California Department of
State Hospitals

Evaluation of Effectiveness of The Independent Placement Panel (IPP)

May 18, 2026

California Department of State Hospitals

Forensic Services

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Independent Placement Panel (IPP) Pilot Program Evaluation

EXECUTIVE SUMMARY

Introduction

The Budget Act of 2022 authorized the Department of State Hospitals (DSH) to pilot over a 4-year period, a statewide Independent Placement Panel (IPP), for purposes of evaluating state hospital patients who are ready for step down from a state hospital into community-based housing and treatment via the Conditional Release Program (CONREP). The IPP was intended as a supporting strategy to the broader set of solutions aimed at responding to the increasing rate of individuals deemed Incompetent to Stand Trial (IST) and referred to DSH for treatment. Through the identification and placement of state hospital patients into the community by way of CONREP, DSH can free up limited state hospital beds for IST individuals who require a higher level of care.

Welfare and Institutions Code section 4360.5 outlines the authority for the IPP to conduct independent evaluations to inform CONREP step-down and placement decisions, in lieu of the Community Program Director (CPD) assigned to each CONREP program. By statute DSH is required to conduct an evaluation of the IPP program, which is due to sunset on July 1, 2026. WIC 4360.5 (d) states:

> *The department shall conduct an evaluation of the effectiveness of the program created pursuant to this section to determine whether to extend the use of the statewide independent evaluation panel after June 30, 2026.*

This report summarizes DSH's evaluation of the IPP pilot in response in accordance with WIC 4360.5(d).

Purpose and Goals

CONREP is DSH's statewide system of community-based services for specified court-ordered forensic individuals. 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) for those who have been court-approved for outpatient placement in lieu of state hospital placement.

Historically, some CONREP programs were reluctant to accept patients that state hospital treatment teams identified as ready for CONREP. An original aim of the IPP program was to improve CONREP access and participation for primarily NGI

and OMD commitments[1]. The IPP could thereby expand the availability of state hospital beds for IST individuals by facilitating discharge of DSH patients to CONREP for commitment types with historically longer lengths of stay. Providing impartial assessments that applied fair and consistent placement standards would expand access to CONREP across its diverse statewide continuum of care. The IPP would also standardize the quality of reports to courts across programs, contribute to public safety through best practice risk assessment and increase consensus between hospital treatment teams and CONREP programs. The IPP has largely fulfilled these expectations, and key takeaways are summarized below:

Increased CONREP Participation

Continuous quality improvements over time have driven a trend toward increasing step-downs. For example, the IPP identified CONREP's locked Institutes for Mental Disorders (IMD) as effective transition points for facilitating step-down to Community Outpatient Treatment (COT) for certain patients. The IPP began a proactive screening process to accelerate these transitions. This and other reforms led to a higher proportion of evaluations recommending step-downs to lower levels of care and to outpatient programs.

The program has met most of its objectives, even though the number of NGI and OMD patient step-downs to CONREP is mostly stable. Recent fiscal years show a decline in the overall DSH state hospital population of OMD-Civil Commitments and NGI patients and a concentration of high acuity hospital patients who are not ready for step-down which contribute to the stabilized step-down rates in recent years. As such, the anticipated uptick did not materialize. However, this is not a reflection of the effectiveness of the IPP. Rather, the IPP has enabled the participation of the hardest to place patients and likely forestalled declines. DSH is actively addressing other factors affecting step-down, such as increasing availability of outpatient facilities for elderly and medically fragile patients. Together with the expanded continuum and facilities, DSH expected recent trends of increased participation to rise.

Standardization, Quality and Neutrality

The program has brought consistency, quality, and objectivity to the evaluation process through standardized assessment practices and independent reports. Court orders align with the IPP recommendations at high rates, suggesting the courts view them as valid and reliable. External

[1] Mentally Disordered Sex Offenders (MDSO) are also included but there are very few MDSO patients within DSH as this commitment is no longer utilized. For reporting purposes, MDSO patients are typically grouped together with OMD data.

consultants commended the quality of the IPP reports, finding them consistent with best practices in forensic evaluation. Survey results further show that court, CONREP, and state hospital stakeholders perceive improved quality and greater independence of placement evaluations under the IPP program. Surveys also reveal increased collaboration between CONREP and state hospital in step-down decisions. Previously, DSH could not attain this level of standardized quality and CONREP-state hospital collaboration across its diverse network of 17 CONREP providers.

Public Safety and Risk Mitigation

The program improved public safety through best practice risk analysis and mitigation plans, which better matched patients to their treatment and risk management needs. The program led to half the rate of arrests, dramatic reduction in AWOLs overall, and stable hospital return rates when the court's decision on release to CONREP aligned with evaluator opinions. Critically, there were no violent incidents involving any patients released through the IPP program. The high quality of the IPP evaluations and resulting CONREP placements help ensure patients have a safe and effective transition from the state hospital without posing a danger to the community.

Successful Placements and Expanded System Utilization

The panel's expertise in all levels of care and CONREP programs and its centralized nature improved placements by permitting consideration of an expanded array of suitable options beyond those in patients' home CONREP programs. This allowed the panel to match patients to appropriate and stable placements. The independence of the IPP ensured patient care placements focused on individual needs. Eighty-eight percent of recommended placements were outside of the patients' home CONREP programs and into the expanded CONREP continuum of levels of care, demonstrating this expanded access and personalized placement to meet the individual's specific treatment and risk needs.

Timeliness and Efficiency

The IPP can more efficiently monitor patients recommended for CONREP evaluation and placement through its centralized administration. Program administrators proactively monitor timelines to ensure hearings schedules comply with court mandates and follow up evaluations are scheduled. This was previously a challenged function across the 17 CONREP programs that delayed placement. Centralized administration consolidates and streamlines record gathering, schedules, tracks and assigns evaluator workload, promptly submits completed evaluations and notifies stakeholders. To ensure data-driven decisions, centralized administration

collects and reports CONREP evaluation and placement information, including IPP stakeholder surveys.

Challenges to Consider if IPP is Eliminated

The statewide IPP fills a critical, longstanding gap in forensic evaluation capacity across CONREP programs. Additionally, over the last few years, there have been increasing evaluation and workload demands placed on CONREP CPDs in support of local IST diversion recommendations, initiating Community Assistance, Recovery, and Empowerment (CARE) petitions for eligible CONREP patients pending discharge and release from their forensic commitment, and increased training requirements needed to address increased turnover of clinical staff across the programs. Eliminating the IPP and reverting back to the prior service model, would likely strain local program resources leading to delays in evaluations and placements.

Moreover, CONREP programs already face staff turnover and ongoing recruitment and retention challenges that would hinder their capacity to reestablish this function.

Conclusion and Recommendation

The program's demonstrated and accelerating successes show proof of concept in the program's utility and value. The IPP has the potential to make IST hospital beds available sooner through centralized and efficient identification of step-down ready NGI and OMD patients to CONREP programs matched to their treatment and risk needs.

DSH recommends making the IPP an ongoing component of CONREP and DSH's IST solutions. The 2026-27 May Revision proposes statutory changes to eliminate the sunset date of the IPP and to make the panel a permanent component of DSH's continuum of care.

PROGRAM BACKGROUND

Conditional Release Program (CONREP)

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 community outpatient treatment system. CONREP is an effective way to transition patients to the community and results in dramatically better outcomes than direct release to the community at the end of a commitment term. Individuals suitable 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 in California. 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, home visits, substance abuse screenings, psychiatric services, case management, court reports, and 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 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.

CONREP Continuum of Care

In order to address these service model limitations, CONREP began expanding its continuum of care beyond the traditional community outpatient treatment (COT) model in 2021 to include Forensic Assertive Community Treatment (FACT) Programs, Statewide Transitional Residential Programs (STRP), and other secured transitional programs supporting both step-down and step-up placement options within Institution for Mental Disease (IMD) and Mental Health Rehabilitation Center (MHRC) facilities. These programs allow for care in an enhanced supportive community setting with services delivered on-site where the CONREP clients reside. Not only do these various settings allow for better continuity of care and the ability to progress clients down to the least restrictive setting, but this expanded continuum also allows the ability to step clients up as needed for stabilization and with the goal of avoiding rehospitalization in the state hospital or revocation. An added benefit of the expanded CONREP continuum is that it allows for sooner step-down of state hospital patients into CONREP, allowing for

the backfill of those state hospital beds with IST patients. Additionally, these service options provide an alternative to state hospital step-up placement when a CONREP patient may need to be rehospitalized.

The implementation of CONREP's expanded continuum of treatment options has occurred in parallel with the implementation of the IPP. To that end, the IPP has developed the expertise required for effective evaluation and placement to these programs.

Statutory Authority
Under California Penal Code section 1604, the court orders an evaluation when a state hospital or treatment facility[2] director recommends an individual for consideration of COT or step-down from a state hospital. Traditionally, the CPD was responsible for these evaluations. Pursuant to California Welfare and Institutions Code (WIC) section 4360.5 (a), the IPP pilot designates the IPP as the CONREP CPD, replacing the traditional CPD role in placement evaluations for NGI, OMD and MDSO patients.

IPP Program Staff Allocation

The program was authorized for eight (8) positions at a cost of approximately $1.7M annually as detailed below. This funding was initially authorized in FY 22/23 as part of the IST Solutions budget package.

1.0 Senior Psychologist Supervisor
5.0 Consulting Psychologist Evaluators
2.0 Administrative positions
- 1.0 Office Technician
- 1.0 Analyst II

IPP Referral Process and Types of Referrals

The IPP can receive referrals from the court, state hospitals, and CONREP programs, which include both COT and CONREP continuum locked mental health facilities, specifically MHRCs and IMDs. Referrals to the IPP are initiated in three ways:

> **Court (Minute) Order -** Court Ordered Referrals - A court issues a minute order, often after a patient files a writ of habeas corpus or during commitment extension hearings to consider CONREP as an alternative to unconditional release.

[2] The term treatment facility includes IMDs (i.e., Golden Legacy or Canyon Manor, these are the only two other locked facilities available within the DSH-CONREP continuum of care.)

Standard - State hospital and CONREP IMDs refer patients that have been identified as potentially ready for COT in the CONREP continuum of care.

Screening - IPP evaluators screen medical and custody records to identify IMD and select state hospital patients who may be ready for CONREP. When indicators are present, the patient is referred for full evaluation.

IPP Evaluation and Placement Recommendation

Evaluations are comprehensive and comprised of the following: participation in CONREP-State Hospital collaboration meetings regarding the case; comprehensive medical and criminal/custodial record review; collateral interviews with DSH, IMD (when applicable), and CONREP interdisciplinary team members; violence risk assessment- using the HCR-20v3, a well-validated risk assessment instrument and protocol; sexual violence risk assessment (when relevant to the referral); and analysis of violence mitigation strategies and treatment needs.

Consistent with California Penal Code section 1604, evaluations require the IPP to opine whether the patient is no longer a danger to the health and safety of others or themselves when under supervision and treatment in the community, recommend the most appropriate level of care for a patient, whether to be placed in the CONREP continuum of care or retained at the state hospital, (Retain and Treat[3]); and recommend a plan for supervision and treatment. The Medical Director or designee of the applicable treatment facility determines the final placement recommendation.

IPP Program Development

The IPP program was developed in four phases outlined below.

Phase 1: Program Development (July 2022–June 2023)

DSH established the IPP by hiring dedicated staff and implementing a standardized statewide process to assess outpatient readiness. The assessment is based on risk, need, responsivity (RNR) principles[4] and is used to guide placement decisions.

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[3] Retain and recommendations result when an evaluation determines that the patient remains a danger to the health and safety of others and cannot be safely and effectively treated at a less restrictive environment or the community. For the IMD Recommendations, the evaluation finds that a patient is not a suitable candidate for community outpatient treatment at the time of the evaluation but can be safely and effectively treated in a locked community treatment facility (i.e., an IMD). At the IMD, the patient can continue to work on treatment and should be considered for transfer as provided in California Penal Code section 1026(c), pursuant to Penal Code section 1604. (Note: The CPD continues to be responsible for restoration of sanity evaluations, annual progress reports, and OMD-Civil extensions).

[4] Risk, Need, Responsivity (RNR) Principles, and evidenced based model for maximizing the effectiveness of forensic patient treatment (Andrews and Bonta, 2017.

Before IPP, CONREP programs did not use a consistent approach. Report quality varied widely, and some lacked enough information to support placement decisions. To address this, IPP worked with DSH hospitals and pilot CONREP programs to define referral requirements, standardize documentation, and establish a consistent evaluation protocol.

IPP evaluators were trained in the features and capabilities of CONREP programs statewide, to assess placement across the continuum and provide structured, evidence-based recommendations. Six CONREP programs participated in Phases 1 and 2.

Phase 2: FY 23/24 - Pilot Implementation

During Phase 2, the IPP began piloted the process, conducting evaluations for all referrals related to participating programs. CONREP programs participating in the pilot used the newly established CONREP Collaboration Referral Process with DSH facilities and IMDs. The new process implemented a consistent method for identifying and evaluating individuals for outpatient placement.

Phase 3: FY 24/25 - Expansion

IPP expanded beyond the initial six pilot sites to nine programs statewide, increasing evaluation capacity and extending standardized practices to additional regions. Between Phases 3 and 4, DSH conducted a preliminary evaluation of the work being performed. This evaluation drove adjustments to the approach and shifted operational oversight of the IPP to the team with expertise in forensic evaluations

Phase 4: FY 25/26 - Full Expansion and Ongoing Quality Improvement

IPP expanded to all CONREP programs statewide and increased evaluation activity following an internal review in June 2025. The program also streamlined its evaluation process and report protocol to improve clarity and usability. This allowed evaluators to manage higher caseloads and increased the number of individuals evaluated for step-down placement. The revised report was commended for its use of best practices in forensic and risk assessment by national expert consultants.

IPP also implemented a screening and monitoring process within the state hospitals and IMDs to identify patients earlier in the process. In addition to identifying candidates for evaluation, the screening helped outline steps for patients who are not yet ready for placement. These changes have improved coordination with treatment teams and increased overall program efficiency.

Recent operational changes increased efficiencies and activity of the IPP team which has led to increased recommendations for step-down. Accordingly, these refinements show promise to increase appropriate

CONREP placements. The IPP continues its quality improvement effort with CONREP programs and DSH hospitals through stakeholder meetings, data collection, surveys, and feedback.

DATA AND ANALYSIS

DSH gathered data to answer the following questions about the IPP program as it was originally conceived and as it evolved in response to actual experience. DSH consulted a team of forensic evaluators to review reports and gather data from those reports, satisfaction surveys, and other internal data sources tracking patient and referral data.

1. Did the IPP program lead to expanded access to CONREP for NGI and OMD patients?
2. Is the program productive and efficient in its use of resources?
3. Has IPP improved the quality and utility of CONREP placement reports?
4. Do IPP placements improve outcomes or affect public safety?
5. Did the program lead to increased participation in CONREP for NGI and OMD patients?
6. How do courts, hospitals and CONREP programs perceive the IPP?

Limitations
DSH could not compare the number of completed evaluations, placement recommendations and outcomes, and other metrics to pre-IPP years because CONREP programs did not track this data.

1. Did the IPP Program Lead to Expanded Access to CONREP for NGI and OMD Patients?

Data reveals the IPP is expanding access to lower levels of care for DSH patients. Notably, the IPP has increased access by allowing placement in the most appropriate program available statewide. This is a significant improvement from the prior process where the local CPD assessed placement options only available within their assigned program/region. Increasingly, IPP evaluators are able to recommend step-downs to lower levels of care as the CONREP continuum expands and as a transitional step prior to placement in the patient's home CONREP. Over time, a greater proportion of patients have been placed in COT via their home CONREP. Standard (treatment team initiated) referrals were more likely to lead to a step-down recommendation and placement. Additional details are provided below.

Placement Outside of Home CONREP
Centralized placement and the IPP evaluators' in-depth expertise in the array of statewide placement options expanded patient access to programs that meet their individual treatment and risk needs. The majority of placements (77%) and

placement recommendations (88%) were for programs outside the patients' home CONREP program. These results reveal that IPP allows for a fair application of program considerations for all patients and the expanded CONREP continuum, demonstrating the utility of centralized placement expertise.

- Total patients ordered for placement in CONREP treatment option outside the patients' home program 60 of 74 total placements (81%)
    - IMD 45
    - COT, FACT, STRP 15
- Total patients recommended for placement outside their home program 97 of 110 total step-down recommendations (88%)

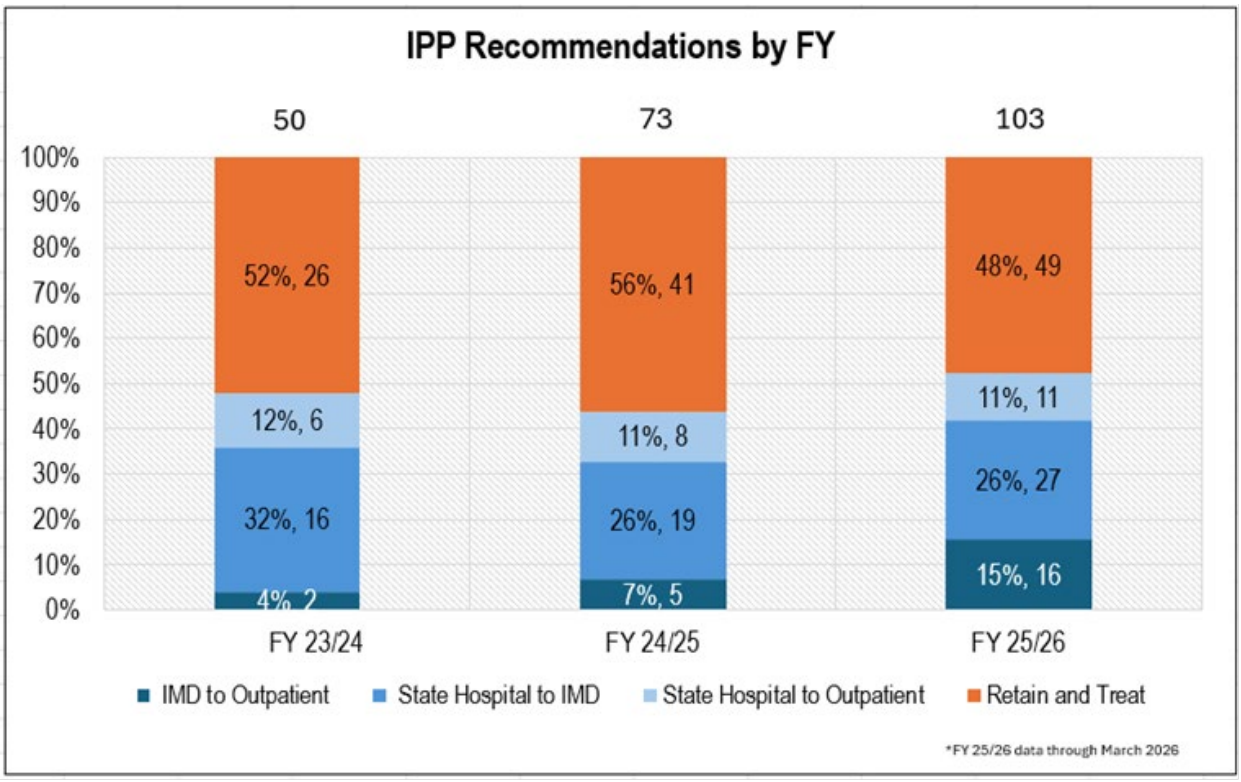
Placement Recommendations – IPP Findings

As of March 31, 2026, of the 226 individuals evaluated, IPP evaluators recommended 110 (49%) patients be placed in a lower level of care. Of the 110 recommended for a lower level of care, 85 (76%) were in the NGI commitment class and 26 (24%) were in the OMD[5] commitment class.

The data show a shift from retain and treat recommendations toward lower levels of care and outpatient placement. Recommendation rates for retain and treat declined (from 52% in FY 23/24 and 56% in FY 24/25 to 48% so far in FY 25/26). Additionally, the IMD to outpatient recommendation rate nearly doubled year by year (from 4% in FY 23/24 to 7% in FY 24/25, to 15% so far in FY 25/26).

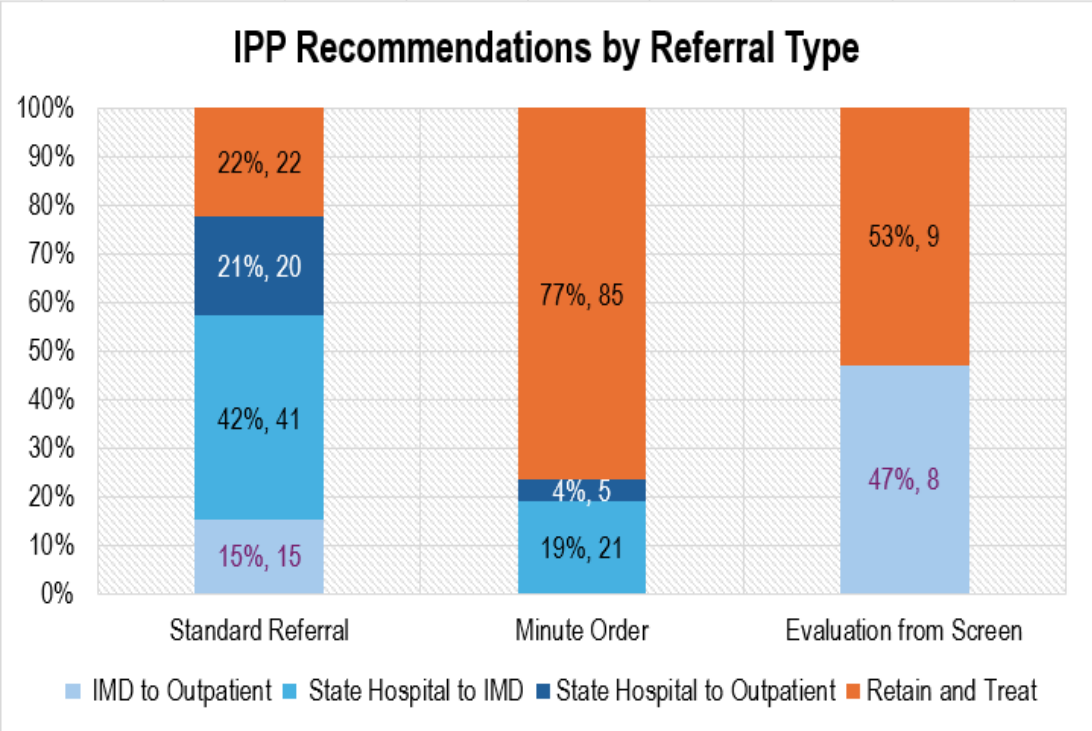
The figure below shows the number of evaluations and proportion of recommendations to the various lower levels of care and retain and treat by Fiscal Year.

[5] Inclusive of MDSO commitments placed into CONREP.



IPP Recommendations by Referral Type

Standard referrals are the most likely to lead to step-down recommendations, at a rate of 78%, followed by referrals from screens at 47%. These results show that standard treatment team referrals are the most fruitful. Court (minute) order referrals were substantially less likely to lead to a step-down recommendation (24%), suggesting a less efficient pathway to step-downs than standard treatment team referrals. Treatment teams generally initiate referrals after extended clinical observation and multidisciplinary review of psychiatric stability, treatment engagement, and violence risk, which may contribute to the higher rate of step-down recommendations observed in standard referrals. The figure below shows the placement recommendations for standard and minute order referrals and evaluations resulting from CONREP readiness screenings.



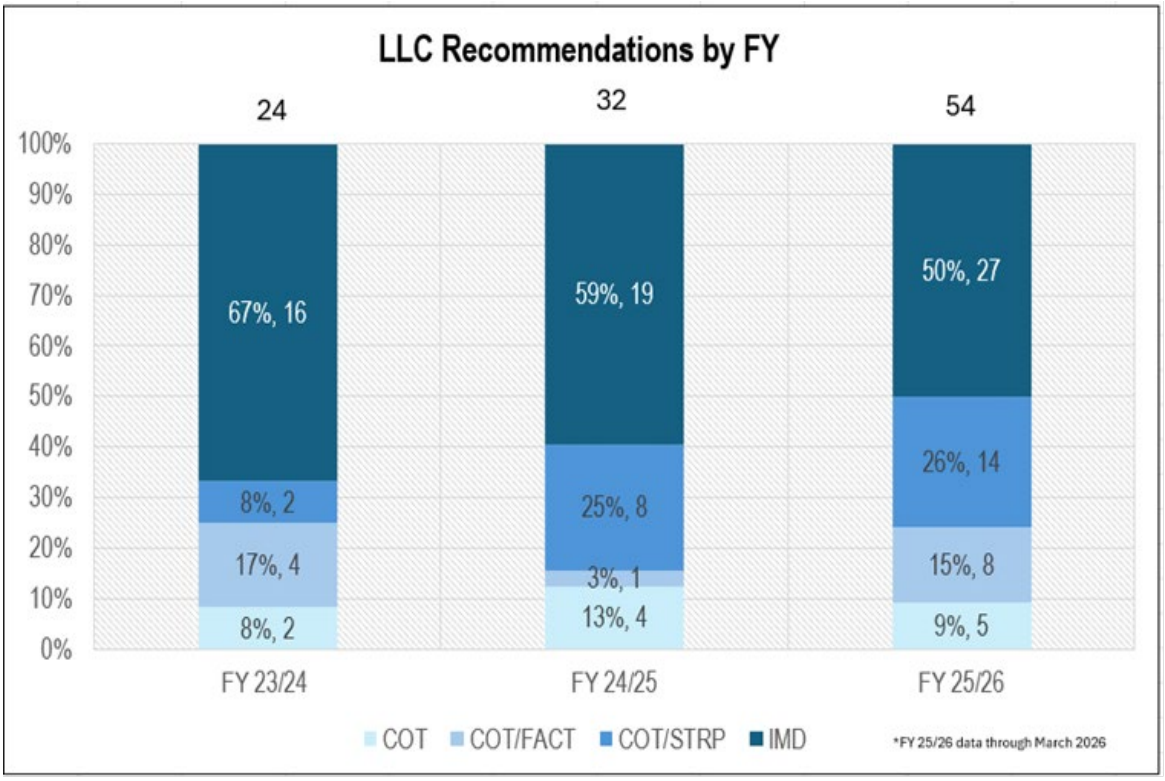
Court Outcomes and Placement

Courts have ordered placement of 96 IPP-evaluated patients to a lower level of care (LLC). Of the 48 evaluations pending court outcome, evaluators recommended placement to a LLC in 25 of these cases. Note: Of those ordered placed at a LLC, 18 patients were pending placement at the time of this report.

Recommendations to Lower Levels of Care

Over time, the proportion of IMD placement recommendations decreased, while the proportion of lower-level COT recommendations, primarily to STRP and FACT placements, has increased. Early in program implementation, about 67% percent were recommended for IMD placement. By Phase 4 (FY 25/26) LLC recommendations were evenly split between IMD (50%) and COT (50%). Overall, of the COT recommendations, 22.9% were for regular COT; 27.1% were for STRP; and 50% were for FACT.

The figure below shows the proportion of IMD and COT recommendations: regular COT, STRP, and FACT resulting from IPP evaluations by Fiscal Year.



2. Is the Program Productive and Efficient in its Use of Resources?

The IPP is an effective way to manage and conduct CONREP placement evaluations. The centralized nature of the IPP supports efficient use of resources, permitting consolidation of multiple functions that would be otherwise scattered across the state with varying levels of quality control. The data show the IPP is an effective way to manage quality control and efficiency. Additionally, it can increase the tempo of step-down referrals. The sections below detail these results.

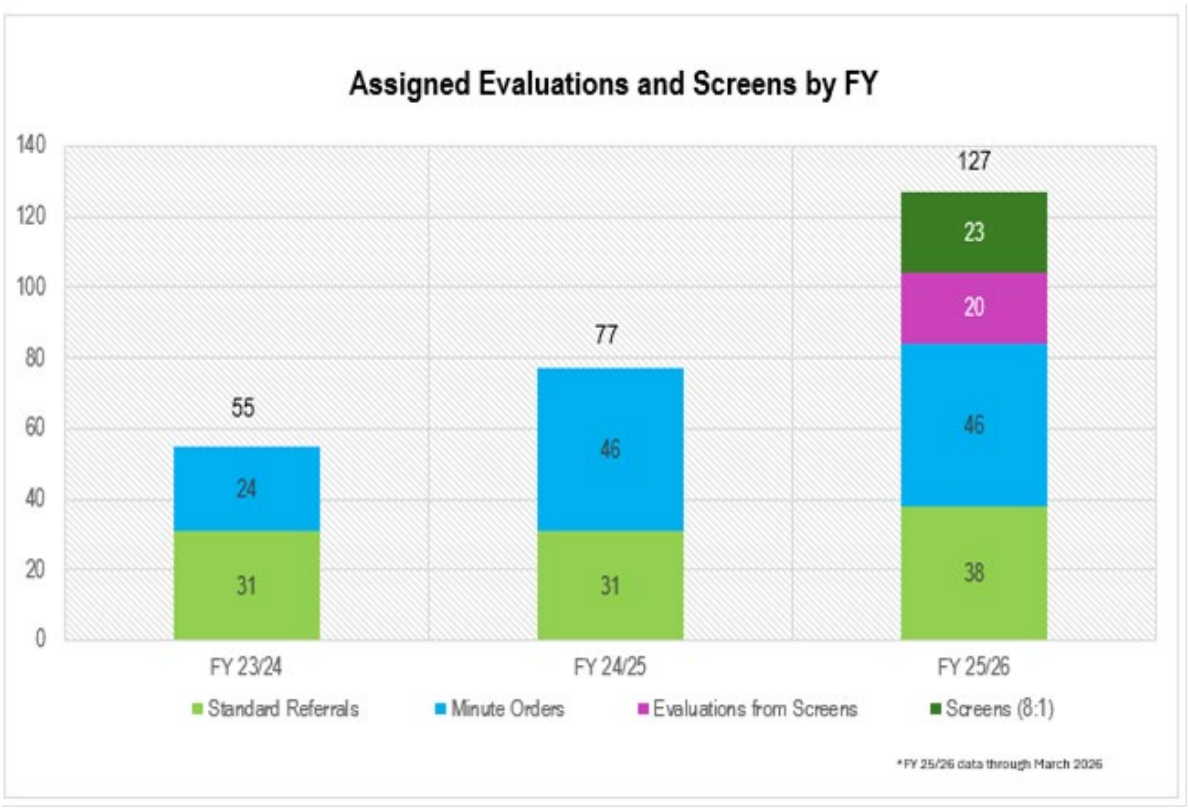
IPP Productivity

The IPP has demonstrated expanded and sustained forensic evaluation capacity over time, particularly in response to programmatic changes. These changes included streamlining evaluation protocols, increasing evaluator caseloads, and screening patients for CONREP readiness. This increased productivity reveals the program's potential. It also shows that the IPP is meeting and even exceeding the demands of its role.

Efficiency as a Result of Centralized Administration

The IPP significantly enhances efficiency in managing patients referred for CONREP evaluation and placement through its centralized administration structure. Program administrators proactively track key timelines to ensure court-ordered hearing schedules are met and follow-up evaluations are completed without delay. This replaces a previously fragmented and inconsistent process that often contributed to unnecessary delays in placement. Centralized administration improves operational efficiency by streamlining record collection,

coordinating and standardizing scheduling, monitoring and balancing evaluator workloads, ensuring prompt submission of completed evaluations, and facilitating timely communication with stakeholders. In addition, the centralized structure strengthens efficiency in decision-making by systematically collecting, analyzing, and reporting CONREP evaluation and placement data, including IPP stakeholder survey feedback, to support ongoing performance monitoring and process improvement. The figure below displays the number of completed IPP evaluations and equivalents by type per month over the course of the program.



Note: Eight screens are equal to the workload of one evaluation.

Increased productivity and efficiency via pre-evaluation screening process

The IPP implemented a screening process to identify potentially step-down ready patients through medical record review and treatment team consultation, with promising results. The program completed 33 screens in the IMDs, creating 8 recommendations for COT, a rate of 24%. This outcome reveals the potential for using screens to proactively identify IMD patients for step-down to outpatient settings. The screening process improved IMD patient access to less restrictive levels of care and supported greater utilization of IMD bed capacity for patients to step-down from the state hospitals. The IPP program has also begun screenings at select state hospitals to further expand step-down access and increase availability of state hospital beds.

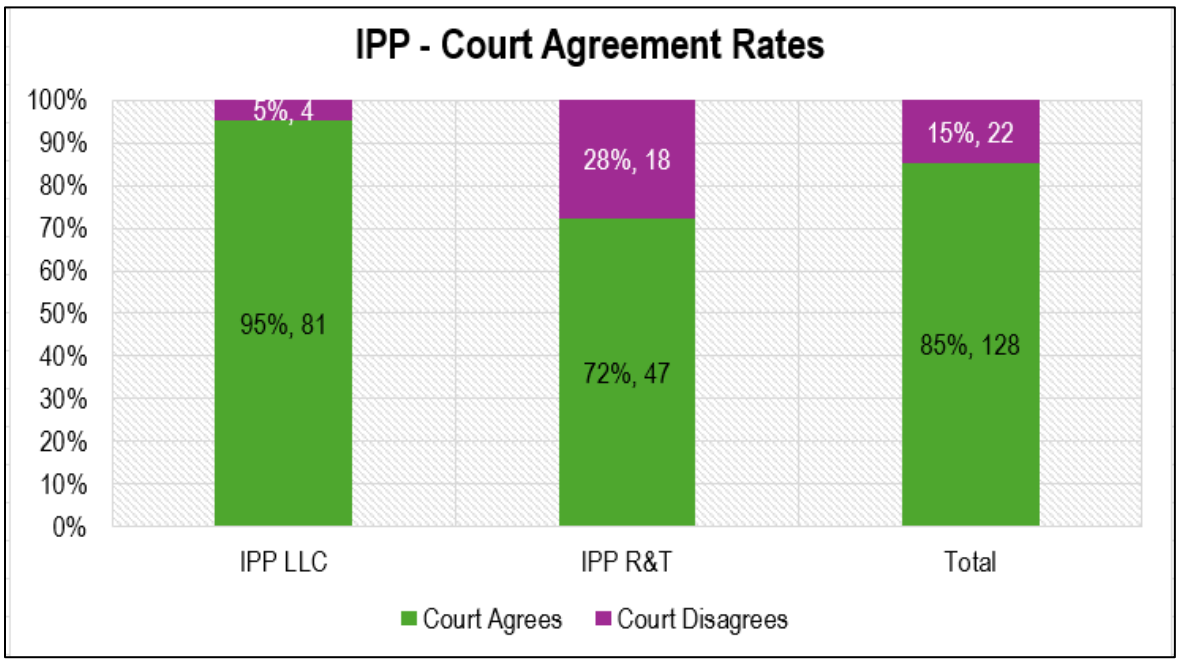
3. Has IPP Improved the Quality and Utility of CONREP Placement Reports?

Only trained and experienced forensic psychologists can serve on the panel and the panel has a standardized protocol and a robust quality review process. Previously, report quality and content varied considerably, and clinicians from the various CONREP programs without doctoral degrees or forensic training would often complete the reports. A team of nationally recognized experts attest their alignment with forensic best practices, and courts and other stakeholders praise their objectivity and quality. Courts agree with the evaluators' opinions at a high rate (85%), indicating the reports are useful to their decisions. When courts order a lower level of care against evaluator recommendations, patients return to the hospital at higher rates. Overall, the IPP have improved the reports stakeholders rely upon. The sections below detail these findings.

a) Are the Courts Accepting IPP Report Recommendations?

IPP-Court agreement rates show that courts value IPP evaluations and rely on them to form their decisions. The courts agree with the IPP placement recommendations at a high rate, when considering agreement rates reported in forensic research.[6] Overall, the courts agree with IPP recommendations 85% of the time. When the IPP recommends a lower level of care, the court agrees 95% of the time. Courts were more likely to disagree with retain and treat recommendations, disagreeing with 28% of these recommendations. Notably, individuals placed in step-down against the IPP's retain and treat recommendation were returned at a substantially higher rate (88%) than those placed in accordance with the recommendation (5%). Better outcomes for placements aligned with IPP recommendations may reflect the validity of evaluators' clinical risk assessment, placement recommendations, and the capacity of recommended CONREP programs to manage patients effectively.
The figure below displays court agreement rates with IPP recommendations categorized by LLC, Retain and Treat, and the overall agreement rate.

[6] Evaluator- Court agreement rates in a frequently cited article indicate 67 to 87 percent agreement rates. Annie H. Nguyen, Marvin W. Acklin, Kristen Fuger, W.N. Gowensmith, Lawrie A. Ignacio, Freedom in paradise: Quality of conditional release reports submitted to the Hawaii judiciary, International Journal of Law and Psychiatry, Volume 34, Issue 5, 2011, Pages 341-348.



b) What Aspects of the IPP Reports Improve the Utility of the Reports?

Standardized Report Process and Qualifications

Statewide, the quality and consistency of CONREP placement evaluations have improved under the IPP. Prior to the IPP, evaluation practices varied widely across programs. Some reports included comprehensive risk assessments, while others omitted risk analyses entirely or consisted of brief, unsupported conclusions regarding acceptance or rejection. Evaluations were often conducted by Licensed Clinical Social Workers (LCSWs) and Marriage and Family Therapists (MFTs), with a wide variability in level of forensic expertise and knowledge of the various placement options within CONREP.

Under IPP, all evaluations are conducted by forensically trained psychologists with deep knowledge of statewide CONREP programs. Additionally, evaluations are subject to structured quality review by a senior forensic psychologist. Evaluators follow a standardized assessment protocol that includes comprehensive record review, collateral and patient interviews, and use of a validated risk assessment instrument. Regular consultation and weekly clinical case reviews further support consistency and clinical rigor. Courts and other extremal stakeholders have consistently praised the quality and utility of the reports.

Program Refinements

In response to an internal efficiency review and court feedback, the program revised its evaluation report template. The new template reduced the length by more than half and prioritized clinically relevant risk and placement factors. This allowed IPP to expand its caseload. Nationally recognized experts were engaged to review revised IPP reports and they commended the quality and alignment with forensic assessment best practices.

4. Do IPP Placements Improve Outcomes and Impact Public Safety?

Overall Public Safety Impact

The validity of IPP evaluations is reflected in the low rate of rearrests, AWOLs, and hospital returns, all indicators of potential destabilization. Notably, no violent behavior was reported among individuals placed in CONREP with IPP evaluations over the nearly three years of the program. Although sample sizes are small, rearrest rates were even lower than those reported in the 2024 CONREP Effectiveness Report[7]. There was only one AWOL, and rehospitalization rates did not increase in placements aligned to IPP evaluator recommendations. Returns to higher levels of care occurred more often when court-ordered placements did not align with IPP recommendations. The sections below provide further detail.

a) Do IPP Evaluations Result in Lower Re-Arrest Rates?

Only one person who received an IPP evaluation and was placed at a lower level of care (1 of 74 or 1.4%) was arrested on a misdemeanor charge and later released. This 1.4% rearrest rate is about half of the one-year fixed recidivism rate of 3.2% reported in the DSH 2024 CONREP Effectiveness Report which assessed the effectiveness of CONREP, a supervised outpatient treatment program, in effectively reducing recidivism and improving patient outcomes. In this case, the court's decision to release to a lower level of care did not align with the IPP evaluator's recommendation.

b) Do IPP Evaluations Result in Lower AWOL Rates?

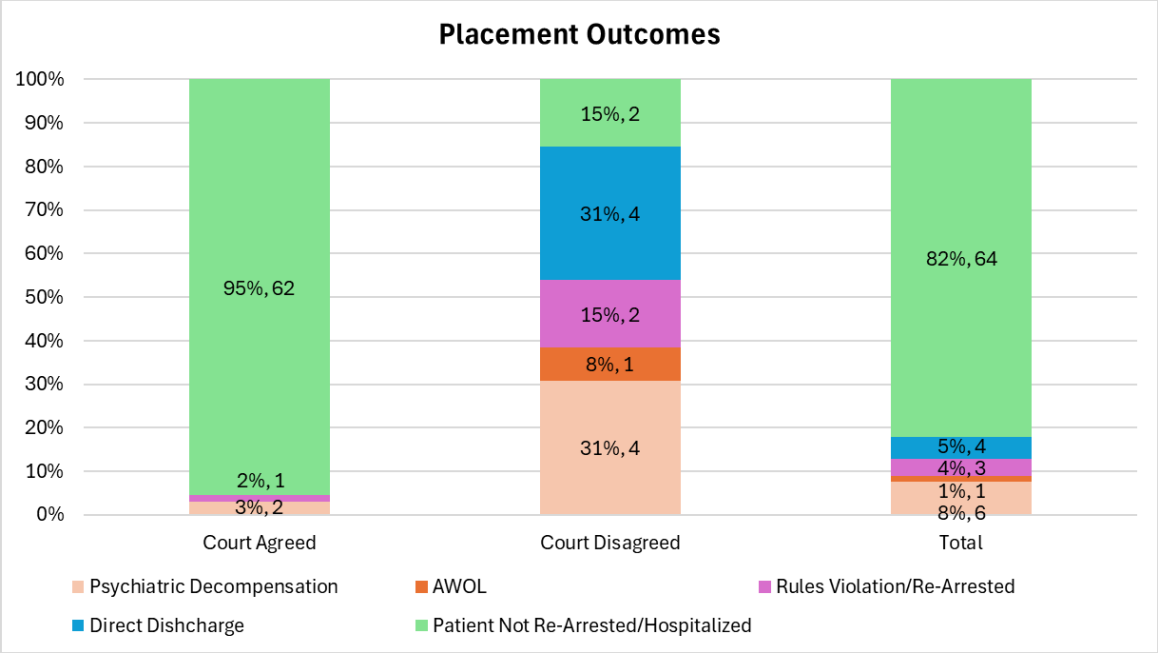
Overall, only one person who received an IPP evaluation and was placed in a step-down program (1 of 74 or 1.4%) went AWOL. Of note, the court's order to place the individual in a step-down program did not align with the IPP evaluator's opinion. In one large CONREP program tracking AWOL rates, the AWOL rate fell from 17% pre-IPP implementation to 0 post full implementation of IPP.

c) Do IPP Evaluations Result in Fewer Returns to Higher Levels of Care?

Ten of the 74 (13.5%) individuals evaluated by IPP and ultimately placed in a lower level of care were returned to a state hospital for stabilization and treatment. This rate is higher than the 5% hospital return rate reported in the 2024 CONREP Effectiveness Report, as a benchmark for comparison. However, outcomes differed markedly by alignment with IPP recommendations. Individuals court-ordered to step-down programs that were not aligned with the IPP recommendation were returned at a substantially higher rate (88%) than those ordered in accordance with the IPP's recommendation (5%), a rate consistent with the CONREP Effectiveness Report benchmark.

[7] The CONREP Effectiveness Report, required pursuant to PC 1617, was last completed in July 2024 and based on patients released from state hospitals between 2012 and 2017

Of note, none of the hospital returns included violent or aggressive actions, including those for arrests, AWOL, rules violations, or psychiatric decompensation. The three returns in court concordant cases included cases returned for clinical decompensation and one for a rule violation. The seven cases where there was a misalignment between IPP's recommendation and the court's decision included one arrest, one AWOL, a rules violation, and four cases of clinical decompensation. The chart below depicts hospital return rates (categorized by reason for return) by court agreement and disagreement with the IPP evaluator opinion.



5. Did the Program Lead to Increased Participation in CONREP for NGI and OMD Patients?

The data show a trend towards achieving this goal. While the number and proportion of patients placed in CONREP have not yet yielded significant increases, DSH expects these numbers to rise. IPP-related placements have remained mostly stable pre and post IPP implementation but are now showing an upward trend. Increasing acuity of the patient population, higher numbers of older adult and medically fragile patients, and sex offender registrants pose increased placement challenges. The IPP's ability to identify statewide CONREP resources and programs that meet the unique placement challenges of these patients as the continuum expands, will facilitate increased participation.

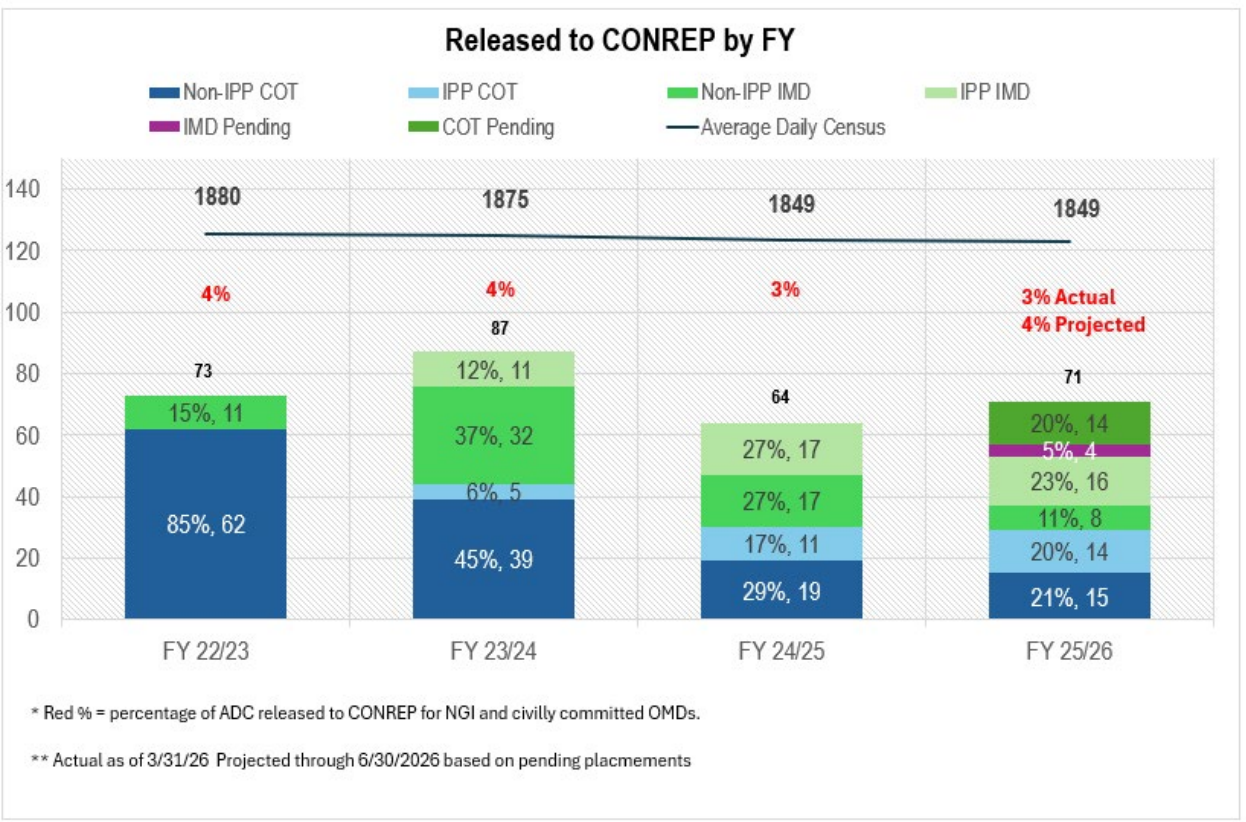
Recent fiscal years show declines in annual releases to CONREP which may be attributed to a decline in the overall DSH state hospital population eligible for CONREP. However, FY 25/26 shows a promising upward trend, particularly as the continuum of expanded treatment options in CONREP become available. Notably, a large number of patients were released to CONREP in November 2023,

after the Golden Legacy IMD opened, partially accounting for the uptick in FY 23/24 placements and the increased proportion of IMD placements in that time frame.

Cumulatively, from FY 23/24 to date, the IPP accounted for 74 of 204 actual placements (36%) and is projected to account for 92 of 222 (41%) of the projected placements through FY 25/26. This proportion will reach 100% in future years, because all CONREP programs are now participating in the IPP program. As of FY 25/26, CONREP pending and actual placements are trending 4% of the average daily census, indicating the current level of releases aligns with prior year trends.

The figure below shows the number and proportion of (COT vs IMD) and CONREP placements in the fiscal year before and fiscal years after IPP implementation. Patients currently awaiting CONREP placement (IPP-evaluated) were added to FY 25/26 as a metric for projected placements for the last quarter.

In addition, the figure below shows the percentage of the IPP-eligible population (average daily census of hospitalized NGI and civilly committed OMD patients) released to CONREP by Fiscal Year. Note: the FY 24/25 average daily census has been applied to FY 25/26 as the year has not concluded.



6. How do Courts, Hospitals and CONREP Programs Perceive the IPP?

The IPP conducts regular satisfaction surveys with CONREP and state hospital programs to gauge the level of satisfaction with aspects of the program and identify areas for improvement, with the latest report conducted in November 2025. In December 2025, the IPP began surveying judges or other court officers. The results for the latest surveys are summarized below.

In general, courts, hospitals and CONREP programs perceive the IPP evaluations as neutral, well-reasoned, and of high quality. Survey results suggest that stakeholders generally view IPP positively and see it as a neutral, fact-based source of independent clinical assessment that adds credibility to placement decisions. While the IPP program is accepted and trusted, more time is needed to evaluate its full impact on collaboration and placement outcomes. During the implementation of the program, issues identified included confusion about the referral process, report length and timing, and some unrealistic expectations for release, all of which have already been or are being addressed.

Justice Partner Stakeholder Survey Results

In December 2025, DSH surveyed court-based justice partners, including judges, attorneys, courtroom clerks, and court supervisors, from six CONREP programs statewide.

Overall, justice partners express positive views about the program and little negative criticism. They find IPP evaluations to be independent, fact-based, and well-reasoned. Standardized risk assessment was seen as a meaningful improvement over prior practice and was the most consistently cited positive development. Perceptions of evaluation quality were mostly positive. A majority agreed or strongly agreed that IPP evaluations contain sufficient information to support placement opinions and decisions. They generally viewed IPP evaluations as independent from hospital or CONREP perspectives and benefited the courts with a neutral perspective.

CONREP and State Hospital Stakeholder Survey Results

In November 2025, DSH surveyed clinical and programmatic stakeholders, including treatment team clinicians, social workers, psychiatrists, and program staff – across DSH hospitals, CONREP COT, IMD, and FACT settings. Sixty-one participants responded, representing programs statewide. Results reflect frontline perspectives on IPP utility, program understanding, and operational functioning.

In general, clinical and program stakeholders generally see the IPP as providing high quality, independent assessments. Stakeholders largely trust the neutrality and factual basis of evaluations.

Satisfaction with the program is positive, though many respondents remain neutral. This indicates general acceptance of the program and suggests there is general trust in the neutrality of IPP evaluations. Many respondents reported that IPP provides a neutral perspective, a good way to resolve disagreements between hospitals and CONREP, and a way to provide additional clinical insight into patient readiness for step-down.

OTHER CONSIDERATIONS

The information below highlights the issues and considerations if the IPP program were eliminated and the placement evaluation service were returned back to the responsibility of local CONREP CPD's.

The statewide IPP fills a critical, longstanding gap in forensic evaluation capacity across CONREP programs. CONREP programs have faced increasing rates of staff turnover and ongoing recruitment and retention challenges that would hinder their capacity to reestablish this function. Additionally, over the last few years, there have been increasing evaluation and workload demands placed on CONREP CPDs in support of local IST diversion recommendations, initiating CARE petitions for eligible CONREP patients pending discharge and release from their forensic commitment, and increased training requirements needed to address increased turnover of clinical staff across the programs. Eliminating the IPP and reverting back to the prior service model, would likely strain local program resources leading to delays in evaluations and placements.

Further, access to CONREP programs would diminish as centralized placement coordination would no longer be available. This would be driven by a loss of established IPP advantages, including timely identification of people eligible for step-down, less focus on treatment targets for CONREP readiness, and restrictions on the range of CONREP options considered. Reductions would be especially evident for hard-to-place patients, such as Penal Code 290 registrants and those with medical needs. As a result, more patients could be retained at higher, more costly, levels of care.

CONCLUSION

The program's demonstrated and accelerating successes show proof of concept in the program's utility and value. The IPP has the potential to make IST hospital beds available sooner through centralized and efficient identification of step-down ready NGI and OMD patients to CONREP programs matched to their treatment and risk needs.