

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

This report encompasses data collected between September 14, 2021, and September 30, 2023. For comparison, it also presents data for the first year of ETP activation (September 14, 2021, to September 30, 2022), as well as data for the second year of activation (October 1, 2022, to September 30, 2023). The data shows patient characteristics including gender, ethnicity, age on admission, legal group, and years at DSH. Data also includes information on staffing requirements and 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 the training offered to staff who are primarily assigned to other units but could be asked to provide support in the ETP.

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 C2).

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

BACKGROUND

Assembly Bill 1340 (Achadjian, Statutes of 2014) authorized DSH to establish 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, and 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, 2023. 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. (45 CFR 164.512(a); Civ. Code, § 56.10, subd. (b)(9).)

I. Methodology

This reporting period encompasses data collected between September 14, 2021, and September 30, 2023. In addition to cumulative data, this report also presents data for the reporting period from September 14, 2021, to September 30, 2022 (Period 1), as well as data for the reporting period from October 1, 2022, to September 30, 2023 (Period 2). 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. 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	Period 1 N%^a	Period 2 N%^a	ETP Total N (%)^b
Male	*** (***)%	<11 (***)%	19 (100%)
Female ^c	0 (0%)	0 (0%)	0 (0%)

^a Admissions per reporting period.

^b Total patients served.

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

Ethnicity ^{a, b}	Period 1 N (%)	Period 2 N (%)	ETP Total N (%)	DSH Patients (%) ^a	DSH Population (%)	CA Population (%)
Asian	<11 (***%)	<11 (***%)	<11 (***%)	4%	2.6%	16%
Black or African American	<11 (***%)	<11 (***%)	<11 (***%)	26%	26.3%	6%
Hispanic or Latino	<11 (***%)	<11 (***%)	<11 (***%)	29%	29.9%	40%
White	<11 (***%)	<11 (***%)	<11 (***%)	37%	35.7%	35%
Other Non- White/Unknown	<11 (***%)	<11 (***%)	<11 (***%)	4%	5.5%	3%

^a Data represents DSH inpatients only. Data sources: Business Intelligence Center (BIC) reports managed by the DSH Data Management Office (DMO), and the U.S. Census Bureau (<https://www.census.gov/quickfacts/fact/table/CA>).

^b Total patients served per reporting period.

¹ Data has been de-identified in accordance with the California Health and Human Services Agency 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.

Age	Period 1 N (%)	Period 2 N(%)	ETP N (%)	DSH N (%)
18-29	<11 (***%)	<11 (***)	<11 (***)	493 (9%)
30-41	<11 (***%)	<11 (***)	*** (***)	1,556 (28%)
42-53	<11 (***%)	<11 (***)	*** (***)	1,272 (23%)
54-65	0 (0%)	0 (0%)	0 (0%)	1,419 (26%)
66-77	0 (0%)	0 (0%)	0 (0%)	723 (13%)
78-90	0 (0%)	0 (0%)	0 (0%)	*** (***)
91+	0 (0%)	0 (0%)	0 (0%)	<11 (***)
Mean Age (years)	41.25	39.0	40.84	48.91

Legal Group	Period 1 N(%)	Period 2 N(%)	ETP N (%)	DSH N (%) ^a
Incompetent to Stand Trial	<11 (***%)	<11 (***%)	<11 (***%)	1,740 (31%)
Not Guilty by Reason of Insanity	<11 (***%)	<11 (***%)	<11 (***%)	1,207 (22%)
Offender with a Mental Disorder	<11 (***%)	<11 (***%)	<11 (***%)	998 (18%)
Lanterman-Petris-Short Act	<11 (***%)	<11 (***%)	<11 (***%)	570 (10%)
Sexually Violent Predator	<11 (***%)	<11 (***%)	<11 (***%)	943 (17%)
Coleman ^b	0 (0%)	0 (0%)	0 (0%)	105 (2%)

^a DSH residents' information on census as of 9/30/2023.

^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 ^a – Current Admission ^b	Period 1 N (%)	Period 2 N (%)	ETP N (%)	DSH N(%) ^c
0-5	11 (69%)	<11 (***%)	12 (63%)	3,651 (66%)
6-10	<11 (***%)	<11 (***%)	<11 (***%)	693 (12%)
11-15	0 (0%)	0 (0%)	0 (0%)	522 (9%)
15 -20	<11 (***%)	<11 (***%)	<11 (***%)	385 (7%)
20-25	0 (0%)	0 (0%)	0 (0%)	148 (3%)
25+	0 (0%)	0 (0%)	0 (0%)	164 (3%)
Mean (years):	5.75	5.65	5.64	5.96

^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 residents' information on census as of 9/30/2023.

Years at DSH ^a – Overall ^b	Period 1 N (%)	Period 2 N (%)	ETP N (%)
0-5	<11 (***%)	<11 (***%)	<11 (***%)
6-10	<11 (***%)	<11 (***%)	<11 (***%)
11-15	<11 (***%)	<11 (***%)	<11 (***%)
15 -20	<11 (***%)	<11 (***%)	<11 (***%)
20-25	<11 (***%)	<11 (***%)	<11 (***%)
25+	0 (0%)	0 (0%)	0 (%)
Mean (years):	9.38	8.48	9.05

^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 May 2024. ETP patient (residents) mean age is 40.84 years, which is about 8 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 ETP patients (residents) closely matches that of DSH in general, though differs from the overall CA population. 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 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 5.64 years at DSH, which is equitable to the average length of stay (ALOS) through DSH at 5.96 years. However, as some ETP patients (residents) have been admitted to DSH on multiple occasions, the combined average time spent in DSH is 9.05 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 stayed consistent across Period 1 (September 14, 2021 – September 30, 2022) and Period 2 (October 1, 2022 – September 30, 2023).

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

^aThis ratio stayed consistent across Period 1 (September 14, 2021 – September 30, 2022) and Period 2 (October 1, 2022 – September 30, 2023).

^bLevel of Care staff include Psychiatric Technicians and Registered Nurses.

Occupancy

Average Monthly Occupancy	N
September 2021	<11
October 2021	<11
November 2021	<11
December 2021	12.52
January 2022	11.97
February 2022	11.50
March 2022	11.00
April 2022	<11
May 2022	<11
June 2022	11.80
July 2022	12.39
August 2022	13.00
September 2022	13.00
October 2022	13.00
November 2022	13.00
December 2022	13.00
January 2023	13.00

February 2023	12.50
March 2023	13.00
April 2023	12.13
May 2023	12.00
June 2023	12.13
July 2023	13.00
August 2023	13.00
September 2023	12.50
Average	11.68

Average Length of Stay	Period 1 Days ^b	Period 2 Days	Cumulative Days ^a
DSH- Atascadero Unit 29 Current Patients	292.85 ± 111.54	304.75 ± 115.20	543.83 (± 268.75)
DSH-Atascadero Unit 29 Discharged Patients	132.33 ± 73.51	244.25 ± 104.00	330.29 (± 230.28)
Total	262.75 ± 121.90	289.63 ± 112.37	465.16 ± 270.22

^a Days are full days and (Standard Deviation).

^b Period 1 included 382 days, while Period 2 included 365 days.

Other Occupancy	Cumulative N ^a	Period 1 N	Period 2 N
The number of patients (residents) whose length of stay exceeds 90 days.	17	14	15
The number of patients (residents) with multiple ETP stays.	0	0	0
The number of patients (residents) whose discharge was delayed due to lack of available beds in a standard treatment environment.	0	0	0

^a The cumulative number will be less than Periods 1 and 2 combined since many patients were present in ETP during both periods,

The ETP began accepting patients on September 14, 2021. Since then, there have been a total of 19 admissions and less than 11 discharges. Between September 14, 2021, and September 30, 2022, there were 16 admissions and less than 11 discharges. Between October 1, 2022, and September 30, 2023, there were less than 11 admissions and less than 11 discharges.

At the end of this reporting period on September 30, 2023, there were 12 patients (residents) on the unit. 17 patients' (residents') length of stay exceeded 90 days during the reporting period. Of those patients (residents), less than 11 have been discharged. No patient (resident) had multiple ETP stays. None of these 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.

Over the reporting period from September 14, 2021, to September 30, 2022, there were less than 11 incidents of seclusion and 92 incidents of ambulatory and non-ambulatory restraints. 44 incidents of seclusion or restraint during that reporting period were related to patients (residents) being deemed an imminent danger to others, while 53 incidents of seclusion or restraint incidents were related to imminent danger to self. Of the 92 incidents of ambulatory and non-ambulatory restraints, 84 involved 5-point bed restraint (non-ambulatory restraints). Less than 11 incidents of ambulatory restraints lasted for 6.56 hours. Non-ambulatory restraint usage lasted for a combined 914.15 hours. These 84 restraint incidents involved less than 11 of 16 patients, however less than 11 of those less than 11 patients accounted for 47 (55%) of the incidents and 689.84 (75%) of the total restraint hours. The less than 11 incidents of seclusion that occurred during that period involved less than 11 patients for a total of 9.13 hours. There have been no incidents of seclusion during subsequent reporting periods.

Over the following period from October 1, 2022, to September 30, 2023, there were 21 incidents of non-ambulatory g restraints. Less than 11 incidents of non-ambulatory restraint use during the reporting period were related to patients (residents) being deemed an imminent danger to others, while 16 incidents of seclusion or restraint were related to imminent danger to self. The total time of non-ambulatory restraint use was 424.08 hours. There were no incidents of ambulatory restraint usage or seclusion during that period.

Cumulatively, since activating the ETP on September 14, 2021, to the end of this reporting period on September 30, 2023, there were less than 11 incidents of seclusion and 113 incidents of both ambulatory and non-ambulatory restraints, for a total of 118 seclusion and restraint episodes. 49 (42%) incidents of seclusion or restraint during the cumulative period were related to patients (residents) being deemed an imminent danger to others, while 69 (58%) incidents of seclusion or restraint were related to imminent danger to self. A total of less than 11 incidents of seclusion involved less than 11² patients for a total of 9.13 hours. These incidents occurred prior to September 30, 2022, and there has been no seclusion use since. Since activation, 105 incidents of 5-point bed restraint (non-ambulatory) occurred in ETP. 5-point restraint usage lasted for a combined 1,338.18 hours. These 105 restraint incidents involved less than 11 of 19 patients. Less than 11 (44%) of these less than 11 patients accounted for 81(77%) of these incidents and 1,188.16 (89%) of the total restraint hours. There were also less 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. Less than 11 patients accounted for 236.35 (18%) of the total non-ambulatory restraint hours.

Restraint and Seclusion Use	Period 1		Period 2		Cumulative	
	N ^a	Duration ^b	N ^a	Duration ^b	N ^a	Duration ^b
Seclusion	<11	9.13	0	0.00	<11	9.13
Ambulatory Restraint	<11	6.56	0	0.00	<11	6.56
Non-Ambulatory Restraint	84	914.10	21	424.08	105	1338.18
Total	97	929.79	21	424.08	118	1353.87

^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									
	Period 1			Period 2			Cumulative		
	N ^b	%	Duration ^c	N ^b	%	Duration ^c	N ^b	%	Duration ^c
Danger to Others	33	39%	262.43	<11	***%	226.76	38	21.5%	489.19
Danger to Self	51	61%	651.67	16	76%	197.32	67	68.5%	848.99

² The 2023 Legislative Report erroneously stated that the incident of seclusion involved less than 11 patients. This was due to a calculation error. For the reporting period covering the 2023 Legislative Report only less than 11 patients were placed in seclusion. This number did not change for the current reporting period.

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

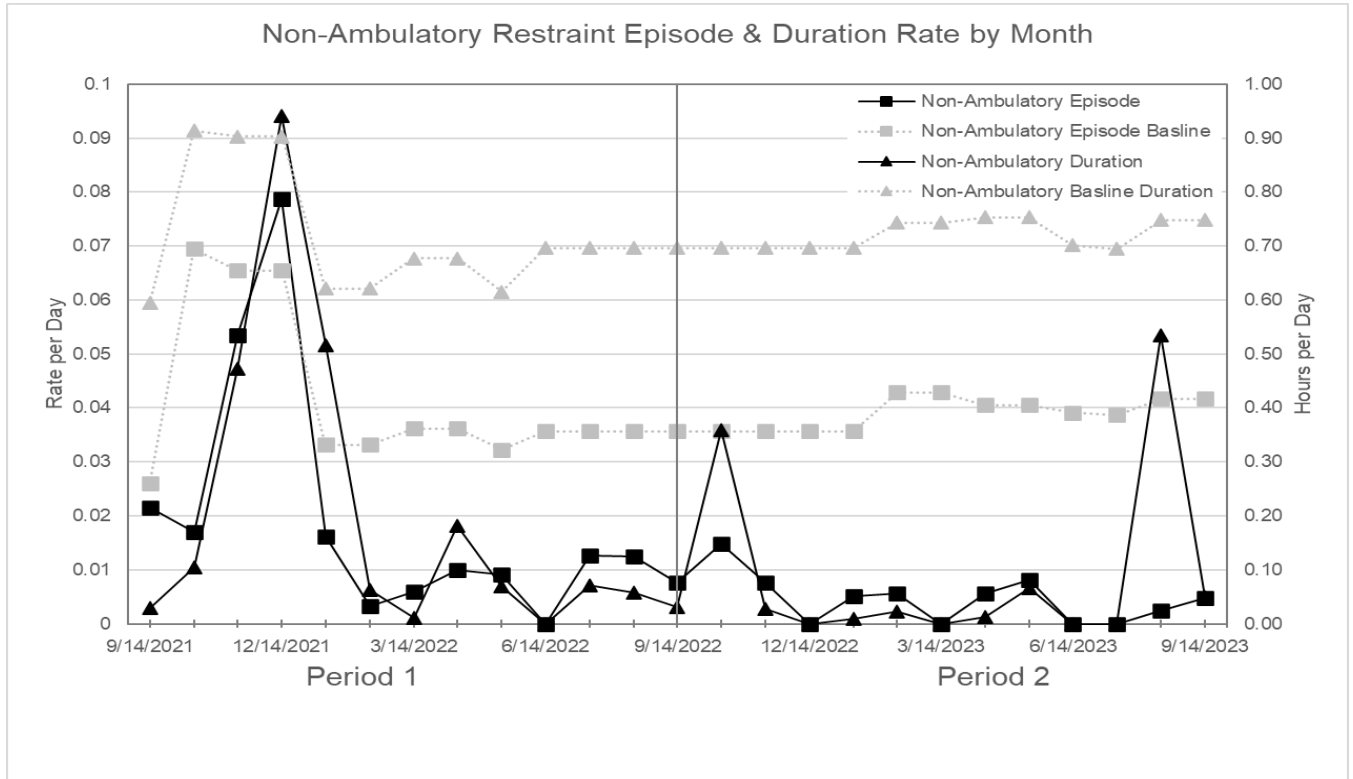
Rates of ETP patient (resident) non-ambulatory restraint use per month were obtained for the six months prior to ETP admission and were compared to non-ambulatory restraint. During both reporting periods rates for frequency and duration of non-ambulatory restraint use significantly decreased after patients were admitted to the ETP. For the combined period between September 14, 2021, and September 30, 2023, placement in the ETP resulted in a decrease in the rates of frequency and duration of non-ambulatory restraint use. Specifically, frequency of non-ambulatory restraint use decreased by 79.22%, while the duration of non-ambulatory restraint use decreased by 80.53%. 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 Admission											
Period 1 ^a						Period 2 ^b					
Prior to ETP Admission			During ETP Admission			Prior to ETP Admission			During ETP Admission		
N ^c	Rate ^d	Duration ^e	N ^c	Rate ^d	Duration ^e	N ^c	Rate ^d	Duration	N ^c	Rate ^d	Duration
162	0.0619	2342.96	84	0.0200	914.10	104	0.0398	1779.83	21	0.0045	424.08

- ^a Period 1 covers September 14, 2021, to September 30, 2022.
- ^b Period 2 covers October 1, 2022, to September 30, 2023.
- ^c Number of distinct incidents requiring non-ambulatory restraint of a patient.
- ^d Rates of aggression are calculated per 1 patient day.
- ^e Time in hours.

Non-Ambulatory Restraint Rate and Duration Prior to ETP vs. During ETP Admission					
Cumulative ^a					
Prior to ETP Admission			During ETP Admission		
N ^b	Rate ^c	Duration ^d	N ^b	Rate ^c	Duration ^d
190	0.0600	2585.76	105	0.0119	1338.18

- ^a Cumulative data covers September 14, 2021, to September 30, 2023.
- ^b Number of distinct incidents requiring non-ambulatory restraint of a patient.
- ^c Rates of aggression are calculated per 1 patient day.
- ^d 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."

Based on this definition there were 12 aggressive incidents that resulted in serious injuries to staff between September 14, 2021, and September 30, 2022. None of these incidents resulted in serious injuries requiring hospitalization. During that review period, there were less than 11 incidents of patient (resident) aggression to self that resulted in serious patients (residents) injuries. None of these injuries required hospitalization. There were no aggressive acts to other patients resulting in injury during the review period.

Between October 1, 2022, and September 30, 2023, less than 11 aggressive incidents resulted in serious injury to staff. None of these injuries required hospitalization. There were less than 11 serious injuries to patients (residents) that were the result of self-injury. None of these incidents required hospitalization. There were no aggressive acts to other patients resulting in serious injury during the review period.

Cumulatively, since activation of the ETP on September 14, 2021, to September 30, 2023, there were 16 aggressive incidents resulting in serious injury to staff. None of these injuries required hospitalization. There were less than 11 serious injuries to patients (residents) as a result of patient aggression to self. None of these incidents required hospitalization. There were no aggressive acts to other patients resulting in serious injury during the review period.

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 the first reporting period dating from September 14, 2021, through September 30, 2022, included no injuries to staff or patients as the result of restraint use. Between October 1, 2022, and September 30, 2023, less than 11 patients (residents) and 1 staff member were injured as the result of restraint use, both individuals were injured during the stabilization process. The patient was not placed in full bed restraints following this incident.

To summarize, there were a total of 26 serious injuries that occurred since activation of the ETP on September 14, 2021, to September 30, 2023. There were 16 aggressive incidents resulting in serious injury to staff (as defined by Policy Directive #9500) during

that period. There were less than 11 serious injuries to staff (as defined by Health and Safety Code 1180.1(g)) that was related to the use of seclusion or restraint. There were less than 11 incidents of patient aggression to self that resulted in serious injuries to patients (residents) (as defined by Policy Directive #9500.). Less than 11 incidents of serious patient injury (defined by Health and Safety Code 1180.1(g)) occurred during stabilization of the patient (resident). None of these 26 incidents required hospitalization. There were no aggressive acts to other patients (residents) resulting in serious injury during the review period.

Serious Injuries	Period 1 N	Period 2 N	Cumulative N
Serious Injuries to Staff ^a	***	<11	***
Serious Injuries to Patients (Residents) ^a	<11	<11	<11
Serious injuries to Staff related to the use of seclusion and restraints ^{b,c}	0	<11	<11
Serious injuries to Patients (Residents) related to the use of seclusion and restraints ^{b,c}	0	<11	<11
Serious Injuries to Patients (Residents) as a result of self-injurious behavior ^{a,d}	<11	<11	<11
Total:	18	<11	26

^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.

^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).

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

Rates of Aggression and Injury Prior to ETP vs. During ETP Admission ^a										
	Period 1 ^b					Period 2 ^c				
	Prior to ETP Admission		During ETP Admission			Prior to ETP Admission		During ETP Admission		
	N	Rate	N	Rate	Change ^e	N	Rate	N	Rate	Change ^e
Physical Aggression towards Staff	149	0.0569	124	0.0295	-49%	90	0.0344	41	0.0088	-75%

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Physical Aggression towards Peers	68	0.0260	13	0.0031	-88%	62	0.0237	<11	0.0009	-96%
Serious Injuries to Staff ^d	14	0.0053	12	0.0029	-45.3	12	0.0046	<11	0.0011	-76%
Serious Injuries to Peers ^d	<11	0.0015	0	0.0000	-100%	<11	0.0015	0	0.0000	-100%
Physical Aggression towards Self	17	0.0065	42	0.0100	+54%	15	0.0057	39	0.0084	+47%
Serious Injuries towards Self ^d	<11	0.0004	<11	0.0014	+274%	<11	0.0004	<11	0.0004	+13%

^a Rates of aggression are calculated per 1 patient day.

^b Period 1 covers September 14, 2021, to September 30, 2022

^c Period 2 covers October 1, 2022, to September 30, 2023

^d Serious injury is defined as requiring medical care beyond first aid or overnight stay in a hospital as defined by Policy Directive #9500.

^e Percent change is calculated from non-rounded values.

Cumulative Rates of Aggression and Injury Prior to ETP vs. During ETP Admission^{a,b}					
	Prior to ETP Admission		During ETP Admission		Cumulative Rate of Change
	N	Rate	N	Rate	
Physical Aggression towards Staff	239	0.0529	165	0.0187	-65%
Physical Aggression towards Peers	130	0.0307	17	0.0019	-94%
Serious Injuries ^c of Staff	26	0.0055	17	0.0020	-63%
Serious Injuries ^c of Peers	<11	0.0017	0	0.0000	-100%
Physical Aggression towards Self	32	0.0066	81	0.0092	38%
Serious Injuries towards Self ^c	<11	0.0003	<11	0.0009	187%

^a Rates of aggression are calculated per 1 patient day.

^b Cumulative data covers September 14, 2021, to September 30, 2023.

^c Serious injury is defined as requiring medical care beyond first aid or overnight stay in a hospital as defined by Policy Directive #9500.

Cumulative results covering the period from September 14, 2021, to September 30, 2023, show a 94% reduction in frequency of aggressive acts towards peers, and a 65% reduction in frequency of aggressive acts towards staff. 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 63%. This data highlights that the ETP is meeting its goal for reduction of severe physical aggression towards both staff and patients. Rates of physical aggression towards self increased while patients were on the ETP, as did the injuries that occurred as a result. less than 11 of the 19 ETP patients were responsible for the less than 11 self-harm incidents that occurred in the period covering September 14, 2021, to September 30, 2023. 50% (less than 11) of these less than 11 incidents were committed by less than 11 patients.

Staff Turnover

During the reporting period from September 14, 2021, through September 30, 2022, 4.0 registered nurses (RNs) left the ETP; 2.0 nurses left employment at the facility and 2.0 nurses transferred to other units within the facility. During this same time period, 15.0 psychiatric technicians left the ETP; 1.0 promoted to a position outside the ETP, 7.0 left employment at the facility and 7.0 transferred to other units within the facility. During that reporting period, 4.0 RNs were hired to the ETP as well as 4.0 psychiatric technicians. 7.0 psychiatric technicians transferred into the ETP from other units within the facility.

During the reporting period of October 1, 2022, through September 30, 2023, 4.0 RNs left the ETP; 2.0 nurse left employment with the facility and 2.0 nurse transferred to other unit within the facility. During this same time period 10.0 psychiatric technicians left the ETP; 2.0 promoted to positions outside the ETP, 3.0 left employment with the facility and 5.0 transferred to other units within the facility. During this reporting period, 1.0 psychiatric technician was hired into the ETP, and 11.0 psychiatric technicians transferred in 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, 2023, 8.0 RNs left the ETP; 2.0 nurses retired, 2.0 nurses transferred to other units within the facility, 1.0 nurse left the facility and 3.0 nurses left state service. During this same time period, 21.0 psychiatric technicians, including 2.0 senior psychiatric technicians, left the ETP; 12.0 transferred to other units inside the facility, 2.0 psychiatric technicians retired, 1.0 transferred to another facility within DSH and 8.0 left the facility for other employment outside of DSH. During this reporting period the ETP hired 4.0 new RNs, and 5.0 new psychiatric

technicians. 16.0 psychiatric technicians, including 3.0 senior psychiatric technicians, transferred into the ETP from other units in 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 (Note: This occurred in August 2023 and the new social worker is providing 0.25 coverage on another unit temporarily. Recruitment is in process for additional social work resources). 1.0 Psychologist retired from state service, and 0.9 Senior Supervising Psychologist transferred into the unit to provide coverage. During this period 2.0 FNAT psychologists left the ETP. One FNAT psychologist left state service, and the other transferred to another division within DSH. One FNAT psychologist was hired. The remaining FNAT psychologist position was providing temporary relief (filling behind another psychologist on family leave) and was not refilled.

Patients' Rights Complaints

The Disability Rights California, California Office of Patients' Rights provided information pertaining to patients' rights complaints received for each reporting period. For the cumulative period of September 14, 2021, through September 30, 2023. A total of 75 complaints were made by 12 patients (residents).

Complaint Category	Period 1 ^a		Period 2 ^b		Cumulative ^c	
	Patients ^d	Complaints ^e	Patients	Complaints	Patients	Complaints
Access / Use of Personal Possessions	<11	<11	<11	<11	<11	<11
Advocacy Services	<11	<11	0	0	<11	<11
Confidentiality, records, etc.	0	0	<11	<11	<11	<11
Conservatorship	<11	<11	0	0	<11	<11
Daily Living	<11	<11	<11	<11	<11	<11
Dignity / Privacy / Respect / Human Care	<11	<11	<11	<11	<11	15
Free from Harm	0	0	<11	<11	<11	<11
Keep / Spend Reasonable Sum of Money / Personal Funds	<11	<11	0	0	<11	<11
Legal	<11	<11	<11	<11	<11	<11
Medical Care and Treatment	<11	<11	<11	<11	<11	<11
Medication Side Effects	<11	<11	0	0	<11	<11

Mental Health Treatment	<11	<11	<11	<11	<11	<11
Patient Withdrew the Complaint	<11	<11	<11	<11	<11	<11
Physical Abuse	<11	<11	0	0	<11	<11
Physical Exercise/Recreation / Out of Doors	<11	<11	0	0	<11	<11
Religious Freedom and Practice	<11	<11	0	0	<11	<11
Social Interaction / Participation	<11	<11	0	0	<11	<11
Telephones / Confidential Use	<11	<11	0	0	<11	<11
Treatment Services Promoting Independence	<11	<11	0	0	<11	<11
Unable to read, to understand or unrelated	<11	<11	0	0	<11	<11
Visitors / Visiting Space	<11	<11	<11	<11	<11	<11
TOTAL PATIENTS ^d	11	61	<11	21	12	82

^a Period 1 covers September 14, 2021, to September 30, 2022.

^b Period 2 covers October 1, 2022, to September 30, 2023.

^c Cumulative data covers September 14, 2021, to September 30, 2023.

^d Total number of 19 patients making complaints.

^e Total complaints made may include multiple complaints by one patient.

Access / Use of Personal Possessions

- Less than 11 complaints were regarding wanting a laptop, wanting a radio returned, access to money and personal property from transfer, missing personal items after transfer, and wanting personal papers/legal paperwork returned.
 - Resolution: The Patients' Rights Advocate (PRA) resolved most complaints by informing patients about items deemed to be contraband on the ETP, working with staff to gain access to personal property, and confirmation from patient or staff that the item(s) were back in the patient's possession.

Advocacy Services

- Less than 11 complaints were regarding patients not satisfied with ETP placement hearing and personal property.
 - Resolution: The PRA discussed and provided information on the purpose of the ETP referral, admission criteria, and the ETP screening process, along with the acceptable personal property items list. The PRA also

raised concerns the patient had with DSH regarding the patient feeling they were not adequately heard in the hearing. Patient was informed of the current laws and regulations outlining the ETP Forensic Needs Assessment Panel (FNAP) placement evaluation meetings and certification process.

Confidentiality, records, etc.

- Less than 11 complaints were regarding patients being potentially unable to do a Chart Review before his ETP one-year continuation hearing.
 - Resolution: The PRA worked with the patient and the Health Information Management Department (HIMD) to ensure request to access records was received, processed, and provided by HIMD before the ETP hearing.

Conservatorship

- Less than 11 complaints were regarding conservatorship hearings and not receiving information about how to participate in the hearings.
 - Resolution: The PRA provided information on a mental health conservatorship (WIC 5361-5364) and confirmed that the patient had the Handbook for Challenging Mental Health Conservatorships that the Patients' Rights office provided earlier in the year. The PRA spoke with the social worker who stated they would be working with the conservator and the appointed attorney to facilitate communication with the patient.

Daily Living

- Less than 11 complaints were regarding cold water not working, wanting more activities on the unit, and wanting a haircut.
 - Resolution: The PRA resolved most concerns during phone and/or in-person conversations with the patient. Patient informed the PRA that advocacy efforts resulted in approval for his future haircuts to have the option to be done off unit where he can get a styled cut, if he chooses. The PRA informed patient that as soon as current quarantine is lifted, the Barbershop can be scheduled to visit the unit.

Dignity / Privacy / Respect / Humane Care

- 15 complaints were regarding being disrespected by staff.
 - Resolution: The PRA resolved these complaints by communicating with the unit supervisor to help find resolutions for these issues.

Free from Harm

- Less than 11 complaints were regarding feeling threatened by a Hospital Police Officer on the unit.
 - Resolutions: The PRA referred patient to the complaint process regarding State Hospital Police Officers and provided the appropriate form. The patient was advised about the Office of Protective Services (OPS) complaint process and did not reach out to PRA for follow-up.

Keep / Spend Reasonable Sum of Money / Personal Funds

- Less than 11 complaints were regarding tax forms, Canteen Bucks, access to personal funds, vocational assignment pay, not being taken to The Grill by staff, and a Canteen order refund.
 - Resolution: The PRA spoke with the patients who informed them that the issue(s) were resolved. The PRA provided the requested tax forms, information on how to earn Canteen Bucks as a treatment incentive, informed the patients of what staff to contact regarding their vocational pay, and the PRA provided claim forms and process for Canteen refunds.
 - Resolution: The PRA contacted the patients' psychologist regarding the patients' desire to go to The Grill. The patients were informed to work with his treatment team on the requirements to access The Grill, which is considered a high-risk area, as there are safety requirements that need to be met before The Grill could be included in their behavior plan. The PRA confirmed that the patient is still able to spend money through the Canteen once per week.

Legal

- Less than 11 complaints were regarding wanting to be transferred, not being satisfied with their legal representation, and their LPS conservatorship.
 - Resolution: The PRA spoke with each patient and provided them with information and materials in the areas of concern.

Medical Care and Treatment

- Less than 11 complaints were regarding pro re nata (PRN) "as needed" medications, dental needs not being met, pain medication, experiencing physical pain, and needing corrective lenses.
 - Resolution: The PRA confirmed that patients were able to visit the dentist and resolve their dental issues, provided self-advocacy tools for patient to use in future situations in regard to PRNs, process to request alternative pain medication, process for medical referrals, and confirmed pending eye appointment when unit comes off of quarantine.

Medication Side Effects

- Less than 11 complaints were regarding medication side effects.
 - Resolution: The PRA advised patient(s) to speak with their nurse or psychiatrist directly to work on resolutions to medication side effects. The PRA communicated with unit staff and continued to monitor patient during the following weeks. The patient stated the medication dosage was lowered and no longer had concerns about medication side effects.

Mental Health Treatment

- Less than 11 complaints were regarding treatment team meetings and treatment for sex offenders on the ETP.
 - Resolution: The PRA confirmed patients were receiving mental health treatment while on ETP that would help meet discharge goals. The PRA met with patient to confirm the staff are giving him reminders of treatment team meetings.

Patient Withdrew the Complaint

- Less than 11 complaints were regarding groups, phones not working, not being informed of medical treatment, not being seen by the Podiatrist, not being able to go in the day room, and not being able to shower.
 - Resolution: The PRA spoke with the patients, the patients confirmed that the issues had resolved and withdrew the complaint.

Physical Abuse

- Less than 11 complaints were regarding wanting to sue a state prison for abuse.
 - Resolution: The PRA, with patient approval, filed an abuse report (SOC341) and provided a copy to the patient. The PRA provided legal contact information as well as educated patient on what next steps will be taken and suggested for him to talk with hospital police (DPS) with any follow up.

Physical Exercise / Recreation / Out of Doors

- Less than 11 complaints were regarding safety from another patient in the courtyard.
 - Resolution: The PRA communicated with staff and was informed that a safety plan has been created for these patients and that these patients will remain separate from the other patient while in the courtyard.

Religious Freedom and Practice

- Less than 11 complaints were regarding wanting to see the Chaplain.
 - Resolution: The PRA informed the patient of the unit's process for patients to request religious services and that group religious services were temporarily suspended due to the facility wide COVID-19 prevention measures.

Social Interaction (<11) and Participation and Telephones / Confidential Use (<11)

- Less than 11 complaints were regarding having a movie night on Sunday, telephones not working, and getting in touch with family.
 - Resolution: The PRA determined that these patients have access to movie night on Saturdays and that patients' requests for Sunday afternoon interferes with Unit Schedule (medication pass and physical assessments). The PRA confirmed that the telephones were repaired, and patients were able to contact family. The PRA will monitor telephone system during regular unit visits and ensure that information is posted of how to use the new telephone system.

Treatment Services Promoting Independence

- Less than 11 complaints were regarding not wanting to be on the ETP unit and would like to get magazines and acquire a General Educational Diploma (GED).
 - Resolution: The PRA spoke with these patients and resolved these issues. The PRA discussed that DSH, including ETP, does not offer GED services because it is an internet-based program, but instead provides the High School Equivalency Test (HiSET). Patients were referred to their treatment team to request a referral to educational services.

Unable to read, to understand, or unrelated

- Less than 11 complaints were regarding requests that the PRA give their letters to the nurse.
 - Resolution: The nurse received the letters per patients' request.

Visitors / Visiting Space

- Less than 11 complaints were regarding not being allowed to have a video call with girlfriend.
 - Resolution: The PRA informed the patients that it is his visitor's responsibility to contact the DSH-Atascadero Executive Director to ask for an exception to the Administrative Directive if they are a former employee of DSH.

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. 21 staff completed this video training during the reporting period of September 14, 2021, through September 30, 2022, and 13 staff completed this training during the reporting period of October 1, 2022, through September 30, 2023. Overall, 34 staff completed this video training since activation of the ETP on

September 14, 2021, through September 30, 2023. 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. 892 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, 2022, and 160 completed it during the reporting period of October 1, 2022, through September 30, 2023. Courses provided included:

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

In August 2023, 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.

In addition to the formalized training outlined above, ETP team members received informal consultation from subject matter experts under contract with DSH. These consultants assisted ETP team members with honing their skills in the treatment of complex psychopathology and behavioral issues. Consultations provided included advanced psychopharmacology, Dialectical Behavior Therapy, Cognitive Behavioral Therapy for Psychosis, and Cognitive Remediation.

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 for at the end of each reporting period.

ETP Permanent ^a Staff				
	Period 1 ^b		Period 2 ^c	
	Filled	Vacant	Filled	Vacant
Registered Nurse	14	3	10	3
Psychiatric Technician (includes Senior Psychiatric Technician)	20	5	20	5
Licensed Vocational Nurse	1	0	1	0
Psychiatrist	1	0	1	0
Psychologist	2	0	.9 ^d	1
Social Worker	1	0	.75 ^d	.25
Rehabilitation Therapist	2	0	2	0
FNAT Psychologist	3	0	2	0
Hospital Police Officers	9	0	9	0
Unit Supervisor	1	0	1	0

^a Staff permanently assigned to the ETP, not including coverage to meet required staff-to-patient ratios.

^b Staff vacancies as of September 30, 2022.

^c Staff vacancies as of September 30, 2023.

^d Staff are also assigned duties/coverage outside of the ETP.

FINDINGS AND RECOMMENDATIONS

Review of the data suggests areas of opportunity for ETP operations.

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 outside of restraint use. A foremost goal of the ETP is to reduce the use of restraints. During this reporting period from September 14, 2021, through September 30, 2023, 35% of non-ambulatory restraint use was related to aggressive acts towards staff, which is a 7% reduction from the first year of ETP operations, spanning from September 14, 2021, through September 30, 2021. 69% of restraint use was related to self-injurious behavior, which presents a 7% increase from the first year of ETP operations. Less than 11 of the 19 ETP patients were responsible for 80% of restraint use.

Of note is that 50 (47%) of the 105 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.

Compared to 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, 2023, there were only 21 non-ambulatory restraint episodes between September 14, 2021, to September 30, 2023. During the last reporting period, 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.

This data supports the ETP is successful in meeting its goals for reduction of severe physical aggression towards others, as well as reduction of non-ambulatory restraint use. Patients engage in significantly less aggression towards others after being admitted to the ETP compared to when they received care in the standard treatment environment. Following ETP admission, the rates of aggressive incidents towards staff decreased by 64.69%, while aggressive acts towards other patients decreased by 93.74%. Patients also are placed in non-ambulatory restraints less frequently and for shorter periods of time after being placed in the ETP. Furthermore, the data highlights that the frequency of severe physical violence and the use of restraint has decreased even more over the course of ETP operations. In sum, this demonstrates that the ETP is meeting the stated objectives for reduction of violence and restraint use compared to treatment in the standard treatment environment. However, it also highlights that the ETP clinicians and staff have become more proficient in using their skills to further reduce the incidents of severe physical violence as well as restraint use since ETP activation.

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 organizational and operational excellence. Examples of specific efforts to address workforce challenges are outlined below. 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. For further information on recruitment and retention efforts, please see the Report on Mental Health Services Staffing (section G5).