defined by the Health Insurance Portability and Accountability Act of 1996 (42 C.F.R. part 164.501) and as a program evaluator and auditor per 42 C.F.R. part 2.53. Clarifying this authority to the counties allowed DSH to require the submission of patient-level mental health and substance use disorder treatment for the purposes of evaluating these programs.

In FY 2019-20, data collection for this program was also impacted by COVID-19. Numerous counties which had planned to activate programs and begin diverting individuals before June 30, 2020, were delayed due to the numerous impacts of the pandemic, including court closures, and resource constraints in the county, mass releases of inmates at the local jails and virus outbreaks at the jails. These delays reduced the number of counties reporting to DSH in FY 2019-20. As of Fall 2022, all current DSH-contracted programs have been activated and reported data as of June 30, 2024.

SUMMARY OF REPORTED DATA

The following tables display high-level summaries of the data reported to DSH and the Judicial Council per the requirements of the above referenced Provisional Language.

FY 2018-19

DSH began collecting county data in FY 2018-19 as the first two county programs activated. The Judicial Council, however, was not required to collect data from counties prior to Quarter 1 of FY 2019-20.

FY 2018-19 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	N/A
PC 1001.36 Petitions Received (Felony)	N/A
PC 1001.36 Petitions Granted	N/A
PC 1001.36 Petitions Granted (Felony)	N/A
PC 1001.36 Petitions Denied	N/A
PC 1001.36 Petitions Denied (Felony)	N/A
PC 1001.36 Petitions Denied due to Statute	N/A
PC 1001.36 Petitions Denied due to Statute (Felony)	N/A
PC 1001.36 Successful Completions	N/A
PC 1001.36 Successful Completions (Felony)	N/A
PC 1001.36 Unsuccessful Terminations	N/A
PC 1001.36 Unsuccessful Terminations (Felony)	N/A
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	34
WIC 4361 Diversion Started	29
WIC 4361 Unsuccessful Terminations	0
WIC 4361 Successful Completions	0

FY 2019-20

During this period DSH collected data on existing programs and activated three additional county programs. The Judicial Council officially began collecting data in the third quarter of the fiscal year. However, courts were able to voluntarily submit data prior to the required compliance date.

FY 2019-20 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	1,923*
PC 1001.36 Petitions Received (Felony)	563
PC 1001.36 Petitions Granted	680
PC 1001.36 Petitions Granted (Felony)	222
PC 1001.36 Petitions Denied	246
PC 1001.36 Petitions Denied (Felony)	99
PC 1001.36 Petitions Denied due to Statute	93
PC 1001.36 Petitions Denied due to Statute (Felony)	48
PC 1001.36 Successful Completions	78
PC 1001.36 Successful Completions (Felony)	30
PC 1001.36 Unsuccessful Terminations	62
PC 1001.36 Unsuccessful Terminations (Felony)	7
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	114
WIC 4361 Diversion Started	115
WIC 4361 Unsuccessful Terminations	<11
WIC 4361 Successful Completions	0

*FY 2019-20 Petitions Received Statewide Total has been updated following receipt of updated data for this reporting period from the Judicial Council

FY 2020-21

DSH collected data throughout the fiscal year and activated three additional county programs. All 24 contracted programs activated by Spring 2021 and all programs reported data by Quarter 4 (April-June).

FY 2020-21 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	2,279*
PC 1001.36 Petitions Received (Felony)	1,312
PC 1001.36 Petitions Granted	1,415
PC 1001.36 Petitions Granted (Felony)	624
PC 1001.36 Petitions Denied	735
PC 1001.36 Petitions Denied (Felony)	455
PC 1001.36 Petitions Denied due to Statute	413
PC 1001.36 Petitions Denied due to Statute (Felony)	269
PC 1001.36 Successful Completions	658
PC 1001.36 Successful Completions (Felony)	219
PC 1001.36 Unsuccessful Terminations	164
PC 1001.36 Unsuccessful Terminations (Felony)	86
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	258
WIC 4361 Diversion Started	259
WIC 4361 Unsuccessful Terminations	38
WIC 4361 Successful Completions	44

*FY 2020-21 Petitions Received Statewide Total has been updated following receipt of updated data for this reporting period from the Judicial Council

FY 2021-22

DSH collected data throughout the fiscal year. All 24 contracted programs reported data through Quarter 4 (April-June) of 2022.

FY 2021-22 Totals*	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	4,133*
PC 1001.36 Petitions Received (Felony)	2,303
PC 1001.36 Petitions Granted	2,676
PC 1001.36 Petitions Granted (Felony)	1,455
PC 1001.36 Petitions Denied	980
PC 1001.36 Petitions Denied (Felony)	577
PC 1001.36 Petitions Denied due to Statute	507
PC 1001.36 Petitions Denied due to Statute (Felony)	294
PC 1001.36 Successful Completions	1,011
PC 1001.36 Successful Completions (Felony)	322
PC 1001.36 Unsuccessful Terminations	293
PC 1001.36 Unsuccessful Terminations (Felony)	151
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	409
WIC 4361 Diversion Started	389
WIC 4361 Unsuccessful Terminations	134
WIC 4361 Successful Completions	116

*FY 2021-22 Petitions Received Statewide Total has been updated following receipt of updated data for this reporting period from the Judicial Council

FY 2022-23

DSH collected data throughout the fiscal year and activated five additional county programs. All 29 contracted programs activated by Fall 2022 and 23 contracted programs reported data through Quarter 4 (April-June) of FY 2022-23.

FY 2022-23 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	5,393*
PC 1001.36 Petitions Received (Felony)	2,839
PC 1001.36 Petitions Granted	3,313
PC 1001.36 Petitions Granted (Felony)	1,634
PC 1001.36 Petitions Denied	815
PC 1001.36 Petitions Denied (Felony)	467
PC 1001.36 Petitions Denied due to Statute	455
PC 1001.36 Petitions Denied due to Statute (Felony)	273
PC 1001.36 Successful Completions	1,140
PC 1001.36 Successful Completions (Felony)	405
PC 1001.36 Unsuccessful Terminations	472
PC 1001.36 Unsuccessful Terminations (Felony)	208
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	576
WIC 4361 Diversion Started	620
WIC 4361 Unsuccessful Terminations	210
WIC 4361 Successful Completions	159

*FY 2022-23 Petitions Received Statewide Total has been updated following receipt of updated data for this reporting period from the Judicial Council

FY 2023-24

DSH collected data throughout the fiscal year. 28 contracted programs reported data through Quarter 3 (July-March) of FY 2023-24. 25 contracted programs reported data in Quarter 4 (April-June) of FY 2023-24.

FY 2023-24 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	8,193
PC 1001.36 Petitions Received (Felony)	4,583
PC 1001.36 Petitions Granted	5,469
PC 1001.36 Petitions Granted (Felony)	3,100
PC 1001.36 Petitions Denied	1,725
PC 1001.36 Petitions Denied (Felony)	1,015
PC 1001.36 Petitions Denied due to Statute	725
PC 1001.36 Petitions Denied due to Statute (Felony)	413
PC 1001.36 Successful Completions	1,902
PC 1001.36 Successful Completions (Felony)	707
PC 1001.36 Unsuccessful Terminations	740
PC 1001.36 Unsuccessful Terminations (Felony)	396
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	232
WIC 4361 Diversion Started	247
WIC 4361 Unsuccessful Terminations	134
WIC 4361 Successful Completions	276

Number of Counties Reporting by Quarter

The first table below provides a summary of the total number of counties reporting data each quarter. The following tables display a more detailed count of the total number of counties reporting on each data element by fiscal year quarter, from 2018-19 through 2023-24.

Summary of Total Counties Reporting		
Numbers of Counties Reporting	Judicial Council	DSH
Q3 2018 (January through March)	**	2
Q4 2018 (April through June)	**	2
Q1 2019 (July through September)	25	3
Q2 2019 (October through December)	24	3
Q3 2020 (January through March)	40	4
Q4 2020 (April through June)	41	5
Q1 2020 (July through September)	43	11
Q2 2020 (October through December)	43	12
Q3 2021 (January through March)	44	19
Q4 2021 (April through June)	44	24
Q1 2021 (July through September)	49	24
Q2 2021 (October through December)	47	24
Q3 2022 (January through March)	49	24
Q4 2022 (April through June)	48	24
Q1 2022 (July through September)	47	24
Q2 2022 (October through December)	50	24
Q3 2023 (January through March)	48	23
Q4 2023 (April through June)	49	23
Q1 2023 (July through September)	50	28
Q2 2023 (October through December)	49	28
Q3 2024 (January through March)	47	28
Q4 2024 (April through June)	49	25

Fiscal Year 2018-19				
January - March 2019				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Received (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Granted	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Granted (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied due to Statute	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied due to Statute (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Successful Completions	N/A	N/A	N/A	N/A
PC 1001.36 Successful Completions (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Unsuccessful Terminations	N/A	N/A	N/A	N/A
PC 1001.36 Unsuccessful Terminations (Felony)	N/A	N/A	N/A	N/A
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	2	0	0	0
WIC 4361 Diversion Started	2	0	0	0
WIC 4361 Unsuccessful Terminations	2	0	0	0
WIC 4361 Successful Completions	2	0	0	0

April - June 2019				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Received (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Granted	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Granted (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied due to Statute	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied due to Statute (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Successful Completions	N/A	N/A	N/A	N/A
PC 1001.36 Successful Completions (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Unsuccessful Terminations	N/A	N/A	N/A	N/A
PC 1001.36 Unsuccessful Terminations (Felony)	N/A	N/A	N/A	N/A
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	2	0	0	0
WIC 4361 Diversion Started	2	0	0	0
WIC 4361 Unsuccessful Terminations	2	0	0	0
WIC 4361 Successful Completions	2	0	0	0

Fiscal Year 2019-20				
July - September 2019				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	25	16	15	2
PC 1001.36 Petitions Received (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Granted	25	16	15	2
PC 1001.36 Petitions Granted (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied	23	17	16	2
PC 1001.36 Petitions Denied (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied due to Statute	19	21	16	2
PC 1001.36 Petitions Denied due to Statute (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Successful Completions	22	18	16	2
PC 1001.36 Successful Completions (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Unsuccessful Terminations	22	18	16	2
PC 1001.36 Unsuccessful Terminations (Felony)	N/A	N/A	N/A	N/A
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	3	0	0	0
WIC 4361 Diversion Started	3	0	0	0
WIC 4361 Unsuccessful Terminations	3	0	0	0
WIC 4361 Successful Completions	3	0	0	0

October - December 2019				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	25	16	16	1
PC 1001.36 Petitions Received (Felony)	25	16	16	1
PC 1001.36 Petitions Granted	24	16	17	1
PC 1001.36 Petitions Granted (Felony)	24	16	17	1
PC 1001.36 Petitions Denied	23	17	17	1
PC 1001.36 Petitions Denied (Felony)	23	17	17	1
PC 1001.36 Petitions Denied due to Statute	21	19	17	1
PC 1001.36 Petitions Denied due to Statute (Felony)	20	20	17	1
PC 1001.36 Successful Completions	24	16	17	1
PC 1001.36 Successful Completions (Felony)	24	16	17	1
PC 1001.36 Unsuccessful Terminations	22	18	17	1
PC 1001.36 Unsuccessful Terminations (Felony)	22	18	17	1
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	3	0	0	0
WIC 4361 Diversion Started	3	0	0	0
WIC 4361 Unsuccessful Terminations	3	0	0	0
WIC 4361 Successful Completions	3	0	0	0

January - March 2020				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	40	11	7	0
PC 1001.36 Petitions Received (Felony)	39	12	7	0
PC 1001.36 Petitions Granted	40	10	8	0
PC 1001.36 Petitions Granted (Felony)	39	11	8	0
PC 1001.36 Petitions Denied	38	13	7	0
PC 1001.36 Petitions Denied (Felony)	37	13	8	0
PC 1001.36 Petitions Denied due to Statute	31	17	10	0
PC 1001.36 Petitions Denied due to Statute (Felony)	31	19	8	0
PC 1001.36 Successful Completions	39	11	8	0
PC 1001.36 Successful Completions (Felony)	39	11	8	0
PC 1001.36 Unsuccessful Terminations	38	12	8	0
PC 1001.36 Unsuccessful Terminations (Felony)	37	13	8	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	4	0	0	0
WIC 4361 Diversion Started	4	0	0	0
WIC 4361 Unsuccessful Terminations	4	0	0	0
WIC 4361 Successful Completions	4	0	0	0

April - June 2020				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	41	8	7	2
PC 1001.36 Petitions Received (Felony)	40	9	7	2
PC 1001.36 Petitions Granted	41	8	7	2
PC 1001.36 Petitions Granted (Felony)	40	8	8	2
PC 1001.36 Petitions Denied	39	10	7	2
PC 1001.36 Petitions Denied (Felony)	38	11	7	2
PC 1001.36 Petitions Denied due to Statute	33	16	7	2
PC 1001.36 Petitions Denied due to Statute (Felony)	32	17	7	2
PC 1001.36 Successful Completions	40	8	8	2
PC 1001.36 Successful Completions (Felony)	40	8	8	2
PC 1001.36 Unsuccessful Terminations	40	9	7	2
PC 1001.36 Unsuccessful Terminations (Felony)	40	9	7	2
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	5	0	0	0
WIC 4361 Diversion Started	5	0	0	0
WIC 4361 Unsuccessful Terminations	5	0	0	0
WIC 4361 Successful Completions	5	0	0	0

Fiscal Year 2020-21				
July - September 2020				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	41	10	4	3
PC 1001.36 Petitions Received (Felony)	40	11	4	3
PC 1001.36 Petitions Granted	43	8	4	3
PC 1001.36 Petitions Granted (Felony)	42	9	4	3
PC 1001.36 Petitions Denied	39	11	5	3
PC 1001.36 Petitions Denied (Felony)	40	11	4	3
PC 1001.36 Petitions Denied due to Statute	36	15	4	3
PC 1001.36 Petitions Denied due to Statute (Felony)	36	15	4	3
PC 1001.36 Successful Completions	41	10	4	3
PC 1001.36 Successful Completions (Felony)	39	11	5	3
PC 1001.36 Unsuccessful Terminations	41	9	5	3
PC 1001.36 Unsuccessful Terminations (Felony)	41	10	4	3
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	11	0	0	1
WIC 4361 Diversion Started	11	0	0	1
WIC 4361 Unsuccessful Terminations	11	0	0	1
WIC 4361 Successful Completions	11	0	0	1

October - December 2020				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	41	13	3	1
PC 1001.36 Petitions Received (Felony)	40	14	3	1
PC 1001.36 Petitions Granted	43	11	3	1
PC 1001.36 Petitions Granted (Felony)	42	12	3	1
PC 1001.36 Petitions Denied	41	13	3	1
PC 1001.36 Petitions Denied (Felony)	40	14	3	1
PC 1001.36 Petitions Denied due to Statute	35	19	3	1
PC 1001.36 Petitions Denied due to Statute (Felony)	34	20	3	1
PC 1001.36 Successful Completions	41	13	3	1
PC 1001.36 Successful Completions (Felony)	40	14	3	1
PC 1001.36 Unsuccessful Terminations	41	13	3	1
PC 1001.36 Unsuccessful Terminations (Felony)	40	14	3	1
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	12	0	0	1
WIC 4361 Diversion Started	12	0	0	1
WIC 4361 Unsuccessful Terminations	12	0	0	1
WIC 4361 Successful Completions	12	0	0	1

January - March 2021				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	43	11	4	0
PC 1001.36 Petitions Received (Felony)	41	13	4	0
PC 1001.36 Petitions Granted	44	10	4	0
PC 1001.36 Petitions Granted (Felony)	42	12	4	0
PC 1001.36 Petitions Denied	43	11	4	0
PC 1001.36 Petitions Denied (Felony)	41	13	4	0
PC 1001.36 Petitions Denied due to Statute	36	18	4	0
PC 1001.36 Petitions Denied due to Statute (Felony)	35	19	4	0
PC 1001.36 Successful Completions	43	11	4	0
PC 1001.36 Successful Completions (Felony)	41	13	4	0
PC 1001.36 Unsuccessful Terminations	43	11	4	0
PC 1001.36 Unsuccessful Terminations (Felony)	41	13	4	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	19	0	0	0
WIC 4361 Diversion Started	19	0	0	0
WIC 4361 Unsuccessful Terminations	19	0	0	0
WIC 4361 Successful Completions	19	0	0	0

April - June 2021				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	43	11	4	0
PC 1001.36 Petitions Received (Felony)	41	13	4	0
PC 1001.36 Petitions Granted	44	10	4	0
PC 1001.36 Petitions Granted (Felony)	43	11	4	0
PC 1001.36 Petitions Denied	41	12	5	0
PC 1001.36 Petitions Denied (Felony)	41	13	4	0
PC 1001.36 Petitions Denied due to Statute	36	18	4	0
PC 1001.36 Petitions Denied due to Statute (Felony)	35	18	5	0
PC 1001.36 Successful Completions	43	11	4	0
PC 1001.36 Successful Completions (Felony)	41	13	4	0
PC 1001.36 Unsuccessful Terminations	43	11	4	0
PC 1001.36 Unsuccessful Terminations (Felony)	41	13	4	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	0	0
WIC 4361 Diversion Started	24	0	0	0
WIC 4361 Unsuccessful Terminations	24	0	0	0
WIC 4361 Successful Completions	24	0	0	0

Fiscal Year 2021-22				
July - September 2021				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	48	6	4	0
PC 1001.36 Petitions Received (Felony)	47	7	4	0
PC 1001.36 Petitions Granted	49	5	4	0
PC 1001.36 Petitions Granted (Felony)	47	7	4	0
PC 1001.36 Petitions Denied	46	8	4	0
PC 1001.36 Petitions Denied (Felony)	45	9	4	0
PC 1001.36 Petitions Denied due to Statute	42	12	4	0
PC 1001.36 Petitions Denied due to Statute (Felony)	41	13	4	0
PC 1001.36 Successful Completions	46	7	5	0
PC 1001.36 Successful Completions (Felony)	44	9	5	0
PC 1001.36 Unsuccessful Terminations	47	7	4	0
PC 1001.36 Unsuccessful Terminations (Felony)	45	9	4	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	0	0
WIC 4361 Diversion Started	24	0	0	0
WIC 4361 Unsuccessful Terminations	24	0	0	0
WIC 4361 Successful Completions	24	0	0	0

October - December 2021				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	46	8	4	0
PC 1001.36 Petitions Received (Felony)	45	10	3	0
PC 1001.36 Petitions Granted	47	7	4	0
PC 1001.36 Petitions Granted (Felony)	45	9	4	0
PC 1001.36 Petitions Denied	45	9	4	0
PC 1001.36 Petitions Denied (Felony)	44	10	4	0
PC 1001.36 Petitions Denied due to Statute	40	14	4	0
PC 1001.36 Petitions Denied due to Statute (Felony)	39	15	4	0
PC 1001.36 Successful Completions	45	9	4	0
PC 1001.36 Successful Completions (Felony)	43	11	4	0
PC 1001.36 Unsuccessful Terminations	46	8	4	0
PC 1001.36 Unsuccessful Terminations (Felony)	44	10	4	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	0	0
WIC 4361 Diversion Started	24	0	0	0
WIC 4361 Unsuccessful Terminations	24	0	0	0
WIC 4361 Successful Completions	24	0	0	0

January - March 2022				
Judicial Council Data	**Total Counties Reporting***	**Data Unavailable***	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	47	5	6	0
PC 1001.36 Petitions Received (Felony)	47	5	6	0
PC 1001.36 Petitions Granted	49	3	6	0
PC 1001.36 Petitions Granted (Felony)	48	4	6	0
PC 1001.36 Petitions Denied	46	6	6	0
PC 1001.36 Petitions Denied (Felony)	45	7	6	0
PC 1001.36 Petitions Denied due to Statute	42	10	6	0
PC 1001.36 Petitions Denied due to Statute (Felony)	41	11	6	0
PC 1001.36 Successful Completions	47	5	6	0
PC 1001.36 Successful Completions (Felony)	46	6	6	0
PC 1001.36 Unsuccessful Terminations	48	4	6	0
PC 1001.36 Unsuccessful Terminations (Felony)	46	5	7	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	0	0
WIC 4361 Diversion Started	24	0	0	0
WIC 4361 Unsuccessful Terminations	24	0	0	0
WIC 4361 Successful Completions	24	0	0	0

*FY 2021-22 Totals have changed because the Judicial Council has provided updated data for this reporting period.

April - June 2022				
Judicial Council Data	**Total Counties Reporting***	**Data Unavailable***	**Item Left Blank***	**No Data Received***
PC 1001.36 Petitions Received	46	6	5	1
PC 1001.36 Petitions Received (Felony)	47	6	4	1
PC 1001.36 Petitions Granted	48	4	5	1
PC 1001.36 Petitions Granted (Felony)	46	6	5	1
PC 1001.36 Petitions Denied	46	6	5	1
PC 1001.36 Petitions Denied (Felony)	44	8	5	1
PC 1001.36 Petitions Denied due to Statute	41	11	5	1
PC 1001.36 Petitions Denied due to Statute (Felony)	40	12	5	1
PC 1001.36 Successful Completions	46	6	5	1
PC 1001.36 Successful Completions (Felony)	44	8	5	1
PC 1001.36 Unsuccessful Terminations	47	5	5	1
PC 1001.36 Unsuccessful Terminations (Felony)	45	7	5	1
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	0	0
WIC 4361 Diversion Started	24	0	0	0
WIC 4361 Unsuccessful Terminations	24	0	0	0
WIC 4361 Successful Completions	24	0	0	0

*FY 2021-22 Totals have changed because the Judicial Council has provided updated data for this reporting period.

July-September 2022				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	46	5	5	2
PC 1001.36 Petitions Received (Felony)	44	7	5	2
PC 1001.36 Petitions Granted	47	4	5	2
PC 1001.36 Petitions Granted (Felony)	45	6	5	2
PC 1001.36 Petitions Denied	44	7	5	2
PC 1001.36 Petitions Denied (Felony)	42	8	6	2
PC 1001.36 Petitions Denied due to Statute	38	13	5	2
PC 1001.36 Petitions Denied due to Statute (Felony)	37	14	5	2
PC 1001.36 Successful Completions	45	6	5	2
PC 1001.36 Successful Completions (Felony)	43	8	5	2
PC 1001.36 Unsuccessful Terminations	45	6	5	2
PC 1001.36 Unsuccessful Terminations (Felony)	43	8	5	2
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	0	0
WIC 4361 Diversion Started	24	0	0	0
WIC 4361 Unsuccessful Terminations	24	0	0	0
WIC 4361 Successful Completions	24	0	0	0

October-December 2022				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	47	3	7	1
PC 1001.36 Petitions Received (Felony)	47	4	6	1
PC 1001.36 Petitions Granted	50	1	6	1
PC 1001.36 Petitions Granted (Felony)	48	3	6	1
PC 1001.36 Petitions Denied	47	3	7	1
PC 1001.36 Petitions Denied (Felony)	45	5	7	1
PC 1001.36 Petitions Denied due to Statute	43	7	7	1
PC 1001.36 Petitions Denied due to Statute (Felony)	41	9	7	1
PC 1001.36 Successful Completions	48	3	6	1
PC 1001.36 Successful Completions (Felony)	45	5	7	1
PC 1001.36 Unsuccessful Terminations	47	3	7	1
PC 1001.36 Unsuccessful Terminations (Felony)	45	5	7	1
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item* Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	1	4
WIC 4361 Diversion Started	24	0	1	4
WIC 4361 Unsuccessful Terminations	24	0	1	4
WIC 4361 Successful Completions	24	0	1	4

*Data from Solano County not included due to discrepancies in data reporting.

January-March 2023				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	46	3	5	4
PC 1001.36 Petitions Received (Felony)	46	4	4	4
PC 1001.36 Petitions Granted	48	1	5	4
PC 1001.36 Petitions Granted (Felony)	46	3	5	4
PC 1001.36 Petitions Denied	47	3	4	4
PC 1001.36 Petitions Denied (Felony)	45	5	4	4
PC 1001.36 Petitions Denied due to Statute	40	9	5	4
PC 1001.36 Petitions Denied due to Statute (Felony)	39	10	5	4
PC 1001.36 Successful Completions	46	3	5	4
PC 1001.36 Successful Completions (Felony)	44	5	5	4
PC 1001.36 Unsuccessful Terminations	45	4	5	4
PC 1001.36 Unsuccessful Terminations (Felony)	43	6	5	4
DSH Data*	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	23	0	0	5
WIC 4361 Diversion Started	23	0	0	5
WIC 4361 Unsuccessful Terminations	23	0	0	5
WIC 4361 Successful Completions	23	0	0	5

*DSH's contract with Santa Cruz County ended in Fall 2022. County no longer has an obligation to report data to DSH.

April-June 2023				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	43	4	1	10
PC 1001.36 Petitions Received (Felony)	41	5	2	10
PC 1001.36 Petitions Granted	44	2	2	10
PC 1001.36 Petitions Granted (Felony)	42	4	2	10
PC 1001.36 Petitions Denied	42	4	2	10
PC 1001.36 Petitions Denied (Felony)	40	6	2	10
PC 1001.36 Petitions Denied due to Statute	36	10	2	10
PC 1001.36 Petitions Denied due to Statute (Felony)	35	11	2	10
PC 1001.36 Successful Completions	42	4	2	10
PC 1001.36 Successful Completions (Felony)	40	6	2	10
PC 1001.36 Unsuccessful Terminations	42	4	2	10
PC 1001.36 Unsuccessful Terminations (Felony)	40	6	2	10
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	23	0	0	5
WIC 4361 Diversion Started	23	0	0	5
WIC 4361 Unsuccessful Terminations	23	0	0	5
WIC 4361 Successful Completions	23	0	0	5

Fiscal Year 2023-24				
July - September 2023				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	49	6	3	0
PC 1001.36 Petitions Received (Felony)	48	7	3	0
PC 1001.36 Petitions Granted	50	4	4	0
PC 1001.36 Petitions Granted (Felony)	48	6	4	0
PC 1001.36 Petitions Denied	48	6	4	0
PC 1001.36 Petitions Denied (Felony)	46	8	4	0
PC 1001.36 Petitions Denied due to Statute	39	15	4	0
PC 1001.36 Petitions Denied due to Statute (Felony)	38	16	4	0
PC 1001.36 Successful Completions	48	6	4	0
PC 1001.36 Successful Completions (Felony)	46	8	4	0
PC 1001.36 Unsuccessful Terminations	48	6	4	0
PC 1001.36 Unsuccessful Terminations (Felony)	46	8	4	0
DSH Data	Total Counties Reporting	Data Unavailable	Item Left Blank	No Data Received
WIC 4361 Diversion Orders	28	0	0	0
WIC 4361 Diversion Started	28	0	0	0
WIC 4361 Unsuccessful Terminations	28	0	0	0
WIC 4361 Successful Completions	28	0	0	0

October - December 2023				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	47	7	4	0
PC 1001.36 Petitions Received (Felony)	46	9	3	0
PC 1001.36 Petitions Granted	49	5	4	0
PC 1001.36 Petitions Granted (Felony)	47	7	4	0
PC 1001.36 Petitions Denied	45	8	5	0
PC 1001.36 Petitions Denied (Felony)	44	10	4	0
PC 1001.36 Petitions Denied due to Statute	39	15	4	0
PC 1001.36 Petitions Denied due to Statute (Felony)	38	16	4	0
PC 1001.36 Successful Completions	47	7	4	0
PC 1001.36 Successful Completions (Felony)	45	8	5	0
PC 1001.36 Unsuccessful Terminations	45	9	4	0
PC 1001.36 Unsuccessful Terminations (Felony)	45	9	4	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	28	0	0	0
WIC 4361 Diversion Started	28	0	0	0
WIC 4361 Unsuccessful Terminations	28	0	0	0
WIC 4361 Successful Completions	28	0	0	0

January - March 2024				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	46	4	3	5
PC 1001.36 Petitions Received (Felony)	45	5	3	5
PC 1001.36 Petitions Granted	47	3	3	5
PC 1001.36 Petitions Granted (Felony)	45	5	3	5
PC 1001.36 Petitions Denied	45	5	3	5
PC 1001.36 Petitions Denied (Felony)	43	7	3	5
PC 1001.36 Petitions Denied due to Statute	36	14	3	5
PC 1001.36 Petitions Denied due to Statute (Felony)	35	15	3	5
PC 1001.36 Successful Completions	46	4	3	5
PC 1001.36 Successful Completions (Felony)	44	6	3	5
PC 1001.36 Unsuccessful Terminations	46	4	3	5
PC 1001.36 Unsuccessful Terminations (Felony)	44	6	3	5
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	28	0	0	0
WIC 4361 Diversion Started	28	0	0	0
WIC 4361 Unsuccessful Terminations	28	0	0	0
WIC 4361 Successful Completions	28	0	0	0

April - June 2024				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	48	3	3	4
PC 1001.36 Petitions Received (Felony)	46	5	3	4
PC 1001.36 Petitions Granted	49	2	3	4
PC 1001.36 Petitions Granted (Felony)	47	4	3	4
PC 1001.36 Petitions Denied	48	3	3	4
PC 1001.36 Petitions Denied (Felony)	46	5	3	4
PC 1001.36 Petitions Denied due to Statute	39	12	3	4
PC 1001.36 Petitions Denied due to Statute (Felony)	38	13	3	4
PC 1001.36 Successful Completions	48	3	3	4
PC 1001.36 Successful Completions (Felony)	46	5	3	4
PC 1001.36 Unsuccessful Terminations	48	3	3	4
PC 1001.36 Unsuccessful Terminations (Felony)	46	5	3	4
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	25	0	0	3
WIC 4361 Diversion Started	25	0	0	3
WIC 4361 Unsuccessful Terminations	25	0	0	3
WIC 4361 Successful Completions	25	0	0	3