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

EXECUTIVE SUMMARY

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

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

The current reporting period ranges from October 1, 2024, to September 30, 2025. For comparison, the report also presents cumulative data from activation of the ETP on September 14, 2021, up to the end of the current reporting period. The data reflects patient characteristics including gender, ethnicity, age on admission, legal group, and years at DSH. Data also includes information on staffing requirements, staff-to-patient ratios, as well as staff turnover. Data on restraint and seclusion use and serious injuries is also provided. The report also includes information regarding patients' rights complaints received as provided by the Disability Rights California, California Office of Patients' Rights, and the resolution to these issues. Finally, the report includes information regarding training provided to ETP staff, as well as the training offered to staff who are primarily assigned to other units but could be asked to provide support in the ETP.

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

[1] Status updates on the construction and activation of each ETP unit is provided in the ETP Staffing estimate (see Section C3).

BACKGROUND

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

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

> *4145. (a) The State Department of State Hospitals shall monitor the pilot enhanced treatment programs (ETP), evaluate outcomes, and report on its findings and recommendations. This report shall be provided to the fiscal and policy committees of the Legislature annually, beginning on January 10 of the first year after which the first ETP is opened and services have commenced, and shall be in compliance with Section 9795 of the Government Code. The evaluation shall include, but is not limited to, all of the following:*
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> *(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, 2025. The data contained in this report is limited to what is permitted under the Health Insurance Portability and Accountability Act (HIPAA), and state privacy laws, when disclosure of health information is required by law.

I. Methodology

This current reporting period ranges from October 1, 2024, to September 30, 2025. Data from the current reporting period will be presented alongside cumulative data collected throughout activation of the ETP, beginning September 14, 2021, through September 30, 2025. The data included in this report has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or "less than 11" within the narrative. Complimentary masking is applied using "***" where further de-identification is needed.

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

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

II. Summary of Data

Patient Characteristics

Gender	Reporting Period 10/1/24 to 9/30/25	Cumulative 09/14/21 to 9/30/25
Male	<11 (100%)[a]	*** (100%)[b]
Female[c]	0 (0%)	0 (0%)

[a] Admissions during this reporting period.

[b] Total patients served on the ETP.

[c] The DSH-Patton ETP unit designed to serve female patients activated in October 2025.

Ethnicity	Reporting Period 10/1/24 to 9/30/25	Cumulative 9/14/21 to 9/30/25	DSH[a]	CA[b]
	N (%)	N (%)	%	%
Asian	0 (%)	<11 (***%)	5%	16%
Black or African American	0 (%)	<11 (***%)	24%	5%
Hispanic or Latino	<11 (100%)	12 (39%)	28%	41%
White	0 (0%)	<11 (***%)	40%	33%
Other/Unknown	0 (%)	<11 (***%)	3%	5%

[a] DSH resident census as of 9/30/2025.
[b] CA census population estimates as of July 1, 2024. DP05: ACS Demographic - Census Bureau Table

Age	Reporting Period 10/1/24 to 9/30/25	Cumulative 9/14/21 to 9/30/25	DSH[a]
	N (%)	N (%)	N (%)
18-29	0 (0%)	<11 (***%)	410 (7%)
30-41	<11 (***%)	*** (***%)	1542 (28%)
42-53	<11 (***%)	14 (45%)	1352 (25%)
54-65	0 (0%)	0 (0%)	1296 (24%)
66-77	0 (0%)	0 (0%)	791 (14%)
78-90	0 (0%)	0 (0%)	113 (2%)
91+	0 (0%)	0 (0%)	2 (<1%)
Mean Age (years)	36.33	39.35	49.33

[a] DSH patient census as of 9/30/2025.

Legal Group	Reporting Period 10/1/24 to 9/30/25	Cumulative 9/14/21 to 9/30/25	DSH[a]
	N (%)	N (%)	N (%)
Incompetent to Stand Trial	0 (0%)	<11 (***%)	1600 (29%)
Not Guilty by Reason of Insanity	0 (0%)	<11 (***%)	1199 (22%)
Offender with a Mental Health Disorder	0 (0%)	<11 (***%)	1001 (18%)
Lanterman-Petris- Short Act	<11 (100%)	16 (52%)	558 (10%)
Sexually Violent Predator	0 (0%)	<11 (***%)	954 (17%)
Coleman[b]	0 (0%)	0 (0%)	194 (4%)

[a] DSH patients' information on census as of 9/30/2025.
[b] Per Enhanced Treatment Program Emergency Regulations (California Code of Regulations, Title 9, Division 1, Chapter 17, Article 2, Section 4900), a patient may be referred to the Enhanced Treatment Program if there is no existing contract or memorandum of understanding that provides alternative and clinically appropriate treatment outside of DSH. *Coleman* patients are eligible for treatment in the CDCR Psychiatric Inpatient Programs.

Years at DSH – Current Admission[a,b]	Reporting Period 10/1/24 to 9/30/25	Cumulative 9/14/21 to 9/30/25	DSH[c]
	N (%)	N (%)	N (%)
0-5	<11 (***%)	21 (68%)	3554 (65%)
6-10	<11 (***%)	<11 (***%)	692 (13%)
11-15	0 (0%)	<11 (***%)	425 (8%)
16-20	<11 (***%)	<11 (***%)	511 (9%)
21-24	0 (0%)	<11 (***%)	94 (2%)
25+	0 (0%)	0 (0%)	230 (4%)
Mean:	4.96	5.33	6.22

[a] This data captures years at DSH *prior* to ETP Admission.
[b] "Current Admission" includes hospital years during most recent commitment that did not result in a discharge from DSH.
[c] DSH patients' information on census as of 9/30/2025.

Years at DSH – Overall[a,b]	Reporting Period 10/1/24 to 9/30/25	Cumulative 9/14/21 to 9/30/25
	N (%)	N (%)
0-5	<11 (***%)	13 (42%)
6-10	<11 (***%)	<11 (***%)
11-15	<11 (***%)	<11 (***%)
16-20	<11 (***%)	<11 (***%)
21-24	<11 (***%)	<11 (***%)
25+	0 (0%)	0 (0%)
Mean:	8.09	8.91

[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 activated in October 2025. ETP patients' (residents) mean age is 39.35 years, which is about 10 years below the DSH wide age average. ETP patients (residents) come from Asian, Black or African American, Hispanic or Latino, White, and Other or Unknown ethnic backgrounds. The ethnic distribution of the total ETP patients served (residents) generally aligns with DSH patient mix, except for a larger segment of White patients (residence) receiving care in the standard treatment environment compared to the ETP. The ethnic distribution of ETP patients differs from the overall CA population with a lower representation of Asian individuals and a higher representation of Black or African American individuals on the ETP. The primary legal commitment for patients (residents) in the ETP are: Not Guilty by Reason of Insanity (NGI), Offenders with Mental Disorders (OMD), Incompetent to Stand Trial (IST), persons designated as Sexually Violent Predators (SVP), and Lanterman-Petris-Short (LPS) Act Conservatees. Compared to the overall DSH population, the ETP serves a significantly higher percentage of LPS patients (residents) and a lower percentage of IST and SVP patients (residents). Since their most recent DSH

admission, ETP patients (residents) have spent an average of 5.33 years at DSH, which is similar to the average length of stay throughout DSH at 6.22 years. However, as some ETP patients (residents) have been admitted to DSH on multiple occasions, their combined average time spent in DSH is 8.91 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, 2024, the ETP maintained a staff-to-patient ratio of one to five or lower. This ratio was maintained during the current reporting period from October 1, 2024, to September 30, 2025.

Staff Classification to Patient Ratio

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

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

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

[a] This ratio stayed consistent from September 14, 2021 through September 30, 2025
[b] Level of Care staff include Psychiatric Technicians and Registered Nurses.

Occupancy

Average Monthly Occupancy	N
October 2024	12.00
November 2024	12.87
December 2024	13.00
January 2025	13.00
February 2025	13.00
March 2025	12.90
April 2025	12.87
May 2025	13.00
June 2025	12.83
July 2025	12.74
August 2025	13.00
September 2025	13.00
Average Oct 2024 – Sept 2025:	12.85
Average Sept 2021 – Sept 2025:	12.03

Average Length of Stay[a]	Reporting Period 10/1/24 to 9/30/25	Cumulative 9/14/21 to 9/30/25
	Days	Days
DSH-Atascadero ETP Current Patients	332.08 ± 80.95	301.82 ± 102.50
DSH-Atascadero ETP Discharged Patients	190.50 ± 109.60	151.17 ± 95.81
Total	313.20 ± 94.64	261.94 ± 120.40

[a] Days are full days and Standard Deviation.

Other Occupancy	Reporting Period 10/1/24 to 9/30/25	Cumulative 9/14/21 to 9/30/25
The number of patients (residents) whose length of stay exceeds 90 days.	14	28
The number of patients (residents) with multiple ETP stays.	<11	<11
The number of patients (residents) whose discharge was delayed due to lack of available beds in a standard treatment environment.	0	0

The ETP began accepting patients on September 14, 2021. Since then, there have been a total of 33 admissions and 18 discharges of individual patients (residents). Between October 1, 2024, and September 30, 2025, there were fewer than 11

admissions and fewer than 11 discharges. At the end of this reporting period on September 30, 2025, there were 13 patients (residents) on the unit.

14 patients' (residents') length of stay exceeded 90 days during this reporting period. None of the ETP discharges were delayed due to lack of available beds in a standard treatment environment.

Restraint and Seclusion Use

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

Cumulatively, since activating the ETP on September 14, 2021, to the end of this reporting period on September 30, 2025, there were fewer than 11 incidents of seclusion and *** incidents of both ambulatory and non-ambulatory (5-point bed restraint) restraints. 47 (30%) incidents of non-ambulatory restraints used during the cumulative period were related to patients (residents) being deemed an imminent danger to others, while 110 (70%) incidents of non-ambulatory restraint use were related to imminent danger to self. There were fewer than 11 incidents of seclusion involving fewer than 11 patients for a total of 195.41 hours. Five of these incidents occurred prior to September 30, 2022, when staff were still becoming familiar with the inherent security features of the ETP. Fewer than 11 episodes of seclusion occurred during this reporting period while a psychiatrist unfamiliar with the ETP proceedings was covering the unit.

Since activation, 157 incidents of non-ambulatory restraints occurred in the ETP. Five-point restraint usage lasted for a combined 2001.6 hours. These 157 restraint incidents involved 13 of the total *** patients admitted to the ETP. 38% of patients involved in the restraint incidents accounted for 127 (80%) of these incidents and 1839.26 (91.8%) of the total restraint hours. There were also fewer than 11 incidents of ambulatory restraint use which lasted for a combined total of 6.56 hours. There have been no ambulatory restraint hours since the end of the September 2022 reporting period.

During the current reporting period from October 1, 2024, to September 30, 2025, there were 45 incidents of non-ambulatory restraints use. Fewer than 11 of these non-ambulatory restraints use incidents were related to patients (residents) being deemed an imminent danger to others. The rest of the incidents of non-ambulatory restraint use were related to imminent danger to self. The total time of non-ambulatory restraint use during this reporting period was 585.01 hours. There were no incidents of ambulatory restraint usage and fewer than 11 incidents of seclusion during this period.

Restraint and Seclusion Use	Reporting Period 10/1/24 to 9/30/25		Cumulative 9/14/21 to 9/30/25	
	N[a]	Duration[b]	N[a]	Duration[b]
Seclusion	<11	186.28	<11	195.41
Ambulatory Restraint	0	0.00	<11	6.56
Non-Ambulatory Restraint	45	585.01	157	2001.60
Total	***	771.29	***	2203.57

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

Non-Ambulatory Restraint Frequency and Duration[a]						
	Reporting Period 10/1/24 to 9/30/25			Cumulative 09/14/21 to 9/30/25		
	N[b]	%	Duration[c]	N	%	Duration
Danger to Others	<11	***%	96.74	47	30%	586.26
Danger to Self	***	***%	488.27	110	70%	1415.34

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

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

During the reporting period from October 1, 2024, to September 30, 2025, rates for frequency and duration of non-ambulatory restraint use significantly decreased following admission to the ETP. Rates in the frequency of non-ambulatory restraint use decreased by 96.5% for patients receiving treatment during this reporting period, compared to the six months prior to admission. Furthermore, patients who received treatment on the ETP during this reporting period spent a total of 3395.72 hours in non-ambulatory restraints within six months prior to their admission. During the twelve months captured in this reporting period these same patients spent 585.01 hours in non-ambulatory restraints.

Findings are similar for changes in duration and frequency of non-ambulatory restraint use throughout the length of the program's existence. From September 14, 2021, to September 30, 2025, frequency rates of non-ambulatory restraint use decreased by 89%. Patients who received treatment on the ETP since inception of the program spent a total of 5896.75 hours in non-ambulatory restraints within six

months prior to their admission, which decreased to 2001.60 hours following ETP placement.

These findings align with the goal of the ETP to provide less restrictive care by reducing the frequency and duration of non-ambulatory restraint use.

Non-Ambulatory Restraint Rate and Duration Prior to ETP vs. During ETP Placement											
Reporting Period 10/1/24 to 9/30/25						**Cumulative 09/14/21 to 9/30/25**					
Prior to ETP Admission			During ETP Placement			Prior to ETP Admission			During ETP Placement		
N[a]	Rate[bc]	Duration[d]	N	Rate	Duration	N	Rate	Duration	N	Rate	Duration
162	0.0715	3395.72	45	0.0025	585.01	327	0.0666	5896.75	157	0.0070	2001.60

[a] Number of distinct incidents requiring non-ambulatory restraint of a patient.
[b] Rates of aggression are calculated per 1 patient day.
[c] Pre ETP Admission data was not available for one patient.
[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."*

Serious injury to staff and patients (residents) related to the use of seclusion and restraint was defined per Health and Safety Code 1180.1 (g), "*Serious injury*" *means significant impairment of the physical condition as determined by qualified*

medical personnel, and includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, or injuries to internal organs."

Based on this definition, there were fewer than 11 incidents that resulted in serious injuries to staff between October 1, 2024, and September 30, 2025. None of these incidents resulted in injuries requiring hospitalization. Majority of those injuries to staff were related to the use of seclusion and restraint. During this review period, there were fewer than eleven serious injuries to a patient (resident). These fewer than eleven injuries occurred because of self-injury.
Cumulatively, since activation of the ETP on September 14, 2021, through September 30, 2025, there were 26 incidents resulting in serious injury to staff. Eighteen of these injuries were due to physical aggression by fewer than 11 patients; and eight of these injuries were related to the use of seclusion or restraint. None of these injuries required hospitalization. There were a total of fewer than 11 serious injuries to patients (residents). Fewer than 11 of these injuries were the result of patient aggression to self; fewer than 11 injuries occurred related to the use of seclusion and restraint. None of these injuries required hospitalization. Fewer than 11 injuries resulted from use of restraint and seclusion within the October 2022 to September 2023 reporting period. The fewer than 11 injuries occurred during the stabilization process.

To summarize, there were a total of 36 serious injuries to either staff or patients (residents) that occurred since activation of the ETP on September 14, 2021, to September 30, 2025. There were 18 aggressive incidents resulting in serious injury to staff (as defined by Policy Directive #9500) during that period. There were fewer than 11 serious injuries to staff (as defined by Health and Safety Code 1180.1(g)) related to the use of seclusion or restraint. There were fewer than 11 incidents of patient aggression to self that resulted in serious injuries to patients (residents) (as defined by Policy Directive #9500.). Fewer than 11 serious patient injuries (defined by Health and Safety Code 1180.1(g)) occurred during stabilization of patients (residents). None of these 36 incidents required hospitalization. There were no aggressive acts to other patients (residents) resulting in serious injury during the review period.

Serious Injuries	Reporting Period 10/1/24 to 9/30/25	Cumulative 9/14/21 to 9/30/25
	N	N
All Serious Injuries to Staff[a]	<11	***
All Serious Injuries to Patients (Residents)[a]	<11	<11
Serious injuries to Staff related to the use of seclusion and restraints[b,c]	<11	<11
Serious injuries to Patients (Residents) related to the use of seclusion and restraints[b,c]	0	<11

Serious Injuries to Patients (Residents) as a result of self-injurious behavior[a,d]	<11	<11
Total[e]:	***	36

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

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

Rates of Aggression and Injury Prior to ETP vs. During ETP Admission[a]										
	Reporting Period 10/1/24 to 9/30/25					**Cumulative 09/14/21 to 9/30/25**				
	Prior to ETP Admission		During ETP Admission			Prior to ETP Admission		During ETP Admission		
	N	Rate	N	Rate	Change	N	Rate	N	Rate	Change[d]
Physical Aggression towards Staff	108	0.0476	25	0.0046	-90%	250	0.0509	222	0.0124	-76%
Physical Aggression towards Peers	***	***	<11	***	-97%	145	0.0295	26	0.0015	-95%
Serious Injuries to Staff[b]	***	***	<11	***	-85%	30	0.0061	26	0.0015	-76%
Serious Injuries to Peers[b]	<11	***	0	0.0000	-100%	<11	***	0	0.0000	-100%
Physical Aggression towards Self	<11	***	47	0.0030	NA[d]	23	0.0047	143	0.0062	+33%
Serious Injuries towards Self[c]	0	0.0000	<11	***	0%	<11	***	<11	***	+125%

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

[c] Percent change is calculated from non-rounded values.
[d] Pre ETP Admission data for aggression towards self was not available for one patient. The rate of change therefore cannot be meaningfully calculated.

Compared to the six months prior to admission, patients receiving treatment on the ETP between October 1, 2024, to September 30, 2025, had a 90% decrease in rate of aggression towards staff, and a 97% decrease in aggression towards peers. Cumulative results covering the period from September 14, 2021, to September 30, 2025, show a 76% reduction in rate of aggression towards staff and a 95% reduction in rate of aggression towards peers. Furthermore, the severity of injuries resulting from these aggressive acts decreased by 100% for patient to patient (resident) aggression. The severity of injuries to staff decreased by 76%.

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

Rates of physical aggression towards self increased while patients were on the ETP, as did the injuries that occurred as a result. Since activation of the ETP on September 14, 2021, there have been 143 self-harm incidents resulting in serious injuries. Fewer than 11 of the total *** ETP patients were responsible for all self-harm incidents.

The ETP was established as a treatment program addressing physical violence towards others. In many patients, physical violence towards others is accompanied by physical aggression towards self. Thus, the ETP initially accepted referrals for patients who, in addition to high levels of physical aggression towards others, also engaged in self-harm behaviors. Our data showed that patients who had a significant history of self-harm in the standard treatment environment experienced an increase in those behaviors following ETP placement. Due to the observed increase in self-harm behaviors following placement in the ETP, the selection process for admission was adjusted to admit individuals with self-harm behavior only after extensive review. Over time, we learned that excluding patients who experience both aggression to others and to self does not meet operational needs of the DSH facilities. Therefore, the ETP is slowly transitioning to accepting more patients who present with self-injurious behavior in addition to predominant violence towards others. Efforts to establish treatment programming to better accommodate the needs of patients who are both at risk for danger to others and to self are underway.

Staff Turnover

During the current reporting period of October 1, 2024, through September 30, 2025, 8.0 registered nurses left the ETP. 5.0 of these nurses transferred during the SEIU new post-and bin process. The other 3.0 nurses transferred to other units within the facility. During this same period, 7.0 psychiatric technicians left the ETP, 1.0 psychiatric

technicians separated from state service, 5.0 transferred to other units inside the facility, and 1.0 transferred to another facility but remained in state service.

During this reporting period, 1.0 registered nurse was hired into the ETP. Eight registered nurses transferred into the ETP from other units within the facility. Of the registered nursing transferring into the ETP 4.0 transferred during the SEIU new post and bid process. Eight psychiatric technicians transferred into the ETP from other units within the facility.

Cumulatively, from activation of the ETP on September 14, 2021, through the end of this most recent reporting period on September 30, 2025, 18.0 registered nurses left the ETP; 7.0 registered nurses left employment with DSH, 1.0 transferred to another DSH facility, 10.0 registered nurses transferred to other units within the facility. During this time, 34.0 psychiatric technicians left the ETP; 4.0 promoted to a position outside the ETP, 12.0 left employment with DSH, 3.0 transferred to another DSH facility, and 15.0 transferred to other units within the facility.

During the reporting period from September 14, 2021, through September 30, 2025, 7.0 registered nurses were hired to the ETP as well as 7.0 psychiatric technicians. An additional 10.0 registered nurses and 30.0 psychiatric technicians transferred into the ETP from other units within the facility.

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

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

On July 1, 2024, 1.0 Psychiatrist went on extended leave and then took an out-of-class assignment. During the period October 1, 2024, to September 30, 2025, psychiatric coverage was provided by various psychiatrists within the facility.

Patients' Rights Complaints

The Disability Rights California, California Office of Patients' Rights provided information pertaining to patients' rights complaints received from October 1, 2024, to September 30, 2025. During this period eight patients made a total of 35 complaints.

Complaint Category	Patients	Complaints
Access and Use of Personal Possessions/ Keep and Spend Reasonable Sum of Money	<11	<11
Advocacy Services/ Legal/ Mental Health Treatment	<11	<11
Daily Living	<11	<11
Dignity / Privacy / Respect / Humane Care	<11	<11
Medical Care and Treatment/Medication Side Effects	<11	<11
Packages	<11	<11
Physical Exercise/Recreation/Out of Doors	<11	<11
Religious Freedom and Practice	<11	<11
Restraint/Visiting	<11	<11
Telephones/Confidential Use	<11	<11
Totals [a]	***	**35**

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

Access / Use of Personal Possessions

- Complaints were regarding missing property and reimbursement for lost property.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved these complaints by reviewing hospital records, providing information on the whereabouts of the property, providing patients with information on how to self-advocate, requesting updates from hospital staff, and offering assistance on submitting an appeal to the hospital Executive Director.

Advocacy Services/ Mental Health Treatment

- Complaints were regarding process and outcome of ETP certification hearings, including independent medical reviews. Complaints also requested information about conservatorship, psychiatric medications, and options for transferring out of the ETP unit.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved these complaints by informing the patient of their rights, discussing ETP certification hearings and independent medical reviews, including

related advocacy efforts and decertification timelines. PRA also attended treatment team meetings, spoke with the treatment staff, provided information on conservatorship, and encouraged patients to self-advocate with their care provider.

Daily Living

- Complaints were regarding staff not answering the intercom, no hot water in the shower, missing food in meals, problems with staff, and the cleanliness of living spaces.
    - Resolutions: The Patients' Rights Advocate (PRA) encouraged patients to reach out to staff if they are having any issues with water temperature or for any missing items in their meals. The PRA also informed patients that the living spaces are cleaned weekly and as needed by the janitorial staff, and that they also have the option of requesting cleaning supplies from staff when needed. The PRA resolved complaints about the intercom by speaking with staff on the unit regarding these concerns and testing the intercom system with patients to ensure it is functioning properly.

Dignity / Privacy / Respect / Humane Care

- Complaints were regarding staff interactions with patients, privacy issues, and staff not addressing negative interactions between patients.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved these complaints by visiting the unit and discussing concerns with staff and patients. Patients were advised to continue to communicate their concerns with staff, shift leads, the unit supervisor, and/or their treatment team, most of whom were already aware of patient concerns.

Medical Care and Treatment/Medication Side Effects

- Complaints were regarding medication side effects, need for medical items, and prescribed medications.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved these complaints by raising concerns with nursing staff, attending treatment team meetings and speaking with the patient, and encouraging patients to continue to report any pain or discomfort to staff. The PRA provided information to the patients regarding the process for scheduled and as-needed (PRN) medications.

Packages

- Complaint was regarding delays in receiving a package.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved this complaint by speaking to the packaging department and informing the patient that the package was processed and out for delivery to the unit on the day following the complaint.

Physical Exercise/Recreation/Out of Doors

- Complaints were regarding not being able to go outside to the courtyard and not having the ability to participate in weightlifting groups.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved these complaints by reviewing documentation, communicating with staff, and confirming outdoor access was being offered daily. The PRA also advocated for patient's expressed interest to participate in physical exercise groups; this was not approved; however, patient was offered individual access to the weight room as an alternative.

Religious Freedom and Practice

- Complaints were regarding religious services.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved these complaints by advocating for coordination of access to religious services, either in-person or remotely. Patient was able to attend religious services remotely through the Patient Education Network channel on the unit's television

Restraint/Visiting

- Complaint was requesting the ability to visit his family in-person and to be escorted to the Visiting Room without the use of custodial restraints.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved this complaint by informing the patient about the milieu management plan and of the process for being escorted off the ETP unit to the Visiting Room, and by supporting the patient in their self-advocacy efforts to make this request to the Treatment Team. PRA followed up with treatment staff, and the patient was eventually able to be escorted to the Visiting Room, without the use of custodial restraints, to visit his family.

Telephones/Confidential Use (and Medication Side Effects)

- Complaints were regarding adjusting timing of scheduled medications to be able to speak to family in the evening, and a patient answering phone calls and impersonating another patient.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved these complaints by attending treatment team meetings and communicating with staff to patient's concerns about how the medication side effects were impacting patient's ability to get phone calls from his family during evening phone hours. Medication times were adjusted as per patient's request. Complaint about another patient impersonating peers was resolved by a patient being decertified from the ETP.

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 at DSH-Atascadero, 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. Seventeen staff completed this training during the reporting period of October 1, 2024, through September 30, 2025. Cumulatively, 56 staff completed this video training during the reporting period of September 14, 2021, through September 30, 2025. Courses recorded and provided to staff included:

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

- ETP Specific Charting Requirements
- ETP Operational Processes

Lastly, a one-hour orientation to working on the ETP was developed for those whose primary work assignment is elsewhere, but who may be asked to provide treatment coverage on the ETP. 565 staff completed this training prior to the activation of the ETP. 1052 level-of-care (e.g., licensed nurses and psychiatric technicians) and clinical (e.g., psychiatrists, psychologists, social workers, rehabilitation therapists) staff completed this training during the reporting period of September 14, 2021, through September 30, 2023. This video included:

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

On November 23, 2023, a revised version of this video was created. By September 30, 2024, 585 level-of-care (e.g., licensed nurses and psychiatric technicians) and clinical (e.g., psychiatrists, psychologists, social workers, rehabilitation therapists) staff have completed this training. Courses provided in the updated video are:

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

This training is provided for all new level-of-care and clinical staff at DSH-Atascadero. Due to changes in the recording procedures for training provided at DSH-Atascadero, the updated number of persons having received this training is unavailable for this recording period.

In anticipation of ETP activation at DSH-Patton in October 2025, 55 ETP staff participated in a seven-week in-person training academy from February 11, 2025 through March 28, 2025 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, another abbreviated one-week training academy was held in October 2025 for 35 staff. The data below details the training topics presented during the initial training academy, held from February 11, 2025, through March 28, 2025.

- ETP Background, Philosophy & Culture
- ETP Positive Psychology
- ETP Trauma Informed Care
- ETP Motivational Interviewing
- ETP Introduction to Behavior: "Language of Behavior" and Behavioral Concepts
- ETP Fundamentals of Psychiatric Symptoms

- ETP HIMD
- ETP Sensory Modulation
- ETP Admission and Discharge Process
- ETP MAT and ECT
- ETP Milieu Management Skills (DBT)
- ETP Cognitive Remediation
- ETP Treatment of Criminogenic Risk
- ETP The Roles of Disciplines in the ETP
- ETP Tactical Communication
- ETP Patient's Rights
- ETP Risk Assessment Process & Application
- ETP Specific Charting Requirements
- ETP Therapeutic Options
- ETP Incident Management Overview
- ETP Therapeutic Strategies and Interventions Theory
- ETP Substance Recovery & Stages of Change
- ETP Additional Strategies for Identifying Aggression Before It Begins
- ETP Dynamic Appraisal of Situational Aggression (DASA)
- ETP Unit Orientation
- ETP Treatment for Transgender Patients
- ETP Behavioral Treatment Planning & Incentive Plans
- ETP CBT for Psychosis
- ETP Practical Clinical Interviewing
- ETP General Nutrition and Mental Health
- ETP The Use of Psychiatric Medication in the Reduction of Violence
- ETP Social Skills Training for Schizophrenia

In addition, an abbreviated in-person 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. Eight staff completed this training between October 13, 2025 and October 17 2025. Training topics included:

- ETP Orientation
- ETP Transdisciplinary Approach
- ETP Unit Orientation
- ETP ECT
- ETP Operational Processes
- ETP DASA
- ETP Trauma Informed Care
- ETP Philosophy
- ETP Milieu Status
- ETP Escorting
- ETP Positive Psychology
- ETP Patients' Rights
- ETP Behavior Documentation
- ETP Radio Communications

A 20-minute orientation to working on the ETP at DSH-Patton was developed for those whose primary work assignment is elsewhere, but who may be asked to provide treatment coverage on the ETP.

In addition to the formalized training outlined above, ETP team members received informal consultation from subject matter experts outside of DSH. Department of Development Services as well as consultants under contract with DSH assisted ETP

team members with honing their skills in the treatment of complex psychopathology and behavioral issues. Consultations provided included advanced psycho pharmacology, Dialectical Behavior Therapy, Cognitive Behavioral Therapy for Psychosis, Behavioral Analysis, and Cognitive Remediation. In 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.

During this reporting period, 13 level of care, eight clinical, and six management staff attended a four-hour training on the implementation of the Dynamic Appraisal of Situational Aggression (DASA) and the associated Aggression Prevention Protocol.

Staffing Levels for ETPs

The table below summarizes the number of staff permanently assigned to provide direct patient care on the ETP and their classifications. Included are positions currently filled, as well as those being actively recruited as of September 30, 2025.

ETP Permanent Staff[a]	Filled	Vacant
Registered Nurse	11	0
Psychiatric Technician (includes Senior Psychiatric Technician)	28	5
Licensed Vocational Nurse	1	0
Psychiatrist	1[b]	0
Psychologist	2	0
Social Worker	1	0
Rehabilitation Therapist	2	0
FNAT Psychologist	4	0
Hospital Police Officers	10	0
Unit Supervisor	1	0

[a] Staff permanently assigned to the ETP, not including coverage to meet required staff-to-patient ratios.
[b] Providing temporary coverage for staff on leave.

FINDINGS AND RECOMMENDATIONS

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

Since implementation on September 14, 2021, the ETP has met these goals. Patients (residents) engage in significantly less aggression towards others after being admitted to the ETP compared to when they received care in the standard

treatment environment. Our data shows that following ETP admission, the rates of aggressive incidents towards staff decreased by 76%, while aggressive acts towards other patients decreased by 95%. Serious injuries to staff decreased by 76%, and serious injuries to patients due to aggression by peers were altogether eliminated.

Patients (residents) also are placed in non-ambulatory restraints less frequently and for shorter periods of time after being placed in the ETP. Since activation of the ETP on September 14, 2021, through September 30, 2025, there have been a total of 157 episodes of non-ambulatory restraint use. 47 (30%) of these were related to aggressive acts towards others, and 110 (70%) of restraint use was related to self-injurious behavior.

Of note is that 50 (32%) of the 157 non-ambulatory restraint incidents occurred within the first three months of activation. During the first three months of activation, staff were still getting accustomed to utilizing the unique features and treatment enhancements of the ETP. Consequently, staff were educated about ETP-specific procedures of locking the patient room door as a less restrictive alternative to manage aggressive behavior.

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

In the current reporting period from October 1, 2024, to September 30, 2025 there were 45 non-ambulatory restraint episodes. In previous years DSH learned that around 70% of non-ambulatory restraint use was due to patients (residents) engaging in self-harm behaviors.

The ETP referral process was adjusted to increase screening for self-injurious behavior. While this approach has significantly reduced the need for non-ambulatory restraints it no longer met the needs of the DSH facilities who continued to face a threat to staff and patient (resident) safety by those who engage in both aggression towards others and self.

The aim over the next reporting period is to further develop staff skills in treating patients who are at risk for self-injurious behavior to reduce the need for restraints and utilize the unique features of the ETP environment instead.

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

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