Department of State Hospitals

2023-24

Governor's Budget
Proposals and Estimates

Submitted to:
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Department of State Hospitals
2023-24 Governor's Budget
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DEPARTMENT OF STATE HOSPITALS
PROGRAM OVERVIEW
Informational Only

BACKGROUND

The California Department of State Hospitals (DSH) manages the nation's largest inpatient forensic mental health hospital system. The mission of DSH is to provide evaluation and treatment to patients in a safe and responsible manner, by leading innovation and excellence across a continuum of care and settings. DSH is responsible for the daily care and provision of mental health treatment of its patients. DSH was established on July 1, 2012, in accordance with Assembly Bill (AB) 1470, Statutes of 2012. AB 1470 reorganized the Department of Mental Health (DMH), which formerly was responsible for managing the state hospital system and community mental health services. DSH was created to manage and operate the state hospital system and is governed by Welfare and Institutions Code Sections 4000-4027. The community mental health services functions under the former DMH were transferred to other state departments.

DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton). In addition to state hospital treatment, DSH provides services in contracted Jail-Based Competency Treatment (JBCT), Community-Based Restoration (CBR), pre-trial felony mental health diversion programs, other community-based facilities, and the conditional release program (CONREP). DSH is responsible for the daily care to over 7,000 patients, in fiscal year (FY) 2021-22, DSH served 8,055 across the state hospitals, 2,014 in JBCT and 813 CBR contracted programs and 885 in CONREP programs. In addition, during FY 2021-22, 340 individuals were diverted from jail into county diversion programs funded by DSH.

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

DSH is funded through the General Fund and reimbursements from counties for the care of Lanterman-Petris-Short (LPS) patients. All DSH facilities are licensed through the California Department of Public Health (CDPH) and four of the five facilities (Atascadero, Metropolitan, Napa, and Patton) are accredited by The Joint

Commission, an independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States.

STATE HOSPITALS

DSH-Atascadero

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

DSH-Coalinga

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

DSH-Metropolitan

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

constructed to surround the housing units located next to the existing secure treatment area. To provide additional capacity to address an ongoing system-wide forensic waitlist, the 2016 Budget Act included the capital outlay construction funding for the Increased Secure Bed Capacity project, which is now complete. DSH-Metropolitan primarily serves the following four patient commitment types: LPS, IST, OMD and NGI.

DSH-Napa

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

DSH-Patton

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

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

DEPARTMENT OF STATE HOSPITALS
FUNCTIONAL VACANCY DISPLAY
Informational Only

BACKGROUND

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

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

- Departmental Regular/Ongoing Authorized Positions ties to the 4440-fiscal year (FY) 2022-23 Schedule 7A, 2021-22 Authorized Positions
- Temporary Help includes employees working second positions, retired annuitants, limited term, and permanent intermittent
- Total Authorized Positions contains the total Regular/Ongoing Authorized Positions and Temporary Help positions for specific classifications.
- Contracted Full-Time Equivalent (FTE) and Overtime FTE contain FTE positions which have been converted from contract hours and overtime hours
- Total Filled FTE is the grand total of Total Filled Civil Service Positions, Temp Help Filled, Contracted FTE, and Overtime FTE
- Functional Vacancy FTE is the calculated difference between Total Filled Civil Service Positions and Total Filled FTE
- Functional Vacancy Rate is calculated by dividing Functional Vacancy FTE by Total Authorized Positions

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

- Clinical Services – Treatment Team and Primary Care: For the Staff Psychiatrist positions, State Hospitals utilized temporary help and contract employees to staff 31.7 percent of the filled positions. These positions are a hard-to-fill classification at State Hospitals, due in part to the nationwide shortage of psychiatrists. DSH has been authorized to establish a psychiatry residency program at DSH-Napa in partnership with St. Joseph's Medical Center to assist with training more psychiatrists to work in the DSH system. The first cohort started July 2021.

- Clinical Services – Nursing: The high utilization rates for temporary help and overtime reflect a finding from the Clinical Staffing Study for 24-Hour Care Nursing Services, which determined that the state hospitals do not have enough authorized nursing positions to fill all the posts on the units. This finding was discussed in the Direct Care Nursing Budget Change Proposal (BCP) included in the 2019 Budget Act. This BCP provided resources to help close the gap but assumed some temporary help and overtime will continue to be utilized to meet the patient care needs. Additionally, overtime hours associated with these classifications have increased as a result of the COVID-19 pandemic.

- Protective Services: In order to better protect patients during the COVID-19 pandemic, employee screening stations were implemented to perform wellness checks. Hospital Police Officers (HPOs) were assigned to these stations, which resulted in increased overtime. Additionally, as discussed in the Protective Services BCP included in the 2020 Budget Act, Napa State Hospital does not have sufficient position authority to cover the protective services posts necessary to fulfill essential police functions which is a driver for overtime for protective services classifications.

Department of State Hospitals	Hospital Position Report Average of FY 21-22									
Classifications	Departmental Regular/Ongoing Authorized Positions (1)	Temporary Help	Total Authorized Positions	Total Filled Civil Service Positions (1)	Temp Help Filled	Contracted FTE	Overtime FTE (2)	Total Filled FTE	Functional Vacancy FTE (3)	Functional Vacancy Rate
Clinical Services -Treatment Team and Primary Care										
Social Worker (9872, 9874)	277.7	0.0	277.7	238.7	3.9	0.0	0.0	242.6	35.2	12.7%
Rehab Therapist - Safety (8321, 8323, 8324, 8420, 8422)	287.4	0.0	287.4	249.1	1.8	0.0	4.5	255.3	32.1	11.2%
Psychologist-Clinical-Safety (9873)	241.7	0.0	241.7	182.5	4.2	4.2	0.0	190.9	50.8	21.0%
Staff Psychiatrist-Safety (7619)	277.4	0.0	277.4	128.0	4.1	54.6	0.0	186.7	90.7	32.7%
Nurse Practitioner-Safety (9700)	41.0	0.0	41.0	33.1	1.3	0.0	0.1	34.5	7.5	18.2%
Physician & Surgeon-Safety (7552)	112.7	0.0	112.7	94.2	1.7	6.5	0.0	102.4	10.5	9.3%
Total: Clinical Services -Treatment Team and Primary Care	**1,237.9**	**0.0**	**1,237.9**	**925.5**	**17.0**	**65.3**	**4.6**	**1,012.3**	**226.8**	**18.3%**
Clinical Services - Nursing										
Psychiatric Technician (8236, 8253, 8254, 8274)	3,569.9	137.6	3,707.5	2,880.1	216.2	12.3	523.5	3,632.1	197.4	5.3%
Registered Nurse-Safety (8094)	1,584.0	115.2	1,699.2	1,342.6	79.2	13.7	225.1	1,660.5	108.1	6.4%
Senior Psych Tech-Safety (8252)	363.7	1.3	365.0	361.4	5.8	0.0	89.1	456.3	0.0	0.0%
Total: Clinical Services - Nursing	**5,517.6**	**254.1**	**5,771.7**	**4,584.1**	**301.2**	**26.0**	**837.7**	**5,748.9**	**305.5**	**5.3%**
Protective Services										
Hosp Police Lieut (1935)	29.8	0.0	29.8	22.4	2.1	0.0	5.7	30.2	2.0	6.7%
Hosp Police Sgt (1936)	102.9	0.0	102.9	82.3	2.0	0.0	16.5	100.8	6.0	5.8%
Hosp Police Ofcr (1937)	711.4	0.0	711.4	559.9	21.4	0.0	132.8	714.1	29.2	4.1%
Total: Protective Services	**844.1**	**0.0**	**844.1**	**664.6**	**25.5**	**0.0**	**155.0**	**845.1**	**37.2**	**4.4%**

(1) This total includes Administratively Established positions.
(2) The overtime data per month is at a point in time. There may exist fluctuations due to monthly updates potentially affecting previous months' data.
(3) The Functional Vacancy FTE is calculated individually per hospital, and then added together to display a final total.

STATE HOSPITALS POPULATION

	2022-23 May Revision Projection	CURRENT YEAR 2022-23				
POPULATION BY HOSPITAL	***June 30, 2022 Projected Census***	**July 1, 2022 Actual Census[1]**	**Previously Approved Adjustments CY 2022-23**	**2023-24 November Adjustment CY 2022-23**	**2023-24 May Revision Adjustment CY 2022-23**	**June 30, 2023 Projected Census**
ATASCADERO	*1,000*	1,001	0	0	0	1,001
COALINGA	*1,311*	1,327	0	0	0	1,327
METROPOLITAN	*808*	665	140	0	0	805
NAPA	*1,122*	1,014	0	0	0	1,014
PATTON	*1,349*	1,311	0	0	0	1,311
TOTAL BY HOSPITAL	***5,590***	**5,318**	**140**	**0**	**0**	**5,458**
POPULATION BY COMMITMENT						
Coleman - PC 2684[2]	*169*	115	0	0	0	115
IST - PC 1370	*1,197*	1,226	140	0	0	1,366
LPS & PC 2974	*801*	698	0	0	0	698
OMD[3] - PC 2962	*417*	394	0	0	0	394
OMD[3] - PC 2972	*732*	683	0	0	0	683
NGI - PC 1026	*1,343*	1,246	0	0	0	1,246
SVP - WIC 6602/6604	*931*	956	0	0	0	956
TOTAL BY COMMITMENT	***5,590***	**5,318**	**140**	**0**	**0**	**5,458**
CONTRACTED PROGRAMS						
JAIL BASED COMPETENCY TREATMENT PROGRAMS	*417*	365	86	0	0	451
COMMUNITY BASED RESTORATION	*569*	487	196	252	0	935
COMMUNITY INPATIENT FACILITIES	*60*	29	49	0	0	78
TOTAL - CONTRACTED PROGRAMS	***1,046***	**881**	**331**	**252**	**0**	**1,464**
CONREP PROGRAMS						
CONREP SVP	*22*	19	8	0	0	27
CONREP NON-SVP	*653*	606	49	0	0	655
CONREP FACT PROGRAM	*100*	48	132	0	0	180
CONREP STEP DOWN FACILITIES	*115*	41	146	0	0	187
TOTAL - CONREP PROGRAMS	***890***	**714**	**335**	**0**	**0**	**1,049**
CY POPULATION AND CONTRACTED TOTAL	***7,526***	**6,913**	**806**	**252**	**0**	**7,971**

Projected census will be adjusted as contracts are entered into as a result of the IST Solutions program implementation.
DJJ census is not displayed in accordance with data de-identification guidelines.

[1] Fiscal year 2019-2020 and 2020-21 have been impacted by the COVID-19 pandemic. Inpatient census has been temporarily decreased due to the need to create Admission Observation Units (AOUs), isolation units for COVID-19 positive patients, and spaces to isolate patients under investigation for COVID 19. Additionally, admission rates have been impacted by the need to admit patients through AOUs to observe and test patients for COVID-19 for at least 10 days before being transferred to a treatment unit. Admission rates have further been reduced at various times throughout the pandemic due to COVID-19 outbreaks requiring quarantines of AOU's and other units within the hospitals.

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

STATE HOSPITALS POPULATION

	2022-23 May Revision Projection	BUDGET YEAR 2023-24				
	June 30, 2023 Projected Census	**July 1, 2023 Projected Census**	**Previously Approved Adjustments BY 2023-24**	**2023-24 November Adjustment BY 2023-24**	**2023-24 May Revision Adjustment BY 2023-24**	**June 30, 2024 Projected Census**
POPULATION BY HOSPITAL						
ATASCADERO	*1,000*	1,001	0	0	0	1,001
COALINGA	*1,311*	1,327	0	0	0	1,327
METROPOLITAN	*948*	805	0	0	0	805
NAPA	*1,122*	1,014	0	0	0	1,014
PATTON	*1,359*	1,311	10	0	0	1,321
TOTAL BY HOSPITAL	***5,740***	**5,458**	**10**	**0**	**0**	**5,468**
POPULATION BY COMMITMENT						
Coleman - PC 2684[1]	*169*	115	0	0	0	115
IST - PC 1370	*1,341*	1,366	4	0	0	1,370
LPS & PC 2974	*801*	698	0	0	0	698
OMD - PC 2962	*420*	394	3	0	0	397
OMD - PC 2972	*735*	683	3	0	0	686
NGI - PC 1026	*1,343*	1,246	0	0	0	1,246
SVP - WIC 6602/6604	*931*	956	0	0	0	956
TOTAL BY COMMITMENT	***5,740***	**5,458**	**10**	**0**	**0**	**5,468**
CONTRACTED PROGRAMS						
JAIL BASED COMPETENCY TREATMENT PROGRAMS	*610*	451	164	0	0	615
COMMUNITY BASED RESTORATION	*737*	935	0	1,065	0	2,000
COMMUNITY INPATIENT FACILITIES	*157*	78	79	0	0	157
TOTAL - CONTRACTED PROGRAMS	***1,504***	**1,464**	**243**	**1,065**	**0**	**2,772**
CONREP PROGRAMS						
CONREP SVP	*27*	27	0	0	0	27
CONREP NON-SVP	*653*	655	0	0	0	655
CONREP FACT PROGRAM	*180*	180	0	0	0	180
CONREP STEP DOWN FACILITIES	*185*	187	0	0	0	187
TOTAL - CONREP PROGRAMS	***1,045***	**1,049**	**0**	**0**	**0**	**1,049**
BY POPULATION AND CONTRACTED TOTAL	***8,289***	**7,971**	**253**	**1,065**	**0**	**9,289**

Projected census will be adjusted as contracts are entered into as a result of the IST Solutions program implementation.
DJJ census is not displayed in accordance with data de-identification guidelines.

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

POPULATION DATA
STATE HOSPITALS
POPULATION AND PERSONAL SERVICES ADJUSTMENTS
Informational Only

COVID-19 IMPACT ON CENSUS AND REFERRALS

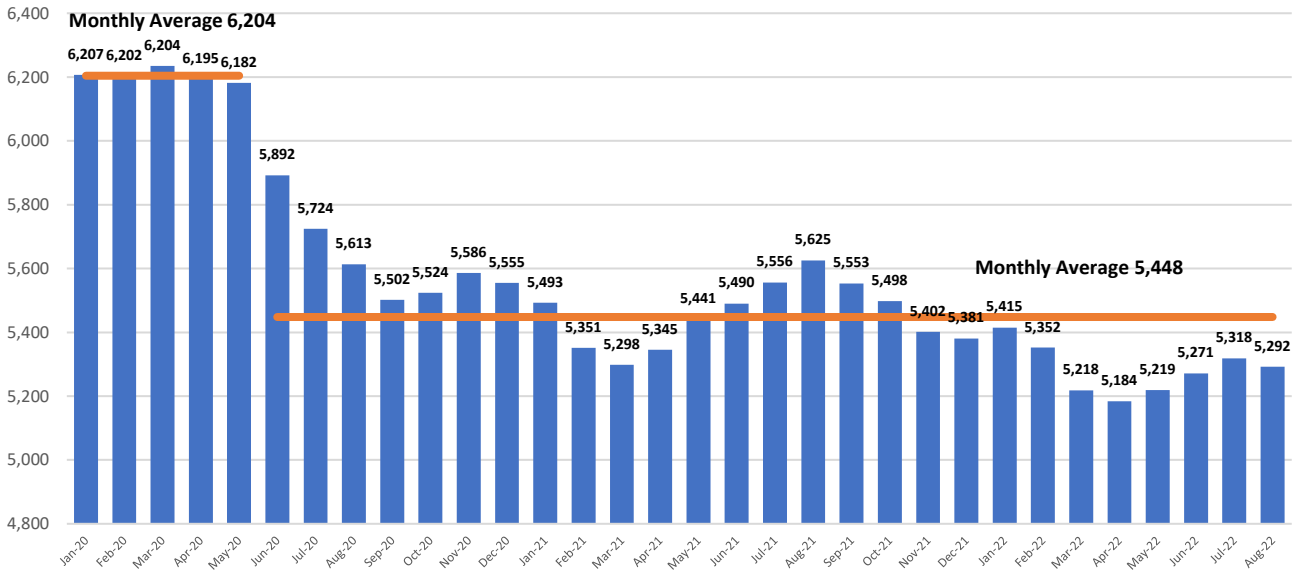
Temporary Census Reduction due to COVID-19

On March 2, 2020, Governor Gavin Newsom issued a Proclamation of a State of Emergency, followed by a shelter-in-place (SIP) order that went into effect on March 19, 2020. On March 21, 2020, the Department of State Hospitals (DSH) temporarily suspended patient admissions into its hospitals for all patient commitment types, excluding Offenders with a Mental Health Disorder (OMD) under authority of Executive Order N-35-20.

As DSH resumed admissions at the end of May 2020, in-patient census was temporarily decreased due to the need to create Admission Observation Units (AOUs) and isolation units to mitigate the impacts of COVID-19 and prioritize the safety of patients and staff. To establish AOUs and isolation units, hospitals needed to empty units which impacted DSH's in-patient census and the ability to maintain admission rates. As a result of the need to keep newly admitted patients separate, units that normally housed multiple patients in dorm rooms were only able to house one patient per room, thus limiting the census on AOUs to the number of rooms within the unit. As admissions resumed, DSH also needed to isolate patients in AOUs for at least 14 days while testing the cohort for COVID-19. Further testing and quarantine procedures were observed when positive COVID-19 cases were identified in an admission cohort or when hospitals experienced an outbreak.

Due to the need to create AOUs and isolation units and other impacts of COVID-19 on admissions, DSH's census reduced by approximately 15 percent from 6,204 on March 1, 2020, to 5,292 on August 1, 2022. This census reduction caused DSH's occupancy rates to decrease down to 87 percent from the pre-COVID-19 occupancy rate of 96 percent. DSH continues to evaluate the changing nature of the pandemic and adjust its use of AOU and isolation units accordingly. It anticipates the decrease in population to be temporary until AOUs and isolation units are no longer needed for COVID-19 response.

Chart 1: State Hospitals Monthly Census Trend: January 2020 – August 2022



Staffing Needs

While the DSH census has temporarily decreased as a result of COVID-19, staffing needs and responsibilities at all hospitals have increased. Maintaining appropriate staffing levels in a hospital is essential to providing a safe work environment for health care personnel and preserving safe patient care. With the onset and progression of the COVID-19 pandemic, hospitals have been and continue to experience impacts to staffing levels with staff quarantining due to exposure or testing positive as well as an increase in responsibilities in continuing to mitigate the spread of COVID-19 within the hospital.

Below is an overview of the additional protocols and responsibilities that have been established throughout the hospitals that healthcare personnel performing as a result of COVID-19. Hospitals have had to implement the following additional protocols and procedures to ensure the safety of patients and staff during this pandemic:

- Staff a full COVID-19 screening line across three shifts to perform primary and secondary screening and evaluation for all staff entering the hospitals, with the secondary screening being provided by a health care personnel
- Set up AOUs to house newly admitted patients for a quarantine period
- Establish Isolation Units to separate COVID-19 positive patients from patients that are not sick
- Set up Patient Under Investigation (PUI) Rooms or Units for patients that have symptoms consistent with COVID-19 but are not confirmed to be infected
- Quarantine units as needed to safeguard against spread of COVID-19
- Provide increased cleaning and sanitation protocols on the units

- Limit movement of staff between quarantined units and non-quarantine units and dedicate staffing to isolation units to prevent cross-contamination between units
- Observe and audit staff compliance with personal protective equipment (PPE) protocols and social distancing protocols
- Increase resources for the DSH Public Health teams to perform COVID-19 related functions such as contact tracing, testing, reporting and coordination with county Public Health Department
- Coordinate and manage all off-unit patient movement to avoid cross-contamination between units by requiring staff to escort patients
- Coordinate return to work functions for staff returning from COVID-19 related leave
- Provide all meals on unit for high-risk populations and quarantined units, impacting both nutrition services and staff on unit
- Suspend all in-person patient visits and switch to a virtual visitation experience

With the additional protocols and procedures being implemented at the hospitals staff are having to assume additional responsibilities which include the following:

- Increased tracking and documentation requirements related to COVID-19
- Admit patients in cohorts, which involves bringing in larger groups of patients over a short period of time, increasing the treatment team workload as documentation requirements are needing to be completed quicker for a larger group of patients
- Perform screening protocols for patients and staff arriving at the hospital
- Provide continuous education to patients and other staff regarding safety protocols, droplet/contact precautions, and medical isolation process and expectations to mitigate COVID-19 risk and exposure
- Continuously clean and disinfect units, equipment, and high touch surface areas in both patient and staff occupied areas
- Perform high-risk procedures such as administering COVID-19 tests on patients, made more complex by DSH's patient population
- Follow specific testing protocols for quarantined units including baseline testing for all patients and staff and subsequent testing until two sequential rounds of testing show negative results for all employees and patients
- Perform surveillance testing for Skilled Nursing Facility (SNF) patients and health care personnel.
- Perform assessments of patients displaying symptoms of COVID-19
- Continuously assess vital signs and respiratory status for patients in quarantined units, isolation units and PUI rooms
- Coordinate all on unit meal services for high-risk populations and quarantined units

- Provide all treatment, including religious service options and group treatment, on unit, creating the need to rewrite/restructure treatment plans and groups to accommodate the new delivery formats
- Coordinate virtual visits for patients

Referral and Census Trends

Since the inception of COVID-19 and the implementation of the SIP order, followed by the implementation of a safe admission process into AOUs, the Incompetent to Stand Trial (IST) waitlist has increased by almost 100 percent to 1,737 as of August 29, 2022. Although DSH observed a 49 percent decrease in weekly IST referral rates associated with county court closures following the SIP order, the IST waitlist increased following DSH's temporary suspension of admissions. Similar referral trends were observed with the Lanterman–Petris–Short (LPS), Not Guilty by Reason of Insanity (NGI), OMD 2972, Sexually Violent Predator (SVP), and *Coleman* legal classes following the SIP order. Weekly referral rates decreased by the following rates: 23 percent for LPS population, 43 percent for the NGI population, 57 percent for the OMD 2972 population, 51 percent for the SVP population and 77 percent for the *Coleman* population. As county courts resumed court proceedings, DSH's referral rates have steadily increased. In the current fiscal year (FY), weekly IST referral rates reached an average of 111 referral, surpassing the rates DSH observed prior to March 2020.

Table 1: Pre and Post SIP Order Waitlist and Weekly Referral Averages*

CA Statewide Shelter-in-Place Order: **March 19, 2020**							
	IST	LPS	OMD 2962	OMD 2972	NGI	SVP	*Coleman*
Pre-SIP Waitlist: 3/16/2020	869	241	54	<11	24	0	<11
Post-SIP Waitlist: 5/25/2020	1144	196	97	11	38	<11	<11
Current Waitlist: 8/29/2022	1737	319	29	<11	40	<11	<11
Pre-SIP Average Weekly Referrals: (7/1/19 – 3/21/20)	89	<11	<11	<11	<11	<11	12.8
Post-SIP Average Weekly Referrals: (3/22/20 – 5/30/20)	45	<11	<11	<11	<11	<11	<11
% Change (Referrals):	*-49%*	*-23%*	*23%*	*-57%*	*-43%*	*-51%*	*-77%*
Current Average Weekly Referrals[1]:	111	<11	<11	<11	<11	<11	<11

*Referral data excludes any administrative errors, duplicate records, transfers, court returns.
[1]Current average weekly referrals reflect most recent referral data from July 2022 through August 2022.

Prior to the onset of COVID-19 in March 2020, DSH's average monthly IST referrals were trending close to FY 2018-19 averages and overall DSH referrals were over two percent higher. Due to COVID-19, average monthly referrals have generally declined with an overall 8 percent decrease from FY 2018-19 to FY 2019-20, with *Coleman* being the only population to have an increase in average monthly referrals (+31%). As county courts resumed court proceedings, IST referral rates have steadily increased in FY 2020-21 and FY 2021-22, with average monthly referral rates reaching 411 in FY 2021-22 (+19%).

Table 2: Average Monthly Referrals*

	FY 2018-19	**FY 2019-20**[1] (Pre-COVID-19)	**FY 2019-20**[2] (Post-COVID-19)	**FY 2019-20** (Full FY)	**FY 2020-21**	**FY 2021-22**	**% Change**
IST	383	387	255	343	346	411	18.8%
LPS	16	<11	<11	<11	12	<11	-28.9%
OMD2962	46	41	47	43	26	27	5.9%
OMD2972	<11	<11	<11	<11	<11	<11	-11.9%
NGI	44	***	<11	<11	<11	<11	14.3%
SVP	<11	<11	<11	<11	<11	<11	-3.1%
CDCR	35	56	26	46	16	16	-0.9%
	498	**510**	**347**	**456**	**415**	**478**	**15.2%**

[1]FY 2019-20 pre-COVID-19 referral data reflects averages from July 2019 through February 2020.
[2]FY 2019-20 post-COVID-19 referral data reflects averages from March 2020 through June 2020.
Referrals include all ISTs initially committed to DSH or a DSH-funded program. Excludes any administrative errors, duplicate records, transfers, court returns.

* 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.

Table 3: Patient Census

	6/30/2019	**2/29/2020** (Pre-COVID-19)	**6/30/2021**	**6/30/2022**	**% Change** (6/30/2021 to 6/30/2022)
IST	1,929	2,108	1,951	2,096	7.4%
LPS	736	747	789	707	-10.4%
OMD2962	559	508	415	383	-7.7%
OMD2972	778	760	716	685	-4.3%
NGI	1,416	1,415	1,338	1,244	-7.0%
SVP	962	943	939	956	1.8%
Coleman	185	296	169	114	-32.5%
	6,447	**6,777**	**6,317**	**6,185**	**-2.1%**
CONREP	646	661	647	714	10.4%

POPULATION PROJECTIONS

Census and Pending Placement List Projections

DSH utilizes the actual census as the baseline census for both current year (CY) and budget year (BY). For the Governor's Budget and May Revision, the methodologies to project future census figures are applied as described below.

Methodology

In the 2016 Governor's Budget, DSH implemented a methodology to project the pending placement list. Through collaborative efforts with the University of California, Irvine's (UCI) Department of Criminology, Law, and Society research team this methodology has been enhanced and expanded to include additional commitments. DSH continues to use this as the standard forecasting tool to project the pending placement list for the IST, LPS, OMD, NGI and Sexually Violent Predator (SVP) populations. This methodology does not project for the *Coleman* or the Division of Juvenile Justice (DJJ) patients. Department of Corrections and Rehabilitation (CDCR) determines the bed need and produces projections for the *Coleman* population and contracts with DSH for a specific number of beds to serve the DJJ population.

This methodology utilizes four main measures, as well as expected systemwide capacity expansions, to forecast the pending placement list. Systemwide capacity expansions include state hospitals, jail-based competency treatment programs, and community-based programs. These measures include pending admissions, average referrals, average admissions and average length of stay (ALOS). A projected pending placement list is generated by adding a point-in-time pending placement

list value to an average of monthly new patient referrals. This value is then reduced by the correlating average of monthly admissions, which are offset to incorporate any bed decreases. Expected systemwide capacity increases, augmented by the appropriate ALOS, are then subtracted from the projected pending placement list to yield a modified pending placement list projection for future months.

The projected pending placement list for CY and BY is based on the modified pending placement list value calculated for June 30, 2023, and June 30, 2024. Variables are specific to patient legal class and are typically calculated using actual data for the most recent 12-month period. Variables had to be adjusted for the FY 2023-24 Governor's Budget Estimate to incorporate COVID-19-related circumstances for admissions and referrals.

To ensure that admission and referral variables reflect current conditions, pending placement projections are calculated based on the trends observed in March 2022 through August 2022 for the IST, NGI, LPS and SVP populations. OMD variables continue to be based on the most recent 12-month period ending August 31, 2022, as OMD admissions were not suspended.

The table 4 below presents the DSH pending placement list projections for the IST, LPS, OMD, NGI and SVP populations. The table also presents the actual census for July 1, 2022, as well as the projected census for CY and BY for all DSH populations. The actual census reflects the systemwide total number of patients at DSH on July 1, 2022. The projected census for June 30, 2023 (for CY) and June 30, 2024 (for BY) reflects the actual census as well as the approved and proposed census adjustments.

Table 4: Census and Pending Placement List Projections

CURRENT YEAR			
Legal Class	**July 1, 2022 Actual Census**	**June 30, 2023 Projected Census**	**June 30, 2023 Projected Pending Placement List**
IST	2,107	2,830	1,423
LPS	698	698	399
OMD2962	394	394	31
OMD2972	683	683	6
NGI	1,246	1,246	51
SVP	956	956	6
Subtotal	*6,084*	*6,807*	*1,916*
Coleman[1]	115	115	-
CONREP	714	1,047	-
Total	**6,913**	**7,969**	**1,916**
BUDGET YEAR			
Legal Class	**July 1, 2023 Projected Census**	**June 30, 2024 Projected Census**	**June 30, 2024 Projected Pending Placement List**
IST	2,830	4,142	234
LPS	698	698	495
OMD2962	394	397	31
OMD2972	683	686	5
NGI	1,246	1,246	61
SVP	956	956	4
Subtotal	*6,807*	*8,125*	*830*
Coleman[1]	115	115	-
CONREP	1,047	1,047	-
Total	**7,969**	**9,287**	**830**

[1] The projected pending place list is not calculated for the Coleman and DJJ populations within the DSH forecasting model. Projections for the Coleman population is developed by CDCR; the DJJ population is based on contracted beds agreed to between CDCR and DSH. DJJ census is not displayed to protect confidentiality of the individuals.

COMMITMENT CODES			
Legal Category	**Legal Class Text**	**Code Section**	**Description**
NGI	NGI PC1026	PC 1026	Not Guilty by Reason of Insanity
Other NGI*	RONGI, RO1026	PC 1610	Temporary Admission while waiting for Court Revocation of a PC 1026 (NGI)
Other NGI	MNGI	WIC 702.3	Minor Not Guilty by Reason of Insanity
IST	IST PC1370	PC 1370 or TITLE 18 USC 4244	Incompetent to Stand Trial
Other IST	MIST	PC 1370.01	Misdemeanant Incompetent to Stand Trial
Other IST	EIST	PC 1372(e)	Restored (IST) on Court Hold
Other IST	ROIST, RO1370	PC 1610	Temporary Admission while waiting for Court Revocation of a PC 1370 (IST)
Other IST*	DDIST	PC 1370.1	Commitment as Incompetent to Stand Trial because of Developmental Disability (up to 6 months) and Mental Disorder
OMD	PC2962	PC 2962	Parolee Referred from the Department of Corrections
OMD	PC2964a	PC 2964(a)	Parolee Rehospitalized from CONREP after DSH hearing
OMD	PC2972	PC 2972	Former Parolee Referred from Superior Court
OMD*	RO2972	PC 1610	Temporary admission while waiting for court revocation of PC 2972
MDSO*	MDSO	WIC 6316	Mentally Disordered Sex Offender--Observation
MDSO*	MDSOI	WIC 6316	1. MDSO Observation Indeterminate; 2. MDSO Return by Court
MDSO*	ROMDSO	PC 1610	Temporary Admission while waiting for Court Revocation of MDSO
Other SVP	SVPH	WIC 6601.3	Sexually Violent Predator BPH Hold
Other SVP	SVPE	WIC 6600	Sexually Violent Predator Court Hold
SVP	SVP	WIC 6604	Sexually Violent Predator
SVP	SVPP	WIC 6602	Sexually Violent Predator Probable Cause
PC 2684	PC2684	PC 2684	Prisoner from the Department of Corrections
PC 2685	PC2684A	PC 2684A	Prisoner from the Department of Corrections
DJJ W&I 1756	YAC	WIC 1756	Youth Authority Certification/Youth Authority Referral through Regional Office
LPS	T.CONS	WIC 5353	Temporary Conservatorship
LPS	CONS	WIC 5358	Conservatorship for Gravely Disabled Persons
LPS	VOL	WIC 6000	Voluntary
LPS	DET	WIC 5150	72-Hour Detention
LPS	CERT	WIC 5250	14-Day Certification
LPS	SUIC	WIC 5260	Additional 14-Day Certification for Suicidal Persons
LPS	POST	WIC 5304(a)	180-Day Post Certification--ONLY (until 6/91 used for pending cases also, see 37)
LPS	ADD	WIC 5304(b)	Additional 180-Day Post Certification
LPS	A-CERT	WIC 5270.15	30-Day Certification
LPS	PCD	WIC 5303	Pending Court Decision on 180-Day Post Certification
LPS	MURCONS	WIC 5008(h)(1)(B)	Murphy's Conservatorship
LPS	DMR	WIC 6500, 6509	Persons with Intellectual Disabilities Committed by Court
LPS	CAMR	WIC 4825, 6000(a)	Voluntary Adult Developmentally Disabled Under Own Signature by Regional Center
LPS	VJCW	WIC 6552	Voluntary Juvenile Court Ward
LPS	DMRH	WIC 6506	Hold Pending Hearing on W&I 6509 Petition
LPS*	PC 2974	PC 2974	Recommitment after expiration of prison term (must have concurrent W&I commitment)

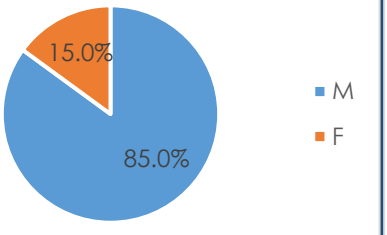
***** Items marked with an asterisk were previously captured in the "Other PC" category

Demographic Snapshot: All Commitment Types

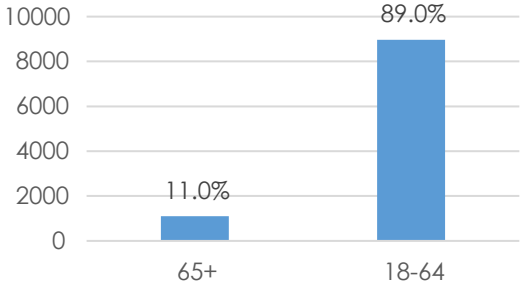
Patients Served from July 1, 2021 to June 30, 2022 is 10,071

Basic Demographics

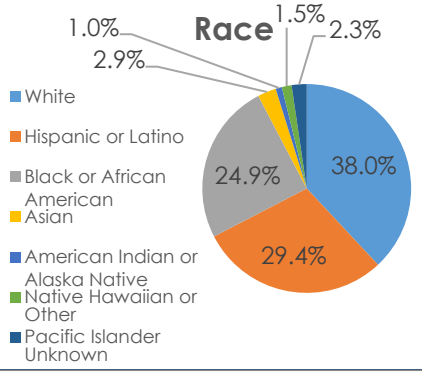
Gender



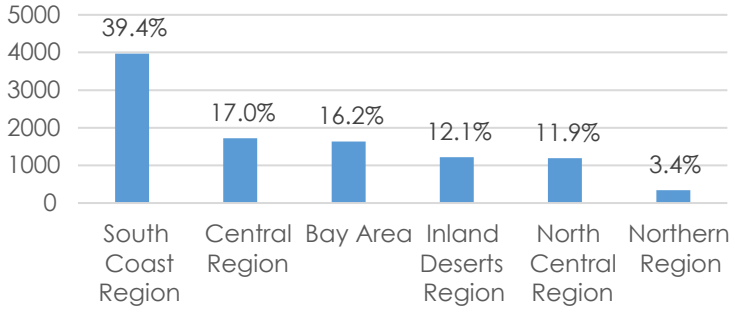
Age on June 30, 2022



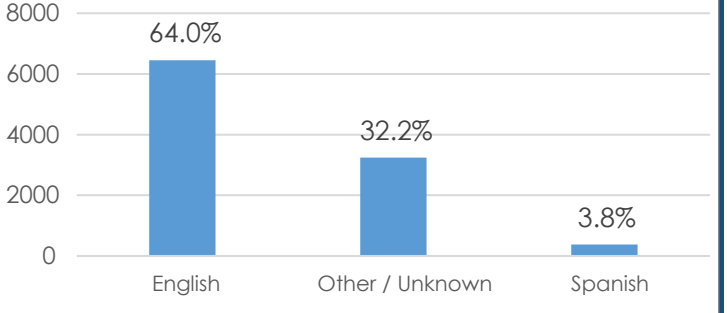
Race



Resident County

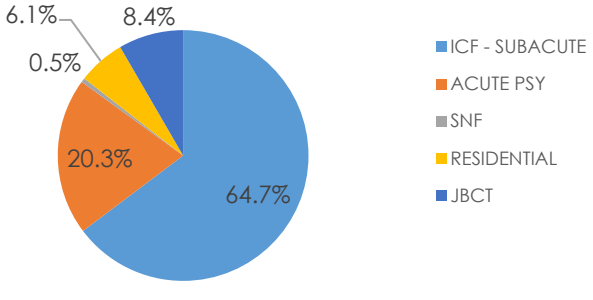


Language Spoken at Home

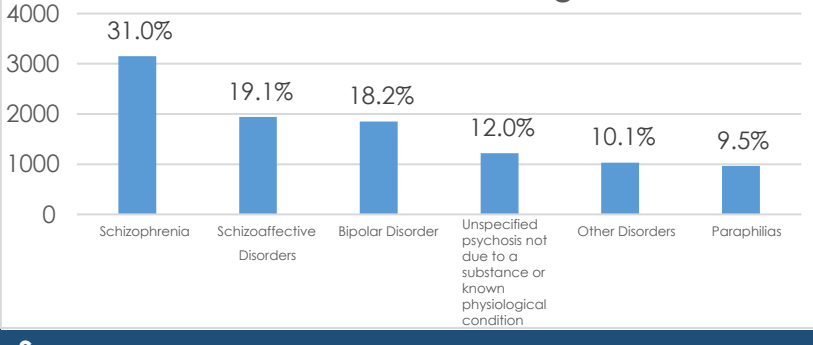


While at a State Hospital

Level of Care



Prevelance of Diagnoses



Summary

The data shown above is a combination of State Hospitals and JBCT information. The DSH population is composed of 85% males and 15% females; a majority of this population is between the ages of 18 and 64. The age of all patients is calculated as of June 30, 2022. Approximately 38% identify as White, 25% Black, and 29% Hispanic with mostly English spoken at home. The majority of the DSH population are residents of South Coast and Bay Area counties. DSH patients are being treated at an Intermediate level of care approximately 65% of the time, followed by 20% at an Acute level of care, 8.4% at a JBCT facility, 6.1% at an RRU level of care, and .5% at an SNF level of care. The level of care data is derived by totaling the number of days the patients were at each level of care during the reporting period. Schizophrenia, Schizoaffective, and Bipolar-type disorders are the three most common diagnoses for the DSH population, accounting for 68% of the population.

DIVISION OF HOSPITAL STRATEGIC PLANNING AND IMPLEMENTATION

RESEARCH, EVALUATION AND DATA

Patients Served by Race

Fiscal Year 2021-2022

		CDCR	IST	LPS	NGI	OMD[4]	SVP	Grand Total
State Hospitals and JBCT Patients Served by Count[1]	*White*	135	1,644	276	682	520	571	3,828
	Hispanic or Latino	111	1,701	245	308	444	144	2,953
	Black or African American	87	1,251	232	286	434	222	2,512
	Asian	<11	150	41	61	26	<11	288
	Unknown	<11	147	22	19	18	17	***
	Native Hawaiian or Other Pacific Islander	<11	59	19	***	22	<11	153
	American Indian or Alaska Native	<11	50		<11	14	14	***
	TOTAL	362	5,002	835	1,406	1,478	981	**10,064**

		CDCR	IST	LPS	NGI	OMD[4]	SVP	Grand Total	2020 State of California[2]	2021 State of California[3]
State Hospitals and JBCT Patients Served by Percentage[1]	*White*	37.3%	32.9%	33.1%	48.5%	35.2%	58.2%	38.0%	36.5%	34.3%
	Hispanic or Latino	30.7%	34.0%	29.3%	21.9%	30.0%	14.7%	29.3%	39.1%	40.2%
	Black or African American	24.0%	25.0%	27.8%	20.3%	29.4%	22.6%	25.0%	5.4%	5.3%
	Asian	***	3.0%	4.9%	4.3%	1.8%	***	2.9%	14.6%	15.0%
	Unknown	***	2.9%	2.6%	1.4%	1.2%	1.7%	***	0.3%	0.6%
	Native Hawaiian or Other Pacific Islander	***	1.2%	2.3%	***	1.5%	***	1.5%	0.3%	0.4%
	American Indian or Alaska Native	***	1.0%	0.0%	***	0.9%	1.4%	***	0.3%	0.2%
	TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	**100.0%**		

1 State Hospital total counts of Patients Served do not include JBCT admissions, JBCT transfers, or patient transfers.

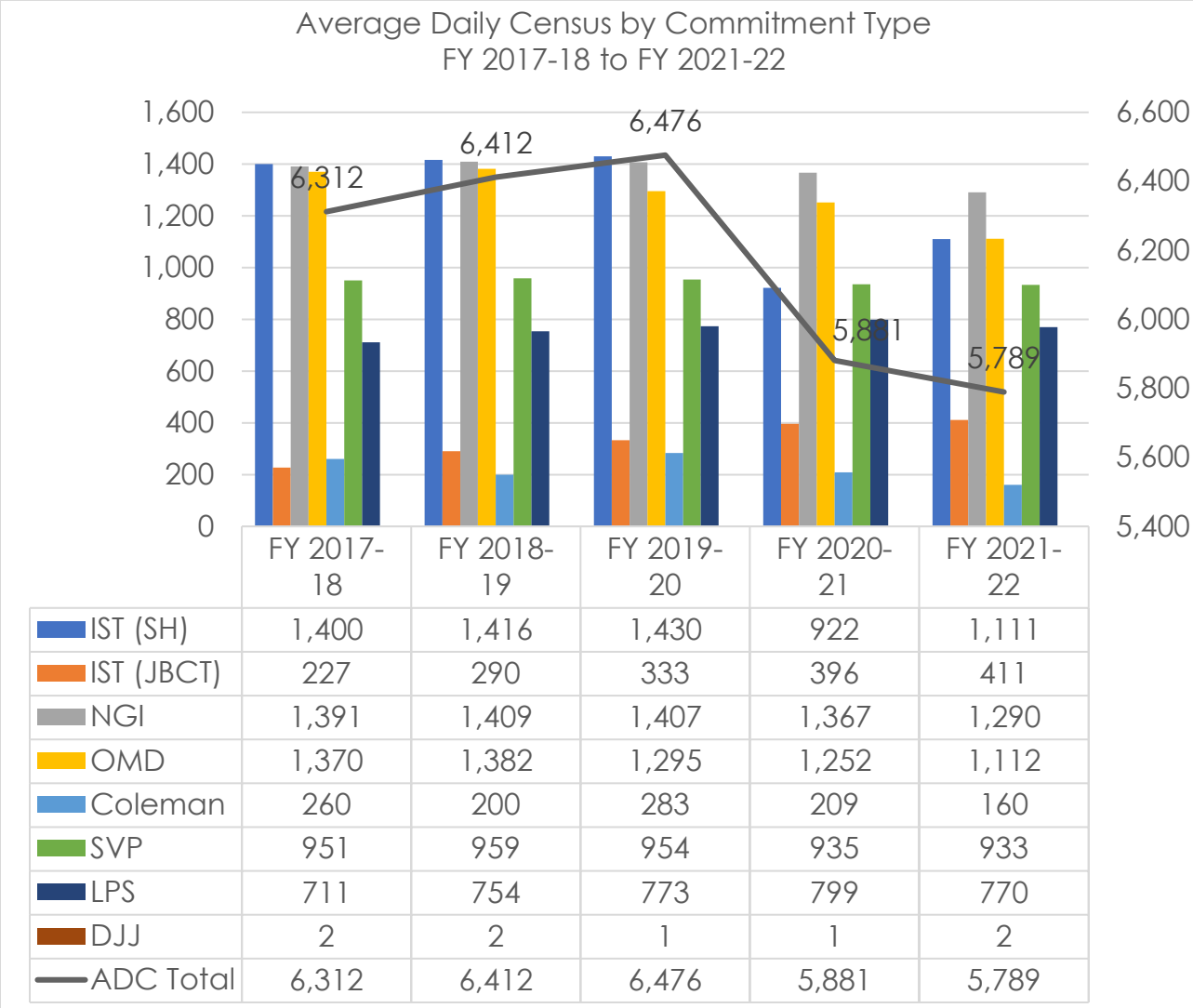
2 Taken from U.S. Census Bureau 2020 American Community Survey (ACS 5-Year Estimates). Does not include 3.4% labeled "two or more races".

3 Taken from the U.S. Census Bureau 2021 American Community Survey (ACS 1-Year Estimates). Does not include 4.2% labeled "two or more races".

4 Includes MDSO.

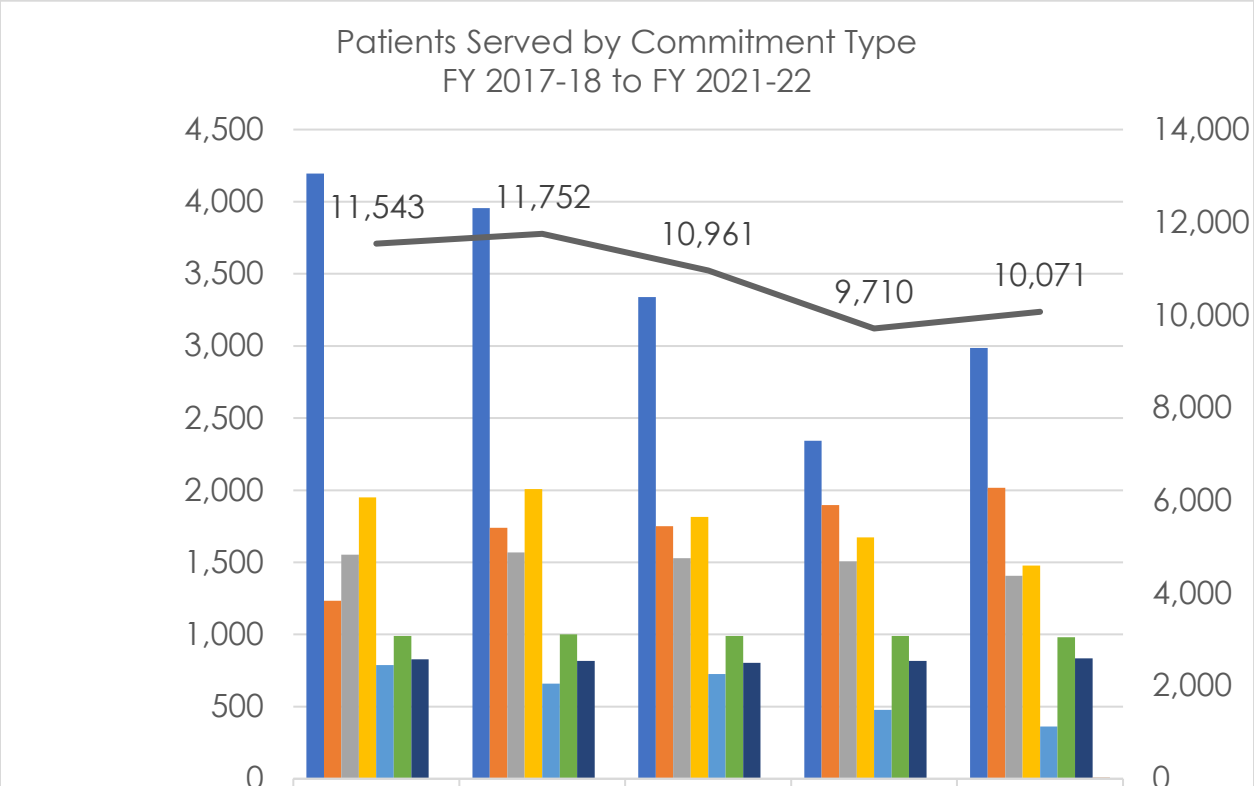
Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data.

De-Identification Legend: Counts between 1-10 are masked with "<11". Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

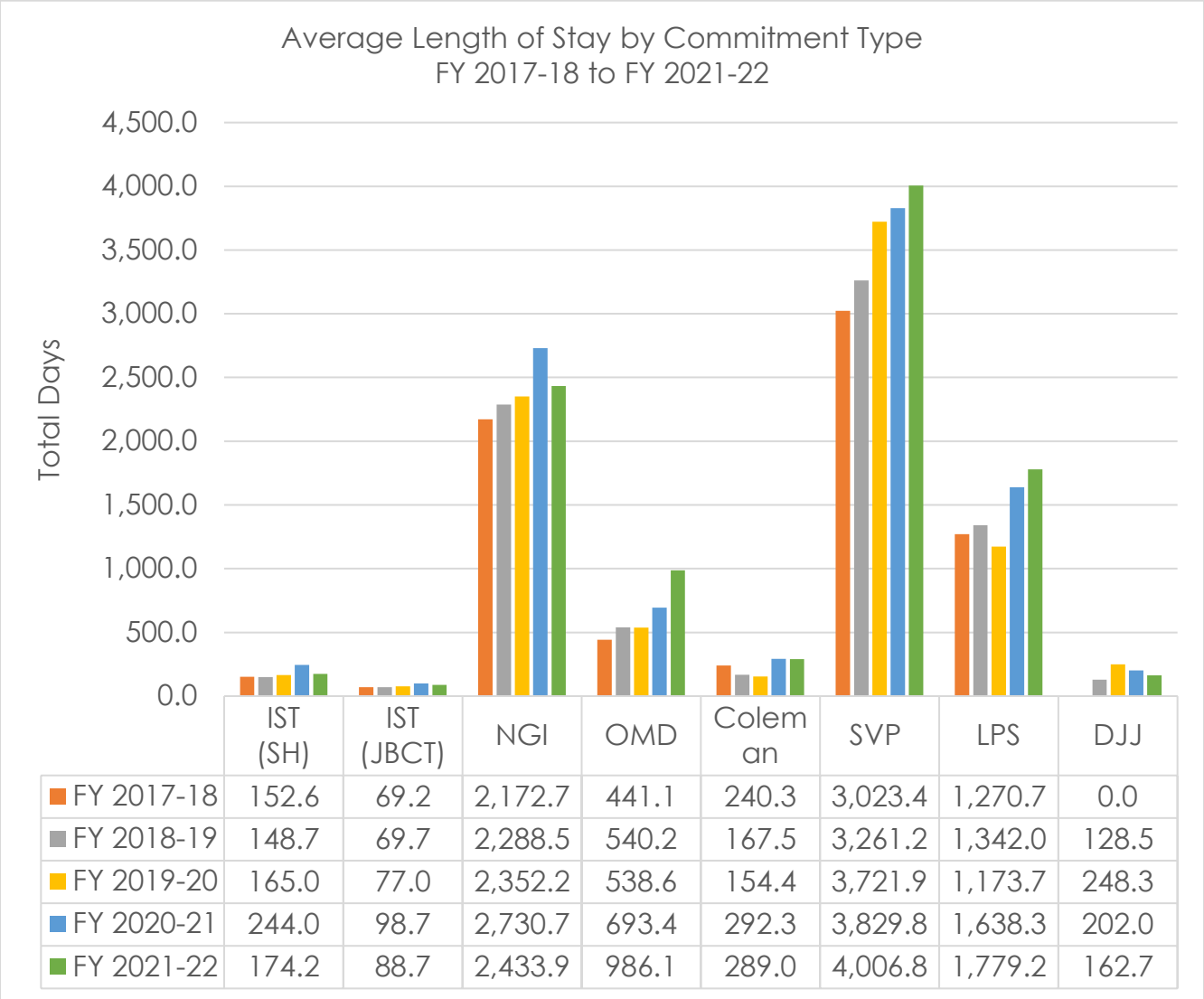


	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
IST (SH)	1,400	1,416	1,430	922	1,111
IST (JBCT)	227	290	333	396	411
NGI	1,391	1,409	1,407	1,367	1,290
OMD	1,370	1,382	1,295	1,252	1,112
Coleman	260	200	283	209	160
SVP	951	959	954	935	933
LPS	711	754	773	799	770
DJJ	2	2	1	1	2
ADC Total	6,312	6,412	6,476	5,881	5,789

Fiscal year (FY) 2020-2021 and 2021-22 have been impacted by the COVID-19 pandemic. Inpatient census has been temporarily decreased due to the need to create Admission Observation Units (AOUs), isolation units for COVID-19 positive patients, and spaces to isolate patients under investigation for COVID-19. Additionally, admission rates have been impacted by the need to admit patients through AOUs to observe and test patients for COVID-19 for at least 10 days before being transferred to a treatment unit. Admission rates have further been reduced at various times throughout the pandemic due to COVID-19 outbreaks requiring quarantines of AOU's and other units within the hospitals.



	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
IST (SH)	4,196	3,955	3,340	2,344	2,986
IST (JBCT)	1,235	1,739	1,750	1,897	2,016
NGI	1,553	1,568	1,530	1,506	1,406
OMD	1,951	2,008	1,815	1,673	1,478
Coleman	787	660	727	477	362
SVP	991	1,001	989	991	981
LPS	827	816	804	817	835
DJJ	3	5	6	5	7
Total Served	11,543	11,752	10,961	9,710	10,071



	IST (SH)	IST (JBCT)	NGI	OMD	Coleman	SVP	LPS	DJJ
FY 2017-18	152.6	69.2	2,172.7	441.1	240.3	3,023.4	1,270.7	0.0
FY 2018-19	148.7	69.7	2,288.5	540.2	167.5	3,261.2	1,342.0	128.5
FY 2019-20	165.0	77.0	2,352.2	538.6	154.4	3,721.9	1,173.7	248.3
FY 2020-21	244.0	98.7	2,730.7	693.4	292.3	3,829.8	1,638.3	202.0
FY 2021-22	174.2	88.7	2,433.9	986.1	289.0	4,006.8	1,779.2	162.7

All Budget Change Proposals (BCPs) can be found at the Department of Finance Website.

Department of Finance (ca.gov)

STATE HOSPITALS
COUNTY BED BILLING REIMBURSEMENT AUTHORITY
Program Update

SUMMARY

The Department of State Hospitals (DSH) does not project an adjustment to current County Bed Billing Reimbursement Authority. An update will be provided in the 2023-24 May Revision.

BACKGROUND

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

LPS Population

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

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

Pursuant to penal code (PC) §1370 (b)(1) and §1370 (c)(1), if a county does not take custody of a defendant committed to DSH within 10 calendar days following notification DSH is authorized to charge counties the daily rate for a state hospital bed. Pursuant to PC §1370, when the state hospital issues a progress report stating there is no substantial likelihood a defendant will recover mental competence, the defendant shall be returned to the committing court, and custody of the defendant shall be transferred without delay to the committing county and shall remain with the county until further order of the court. Assembly Bill 133 (Chapter 143, Statutes 20221), reconfirms authorization for DSH to apply a daily bed rate charge to a county that does not take custody of a defendant, as specified, for any time that the defendant remains in DSH custody.

JUSTIFICATION

DSH assumes no adjustments to the current reimbursement authority for fiscal year (FY) 2022-23 or FY 2023-24. DSH will continue to monitor and provide an update in the 2023-24 May Revision.

Resource Table

Description	CY	BY	BY+
Current Service Level	$191,647	$191,647	$191,647
Governor's Budget Request	$0	$0	$0
TOTAL	**$191,647**	**$191,647**	**$191,647**

*Dollars in thousands

STATE HOSPITAL
DSH - METROPOLITAN INCREASED SECURE BED CAPACITY
Program Update

SUMMARY

The Department of State Hospitals (DSH)-Metropolitan Increased Secure Bed Capacity (ISBC) project continues to experience delays in the activation of the remaining units for Incompetent to Stand Trial (IST) forensic patients. The three remaining units continue to be used for COVID-19 response and persisting water damage in the Skilled Nursing Facility (SNF) Building, resulting in a one-time savings of $11.2 million in fiscal year (FY) 2022-23.

BACKGROUND

To provide additional capacity to address the ongoing system-wide forensic waitlist, particularly focusing on the IST patient waitlist, the Budget Act of 2016 included capital outlay construction funding for the ISBC project at DSH-Metropolitan. This project added security fencing and infrastructure for existing patient buildings at the hospital, which had primarily been used to house civilly committed Lanterman-Petris-Short (LPS) patients. As of the 2022-23 May Revision, DSH had activated only two units for the treatment of IST forensic patients.

While construction of all five ISBC units is complete, the remaining three units have been utilized as swing space to accommodate various operational priorities related to DSH's COVID-19 response, the Continuing Treatment East (CTE) Fire Alarm Project, and most recently, to provide temporary housing to DSH-Metropolitan SNF patients while their building remains uninhabitable following extensive water damage.

While Units 1 and 2 were activated in September 2019 and January 2020, respectively, after the State of Emergency declaration by the Governor in March of 2020, Units 3-5 were repurposed to respond to COVID-19. Unit 3 was designated as a COVID-19 isolation unit, and Units 4 and 5 were used as Admission Observation Units (AOUs) to test and observe newly admitted patients for COVID-19 prior to being moved to a housing unit. Units 4 and 5 served as AOUs until the Norwalk Alternate Care Site (ACS) was activated for this function in March 2021.

In 2021, Unit 3 remained a COVID-19 isolation unit. Units 4 and 5 were no longer needed as AOUs following the relocation of those units to Norwalk ACS in March. When DSH-Metropolitan began the CTE Fire Alarm construction project the following month, in April 2021, the units were repurposed to provide patient housing swing space through construction completion. In July 2021, following the relocation of patients back to CTE, these units were again impacted when the SNF Building at DSH-Metropolitan sustained significant water damage due to a rainstorm which occurred

while the roof was being replaced, resulting in SNF patients being relocated to Units 4 and 5.

Despite this, DSH has increased the number of IST patients provided treatment at DSH-Metropolitan through a combination of efforts, including a reduction in the LPS census, conversion of two DSH-Metropolitan ISBC units for use by ISTs, and the movement of long-term commitments to other DSH hospitals, including DSH-Atascadero and DSH-Patton. In August 2019, before the first ISBC unit was opened, DSH-Metropolitan had an average daily census of 321.8 ISTs, and in September 2022 DSH-Metropolitan's IST average daily census of ISTs was 420.5.

JUSTIFICATION

As of September 2022, DSH-Metropolitan continues to experience delays in the activation of the remaining three units due to the following challenges:

1. Unit 3 continues to be utilized for COVID-19 isolation space.
2. Units 4 and 5 are currently housing SNF patients while DSH continues to work with the Department of General Services (DGS) to repair the SNF Building damage. As of the 2023-24 Governor's Budget, DSH and DGS anticipate repairs to the SNF Building to be completed by July 2023, at which point the SNF patients will be relocated back to the repaired SNF building, allowing Units 4 and 5 to be utilized for IST forensic patients as intended.

Due to these impacts, the activation of the three remaining units continue to experience delays. An update will be provided in the 2023-24 May Revision.

Activation Timeline Adjustment

Unit	# of Beds	Scheduled Activation as of 2022 Budget Act	Scheduled Activation as of 2023-24 Governor's Budget	Change from the 2022 Budget Act
Unit 1	46	September 23, 2019	September 23, 2019	No change - Activated
Unit 2	46	January 29, 2020	January 29,2020	No change - Activated
Unit 3	46	July 2022	July 2023	1-year delay
Unit 4	48	July 2022	July 2023	1-year delay
Unit 5	48	July 2022	July 2023	1-year delay

Resource Table

Description	CY	BY	BY+
Current Service Level	$74,857	$74,857	$74,857
Governor's Budget Request	-$11,221	$0	$0
TOTAL	**$63,636**	**$74,857**	**$74,857**

*Dollars in thousands

BCP Fiscal Detail Sheet

BCP Title: DSH - Metropolitan Increased Secure Bed Capacity **BR Name: 4440-031-ECP-2023-GB**

Budget Request Summary

	FY23					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Salaries and Wages						
Earnings - Permanent	-6,899	0	0	0	0	0
Total Salaries and Wages	**$-6,899**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-3,346	0	0	0	0	0
Total Personal Services	**$-10,245**	**$0**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-488	0	0	0	0	0
5304 - Communications	-61	0	0	0	0	0
5320 - Travel: In-State	-61	0	0	0	0	0
5324 - Facilities Operation	-305	0	0	0	0	0
5346 - Information Technology	-61	0	0	0	0	0
Total Operating Expenses and Equipment	**$-976**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-11,221**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-11,221	0	0	0	0	0
Total State Operations Expenditures	**$-11,221**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-11,221**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4400020 - Hospital Administration	-61	0	0	0	0	0
4410030 - Metropolitan	-11,160	0	0	0	0	0
Total All Programs	**$-11,221**	**$0**	**$0**	**$0**	**$0**	**$0**

Personal Services Details

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
2011 - Custodian I	-118	0	0	0	0	0
7552 - Physician & Surgeon (Safety)	-340	0	0	0	0	0
7619 - Staff Psychiatrist (Safety)	-1,659	0	0	0	0	0
8094 - Registered Nurse (Safety)	-1,351	0	0	0	0	0
8104 - Unit Supvr (Safety)	-154	0	0	0	0	0
8252 - Sr Psych Techn (Safety)	-669	0	0	0	0	0
8253 - Psych Techn (Safety)	-956	0	0	0	0	0
8420 - Rehab Therapist (Art-Safety)	-483	0	0	0	0	0
9872 - Clinical Soc Worker (Hlth/CF)-Safety	-513	0	0	0	0	0
9873 - Psychologist (Hlth Facility-Clinical-Safety)	-656	0	0	0	0	0
Total Salaries and Wages	**$-6,899**	**$0**	**$0**	**$0**	**$0**	**$0**
Staff Benefits						
5150200 - Disability Leave - Industrial	-90	0	0	0	0	0
5150210 - Disability Leave - Nonindustrial	-28	0	0	0	0	0
5150350 - Health Insurance	-317	0	0	0	0	0
5150450 - Medicare Taxation	-103	0	0	0	0	0
5150600 - Retirement - General	-1,380	0	0	0	0	0
5150700 - Unemployment Insurance	-7	0	0	0	0	0
5150800 - Workers' Compensation	-317	0	0	0	0	0
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	-193	0	0	0	0	0
5150900 - Staff Benefits - Other	-911	0	0	0	0	0
Total Staff Benefits	**$-3,346**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$-10,245**	**$0**	**$0**	**$0**	**$0**	**$0**

STATE HOSPITALS
ENHANCED TREATMENT PROGRAM (ETP) STAFFING
Program Update

SUMMARY

Construction on the Department of State Hospitals (DSH)-Patton Enhanced Treatment Program (ETP) unit, Unit 06, is scheduled to be complete December 2023. This delay will result in a one-time savings of $4.8 million in fiscal year (FY) 2022-23. Please see Section G3 for the ETP Annual Report.

BACKGROUND

The ETP was developed to accept patients who are at the highest risk of violence and cannot be safely treated in a standard treatment environment.

The Budget Act of 2018 authorized DSH to construct four ETP units; three 13-bed units at DSH-Atascadero to serve male patients and one 10-bed unit at DSH-Patton to serve female patients. The four-year pilot project was initiated with the opening of the first ETP unit and will end effective September 13, 2025, under current statute. At DSH-Atascadero, ETP Unit 29 was activated in September 2021, while construction for Units 33 and 34 was postponed until bed capacity pressures associated with Incompetent to Stand Trial (IST) referrals are alleviated. As of the Budget Act of 2022, DSH-Patton anticipated activation of ETP Unit U-06 in March 2023, which was delayed due to issues with the fire alarm system redesign.

JUSTIFICATION

DSH anticipates continued delays in the activation of U-06 at DSH-Patton due to redesign of the fire sprinklers and delays in State Fire Marshal approval. The fire sprinkler project precedes the ETP unit construction. Once the fire sprinkler project has been completed, the ETP unit construction can be initiated. Construction is now scheduled to be completed in December 2023 (9-month delay), followed by unit activation in March 2024. Please see the table below for a complete activation timeline.

ETP Activation Timeline			
Units/Hospital	**Scheduled Initiation**	**Scheduled Completion**	**Delay from 2022-23 May Revision**
DSH-Atascadero Unit 29	September 24, 2018 (Actual)	July 2021 (Actual)	N/A
DSH-Atascadero Unit 33	Postponed	Postponed	Unknown
DSH-Atascadero Unit 34	Postponed	Postponed	Unknown
DSH-Patton Unit U-06	June 2023	December 2023	9-month delay

Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$16,397	$15,129	$15,129
Governor's Budget Request	-$4,809	$0	$0
TOTAL	**$11,588**	**$15,129**	**$15,129**

*Dollars in thousands

BCP Fiscal Detail Sheet

BCP Title: Enhanced Treatment Program (ETP) **BR Name: 4440-032-ECP-2023-GB**

Budget Request Summary

	FY23					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Salaries and Wages						
Earnings - Permanent	-2,664	0	0	0	0	0
Total Salaries and Wages	**$-2,664**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-1,639	0	0	0	0	0
Total Personal Services	**$-4,303**	**$0**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-252	0	0	0	0	0
5304 - Communications	-32	0	0	0	0	0
5320 - Travel: In-State	-32	0	0	0	0	0
5324 - Facilities Operation	-158	0	0	0	0	0
5346 - Information Technology	-32	0	0	0	0	0
Total Operating Expenses and Equipment	**$-506**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-4,809**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-4,809	0	0	0	0	0
Total State Operations Expenditures	**$-4,809**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-4,809**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4400020 - Hospital Administration	-32	0	0	0	0	0
4410050 - Patton	-4,777	0	0	0	0	0
Total All Programs	**$-4,809**	**$0**	**$0**	**$0**	**$0**	**$0**

BCP Title: Enhanced Treatment Program (ETP) **BR Name: 4440-032-ECP-2023-GB**

Personal Services Details

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
1138 - Office Techn (Gen)	-45	0	0	0	0	0
1303 - Personnel Spec	-17	0	0	0	0	0
1935 - Hosp Police Lieut	-105	0	0	0	0	0
1936 - Hosp Police Sgt	-141	0	0	0	0	0
1937 - Hosp Police Officer	-1,596	0	0	0	0	0
4588 - Assoc Accounting Analyst	-16	0	0	0	0	0
5393 - Assoc Govtl Program Analyst	-89	0	0	0	0	0
7619 - Staff Psychiatrist (Safety)	119	0	0	0	0	0
8094 - Registered Nurse (Safety)	-458	0	0	0	0	0
8096 - Supvng Registered Nurse (Safety)	-157	0	0	0	0	0
8104 - Unit Supvr (Safety)	123	0	0	0	0	0
8252 - Sr Psych Techn (Safety)	-8	0	0	0	0	0
8253 - Psych Techn (Safety)	232	0	0	0	0	0
8321 - Rehab Therapist (Music-Safety)	-70	0	0	0	0	0
9699 - Hlth Svcs Spec (Safety)	-120	0	0	0	0	0
9839 - Sr Psychologist (Hlth Facility) (Spec)	-259	0	0	0	0	0
9872 - Clinical Soc Worker (Hlth/CF)-Safety	37	0	0	0	0	0
9873 - Psychologist (Hlth Facility-Clinical-Safety)	-94	0	0	0	0	0
Total Salaries and Wages	**$-2,664**	**$0**	**$0**	**$0**	**$0**	**$0**

Staff Benefits						
5150200 - Disability Leave - Industrial	-35	0	0	0	0	0
5150210 - Disability Leave - Nonindustrial	-11	0	0	0	0	0
5150350 - Health Insurance	-123	0	0	0	0	0
5150450 - Medicare Taxation	-40	0	0	0	0	0
5150500 - OASDI	-10	0	0	0	0	0
5150600 - Retirement - General	-845	0	0	0	0	0
5150700 - Unemployment Insurance	-3	0	0	0	0	0
5150800 - Workers' Compensation	-123	0	0	0	0	0
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	-97	0	0	0	0	0
5150900 - Staff Benefits - Other	-352	0	0	0	0	0
Total Staff Benefits	**$-1,639**	**$0**	**$0**	**$0**	**$0**	**$0**

Total Personal Services	**$-4,303**	**$0**	**$0**	**$0**	**$0**	**$0**

STATE HOSPITALS
MISSION-BASED REVIEW Combined
Program Update

SUMMARY

In the 2023-24 Governor's Budget, the Department of State Hospitals (DSH) reflects a savings of $44.9 million in FY 2022-23, savings of $24 million and 46.5 positions in FY 2023-24, savings of $10.9 million and 46.5 positions in FY 2024-25 and a savings of $10.9 million and 46.5 positions in FY 2025-26. Savings are due to delays in hiring and a request to shift 50.5 positions scheduled for phase-in in FY 2023-24 to FY 2026-27 to allow time to recruit for positions already authorized. DSH also provides updates on position phase-ins, hiring and post implementation evaluations.

BACKGROUND

In 2013, DSH initiated a comprehensive effort to evaluate staffing practices amongst the five state hospitals. This study, identified as DSH's Clinical Staffing Study, was assembled to perform a thorough analysis of past practices and staffing methodologies, and ensure they continue to be adequate and appropriate for the department's growing, increasingly more forensic, and aging populations across all DSH facilities. These dynamics, along with the application of new treatment modalities, over time, necessitate the regular review and analysis of current staffing models.

The Clinical Staffing Study is comprised of four components: Hospital Forensic Departments, 24-Hour Care Nursing Services, Protective Services, and Treatment Planning and Delivery. Each of these components involve a comprehensive examination into current staffing practices and development of staffing methodologies. These four components each provide critical and required services to DSH patients through statutorily required forensic evaluations for the courts, 24-hour housing and nursing care, safety to patients and treatment providers, and delivery of psychiatric treatment. As part of each component's assessment, the Clinical Staffing Study reviewed current staffing standards and practices, proposed new data-driven staffing methodologies to adequately support the current populations served, assessed relief factor coverage needs and reviewed current staffing levels within core clinical and safety functions.

Court Evaluations and Reports

As part of DSH's staffing study efforts and in collaboration with the Department of Finance (DOF) Research and Analysis Unit through a Mission-Based Review, the process for completing all forensic services workload within each hospital's Forensic Services Department was examined. This examination involved review of all statutory

language directing the commitment and treatment of patients, depiction of the forensic process (i.e., flow charts) from commitment to discharge for each commitment type, review of datasets available to document the throughput of the process and convening a multitude of subject matter expert interviews to document current practices and challenges. This in-depth review led to the proposed methodologies for staffing each component of Forensic Services.

Direct Care Nursing

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

Protective Services

DSH Protective Services encompasses all operations necessary for providing a secure and safe treatment environment for patients and a safe work environment for DSH employees. This service extends to operating a safe facility within the residing communities and ensuring safety to all individuals entering the hospital grounds. As a law enforcement agency, DSH Protective Services provide 24-hour police services responsible for the safety of all hospital operations, including:

- Ensuring safety and security for the patients and staff during daily living activities and therapeutic treatments
- Securing all hospital housing and buildings occupied by patients and staff
- Securely managing and overseeing the inflow and outflow of patients, staff and visitors
- Safely transporting forensic patients to medical appointments, procedures and court appearances
- Providing 24-hour safety and security custodial presence to patients hospitalized in outside hospitals
- Securing all hospital grounds both inside and outside the secured treatment areas (STA)

The Protective Services component focuses entirely on three key elements:

- Identification of staffing standards across all protective services operations
- Developing standardized methodologies for calculating staffing needs
- Identification of the appropriate relief factors to ensure sufficient coverage across all posts

Treatment Team and Primary Care Services

As part of DSH's staffing study efforts and in collaboration with the DOF Research and Analysis Unit through a Mission-Based Review, the four core areas of Treatment Planning and Delivery were examined:

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

MBR Summary Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$108,129	$123,700	$131,105
Governor's Budget Request	-$44,930	-$24,099	-$10,858
TOTAL	**$63,199**	**$99,601**	**$120,247**

*Dollars in thousands

The following sections will provide specific updates on implementation and outcomes for all five core areas of the clinical staffing study listed above.

STATE HOSPITALS
MISSION-BASED REVIEW—COURT EVALUATIONS AND REPORTS
Program Update

SUMMARY

In the 2023-24 Governor's Budget, DSH makes no request for changes to funding or position authority. DSH also provides updates on position phase-ins, hiring and post implementation evaluation.

PROGRAM UPDATE

Evaluations, Court Reports and Testimony

A total of 53.1 positions were allocated to support forensic evaluations, court reports and testimony, to be phased-in over three years. In the FY 2020-21 May Revision, recruitment efforts were paused, and resources shifted to focus on managing COVID-19 priorities and minimizing staff and patient exposure. DSH adjusted the 53.1 positions to be phased-in over four years.

As of August 31, 2022, all position phase-ins are complete, and 42.3 positions have been filled.

Forensic Case Management and Data Tracking

A total of 16.3 positions were allocated to support forensic case management and data tracking, phased-in over two years. In the FY 2020-21 May Revision, recruitment efforts were paused, and resources shifted to focus on managing COVID-19 priorities and minimizing patient and staff exposure. DSH adjusted the 16.3 positions to be phased-in over three years.

As of August 31, 2022, all position phase-ins are complete, and 8.0 positions have been filled.

Neuropsychological Services

A total of 25.2 positions were allocated to support neuropsychological services, phased-in over two years. This included 11.2 positions for conducting Neuropsychological Assessments and 14.0 positions in a Cognitive Remediation Pilot Program at DSH-Metropolitan and DSH-Napa. In the FY 2020-21 May Revision, recruitment efforts were paused, and resources shifted to focus on managing COVID-19 priorities and minimizing exposure. DSH adjusted the 25.2 positions to be phased-in over three years.

As of August 31, 2022, all position phase-ins are complete, and 18.5 positions have been filled.

Outcomes

Neuropsychological Services consists of a small staff that provide neuropsychological consultation and evaluation for any patient at the hospital. The increase in positions has decreased the wait time for completion of referrals and increased the number of patients seen monthly.

The Cognitive Remediation Pilot Programs are fully staffed at both DSH-Metropolitan and DSH-Napa. These programs focus on treatment for patients identified during second level screening as having severe neurocognitive disorders. Treatment space with computers has been set up and expanded in both hospitals to two treatment spaces each.

As of August 31, 2022, DSH-Napa is serving 10 patients in its two treatment spaces and DSH-Metropolitan is serving 8 patients. Patient data being collected is pre-treatment and post-treatment data related to violence and aggression. However, quantitative data is still being collected and not yet readily available. The qualitative data suggests a reduction in aggression and improvements in overall unit functioning (e.g., some patients have received Patient of the Week status).

Post Implementation Evaluation

DSH will conduct a Post Implementation Evaluation to assess all methodologies and data elements, identify any changes in operations, forensic processes, and statutory requirements and any impact to the forensic services workload. This will include a review of the original forensic functions: Evaluations, Court Reports, and Testimony; Forensic Case Management and Data Tracking; and Neuropsychological Services.

Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$18,318	$18,318	$18,318
Governor's Budget Request	$0	$0	$0
TOTAL	**$18,318**	**$18,318**	**$18,318**

*Dollars in thousands

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

SUMMARY

In the 2023-24 Governor's Budget, DSH reflects a current year savings of $17.1 million and a budget year savings of $4.8 million due to delays in hiring. DSH also provides updates on position phase-ins, hiring and post implementation evaluation.

JUSTIFICATION

Medication Pass Psychiatric Technicians (PT)

A total of 335.0 positions were allocated to support the Medication Pass rooms to be phased-in over three years. In the FY 2020-21 May Revision, all recruitment efforts were paused, and resources shifted to focus on managing COVID-19 priorities and minimizing exposure. DSH adjusted the 335.0 positions to be phased-in over four years.

As of August 31, 2022, a total of 254.5 positions have been established and 163.0 positions have been filled. DSH is actively recruiting to fill these positions, however not all positions have been filled. Additionally, remaining position phase-ins for current year has been pushed out due to delays in hiring. As a result, DSH is projecting a one-time savings in FY 2022-23 of $13.1 million and $3.1 million in FY 2023-24.

Recruiting for these PT positions has proven to be challenging due to lack of candidates available and the need to fill other vacant PT positions on-unit. DSH has been evaluating other nursing classifications that may assist in completing the duties dedicated to this function. Licensed Vocational Nurses (LVN) have been identified as a classification that may be viable to meet the intended need. LVN's have the same qualifications as a PT to work within the dedicated Medication Pass rooms. If hospitals have been unsuccessful in their recruiting efforts with the PT classification, LVNs may be able to be recruited for to assist in getting vacancies filled. DSH will provide a report on in the 2023-24 May Revision on the status of filling these positions with either classification.

Afterhours Supervising Registered Nurses (SRN)

A total of 44.5 positions were allocated to provide nursing supervision afterhours to be phased-in over one year. In the FY 2020-21 May Revision, all recruitment efforts were paused, and resources shifted to focus on managing the COVID-19 priorities and minimizing staff and patient exposure. DSH adjusted the 44.5 positions to be phased-in over two years.

As of August 31, 2022, all 44.5 positions have been established and 25.0 positions have been filled. DSH is actively recruiting to fill these positions, however not all positions have been filled. As a result, DSH is projecting a one-time savings in FY 2022-23 of $4.0 million and $1.7 million in FY 2023-24.

Afterhours Supervising Registered Nurses Phase-ins		
Fiscal Year	**Total**	**Filled**
2019-20	3.0	3.0
2020-21	6.0	6.0
2021-22	35.5	16.0
TOTAL	**44.5**	**25.0**

Redirected Off-Unit Positions

In the original Budget Change Proposal from the 2019 Budget Act, DSH identified level of care positions to be redirected from administrative functions off-unit back to providing services on the units. As part of this redirection of off-unit staff, DSH established administrative positions, primarily using classifications of a Staff Services Analysts (SSA) or Associate Governmental Program Analysts (AGPA) to ensure the administrative functions are still completed. The administrative position requests are for position authority only. This review has continued annually as DSH continually reevaluates staffing and identifying level of care positions that can be returned on the units.

In the 2023-24 Governor's Budget, DSH is requesting position authority (no funding) for 29.0 positions, allowing 29.0 positions back on-unit. The positions requested are 11.0 Associate Governmental Program Analysts, 3.0 Behavioral Specialists, 14.0 Medical Assistants, and 1.0 Staff Services Manager I (Specialist). These positions will allow 24.0 Psychiatric Technicians, 1.0 Registered Nurse, 1.0 Licensed Vocational Nurse, and 3.0 Psychiatric Technician Assistants to return to units. As in the previous two phases, funding for these positions will be covered by the anticipated decrease in overtime needed to staff on-unit positions.

Post Implementation Evaluation

DSH has begun conducting a Post Implementation Evaluation which will re-assess all methodologies and data elements from the original study to determine effectiveness and applicability following the impacts of the COVID-19 pandemic and any changes in patient population commitment type composition among the hospitals. This will include a review of staffing practices, data sources, and nursing staffing resource availability and utilization by type (i.e., position authority, overtime, and temporary help). The Post Implementation Evaluation will also encompass an

assessment of the 12-hour medication pass psychiatric technicians and afterhours supervising registered nurses to gauge the effectiveness of these resources.

Resource Table

Description	CY	BY	Ongoing
Current Service Level	$42,701	$47,068	$47,068
Governor's Budget Request	-$17,079	-$4,781	$0
TOTAL	**$25,622**	**$42,287**	**$47,068**

*Dollars in thousands

BCP Fiscal Detail Sheet

BCP Title: Mission-Based Review: Direct Care Nursing **BR Name: 4440-028-ECP-2023-GB**

Budget Request Summary

	FY23					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	0.0	29.0	29.0	29.0	29.0	29.0
Total Positions	**0.0**	**29.0**	**29.0**	**29.0**	**29.0**	**29.0**
Salaries and Wages						
Earnings - Permanent	-10,154	-2,863	0	0	0	0
Total Salaries and Wages	**$-10,154**	**$-2,863**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-4,920	-1,385	0	0	0	0
Total Personal Services	**$-15,074**	**$-4,248**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-999	-265	0	0	0	0
5304 - Communications	-127	-34	0	0	0	0
5320 - Travel: In-State	-127	-34	0	0	0	0
5324 - Facilities Operation	-627	-167	0	0	0	0
5346 - Information Technology	-125	-33	0	0	0	0
Total Operating Expenses and Equipment	**$-2,005**	**$-533**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-17,079**	**$-4,781**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-17,079	-4,781	0	0	0	0
Total State Operations Expenditures	**$-17,079**	**$-4,781**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-17,079**	**$-4,781**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4400020 - Hospital Administration	-125	-33	0	0	0	0
4410010 - Atascadero	-8,894	-1,878	0	0	0	0
4410020 - Coalinga	-3,574	-836	0	0	0	0
4410030 - Metropolitan	-1,414	-489	0	0	0	0
4410040 - Napa	-1,099	-552	0	0	0	0
4410050 - Patton	-1,973	-993	0	0	0	0
Total All Programs	**$-17,079**	**$-4,781**	**$0**	**$0**	**$0**	**$0**

BCP Title: Mission-Based Review: Direct Care Nursing **BR Name: 4440-028-ECP-2023-GB**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
4800 - Staff Svcs Mgr I				0.0	1.0	1.0	1.0	1.0	1.0
5157 - Staff Svcs Analyst (Gen)				0.0	8.0	8.0	8.0	8.0	8.0
5393 - Assoc Govtl Program Analyst				0.0	3.0	3.0	3.0	3.0	3.0
7374 - Medical Assistant				0.0	14.0	14.0	14.0	14.0	14.0
8161 - Supvng Registered Nurse				0.0	0.0	0.0	0.0	0.0	0.0
8253 - Psych Techn (Safety)				0.0	0.0	0.0	0.0	0.0	0.0
9823 - Behavior Spec I				0.0	3.0	3.0	3.0	3.0	3.0
Total Positions				**0.0**	**29.0**	**29.0**	**29.0**	**29.0**	**29.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
4800 - Staff Svcs Mgr I	0	0	0	0	0	0
5157 - Staff Svcs Analyst (Gen)	0	0	0	0	0	0
5393 - Assoc Govtl Program Analyst	0	0	0	0	0	0
7374 - Medical Assistant	0	0	0	0	0	0
8161 - Supvng Registered Nurse	-2,504	-1,044	0	0	0	0
8253 - Psych Techn (Safety)	-7,650	-1,819	0	0	0	0
9823 - Behavior Spec I	0	0	0	0	0	0
Total Salaries and Wages	**$-10,154**	**$-2,863**	**$0**	**$0**	**$0**	**$0**
Staff Benefits						
5150200 - Disability Leave - Industrial	-130	-38	0	0	0	0
5150210 - Disability Leave - Nonindustrial	-41	-10	0	0	0	0
5150350 - Health Insurance	-466	-131	0	0	0	0
5150450 - Medicare Taxation	-151	-43	0	0	0	0
5150600 - Retirement - General	-2,032	-571	0	0	0	0
5150700 - Unemployment Insurance	-9	-4	0	0	0	0
5150800 - Workers' Compensation	-466	-131	0	0	0	0
5150820 - Other Post-Employment Benefits	-283	-80	0	0	0	0
5150900 - Staff Benefits - Other	-1,342	-377	0	0	0	0
Total Staff Benefits	**$-4,920**	**$-1,385**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$-15,074**	**$-4,248**	**$0**	**$0**	**$0**	**$0**

STATE HOSPITALS
MISSION-BASED REVIEW—PROTECTIVE SERVICES
Program Update

SUMMARY

In the 2023-24 Governor's Budget, DSH reflects a current year savings of $6.8 million due to delays in hiring. DSH also provides updates on position phase-ins, hiring and post implementation evaluation.

JUSTIFICATION

Support and Operations Division

A total of 98.1 positions were allocated to support the Support and Operations Division to be phased in over two years. As result of the OPS Police Academy schedule, DSH has determined a phase-in schedule for the requested positions which aligns with cohorts to maximize funding and recruitment.

As of August 31, 2022, a total of 74.8 positions have been established and 9.0 have been filled. To fill the remaining positions, DSH has converted the required exams to online, with Hospital Police Officer exams offered monthly and the sergeant and lieutenant exams offered every six months. DSH has also contracted with CPS HR Consulting to market the current vacancies and DSH has centralized the five hospitals' separate job postings into one posting. The DSH Academy ran a cohort from May 2, 2022, through August 10, 2022; this cohort graduated 18 cadets. The next cohort runs from August 23, 2022 to December 8, 2022 and has 16 cadets attending. As a result, DSH is projecting a one-time savings in FY 2022-23 of $6.2 million.

Classification	Total as of 8/31/22	Filled as of 8/31/22
Hospital Police Lieutenant	3.0	0.0
Hospital Police Sergeant	4.3	0.0
Hospital Police Officer	67.5	9.0
TOTAL	**74.8**	**9.0**

Executive Leadership Structure

A total of 6.0 positions were allocated to support the Executive Leadership Structure in the beginning of FY 2021-22.

As of August 31, 2022, a total of 6.0 positions have been established and 2.0 have been filled. DSH is recruiting for the three remaining Chief of Police positions. As a result, DSH is projecting a one-time savings in FY 2022-23 of $605,000.

Executive Leadership Structure	Total	Filled
OPS: Chief of Law Enforcement	0.0	0.0
OPS: Assistant Chief of Law Enforcement	1.0	0.0
Chief of Police	5.0	2.0
Assistant Chief of Police	0.0	0.0
TOTAL	**6.0**	**2.0**

Post Implementation Evaluation

Following the implementation of the MBR Protective Services Staffing Standards at DSH-Napa, DSH will conduct a Post Implementation Evaluation of all data elements and will consider the expansion of staffing standards to the four remaining state hospitals. The review will include the gathering of more recent data that will account for resources received to-date, impacts of COVID, and an assessment of current HPO overtime rates.

Resource Table

Description	CY	BY	BY+
Current Service Level	$13,708	$14,178	$13,876
Governor's Budget Request	-$6,777	$0	$0
TOTAL	**$6,931**	**$14,178**	**$13,876**

*Dollars in thousands

BCP Fiscal Detail Sheet

BCP Title: Mission-Based Review: Protective Services **BR Name: 4440-029-ECP-2023-GB**

Budget Request Summary

	FY23					
	CY	BY	BY+1	BY+2	BY+3	BY+4
Salaries and Wages						
Earnings - Permanent	-3,653	0	0	0	0	0
Total Salaries and Wages	**$-3,653**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-2,391	0	0	0	0	0
Total Personal Services	**$-6,044**	**$0**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-362	0	0	0	0	0
5304 - Communications	-48	0	0	0	0	0
5320 - Travel: In-State	-48	0	0	0	0	0
5324 - Facilities Operation	-230	0	0	0	0	0
5346 - Information Technology	-45	0	0	0	0	0
Total Operating Expenses and Equipment	**$-733**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-6,777**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-6,777	0	0	0	0	0
Total State Operations Expenditures	**$-6,777**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-6,777**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4400010 - Headquarters Administration	-152	0	0	0	0	0
4400020 - Hospital Administration	-45	0	0	0	0	0
4410010 - Atascadero	-224	0	0	0	0	0
4410020 - Coalinga	-1,055	0	0	0	0	0
4410030 - Metropolitan	-1,138	0	0	0	0	0
4410040 - Napa	-4,013	0	0	0	0	0
4410050 - Patton	-150	0	0	0	0	0
Total All Programs	**$-6,777**	**$0**	**$0**	**$0**	**$0**	**$0**

BCP Title: Mission-Based Review: Protective Services **BR Name: 4440-029-ECP-2023-GB**

Personal Services Details

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
1935 - Hosp Police Lieut	-211	0	0	0	0	0
1936 - Hosp Police Sgt	-274	0	0	0	0	0
1937 - Hosp Police Officer	-2,822	0	0	0	0	0
7500 - - C.E.A. - A	-346	0	0	0	0	0
Total Salaries and Wages	**$-3,653**	**$0**	**$0**	**$0**	**$0**	**$0**
Staff Benefits						
5150200 - Disability Leave - Industrial	-46	0	0	0	0	0
5150210 - Disability Leave - Nonindustrial	-12	0	0	0	0	0
5150350 - Health Insurance	-169	0	0	0	0	0
5150450 - Medicare Taxation	-55	0	0	0	0	0
5150600 - Retirement - General	-1,308	0	0	0	0	0
5150700 - Unemployment Insurance	-5	0	0	0	0	0
5150800 - Workers' Compensation	-169	0	0	0	0	0
5150820 - Other Post-Employment Benefits	-145	0	0	0	0	0
5150900 - Staff Benefits - Other	-482	0	0	0	0	0
Total Staff Benefits	**$-2,391**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$-6,044**	**$0**	**$0**	**$0**	**$0**	**$0**

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

SUMMARY

In the 2023-24 Governor's Budget, DSH reflects a current year savings of $21.1 million and a budget year savings of $8.4 million due to delays in hiring. DSH requests to delay 50.5 positions that were scheduled to phase-in in FY 2023-24 until July 1, 2026. This provides an additional $10.9 million in savings per year until phase-in resumes. DSH also provides updates on position phase-ins and hiring.

JUSTIFICATION

Interdisciplinary Treatment Team

A total of 180.4 positions were allocated to support the Interdisciplinary Treatment Team to be phased in over five years. In the FY 2022-23 May Revision, due to the delays and challenges in hiring, DSH shifted 29.5 of positions that were scheduled to be authorized in 2022-23 to January 1, 2026 (FY 2025-26) to allow time to recruit for positions already authorized. By pushing these positions back, DSH will be able toto get caught up in current recruitment and be better positioned for future hires. This shift did not adjust the length of the phase-in.

As of August 31, 2022, a total of 52.8 positions have been established and 9.0 have been filled. DSH is actively recruiting to fill these positions. DSH is pursuing a contract with CPS HR Consulting for marketing and outreach and streamlining the application process. However not all positions have been filled. As a result, DSH is projecting a one-time savings in FY 2022-23 of $11.1 million and $8.4 million in FY 2023-24. Due to the delays and challenges in hiring, DSH is requesting to shift 50.5 positions back to allow time to recruit for positions already authorized. By pushing these positions back, DSH will be able to get caught up in current recruitment and be better positioned for future hires. This shift will not adjust the length of the phase-in. DSH is proposing to shift 46.5 positions that are scheduled to be authorized in FY 2023-24 to July 1, 2026 (FY 2026-27). This shift will result in a budget reduction of $10.9 million in FY 2023-24, $10.9 million in FY 2024-25 and $10.9 million in FY 2025-26.

Interdisciplinary Treatment Team	Total	Filled
Psychiatrist	11.0	0.0
Psychologist	10.0	4.0
Clinical Social Worker	15.8	0.0
Rehabilitation Therapist	16.0	5.0
TOTAL	**52.8**	**9.0**

Primary Medical Care

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

As of August 31, 2022, all 31.9 positions have been established and 5.0 positions have been filled. DSH is actively recruiting to fill these positions and is working to streamline the application process for both Chief Physician & Surgeon and Physician & Surgeon classifications. However not all positions have been filled. As a result, DSH is projecting a one-time savings in FY 2022-23 of $7.7 million.

Primary Medical Care	Total	Filled
Chief Physician & Surgeon	6.1	0.0
Physician & Surgeon	25.9	5.0
TOTAL	**31.9**	**5.0**

Trauma-Informed Care

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

As of August 31, 2022, all 6.0 positions have been established and all 6.0 positions have been filled.

Trauma-Informed Care	Total	Filled
Senior Psychologist Supervisor[1]	1.0	1.0
Senior Psychologist Specialist[2]	5.0	5.0
TOTAL	**6.0**	**6.0**

[1] Position reclassed to a Program Director
[2] 4 of the 5 Senior Psychologist Specialists reclassed to Program Assistants

Clinical Executive Structure

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

Administrative Support Positions

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

As of August 31, 2022, all 6.0 positions have been established and all 6.0 have been filled.

Administrative Support	Total	Filled
Associate Personnel Analyst	6.0	6.0
TOTAL	**6.0**	**6.0**

Clinical Executive Leadership

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

As of August 31, 2022, all 12.0 positions have been established and 4.0 have been filled. Four of the remaining eight positions are waiting on approval from the Governor's Office for appointment and the other four are being actively recruited for. As a result, DSH is projecting a one-time savings in FY 2022-23 of $2.2 million.

Clinical Executive Leadership	Total	Filled
Medical Director	6.0	1.0
Assistant Medical Director	1.0	0.0
Chief of Primary Care Services	5.0	3.0
TOTAL	**12.0**	**4.0**

Discharge Strike Team

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

As of August 31, 2022, all 6.0 positions have been established and all 6.0 have been filled.

Discharge Strike Team	Total	Filled
Program Director	1.0	1.0
Clinical Social Worker	5.0	5.0
TOTAL	**6.0**	**6.0**

Resource Table

Description	CY	BY	BY+
Current Service Level	$30,859	$41,572	$49,279
Governor's Budget Request	-$21,074	-$19,318	-$10,858
TOTAL	**$9,785**	**$22,254**	**$38,421**

*Dollars in thousands

BCP Fiscal Detail Sheet

BCP Title: Mission-Based Review: Treatment Team and Primary Care **BR Name: 4440-030-ECP-2023-GB**

Budget Request Summary

	FY23					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	0.0	-46.5	-46.5	-46.5	0.0	0.0
Total Positions	**0.0**	**-46.5**	**-46.5**	**-46.5**	**0.0**	**0.0**
Salaries and Wages						
Earnings - Permanent	-13,412	-12,100	-6,809	-6,809	0	0
Total Salaries and Wages	**$-13,412**	**$-12,100**	**$-6,809**	**$-6,809**	**$0**	**$0**
Total Staff Benefits	-6,491	-5,864	-3,301	-3,301	0	0
Total Personal Services	**$-19,903**	**$-17,964**	**$-10,110**	**$-10,110**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-582	-673	-372	-372	0	0
5304 - Communications	-75	-85	-47	-47	0	0
5320 - Travel: In-State	-75	-85	-47	-47	0	0
5324 - Facilities Operation	-366	-426	-235	-235	0	0
5346 - Information Technology	-73	-85	-47	-47	0	0
Total Operating Expenses and Equipment	**$-1,171**	**$-1,354**	**$-748**	**$-748**	**$0**	**$0**
Total Budget Request	**$-21,074**	**$-19,318**	**$-10,858**	**$-10,858**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-21,074	-19,318	-10,858	-10,858	0	0
Total State Operations Expenditures	**$-21,074**	**$-19,318**	**$-10,858**	**$-10,858**	**$0**	**$0**
Total All Funds	**$-21,074**	**$-19,318**	**$-10,858**	**$-10,858**	**$0**	**$0**

Program Summary

Program Funding						
4400010 - Headquarters Administration	-558	0	0	0	0	0
4400020 - Hospital Administration	-73	-85	-47	-47	0	0
4410010 - Atascadero	-3,105	-3,224	-1,544	-1,544	0	0
4410020 - Coalinga	-5,819	-2,975	-1,930	-1,930	0	0
4410030 - Metropolitan	-4,005	-4,703	-2,520	-2,520	0	0
4410040 - Napa	-3,197	-5,311	-3,374	-3,374	0	0
4410050 - Patton	-4,317	-3,020	-1,443	-1,443	0	0
Total All Programs	**$-21,074**	**$-19,318**	**$-10,858**	**$-10,858**	**$0**	**$0**

BCP Title: Mission-Based Review: Treatment Team and Primary Care **BR Name: 4440-030-ECP-2023-GB**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
7552 - Physician & Surgeon (Safety)				0.0	0.0	0.0	0.0	0.0	0.0
7561 - Chief Physician & Surgeon				0.0	0.0	0.0	0.0	0.0	0.0
7619 - Staff Psychiatrist (Safety)				0.0	-13.1	-13.1	-13.1	0.0	0.0
8323 - Rehab Therapist (Occ-Safety)				0.0	-9.7	-9.7	-9.7	0.0	0.0
9872 - Clinical Soc Worker (Hlth/CF)-Safety				0.0	-8.2	-8.2	-8.2	0.0	0.0
9873 - Psychologist (Hlth Facility-Clinical-				0.0	-15.5	-15.5	-15.5	0.0	0.0
VR00 - Various				0.0	0.0	0.0	0.0	0.0	0.0
Total Positions				**0.0**	**-46.5**	**-46.5**	**-46.5**	**0.0**	**0.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
7552 - Physician & Surgeon (Safety)	-4,156	0	0	0	0	0
7561 - Chief Physician & Surgeon	-830	0	0	0	0	0
7619 - Staff Psychiatrist (Safety)	-3,259	-6,111	-3,622	-3,622	0	0
8323 - Rehab Therapist (Occ-Safety)	-1,071	-1,607	-791	-791	0	0
9872 - Clinical Soc Worker (Hlth/CF)-Safety	-1,923	-2,158	-711	-711	0	0
9873 - Psychologist (Hlth Facility-Clinical-	-703	-2,224	-1,685	-1,685	0	0
VR00 - Various	-1,470	0	0	0	0	0
Total Salaries and Wages	**$-13,412**	**$-12,100**	**$-6,809**	**$-6,809**	**$0**	**$0**
Staff Benefits						
5150200 - Disability Leave - Industrial	-177	-158	-88	-88	0	0
5150210 - Disability Leave - Nonindustrial	-54	-48	-27	-27	0	0
5150350 - Health Insurance	-618	-556	-313	-313	0	0
5150450 - Medicare Taxation	-201	-182	-103	-103	0	0
5150600 - Retirement - General	-2,677	-2,420	-1,362	-1,362	0	0
5150700 - Unemployment Insurance	-12	-12	-7	-7	0	0
5150800 - Workers' Compensation	-618	-556	-313	-313	0	0
5150820 - Other Post-Employment Benefits	-377	-340	-192	-192	0	0
5150900 - Staff Benefits - Other	-1,757	-1,592	-896	-896	0	0
Total Staff Benefits	**$-6,491**	**$-5,864**	**$-3,301**	**$-3,301**	**$0**	**$0**
Total Personal Services	**$-19,903**	**$-17,964**	**$-10,110**	**$-10,110**	**$0**	**$0**

STATE HOSPITALS
PATIENT-DRIVEN OPERATING EXPENSES & EQUIPMENT
Program Update

SUMMARY

Due to cost increases attributed to inflation and changes in patient census, the Department of State Hospitals (DSH) requests to redirect $20.3 million in fiscal year (FY) 2022-23 savings from other areas due to delays in activations and requests $20.5 million in FY 2023-24 and ongoing to support patient-related operating expense and equipment (OE&E) costs.

BACKGROUND

The Budget Act of 2019 adopted a standardized cost estimate methodology to provide funding for patient-related OE&E items such as outside medical care, pharmaceuticals, patient clothing, foodstuffs, etc. based on updated census estimates for each fiscal year and an estimated cost per patient, derived from past year actual expenditures. Throughout the COVID-19 pandemic, DSH has closely monitored and managed these expenditures.

JUSTIFICATION

Estimated patient-driven OE&E costs for FY 2022-23 and FY 2023-24 are based on updated census figures and updated per patient costs using FY 2021-22 actual expenditures. In FY 2021-22, DSH spent $137.7 million in patient-driven OE&E with a census count of 5,318 patients. This resulted in a cost per patient of $25,889.

Per Patient Cost

Following the methodology adopted in the Budget Act of 2019, DSH captured the FY 2021-22 actuals to derive a per patient cost. Increasing global inflation, observed in 2021 and continuing into 2022, has resulted in cost increases nationwide. Correspondingly, the cost per patient has risen significantly in recent years. Some of the most heavily impacted areas include outside hospitalization, foodstuffs, and pharmaceuticals. The chart below shows the rising cost of each category impacting the per patient cost from FY 2018-19 through FY 2021-22.

Average Cost Per Patient Comparison					
Budget Categories	FY 2018-19 Avg. Cost Per Patient	FY 2019-20 Avg. Cost Per Patient	FY 2020-21 Avg. Cost Per Patient	FY 2021-22 Avg. Cost Per Patient	Percentage Change FY 2018-19 – FY 2021-22
State Hospital Census	*6,126*	*6,317*	*5,577*	*5,318*	*-13%*
Utilities	$2,936	$3,654	$3,641	$4,188	43%
Outside Hospitalization	$5,960	$22,284	$5,926	$6,861	15%
Clothing/Personal Supplies	$501	$414	$219	$443	-12%
Recreation & Religion	$55	$69	$67	$98	79%
Foodstuffs	$3,040	$3,160	$3,246	$3,972	31%
Quartering & Housekeeping	$758	$899	$625	$852	12%
Laundry	$727	$657	$775	$930	28%
Miscellaneous Client Services	$74	$110	$142	$234	216%
Chemicals, Drugs and Lab Supplies	$728	$1,644	$585	$920	26%
Pharmaceuticals	$6,296	$6,064	$6,770	$7,375	17%
Educational Supplies	$10	$10	$14	$16	62%
Total	**$21,085**	**$38,965**	**$22,010**	**$25,889**	**23%**

These inflation impacts are reflected in the recent Department of Finance Budget Letter (BL) 22-22, 2023-24 Price Letter which cites a 5.1% California Consumer Price Index (CPI) for all urban consumers in FY 2022-23, with a projected CPI of 8.3% in FY 2023-24. Increases in the cost of items such as medical care, clothing and personal supplies, and foodstuffs directly impact the cost per patient.

Allotment Adjustment for FY 2022-23

In the Budget Act of 2022, DSH used the projected census for FY 2022-23 and the per patient cost derived from FY 2018-19 actuals to determine the total cost for Patient-Driven OE&E. Since that time, there have been changes to both the patient census and the per patient cost, requiring an adjustment to the total funding needed. To calculate the projection, the per patient cost difference from FY 2018-19 and FY 2021-22 ($25,889 - $21,085 = $4,804) was multiplied by the census projected FY 2022-23 at the time of the 2022-23 Governor's Budget (5,740). The table below displays the total amount needed to fund Patient-Driven OE&E for the census recognized in FY 2022-23.

FY 2022-23 Cost Adjustment for Existing Census		
Projected FY 2022-23 Census	Increase in Per Patient Cost between FY 2018-19 and FY 2021-22	Total
5,740	**$4,804**	**$27,577,656**

While this addresses the projected census from the Budget Act of 2022, a second calculation is needed to obtain the adjustment needed for the updated FY 2022-23 patient census projection. Following the Budget Act of 2022, the projected patient census for FY 2022-23 has decreased from 5,740 to 5,548, resulting in a census reduction of 282. This reduction amount was applied to the FY 2021-22 per patient cost. The table below displays the total adjusted amount resulting from the decrease in projected census recognized between the Budget Act of 2022 and the 2023-24 Governor's Budget.

FY 2022-23 Cost Adjustment for Updated Census		
Per Patient Cost FY 2021-22 Actuals	Change in Patient Census between Budget Act of 2022 and 2023-24 Governor's Budget	Total
$25,889	**-282**	**-$7,300,714**

Based off the methodology adopted in the Budget Act of 2019, with updated per patient costs and adjusted patient census, DSH requests $20.3 million in FY 2022-23 and ongoing. The figure below displays the cost adjustment for the existing census minus the cost adjustment for the new census to determine the total budget request for FY 2022-23.

FY 2022-23 Cost Adjustment for Per Patient and Census Adjustments	
Cost Adjustment for Existing Census	$27,577,656
Cost Adjustment for New Census	-$7,300,714
Total Request FY 2022-23	**$20,276,942**

To support this need, DSH requests a redirection of a portion of FY 2022-23 savings reflected in the 2023-24 Governor's Budget in the amount of $20,276,942.

Allotment Adjustment for FY 2023-24

For FY 2023-24, DSH is projecting a census increase of 10 patients from FY 2022-23 (5,458) to FY 2023-24 (5,468). To calculate the increased need for Patient-Driven OE&E for FY 2023-24, the change in census was multiplied by the FY 2021-22 cost per patient. The additional cost for the increased census is shown below.

FY 2023-24 Cost Adjustment for Updated Census		
Per Patient Cost FY 2021-22 Actuals	Change in Patient Census between Budget Act of 2022 and 2023-24 Governor's Budget	Total
$25,889	**10**	**$258,891**

Based on the updated per patient costs and increased census, DSH requests $259,000 in FY 2023-24 and ongoing. The table below shows the total budget request for FY 2022-23 and FY 2023-24.

2023-24 Governor's Budget Total Funding Request - Patient-Driven OE&E	
Budget Request for FY 2022-23	$20,276,942
Budget Request for FY 2023-24	$258,891
Total Request FY 2023-24	**$20,535,833**

Resource Table

Description	CY	BY	BY+
Current Service Level	$109,088	$109,283	$109,283
Governor's Budget Request	$20,277	$20,536	$20,536
TOTAL	**$129,365**	**$129,819**	**$129,819**

*Dollars in thousands

BCP Fiscal Detail Sheet

BCP Title: Patient Driven Operating Expenses & Equipment **BR Name: 4440-033-ECP-2023-GB**

Budget Request Summary

	FY23					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5326 - Utilities	6,007	6,049	6,049	6,049	6,049	6,049
5340 - Consulting and Professional Services - External	3,237	3,306	3,306	3,306	3,306	3,306
539X - Other	11,033	11,181	11,181	11,181	11,181	11,181
Total Operating Expenses and Equipment	**$20,277**	**$20,536**	**$20,536**	**$20,536**	**$20,536**	**$20,536**
Total Budget Request	**$20,277**	**$20,536**	**$20,536**	**$20,536**	**$20,536**	**$20,536**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	20,277	20,536	20,536	20,536	20,536	20,536
Total State Operations Expenditures	**$20,277**	**$20,536**	**$20,536**	**$20,536**	**$20,536**	**$20,536**
Total All Funds	**$20,277**	**$20,536**	**$20,536**	**$20,536**	**$20,536**	**$20,536**

Program Summary

Program Funding						
4410010 - Atascadero	4,830	4,830	4,830	4,830	4,830	4,830
4410020 - Coalinga	6,713	6,713	6,713	6,713	6,713	6,713
4410030 - Metropolitan	852	852	852	852	852	852
4410040 - Napa	2,595	2,595	2,595	2,595	2,595	2,595
4410050 - Patton	5,287	5,546	5,546	5,546	5,546	5,546
Total All Programs	**$20,277**	**$20,536**	**$20,536**	**$20,536**	**$20,536**	**$20,536**

STATE HOSPITALS
COVID-19 UPDATE
Program Update

SUMMARY

The Department of State Hospitals (DSH) requests $51.3 million in General Fund (GF) in fiscal year (FY) 2023-24 to support COVID-19 driven workload and expenditures that will continue in the DSH hospital system following the end of the State of Emergency. To continue to protect the health and safety of staff and patients DSH requests funding for the personal services costs only for state staff dedicated to implementing infection control measures, and operating expenses and equipment (OE&E) costs for related to level of care (LOC) and non-LOC surge staffing contracts, in addition to personal protective equipment (PPE), and sanitation and testing supplies.

BACKGROUND

DSH executed a COVID-19 response plan across its system to follow guidance from the California Department of Public Health (CDPH), the Centers for Disease Control and Prevention (CDC) and other state and local partners. Under these circumstances, DSH took the necessary steps to mitigate the spread of COVID-19 at all facilities. An Emergency Operation Center was activated and DSH hospitals activated their Incident Command Centers and developed incident action plans to better communicate and coordinate DSH's pandemic response efforts. DSH implemented policies and procedures for infection control, respiratory protection, COVID-19 testing and personal protective equipment and established isolation units. Once a vaccination was available, DSH implemented policies in accordance with State Public Health Orders and guidance.

As of the 2023-24 Governor's Budget, DSH has the below updates on vaccination efforts and COVID-19 cases, including the number of tests and number of positive cases.

- Vaccination Update – As of December 14, 2022, DSH has achieved a staff vaccination rate of 83% and a staff booster rate of 66% of staff eligible for booster doses. For patients, DSH has achieved a vaccination rate of 74% and patient booster rate of 63% of patients eligible for booster doses. DSH currently is administering bivalent boosters to patients and staff and is actively promoting the bivalent booster for increased protection during the winter season.
- COVID-19 Cases and Hospital Update – As of December 11, 2022, DSH performed 232,378 PCR tests on patients across all five hospitals, with 4,317

patients testing positive. DSH also performed 365,709 PCR tests and 2,535,418 antigen tests on staff statewide and with a total of 9,500 staff testing positive.

The Governor has issued a date of February 28, 2023, for the end of the State of Emergency. While the State of Emergency is ending, DSH will continue to need to maintain COVID-19 infection control measures, testing, and patient treatment of COVID-19 infections. DSH reviewed the aforementioned COVID-19 policies to determine what will be needed to continue to mitigate the spread of COVID-19 throughout DSH facilities and ensure all DSH staff and patients remain safe.

JUSTIFICATION

As of the 2023-23 Governor's Budget, DSH requests $51.3 million GF in FY 2023-24 to continue to support infection control measures to protect the health and safety of its employees and patients beyond the State of Emergency end date. The resources needed support testing, surge resources, public health related personnel, and commodity goods.

Testing

The purpose of a diagnostic screening testing is to detect new cases, prevent exposure, and mitigate outbreaks. Congregate living environments, such as DSH, have an increased risk for rapid and widespread transmission of COVID-19. A strategy of frequent testing is recommended to reduce the chance of a large outbreak when a COVID-19 exposure occurs and when contact tracing is difficult to perform. This is especially relevant as COVID-19 has a high proportion of asymptomatic cases.

Following the end of the State of Emergency, DSH will continue to have testing present throughout its hospital system for both patients and staff. This includes both Rapid Antigen Test (RAT) and polymerase chain reaction (PCR). DSH will need to continue to perform diagnostic screening testing and response testing of both patients and staff. Hospitals are currently pulling from existing resources to staff testing locations, with oversight by the Public Health teams. Currently COVID-19 antigen tests and PCR outside laboratory tests are provided to DSH through another state department. After the end of the State of Emergency, these services will no longer be available to DSH from the other department and DSH will need to procure these tests and services directly. Testing will need to continue after the end of the State of Emergency, therefore, DSH requests $29 million in FY 2023-24 for staffing to administer tests and to procure tests and associated materials needed.

Surge Capacity Resources

Hospital Staffing

As COVID-19 cases increase and staff are out due to COVID-19, DSH is required to continue to staff at bed licensing and staffing minimums. Based on trends observed over the past three years of the pandemic, DSH has experienced surges in the winter and summer months. During the Omicron winter surge from December 2021-February 2022, DSH experienced an average of 36 new staff positives daily, reaching as high as 90 staff positives per day. During the summer 2022 surge, DSH experienced an average of 16 new staff positives daily, reaching a max of 32 staff positive per day. To account for these spikes in cases and necessary time for staff to be off work, DSH is requesting $7.6 million in FY 2023-24 to provide contracted short-term staffing support during surges.

Norwalk Alternate Care Site (ACS)

As a response to COVID-19, DSH entered into an Interagency Agreement (IA) with the California Department of Corrections and Rehabilitation to utilize a portion of the Southern Youth Correctional Reception Center and Clinic in Norwalk, CA. The ACS is being operated as a satellite facility to the Metropolitan State Hospital and features two housing units, one 50-bed and one 48-bed, plus a separate building for treatment and office space. The ACS is being used to house patients that have tested negative for COVID-19, providing additional space within the state hospital facilities for isolation or quarantine space. This IA has been extended and the current contract is in effect until December 31, 2023. In order to run this additional facility, DSH has needed additional resources for personnel and OE&E. DSH is requesting $4 million in funding for six months in FY 2023-24 to align with the existing IA contract dates.

Public Health Teams

Public Health Nurses

DSH Public Health teams have led efforts to provide COVID-19 vaccines to patients and staff. Public Health personnel not only administer vaccinations but also provide continual education regarding vaccination benefits. This includes addressing misinformation regarding COVID-19 vaccines, building vaccine confidence, and ensuring only the most reliable and up to date education is provided. To do so, Public Health teams must stay informed of current vaccine guidance and clinical considerations. As authorized COVID-19 vaccination sites, DSH hospitals must maintain detailed records of all staff and patient COVID-19 vaccinations administered and report vaccine administration data to CDPH. To maintain compliance with State Public Health Officer orders, DSH hospitals must retain records

of staff vaccinations, boosters, and exemptions. Public Health teams must track when and which patients are due for the initial vaccination series and additional boosters. With new admissions to hospitals every week, this is a continuous effort. Hospitals must also continue to offer vaccines to patients that refuse multiple times, while also documenting refusals and education efforts.

DSH Public Health Departments are tasked with conducting and/or coordinating case investigations and contact tracing. Each reported COVID-19 infection takes anywhere from 30 minutes to 2 hours to complete this tracing, depending on the reach of the exposure. Findings are reported to the hospital's Chief Public Health Officer or Medical Director within four to 12 hours, depending on immediate exposure risk to the county public health department and to CDPH. Contact tracing and case investigations involve complex analysis and require obtaining critical information from the source, and rapid contact of all individuals with significant exposure. Accurate clinical guidance must be provided to each individual involved regarding isolation requirements, health care follow up, testing to return to work requirements, continued patient and staff surveillance, and education to ensure compliance. Public health staff complete an average of one to 10 case investigations per day, and during surges, as many as 15-20. A strong case investigation and contact tracing system must be maintained to slow the spread of COVID-19 and is a required public health measure.

Currently DSH has 10.0 limited term Public Health Nurses (PHN) in blanket positions to ensure compliance with the additional workload tied to vaccination and monitoring functions. DSH requests $1.9 million in FY 2023-24 to continue funding these positions.

Cleaning

In response to increased infection control efforts due to COVID-19, DSH has had to implement additional cleaning teams to ensure patient occupied areas are being adequately maintained and sanitized to prevent the spread of Aerosol Transmissible Diseases (ATD). DSH requests $2.2 million in FY 2023-24 to continue these increased sanitation measures.

Environmental Hygienists

DSH hospitals need the technical, scientific, and worksite experience of industrial hygienists to ensure worker and patient safety within its high-risk care environment. Complex, regulatory patient and employee safety requirements for DSH are administered by analysts, clinicians, and managers who do not possess the scientific, environmental, and technical expertise to monitor, consult, and guide environmental health practices and performance improvements across many disciplines. Hiring a Senior Industrial Hygienist to lead a statewide team with an Associate Industrial Hygienist at each hospital will provide each hospital an on-site,

full-time technical and scientific expert to work with the Standards Compliance, Health and Safety, Plant Operations, Nutrition Services, Pharmacy, and Clinical/Medical teams to prevent workplace exposures to Aerosol Transmissible Diseases and injuries, and support state and local agency regulatory compliance. DSH requests $1 million in FY 2023-24 to support the need for safety hygienist staffing to protect the department's environment of care related to ATD and other airborne infection risks.

Commodity Goods

DSH requests $5.6 million in FY 2023-24 for operating expenses that are tangible and generally consumable in nature, requiring continuous replenishment. As the State of Emergency is ending, items such as PPE may no longer be available through statewide stockpiles or through other state departments. However, due to the continuation of testing and vaccination guidelines mentioned above, DSH will continue to need a higher level of PPE such as gloves, gowns, surgical masks, N95 masks, protective clothing, and face shields. Additionally, due to the increased cleanings and additional teams requested, DSH will need to increase sanitation supplies such as germicidal bleach, hand sanitizer and hydrogen peroxide wipes. DSH dining rooms are closed when COVID-19 infections spike in the facility. However, when dining rooms are open, quarantined patient units and isolated patients cannot eat in the dining rooms. In these instances, patients are served food on the housing units. This drives a need for additional food and food supplies as meals need to be individually packaged and items normally available for communal use need to be served individually.

Funding Methodology

These cost estimates are based upon the best available information at this time, and it is anticipated this request will be updated as part of 2023-24 May Revision as additional information continues to be gathered, evaluated, and CDC/CDPH guidance evolves. DSH utilized actual expenditures from implementing COVID-19 protocols to inform the ongoing request, however, reduced the costs assuming the utilization of some practices will diminish. However, DSH does assume it will become responsible for testing costs (i.e. RAT and PCR testing) currently provided through CDPH in response to the public health emergency.

Resource Table[1]

Description	CY	BY	BY+
Current Service Level[2]	$83,124	$0	$0
Governor's Budget Request	$0	$51,278	$0
TOTAL	**$83,124**	**$51,278**	**$0**

[1] Dollars in thousands
[2] Excludes COVID-19 Worker's Compensation BCP funding which concludes in FY 2024-25

BCP Fiscal Detail Sheet

BCP Title: COVID-19 Update **BR Name: 4440-037-ECP-2023-GB**

Budget Request Summary

	FY23					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Salaries and Wages						
Earnings - Permanent	0	8,778	0	0	0	0
Total Salaries and Wages	**$0**	**$8,778**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	0	938	0	0	0	0
Total Personal Services	**$0**	**$9,716**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	0	31,330	0	0	0	0
5304 - Communications	0	16	0	0	0	0
5320 - Travel: In-State	0	16	0	0	0	0
5324 - Facilities Operation	0	80	0	0	0	0
5340 - Consulting and Professional Services - External	0	10,104	0	0	0	0
5346 - Information Technology	0	16	0	0	0	0
Total Operating Expenses and Equipment	**$0**	**$41,562**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$0**	**$51,278**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	0	51,278	0	0	0	0
Total State Operations Expenditures	**$0**	**$51,278**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$0**	**$51,278**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4400010 - Headquarters Administration	0	214	0	0	0	0
4400020 - Hospital Administration	0	16	0	0	0	0
4410010 - Atascadero	0	8,775	0	0	0	0
4410020 - Coalinga	0	9,192	0	0	0	0
4410030 - Metropolitan	0	14,992	0	0	0	0
4410040 - Napa	0	8,919	0	0	0	0
4410050 - Patton	0	9,170	0	0	0	0
Total All Programs	**$0**	**$51,278**	**$0**	**$0**	**$0**	**$0**

BCP Title: COVID-19 Update **BR Name: 4440-037-ECP-2023-GB**

Personal Services Details

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
3852 - Sr Industrial Hygienist	0	116	0	0	0	0
3856 - Assoc Industrial Hygienist	0	420	0	0	0	0
8297 - Public Hlth Nurse I	0	1,160	0	0	0	0
VR00 - Various	0	7,082	0	0	0	0
Total Salaries and Wages	**$0**	**$8,778**	**$0**	**$0**	**$0**	**$0**
Staff Benefits						
5150200 - Disability Leave - Industrial	0	22	0	0	0	0
5150210 - Disability Leave - Nonindustrial	0	6	0	0	0	0
5150350 - Health Insurance	0	81	0	0	0	0
5150450 - Medicare Taxation	0	27	0	0	0	0
5150500 - OASDI	0	38	0	0	0	0
5150600 - Retirement - General	0	414	0	0	0	0
5150800 - Workers' Compensation	0	81	0	0	0	0
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	0	54	0	0	0	0
5150900 - Staff Benefits - Other	0	215	0	0	0	0
Total Staff Benefits	**$0**	**$938**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$0**	**$9,716**	**$0**	**$0**	**$0**	**$0**

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

SUMMARY

The Department of State Hospitals (DSH) requests a total of $2.6 million and 2.0 positions in fiscal year (FY) 2023-24 and ongoing to support DSH's continued efforts to build out its continuum of care via the Non-Sexually Violent Predator (Non-SVP) Conditional Release Program (CONREP) program. DSH anticipates a total contracted caseload of 1,020 CONREP clients in FY 2022-23 and FY 2023-24.

BACKGROUND

The Forensic CONREP is DSH's statewide system of community-based services for specified court-ordered forensic individuals. Mandated as a State responsibility in 1984 by the Governor's Mental Health Initiative, the program began operations on January 1, 1986, and operates pursuant to statutes in Welfare and Institutions Code (WIC) 4360 (a) and (b). CONREP aims to promote greater public protection in California's communities via an effective and standardized community outpatient treatment system. The CONREP Non-SVP population includes patients deemed Not Guilty by Reason of Insanity (NGI), Offender with a Mental Health Disorder (OMD), and Incompetent to Stand Trial (IST). Individuals suitable[1] for CONREP may be recommended to the courts by the state hospital Medical Director.

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

- Forensic mental health treatment through individual and group therapy settings
- Life skills training
- Residential placement
- Collateral contacts (e.g., other individuals/agencies)
- Home visits
- Substance abuse screenings
- Psychiatric services
- Case management
- Court reports
- Psychological assessments

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

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

Step-Down Transitional Program

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

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

The CONREP FACT Regional Program (CFRP) services are available 24/7 through a mobile treatment team who provides onsite individual and group treatment where the clients live and also respond to clients as needed to reduce the likelihood of rehospitalization through de-escalation and crisis intervention practices. DSH has contracted with a provider for at least 180 dedicated beds and staff resources for this new treatment option in CONREP across three regions of the state:

- 60 beds in Northern CA
- 60 beds in the Bay Area
- 60 beds in Southern CA

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

PROGRAM UPDATE

DSH anticipates a total contracted caseload of 1,020 CONREP clients in FY 2022-23 and FY 2023-24. This contracted caseload includes 655 regular CONREP clients currently placed in settings which do not offer dedicated beds to the program. In addition, CONREP's contracted caseload includes the following current and planned specialized beds dedicated to the program:

- 65 STRP Beds in FY 2022-23
  - 35-bed activated Southern CA STRP
  - 30-bed activated Northern CA STRP
- 180 FACT Beds
  - 80 newly activated beds in Central CA in FY 2022-23
  - 100 beds activated in Northern CA and Southern CA in FY 2021-22
- 120 Institute of Mental Disorder (IMD) beds in FY 2022-23
  - 78-bed Southern CA IMD (to be activated)
  - 24-bed activated Southern CA IMD
  - 20-bed activated Northern CA IMD

This contracted caseload reflects the total number of clients and beds available by the end of FY 2022-23 and FY 2023-24, which may vary based on activation delays. While DSH anticipates the activation of new beds dedicated to CONREP in FY 2023-24, the actual number of patients will be phased in and vary over the course of two years. Reflecting the projected patient phase-in, DSH estimates an average census of 769 in FY 2022-23 and 877 in FY 2023-24.

Step-Down Transitional Programs

As of the 2023-24 Governor's Budget, DSH requests $296,000 in FY 2023-24 and ongoing to support an increase in personnel and operating expenses needed for the step-down transitional programs.

78-Bed Southern CA IMD Facility (Golden Legacy)

Using space previously licensed as a skilled nursing facility (SNF), and in partnership with a Southern CA IMD facility, DSH developed plans for a 78-bed step-down program for OMD and NGI state hospital patients ready for CONREP in 18 to 24 months. Construction activities began in January 2022, with anticipated program activation to occur in August 2022. However, physical space modifications required to assure the safety and security of the patients, coupled with supply chain and labor shortages related to the COVID-19 pandemic, have further delayed program activation. DSH now projects the full-78-bed program to

activate in February 2023. In concert with this effort, Golden Legacy has developed a proactive patient referral process to identify prospective patients for transfer upon activation. Savings from the delayed program activation will be used to cover ongoing construction costs.

20-bed Northern CA IMD Facility (Canyon Manor)

As of November 2022, all 20 beds are filled or reserved for patients ready for placement pending a court-ordered release from the state hospital. The provider continues to evaluate additional patients for admission, and the program must remain appropriately staffed to maintain functionality for full bed capacity. During recent contract renewal negotiations, DSH was informed of the need for additional funding by the contractor.

30-bed Northern CA STRP Facility (A&A Health Services)

As of November 2022, 15 of the 30 beds are filled. The provider is currently reviewing referral packets, and up to six additional beds are expected to be filled by January 2023. DSH will continue to work closely with A&A Health Services to fill these remaining beds.

CONREP FACT Regional Program (CFRP)

The contracted CFRP provider has secured program housing in Sacramento and San Diego counties, both of which support regional FACT programs for CONREP clients. As of November, CFRP-Sacramento has filled 45 of 60 activated beds, and CFRP-San Diego has filled 22 of 60 activated beds. Activation for CFRP-Alameda has shifted from October 2022 to January 2023 to provide additional time to train staff prior to activation.

California Forensic Assessment Project (CFAP) Expansion

The California Forensic Assessment Project (CFAP) is a panel of evaluators who provide specialized psychological testing and consultations for individuals clinically referred by CONREP providers who feel additional assessment and clinical care may be necessary. These evaluators are contracted with DSH and accept referrals statewide from all CONREP providers. New CONREP programs presented in CFRP, in addition to step-down transitional programs, has created increased caseloads to evaluate, requiring an adjustment to current CFAP evaluator contracts.

DSH is requesting funding to add three additional CFAP evaluators for a total of 12 CFAP evaluators statewide to address the increased caseload. In addition,

none of the nine current CFAP evaluators statewide have seen increases in their assessment rates over the last five years. To remain competitive and incentivize contractors to take on additional assessments, DSH proposes phase-in assessment rate increases over the next two fiscal years.

As of the 2023-24 Governor's Budget, DSH requests $177,000 in FY 2023-24 and $228,000 in FY 2024-25 and ongoing to support the necessary assessment rate increases, additional CFAP contractors, and supplies needed commensurate with the rise in CONREP census and requests.

CONREP Operations Staffing Resources

The expansions of the CONREP Continuum of Care program, plans for future growth, and increases in caseload, have significantly increased the workload of CONREP Operations administrative staff. DSH's CONREP Operations Unit consists of Clinical Psychologists and support analysts responsible for:

- Monitoring programs for census and patient outcomes
- Supporting patient referrals to higher or lower acuity settings, including revocations and rehospitalizations
- Providing technical and clinical support
- Managing the multiple provider contracts, including execution of new agreements, and the maintenance and renewal of existing contracts

Currently, CONREP Operations does not have the resources required to provide needed operational and administrative program support, directly impacting patient care. Without dedicated DSH analysts to manage program contracts and subcontracted services, DSH risks losing private CONREP providers. Private contractors could elect to not engage their CONREP program, leaving DSH to locate new providers to remain in compliance with WIC 4360 (a) and (b). In the event a provider *is* lost, program analysts must deviate time from their dedicated assignments to support the programmatic workload associated with securing a replacement provider.

As of the 2023-24 Governor's Budget, DSH requests $277,000 and 2.0 Staff Services Analyst (SSA)/Associate Governmental Program Analysts (AGPA) positions in FY 2023-24 and ongoing to support the increased workload of the CONREP Operations Unit and provide administrative and programmatic support to contracted CONREP partners.

Provider Personnel Funding Adjustments

Due to a significant delay in compensation package development over the past ten years, DSH's contracted CONREP providers are unable to remain competitive in the industry, impacting their ability to recruit and retain staff. Recent salary comparisons indicate current contracted clinical staff salaries are below competitors' base rates. Program workload requires staff to work in person, making providers unable to compete with telework options. Lastly, several counties are pursuing legislation to raise the minimum hourly wages for health care workers which would initiate additional salary increases.

As of the 2023-24 Governor's Budget, DSH requests $1.9 million in FY 2023-24 and ongoing to bridge personnel gaps for CONREP contracted providers.

Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$44,887	$45,371	$45,781
Governor's Budget Request	$0	$2,676	$2,727
TOTAL	**$44,887**	**$48,047**	**$48,508**

*Dollars in thousands

BCP Fiscal Detail Sheet

BCP Title: CONREP Non-SVP **BR Name: 4440-034-ECP-2023-GB**

Budget Request Summary

	FY23					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	0.0	2.0	2.0	2.0	2.0	2.0
Total Positions	**0.0**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**
Salaries and Wages						
Earnings - Permanent	0	149	149	149	149	149
Total Salaries and Wages	**$0**	**$149**	**$149**	**$149**	**$149**	**$149**
Total Staff Benefits	0	96	96	96	96	96
Total Personal Services	**$0**	**$245**	**$245**	**$245**	**$245**	**$245**
Operating Expenses and Equipment						
5301 - General Expense	0	16	16	16	16	16
5304 - Communications	0	2	2	2	2	2
5320 - Travel: In-State	0	2	2	2	2	2
5324 - Facilities Operation	0	10	10	10	10	10
5340 - Consulting and Professional Services - External	0	2,399	2,450	2,450	2,450	2,450
5346 - Information Technology	0	2	2	2	2	2
Total Operating Expenses and Equipment	**$0**	**$2,431**	**$2,482**	**$2,482**	**$2,482**	**$2,482**
Total Budget Request	**$0**	**$2,676**	**$2,727**	**$2,727**	**$2,727**	**$2,727**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	0	2,676	2,727	2,727	2,727	2,727
Total State Operations Expenditures	**$0**	**$2,676**	**$2,727**	**$2,727**	**$2,727**	**$2,727**
Total All Funds	**$0**	**$2,676**	**$2,727**	**$2,727**	**$2,727**	**$2,727**

Program Summary

Program Funding						
4400010 - Headquarters Administration	0	17	17	17	17	17
4400020 - Hospital Administration	0	2	2	2	2	2
4420010 - Conditional Release Program	0	2,657	2,708	2,708	2,708	2,708
Total All Programs	**$0**	**$2,676**	**$2,727**	**$2,727**	**$2,727**	**$2,727**

BCP Title: CONREP Non-SVP **BR Name: 4440-034-ECP-2023-GB**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
5393 - Assoc Govtl Program Analyst				0.0	2.0	2.0	2.0	2.0	2.0
Total Positions				**0.0**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
5393 - Assoc Govtl Program Analyst	0	149	149	149	149	149
Total Salaries and Wages	**$0**	**$149**	**$149**	**$149**	**$149**	**$149**
Staff Benefits						
5150200 - Disability Leave - Industrial	0	2	2	2	2	2
5150210 - Disability Leave - Nonindustrial	0	1	1	1	1	1
5150350 - Health Insurance	0	7	7	7	7	7
5150450 - Medicare Taxation	0	2	2	2	2	2
5150500 - OASDI	0	9	9	9	9	9
5150600 - Retirement - General	0	44	44	44	44	44
5150800 - Workers' Compensation	0	7	7	7	7	7
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	0	4	4	4	4	4
5150900 - Staff Benefits - Other	0	20	20	20	20	20
Total Staff Benefits	**$0**	**$96**	**$96**	**$96**	**$96**	**$96**
Total Personal Services	**$0**	**$245**	**$245**	**$245**	**$245**	**$245**

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

SUMMARY

The Department of State Hospital's (DSH) projects a caseload of 27 Sexually Violent Predators (SVP)s conditionally released into the community by June 30, 2024. As of the 2023-24 Governor's Budget, no additional position authority or funding is requested.

BACKGROUND

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

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

In recent years, DSH experienced significant public resistance to the placement of SVP patients within their communities. As a result, securing housing for an SVP patient to be released via CONREP takes an average of 12 months.

PROGRAM UPDATE

There are currently 20 court-ordered clients participating in CONREP-SVP and 13 individuals with court-approved petitions awaiting placement into the community. Additionally, 14 more individuals have filed petitions for conditional release and are proceeding through the court process. Due to the unpredictable nature of the court process, challenges surrounding housing availability for SVP clients, and other factors, a conservative average caseload of 27 SVP clients may be conditionally released to CONREP by the end of FY 2023-24. To ensure compliance with Senate Bill (SB) 1034 (Chapter 883, Statutes 2022), DSH has a Budget Change Proposal (BCP) aimed to help address ongoing SVP housing identification and approval challenges by

increasing collaboration with community partners as required by the new statutory changes. DSH will continue to monitor this caseload and provide an update in the 2023-24 May Revision.

Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$12,134	$12,680	$12,680
Governor's Budget Request	$0	$0	$0
TOTAL	**$12,134**	**$12,680**	**$12,680**

*Dollars in thousands

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

SUMMARY

The Department of State Hospitals (DSH) has fully executed five new county contracts as part of the Felony Mental Health Diversion (Diversion) Pilot Program and, following activation, will bring the total number of counties with participating Diversion programs to 29. DSH continues efforts to successfully onboard and activate programs in the new counties. As of June 30, 2022, a total of 886 eligible individuals have been diverted to a county run program. In the 2022 Budget Act, DSH received ongoing resources to support county-run Diversion programs permanently. As DSH implements the permanent Diversion program, the Department will continue to provide status updates on the pilot program and permanent Diversion program updates in the IST Solutions update (see section C10).

BACKGROUND

The 2018 Budget Act provided funding, on a pilot basis, for DSH to contract with various counties throughout California to develop new or expand existing Diversion programs. These county programs serve individuals with a serious mental illness diagnoses such as schizophrenia, schizoaffective disorder, or bipolar disorder, who have been found or have the potential to be found Incompetent to Stand Trial (IST) on felony charges.

Funding for Existing County Programs

Of the resources provided, 99.5% was allocated by November 15, 2022, for contracts with the following 24 counties:

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

New Pilot County Program Funding

Based on the success of prior efforts, DSH received additional resources in the 2021 Budget Act to expand the Diversion pilot program. The pilot programs in new counties established under this expansion were required to follow the requirements of the original pilot. In fall 2021, DSH provided intensive technical assistance to aid counties in developing their programs, resulting in five new proposals to establish Diversion programs in the following counties:

- Madera
- Nevada
- San Joaquin
- Tulare
- Tuolumne

As of summer 2022, contracts with all five counties have been fully executed. In Fall 2022, DSH began holding implementation check-in meetings with each county to assist with the activation of their diversion programs.

Expanding Existing County Programs

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

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

Sixteen counties elected to participate in this expansion, accounting for 294 Diversion slots. Twelve of the contract amendments have been executed while the remaining four are finalizing execution. As of November 15, 2022, DSH has fully executed five new county contracts and has successfully onboarded and activated programs in the new counties. All expansion efforts have increased the number of contract slots, ultimately serving 1,189 felony ISTs over the course of the pilot.

Diversion Pilot Program Data Collection Efforts and Research

As of June 30, 2022, 886 eligible individuals have been diverted to a county-run program. DSH continues working one-on-one with all counties to ensure data collection quality. The following table provides a high-level snapshot of Diversion program participants:

Diversion Program Participant Descriptive Data		
Program Information	**Total Number**	**Percentage**
Total Enrolled, Eligible & Diverted as of 6/30/2022	886	100%
At risk of IST	489	55.5%
IST	392	44.5%
Removed from DSH Waitlist	186	21%
Diagnosis	**Total Number**	**Percentage**
Schizophrenia	317	35.8%
Schizoaffective Disorder	325	36.7%
Bipolar Disorder	195	22.0%
Other	49	5.5%
Ethnicity	**Total Number**	**Percentage**
White	247	27.9%
People of Color	639	72.1%
Gender	**Total Number**	**Percentage**
Male	599	67.6%
Female	280	31.6%
Other	7	0.8%
Living Situation at Arrest	**Total Number**	**Percentage**
Homeless	686	77.5%
Not Homeless	199	22.5%
Felony Charges	**Total Number**	**Percentage**
Assault/ Battery	295	33.3%
Theft	146	16.5%
Other (primarily Vandalism)	132	14.9%
Robbery	118	13.3%
Arson	74	8.4%
Criminal Threats	74	8.4%
Resisting Arrest	28	3.2%
Kidnapping	19	2.1%

Diversion Pilot Program Outcome & Predictive Data

Enrollment in Diversion has steadily increased since the program's introduction in 2018. Data collected over this period allows DSH to now analyze and share participant predictor data outcomes and assess program impacts. Using the quarter four data from FY 2021-22 for all participating counties, DSH was able to analyze the outcomes of 886 eligible participants. Of the participants analyzed, only 845 were included to provide information on the subsequent data tables due to the following:

- <11[1] clients were deceased
- 22 clients had transferred to a state hospital or another DSH program
- <11 clients were over the two-year program time limit and/or dismissed by court
- <11 clients had unclear outcomes

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

Current Status		
	Total Number	**Percent**
Still In	462	54.7%
Revoked/AWOL/Re-incarcerated	199	23.6%
Successful Completion	184	21.8%
Total	**845**	**100%**
Length of Stay by Current Status		
	Mean	**Standard Deviation**
Still In (as of 8/31/2022)	296.7	235.4%
Revoked/AWOL/Re-incarcerated	232.8	200.5%
Successful Completion	639.3	150.4%
Risk Assessment[2] Conducted		
	Total Number	**Percent**
Yes	298	66.8%
No	148	33.2%
Total	**446**	**100%**

[1] To protect patient information, DSH deidentifies any number less than 11 and displays it as <11.
[2] Clinical assessment designed to evaluate an individual's risk of violence

Development of Treatment Plan[3]		
	Total Number	**Percent**
Intensive evaluation[4]	367	86.6%
Formal RNR assessment[5]	44	10.4 %
Both	13	3.1%
Total	**424**	**100%**

Diversion Program Participant Outcome Data		
Incompetent to Stand Trial	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
IST	90 (52.9%)	80 (47.1%)
At risk of IST	94 (44.1%)	119 (55.9%)
Homeless	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
Yes	149 (47.26%)	167 (52. 8%)
No	35 (53.0%)	31 (47.0%)
Abuse of Substances	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
Yes	154 (47.4%)	171 (52.6%)
No	29 (53.7%)	25 (46.3%)
Methamphetamine Use	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
Methamphetamine	66 (32.7%)	136 (67.3%)
No drug use/Other drugs	114 (65.9%)	59 (34.1%)

A best practice for mental health treatment within DSH programs is utilization of Long-Acting Injectable medications (LAIs), which allows for the slow release of medicine into the blood, lasting anywhere from two to 12 weeks, which assists in stabilizing symptoms of mental illness. Based on data collected to date, DSH has observed Diversion programs have greater levels of success when participants experiencing homelessness at the time of their arrest are placed on an LAI. The

[3] Individualized course of treatment and interventions based on specific patient needs
[4] The use of various disciplines, including psychiatry, to evaluate a patient's needs and the best course of treatment to meet those needs.
[5] Structured assessment that determines what factors elevate a patient's risk of reoffending or responding poorly to treatment, how to minimize those risk factors for the patient through a treatment plan, and how to adjust the treatment plan over time as a patient's risk factors change.

following tables provide statistics on all program participants, including those who did not successfully complete the program.

Incompetent to Stand Trial WITHOUT LAI	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
IST	43 (48.3%)	46 (51.7%)
At risk of IST	57 (52.3%)	53 (47.7%)

Incompetent to Stand Trial WITH LAI	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/ Revoked** Total (Percent)
IST	39 (65.0%)	21 (35.0%)
At risk of IST	35 (36.8%)	60 (63.2%)

IST and Housed at Time of Arrest	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/ Revoked** Total (Percent)
IST	21 (61.8%)	13 (38.2%)
At risk of IST	14 (43.8%)	18 (56.3%)

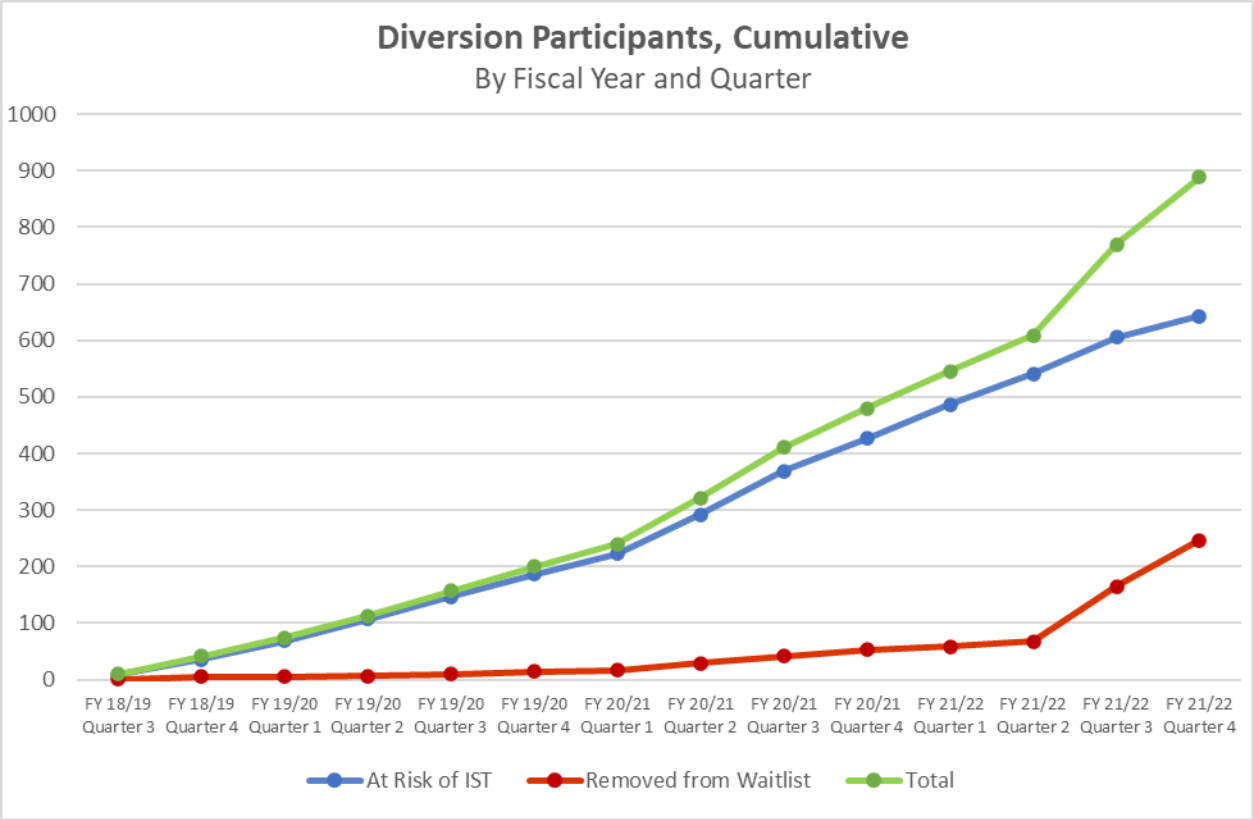
IST and Homeless at Time of Arrest	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/ Revoked** Total (Percent)
IST	69 (51.1%)	66 (48.9%)
At risk of IST	80 (44.2%)	101 (55.8%)

IST, Homeless WITHOUT LAI	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/ Revoked** Total (Percent)
IST	29 (43.9%)	37 (56.1%)
At risk of IST	49 (53.8%)	42 (46.2%)

IST, Homeless WITH LAI	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/ Revoked** Total (Percent)
IST	33 (63.5%)	19 (36.5%)
At risk of IST	30 (34.9%)	56 (65.1%)

To date, the strongest criteria predictors of successful program completion are clients deemed IST, experiencing homelessness before arrest, and having an LAI prescription. Of participants who have exited the diversion program and met

these three criteria, 63.5 percent successfully completed the program. Conversely, participants who are *likely* to be IST but also were homeless and prescribed an LAI have a 65.1 percent failure rate, indicating the program works best for those individuals who are determined to be IST.



Additionally, in the Budget Act of 2022, the penal code was updated to clarify the issue of consent and affirmed that courts can order felony IST individuals into a diversion program and WIC 4361 was revised, limiting the permanent DSH Diversion program to serving individuals who are found IST on a felony charge and not those who may be "likely-to-be IST" as was included in the pilot program. As the investments from the IST Solutions budget package authorized in 2022-23 expand the availability of housing for IST community-based treatment options, DSH expects to see further growth in the number of ISTs participating in diversion programs.

PROGRAM UPDATE

DSH works closely with the Council of State Governments Justice Center (CSG) and the Council on Criminal Justice and Behavioral Health (CCJBH) to implement the Diversion program. DSH and CCJBH have contracts with CSG to develop technical assistance trainings, learning materials, and county-wide program

templates. As of November 15, 2022, DSH has provided counties with 207 plus hours of in-person and web-based training, covering topics focused on supporting counties as their programs were activated and established, such as:

- Medications and psychopharmacology considerations for prescribers
- "How to" Sessions on the use of risk assessments to inform client treatment plans
- Case plan review sessions with DSH psychiatrists, external experts, and other county staff to assist counties in evaluating more difficult cases
- 1:1 assistance with producing required fiscal reports
- Trailer Bill Language Changes and the effect on Diversion pilot programs
- Co-Occurring Substance Use Disorders presentations from clinical experts
- 1:1 assistance with billing and invoicing pertaining to contracts
- 1:1 assistance focused on onboarding, contracts, data reporting, and specific topics raised by counties
- IST Budget Solutions overview with an emphasis on DSH-funded Diversion Program impacts

Other areas of focus will be ongoing risk management strategies, psychopharmacology learning opportunities, and evaluating co-occurring risks resulting from substance use disorders (SUDs) related to this population. This approach will optimize current programs and provide better patient outcomes.

Supplemental County Housing Support

In FY 2021-22, DSH released funding to participating diversion counties to support housing costs for the IST population. DSH received 17 requests from counties to participate in this opportunity. As of November 15, 2022, DSH executed 16 housing funding contracts, with one additional contract pending final execution.

DSH will continue working with existing counties and provide an update in the 2023-24 May Revision.

Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$1,230	$1,243	$1,256
Governor's Budget Request	$0	$0	$0
TOTAL	**$1,230**	**$1,243**	**$1,256**

*Dollars in thousands

CONTRACTED PATIENT SERVICES
INCOMPETENT TO STAND TRIAL SOLUTIONS
Program Update

SUMMARY

As of the 2023-24 Governor's Budget, the Department of State Hospitals (DSH) requests position authority for 1.0 Office Technician (OT) to address the Incompetent to Stand Trial (IST) waitlist, while reporting a net savings of $27.4 million in fiscal year (FY) 2022-23, and $3.1 million in FY 2023-24 and ongoing, due to changes in jail-based competency treatment program (JBCT) implementation. Furthermore, due to the passage of SB121 as a part of the 2022 Budget Act package, DSH requests to reappropriate the remaining balance of all Community Inpatient Facilities FY 2021-22 funding for an additional 12 months, allowing DSH to finalize contracts towards this effort.

BACKGROUND

Over the last decade, the State of California has seen significant growth in the number of individuals found IST on felony charges and referred to DSH for restoration of competency treatment. The year-over-year growth in IST referrals from the superior courts to DSH has outpaced the department's ability to create additional capacity. Despite recent efforts, including increased bed capacity, decreased average length of stay, and implementation of county-based treatment programs, this insufficient bed capacity has led to a large waitlist and extended wait times for IST defendants pending DSH placement. Furthermore, the impacts of the COVID-19 pandemic and infection control measures required at DSH facilities necessitated slower admissions and reduced capacity for the treatment of felony ISTs at DSH.

In 2015, the American Civil Liberties Union filed a lawsuit against DSH (*Stiavetti v. Clendenin*), alleging the time IST defendants were waiting for admission into a DSH treatment program violated the IST defendants constitutional right to due process. The Alameda Superior Court ultimately ruled in 2021 that DSH must commence substantive treatment services the restore an IST defendant to competency within 28 days from transfer of responsibility to DSH which is the date of service of the commitment packet to DSH for felony IST patients, with a specified timeline for meeting that standard over the next three years. By February 27, 2024, DSH must provide substantive treatment services within 28 days of transfer of responsibility.

In 2021, the Legislature enacted the Welfare & Institutions Code (WIC) section 4147 through the passage of Assembly Bill 133 (Chapter 143, Statutes of 2021) and

the Budget Act of 2021 (Chapter 69, Statutes of 2021), which charged the California Health & Human Services Agency (CalHHS) and DSH to convene an IST Solutions Workgroup (Workgroup) to identify actionable solutions that address the increasing number of individuals with serious mental illness who become justice-involved and deemed IST on felony charges. The IST Workgroup convened between August 2021 and November 2021 with various representatives and stakeholders. Per the statute, the Workgroup identified short-, medium-, and long-term solutions to advance alternatives to placement in DSH competency restoration programs.

The Budget Act of 2022 appropriated DSH the following funding to implement many of the IST Solutions discussed with country partners and stakeholders:

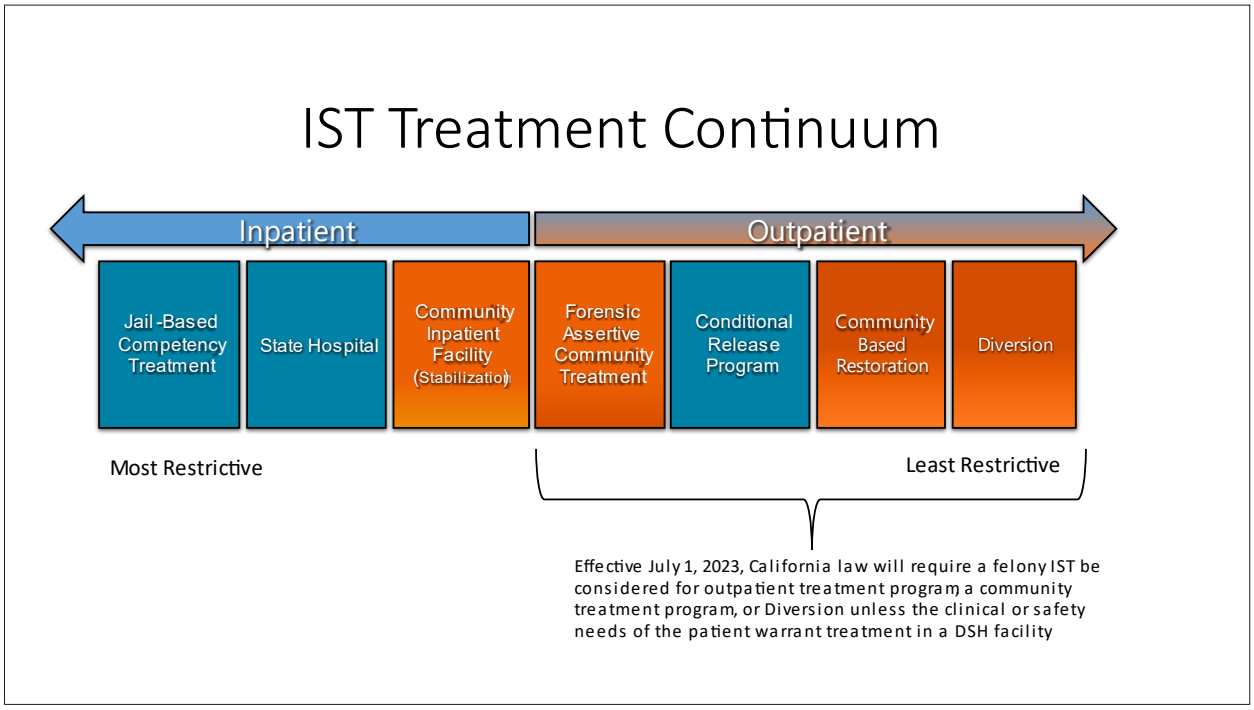
- $535.5 million in FY 2022-23; $328.8M is one-time funding
- $482.2 million in FY 2023-24; $160 million is one-time funding
- $517.9 million in FY 2024-25; $5 million is one-time funding
- $638 million and ongoing

The components of the IST solutions provide early stabilization and care coordination, expand community-based treatment and diversion options for felony ISTs, improve IST discharge planning and coordination, implement a pilot for independent placement panels, and improve alienist training. Together, these solutions will help to reverse the cycle of criminalization for individuals with serious mental illnesses and increase community transitions for state hospital patients. The Budget Act of 2022 also included an increase of $15.5 million to support expanding existing JBCT programs and associated funding for patients' rights advocacy services. Collectively, these proposals will also assist the state in meeting treatment timelines ordered by the Superior Court in *Stiavetti v. Clendenin*.

IST Treatment Continuum

The following chart displays the continuum of IST treatment placement options DSH continues to expand upon with the funding recently authorized. The blue boxes represent programs which have been part of DSH's continuum for a decade or more, while orange boxes represent newer placement options which have only recently begun implementation. Historically, restoration treatment options for individuals deemed IST on felony charges were primarily provided in State Hospitals and JBCT programs. In 2018, DSH was authorized to partner with counties to pilot Felony Mental Health Diversion (diversion) opportunities for individuals deemed IST on felony charges or who were likely to be found IST on felony charges. Additionally, in 2018 DSH was authorized to partner with Los Angeles County to establish the first community-based restoration of competency

program for individuals from LA County who were determined to be IST on felony charges. Utilizing the recent investments made in the Budget Acts of 2021 and 2022, DSH is building upon these initial community-based programs to expand the treatment continuum serving ISTs in the least restrictive community treatment options.



IST Waitlist

Despite DSH's efforts to expand its continuum and address the IST waitlist, the number of individuals found IST on felony charges and referred by the superior courts to DSH for restoration of competency treatment has continued to increase. Furthermore, DSH has experienced significant operational impacts due to the COVID-19 pandemic which have negatively impacted the waitlist.

In February 2020, a month prior to the Governor's State of Emergency Declaration, there were 850 individuals on DSH's waitlist pending placement into a DSH IST treatment program. Since that time, and throughout the pandemic, DSH has observed seasonal fluctuations in the waitlist, with higher waitlists during winter and summer, and lower waitlists in spring and fall as DSH recovers from COVID-19 surges. In January 2022, during the COVID-19 surge fueled by the Omicron variant, the IST waitlist reached a high of 1,953.

As of December 12, 2022, the waitlist has declined to 1,473. This decline in the waitlist was achieved through new program implementation including IST Re-

Evaluations, the activation of a new community-based treatment facility and implementation of Early Access and Stabilization Services in jail settings and expanding existing IST treatment programs such as DSH IST Diversion and the Los Angeles Community-Based Restoration Program. Admissions were also aided by lower infection rates following a summer surge and through November 2022 as well as an increase in DSH's operational efficiency resulting from recent changes by the Center for Disease Control and California Department of Public Health to infection control guidance.

Program Updates

Early Access and Stabilization Services (EASS)

EASS, a new program funded in FY 2022-23 as part of the IST Solutions budget, provides treatment at the earliest point possible upon an individual's IST commitment to DSH, and promotes stabilization to increase community-based treatment placements. This treatment begins while an individual who has been deemed IST on felony charges is in jail pending placement into the IST treatment continuum. The goal is to facilitate the stabilization and medication compliance of IST patients, both of which will promote increased eligibility and placement in a Diversion or other community-based treatment program.

To rapidly establish the EASS programs in county jails, DSH is leveraging its existing JBCT programs and starting new programs in county jails that do not currently operate a JBCT. DSH has executed contracts with two county jail mental health providers to implement EASS programs in multiple counties across the state. DSH is actively meeting with a third vendor and expects to finalize a contract with the new vendor by the end of the year. The first EASS program was activated in July 2022, and as of December 19, 2022, a total of 27 counties have activated EASS programs, with additional county programs expected to activate through the end of the year.

Early Access and Stabilization Services (EASS) Updates	
County	**Activation Date**
Kings	07/18/22
Monterey	07/25/22
Ventura*	08/03/22
Fresno	08/22/22
Calaveras*	08/25/22
Stanislaus*	08/29/22
Yuba	08/29/22

Nevada	08/31/22
Sierra	08/31/22
Shasta*	09/12/22
Santa Barbara*	09/16/22
Merced	09/19/22
San Bernadino*	09/26/22
Madera*	10/06/22
Lassen	10/17/22
Sonoma*	10/17/22
Del Norte	10/19/22
Humboldt	10/19/22
Imperial*	10/26/22
Santa Cruz*	11/09/22
Napa*	11/16/22
Sutter*	12/01/22
Riverside*	12/05/22
Lake	12/07/22
San Benito*	12/07/22
Tuolumne	12/14/22
Amador*	12/19/22

*Soft activation with full activation pending hire of additional staffing

Jail-Based Competency Treatment (JBCT)

DSH contracts with a number of California county Sheriffs' departments to provide restoration of competency treatment programs to patients committed as IST while they are housed in county jail facilities. JBCT programs are designed to treat patients presenting with lower acuity and quickly restore them to trial competency, generally within 90 days. In FY 2021-22, patients committed as IST had an average length of stay of 89.4 days in a JBCT program. This year-over-year decrease of 9.7 days is in line with intended targets as the state transitions out of the most significant operational impacts of the COVID-19 pandemic. If a JBCT program cannot quickly restore an IST patient to trial competency, the patient can be referred to a state hospital for longer-term IST treatment. As of December 2022, DSH operates 413 beds in JBCT programs across 23 counties using one of the four JBCT program models:

1. Single-county model – Serves IST patients from one specific county with an established number of dedicated program beds

2. Regional model - Serves IST patients from surrounding counties with an established number of dedicated program beds
3. Statewide model - Serves IST patients from multiple counties statewide with an established number of dedicated program beds
4. Small-county model – Services are delivered individually to a small number of IST patients, generally 12 to 15 annually, and do not have dedicated treatment beds

Community Inpatient Facilities

Community inpatient treatment facilities are being developed under the funding authorized in FY 2021-22 through the Institute for Mental Disease (IMD) and Sub-Acute Bed Capacity program. Under this program, DSH may contract with counties or private providers to develop new or renovate existing community inpatient facilities to provide alternative treatment options to state hospitals which increases the availability of IMDs, Mental Health Rehabilitation Centers (MHRC), Skilled Nursing Facilities (SNF), or other types of facilities appropriate for felony IST patients. The vision for these facilities is to support county-operated community-based IST treatment programs where a higher level of care and/or security may be needed. Individuals transitioning from jail are then able to stabilize prior to stepping up or down into a community treatment setting with different restrictions.

On April 20, 2022, DSH activated its first community inpatient facility for IST treatment at the Sacramento Behavioral Health Hospital (SBHH) in Sacramento County. SBHH is an acute psychiatric hospital serving felony IST patients to facilitate psychiatric stabilization, primarily through administering medications, supporting the restoration of competency, or a pathway to participation in a diversion or other outpatient treatment program. As of December 2022, DSH has activated 78 beds in this facility (39 beds in April 2022 and 39 beds in October 2022).

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

The goal of expanding CBR and the Felony Mental Health Diversion (Diversion) programs is to provide care in the most appropriate community-based setting, an alternative to placement in a DSH inpatient bed. In the 2022-23 Governor's Budget, DSH estimated 60-70% of IST commitments would be eligible for services each year in a community-based program, for a total of approximately 3,000 annual felony IST admissions, based on FY 2021-22 IST referral trends. To support the creation of statewide residential beds to house IST individuals, DSH was allocated one-time infrastructure funding to expand the number of beds available to patient's receiving services through a CBR or Diversion program. This

significant expansion of CBR and Diversion is anticipated to occur over a 4-year period and is dependent upon securing available housing. DSH is currently negotiating a contract with a public service consulting firm to support the development of the residential infrastructure needed to facilitate the expansion of these programs.

Community Based Restoration (CBR)

In FY 2018-19, DSH implemented the first CBR program for felony ISTs in partnership with the Los Angeles County Office of Diversion and Re-entry. CBR programming provides intensive mental health treatment services and competency restoration training in the community. ISTs participating in this programming may receive services in locked acute, sub-acute, and unlocked residential settings, based on each defendant's treatment needs. DSH can contract directly with counties or private providers to establish CBR programs statewide and is currently working with the Los Angeles County Office of Diversion and Reentry to expand their current Diversion and CBR agreements with the department. DSH receives more IST referrals from Los Angeles County than any other county. Expanding capacity in this region will immediately impact achieving the department's benchmarks described above. DSH continues to explore opportunities with counties explicitly interested in launching a CBR program or establishing a CBR or Diversion pilot program contract with the department.

Diversion Program

DSH currently has Diversion contracts with 29 existing counties throughout California and continues to work to develop new or expand existing Diversion Programs. The current county programs serve individuals with serious mental illnesses diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder with the potential to be found IST on felony charges. The Diversion pilot program was established in the Budget Act of 2018. In the Budget Act of 2022, DSH was allocated funding to establish Diversion as a permanent, ongoing program. Permanent diversion program updates will be included as a part of the larger IST Solutions budget update, while data gathered and analyzed from the pilot will continue to be reported under the Diversion pilot narrative until its conclusion in FY 2024-25. DSH plans to work directly with the counties already participating in the Diversion pilot to transition them into a new contract for ongoing funding once their pilot program has been completed. DSH also continues to establish diversion programs in counties not already participating in the program through ongoing education and outreach efforts.

County Stakeholder Workgroup Grants

As part of the IST Community programming expansion, DSH has been allocated resources to support the efforts of behavioral health and criminal justice workgroups across the state. These local stakeholder workgroups are responsible for developing interventions in their communities to reduce the overall number of residents with serious mental illness (SMI) who enter the criminal justice system, many of whom may be found IST on felony charges. Another focus area is improving the outcomes of those with SMI who have fallen into cycles of incarceration and homelessness. These stakeholder workgroups are essential to creating successful mental health diversion programs. DSH will support the essential work of these groups by offering $100,000 annually per county to help these efforts. DSH released information about this opportunity to counties December 5, 2022.

IST Re-Evaluation Services

In the Budget Act of 2021-22, DSH was authorized to implement the IST Re-Evaluation Services Program as a 4-year limited-term solution to help address the IST waitlist. DSH has successfully implemented the Re-Evaluation Services for Felony ISTs program in all counties except two because these counties do not have operating jails. Under the Re-Evaluation Services program, DSH evaluators re-evaluate individuals who have been deemed IST and are waiting in jail pending transfer to a DSH treatment program. The goal of this program is to:

- Assist in reducing the DSH IST waitlist by identifying individuals who have already been restored to competency while receiving treatment in jail
- Identify individuals who may be candidates for involuntary medication orders
- Identify individuals who may warrant increased admission priority
- Identify individuals who may be unlikely to restore
- Identify individuals who may be candidates for Diversion or other outpatient treatment programs

In addition to the re-evaluations, this team also provides competency evaluations for newly emerging community IST treatment programs where programs do not have forensic evaluators yet available. As of December 16, 2022, DSH has completed 1,839 evaluations, of which:

- 1,256 (68%) were found not competent and continued competency restoration treatment

- 577 (31%) were found restored to competency[1]
- <11[2] (<1.0%) were found unlikely to be restored to competency

DSH continues to ramp up its capacity to perform re-evaluations and will provide an update in the 2023-24 May Revision.

Care Coordination & Waitlist Management

The Patient Management Unit (PMU) was established in June 2017 to provide centralized management, oversight, and coordination of the patient pre-admission processes, ensuring the placement of patients to the most appropriate setting based on clinical and safety needs. Prior to the establishment of PMU, courts were able to order commitments to any DSH hospital, creating admission backlogs and inefficiencies.

For each IST referral, the courts are required to provide specified information and documents to PMU to facilitate admission. In FY 2021-22, DSH received over 400 new referrals of patients deemed IST per month.

The Budget Act of 2022 authorized funding and resources for DSH to implement a vertical case management model for IST patient placement. Using small teams comprised of clinical staff and support analysts dedicated to specific regions of the state, this Care Coordination model considers individual county resources, needs, and processes when placing patients to increase successful outcomes. Under this new model, PMU clinical staff complete an intake of each patient upon receipt of commitment or for individuals already on the waitlist when they are enrolled in EASS. The clinical team and the assigned Patient Navigator then work with EASS providers, DSH facilities, and the DSH Diversion and Community Restoration programs to admit patients based on availability, eligibility, and the individual's position on the waitlist. As of December 19, 2022, PMU has implemented Care Coordination in 27 counties, and four Care Coordination teams have been established, with another four planned prior to the end of the FY. This program is available in all counties that have implemented EASS along with San Joaquin and San Luis Obispo counties. An update will be provided in the 2023-24 May Revision.

[1] The courts rejected 2% of the reports which found patients to be restored to competency.
[2] Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines, with values of 11 or less represented as "<11"

Independent Placement Panel (IPP)

In the Budget Act of 2022, DSH received resources to pilot a new independent placement determination panel to help increase the number of individuals found Not Guilty by Reason of Insanity (NGI) and Offenders with Mental health Disorders (OMD) served in the community via the Conditional Release Program (CONREP), increasing available bed capacity in the state hospitals for those on the IST waitlist. As of November 2022, DSH has formed a stakeholder workgroup consisting of CONREP Community Program Directors representing several counties, DSH CONREP clinical staff, and state hospital discharge-planning teams, to develop the IPP and establish an implementation plan. Key areas of focus include determining assessment and referral protocols, justice partner engagement, CONREP program training, technical assistance, and streamlining the referral process and patient records database.

The pilot will roll out implementation in phases, with each phase focused on a select number of counties, with the initial phase covering 36 counties utilizing six CONREP contractors to provide programs statewide. An update on IPP implementation and progress will be provided in the 2023-24 May Revision.

Discharge Planning and Coordination with Counties

Patients discharged from DSH facilities may return to the community with or without supervision, transfer to other DSH facilities, or return to court, prison, or jail. Comprehensive discharge planning encompasses many components, including, but not limited to, the development of treatment goals and objectives in collaboration with interdisciplinary treatment teams and patients, coordination with available community resources, including family and social supports, and partnering with stakeholders and agencies for further treatment options. These include CONREP, county behavioral health, skilled nursing facilities, board and care facilities, California Department of Corrections and Rehabilitation (CDCR), county jails, Office of the Public Guardian, private conservators, and other community placement locations. DSH must provide and coordinate an IST patient's information with county behavioral health to assist in their preparation for returning to their county, where they may be diverted from jail as a result of dropped or reduced charges and supervised release back to the community.

To support continuity of care for IST patients discharged from the state hospitals to the counties, DSH is partnering with representatives from the County Behavioral Health Directors Association (CBHDA) and California State Association of Counties (CSAC) to develop a standardized IST discharge process. This discharge planning workgroup kicked off in August 2022, with the goal of establishing a standard packet of discharge documents, and a method for facilitating the warm handoff

to county behavioral health departments upon transition from a state hospital to county jail and then on to the community. Discharge planning workgroup efforts are ongoing, and an update will be provided in the 2023-24 May Revision.

Alienist Training

DSH is partnering with the Judicial Council to develop statewide court-appointed IST evaluator training and workforce development programs to improve the quality of IST evaluations performed by court-appointed evaluators. These evaluations are utilized by the courts to determine a defendant's competency status and serve as the basis for a commitment to DSH as IST. Beginning in July 2022, the Judicial Council and DSH, serving as a consulting partner in this process, have met regularly to discuss training objectives, desired outcomes, and develop their Scope of Work for the interagency agreement, scheduled to be executed in December 2022. The workgroup has identified a nationally recognized consulting group with experience in establishing training and certification programs in other states led by established experts in IST evaluation and report quality improvement and has begun conferring with this vendor to establish specific goals and milestones. An update will be provided in the 2023-24 May Revision.

Felony IST Referral Growth Cap and Penalties

The Welfare and Institutions Code (WIC) section 4336 was enacted as part of the Budget Act of 2022 to establish a growth cap on the number of felony IST determinations per county, address the growing IST waitlist, and implement a penalty payment structure to be assessed if those caps are exceeded in a FY. Penalty payments to counties will commence in FY 2022-23, with the first invoices scheduled to be sent in the fall of 2023. Penalties collected will be deposited into the Mental Health Diversion Fund (Fund 3404) and redistributed back to the counties which exceeded their baseline IST determinations and remitted the payments. The funds must then be utilized to fund pre-booking diversion and reentry strategies in the county to help reduce the number of individuals who are determined to be felony IST in the future.

In December, DSH released a department letter to all counties identifying the county baseline (equal to the total number of felony IST determinations in FY 2021-22), the penalty rate DSH will apply to FY 2022-23 IST determinations which exceed the established baseline and the counties' baseline versus the first quarter of 2022-23 IST determinations. This initial letter reflects that overall, in the first quarter of FY 2022-23, counties have had an average of 512 felony IST determinations per month, which is 97.1 ISTs per month more than the 2021-22 monthly average of 414.9 ISTs. Additionally, 42 counties have referred more IST determinations on

average per month in the first quarter of this fiscal year than last fiscal year and 15 counties have seen reductions in their average monthly IST determinations this fiscal year (one county has had no change). Going forward, DSH will notify counties of the counties' total number of determinations quarterly to allow counties to assess how they are trending in IST determinations compared to their baseline, and then to act if necessary to avoid penalties.

Placement Presumption

To increase consideration for the placement of IST patients in Diversion, CBR or other community IST facilities, PC Section 1370 was amended in the Budget Act of 2022 to statutorily prioritize community outpatient treatment effective July 1, 2023, unless a court, based on the recommendation of the Community Program Director or designee, finds that the clinical needs or community safety risk warrants placement in a more secure setting, such as a state hospital or JBCT program.

As of December 2022, DSH has convened a workgroup to develop a standardized assessment process and is developing a communications and training strategy. An update will be provided in the 2023-24 May Revision.

JUSTIFICATION

Early Access and Stabilization Services (EASS)

During the implementation of EASS, DSH has encountered various challenges, including the ability of contracted EASS providers to recruit clinical staff, requiring the need for incentives to attract qualified staff such as sign-on bonuses and relocation packages. It was also learned through county engagement and implementation discussions that EASS programs may be needed in more than one jail per county, depending on where IST patients are housed. In addition, feedback from some counties suggest the sheriff would prefer to utilize a different treatment provider or their county behavioral health staffing. Based on this feedback from county sheriff offices during engagement and implementation meetings, DSH continues to monitor contract negotiations and program implementation to assess whether the current funding level authorized for EASS is sufficient to support the establishment of EASS programs in all counties. DSH will provide a fiscal update for the EASS program in the 2023-24 May Revision.

Jail Based Treatment Center (JBCT)

DSH requests 1.0 OT in FY 2023-24 and ongoing to support the shift in administrative workload from clinicians to a dedicated OT where the workload is better suited. Additionally, DSH reflects a net savings of $27.4 million in FY 2022-23 and $3.1 million in FY 2023-24 and ongoing. The primary driver of the savings is a reduction in the San Bernardino JBCT program's capacity from 146 beds to 64, effective September 1, 2022. Offsets to the level of savings reflected in FY 2023-24 and ongoing are due to the adjustments below:

- Eleven currently funded county programs pending activation
- Two program activations in July 2022 yielded 22 additional beds
- Calaveras County JBCT program has been experiencing an increasing rate of IST referrals and can support a bed capacity expansion of 8 beds for a total of 18 beds as of October 2022
- Bed rate increases are anticipated for 20 of the participating counties

With the rapid activation of new programs across multiple counties and the expansion of existing programs, 1.0 OT will help shift the administrative workload from the clinical staff. The JBCT Unit's Consulting Psychologists (CPs) are currently responsible for the clinical and administrative performance of all 22 JBCT programs, the Kern AES, and any future JBCT programs. They provide clinical consultation, training, and technical assistance to the JBCT programs, which are operated by a subcontracted mental health provider (through a direct contract with the Sheriff's Office). The CPs regularly travel to the programs, which are located statewide, to perform routine site visits, observe patient care, and perform formal program reviews. Shifting the coordination of site visits notes, reports, and formal program review reports to a dedicated OT would free up the CPs to focus on the clinical component of these visits, which is directly related to patient care. Additional duties include:

- Coordinating and scheduling the site visits
- Gathering quarterly program operational data in preparation for site visit
- Gathering relevant information from internal and external stakeholders regarding program operation and feedback
- Requesting necessary deliverables needed prior to visit
- Assistance with booking travel to the site
- Tracking and dissemination of site visit reports to program
- Tracking and collecting programs' responses to corrective action as needed

DSH continues to work with other counties to establish dedicated JBCT bed programs. The target range of beds for each county is determined by the trend

of felony IST referrals and the county's interest in establishing a local or regional program. DSH assumes an average estimated daily bed rate of $491, consistent with the rates established for recent JBCT program activations. Attachment A provides details on all JBCT program updates, including total capacity and rate increases. An update will be provided in the 2023-24 May Revision, and savings will be updated in the context of any funding needs identified for EASS.

Expanding Felony IST Community Programing via CBR and Diversion

The 2022 Budget Act provided one-time infrastructure funding in FY 2022-23 and FY 2023-24 to develop residential housing settings to support felony IST individuals who are participating in either CBR or Diversion programs. Similar to the 2022 Budget Act, DSH is requesting to add provisional language to extend the encumbrance and expenditure period of the one-time funding in FY 2023-24. The proposed language is listed below:

Proposed Provisional Language:

14. Of the funds appropriated in schedule (4), $150,000,000 is for support of the Incompetent to Stand Trial Solutions and shall be available for encumbrance or expenditure until June 30, 2028.

IST Solutions Total Request

Resource Table[1]

Description	CY	BY	BY+1	Ongoing
IST Solutions Current Service Level[2]	$567,694	$511,091	$545,222	$665,416
JBCT Current Service Level	$119,932	$121,300	$121,300	$121,300
Community Inpatient Facilities Current Service Level	$88,540	$146,006	$145,526	$145,526
Re-Evaluation Current Service Level[3]	$12,000	$10,176	$10,176	$1,000
Governor's Budget Request – JBCT Programs	($27,359)	($3,083)	($947)	($947)
TOTAL	$760,807	$785,490	$699,977	$810,995

[1]Dollars in thousands
[2] CY One-time of $328,750,000; BY One-time of $160,000,000; BY+1 One-time of $5,000,000
[3]Pilot program ends June 30, 2025

Attachment A

Total JBCT Capacity and Projected Funding									
Existing JBCT Capacity and Projected Funding									
Program	**Bed Capacity in FY 2022-23**	**Bed Capacity in FY 2023-24**	**FY 2022-23 MR[3] Activation/ Expansion**	**FY 2023-24 GB[4] Activation/ Expansion**	**2022-23 MR Per Diem Rate**	**2023-24 GB Per Diem Rate**	**2022-23**	**2023-24**	**2024-25**
Butte JBCT	10	10	Jun-22	Jul-22	$441	$441	-	-	-
Calaveras JBCT	18	18	Jul-22	Oct-22	$441	$469	$455	$59	$131
Humboldt	8	8	Jul-22	Jul-22	$441	$519	$228	$228	$228
Kern AES	60	90	Jul-22	Jul-23	$480	$480	($5,256)	-	-
Kings JBCT	8	8	Jul-22	Dec-22	$441	$520	($68)	$231	$231
Mariposa JBCT	N/A	N/A	N/A	N/A	-	-	-	-	-
Mendocino JBCT	6	6	N/A	N/A	-	-	-	-	-
Monterey JBCT	11	11	Jul-22	Jul-22	$441	$491	-	$201	$201
Placer JBCT	15	15	N/A	N/A	$420	$441	-	$115	$115
Riverside JBCT	25	25	N/A	N/A	$402	$422	-	$91	$183
Sacramento JBCT	44	44	N/A	N/A	$520	$540	-	$322	$675
San Bernardino JBCT	64	64	N/A	N/A	$472	$619	($9,226)	($10,722)	($10,202)
San Diego JBCT	30	40	Jul-22	Jul-23	$420	$420	($1,533)	-	-
San Joaquin JBCT	12	12	N/A	N/A	$403	$424	-	$8	$188

[3] MR = May Revision
[4] GB = Governors Budget

Program	Bed Capacity in FY 2022-23	Bed Capacity in FY 2023-24	FY 2022-23 MR Activation/ Expansion	FY 2023-24 GB Activation/ Expansion	2022-23 MR Per Diem Rate	2023-24 GB Per Diem Rate	2022-23	2023-24	2024-25
San Luis Obispo JBCT	8	8	Jul-22	Jul-22	$446	$486	$117	$117	$117
Santa Barbara JBCT	10	15	Jul-22	Apr-23	$441	$491	($1,266)	$275	$274
Shasta JBCT	8	8	Jul-22	Jul-22	$441	$474	-	$41	$96
Solano JBCT	12	16	Jul-22	Jul-23	$441	$491	($123)	$208	$292
Sonoma JBCT	14	14	Apr-22	Apr-22	$462	$574	$572	$574	$572
Stanislaus JBCT	18	18	N/A	N/A	$441	$490	$322	$382	$447
Tulare JBCT	15	15	Jun-22	Jul-22	$441	$459	$99	$181	$263
Ventura JBCT	10	10	Oct-22	Oct-22	$441	$441	-	-	-
Yolo JBCT	7	7	Mar-22	Mar-22	$452	$491	$49	$164	$230
Central CA County B (Merced)	10	10	Jul-22	Dec-22	$420	$534	$416	$476	$533
Northern CA Small County D (El Dorado)	N/A	N/A	Dec-22	Jul-23	N/A	N/A	($292)	-	-
Northern CA County E (Nevada)	5	5	Dec-22	Jul-23	$420	$491	($382)	$130	$130
Northern CA County F (Sutter)	5	5	Dec-22	Jul-23	$420	$491	($382)	$130	$130

Program	Bed Capacity in FY 2022-23	Bed Capacity in FY 2023-24	FY 2022-23 MR Activation/ Expansion	FY 2023-24 GB Activation/ Expansion	2022-23 MR Per Diem Rate	2023-24 GB Per Diem Rate	2022-23	2023-24	2024-25
Northern CA County H (Lassen)	40	40	Sep-22	Jul-23	$441	$491	($5,345)	$732	$730
Northern CA County I (Alameda)	15	15	Mar-23	Jul-23	$420	$570	($762)	$824	$821
Northern CA County J (San Mateo)	15	15	Mar-23	Jul-23	$420	$491	($762)	$390	$389
Central CA County K (Madera)	7	7	Mar-23	Jul-23	$420	$491	($356)	$182	$181
Northern CA County N (Contra Costa)	19	19	Jul-22	Apr-23	$420	$653	($1,784)	$146	$305
Central CA County L (Fresno)	12	12	Jul-22	Jan-23	$462	$512	($911)	$334	$451
Southern CA County M (Orange)	25	25	Mar-23	Jul-23	$420	$534	($1,169)	$1,043	$1,287
Existing Subtotal	**566**	**615**					**($27,359)**	**($3,138)**	**($1,002)**
TOTAL	**566**	**615**					**($27,359)**	**($3,083)**	**($947)**

New JBCT Capacity and Projected Funding									
Program	**Bed Capacity in FY 2022-23**	**Bed Capacity in FY 2023-24**	**FY22-23 MR Activation/ Expansion**	**FY23-24 GB Activation/ Expansion**	**22-23 MR Per Diem Rate**	**23-24 GB Per Diem Rate**	**2022-23**	**2023-24**	**2024-25**
Patients' Rights Advocate Funding	N/A	N/A	N/A	N/A	N/A	N/A	-	($35)	($35)
JBCT Office Technician	N/A	N/A	N/A	N/A	N/A	N/A	-	$90	$90
New Subtotal	**0**	**0**					**$0**	**$55**	**$55**
TOTAL	**566**	**615**					**($27,359)**	**($3,083)**	**($947)**

BCP Fiscal Detail Sheet

BCP Title: IST Solutions **BR Name: 4440-035-ECP-2023-GB**

Budget Request Summary

	FY23					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	0.0	1.0	1.0	1.0	1.0	1.0
Total Positions	**0.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**
Salaries and Wages						
Earnings - Permanent	0	45	45	45	45	45
Total Salaries and Wages	**$0**	**$45**	**$45**	**$45**	**$45**	**$45**
Total Staff Benefits	0	29	29	29	29	29
Total Personal Services	**$0**	**$74**	**$74**	**$74**	**$74**	**$74**
Operating Expenses and Equipment						
5301 - General Expense	0	8	8	8	8	8
5304 - Communications	0	1	1	1	1	1
5320 - Travel: In-State	0	1	1	1	1	1
5324 - Facilities Operation	0	5	5	5	5	5
5340 - Consulting and Professional Services - External	-27,359	-3,173	-1,037	-1,037	-1,037	-1,037
5346 - Information Technology	0	1	1	1	1	1
Total Operating Expenses and Equipment	**$-27,359**	**$-3,157**	**$-1,021**	**$-1,021**	**$-1,021**	**$-1,021**
Total Budget Request	**$-27,359**	**$-3,083**	**$-947**	**$-947**	**$-947**	**$-947**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-27,359	-3,083	-947	-947	-947	-947
Total State Operations Expenditures	**$-27,359**	**$-3,083**	**$-947**	**$-947**	**$-947**	**$-947**
Total All Funds	**$-27,359**	**$-3,083**	**$-947**	**$-947**	**$-947**	**$-947**

Program Summary

Program Funding						
4400010 - Headquarters Administration	0	7	7	7	7	7
4400020 - Hospital Administration	0	1	1	1	1	1
4430050 - Jail Based Treatment Programs	-27,359	-3,091	-955	-955	-955	-955
Total All Programs	**$-27,359**	**$-3,083**	**$-947**	**$-947**	**$-947**	**$-947**

BCP Title: IST Solutions **BR Name: 4440-035-ECP-2023-GB**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
1138 - Office Techn (Gen)				0.0	1.0	1.0	1.0	1.0	1.0
Total Positions				**0.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
1138 - Office Techn (Gen)	0	45	45	45	45	45
Total Salaries and Wages	**$0**	**$45**	**$45**	**$45**	**$45**	**$45**
Staff Benefits						
5150200 - Disability Leave - Industrial	0	1	1	1	1	1
5150350 - Health Insurance	0	2	2	2	2	2
5150450 - Medicare Taxation	0	1	1	1	1	1
5150500 - OASDI	0	3	3	3	3	3
5150600 - Retirement - General	0	13	13	13	13	13
5150800 - Workers' Compensation	0	2	2	2	2	2
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	0	1	1	1	1	1
5150900 - Staff Benefits - Other	0	6	6	6	6	6
Total Staff Benefits	**$0**	**$29**	**$29**	**$29**	**$29**	**$29**
Total Personal Services	**$0**	**$74**	**$74**	**$74**	**$74**	**$74**

STATE HOSPITALS
VOCATIONAL SERVICES AND PATIENT MINIMUM WAGE CASELOAD
Informational Only

SUMMARY

As the Department of State Hospitals (DSH) continues to assess opportunities to safely resume patient activities under current COVID-19 guidance from the Centers for Disease Control and Prevention (CDC) and California Department of Public Health (CDPH), the DSH Vocational Services Program has almost fully resumed pre-pandemic program operations. Vocational Services operations may continue to be impacted intermittently while hospitals continue to navigate COVID-19 quarantines as they arise.

BACKGROUND

As part of the patient treatment plan and rehabilitation process, DSH offers its patients access to the Vocational Rehabilitation Program, which serves as a therapeutic program that provides a range of vocational skills and therapeutic interventions. DSH clinicians work closely with DSH Vocational Rehabilitation Program managers to incorporate a treatment plan to assist patients in developing social, occupational, life, and career skills, and confidence. Vocational Rehabilitation assists patients by preparing for discharge and/or transition to next level of care, successful community integration when released, obtaining future employment, and reducing criminal recidivism.

PROGRAM UPDATE

The hospitals have almost fully resumed normal program activities; however, facilities continue to experience incidental COVID-19 quarantines which restrict patient movement, impacting which programs they are able to participate in. DSH does not anticipate a resource need at this time and will provide an update in the 2023-24 May Revision.

STATE HOSPITALS
WORKFORCE DEVELOPMENT
Informational Only

SUMMARY

The Workforce Development proposal is fully phased-in. DSH-Napa is now in its second year of residencies with 14 residents in the program. Both DSH-Atascadero and DSH-Napa continue to partner with local community colleges' Psychiatric Technician programs to attract and retain a sufficient workforce of trained medical professionals.

BACKGROUND

The 2019 Budget Act included resources to work in conjunction with the Mission Based Review – Direct Care Nursing proposal as a means to attract and retain a sufficient workforce of trained medical professionals. DSH and other state and national employers of health care professionals are experiencing difficulties in filling these positions largely due to nationwide shortages. In addition, successful recruitment is also challenged by the high-risk work environment.

While nursing level of care classifications vary at DSH, this initiative was focused primarily on recruitment for registered nurses (RNs) and psychiatric technicians (PTs). These two nursing classifications reflect most of the authorized nursing positions at DSH. As a workforce strategy, DSH developed and implemented a Psychiatric Residency Program and expanded resources for Nursing Recruitment to meet the mission of providing mental health services to patients and reduce vacancy rates for mental health providers.

PROGRAM UPDATE

Residency Program Update

The Residency Program at St. Joseph Medical Center (SJMC) received temporary accreditation from the Accreditation Council for Graduate Medical Education (ACGME) in February 2021 and expects to receive ongoing accreditation in March 2023. The program is now in its second year and has two cohorts of seven rotating residents for a total of 14 residents. Over 700 applications for the third-year class have been received and are being reviewed. Based on the success of program so far, DSH is looking into expansion of the program and will provide an update in the FY 2023-24 May Revision estimate. DSH has also proposed expanding psychiatry workforce strategies beyond DSH-Napa, as reflected in the 4440-008-BCP-2023-GB Psychiatry Workforce Pipeline, Recruitment, Hiring and Retention Budget Change Proposal.

Psychiatric Technician Graduation Rates

DSH partners with local community colleges to offer education and training programs to provide an adequate supply of Psychiatric Technicians (PT) for state hospitals. The below table displays actual graduation rates from cohorts conducted from calendar year 2019.

DSH-Atascadero

Cohorts	Number of Attendees	Number of Graduates	DSH Hires
2019	90	73	58
2020	60	44	32
2021	60	53	10
Spring 2022	26	TBD	TBD
Summer 2022	30	TBD	TBD
Fall 2022	33	TBD	TBD

DSH-Napa

Cohorts	Number of Attendees	Number of Graduates	DSH Hires
Spring 2020	24	16	2
Fall 2020[1]	N/A	N/A	N/A
Spring 2021	30	19	11
Fall 2021[2]	N/A	N/A	N/A
Spring 2022	26	16	TBD
Fall 2022	17	13	TBD

[1] COVID-19 Restrictions, no clinical available
[2] No new students

STATE HOSPITALS
SKILLED NURSING FACILITY CONVERSIONS
Informational Only

SUMMARY

The Department of State Hospitals (DSH) has an aging population in need of higher levels of medical care. Addressing their special needs increasingly proves to be a challenge for primary medical care at DSH as the number of DSH Skilled Nursing facilities (SNF) beds statewide are insufficient to meet the needs of existing and future patients. In response, three state hospitals have commenced efforts to evaluate strategies to meet the needs of DSH's aging patient population.

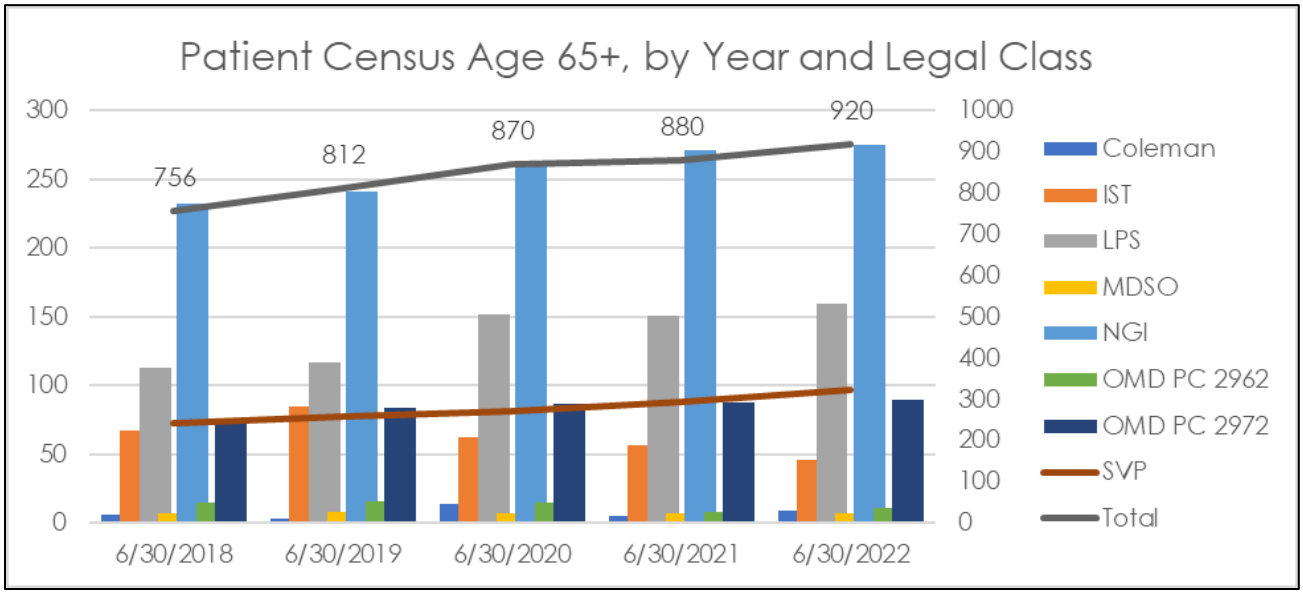
BACKGROUND

As the administrator of the nation's largest inpatient forensic mental health hospital system, DSH is responsible for the daily care of over 7,000 patients; many of whom, due to either the nature of their mental illness or the crimes they have committed, have long lengths of stay. The following provides by commitment type, the average number of patient days for patients in census at the end of FY 2021-22.

Commitment Type	Average Patient Days
Coleman	327.1
IST	158.5
LPS	3,573.9
MDSO	4,462.7
NGI	6,319.4
OMD PC 2962	440.1
OMD PC 2972	3,860.4
SVP	4,697.4

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

In recent years, the number of DSH patients aged 65 and older has continued to increase. As illustrated in the graph and table below, DSH has shown an increase of 31 percent in the number of patients aged 65 and older over the last five years.



While older patients already experience a higher level of prevalence for multiple medical conditions, current research reveals patients with schizophrenia experience accelerated aging and development of age-related illnesses 20 years earlier than expected and suffer from a dramatically decreased life expectancy. As of June 30, 2022, 38% of DSH's population had a diagnosis of schizophrenia. Moreover, mental illness, particularly psychotic spectrum disorders, bipolar disorders, and depressive disorders, are associated with increased prevalence of chronic diseases including asthma, arthritis, cardiovascular disease, cancer, diabetes, and obesity. As of June 30, 2022, 23% of DSH's population had a diagnosis of schizoaffective disorder and 4% had a diagnosis of bipolar disorder.

DSH currently operates three licensed[1] SNF units; two located at DSH-Metropolitan and one at DSH-Napa. As of June 30, 2022, there are 96 active SNF beds at DSH-Metropolitan and 29 at DSH-Napa, for a combined total of 125 active SNF beds. This limited capacity must also accommodate SNF patients transferred from DSH-Atascadero and DSH-Patton. However, due to system limitations, DSH-Metropolitan and DSH-Napa are not able to serve SNF patients committed to DSH-Coalinga as Sexually Violent Predators (SVP).

For DSH-Coalinga, and any other facilities unable to place their SNF patients into one of the three existing DSH SNF units due to capacity limitations, DSH contracts out with community facilities when possible. However, community options pose several challenges which often make placement difficult, including availability of community beds, and the challenge that even when an available bed is identified,

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

many community options are unwilling to accept forensic commitments, particularly those with sexual offenses. DSH has taken steps to convert existing residential units to meet the increased medical needs of patients with a higher level of acuity, including the currently underway conversion one of their residential units to an Intensive Care Facility (ICF) to accommodate their increasingly geriatric population.

PROGRAM UPDATE

Three state hospitals are exploring both internal and external options to create SNF bed capacity. DSH will continue to evaluation options and explore solutions to meet the SNF needs of DSH's aging and high acuity patient population and will provide an update in the 2023-24 May Revision.

STATE HOSPITALS
DSH-COALINGA INTERMEDIATE CARE FACILITY CONVERSION
Informational Only

SUMMARY

The Intermediate Care Facilities (ICF) unit conversion at Department of State Hospitals (DSH)-Coalinga has commenced and activation is scheduled for March 2023.

BACKGROUND

DSH-Coalinga operates a total of 30 residential units; 23 of which are licensed as ICFs by the California Department of Public Health (CDPH), and seven units currently exempted from CDPH licensure which are classified as Residential Recovery Units (RRU).

Many patients committed to DSH-Coalinga have longer lengths of stay. As a result, DSH has an aging population in need of higher levels of medical care. Historically, DSH has converted existing RRUs to ICFs to better serve the medical needs of this aging population. The Budget Act of 2022 included resources to convert one additional unit to an ICF, and in July 2022 DSH-Coalinga began conversion efforts.

PROGRAM UPDATE

As of December 2022, minor adjustments were made to Unit 4, the identified RRU, to ICF standards, including all efforts necessary to meet anti-ligature needs. DSH-Coalinga has experienced some delays in ordering and receiving specialized parts for the remaining unit modifications. Due to these delays, DSH anticipates a revised activation date of March 2023

DSH-Coalinga has been actively engaged in hiring and training efforts for Unit 4 to achieve the licensure needed for the ICF conversion. DSH anticipates all positions will be onboarded in time for unit activation in March 2023. An update on Unit 4 conversion from an RRU to and ICF will be provided in the 2023-24 May Revision.

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

SUMMARY

The Department of State Hospitals (DSH) continues to monitor the Sexually Violent Predator (SVP) and Offenders with a Mental Health Disorder (OMD) referral trends. In fiscal year (FY) 2021-22, DSH received 467 SVP referrals and 2,155 OMD referrals. Based on the number of referrals received between July 2021 and June 2022, DSH currently estimates to receive 410 SVP and 2,428 OMD referrals in FY 2022-23.

BACKGROUND

DSH is required to provide forensic evaluation services to determine if an inmate within the California Department of Corrections and Rehabilitation (CDCR), prior to parole, requires continued treatment in a state hospital as an OMD as condition of parole or as an SVP. DSH administers these services through the Sex Offender Commitment Program (SOCP) and the OMD Program.

During the pandemic, videoconferencing infrastructure expanded widely throughout the state, resulting in a significant decline in required travel for evaluators conducting inmate interviews or providing court testimony. Travel remains minimal as courts have been amenable to continuing remote options. DSH evaluators continue to participate in both activities virtually.

PROGRAM UPDATE

SOCP Program Update

Per WIC 6601(b), CDCR and BPH are responsible for performing a two-part screening process of CDCR inmates to determine whether an individual is likely to be an SVP and warrants further assessment with two forensic psychological evaluations by DSH. Individuals convicted of committing offenses which would qualifying for commitment as an SVP are subject to a clinical review to determine if they are likely to meet the criteria as an SVP. Following this review, CDCR refers the individual to DSH for a full evaluation. For the period between July 2021 and June 2022, approximately 467 cases were referred to DSH for full evaluation, which is 9.2 percent lower than the prior FY projection of 505. DSH projects 410 SVP referrals for FY 2022-2023.

Offender with a Mental Health Disorder (OMD) Program Update

Before a prisoner with a mental health history and a violent commitment offense is released on parole, a CDCR evaluator conducts an initial forensic evaluation to determine if the prisoner is dangerous to others as a result of a severe mental health disorder and could meet criteria for OMD commitment. If the criteria are met, CDCR refers the prisoner to DSH for a second evaluation. If the CDCR evaluator and DSH evaluator disagree, the Board of Parole Hearings (BPH) appoints two independent evaluators to conduct additional evaluations. After reviewing the forensic evaluation reports, the CDCR Chief Psychiatrist certifies whether the person meets the OMD criteria. If so, BPH transfers the prisoner to a state hospital for treatment as a special condition of parole.

DSH received 2,155 referrals from CDCR to perform OMD evaluations for potential commitment to a state hospital in FY 2021-22. DSH projects to receive 2,428, (an increase of 273) OMD referrals for FY 2022-23.

DSH is not requesting a change in funding or position authority at this time. DSH will continue to work closely with the CDCR and BPH to determine if there will be additional workload impacts to the SOCP and OMD programs.

All Capital Outlay Budget Change Proposals (COBCPs) can be found at the Department of Finance Website.

Department of Finance (ca.gov)

POPULATION PROFILE
Penal Code 2684 (*Coleman*) Patients

Description of Legal Class:

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

The following are the various *Coleman* commitments and their corresponding citation in statute:

PC 2684	Prisoner from CDCR, under approval by the Board of Parole Hearings, that is referred to a state hospital for mental health treatment.

Legal Requirements/Legal Statue for Discharge:

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

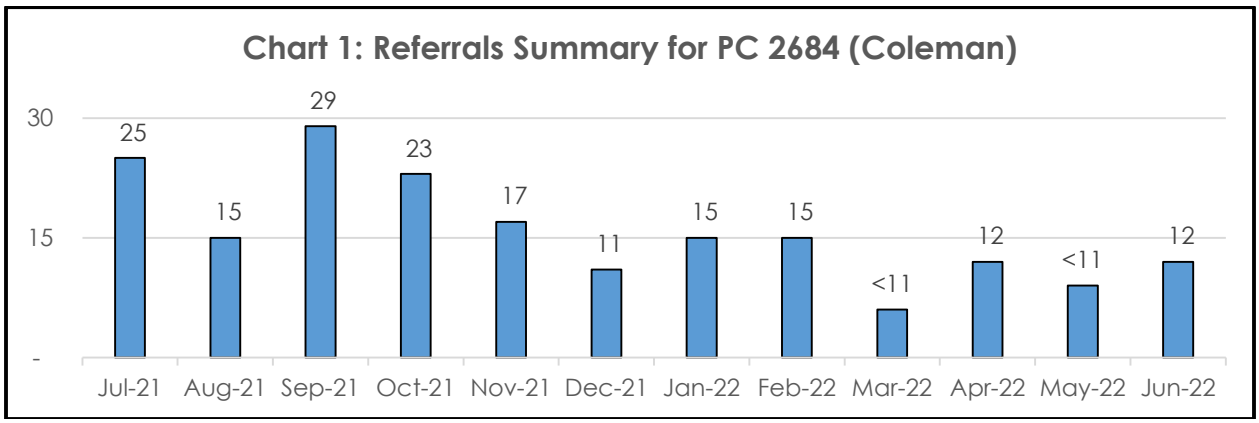
Treatment:

The focus of treatment for the *Coleman* population is on psychiatric stabilization. Several *Coleman* patients are sent to DSH because of complicated presentations, such as complex medical diagnoses, cognitive issues, developmental disabilities,

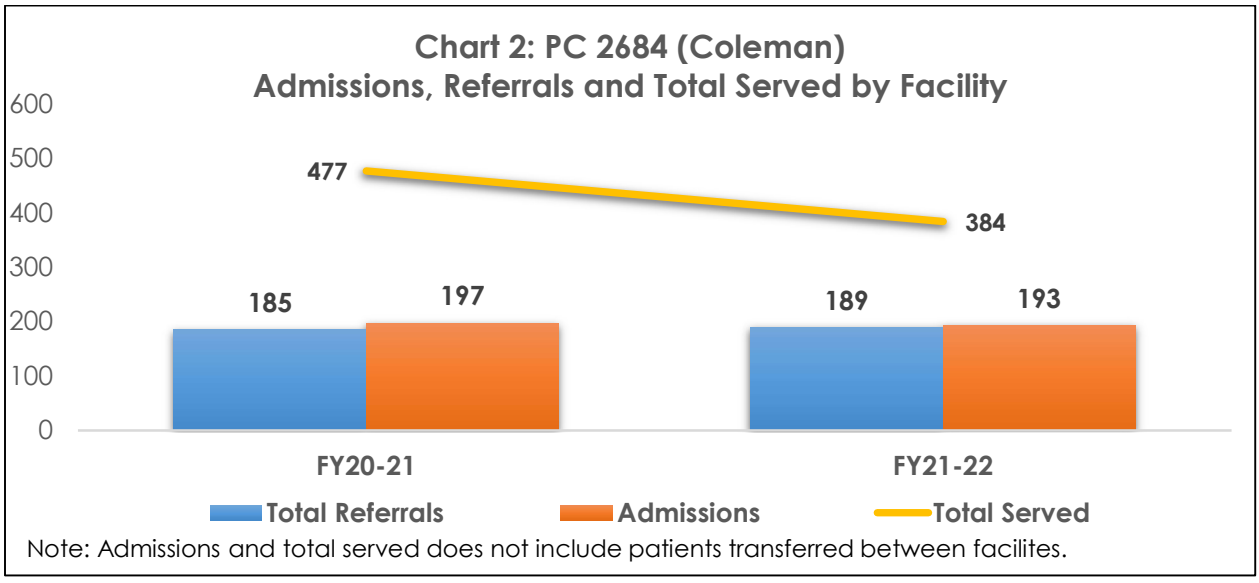
and mental illness. In addition to psychiatric and medical services, psychosocial treatments are provided with a focus on helping the patient manage their mental illness symptoms and reintegrate back into a prison environment when discharged from the state hospital.

Population Data:

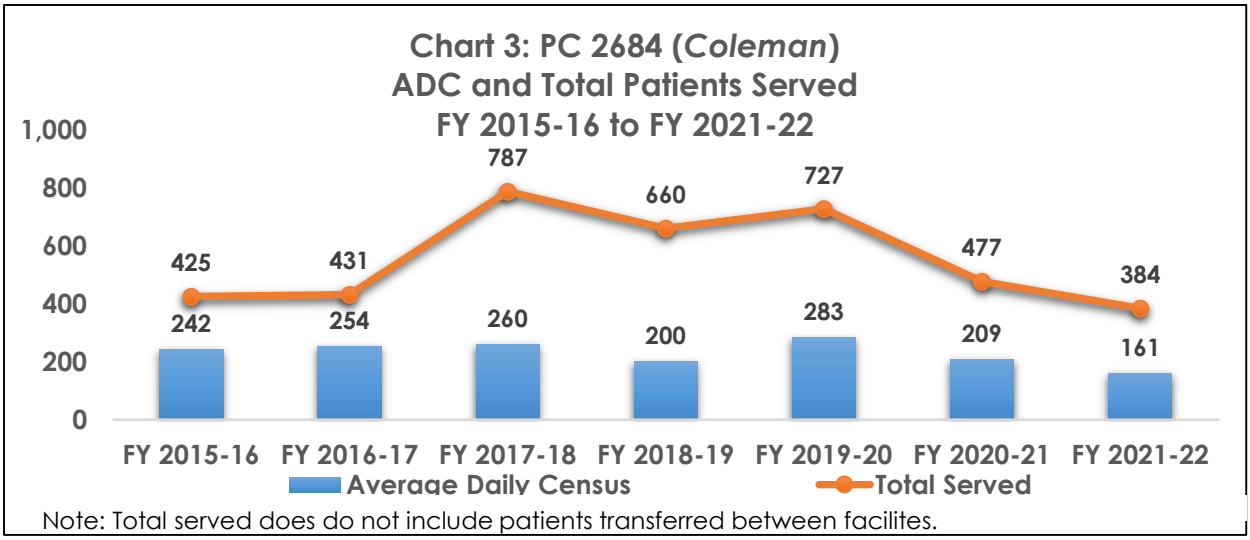
In FY 2021-22, 189 *Coleman* patients were referred and accepted for admission to the state hospitals, excluding referrals rescinded by CDCR. This is a 2 percent increase from FY 2020-21. At the start of the FY 2021-22, the July 1 census was 170, and on June 30, 2022, the census had decreased to 114, a 33 percent decrease.



Over the course of FY 2021-22, 193 *Coleman* patients were admitted into a state hospital. Chart 2 below displays the admission, referrals, and total patients served system-wide for the *Coleman* population in FY 2020-21 and FY 2021-22. The number of admissions decreased by 2 percent.

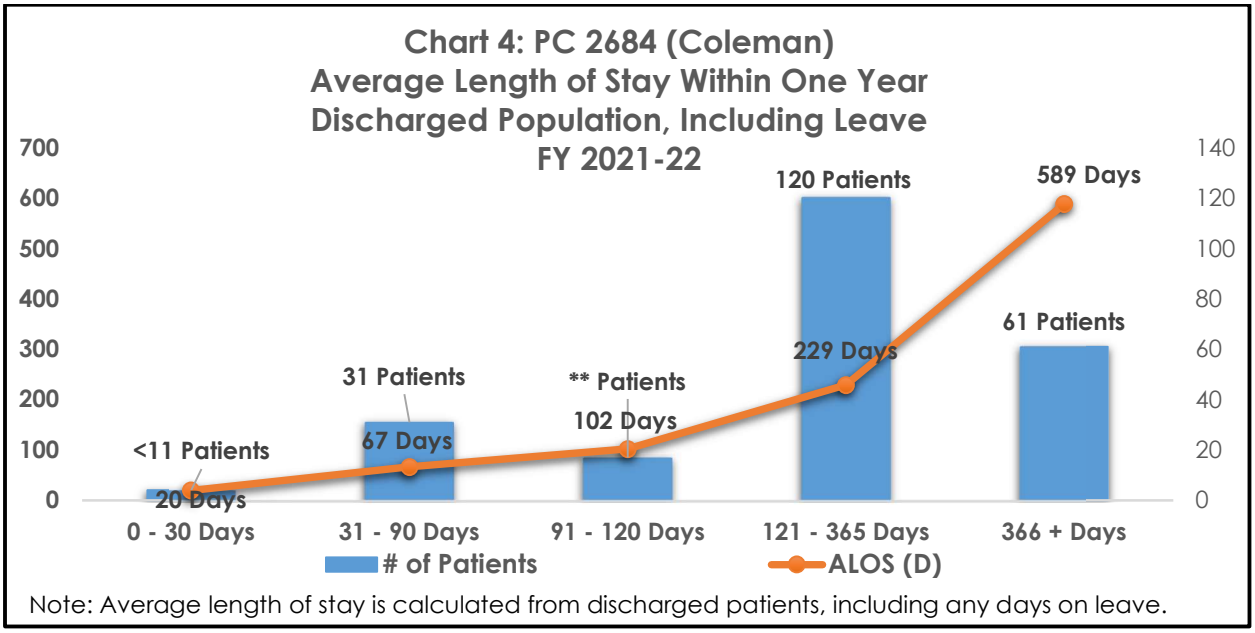


On average, 161 *Coleman* patients are treated daily in the state hospitals, representing 3 percent of the overall patient population in FY 2021-22. Chart 3 below displays the average daily census (ADC) and total number of patients served for the *Coleman* population during FY 2015-16 to FY 2021-22. As of June 30, 2022, the system-wide *Coleman* census was 114 patients.



Note: Total served does do not include patients transferred between facilites.

Because the focus of treatment is acute stabilization, the length of hospitalization for *Coleman* patients tends to be shorter than the other commitment types. In FY 2021-22, 233 *Coleman* patients were discharged, with an average length of stay of 289 days. Chart 4 below displays the distribution of lengths of stay for all discharged *Coleman* patients.



Note: Average length of stay is calculated from discharged patients, including any days on leave.

POPULATION PROFILE
Incompetent to Stand Trial Patients

Description of Legal Class:

The Department of State Hospitals (DSH) admits Incompetent to Stand Trial (IST) patients under Penal Code (PC) 1370: Inquiry into the Competence of the Defendant Before Trial or After Conviction. IST patients are referred to DSH after a court has determined that they are unable to understand the nature of the criminal proceedings or assist counsel in the conduct of a defense. The court then commits these defendants to DSH for treatment specifically designed to enable the defendant to proceed with the trial, conducted as clinically appropriate at either a state hospital or a jail-based competency treatment program. Patients receive competency-based treatment and return to court once they have regained competency and can effectively assist in their trial proceedings, are determined to be unlikely to be restored to competency in the foreseeable future or are within 90-days of their maximum commitment for competency treatment. IST patients committed to DSH mainly include felony criminal charges and occasionally include misdemeanor charges. As of July 27, 2021, defendants only with misdemeanor commitment charges (1370.01) can no longer be committed to DSH. There are still 1370.01 commitments to DSH prior to July 27, 2021.

The following are the various IST commitments, and their corresponding citation in code:

PC 1370	Incompetent to Stand Trial
PC 1370.01	Misdemeanor charges, Incompetent to Stand Trial
PC 1370.1	IST commitment for a defendant whose incompetence is due to developmental disability
PC 1372(e)	Continued hospitalization for an IST defendant who is deemed competent to stand trial, but who requires continued, involuntary treatment in a state hospital to maintain competency during the criminal trial.
PC1370(b)(1)	Unlikely to regain competency in the foreseeable future; may apply to PC 1370, PC 1370.01, or PC 1370.1. The treating facility will provide a report to the court that an individual is unlikely to regain competency. For defendants committed pursuant to Penal Code section 1370, within 10 days following notice to the Sheriff that a defendant is unlikely to be regain competency in the foreseeable future, the Sheriff shall return the defendant to county custody. Defendants remaining in a facility beyond 10 days from notice to the Sheriff will be billed for cost of care

PC1370(c)(1)	IST that remains at DSH within 90 days of their maximum term commitment. Upon notice to the Sheriff, these defendants shall be picked up and returned to county custody within 10-days of notice.
PC 1610	Temporary admission while waiting for court revocation of PC 1370 (IST)

Legal Requirements/Legal Statue for Discharge

An IST patient cannot be confined for longer than is reasonably necessary for restoration of competency or determination that competency cannot be restored. The maximum IST commitment time is two years[1] for felony offenses or up to the maximum term of imprisonment for the alleged crime, whichever is shorter (PC 1370, subdivision (c)(1)). An IST commitment may end when either: (1) the maximum time for confinement runs out; (2) the defendant obtains certification that they have regained competency pursuant to PC section 1372; or (3) DSH determines there is no substantial likelihood a patient will regain competency in the foreseeable future, and the commitment is vacated by the court, usually after a defendant is placed under a Lanterman-Petris-Short Act conservatorship. If a patient/defendant has not regained competency to stand trial by the end of their IST commitment term or is determined there is no substantial likelihood they will regain competency in the foreseeable future, the patient/defendant must be returned to the committing county.

As defined in PC 1370(b)(1), a patient may be deemed by the treatment team as unlikely to regain competency. Upon notification to the county of commitment Sheriff, the patient must be picked up within ten days and returned to county custody. Often, the county will pursue other means to ensure the patient is receives treatment and care, including securing a conservatorship and referring the individual back to the state hospital under a conservatorship commitment. In the event a patient is nearing their maximum term of commitment, the state hospital, pursuant to PC 1370(c)(1) must notify the Sheriff, who must pick up the patient who is within 90 days prior to the expiration of the commitment term within 10-days of notice by DSH. In prior years, DSH noted counties not consistently retrieving their patients promptly, requiring patients to remain on the census for extended periods. In FY 2021-22, when applying the average length of stay for an IST patient, this practice resulted in a loss of 48.5 IST patients served between PC 1370 (b)(1) and PC 1370(c)(1) individuals. Assembly Bill 133 amended and added subdivision to the Penal Code to require defendants remaining in a facility beyond ten days from notice to the Sheriff to pick-up these defendants will be billed for the cost of care.

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

As of July 27, 2021, defendants only with misdemeanor commitment charges (1370.01) can no longer be committed to DSH. There are still 1370.01 commitments to DSH prior to July 27, 2021.

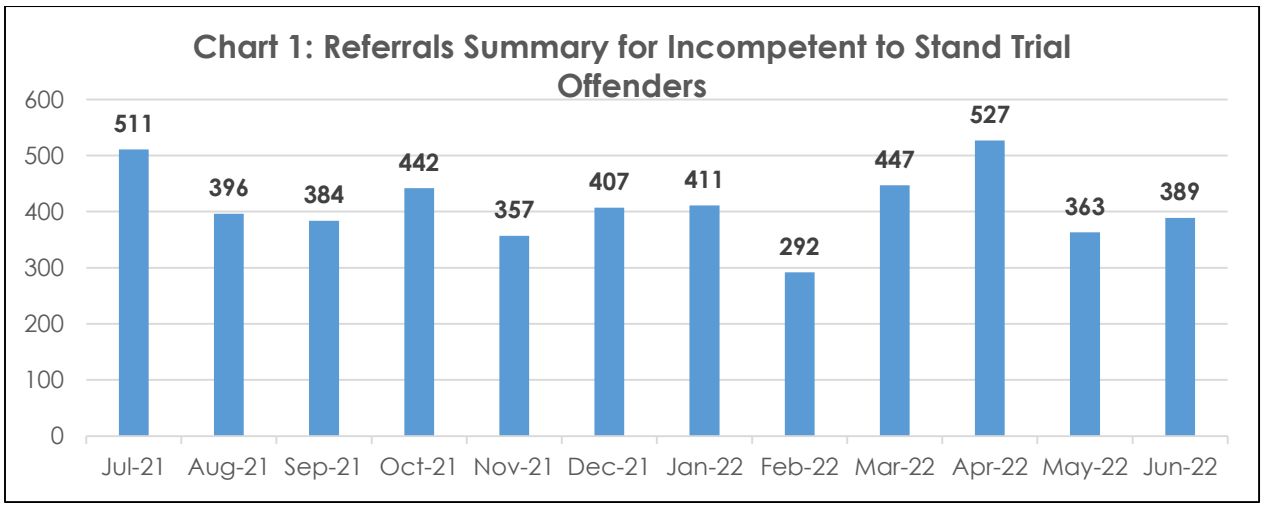
Treatment

The treatment for the IST population focuses on restoring trial competency in the most expeditious manner. To this end, IST patients are treated in one treatment program, so the training in criminal procedures can constantly be present in the treatment milieu. Once specific mental health issues and medication needs are addressed, patients are immersed in groups that train them in the various aspects of the court.

Throughout treatment, patients are regularly evaluated. If there is concurrence that a patient is competent, a forensic report is sent to the court, identifying that the patient is competent and ready to be discharged to the county of commitment, where they can stand trial.

Population Data

In FY 2021-22, 4,926 IST patients were committed[2] to DSH, a 19 percent increase from FY 2020-21. The COVID-19 pandemic directly impacted IST referral rates. After courts resumed court proceedings following 2020 pandemic stay-in-place orders, IST referral rates have steadily increased. Chart 1 below displays monthly referrals system-wide for the IST population in FY 2021-22.

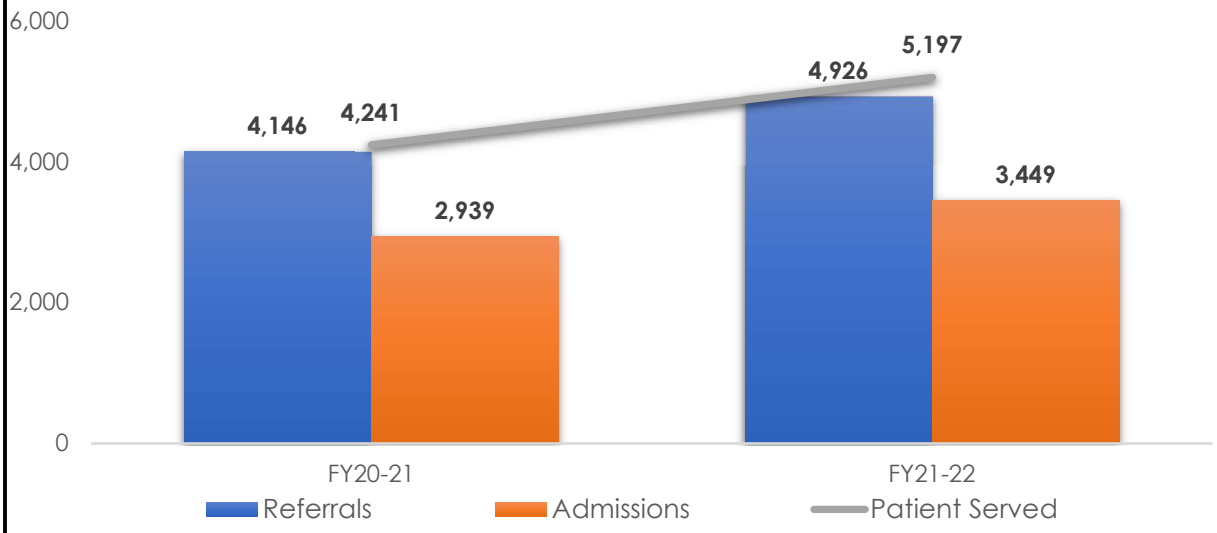


[2] Referral data excludes JBCT Transfers, State Hospital Transfers, Court Returns, CBR referrals/off-ramps.

Incompetent to Stand Trial Data

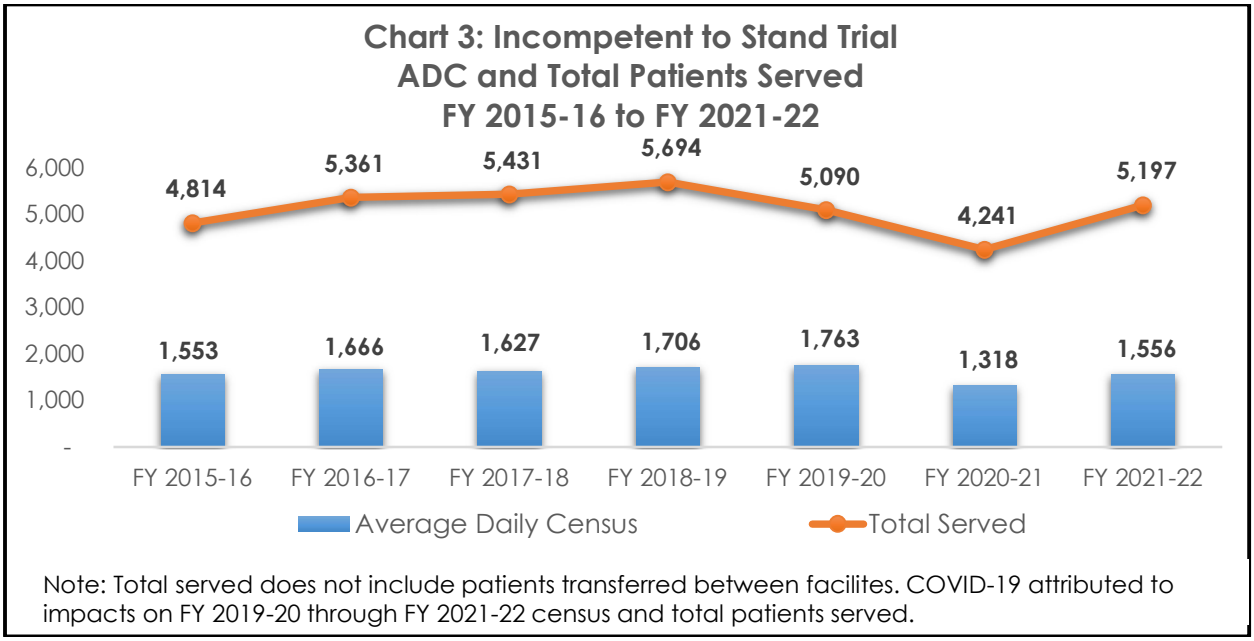
Over the course of FY 2021-22, 3,449 IST patients were admitted into DSH's inpatient programs, including state hospitals, jail-based programs, and Sacramento Behavioral Health (SBHH), an increase of 17 percent from the prior year. COVID- 19 slightly impacted admission rates and restricted patient movement due to quarantine units and the continued need for Admission Observation Units (AOU). AOUs house patients arriving at the hospital for admission and in certain circumstances, patients coming from receiving outside care/services. Patients are isolated and tested for ten days as a prevention measure for routine intake quarantine. As admissions directly correlate to patients served, DSH served 23 percent more patients in FY 2021-22 than in the prior year. Chart 2 below displays referrals, admissions, and total patients served system-wide for the IST population in FY 2020-21 and FY 2021-22.

Chart 2: Incompetent to Stand Trial
Admissions and Total Served



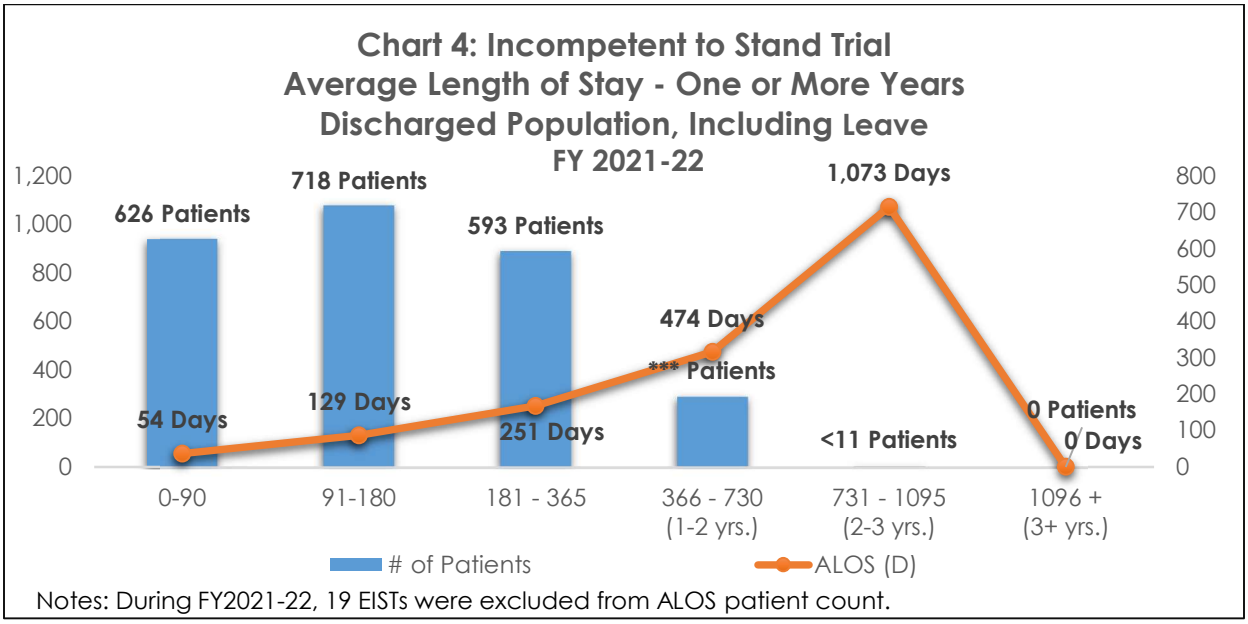
Notes: Total admissions and total served does not include patients transfers from DSH or JBCT facilities. COVID-19 attributed to impacts on FY 2021-22 referrals, admissions and total patients

On average, 1,556 IST patients are treated daily in the state hospitals, jail-based programs, and SBHH representing 27 percent of the overall patient population in FY 2021-22. Chart 3 below displays the average daily census (ADC) and the total number of patients served in state hospital facilities, jail-based programs, and SBHH for the IST population from FY 2015-16 to FY 2021-22. As of June 30, 2022, the system-wide IST census is 1,677 patients.



Note: Total served does not include patients transferred between facilites. COVID-19 attributed to impacts on FY 2019-20 through FY 2021-22 census and total patients served.

In FY 2021-22, 2,135 IST patients were discharged from state hospitals with an average length of stay of 174 days, 0.5 years. The State Hospital's length of stay decreased by 29 percent (or approximately 70 days) as compared to the prior year. Chart 4 below displays the distribution of lengths of stay for all discharged IST patients.

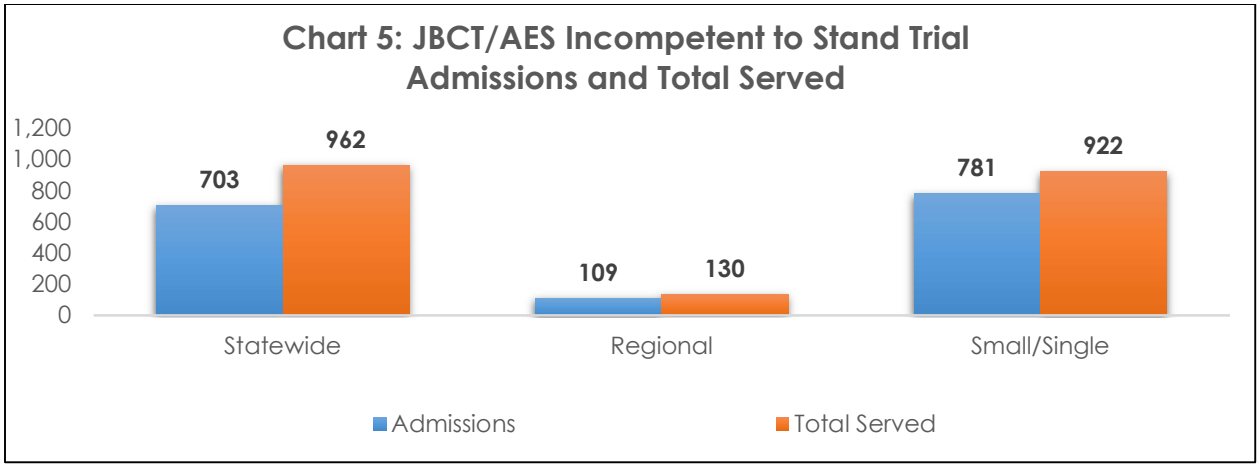


Notes: During FY2021-22, 19 EISTs were excluded from ALOS patient count.

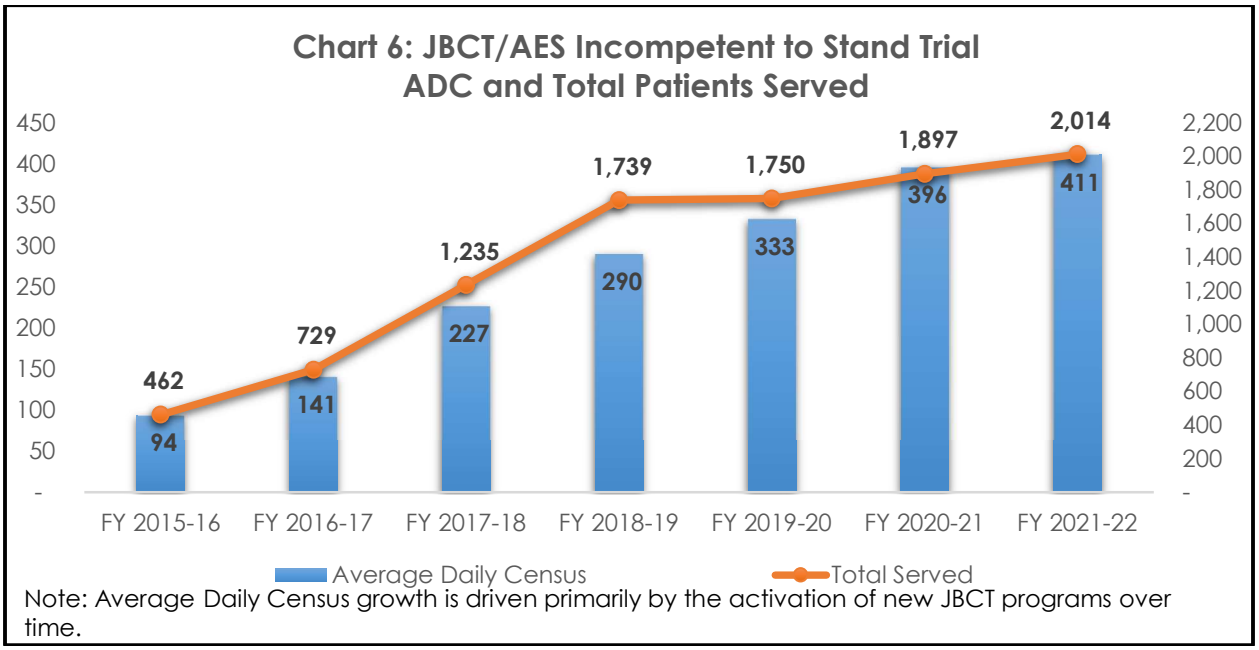
*Chart 4. Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. Counts between 1-10 are masked with "<11". Complementary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.*

Jail-Based Competency Treatment (JBCT) Program Data

Over the course of FY 2021-22, 1,593 IST patients were admitted into a JBCT facility or the Admission, Evaluation, and Stabilization (AES) Center, which reflects no change in percent from the prior year. Chart 5 displays the admission and total patients served distribution by JBCT/AES facility categories for the IST population in FY 2021-22.



On average, 411 IST patients are treated daily in the JBCT/AESs, a 4 percent increase from FY 2020-21. Chart 6 below displays the ADC and a total number of patients served yearly in the JBCT/AESs for the IST population. As of June 30, 2022, the JBCT/AES system-wide IST census is 424 patients.



Note: Average Daily Census growth is driven primarily by the activation of new JBCT programs over time.

The JBCT and AES programs were designed to treat patients with a stronger likelihood of quick restoration of competency, generally under 90 days from admission. However, if, during treatment, the patient demonstrates a need for a higher level of care or restoration is of slower progress than anticipated, the individual can be transferred to a state hospital for the continuation of restoration care. In FY 2021-22, 1,163 IST patients were restored and discharged with an average length of stay of 68 days. During that same period, 432 IST patients were discharged from the JBCT/AES program and transferred to a state hospital, with an average length of stay of 142 days. Chart 7 below displays the lengths of stay for all discharged IST patients that were restored.

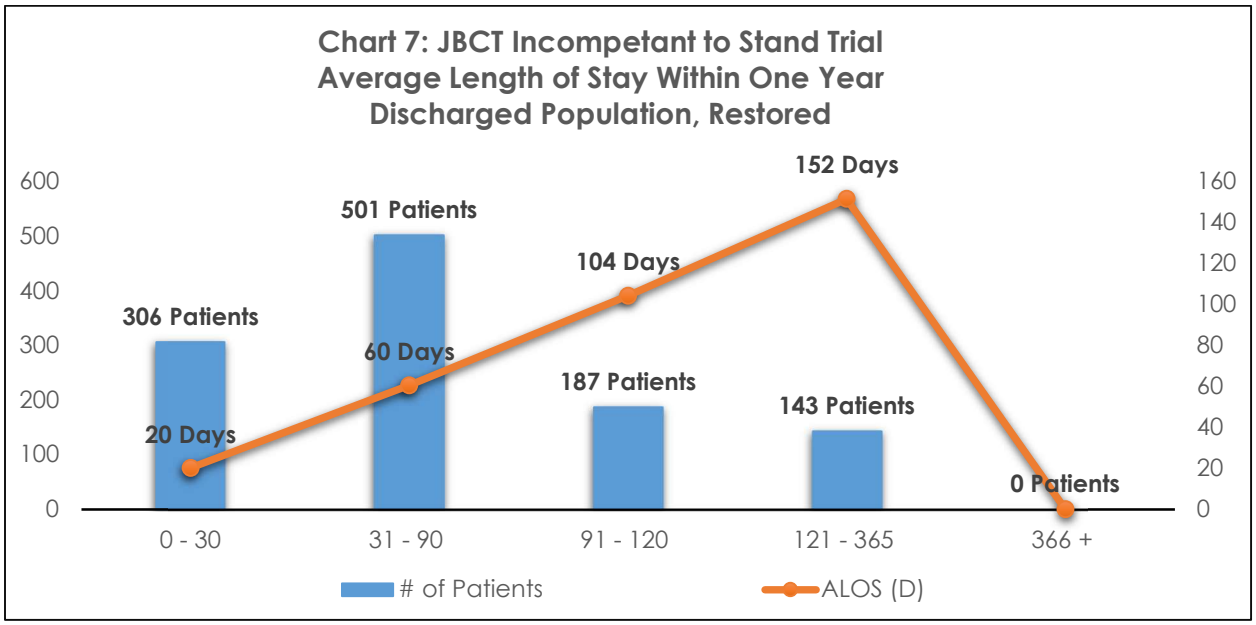


Chart 8 below displays the distribution of lengths of stay for all discharged IST patients that transferred to state hospital facilities.

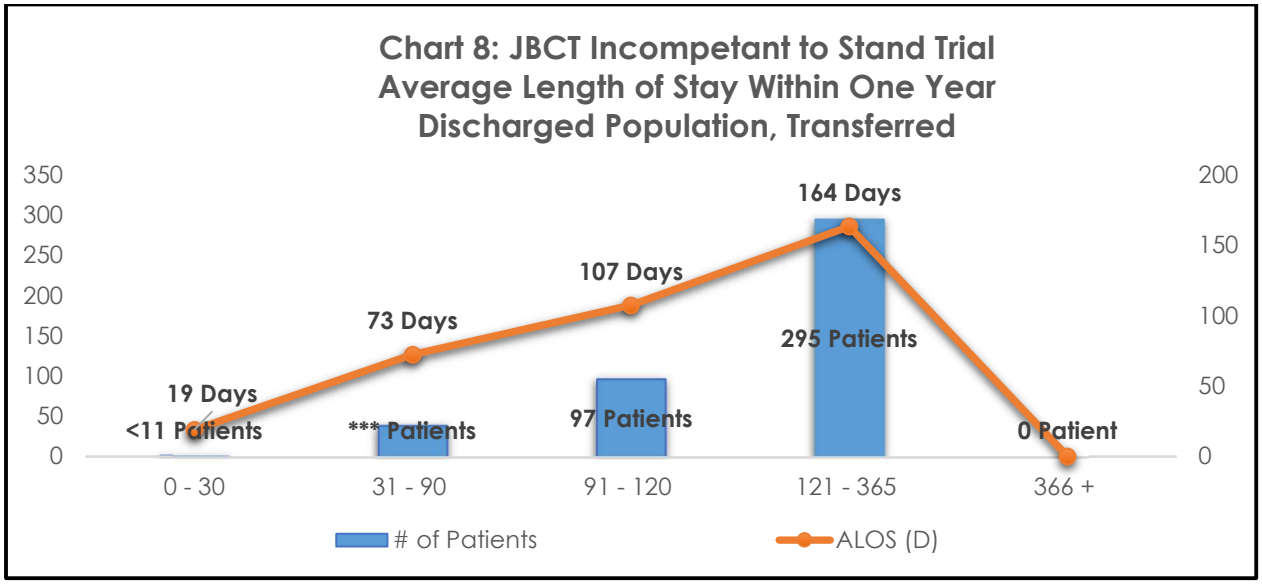


*Chart 8. Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. Counts between 1-10 are masked with "<11". Complementary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.*

Community-Based Restoration Program Data

On July 1, 2018, DSH, in collaboration with Los Angeles County, activated the Community-Based Restoration (CBR) Program for Felony IST commitments. Managed by the Los Angeles (LA) County Office of Diversion and Re-entry, CBR aims to regularly assess committed IST patients while they wait for a bed at DSH to 1) re-evaluate competency and the need for competency treatment ("off-ramp") and 2) identify suitability for a community-based treatment option in a network of 400+ beds.

As part of this two-prong approach, the off-ramp team monitors Felony ISTs in the jail for restoration of competency prior to placement in a state hospital or into the community restoration program. If competence is suspected, the team prepares court documentation and petitions the court to approve the determination of restored competence. Over the course of FY 2021-22, CBR successfully off-ramped 55 patients. Chart 9 below displays the number of patients found competent monthly in CBR's off-ramp assessment.

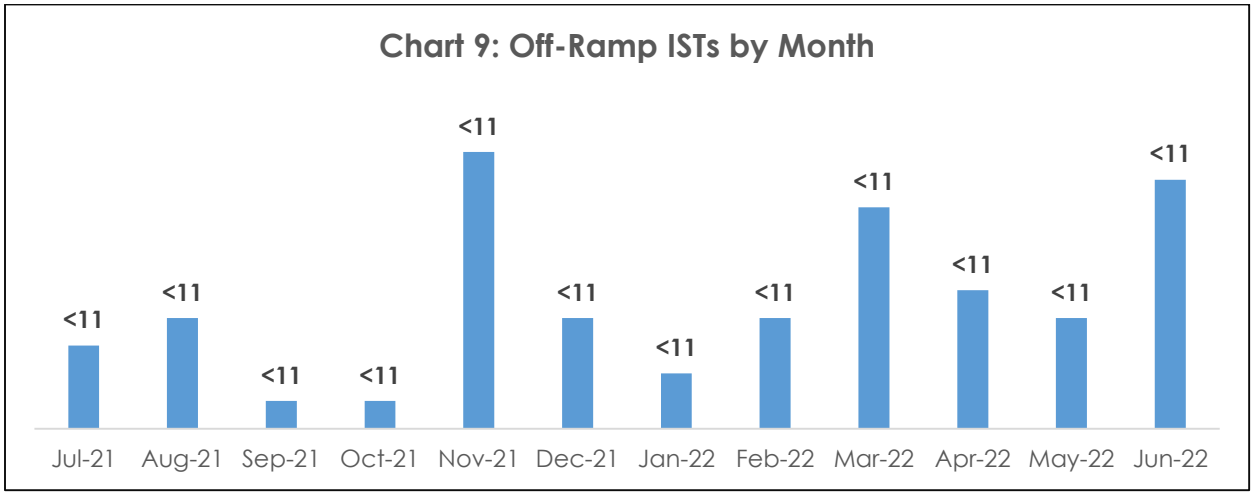


Chart 9. Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. Counts between 1-10 are masked with "<11".

Upon assessment of LA County IST referrals, a patient may still present in need of competency restoration services, and staff may consider a patient appropriate for the CBR program and petition the court for this conditional release and placement. If the court approves conditional release, the matched provider arranges pickup of the patient and admits them into their community facility to begin treatment In FY 2021-22, 445 patients were conditionally released to CBR, and were subsequently admitted into community beds at an acute level of care, subacute level of care, or in an unsecured residential facility. Chart 10 below displays the ADC by month in the various levels of care.

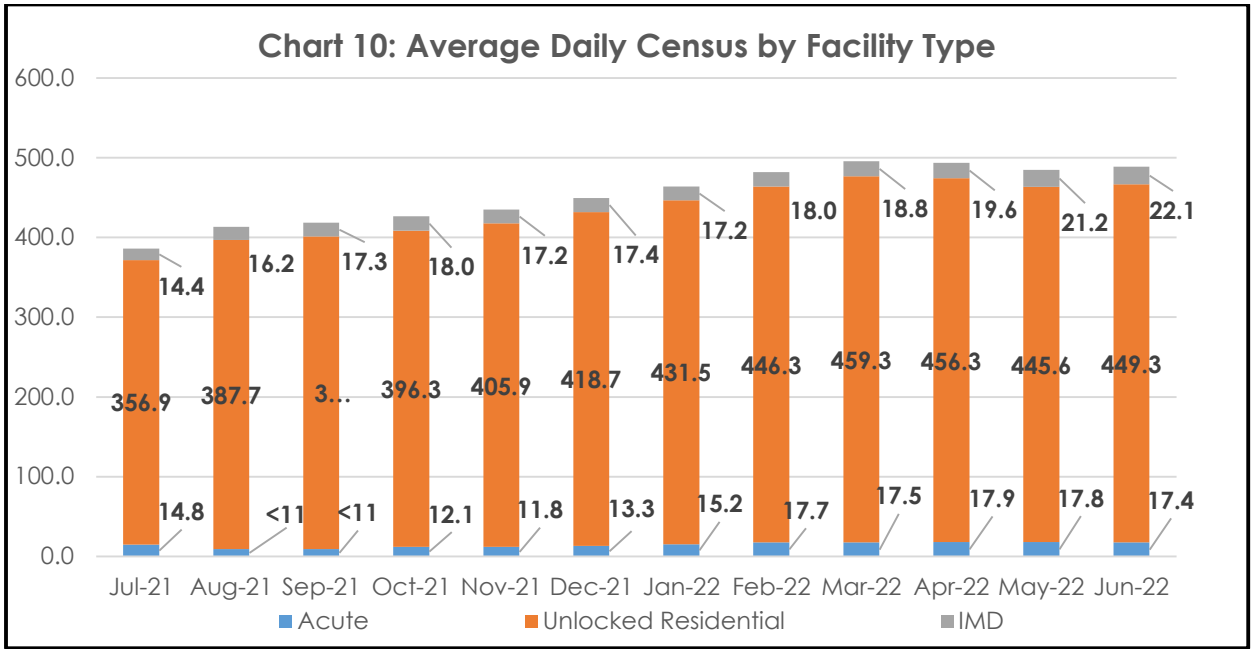


Chart 10. Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. Counts between 1-10 are masked with "<11".

In FY 2021-22, less than 11 patients were restored to competency with an average length of treatment of 177 days.

Without the CBR program, LA County patients who have received competency assessment, off-ramp petition (n = 55), or conditional release and admission to a community facility (n = 445), would continue as referrals to DSH and continue awaiting an available bed in a state hospital or JBCT.

POPULATION PROFILE
Lanterman-Petris-Short Patients

Description of Legal Class

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

Over the past five years, 87 percent of all LPS patients served in state hospitals were committed under WIC 5353 or 5358 as conservatees. During the same period, approximately 1 percent was committed under Penal Code (PC) 2974, and 15 percent were conserved under WIC 5008(h)(1)(B) (Murphy Conservatorship). The remaining LPS population within DSH was comprised of the other four legal statutes under the LPS Act.

The following are the various LPS commitments, and their corresponding citation in code:

PC 2974: Parolee from CDCR	Initiation of a LPS commitment to a state hospital for CDCR parolees. Such inmates must meet LPS criteria of being found to be dangerous to themselves or others, or gravely disabled. Because these patients are parolees, the cost is borne by CDCR and reimbursed to DSH on the same basis as the treatment cost of prison inmates under PC 2684.
WIC 5008(h)(1)(B): Murphy Conservatee	An IST defendant who is deemed gravely disabled and ordered to be held in a state hospital under a Murphy Conservatorship.
WIC 5304(a)	Post certification treatment authorized for 180 days in the event the individual attempted, inflicted, or made a serious threat of physical harm upon another after having been taken into custody, or within seven days of being taken into custody, or as part of the reason for being taken into custody.
WIC 5304(b)	Additional 180-day post certification (ADD) in the event that the individual has attempted, inflicted, or a made a serious threat of physical harm upon another during post certification treatment.

WIC 5353	Temporary conservatorship (T.Cons), in which an appointed temporary conservator may make arrangements, sometimes at a state hospital, to provide the individual with food, shelter, and care pending a conservatorship determination.
WIC 5358	Conservatorship (CONS), in which the appointed conservator places the conservatee in an appropriate facility, such as a state hospital, and can require treatment to remedy or prevent the recurrence of the conservatee's mental illness.
WIC 6000	Voluntary application to a state hospital for treatment and care made by a competent adult; they may leave at any time after notifying, or their conservator notifying in the case of conservatorships, hospital staff and following hospital discharge procedures (VOL)
WIC 4825, 6000(a)[1]	Admission to a state hospital of a developmentally disabled individual by their conservator; if competent, the individual may apply for and receive services at a regional center instead.
WIC 5150[1]	72-hour detention (DET) for assessment, evaluation, and crisis intervention with probable cause that a person is a danger to themselves or others, as a result of a mental health disorder.
WIC 5250[1]	14-day certification (CERT) following detainment pursuant to WIC 5150 (72-hour detention), WIC 5200 (court ordered for evaluation, Article 2), or WIC 5225 (court ordered for evaluation, Article 3). The individual must be offered treatment on a voluntary basis but has been unwilling or unable to accept the recommended treatment, and no family, friend, or other individual has submitted in writing their willingness to provide for the person's basic personal needs.
WIC 5260[1]	Additional 14-day certification for suicidal persons who demonstrated this behavior via threats or attempts during the previous 14-day period or 72-hour evaluation period (SUIC)
WIC 5270.15[1]	30-day certification (A-Cert) upon completion of a 14-day certification pursuant to WIC 5250 in the event that the individual remains gravely disabled or is unwilling or unable to voluntarily accept treatment. A certification review hearing is conducted to determine suitability of commitment.
WIC 5303[1]	Pending court decision on 180-day post certification (PCD), the conservatee remains at the treatment facility until released by court or in the event the petition is withdrawn.
WIC 6500, 6509[1]	A person with a developmental disability committed to a state hospital if found to be a danger to themselves or others; this commitment expires after one year pursuant to WIC 6500(b)(1)(A).
WIC 6506[1]	A temporary hold for an individual with a developmental disability while awaiting a hearing pursuant to WIC 6503.
WIC 6552[1]	Voluntary application as Juvenile court ward to be treated for a mental disorder at a state hospital (VJCW)

[1]During Fiscal Year (FY) 2021-22, this population was not served in the state hospitals.

Legal Requirements/Legal Statue for Discharge

LPS conservatorships have not been charged with a crime but are instead referred by local community mental health programs through involuntary civil commitment procedures pursuant to the LPS Act. Those whose psychiatric conditions require a higher level of care and cannot be treated in locked facilities or board and care homes are sent to DSH for treatment. A patient's LPS conservatorship lasts for one year and can be renewed by the court on an annual basis. A new petition for renewal is filed with the court prior to the current conservatorship's expiration. LPS patients are discharged from DSH when (1) their county of residence places them in a different facility, (2) their county of residence places them in independent living or with family, or (3) they have successfully petitioned the court to remove the conservatorship.

Treatment

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

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

Population Data

LPS Population data in Charts 1 through 5 below displays DSH LPS population including Murphy Conservatorship. A subset of Murphy Conservatorship data can be found on page 6. In Fiscal Year (FY) 2021-22, 105 LPS patients were referred to the state hospitals, a 7 percent decrease from FY 2020-21.

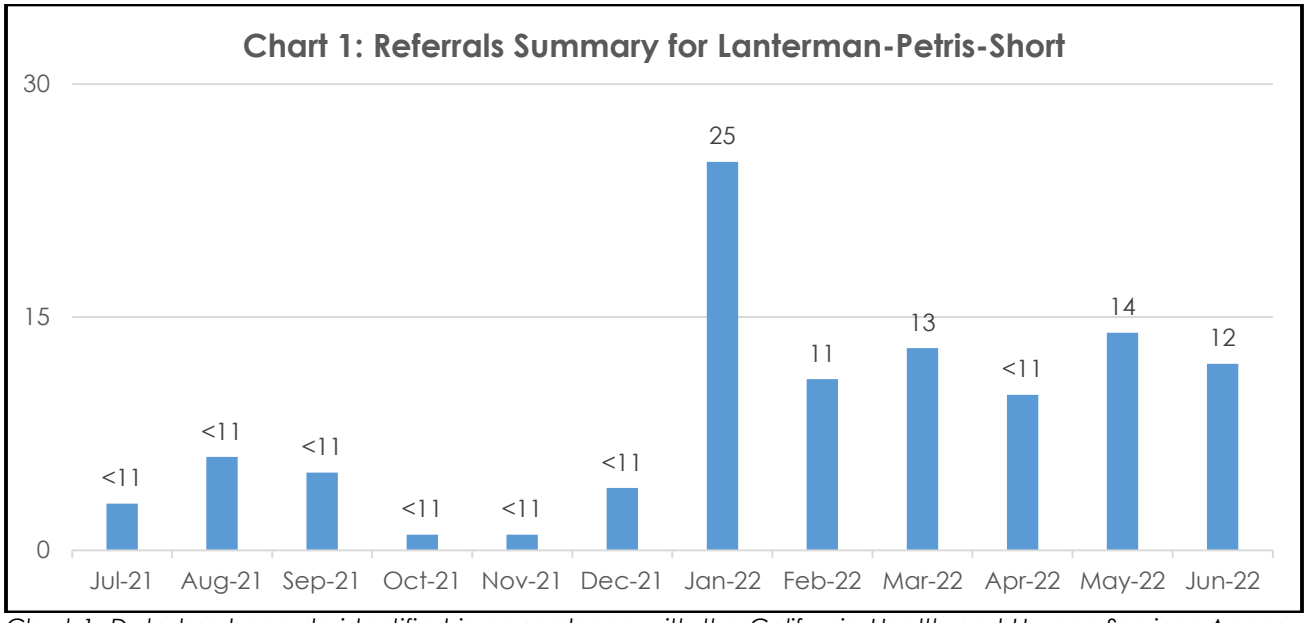


Chart 1. Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. Counts between 1-10 are masked with "<11".

Over the course of FY 2021-22, 23 LPS patients were admitted into a state hospital. Chart 2 displays the referrals, admissions, and total patients served for the LPS population in FY 2020-21 and FY 2021-22

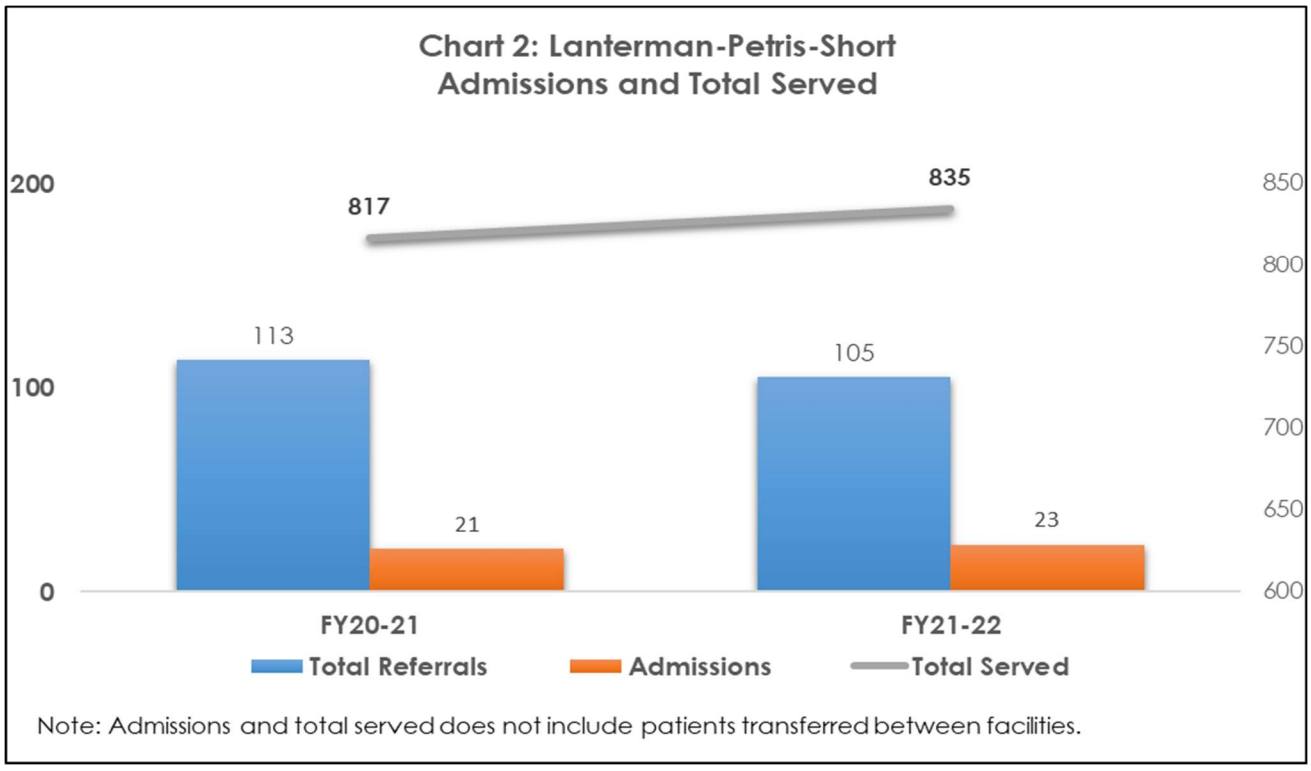
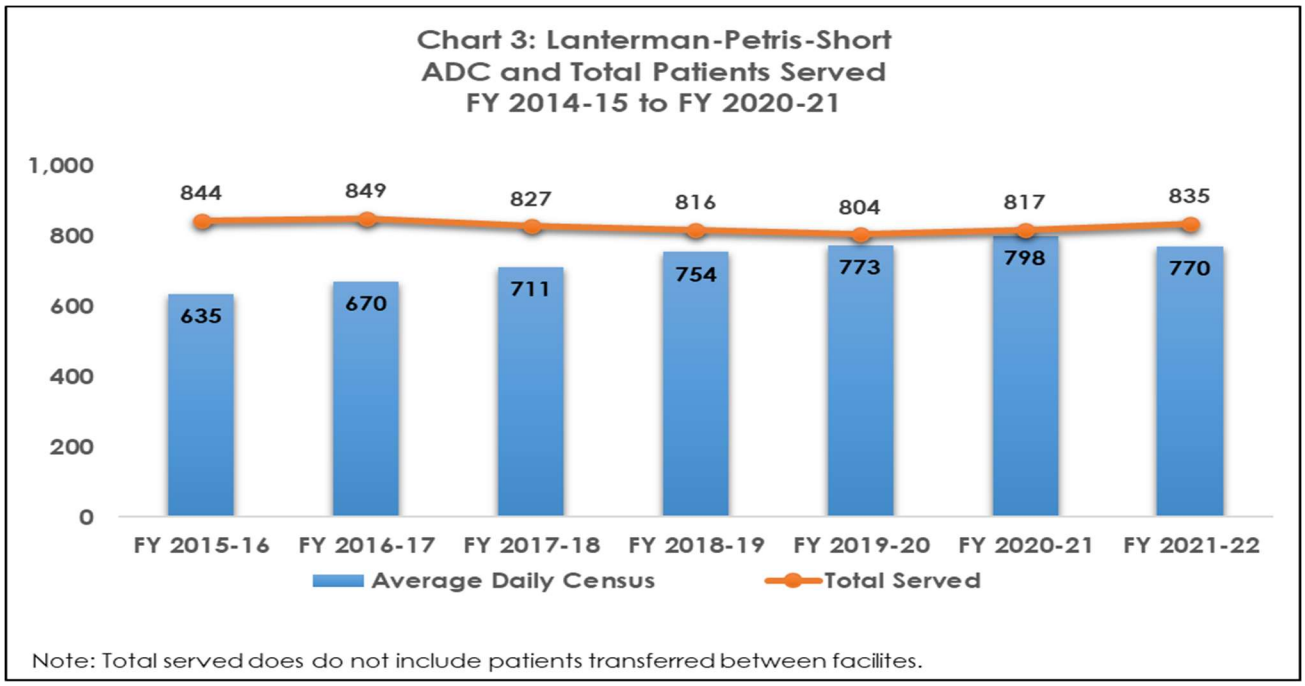
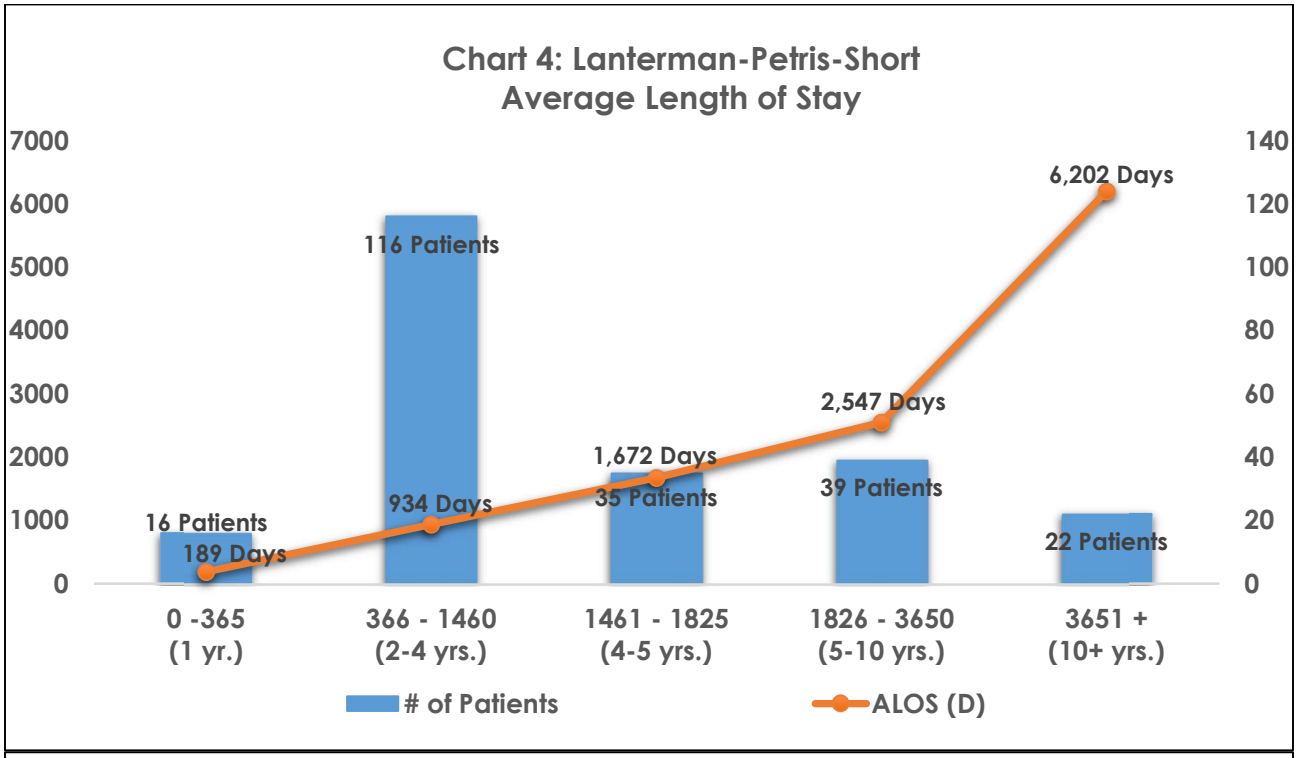
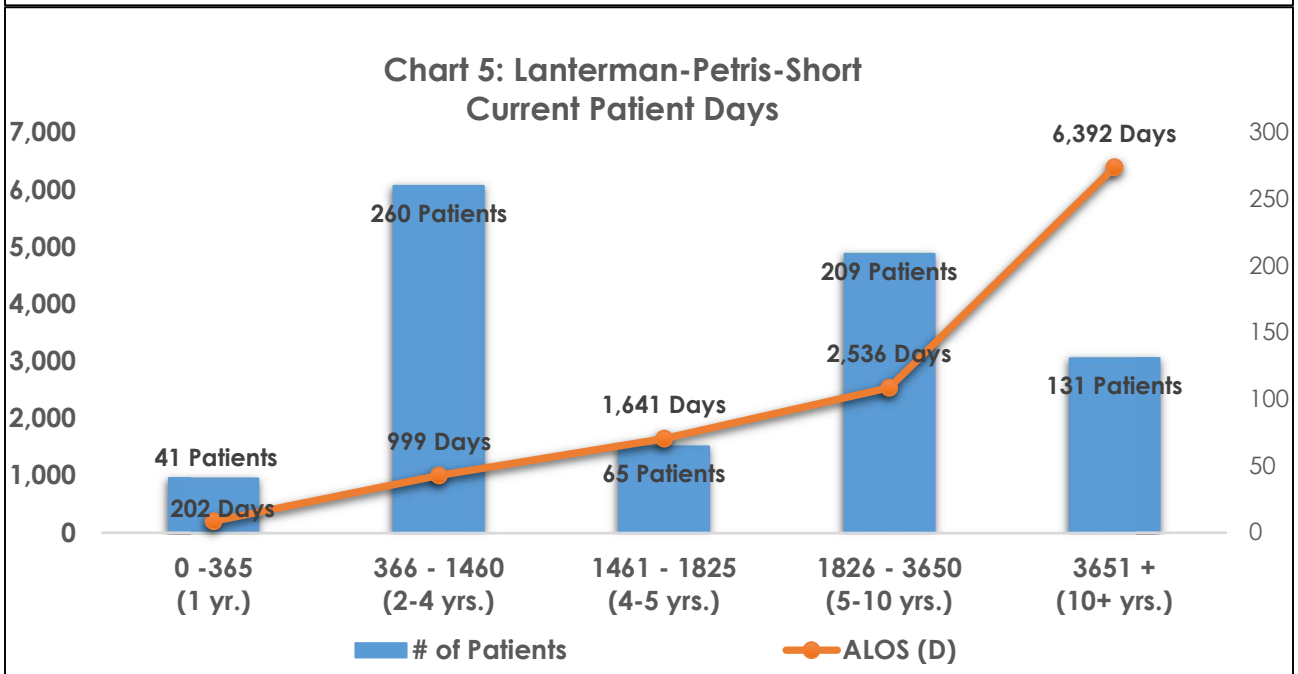


Chart 3 below displays the average daily census (ADC) and total number of patients served for the LPS population during FY 2015-16 to FY 2021-22. On average, 770 LPS patients are treated daily in the state hospitals, representing 13 percent of the overall patient population. As of June 30, 2022, the system wide LPS census was 706.



In FY 2021-22, 228 LPS patients were discharged with an average length of stay of 4.9 years. Chart 4 below displays the distribution of lengths of stay for all discharged LPS patients, and Chart 5 displays the distribution of patient days for those LPS patients who remain residents on unit as of June 30, 2022.





Note: Current patient days is, as of a particular point in time, the number of days residents-on-unit have spent in the state hospital, including leave.

Murphy Conservatorships

Murphy conservatorships (MURCON) are patients that have been previously found to be IST, and at the end of the IST commitment period the patient has been retained for further treatment if all of the following exist: (1) the patient is subject to a pending

indictment or information charging the individual with a felony involving death, great bodily harm, or threat to the physical well-being of another; (2) as a result of a mental disorder, the patient continues to be unable to understand or meaningfully participate in the pending criminal proceedings; (3) the patient has been found incompetent pursuant to PC section 1370; and (4) the patient is currently dangerous as the result of a mental disorder, defect or disorder. The conservatorship lasts for one year, just like any other LPS conservatorship and can be extended indefinitely if a new conservatorship is obtained each year. MURCON patients also have the right to a yearly court review and/or jury trial to petition the court to remove the conservatorship.

Over the course of FY 2021-22, less than 11 Murphy Conservatorship patients were admitted into a state hospital. Chart 6 displays the admissions and total served distribution by state hospital for the LPS Murphy Conservatorship population in FY 2020-21 and FY 2021-22.

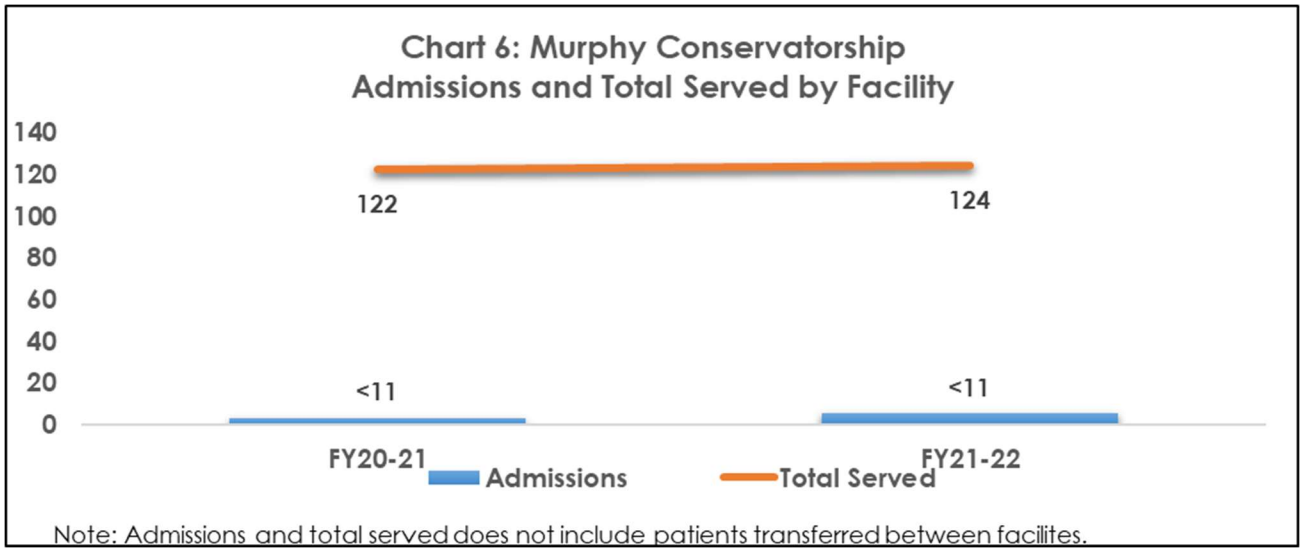
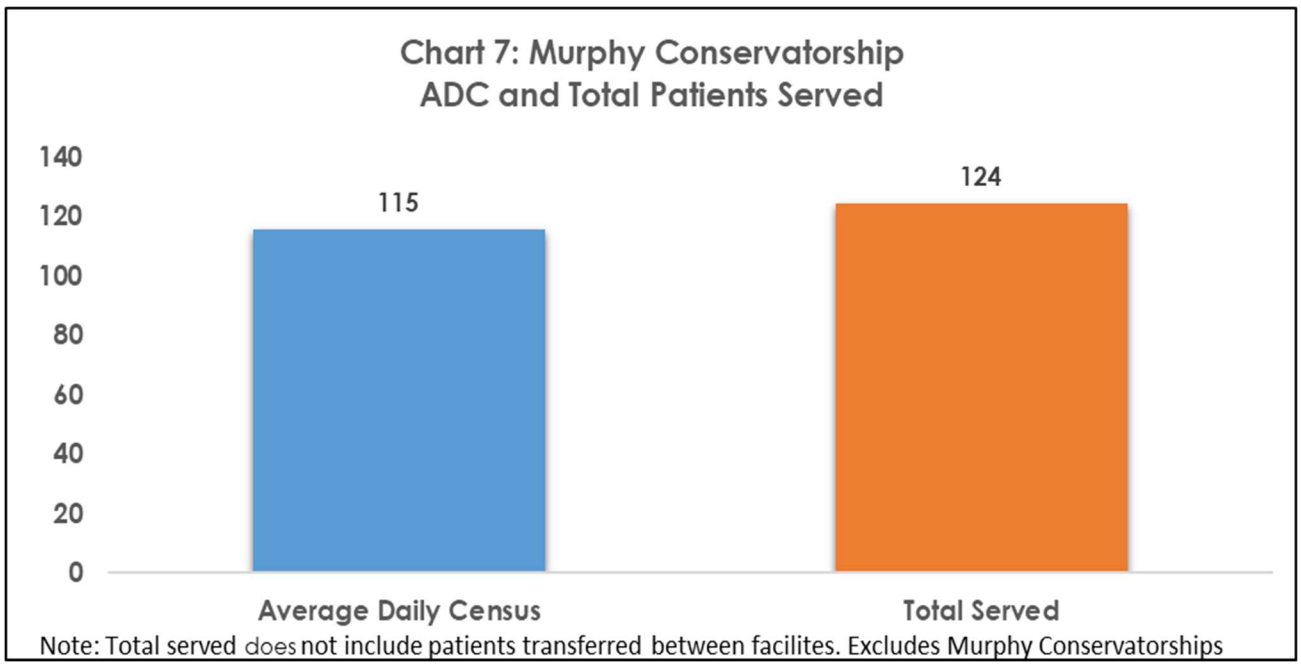


Chart 6. Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. Counts between 1-10 are masked with "<11".

On average, 115 Murphy Conservatorship patients are treated daily in the state hospitals, representing 2 percent of the overall patient population in FY 2021-22. Chart 7 displays the average daily census (ADC) and total number of patients served for the MURCON population in FY 2021-22. As of June 30, 2022, the system wide MURCON census was 113.



In FY 2021-22, 11 MURCON patients were discharged with an average length of stay of 6.7 years. Chart 8 displays the distribution of lengths of stay for all discharged MURCON patients.

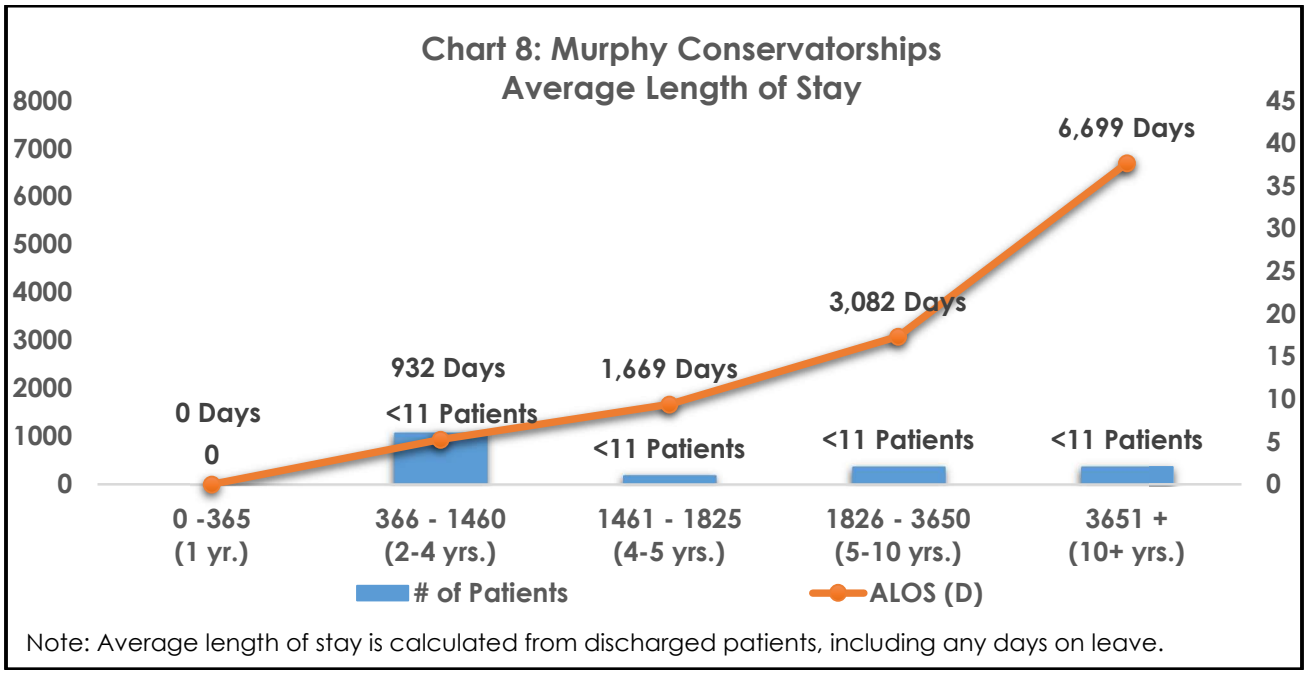
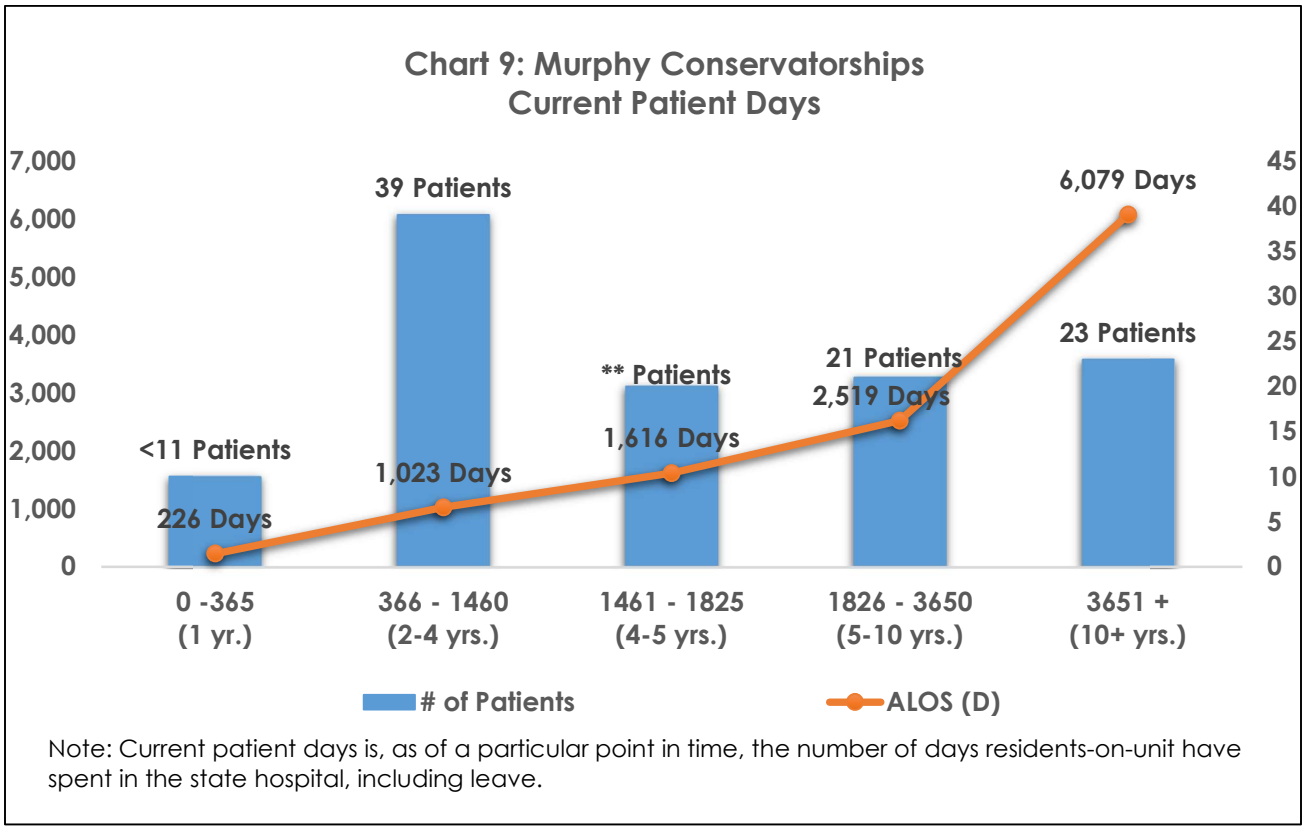


Chart 8. Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. Counts between 1-10 are masked with "<11".

Chart 9 displays the distribution of patient days for those MURCON patients who remain residents on unit as of June 30, 2022.



Note: Current patient days is, as of a particular point in time, the number of days residents-on-unit have spent in the state hospital, including leave.

Chart 9. Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. Counts between 1-10 are masked with "<11".

POPULATION PROFILE
Not Guilty by Reason of Insanity Patients

Description of Legal Class:

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

The following are the various NGI commitments, and their corresponding citation in code:

PC 1026	Not Guilty by Reason of Insanity
PC 1026.5 (extension)	Prior to the expiration of the current maximum term of commitment, PC 1026.5 allows the medical director to recommend to the prosecuting attorney an extension of the maximum term for a patient under Not Guilty by Reason of Insanity. This extension is valid for an additional two years; additional extensions subsequent to the initial extension may be requested in the same manner pursuant to PC 1026.5.
PC 1610	Temporary admission while waiting for court revocation of a PC 1026 (RONGI)
WIC 702.3	Minor Not Guilty by Reason of Insanity (MNGI)

Legal Requirements/Legal Statue for Discharge:

Restoration of sanity is a two-step process in which evidence is presented and reviewed that would determine a patient is a danger to the health and safety of others, due to his or her mental illness, if released under supervision and treatment in the community. The two-step process requires (1) an outpatient placement hearing and (2) a restoration hearing following a year in outpatient care. During the first step of the process the court must find that the patient is no longer a danger to the health and safety of others, due to his or her illness, if released under supervision and treatment in the community. During the second step of the process, the court must determine whether the patient has been fully restored to sanity. The court's finding of restoration will result in the patient's unconditional release from supervision. A

patient may bypass the mandatory one-year of outpatient commitment and have an early restoration hearing in the event the conditional release program director recommends an early release.

Treatment:

Because NGI patients tend to be severely mentally ill and their crimes involve severe violence, treatment requires substantial time resources. The treatment team must demonstrate to the court that the NGI patient has achieved long-term stabilization and no longer poses a danger due to their mental illness. Thus, the patient needs to demonstrate long-term symptom stability, long-term adherence to psychiatric treatments, and an understanding of the factors that exacerbate their mental illness. Each NGI patient's progress in treatment is evaluated and submitted to the court via an annual report completed by the DSH treatment team and medical director of the state hospital. If the maximum term approaches and the treatment team does not feel discharge would be appropriate, the hospital can pursue an extension of the NGI sentence to extend the stay of the individual, pursuant to Penal Code (PC) 1026.5. In Fiscal Year (FY) 2021-22, 404 patients were served at the state hospitals under this extension option.

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

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

Population Data:

In FY 2021-22, 96 NGI patients were committed to the state hospitals, a 23 percent increase from FY 2020-21. Chart 1 below depicts the monthly referrals of NGI patients to DSH.

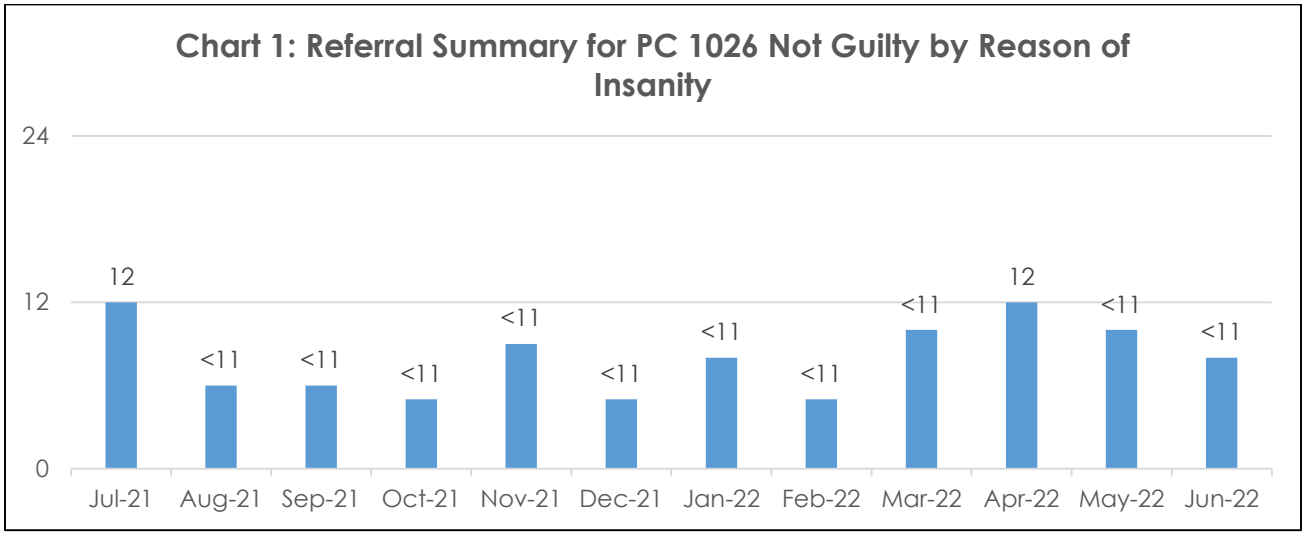
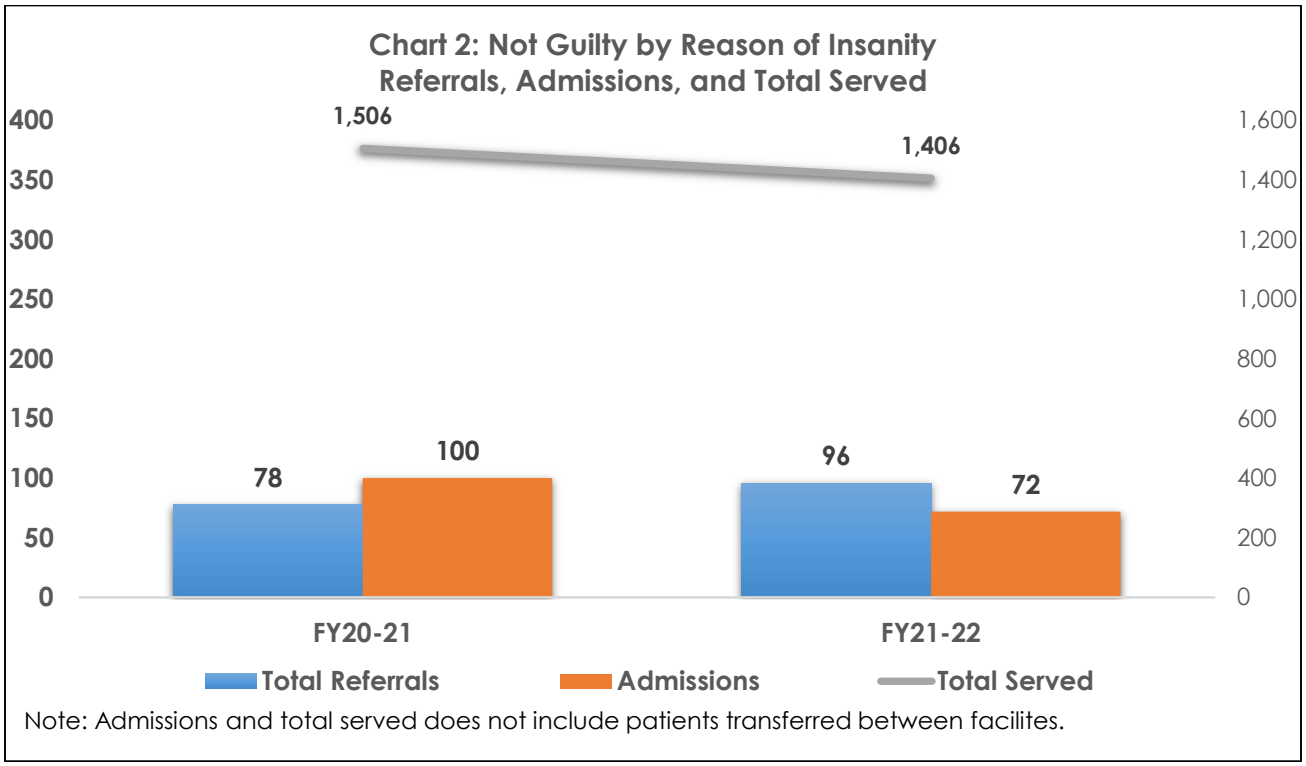


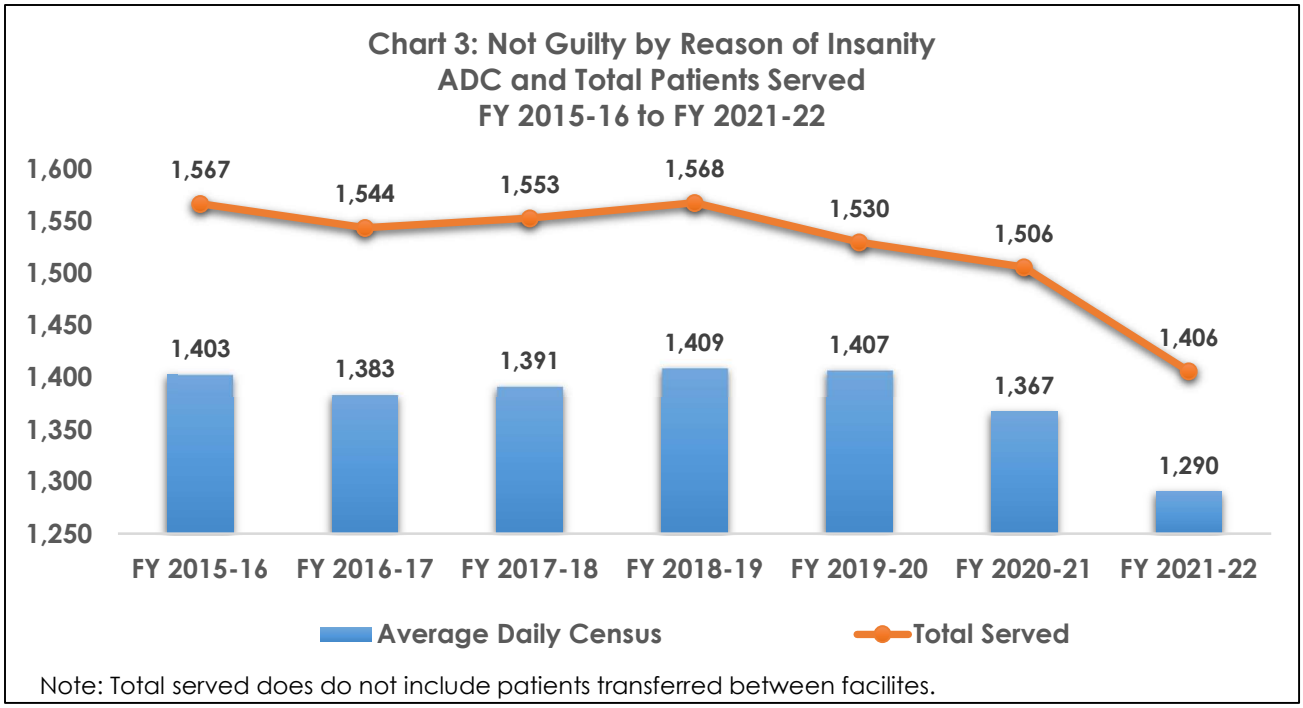
Chart 1. Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. Counts between 1-10 are masked with "<11".

Over the course of FY 2021-22, 72 NGI patients were admitted into a state hospital which is a decrease of 28 percent from the prior year. Chart 2 below displays the referrals, admissions and total patients served for the NGI population for FY 2020-21 and FY 2021-22.



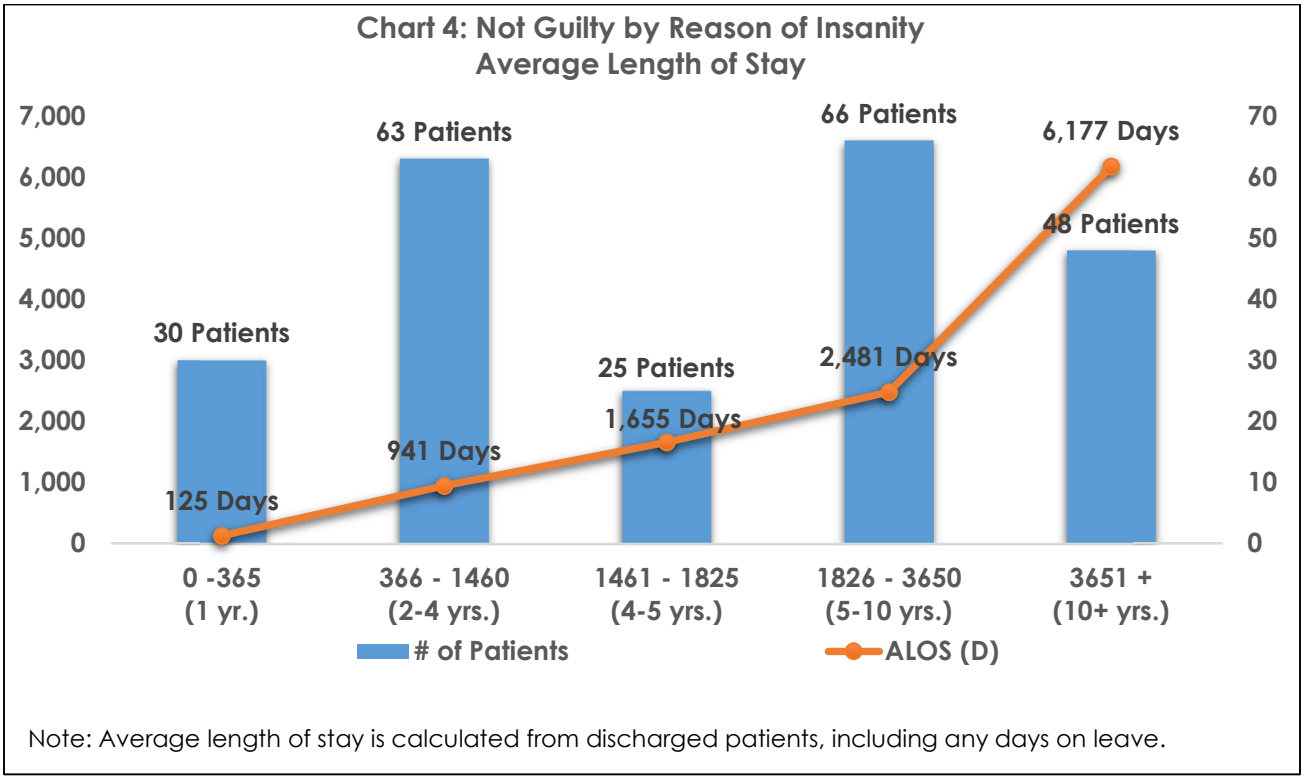
Note: Admissions and total served does not include patients transferred between facilites.

Chart 3 below displays the average daily census (ADC) and total number of patients served for the NGI population during FY 2015-16 to FY 2021-22. On average, 1,290 NGI patients are treated daily in the state hospitals, representing 22 percent of the overall patient population. As admissions directly correlate to patients served, DSH served 7 percent less patients in FY 2021-22 than in the prior year. As of June 30, 2022, the system-wide NGI census was 1,247 patients.



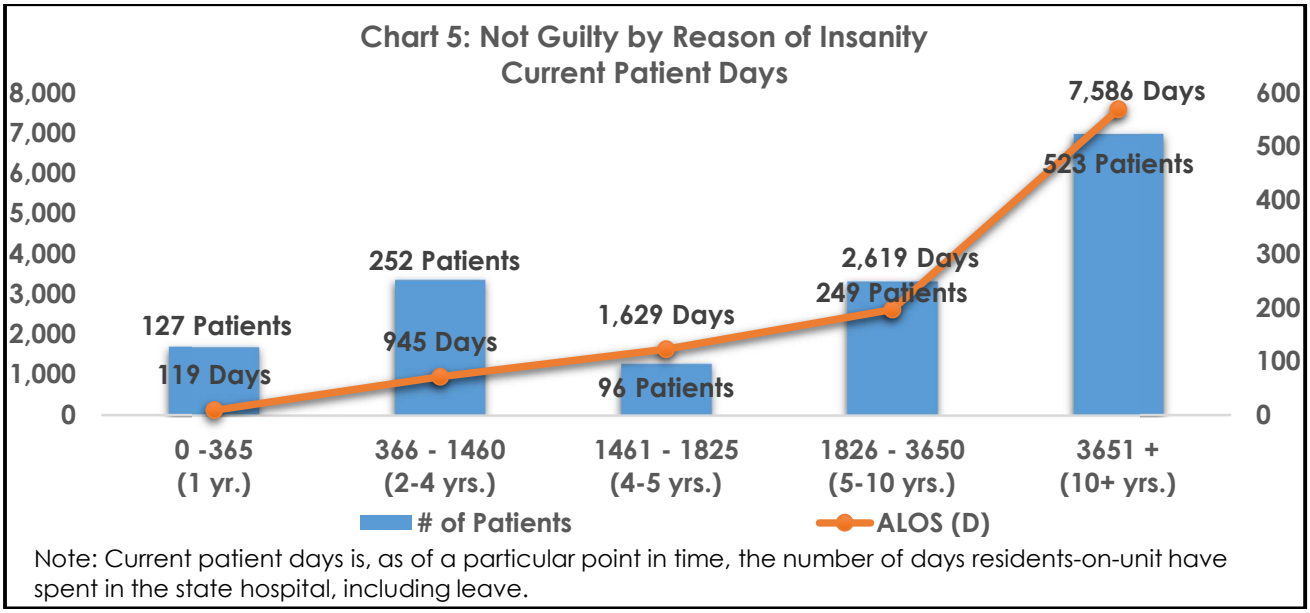
Note: Total served does do not include patients transferred between facilites.

In FY 2021-22, 232 NGI patients were discharged with an average length of stay of 6.7 years. Chart 4 below displays the distribution of lengths of stay for all discharged NGI patients.



Note: Average length of stay is calculated from discharged patients, including any days on leave.

A number of NGI patients remain with DSH for lengthy periods as a result of the various maximum sentences that could have been imposed, and the seriousness of their mental illness and dangerousness. On average, the 1,247 NGI patients who continue to reside at DSH as of June 30, 2022 have been there for 4,033 days, or 11 years. These days will continue to accrue until the individual NGI patients have been discharged. Chart 5 below displays the distribution of patient days for all NGI residents on unit as of June 30, 2022.



Note: Current patient days is, as of a particular point in time, the number of days residents-on-unit have spent in the state hospital, including leave.

POPULATION PROFILE
Offenders with a Mental Health Disorder

Description of Legal Class:

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

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

The following are the various OMD commitments, and their corresponding citation in code:

PC 2962	Parolee referred from the California Department of Corrections and Rehabilitation.
PC 2964(a): OMD admission from outpatient	Outpatient OMD placed in secure mental health facility (usually a state hospital) following determination by community program director that the individual can no longer be safely or effectively treated as an outpatient. DSH is then required to conduct a hearing within 15 days. This usually results in return to inpatient OMD status.
PC 2972	If an OMD still requires treatment at the end of the parole term, the patient can be civilly committed under PC 2972. This commitment must be filed by the district attorney (DA) and must show that the individual has a severe mental disorder that is not in remission and that, due to this mental disorder, the individual is a substantial danger to others. Civil OMD commitments last for one year, upon which they must be renewed by the DA. After an individual is committed, they are treated by DSH until they are either able to be placed in outpatient treatment, conserved, or successful in petitioning for their release.
PC 1610	RO 2972: Temporary admission while waiting for court revocation of PC 2972. ROMDSO: Temporary admission while waiting for court revocation of MDSO.
WIC 6316: MDSO	Former statute, now repealed, under which a person convicted of a sex offense could be ordered by the court to receive mental health treatment. The treatment and extension processes are similar for PC 1026. A few MDSO patients remain in the state hospitals.

Legal Requirements/Legal Statue for Discharge:

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

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

Treatment:

OMD patients have unique needs and challenges. Because their crimes involve violence, many have spent years in prison and need specialized psychosocial treatments to aid in their reintegration back into society. Due to the seriousness and long-term nature of their mental illness, as well as a history of violent crime, these patients require extra assessments and treatment to guide their mental illness treatments and treatment of violence risk.

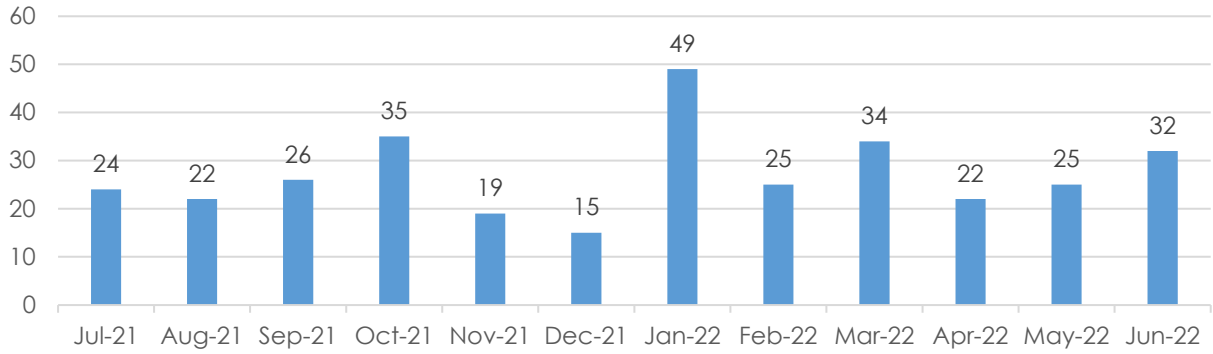
The focus of treatment for the OMD population involves helping patients increase their ability to safely and effectively manage symptoms associated with their mental illness and prepare them for eventual transfer to the CONREP. Another area of focus is substance abuse treatment since a history of substance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

Population Data:

PC 2962/2964a Offenders with a Mental Health Disorder (OMD)

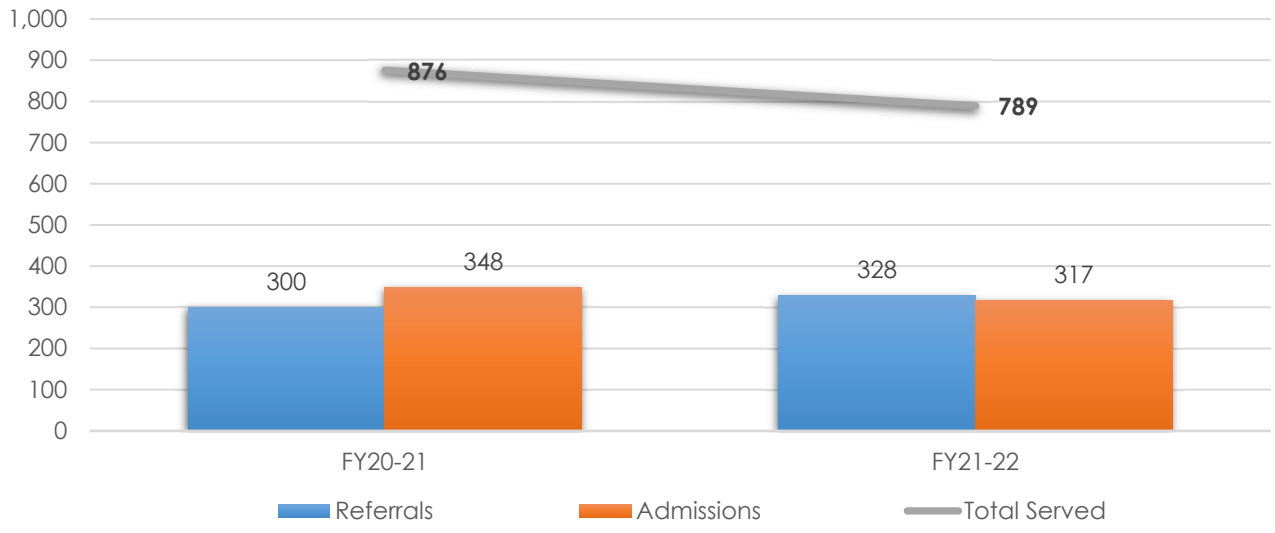
In fiscal year (FY) 2021-22, 328 PC 2962/2964a OMD patients were committed to the state hospitals, a 9 percent increase from FY 2020-21.

Chart 1: Referrals Summary for PC 2962/2964a Offenders with a Mental Health Disorder



Over the course of FY 2021-22, 317 PC 2962/2964a OMD patients were admitted into a state hospital. Chart 2 below displays the referrals, admissions and total patients served for the PC 2962/2964a OMD population in FY 2021-22.

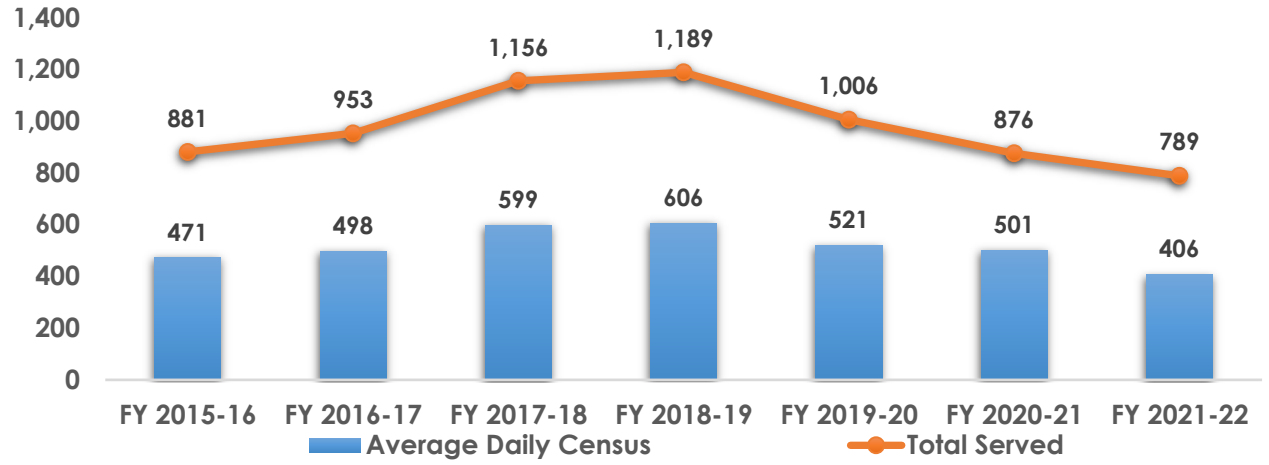
Chart 2: PC 2962/2964a Offenders with a Mental Health Disorder Admissions and Total Served



Note: Admissions and total served does not include patients transferred between facilites.

Chart 3 below displays the average daily census (ADC) and total number of patients served for the PC 2962/2964a OMD population during FY 2015-16 to FY 2021-22. On average, 406 PC 2962/2964a OMD patients are treated daily in the state hospitals, representing 7 percent of the overall patient population. As of June 30, 2022, the system-wide PC 2962/2964a OMD census was 388 patients.

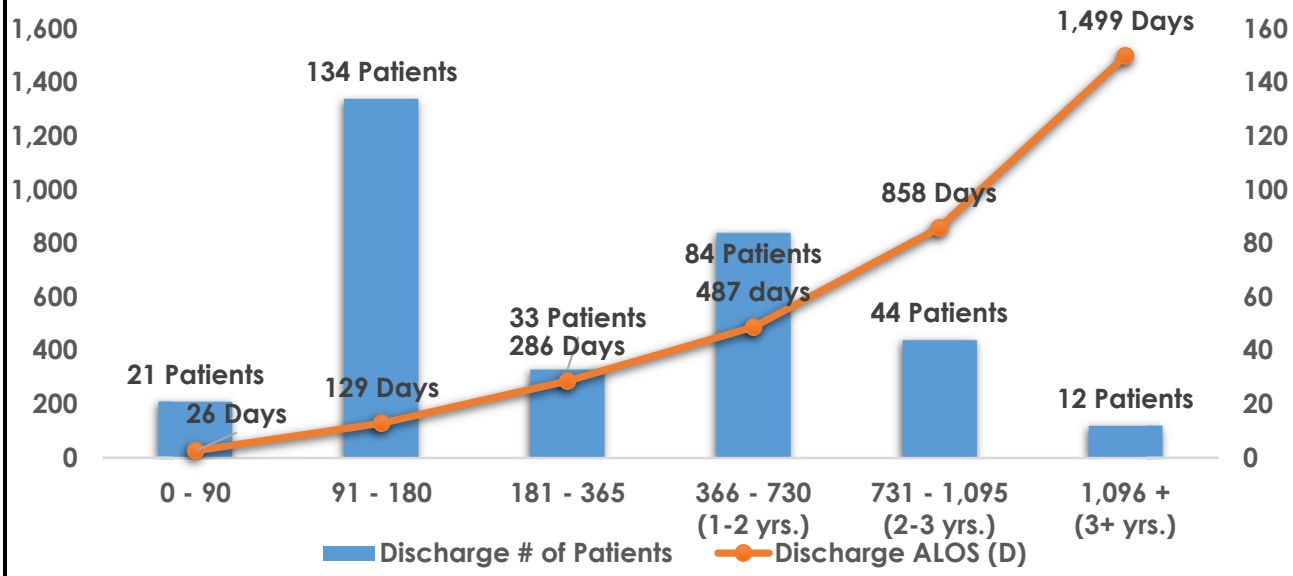
Chart 3: PC 2962/2964a Offenders with a Mental Health Disorder ADC and Total Served FY 2015-16 to FY 2021-22



Note: Total served does do not include patients transferred between facilites.

Chart 4 below displays the distribution of lengths of stay for all discharged PC 2962/2964a OMD patients. In FY 2021-22, 328 PC 2962/2964a OMD patients were discharged with an average length of stay of 437 days, a little more than 1 year.

Chart 4: PC2962/2964a Offenders with a Mental Health Disorder Average Length of Stay

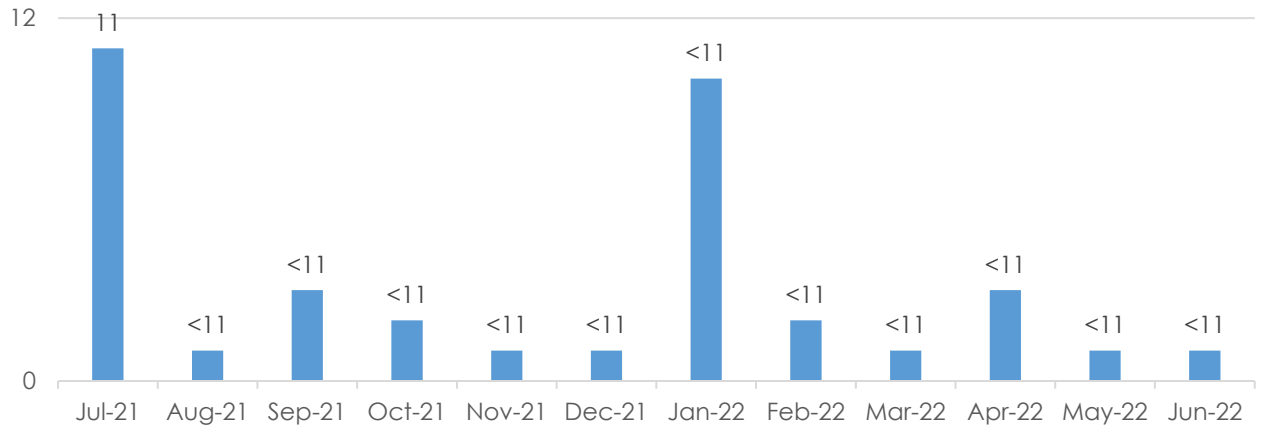


Note: Average length of stay is calculated from discharged patients, including any days on leave.

PC 2972 Offenders with a Mental Health Disorder (OMD)

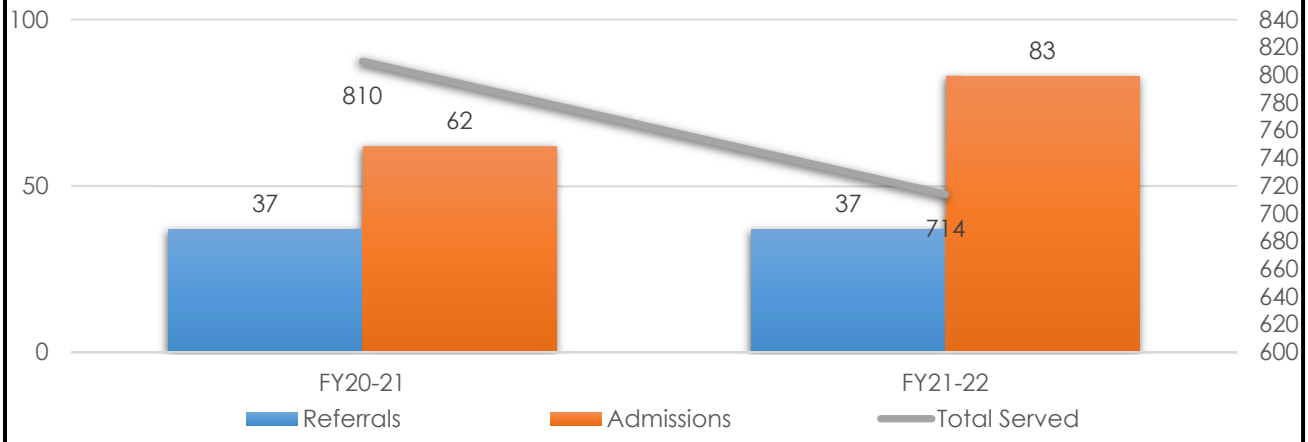
In FY 2021-22, 37 PC 2972 OMD patients were committed to the state hospital, a zero percent increase from FY 2020-21.

Chart 5: Referrals Summary for PC 2972 Offenders with a Mental Health Disorder



Over the course of FY 2021-22, 83 PC 2972 OMD patients were admitted, including transfer admissions, to a state hospital. Chart 6 below displays the referrals, admissions and total patient served for the PC 2972 OMD population in FY 2021-22.

Chart 6: PC 2972 Offenders with a Mental Health Disorder Admissions and Total Served

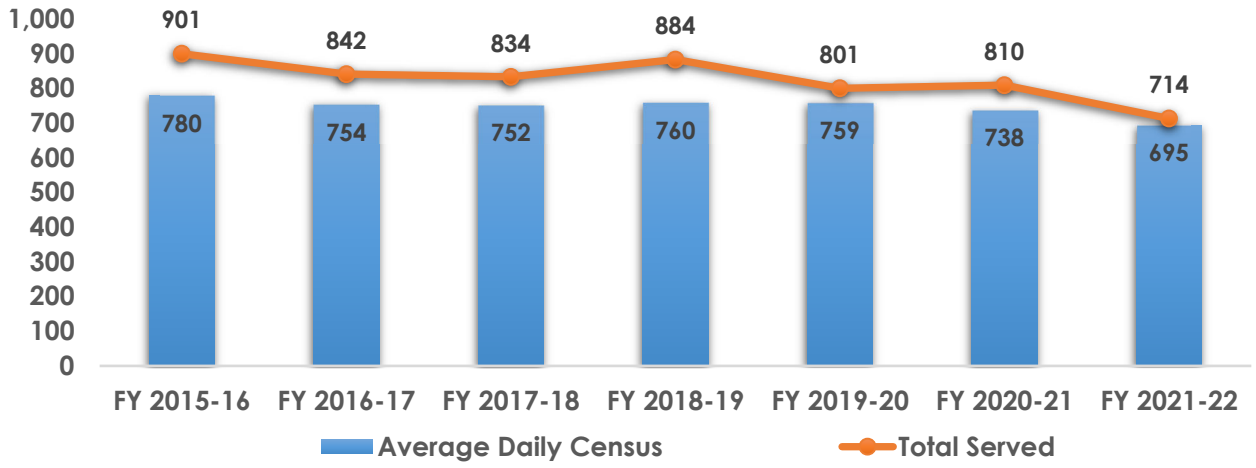


Note: Admissions and total served does include patients transferred between facilites.

Chart 7 displays the ADC and total number of patients served for the PC 2972 OMD population during FY 2015-16 to FY 2021-22. On average, 695 PC 2972 OMD patients are treated daily in the state hospitals, representing 12 percent of the overall patient

population. As of June 30, 2022, the system-wide PC 2972 OMD census was 674 patients.

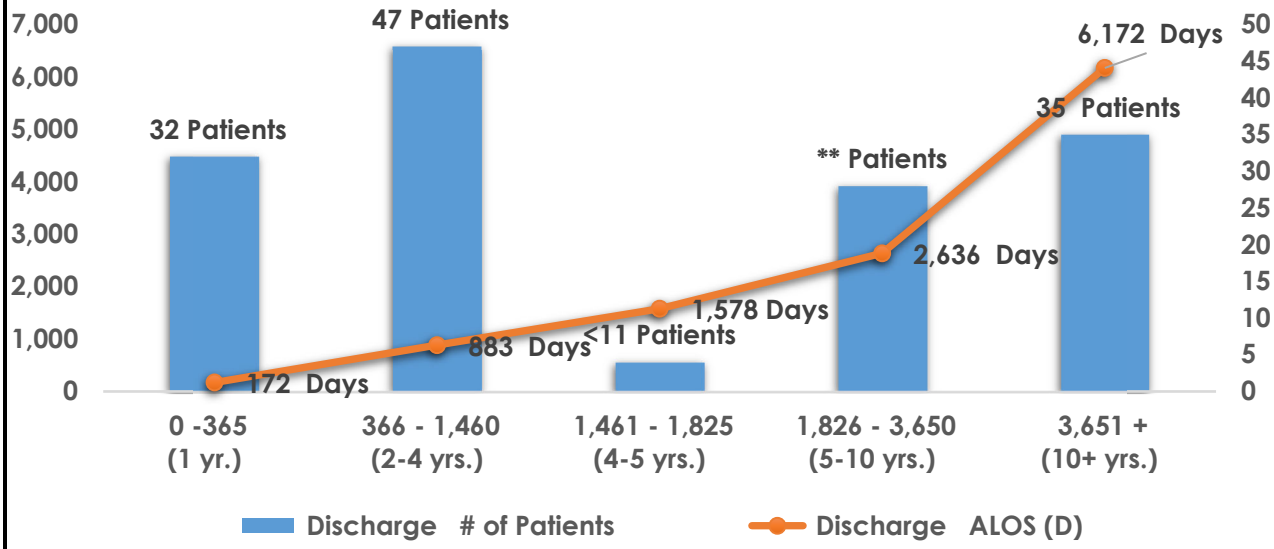
Chart 7: PC 2972 Offenders with a Mental Health Disorder ADC and Total Served FY 2015-16 to FY 2021-22



Note: Total served does include patients transferred between facilites.

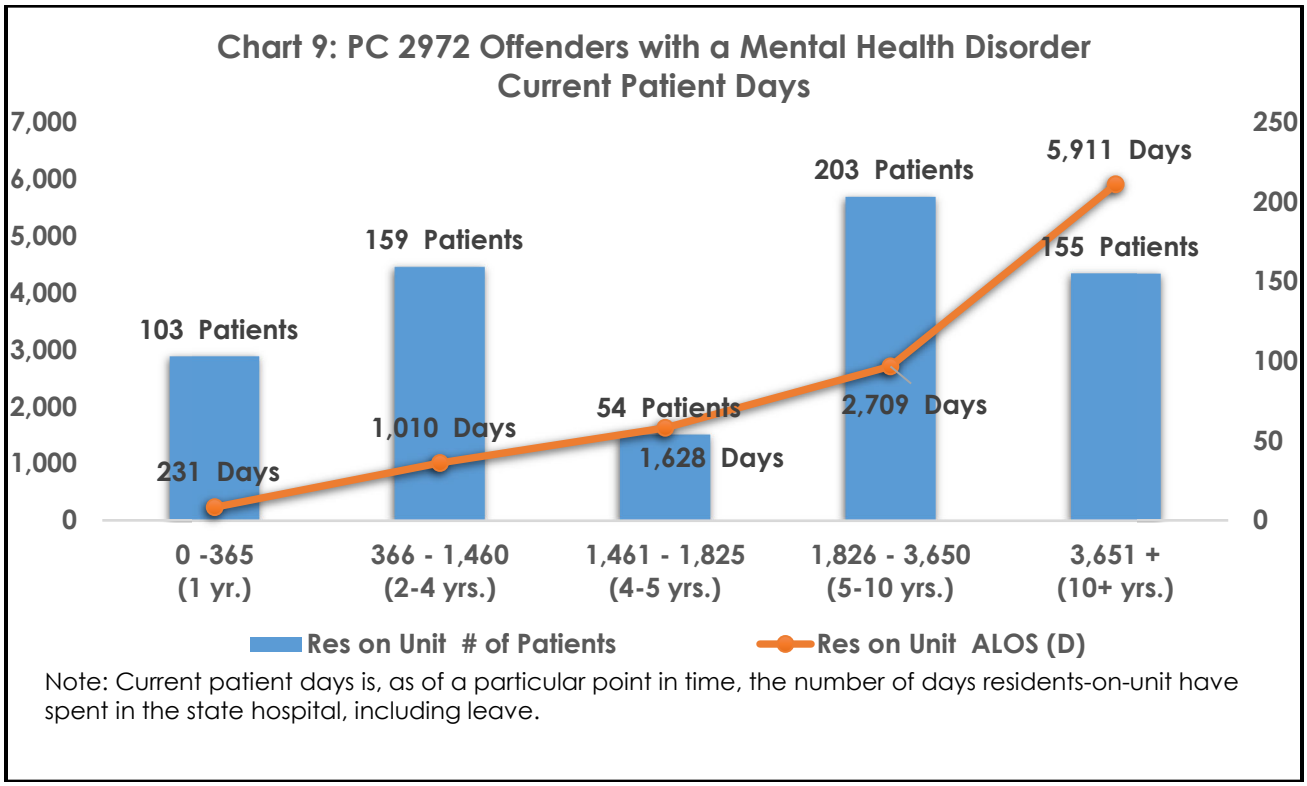
In FY 2021-22, 146 PC 2972 OMD patients were discharged with an average length of stay of 6 years. Chart 8 below displays the distribution of lengths of stay for all discharged PC 2972 OMD patients.

Chart 8: PC 2972 Offenders with a Mental Health Disorder Average Length of Stay



Note: Average length of stay is calculated from discharged patients, including any days on leave.

Chart 9 below displays the distribution of patient days for all PC 2972 OMD residents on unit as of June 30, 2022. On average, the 674 PC 2972 OMD patients who continue to reside at DSH as of June 30, 2022, have been there for 2,579 days or a little over 7 years; these days will continue to accrue until the individual PC 2972 OMD patients have been discharged.



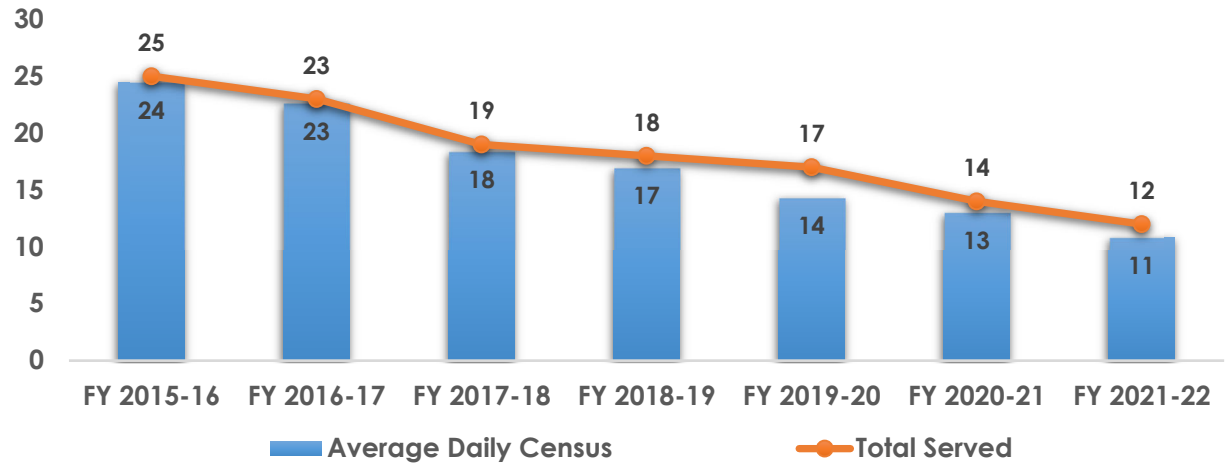
Note: Current patient days is, as of a particular point in time, the number of days residents-on-unit have spent in the state hospital, including leave.

WIC 6316 Mentally Disordered Sex Offender (MDSO) Patients

The entirety of WIC 6300, and therefore the accompanying legal class WIC 6316, was repealed by the Statutes and Amendments to the Codes 1981 (c. 928, p. 3485, § 2). Subsequently, there have since been no new commitments under this legal classification at DSH.

Chart 10 below displays the ADC and total number of patients served for the WIC 6316 MDSO population during FY 2015-16 to FY 2021-22. On average, 11 WIC 6316 MDSO patients are treated daily in the state hospitals, representing 0.2 percent of the overall patient population. As of June 30, 2022, the system-wide WIC 6316 MDSO census was less than 11 patients.

Chart 10: WIC 6316 Offenders with a Mental Health Disorder ADC and Total Served FY 2015-16 to FY 2021-22



Note: Total served does do not include patients transferred between facilites.

In FY 2021-22, WIC 6316 MDSO patients that discharged had an average length of stay of over 2 years. For the 10 WIC 6316 MDSO patients who continue to reside at DSH, they have been there for 3,777 days, or a little over 10 years. These days will continue to accrue until the individual WIC 6316 MDSO patients have been discharged.

POPULATION PROFILE
Sexually Violent Predator Patients

Description of Legal Class

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

SVP patients are evaluated by DSH and the California Department of Corrections and Rehabilitation (CDCR) as to whether an individual meets the criteria of an SVP after completion of their prison term. Before leaving CDCR, SVPs are committed to DSH pending further hearings for probable cause (WIC 6602). A commitment trial is held and, if adjudged to be an SVP, the individual is committed to a state hospital for an indeterminate period of time (WIC 6604).

The following are the various SVP commitments, and their corresponding citation in code:

WIC 6602	An individual who has been identified as likely to engage in sexually violent predatory criminal behavior upon release and will remain in custody until the completion of the probable cause hearing. If the judge determines probable cause exists, the individual will remain in a secured facility until a trial for the determination of WIC 6604 is completed.
WIC 6604	An individual who has been deemed a Sexually Violent Predator by a court or jury pursuant to proceedings as defined by WIC 6602 and committed to the Department of State Hospitals for treatment and confinement of an indeterminate term.
WIC 6601.3[1]	Authorizes the Board of Prison Terms to impose a temporary 45-day hold on CDCR inmates where there is probable cause that the inmate may be an SVP
PC 1610	Temporary admission while waiting for court revocation of Sexually Violent Predator commitment

[1]During Fiscal Year (FY) 2020-21, this population was not served in the state hospitals.

Legal Requirements/Legal Statue for Discharge:

Once a court determines a patient meets the criteria for an SVP commitment, these patients undergo an annual review process where the patient's SVP status is evaluated. At that point, DSH may decide that the patient is ready to be released

into the community on a conditional release basis. A patient may have a hearing to determine whether they should be released from the hospital under conditional release to the community or unconditional release to the community without supervision.

If the court agrees that the patient no longer meets the SVP criteria and will not pose a public safety threat if conditionally released into a supervised program, it will order the patient be conditionally released. If the patient is conditionally released, DSH's Forensic Conditional Release Program (CONREP) takes over the monitoring and supervision of the patient. Alternatively, the court may decide that the patient is ready for unconditional release; if a patient is placed on unconditional release a CDCR parole agent takes over the monitoring and supervision of that individual.

Treatment

Because their crimes typically involve severe sexual violence and many have mental disorders that are not amenable to standard medication treatments, treatment for SVP patients typically requires substantial time resources. Because of the risk to the community, if an SVP patient was not treated effectively, psychosocial treatments, relapse prevention/wellness, and recovery action planning are emphasized and reinforced across all clinical disciplines and treatment modalities.

To assess dangerousness and develop effective treatments to reduce violence risk, specialized violence risk assessments must be conducted to both guide treatment and measure progress in treatment.

DSH must submit an annual report to the court of the SVP patient's mental condition, a review of whether they still meet the SVP criteria, whether conditional release to a less restrictive environment or unrestricted discharge would be in the best interest of the individual, and whether conditions could be imposed upon release that would adequately protect the community. If the state hospital provides the court with the opinion that the individual no longer meets SVP criteria, or that the individual can be treated in a less restrictive setting, a court hearing is held. SVP patients can also petition for a hearing.

Before being recommended for release, the SVP patient must demonstrate long-term stability and adherence to treatments, as well as demonstrate an understanding of their sexual violence risk factors and patterns of thinking that relates to their criminal activity patterns. Furthermore, the SVP patient must be able to demonstrate that they would take preventive actions to avoid or mitigate any factors that would increase their sexual violence risk.

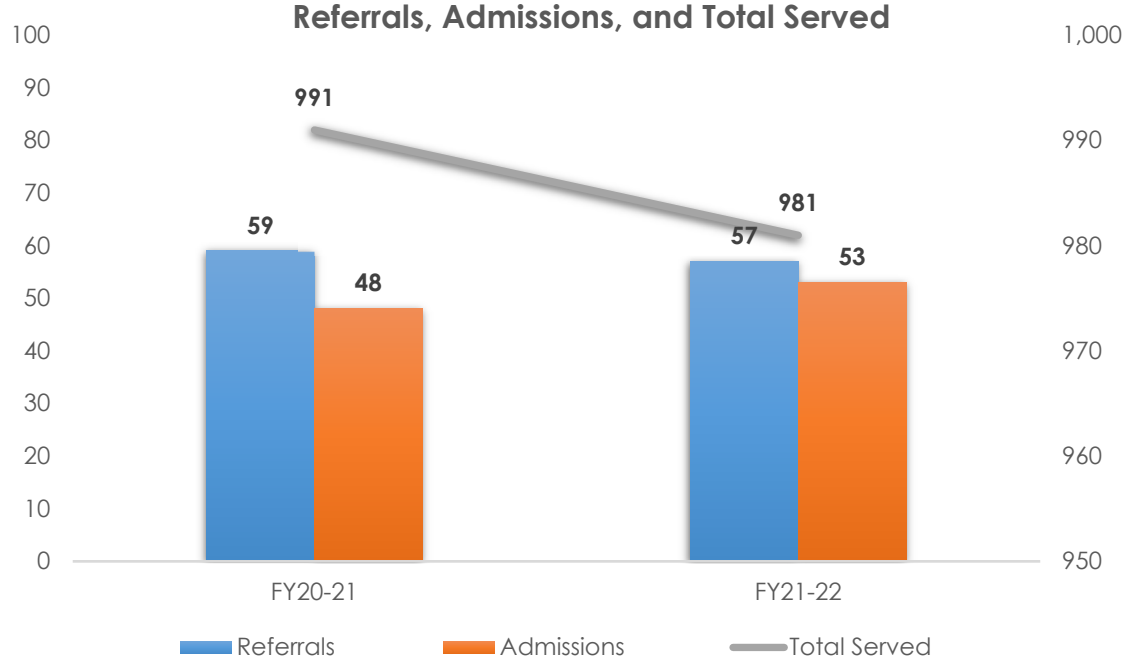
Although SVP patients are admitted to DSH because of severe mental illness and dangerousness, all patients including SVPs have the right to refuse treatment, unless

individually directed by a court to comply. This can effectively lengthen the patient stay at the state hospital if a patient chooses not to actively engage or fully participate in the treatments recommended by their treatment team.

Population Data

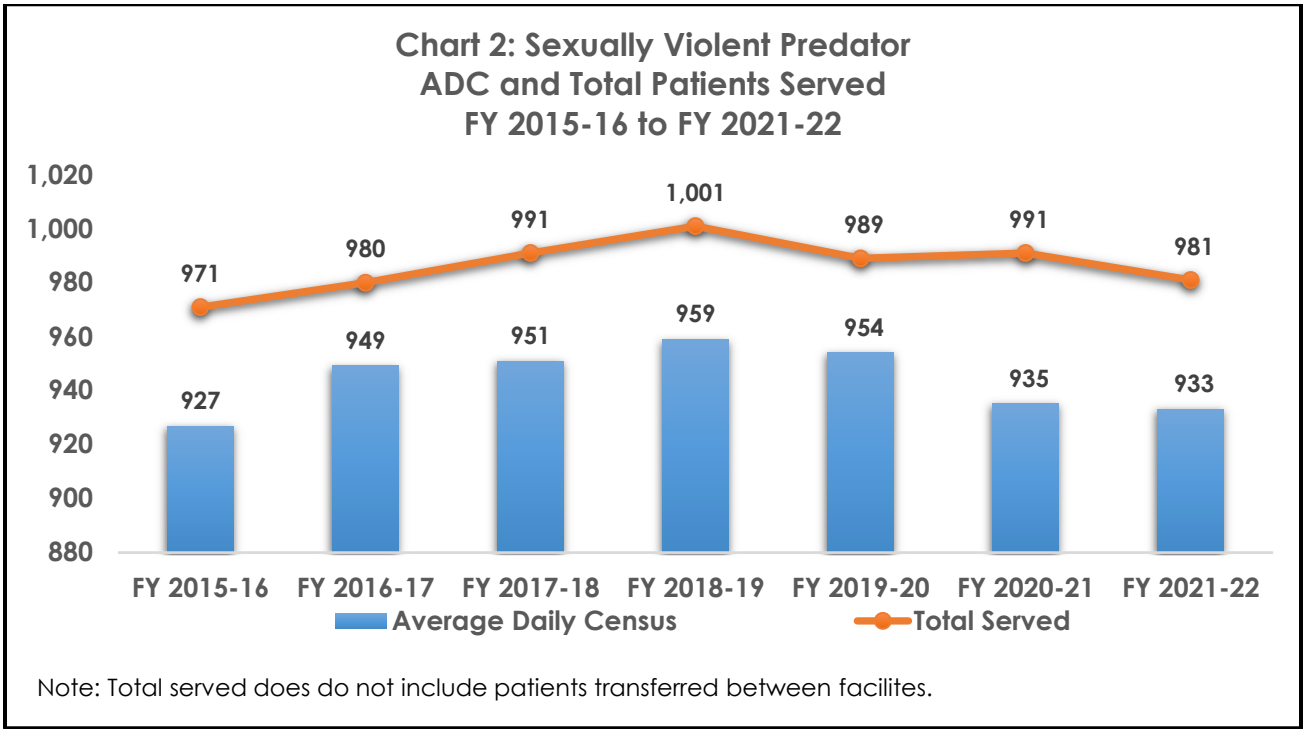
In Fiscal Year (FY) 2021-22, 57 SVP patients were committed, of which 53 SVP patients were admitted into a state hospital. Chart 1 below displays the referrals, admissions, and total patients served for the SVP population in FY 2020-21 and FY 2021-22.

Chart 1: W&I 6604/6602 Sexually Violent Predator Referrals, Admissions, and Total Served



Note: Admissions and total served does not include patients transferred between facilites.

Chart 2 displays the average daily census (ADC) and total number of patients served for the SVP population during FY 2015-16 to FY 2021-22. On average, 933 SVP patients are treated daily in the state hospitals, representing 16 percent of the overall patient population. As of June 30, 2022, the system-wide SVP census was 955 patients.



Note: Total served does do not include patients transferred between facilites.

In FY 2021-22, 25 SVP patients were discharged with an average length of stay of 11 years. Chart 3 below displays the distribution of lengths of stay for all discharged SVP patients.

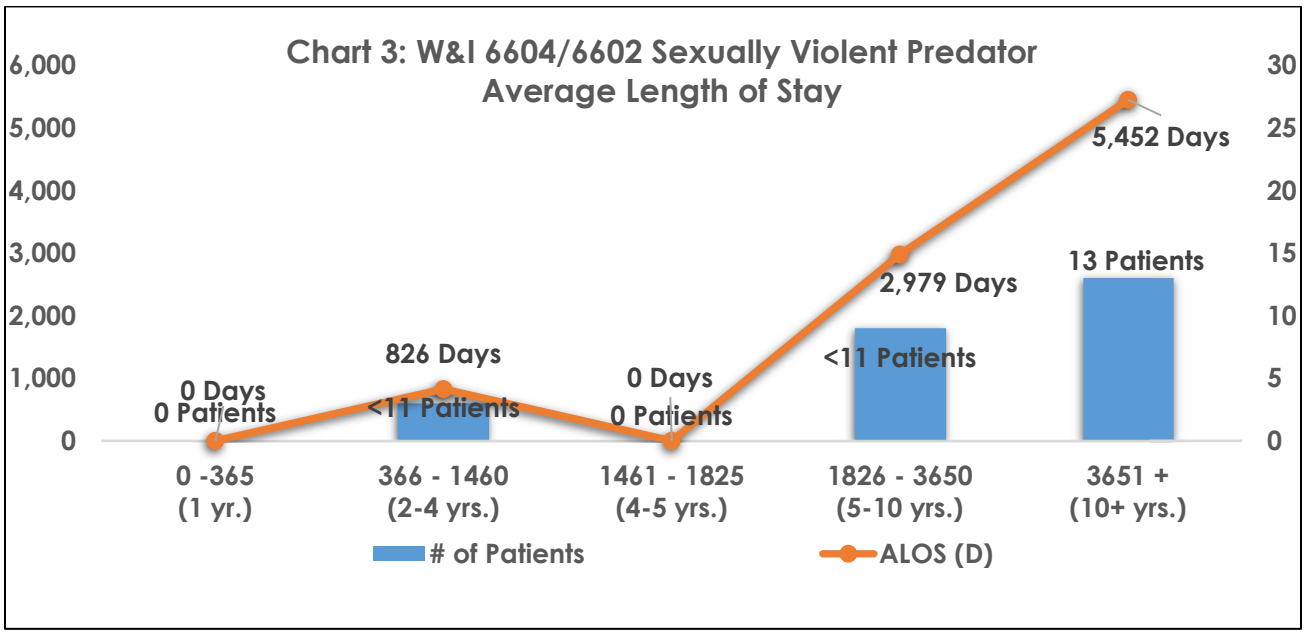
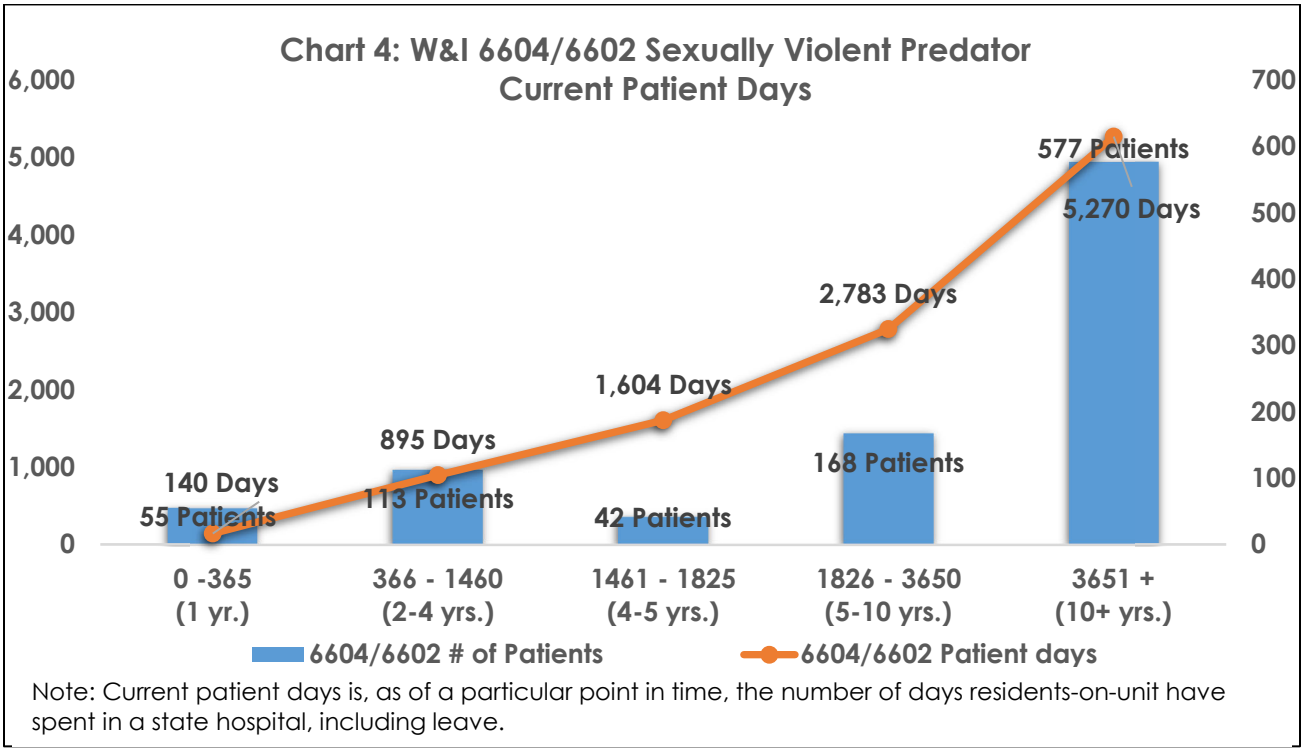


Chart 3. Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. Counts between 1-10 are masked with "<11".

Chart 4 below displays the patient days for all SVP patients that remained on census as of June 30, 2022. On average, the 955 SVP patients who continue to reside at DSH as of June 30, 2022, have been there for an average of 3,858 days, or a little over 10.5 years.



Note: Current patient days is, as of a particular point in time, the number of days residents-on-unit have spent in a state hospital, including leave.

DEPARTMENT OF STATE HOSPITALS - ATASCADERO

HISTORY

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

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,275 beds. In Fiscal Year (FY) 2021-22, DSH-Atascadero served 1,802 patients. The commitment categories of patients treated at DSH-Atascadero are as follows:

Patient Commitments	Penal Code
Incompetent to Stand Trial	1370
Lanterman-Petris Short	WIC 500 Sec.
Offender with a Mental Health Disorder	2962 / 2972
Coleman/CDCR	2684
Not Guilty by Reason of Insanity	1026

HOSPITAL STAFF

Approximately 2,240 employees work at DSH-Atascadero providing round-the-clock care, including psychologists, psychiatrists, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, and other clinical staff. In addition, there are various non-level of care staff at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, and other administrative staff.

TREATMENT AND PROGRAMS

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

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

Treatment Plan

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

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

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

Treatment Team

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

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

Provision of Treatment, Rehabilitation, and Supplemental Activities

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

Recovery and Mall Services (RMS)

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

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

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

Central Medical Services (CMS)

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

Enhanced Treatment Program (ETP)

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

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

ACCREDITATION AND LICENSURE

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

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

TRAINING AND INTERNSHIPS

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

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

[1] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools. The preceptor at each of the hospitals will communicate with the schools to determine

when to send students for their clinical rotations. The contracted schools are University of Southern California (USC), University of California-San Francisco (UCSF), Touro University California College of Pharmacy, California North State University, California Health Sciences University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (UOP), Western University of Health Science, Chapman University.

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

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

DEPARTMENT OF STATE HOSPITALS – COALINGA

HISTORY

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

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

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,500 beds. In Fiscal Year (FY) 2021-22, DSH-Coalinga served 1,327 patients. The commitment categories of patients treated at DSH-Coalinga are as follows:

Patient Commitments	Code Section
Lanterman-Petris Short	WIC 500 Sec.
Offender with a Mental Health Disorder	2972
Coleman/CDCR	2684
Not Guilty by Reason of Insanity	1026
Mentally Disordered Sex Offenders	6316 (WIC)
Sexually Violent Predators	6602/6604

HOSPITAL STAFF

Approximately 2,475 employees work at DSH-Coalinga providing 24/7 care, including psychologists, psychiatrists, social workers, rehabilitation therapists,

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

TREATMENT AND PROGRAMS

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

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

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

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

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

LICENSURE

DSH-Coalinga is licensed by the California Department of Public Health. DSH-Coalinga has two units designated as acute psychiatric. An acute psychiatric facility means having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy and dietary services. In addition, DSH-Coalinga currently has 23 units licensed as an Intermediate Care Facility (ICF). An ICF means a health facility that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care. DSH-Coalinga is currently converting a Residential Recovery Units (RRU) to an ICF with a complete conversion date of March 2023 and will have 24 licensed units. In addition, DSH-Coalinga has six unlicensed RRU's, which provides inpatient care to patients who are required to reside at DSH but have a lesser need for supervision.

TRAINING AND INTERNSHIPS

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

DSH-Coalinga Training Programs

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

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

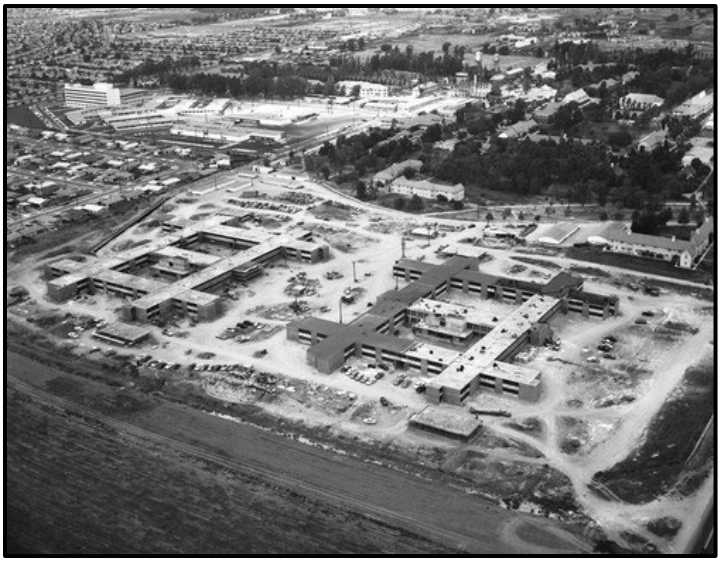
[2] **Psychiatric Technicians:** 1. Psychiatric Technician Trainees are currently enrolled in a Psychiatric Technician School and work part time inside DSH hospitals (up to 20 hours/week). 2. Pre-Licensed Psychiatric Technicians are graduates from Psychiatric Technician School but have not yet passed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

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

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

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

DEPARTMENT OF STATE HOSPITALS – METROPOLITAN



HISTORY

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

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,106 beds. In Fiscal Year (FY) 2020-21, DSH-Metropolitan served 665 patients. The commitment categories of patients treated at DSH-Metropolitan are as follows:

Patient Commitments	Penal Code
Incompetent to Stand Trial	1370
Lanterman-Petris Short	WIC 500 Sec.
Offender with a Mental Health Disorder	2972
Not Guilty by Reason of Insanity	1026

HOSPITAL STAFF

Approximately 2,267 employees work at DSH-Metropolitan providing 24/7 care, including psychiatrists, psychologists, social workers, rehabilitation therapists, registered nurses, psychiatric technicians, and other clinical staff. In addition, there are various non-level of care staff at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, teachers, and other administrative staff.

TREATMENT AND PROGRAMS

DSH-Metropolitan is the first state hospital in California to have a specialized unit dedicated to Dialectical Behavior Therapy (DBT). DBT is a systematic cognitive-behavioral approach founded in the late 1970s by psychologist Marsha Linehan. It balances principles of acceptance (mindfulness) and change (behaviorism) and is effective for treating complex, difficult-to-treat mental disorders. Research indicates DBT to be effective in reducing:

- Suicidal and self-injurious behaviors
- Treatment resistant depression
- Intense anger or difficulty with controlling emotions
- Impulsive behaviors that are potentially self-damaging (e.g., substance abuse, eating disorders)
- Treatment dropout
- Psychiatric hospitalizations

DSH-Metropolitan has a specialized unit dedicated to DBT as a treatment modality for patients who are diagnosed with a serious mental illness and who typically have a complex response to trauma that directly influenced their attachment styles, coping mechanisms, and interpersonal relationships. Each patient in the DBT Program participates in the following activities:

- DBT Skills Groups which include four modules: Mindfulness, Emotional Regulation, Distress Tolerance, and Interpersonal Relationships
- Homework and Review Group
- Weekly Individual Therapy
- Bi-Weekly Outings
- Groups focused on practicing and applying skills

Other treatment programs include:

Trial Competency Program

The Trial Competency Program is for patients admitted to the hospital pursuant to Penal Code (PC) 1370, Incompetent to Stand Trial (IST). The IST patients are trial defendants determined by the court to be unable to participate in their trial because they are not able to understand the nature of the criminal proceedings or assist counsel in the conduct of their defense due to psychiatric symptoms associated with a mental illness. These patients receive a specialized program of treatment which is specifically designed to help the patient gain the knowledge and skills necessary to return to court. The goal is for the patient to understand court proceedings and effectively participate in their defense. Treating the defendant as IST and returning to court for trial is sometimes followed by a court determination that the defendant is Not Guilty by Reason of Insanity (NGI) and requires further treatment under PC 1026.

Offender with a Mental Health Disorder (OMD) Program

The OMD Program is for patients paroled to the hospital by authority of the Board of Paroles under provisions of PC 2962. Patients may be released to parole, placed in a Conditional Release Program (CONREP), or become civilly committed.

Lanterman-Petris Short (LPS) Program

The LPS Program provides treatment for civilly committed patients who suffer from severe symptoms of mental illness, who engage in the behaviors that are dangerous to themselves or others, or who are gravely disabled by their mental illness and thereby unable to formulate a viable plan for self-care. The program provides a highly structured treatment environment for re-socialization in preparation for community placement.

Skilled Nursing Facility (SNF)

The fully licensed SNF provides continuous nursing treatment and care for both Penal Code (PC) and civilly committed patients whose primary need is availability of skilled nursing care on an extended basis. Program objectives include the provision of interventions that are person-appropriate, foster hope and caring, and honor the resident's individual rights, cultural differences, spirituality and dignity.

ACCREDITATION AND LICENSURE

DSH-Metropolitan is accredited by The Joint Commission (TJC) an independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States. TJC conducts unannounced surveys of this hospital at least every three years. The purpose of the survey is to evaluate the hospital's compliance with nationally established TJC standards. The survey results are used to determine whether accreditation should be awarded and under what conditions that happens. TJC standards evaluate organization quality, safety of care issues and the safety of the environment in which care is provided.

DSH-Metropolitan is licensed by the California Department of Public Health and has 23 units designated as acute psychiatric. An acute psychiatric facility means having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary services. DSH-Metropolitan also has three units designated as a Skilled Nursing Facility (SNF). A SNF means a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis.

TRAINING AND PARTNERSHIPS

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

DSH-Metropolitan Training Programs

DISCIPLINE	PROGRAM TYPE
Nursing [1]	• Registered Nursing Clinical Rotation Programs • Nursing Students Preceptorship
Pharmacy [2]	•Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools.
Physician and Surgeon	•Student Volunteer Opportunities
Psychiatric Technicians [3]	•20/20 Psychiatric Technician Training Programs
Psychiatry	•Pacific Northwest University – Psychiatry Clerkship •Western University of Health Sciences – Psychiatry Clerkship
Psychology	•Association of Psychology Postdoctoral and Internship Center – Affiliated Internship Program
Registered Dietitians	•Accredited Dietetic Internship
Rehabilitation Therapy	•Art Therapy (Loyola Marymount University/ Practicum Students) •Music Therapy (American Music Therapy Association National Roster Internship Program /Volunteer Positions) •Recreation Therapy (Volunteer Positions)
Social Work	•Masters of Social Work Internships (Volunteer Positions)

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

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

[3] **Psychiatric Technicians:** DSH-Metropolitan offers 20/20 Psychiatric Technician training program for only Psychiatric Technician Assistants to become a Psychiatric Technician. The modified work

hours shall be a maximum of twelve (12) months in length and the amount of the 20/20 time utilized by each selected employee will depend on the type of education/training programs available.

DEPARTMENT OF STATE HOSPITALS – NAPA

HISTORY

In 1872, a site was selected, and work began for the erection of the 500-bed, four-story, Gothic Style Hospital building. The Hospital originated in response to overcrowding at Stockton Asylum, the first State Hospital. The Department of State Hospitals (DSH)-Napa opened on Monday, November 15, 1875, and is the oldest State Hospital still in operation. DSH-Napa was once self-sufficient, with its own dairy and poultry ranches, vegetable gardens, orchards, and other farming operations. The hospital does not accept voluntary admissions.

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,418 beds, but current maximum capacity is 1,374 beds. In Fiscal Year (FY) 2021-22, DSH-Napa served 1,014 patients. The commitment categories of patients treated at DSH-Napa are as follows:

Patient Commitments	Code Section
Incompetent to Stand Trial	1370
Lanterman-Petris Short	WIC 500 Sec.
Offender with a Mental Health Disorder	2972
Not Guilty by Reason of Insanity	1026
Recommitment After Expiration of Prison Term (Must have concurrent W&I commitment)	2974
Department of Juvenile Justice	-

HOSPITAL STAFF

Approximately 2,635 employees work at DSH-Napa, providing 24/7k care, including psychologists, psychiatrists, physicians, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, and other clinical staff. In addition, there are various non-level of care job classifications at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, and other administrative staff.

TREATMENT PROGRAMS

Patients are screened prior to being scheduled for admission to ensure that DSH-Napa is the appropriate treatment setting. One treatment program is located outside the Secure Treatment Area (STA) for primarily civil commitments and four programs are located inside the STA for forensic commitments. Within these treatment programs there are residential units, each having a focus on a particular population and treatment. Staff orients the patient to the unit on arrival. Members of the Treatment Team meet with patients and continue the assessment process and develop treatment plans. Once developed, the plan is reviewed regularly by the Treatment Team and updated as the patient progresses, and treatment objectives change. Family, significant others, conservators, Conditional Release Program (CONREP) and the courts may play a role as the patient moves through the continuum of care from admission to discharge.

In addition to the living units there are other service sites. For instance, Mall Services provides a variety of off unit services for patients. Mall Services is a centralized approach to delivering services where the patients and staff from throughout the hospital come together to participate in services. Mall Services represents more of a centralized system of programming rather than a reference to a specific building or certain location. The services are provided, as much as possible, in the context of real-life functioning and in the rhythm of life of the patient. Thus, Mall Services extends beyond the context of a "building or place," and its services are based on the needs of the patient, not the needs of the program, the staff members, or the institution. Vocational Services provides opportunities for patients to develop job skills and habits, as well as earn funds. Educational Services enables patients to continue their education, high school, or college, and provide skills groups for anger management and development of interpersonal skills. Rehabilitation Therapy Services, facilitated by music, dance, art, occupational and recreation therapists, provide treatment groups to engage the patient in wellness and improved quality of life. Rehabilitation Therapy Services also provides physical, occupational, and speech therapies. Department of Medicine and Ancillary Services provides clinics that deliver

various medical services, including, but not limited to primary care, dental, podiatry, neurology, cardiac and obstetrics and gynecology clinics.

The goal of treatment services is to assist patients to recognize and manage psychiatric symptoms. Patients also work on developing socially responsible behaviors, independent living skills, and coping skills to address their mental illness and forensic issues.

Specialty units include:

- Admission units- focused on completion of initial assessments and initiation of behavioral stabilization.
- Incompetent to Stand Trial (Penal Code (PC) 1370) treatment, focuses on trial competency treatment, attainment of competency and return them to court for adjudication of pending charges. Patients participate in a wide range of mental health groups and therapeutic activities to assist in addressing symptoms and behaviors that may interfere with their ability to understand the court proceedings and to cooperate with their attorney in preparing a defense.
- Other commitments proceed from admission units through the continuum of care from stabilization to discharge. During a patient's stay some patients may receive specialized treatment.
    - Dialectic Behavior Therapy (DBT) involves individualized treatment and unit milieu management that focuses on supporting patient's use of DBT skills to minimize harm to self and others
    - Treatment for polydipsia (intoxication resulting from excessive consumption of fluids)
    - Sex offender treatment
    - Intensive Substance Abuse Recovery
    - Geropsychiatric
- Discharge units focus on skills development for community living and on relapse prevention. Each patient prepares a personalized relapse prevention plan. The Treatment Teams work closely with CONREP towards returning patients to the community under CONREP supervision.

ACCREDITATION AND LICENSURE

DSH-Napa is accredited by The Joint Commission (TJC) and independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States. TJC conducts unannounced surveys of this hospital at least every three years. The purpose of the survey is to evaluate the hospital's compliance with nationally established TJC standards. The survey results are used to determine whether accreditation should be awarded

and whether certain conditions or reporting requirements should be implemented to maintain accreditation status. TJC standards deal with subject matter such as organization quality, patient safety, provision of care, treatment, and services, as well as the environment in which care is provided.

DSH-Napa is licensed by the California Department of Public Health and has two units designated as acute psychiatric. An acute psychiatric facility means having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy and dietary services. DSH-Napa has one unit designated as a Skilled Nursing Facility (SNF). A SNF is a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. Additionally, DSH-Napa has 33 units designated as an Intermediate Care Facility (ICF). An ICF means a health facility that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care.

TRAINING AND PARTNERSHIPS

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

DSH-Napa Training Programs

DISCIPLINE	PROGRAM TYPE
Nursing	• Registered Nursing Programs Clinical Rotation
Pharmacy [1]	•Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools.
Psychiatric Technicians [2]	•Psychiatric Technician Apprentice •Pre-Licensed Psychiatric Technicians •Psychiatric Technician Prorams Clinical Rotation
Psychiatry	•UC Davis, Psychiatry and Law •Touro University •Clinical Clerkships for Medical School Graduates •Residency Program with St. Joseph Medical Center
Psychology	•American Psychological Association Approved Pre-Doctoral Internship
Registered Dietitians	•Accredited Dietetic Internship
Rehabilitation Therapy	•Recreation Therapy Internship •Occupational Therapy •Music Therapy •Dance Movement Therapy •Art Therapy
Social Work	•Masters of Social Work Internships (Graduate Student Assistants)

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

University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (UOP), Western University of Health Science, Chapman University.

[2] **Psychiatric Technicians:** 1. Psychiatric Technician Apprentice - This class is limited term and designed for entrance and performance in an apprentice program leading to status as a licensed Psychiatric Technician. Persons in this class receive training under the provisions of apprenticeship standards and written apprentice agreements under Chapter 4, Division 3, California Labor Code. 2. Pre-Licensed Psychiatric Technicians are graduates from Psychiatric Technician School but have not yet passed the state licensing exam. They are limited to 9 months in that role (test must be passed within the 9 months) and work full time with some limitations on their job responsibilities.

DEPARTMENT OF STATE HOSPITAL – PATTON

HISTORY

The Department of State Hospitals (DSH)-Patton is a secure forensic psychiatric hospital located in San Bernardino County. DSH-Patton was established in 1890 and opened in 1893. DSH-Patton provides treatment to forensically and civilly committed patients within secure treatment areas (STA's). The hospital does not accept voluntary admissions.

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,287 beds. In Fiscal Year (FY) 2021-22, DSH-Patton served 1,311 patients. The commitment categories of patients treated at DSH-Patton are as follows:

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

HOSPITAL STAFF

Approximately 2,534 employees work at DSH-Patton providing 24/7 care, including psychiatrists, psychologists, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, registered dieticians, and other clinical staff. In addition, there are various non-level-of-care staff at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, information technology staff, plant operations staff, spiritual leaders, and other administrative staff.

TREATMENT AND PROGRAMS

The Trial Competency treatment along with the Court Preparation Project is for patients admitted to the hospital under Penal Code (PC) 1370 as Incompetent to Stand Trial. These patients receive a specialized constellation of treatment which is designed to specifically help the patient gain the knowledge and skills necessary to return to court. The goal is for the patient to understand court proceedings and effectively participate in their defense.

The focus of treatment for Offenders with a Mental Disorder (OMD) and Not Guilty by Reason of Insanity (NGI) population emphasizes the potential for each patient to learn new skills and adaptive coping mechanisms to manage symptoms of a mental illness, while also enhance the patient's awareness and insight into symptoms that led to dangerousness in the past. Other goals include motivation for treatment, development of social skills, understanding co-occurring disorders, independence in Activities of Daily Living (ADL), and helping patients to create an overall lifestyle of recovery from mental illness, addiction, and other co-morbid conditions. Treatment also focuses on improving patients' quality of life for preparation and eventual successful and effective transition to Community Outpatient Treatment (COT) or a less restrictive setting.

All treatment programs at DSH-Patton utilize the recovery philosophy as well as a Trauma-Informed Care approach, offering a broad spectrum of treatment, while fully endorsing the hospital's mission to provide comprehensive clinical services within the context of a biopsychosocial rehabilitation model within an environment of safety and security for all patients, staff, and the community in an atmosphere of dignity and respect.

Enhanced Treatment Program (ETP)

The ETP is designed to provide enhanced treatment in a secure setting for patients at the highest risk of most dangerous behavior. The ETP is intended to provide increased therapy opportunities within a structured, least restrictive environment. The ETP is to be utilized when safe treatment is not possible in a standard treatment environment. The pilot is driven by Assembly Bill 1340. The Budget Act of 2022 reported delays to the unit U-06 fire sprinkler installation due to design changes required to accommodate existing conditions, the discovery of gaps in the existing smoke barrier, redesign of 1-hour fire rated construction in the corridors, and the need to survey for potential asbestos-containing materials. On August 30, 2022, Department of General Services (DGS) and DSH-Patton received approval from the State Fire Marshal for the fire sprinkler installation design

changes. The contractor is currently remobilizing to continue construction activities.

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

ACCREDITATION AND LICENSURE

DSH-Patton is awarded the *Gold Seal of Approval* for achieving accreditation under the (HAP) Hospital Accreditation Program by The Joint Commission (TJC) recognized as an independent, not-for-profit organization and the largest standards-setting and accrediting body in healthcare. The HAP accreditation program is achieved upon successful completion of an on-site triennial survey attained by meeting rigorous performance standards, delivering the best quality care and exhibiting a culture of excellence that inspires to continually improve performance. The hospital sustains accreditation with a mutual belief in patient and employee safety, effective care processes, patient outcomes using evidence-based practices, maintenance in environmental engineering controls, and, performance analysis studies, which are collectively woven into the fabric of our healthcare organization's operation. The hospital recognizes accreditation does not begin and end with an on-site survey, it is a continuous process of monitoring, communication, transparency, education and evaluating sustainability.

DSH-Patton is licensed as an Acute Psychiatric Hospital (APH) by the California Department of Public Health – Licensing and Certification Unit governed by the provisions of the Health and Safety Code of California and its rules and regulations to operate and maintain Acute Psychiatric Care and Intermediate Care bed classifications. Patton hospital meets the APH definition by demonstrating a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients the following basic services: medical, nursing, rehabilitative, pharmacy and dietary services. DSH-Patton is licensed to provide services for 1,287 patients and additional housing not to exceed 1,530 patient beds in adherence to the Welfare and Institutions Code, Section 4107 (c) defining the joint plan between the California Department of Corrections and Rehabilitation and the State Department of Mental Health. DSH-Patton's licensing operation also includes Physical Therapy, Radiological Services, Social Services and Speech Pathology. The hospital maintains licensure through frequent on-site surveys that includes a robust review on the hospitals' safety,

environment, effectiveness, and quality of healthcare, every 3 years for Acute units and 2 years for Intermediate Care units. Communication, education, performance improvement studies, quality improvement analysis and risk management awareness and interventions are additional priorities to the hospital's continued emphasis for optimal patient care and treatment.

DSH-PATTON MUSEUM

On April 17th, 2015, the DSH-Patton Museum opened its doors for the first time to the public. The on-site museum examines the history of psychiatric treatment in California state-run facilities and offers a glimpse of the evolution of mental health treatment during the last 127 years.

Patton accepted its first patients on August 1, 1893. The museum, only the second of its kind west of the Mississippi River, features more than 140 artifacts. Among the artifacts found in the museum are original medical and surgical equipment, firefighting equipment from the early part of the last century and nursing uniforms from the 1950s. It explores the complex and extensive history of Patton State Hospital, including its history as a general psychiatric hospital and the transition to a forensic facility. It avoids reinforcing stigma and attempts to be inclusive of the various individuals whose experiences are reflected in the hospital's past.

The museum itself is located on the grounds of the hospital in a 1920s cottage home that once was inhabited by hospital staff and their families. Since the museum's opening, numerous Southern Californians have visited for tours and researchers from as far away as South Africa have presented to experience the museum. The DSH-Patton Museum remains a valuable resource for state employees and members of the public by providing insight and information about an institution with deep local roots and a history that exemplifies the progression of mental health treatment in America.

TRAINING AND PARTNERSHIPS

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

DSH-Patton Training Programs

DISCIPLINE	PROGRAM TYPE
Nursing	• Registered Nursing Programs Clinical Rotation •20/20 Psychiatric Technician Program
Pharmacy [1]	•Systemwide, DSH's pharmacy discipline is currently contracted with 13 pharmacy schools.
Psychiatry	•UC Riverside •Western University of Health Sciences •CA University of Science and Medicine
Psychology	•Practicum •American Psychological Association Approved Pre-Doctoral Internship •Post-Doctoral Fellowship •Forensic Psychology and Neuropsychology
Registered Dietitians	•Accredited Dietetic Internship
Rehabilitation Therapy	•Recreation Therapy (Student Assistants)
Social Work	•Masters of Social Work and Bachelors of Social Work Internships

[1] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with 13 pharmacy schools. The preceptor at each of the hospitals will communicate with the schools to determine when to send students for their clinical rotations. The contracted schools are University of Southern California (USC), University of California-San Francisco (UCSF), Touro University California College of Pharmacy, California North state University, California Health Sciences University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (Stockton), Western University of Health Science, Chapman University, American University of Health Sciences School of Pharmacy, and Marshal B Ketchum College of Pharmacy.

CALIFORNIA DEPARTMENT OF STATE HOSPITALS

REPORT ON STATE HOSPITAL FINANCIAL ACTIVITY

California Department of State Hospitals

FISCAL YEAR 2022-23

January 10, 2023






DIRECTOR
Stephanie Clendenin

EXECUTIVE SUMMARY

Pursuant of the 2022 Budget Act, the Department of State Hospitals (DSH) submits this report to the California State Legislature on the financial activity of the state hospitals. This report is prepared in accordance with Item 4440-011-0001, Provision 9 of the 2022 Budget Act which requires DSH to provide a year-end summary and an operating budget for each state hospital with the fiscal year (FY) 2023-24 Governor's Budget and May Revision estimate. Specifically, this report includes the following information for each state hospital:

- The number of authorized and vacant positions for each institution
- The number of authorized and vacant positions for each institution, broken out by key classifications
- The number of authorized positions utilized in the temporary help blanket for each institution
- The 2021-22 year-end budget and expenditures by line-item detail for each institution
- The budgeted allocations for each institution for current and budget year
- The projected expenditures for current and budget years

DEPARTMENT OF STATE HOSPITALS OVERVIEW

DSH manages the nation's largest inpatient forensic mental health hospital system. Its mission is to provide evaluation and treatment in a safe and responsible manner, by leading seeking innovation and excellence in state hospital operations, across a continuum of care and settings. DSH is responsible for the daily care and provision of mental health treatment of its patients. DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton) and employs nearly 13,000 staff. In addition to state hospital treatment, DSH provides services in contracted Jail-Based Competency Treatment (JBCT), Community-Based Restoration (CBR), pre-trial felony mental health diversion programs, other community-based facilities, and the conditional release program (CONREP). DSH is responsible for the daily care to over 7,000 patients, in FY 2021-22, DSH served 8,070 across the state hospitals, 2,014 in JBCT and 813 in CBR contracted programs and 885 in CONREP programs. In addition, during FY 2021-22, 340 individuals were diverted into county programs funded by DSH.

SUMMARY OF AUTHORIZED AND VACANT POSITIONS

The following table provides a summary of the authorized and vacant positions for the state hospital system as of November 1, 2022.

State Hospital	Authorized Positions[1]	Vacant as of 11/1/2022	Vacancy Percent
Atascadero	2,229.9	502.3	22.5%
Coalinga	2,479.7	449.8	18.1%
Metropolitan	2,219.6	555.5	25.0%
Napa	2,604.0	450.9	17.3%
Patton	2,477.8	350.4	14.1%
Totals	**12,011.0**	**2,308.8**	**18.8%**

[1]Includes positions approved for Estimate Items Enhanced Treatment Program (27.4 in Patton) and Metropolitan State Hospital Increased Secure Bed Capacity (42.0 in Metropolitan) that will not be filled due to COVID-19 impacts and associated construction delays to these as described in the 2023-24 Governor's Budget Estimate.

AUTHORIZED VERSUS VACANT POSITIONS BY CLASSIFICATION

As of November 1, 2022, DSH's vacancy rate is 18.8 percent. Item 4440-011-0001, Provision 9 requires DSH to provide the number of authorized and vacant classifications, including psychiatric technicians, nurses, physicians, psychiatrists, social workers, and rehabilitation therapists. The following table provides a summary of the authorized and vacant positions for those classifications.

		Atascadero		Coalinga		Metropolitan		Napa		Patton	
Class Title	Class Code	Authorized	Vacant	Authorized	Vacant	Authorized[1]	Vacant	Authorized	Vacant	Authorized[1]	Vacant
Staff Psychiatrist	7619	40.2	32.2	37.3	23.3	67.3	33.3	59.3	13.6	66.5	35.0
Psychologist	9873	45.7	11.7	37.6	14.6	44.0	12.0	55.4	9.9	61.3	22.4
Senior Psychiatric Technician	8252	104.2	30.2	88.0	5.0	84.8	32.8	83.0	15.0	88.0	0.0
Rehabilitation Therapist	Various	55.0	11.0	46.0	4.0	60.0	16.8	66.1	7.1	70.3	8.3
Registered Nurse	8094	244.6	43.6	237.9	35.5	294.1	71.1	461.2	55.0	362.1	27.1
Clinical Social Worker	9872	48.1	12.1	45.0	11.0	62.7	23.7	61.2	8.7	70.0	6.5
Psychiatric Technician	8253	651.7	139.7	737.5	160.3	492.5	131.5	464.0	92.6	727.6	80.6
Physician/Surgeon	7552	17.5	3.0	25.2	15.2	26.4	3.4	26.8	1.3	29.0	2.0

[1]Includes positions approved for Estimate Items Enhanced Treatment Program (27.4 in Patton) and Metropolitan State Hospital Increased Secure Bed Capacity (42.0 in Metropolitan) that will not be filled due to COVID-19 impacts to these as described in the 2023-24 Governor's Budget Estimate.

TEMPORARY HELP BLANKET POSITIONS

Temporary help blanket positions are utilized to offset vacancies and overtime. The following table provides a summary of authorized temporary help blanket positions for the state hospitals as of November 1, 2022. The Department is continuing to evaluate the use of internal registry positions to determine the appropriate temporary help position authority.

Authorized Blanket Positions	
Atascadero	30.1
Coalinga	28.0
Metropolitan	67.2
Napa	47.5
Patton	81.2
Total	**254.0**

STATE HOSPITAL ALLOCATIONS AND EXPENDITURES

Exhibit I (attached) provides detail on the budget and expenditures for all five state hospitals and each facility individually, listed by FI$Cal account code for FY 2021-22. For FY 2022-23 and FY 2023-24, Exhibit II (attached) displays the projected budget and expenditures for all five hospitals and each facility individually. Any anticipated savings due to delayed projects or unit activations have been reflected in these allocations and projected expenditures.

Exhibit I—All Hospitals[1]

		2021-22 Budget	2021-22 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$593,031,000	$589,589,000
	5100150-Earnings - Temporary Civil Service Employees	$32,509,000	$32,320,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$104,450,000	$103,844,000
Salaries and Wages Total		**$730,282,000**	**$729,990,000**
Staff Benefits	5150150-Dental Insurance	$1,039,000	$1,033,000
	5150200-Disability Leave - Industrial	$15,225,000	$15,136,000
	5150210-Disability Leave - Nonindustrial	$3,843,000	$3,820,000
	5150350-Health Insurance	$21,400,000	$21,276,000
	5150400-Life Insurance	$60,000	$60,000
	5150450-Medicare Taxation	$12,606,000	$12,533,000
	5150500-OASDI	$9,583,000	$9,528,000
	5150600-Retirement - General	$168,290,000	$167,313,000
	5150700-Unemployment Insurance	$538,000	$535,000
	5150750-Vision Care	$198,000	$198,000
	5150800-Workers' Compensation	$60,953,000	$60,600,000
	5150900-Staff Benefits - Other	$295,838,000	$294,120,000
Staff Benefits Total		**$589,810,000**	**$589,573,000**
Operating Expenses and Equipment	5301400-Goods - Other	$3,491,000	$3,471,000
	5302900-Printing - Other	$781,000	$776,000
	5304800-Communications - Other	$2,030,000	$2,018,000
	5306700-Postage - Other	$228,000	$228,000
	5308900-Insurance - Other	$629,000	$626,000
	5320490-Travel - In State - Other	$1,094,000	$1,087,000
	5320890-Travel - Out of State - Other	$6,000	$6,000
	5322400-Training - Tuition and Registration	$1,126,000	$1,119,000
	5324350-Rents and Leases	$124,368,000	$123,647,000
	5326900-Utilities - Other	$20,413,000	$20,296,000
	5340330-Consulting and Professional Services – Inter - Other	$4,486,000	$4,461,000
	5340580-Consulting and Professional Services - External - Other	$89,711,000	$89,185,000
	5342600-Departmental Services - Other	$17,000	$17,000
	5344000-Consolidated Data Centers	$59,000	$59,000
	5346900-Information Technology - Other	$645,000	$642,000
	5368115-Office Equipment	$33,567,000	$33,373,000
	5390900-Other Items of Expense - Miscellaneous	$77,589,000	$77,140,000
	5415000-Claims Against the State	$351,000	$349,000
	5490000-Other Special Items of Expense	$8,687,000	$8,637,000
Operating Expenses and Equipment Total		**$369,429,000**	**$369,278,000**
Grand Total		**$1,688,841,000**	**$1,679,042,000**

[1]Budget and expenditure do not include reimbursements.

Exhibit I—Atascadero State Hospital[2&3]

		2021-22 Budget	2021-22 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$119,088,000	$118,397,000
	5100150-Earnings - Temporary Civil Service Employees	$5,851,000	$5,817,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$16,941,000	$16,843,000
Salaries and Wages Total		**$141,937,000**	**$141,880,000**
Staff Benefits	5150150-Dental Insurance	$169,000	$168,000
	5150200-Disability Leave - Industrial	$2,945,000	$2,928,000
	5150210-Disability Leave - Nonindustrial	$1,161,000	$1,154,000
	5150350-Health Insurance	$4,161,000	$4,137,000
	5150400-Life Insurance	$12,000	$12,000
	5150450-Medicare Taxation	$2,383,000	$2,369,000
	5150500-OASDI	$1,720,000	$1,710,000
	5150600-Retirement - General	$33,786,000	$33,590,000
	5150700-Unemployment Insurance	$133,000	$132,000
	5150750-Vision Care	$39,000	$39,000
	5150800-Workers' Compensation	$14,722,000	$14,637,000
	5150900-Staff Benefits - Other	$51,159,000	$50,862,000
Staff Benefits Total		**$112,435,000**	**$112,390,000**
Operating Expenses and Equipment	5301400-Goods - Other	$1,077,000	$1,071,000
	5302900-Printing - Other	$252,000	$251,000
	5304800-Communications - Other	$501,000	$498,000
	5306700-Postage - Other	$50,000	$50,000
	5308900-Insurance - Other	$11,000	$11,000
	5320490-Travel - In State - Other	$301,000	$299,000
	5320890-Travel - Out of State - Other	$3,000	$3,000
	5322400-Training - Tuition and Registration	$281,000	$279,000
	5324350-Rents and Leases	$52,321,000	$52,017,000
	5326900-Utilities - Other	$2,997,000	$2,980,000
	5340330-Consulting and Professional Services – Inter - Other	$1,280,000	$1,273,000
	5340580-Consulting and Professional Services - External - Other	$23,350,000	$23,213,000
	5342600-Departmental Services - Other	$17,000	$17,000
	5344000-Consolidated Data Centers	$22,000	$22,000
	5346900-Information Technology - Other	$56,000	$56,000
	5368115-Office Equipment	$3,820,000	$3,798,000
	5390900-Other Items of Expense - Miscellaneous	$12,910,000	$12,835,000
	5415000-Claims Against the State	$159,000	$158,000
	5490000-Other Special Items of Expense	$1,708,000	$1,698,000
Operating Expenses and Equipment Total		**$101,157,000**	**$101,116,000**
Grand Total		**$355,386,000**	**$353,324,000**

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

Exhibit I—Coalinga State Hospital[4]

		2021-22 Budget	2021-22 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$131,978,000	$131,211,000
	5100150-Earnings - Temporary Civil Service Employees	$766,000	$762,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$23,647,000	$23,510,000
Salaries and Wages Total		**$156,453,000**	**$156,391,000**
Staff Benefits	5150150-Dental Insurance	$223,000	$222,000
	5150200-Disability Leave - Industrial	$3,906,000	$3,883,000
	5150210-Disability Leave - Nonindustrial	$1,055,000	$1,049,000
	5150350-Health Insurance	$4,545,000	$4,519,000
	5150400-Life Insurance	$14,000	$14,000
	5150450-Medicare Taxation	$2,618,000	$2,603,000
	5150500-OASDI	$3,095,000	$3,077,000
	5150600-Retirement - General	$37,908,000	$37,688,000
	5150700-Unemployment Insurance	$187,000	$186,000
	5150750-Vision Care	$41,000	$41,000
	5150800-Workers' Compensation	$11,810,000	$11,742,000
	5150900-Staff Benefits - Other	$60,128,000	$59,778,000
Staff Benefits Total		**$125,581,000**	**$125,530,000**
Operating Expenses and Equipment	5301400-Goods - Other	$524,000	$521,000
	5302900-Printing - Other	$160,000	$159,000
	5304800-Communications - Other	$648,000	$644,000
	5306700-Postage - Other	$43,000	$43,000
	5308900-Insurance - Other	$55,000	$55,000
	5320490-Travel - In State - Other	$362,000	$360,000
	5320890-Travel - Out of State - Other	$3,000	$3,000
	5322400-Training - Tuition and Registration	$171,000	$170,000
	5324350-Rents and Leases	$2,658,000	$2,643,000
	5326900-Utilities - Other	$5,394,000	$5,363,000
	5340330-Consulting and Professional Services – Inter - Other	$366,000	$364,000
	5340580-Consulting and Professional Services - External - Other	$26,060,000	$25,907,000
	5344000-Consolidated Data Centers	$2,000	$2,000
	5346900-Information Technology - Other	$33,000	$33,000
	5368115-Office Equipment	$20,854,000	$20,733,000
	5390900-Other Items of Expense - Miscellaneous	$19,218,000	$19,107,000
	5415000-Claims Against the State	$1,000	$1,000
	5490000-Other Special Items of Expense	$1,921,000	$1,910,000
Operating Expenses and Equipment Total		**$78,505,000**	**$78,473,000**
Grand Total		**$360,394,000**	**$358,303,000**

[4]Budget and expenditure do not include reimbursements.

Exhibit I—Metropolitan State Hospital[5]

		2021-22 Budget	2021-22 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$69,544,000	$69,140,000
	5100150-Earnings - Temporary Civil Service Employees	$4,573,000	$4,546,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$7,411,000	$7,368,000
Salaries and Wages Total		**$81,560,000**	**$81,528,000**
Staff Benefits	5150150-Dental Insurance	$180,000	$179,000
	5150200-Disability Leave – Industrial	$1,842,000	$1,831,000
	5150210-Disability Leave – Nonindustrial	$294,000	$292,000
	5150350-Health Insurance	$3,313,000	$3,294,000
	5150400-Life Insurance	$9,000	$9,000
	5150450-Medicare Taxation	$1,630,000	$1,621,000
	5150500-OASDI	$1,272,000	$1,265,000
	5150600-Retirement – General	$19,845,000	$19,730,000
	5150700-Unemployment Insurance	$62,000	$62,000
	5150750-Vision Care	$30,000	$30,000
	5150800-Workers' Compensation	$7,672,000	$7,627,000
	5150900-Staff Benefits - Other	$50,186,000	$49,894,000
Staff Benefits Total		**$86,370,000**	**$86,335,000**
Operating Expenses and Equipment	5301400-Goods – Other	$400,000	$398,000
	5302900-Printing – Other	$96,000	$95,000
	5304800-Communications – Other	$78,000	$78,000
	5306700-Postage – Other	$32,000	$32,000
	5308900-Insurance – Other	$197,000	$196,000
	5320490-Travel - In State – Other	$115,000	$114,000
	5322400-Training - Tuition and Registration	$129,000	$128,000
	5324350-Rents and Leases	$24,459,000	$24,317,000
	5326900-Utilities – Other	$2,674,000	$2,659,000
	5340330-Consulting and Professional Services - Inter – Other	$588,000	$585,000
	5340580-Consulting and Professional Services - External – Other	$9,053,000	$8,999,000
	5344000-Consolidated Data Centers	$23,000	$23,000
	5346900-Information Technology – Other	$30,000	$30,000
	5368115-Office Equipment	$1,428,000	$1,420,000
	5390900-Other Items of Expense – Miscellaneous	$8,360,000	$8,312,000
	5415000-Claims Against the State	$187,000	$186,000
	5490000-Other Special Items of Expense	$1,234,000	$1,227,000
Operating Expenses and Equipment Total		**$49,103,000**	**$49,083,000**
Grand Total		**$216,946,000**	**$215,687,000**

[5]Budget and expenditure do not include reimbursements.

Exhibit I—Napa State Hospital[6]

		2021-22 Budget	2021-22 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$137,950,000	$137,150,000
	5100150-Earnings - Temporary Civil Service Employees	$7,334,000	$7,291,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$27,036,000	$26,879,000
Salaries and Wages Total		**$172,389,000**	**$172,320,000**
Staff Benefits	5150150-Dental Insurance	$259,000	$257,000
	5150200-Disability Leave – Industrial	$4,015,000	$3,992,000
	5150210-Disability Leave – Nonindustrial	$631,000	$627,000
	5150350-Health Insurance	$5,105,000	$5,075,000
	5150400-Life Insurance	$12,000	$12,000
	5150450-Medicare Taxation	$2,953,000	$2,936,000
	5150500-OASDI	$1,740,000	$1,730,000
	5150600-Retirement – General	$38,396,000	$38,173,000
	5150700-Unemployment Insurance	$106,000	$105,000
	5150750-Vision Care	$46,000	$46,000
	5150800-Workers' Compensation	$13,083,000	$13,007,000
	5150900-Staff Benefits – Other	$67,161,000	$66,772,000
Staff Benefits Total		**$133,560,000**	**$133,507,000**
Operating Expenses and Equipment	5301400-Goods – Other	$870,000	$865,000
	5302900-Printing – Other	$87,000	$86,000
	5304800-Communications – Other	$104,000	$103,000
	5306700-Postage – Other	$44,000	$44,000
	5308900-Insurance – Other	$353,000	$351,000
	5320490-Travel - In State – Other	$123,000	$122,000
	5322400-Training - Tuition and Registration	$304,000	$302,000
	5324350-Rents and Leases	$13,371,000	$13,294,000
	5326900-Utilities – Other	$5,533,000	$5,501,000
	5340330-Consulting and Professional Services - Inter – Other	$1,465,000	$1,457,000
	5340580-Consulting and Professional Services - External – Other	$13,867,000	$13,787,000
	5346900-Information Technology – Other	$506,000	$503,000
	5368115-Office Equipment	$5,063,000	$5,034,000
	5390900-Other Items of Expense – Miscellaneous	$18,410,000	$18,303,000
	5490000-Other Special Items of Expense	$1,695,000	$1,685,000
Operating Expenses and Equipment Total		**$61,821,000**	**$61,795,000**
Grand Total		**$367,622,000**	**$365,489,000**

[6]Budget and expenditure do not include reimbursements.

Exhibit I—Patton State Hospital[7]

		2021-22 Budget	2021-22 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$134,471,000	$133,691,000
	5100150-Earnings - Temporary Civil Service Employees	$13,985,000	$13,904,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$29,415,000	$29,244,000
Salaries and Wages Total		**$177,943,000**	**$177,871,000**
Staff Benefits	5150150-Dental Insurance	$208,000	$207,000
	5150200-Disability Leave - Industrial	$2,517,000	$2,502,000
	5150210-Disability Leave - Nonindustrial	$702,000	$698,000
	5150350-Health Insurance	$4,276,000	$4,251,000
	5150400-Life Insurance	$13,000	$13,000
	5150450-Medicare Taxation	$3,022,000	$3,004,000
	5150500-OASDI	$1,756,000	$1,746,000
	5150600-Retirement - General	$38,355,000	$38,132,000
	5150700-Unemployment Insurance	$50,000	$50,000
	5150750-Vision Care	$42,000	$42,000
	5150800-Workers' Compensation	$13,666,000	$13,587,000
	5150900-Staff Benefits - Other	$67,204,000	$66,814,000
Staff Benefits Total		**$131,864,000**	**$131,811,000**
Operating Expenses and Equipment	5301400-Goods - Other	$620,000	$616,000
	5302900-Printing - Other	$186,000	$185,000
	5304800-Communications - Other	$699,000	$695,000
	5306700-Postage - Other	$59,000	$59,000
	5308900-Insurance - Other	$13,000	$13,000
	5320490-Travel - In State - Other	$193,000	$192,000
	5322400-Training - Tuition and Registration	$241,000	$240,000
	5324350-Rents and Leases	$31,559,000	$31,376,000
	5326900-Utilities - Other	$3,815,000	$3,793,000
	5340330-Consulting and Professional Services – Inter - Other	$787,000	$782,000
	5340580-Consulting and Professional Services - External - Other	$17,381,000	$17,279,000
	5344000-Consolidated Data Centers	$12,000	$12,000
	5346900-Information Technology - Other	$20,000	$20,000
	5368115-Office Equipment	$2,402,000	$2,388,000
	5390900-Other Items of Expense - Miscellaneous	$18,691,000	$18,583,000
	5415000-Claims Against the State	$4,000	$4,000
	5490000-Other Special Items of Expense	$2,129,000	$2,117,000
Operating Expenses and Equipment Total		**$78,843,000**	**$78,811,000**
Grand Total		**$388,493,000**	**$386,239,000**

[7]Budget and expenditure do not include reimbursements.

Exhibit II—All Hospitals[8]

	2022-23 Budget	2023-24 Budget	2022-23 Projected Expenditure	2023-24 Projected Expenditure
4410010-Atascadero	$367,186,000	$387,582,000	$363,514,140	$383,706,180
4410020-Coalinga	$393,639,000	$402,708,000	$389,702,610	$398,680,920
4410030-Metro	$216,604,000	$255,980,000	$214,437,960	$253,420,200
4410040-Napa	$386,668,000	$391,256,000	$382,801,320	$387,343,440
4410050-Patton	$418,273,000	$420,261,000	$414,090,270	$416,058,390
Grand Total	**$1,782,370,000**	**$1,857,787,000**	**$1,764,546,300**	**$1,839,209,130**

[8]Budget and expenditure do not include reimbursements.

STATE HOSPITALS
HOSPITAL POLICE OFFICER/STATE HOSPITAL POLICE ACADEMY
Provisional Language Reporting

BACKGROUND

The Budget Act of 2022 includes Provisional language stating:

"The State Department of State Hospitals shall provide a status update on the recruitment and retention of hospital police officers, to be included in the department's 2022–23 Governor's Budget estimate and subsequent May Revision estimate. The update shall include the number of authorized and vacant positions for each hospital, the actual attrition rate for the 2022–23 fiscal year, the projected attrition rate for the 2023–24 fiscal year, and the rate of success pertaining to the number of hospital police officer cadet graduates of the OPS Police Academy."

Hospital Police Officer Positions

The table below displays the status of Hospital Police Officers (HPO) authorized positions as of November 1, 2022:

HPO Authorized Positions[1] as of November 1, 2022				
Hospitals	Filled	Vacant	FTE[2]	Vacancy Rate
Atascadero	117.0	14.1	131.1	10.8%
Coalinga[3]	186.0	35.5	221.5	16.0%
Metropolitan[4]	94.0	50.0	144.0	34.7%
Napa [5]	97.0	51.9	148.9	34.9%
Patton[6]	58.0	1.0	59.0	1.7%
Total	552.0	152.5	704.5	21.7%

[1] Only includes classification 1937 - Hospital Police Officer
[2] Authorized Positions as of DSH Budget Management Branch (BMB) Hospital Position Report FY 2022-23 November, Rev A.xlsx
3 DSH-Coalinga vacancies include 10.0 positions established 7/1/2022
[4] **DSH-**Metropolitan vacancies include 42.0 positions related to Increased Secure Bed Capacity (ISBC). Per the 2023-24 Governor's Budget Metro ISBC update (see section C02), this space is being used temporarily to respond to COVID-19 and to provide interim housing for Skilled Nursing Facility (SNF) patients while the SNF building is under repair for extensive water damage
[5] DSH-Napa vacancies include 30.0 positions established 7/1/2022
[6] DSH-Patton vacancies include 27.4 positions related to Enhanced Treatment Program that will not be filled due to COVID-19 impacts

Hospital Police Officer Attrition Rate

The table below displays the projected HPO attrition rate as of November 1, 2022, based on actual attrition rates and trends for fiscal years (FYs) 2020-21, 2021-22, and 2022-23:

HPO Attrition Rates as of November 1, 2022					
Hospitals	FY 2022-23 FTE[7]	FY 2022-23 Attrition Rate[8]	Avg Estimated Monthly Pos.	FY 2023-24 Attrition Rate[9]	Avg Estimated Monthly Pos.
Atascadero	131.1	1.3%	1.8	1.3%	1.8
Coalinga	221.5	0.5%	1.0	0.5%	1.0
Metropolitan	144.0	1.2%	1.8	1.2%	1.8
Napa	148.9	0.5%	0.7	0.5%	0.7
Patton	59.0	0.7%	0.4	0.7%	0.4
Total	**704.5**	**0.8%**	**5.7**	**0.8%**	**5.7**

Cadet Graduation Rates

The table below displays actual graduation rates from cohorts conducted from FY 2017-18 through the present.

[7] Authorized Positions as of DSH Budget Management Branch (BMB) Hospital Position Report FY 2022-23 November, Rev A.xlxs
[8] Projected attrition rate based on FY 2020-21, 2021-22, and 2022-23 data
[9] Projected attrition rate based on FY 2020-21, 2021-22, and 2022-23 data

OPS Cadet Graduation Rates				
Academy	Academy Dates	Cadets Attended	Cadets Graduated	Graduation Rate
Academy 27	(02/12/18 – 05/18/18)	50	44	88.0%
Academy 28	(08/13/18 – 11/16/18)	49	42	85.7%
Academy 29	(10/01/18 – 01/10/19)	38	32	84.2%
Academy 30	(02/11/19 – 05/31/19)	33	31	93.9%
Academy 31	(08/12/19 – 11/22/19)	43	34	79.1%
Academy 32	(12/02/19 – 03/20/20)	19	17	89.5%
Academy 33	(02/10/20 – 05/22/20)	20	16	80.0%
Academy 34	(08/24/20 – 12/10/20)	25	21	84.0%
Academy 35	(12/28/20 – 04/22/21)	19	10	52.6%
Academy 36	(05/03/21 – 08/12/21)	16	9	56.3%
Academy 37	(08/23/21 – 12/09/21)	10	4	40.0%
Academy 38	(12/28/21 – 04/17/22)	15	11	73.3%
Academy 39	(05/02/22 – 8/11/22)	24	18	75.0%
Academy 40	(08/23/22-12/08/22)	16	14	87.5%
Academy 41	(12/28/22-04/13/23)	22	-	TBD
	[10]Total	**377**	**303**	**80.4%**

[10] Not including Academy 41, scheduled to begin December 28, 2022

HPO Recruitment Efforts

COVID-19 has continued to impact the recruitment and hiring of cadets for Academy cohorts as the rest of the country continues to struggle with workforce challenges.

In response to these ongoing recruitment efforts, the Office of Protective Services (OPS) established a contract in December 2021 with Cooperative Personnel Services (CPS) to assist with recruitment efforts and increase the number of applications received. In addition to continuing to conduct online virtual Career Fairs, OPS and CPS have worked on creating videos and other media advertisements to increase awareness of DSH and the peace officer employment opportunities. Advertisements are frequently refreshed to continue to attract new applicants.

Prior to entering into the agreement with CPS, registration for the Cadet Entry Examination averaged 78 applicants per month. Since that time, the number of candidates registered for the entry examination now averages at well over 200 applications per month. Since this is a recent change and candidates must also complete a background investigation and psychiatric review prior to entry into the academy, it is anticipated that DSH will experience increases in the number of cadets enrolled in its academies later this year.

While DSH has increased the number of applicants, DSH is also exploring opportunities with CPS on how to increase the number of candidates who successfully make it from application to acceptance into an academy. These efforts will look at how to reduce the number of applicants who apply and do not ultimately take the exam, who are unsuccessful in the exam, and who apply to positions, but have not ever taken the exam. DSH is also reviewing background investigation and psychiatric review processes to identify further opportunities to increase the number of candidates in DSH's academies. DSH will continue to work on HPO recruitment efforts and provide an update in the 2023-24 May Revision.

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
Informational Only

EXECUTIVE SUMMARY

The Department of State Hospitals (DSH) has been 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 that prevent future aggression, increase safety, and protect patients and staff from harm.

DSH has been authorized to establish four ETP units totaling 49 beds. Three 13-bed units will be provided at DSH-Atascadero, and one 10-bed treatment unit will 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. An update on the status of the construction and activation of each unit is provided in DSH's annual Governor's Budget and May Revision Population and Caseload Estimates.

This report encompasses data collected between September 14, 2021, and September 30, 2022. 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.

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 high risk for the most dangerous behavior

against other patients and hospital staff. The ETP was developed to accept patients who are at the highest risk of violence and cannot otherwise be safely treated in a standard treatment environment. The ETP provides treatment intended to return patients to a standard treatment environment, with supports to 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 implement admissions and treatment planning processes to identify and address patients' violence risk factors.

This report covers activity since activation of the first 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, 2022. 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, 2022. 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 were collected using existing software and were 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[1]

Patient Characteristics

Gender	N (%)
Male	16 (100%)
Female[a]	0 (0%)

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

Ethnicity[a]	N (%)
American Indian or Alaska Native	0 (0%)
Asian	<11 (**%)
Black or African American	<11 (**%)
Hispanic or Latino	<11 (**%)
Native Hawaiian or Other Pacific Islander	<11 (**%)
White	<11 (**%)

[a] According to U.S. Census Bureau classifications.

[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 on Admission	N (%)
18-29	<11 (**%)
30-41	<11 (**%)
42-53	<11 (**%)
54-65	0 (0%)
66-77	0 (0%)
78-90	0 (0%)
Mean Age:	41.25 years

Legal Group	N (%)[a]
Incompetent to Stand Trial	<11 (**%)
Not Guilty by Reason of Insanity	<11 (**%)
Offender with a Mental Disorder	<11 (**%)
Lanterman-Petris Short Act	<11 (**%)
Sexually Violent Predator	<11 (**%)
Coleman[b]	0 (0%)

[a] This data captures years at DSH *prior* to ETP Admission.

[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]	N (%)
0-5	11 (68.8%)
6-10	<11 (**%)
11-15	0 (0%)
15 -20	<11 (**%)
20-25	0 (0%)
25+	0 (0%)
Mean:	5.75 years

[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.

Years at DSH[a] – Overall[b]	N (%)
0-5	<11 (**%)
6-10	<11 (**%)
11-15	<11 (**%)
15 -20	<11 (**%)
20-25	<11 (**%)
25+	0 (0%)
Mean:	9.38 years

[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. Their mean age is 41.25 years. Patients (residents) come from African American, Asian, Hispanic, Pacific Islander, and White ethnic backgrounds. Patients (residents) in the ETP belong to one of the following legal groups: 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. Since their most recent DSH admission, they have spent an average of 5.75 years at DSH. However, as some patients (residents) have been admitted to DSH on multiple occasions, the combined average time spent in DSH is 9.38 years.

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, 2022, the ETP maintained a staff-to-patient ratio of one to five or lower.

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 During Reporting Period
Level-of-Care Staff[a]	
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 : 4.3

[a] Level 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
April 2022	<11
May 2022	<11
June 2022	11.80
July 2022	12.39
August 2022	13.00
September 2022	13.00
Mean	10.74

Average Length of Stay	Days[a]
DSH- Atascadero Unit 29 Current Patients	292.85 (±111.54)
DSH-Atascadero Unit 29 Discharged Patients	132 (±73.02)
Total	262.69 (±121.93)

[a] Days are full days and (Standard Deviation)

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

The ETP began accepting patients on September 14, 2021. Since then, there have been a total of *** admissions and <11 discharges. At the end of this reporting period on September 30, 2022, there were 13 patients (residents) on the unit. 14 patients' (residents') length of stay exceeded 90 days during the reporting period. Of those patients (residents), <11 have been discharged. No patient (resident) had multiple stays. <11 patients (residents) were discharged during the reporting period. None of these discharges were delayed due to lack of available beds in a standard treatment environment.

Restraint and Seclusion Use

Over the reporting period from September 14, 2021, to September 30, 2022, there were five incidents of seclusion and 92 incidents of restraints.

Patients (residents) may be placed in seclusion or restraint for being an imminent danger to themselves or to others. Forty-four incidents of seclusion or restraint during the reporting period were related to patients (residents) being deemed an imminent danger to others, while 53 incidents of seclusion or restraint were related to imminent danger to self.

A total of five incidents of seclusion occurred on the ETP Unit and involved <11 patients for a total of 9.13 hours. Eighty-four incidents of 5-point bed restraint occurred on the ETP unit. Restraint usage lasted for a combined 914.15 hours. These 84 restraint incidents involved <11 of the 16 patients, however twenty two percent of those patients accounted for 47 (55%) of the incidents and 689.84 (75%) of the total restraint hours. There were also <11 incidents of ambulatory restraint use which lasted for a combined total of 6.56 hours.

Restraint and Seclusion Use of ETP Patients	N[a]	Duration[b]
Incidents and Duration of Seclusion Use	<11	9.13
Incidents and Duration of Ambulatory Restraint Use	<11	6.56
Incidents and Duration of Non-Ambulatory Restraint Use	84	914.15
Total	97	929.84

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

Reason for Restraint and Seclusion on ETP[a]	N[b]	Duration[c]
Danger to Other	44	273.17
Danger to Self	53	656.67

[a] Restraint and Seclusion while patient located on the ETP Unit.
[b] Number of distinct incidents requiring seclusion or 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 occurring between September 14, 2021, and September 30, 2022. Placement on 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 65.53%, while the duration of non-ambulatory restraint use decreased by 73.44%.

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 resulting in serious injury to staff during the review period. None of these injuries required hospitalization. There were <11 incidents of patient aggression to self that resulted in injuries to patients (residents). One of these incidents required hospitalization. There were no aggressive acts to other patients resulting in 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 there were no serious injuries to staff or patients (residents) related to the use of seclusion or restraints.

Serious Injuries	N
Serious Injuries to Staff[a]	***
Serious Injuries to Patients (Residents)[a]	<11
Serious injuries to Staff related to the use of seclusion and restraints[b]	0
Serious injuries to Patients (Residents) related to the use of seclusion and restraints[b]	0
Total	18

[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).

Rates of patient aggression toward peers and staff per month were obtained for aggressive acts and injuries which occurred six months prior to ETP admission and were compared to aggressive acts and injuries that occurred on the ETP between September 21, 2021, and September 30, 2022.

Rates of Aggression and Injury Prior to ETP vs. During ETP Admission[a]			
	Prior to ETP Admission	During ETP Admission	Rate of Change
Physical Aggression towards Staff	0.0553	0.0295	-46.6%
Physical Aggression towards Peers	0.0256	0.0031	-87.91%
Serious Injuries[b] of Staff	0.0078	.0029	-53.49%
Serious Injuries[b] of Peers	0.0017	0.000	-100%

[a] Rates of aggression are calculated per 30 patient days.
[b] Serious injury is defined as requiring medical care beyond first aid or overnight stay in a hospital as defined by Policy Directive #9500.

Overall results show an 87.91% reduction in frequency of aggressive acts towards peers, and a 46.6% 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 53.49%.

Staff Turnover

During the reporting period from September 14, 2021, through September 30, 2022, 4.0 registered nurses (RNs) left the ETP. These staff departures were unrelated to working on the ETP. 1.0 nurse retired, and the other 3.0 nurses left state service. During this same time period, 13.0 psychiatric technicians, including 2.0 senior psychiatric technicians, left the ETP. 2.0 psychiatric technicians retired, 7.0 transferred to other units inside the facility, and 4.0 left the facility for other employment.

During the reporting period of September 14, 2021, to September 30, 2022, the ETP hired 4.0 new registered nurses and 4.0 new psychiatric technicians. 6.0 psychiatric technicians, including 1.0 senior psychiatric technician, transferred into the ETP from other units in the facility.

Patients' Rights Complaints

The Disability Rights California, California Office of Patients' Rights provided information pertaining to patients' rights complaints received during the reporting period of September 14, 2021, through September 30, 2022. A total of 61 complaints were made by 11 patients (residents).

Complaint Category	Patients	Complaints
Access / Use of Personal Possessions	<11	<11
Advocacy Services	<11	<11
Conservatorship	<11	<11
Daily Living	<11	<11
Dignity / Privacy / Respect / Human Care	<11	<11
Keep / Spend Reasonable Sum of Money / Personal Funds	<11	<11
Legal	<11	<11
Medical Care and Treatment	<11	<11
Medication Side Effects	<11	<11
Mental Health Treatment	<11	<11
Patient Withdrew the Complaint	<11	<11
Physical Abuse	<11	<11
Physical Exercise/Recreation / Out of Doors	<11	<11
Religious Freedom and Practice	<11	<11
Social Interaction / Participation	<11	<11
Telephones / Confidential Use	<11	<11
Treatment Services Promoting Independence	<11	<11
Unable to read, to understand or unrelated	<11	<11
Visitors / Visiting Space	<11	<11

Access / Use of Personal Possessions

- <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

- <11 complaint was regarding patient 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.

Conservatorship

- <11 complaint was regarding a conservatorship hearing and not receiving information about how to participate in the hearing.
    - 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

- <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

- <11 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.

Keep / Spend Reasonable Sum of Money / Personal Funds

- <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 patient 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 patient 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 patient's psychologist regarding the patient's desire to go to The Grill. The patient was 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

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

Medical Care and Treatment

- <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 patient was able to visit 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

- <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 medication dosage was lowered and no longer had concerns about medication side effects.

Mental Health Treatment

- <11 complaints were regarding treatment team meetings and treatment for sex offenders on the ETP.
    - Resolution: The PRA confirmed patient is 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

- <11 complaints were regarding groups, phones not working, 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 patient, the patient confirmed that the issues had resolved and withdrew the complaint.

Physical Abuse

- <11 complaint was 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

- <11 complaint was 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 this patient and that he will remain separate from the other patient while in the courtyard.

Religious Freedom and Practice

- <11 complaint was 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 prevention measures.

Social Interaction (3) and Participation and Telephones / Confidential Use (4)

- <11 complaints were regarding having a movie night on Sunday, telephones not working, and getting in touch with family.
    - Resolution: The PRA determined that the patient has access to movie night on Saturdays and that patient request for Sunday afternoon interferes with Unit Schedule (medication pass and physical assessments). The PRA confirmed that the telephones were repaired, and patient was 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

- <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 patient 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). The patient was referred to their treatment team to request a referral to educational services.

Unable to read, to understand, or unrelated

- <11 complaint was regarding a request that the PRA give their letter to the nurse.
    - Resolution: The nurse received the letter per patient request.

Visitors / Visiting Space

- <11 complaint was regarding not being allowed to have a video call with girlfriend.
    - Resolution: The PRA informed patient that it is his visitor's responsibility to contact the DSH-Atascadero Executive Director to ask for an exception to the administrative directive as 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. Twenty-two staff completed this video training during the reporting period of September 14, 2021, through September 30, 2022. 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. Courses provided included:

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

In addition to the formalized training outlined above, ETP team members received informal consultation from subject matter experts 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 as of September 30, 2022.

ETP Permanent[a] Staff	Filled	Vacant
Registered Nurse	14	3
Psychiatric Technician (includes Senior Psychiatric Technician)	20	5
Licensed Vocational Nurse	1	0
Psychiatrist	1	0
Psychologist	2	0
Social Worker	1	0
Rehabilitation Therapist	2	0
FNAT Psychologist	3	0
Hospital Police Officers	9	0
Unit Supervisor	1	0

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

FINDINGS AND RECOMMENDATIONS

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

The ETP was conceived of as an environment to manage aggression, with units designed and constructed with environmental controls, such as single rooms, to allow for management of aggression outside of restraint use. A foremost goal of the ETP is to reduce the use of restraints. Forty-six percent of restraint use is related to aggressive acts towards staff. Of note is that 50 (60%) of the 84 non-ambulatory restraint incidents occurred within the first three months of activation. Twenty-seven of these episodes of restraint use (54%) were related to aggressive acts towards self. As a result, during this reporting period the ETP referral process was adjusted to increase screening for self-injurious behavior. Additionally, 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.

An additional aim is 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 consist of the following:

- Continuing and seeking additional opportunities to expand DSH's partnerships with educational institutions across the state in nursing, psychology, and psychiatry.

  - DSH partners with Cuesta College, Napa Valley College, and West Hills College to provide psychiatric technician training programs and clinical training sites in our hospital system. This relationship creates and grows the pipeline of psychiatric technicians into our system by cultivating relationships with the students in their pre-licensed status and then ultimately as licensed psychiatric technicians. DSH-Atascadero in partnership with Cuesta College recently expanded the size of its psychiatric technician training program.
  - For psychiatry, DSH provides post-residency training in forensic psychiatry through the University of California Davis and also partners with the University of California School of Medicine, Department of Psychiatry, Los Angles/Harbor to provide clinical and didactic training to psychiatric fellows on rotation at DSH-Metropolitan. DSH-Patton also provides University of California, Riverside with psychiatry rotations, and DSH-Napa recently established a psychiatry residency program.
- Expanding marketing and outreach initiatives to attract a diverse and talented workforce through DSH's established Recruitment Unit.

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

BACKGROUND

The Budget Act of 2019 added the following Provisional Language:

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

In response to the Provisional Language, the Department of State Hospitals (DSH) and the Judicial Council worked to ensure the Superior Courts of California data related to Penal Code (PC) section 1001.36 is transmitted and incorporated into the county data sets collected from the pre-trial diversion program (per Welfare and Institutions Code (WIC) 4361). This report describes the methodologies employed by both departments to collect the data required by WIC 4361 and the Provisional Language, as well as challenges encountered. Additionally, a high-level summary of the data collected as of June 30, 2022, is provided.

2023-24 GOVERNOR'S BUDGET REPORT

Judicial Council Data Collection Methodology

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

beginning January 1, 2020. In response to those requirements, the Judicial Council amended its quarterly superior court data surveys to include requests for totals of petitions for mental health diversion, petition outcomes, and program outcomes. These items were further amended to distinguish between petitions and diversions for cases including at least one felony charge and total petitions and diversions.

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

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

Judicial Council Data Collection Challenges

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

DSH Data Collection Methodology

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

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

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

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

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

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

Data Collection Challenges

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

In FY 2019-20, data collection for this program was also impacted by COVID-19. Numerous counties which had planned to activate programs and begin diverting individuals before June 30, 2020, were delayed due to the numerous impacts of the pandemic, including court closures, and resource constraints in the county, mass releases of inmates at the local jails and virus outbreaks at the jails. These delays reduced the number of counties reporting to DSH in FY 2019-20. As of Spring 2021 all current DSH-contracted programs have been activated and reported data as of June 30, 2022.

SUMMARY OF REPORTED DATA

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

FY 2018-19

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

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

FY 2019-20

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

FY 2019-20 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	1,924
PC 1001.36 Petitions Received (Felony)	563
PC 1001.36 Petitions Granted	680
PC 1001.36 Petitions Granted (Felony)	222
PC 1001.36 Petitions Denied	246
PC 1001.36 Petitions Denied (Felony)	99
PC 1001.36 Petitions Denied due to Statute	93
PC 1001.36 Petitions Denied due to Statute (Felony)	48
PC 1001.36 Successful Completions	78
PC 1001.36 Successful Completions (Felony)	30
PC 1001.36 Unsuccessful Terminations	62
PC 1001.36 Unsuccessful Terminations (Felony)	7
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	114
WIC 4361 Diversion Started	115
WIC 4361 Unsuccessful Terminations	< 11
WIC 4361 Successful Completions	0

FY 2020-21

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

FY 2020-21 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	2,246
PC 1001.36 Petitions Received (Felony)	1,312
PC 1001.36 Petitions Granted	1,415
PC 1001.36 Petitions Granted (Felony)	624
PC 1001.36 Petitions Denied	735
PC 1001.36 Petitions Denied (Felony)	455
PC 1001.36 Petitions Denied due to Statute	413
PC 1001.36 Petitions Denied due to Statute (Felony)	269
PC 1001.36 Successful Completions	658
PC 1001.36 Successful Completions (Felony)	219
PC 1001.36 Unsuccessful Terminations	164
PC 1001.36 Unsuccessful Terminations (Felony)	86
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	258
WIC 4361 Diversion Started	259
WIC 4361 Unsuccessful Terminations	38
WIC 4361 Successful Completions	44

FY 2021-22

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

FY 2021-22 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	3,787
PC 1001.36 Petitions Received (Felony)	2,233
PC 1001.36 Petitions Granted	2,427
PC 1001.36 Petitions Granted (Felony)	1,429
PC 1001.36 Petitions Denied	885
PC 1001.36 Petitions Denied (Felony)	535
PC 1001.36 Petitions Denied due to Statute	504
PC 1001.36 Petitions Denied due to Statute (Felony)	293
PC 1001.36 Successful Completions	927
PC 1001.36 Successful Completions (Felony)	318
PC 1001.36 Unsuccessful Terminations	280
PC 1001.36 Unsuccessful Terminations (Felony)	146
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	407
WIC 4361 Diversion Started	387
WIC 4361 Unsuccessful Terminations	133
WIC 4361 Successful Completions	116

Number of Counties Reporting by Quarter

The first table below provides a summary of the total number of counties reporting data each quarter. The following tables display a more detailed count of the total number of counties reporting on each data element by FY quarter from 2018-19 through 2020-21.

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

** Data was not collected during this time period

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

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

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

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

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

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

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

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

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

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

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

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

January - March 2022				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	46	3	6	3
PC 1001.36 Petitions Received (Felony)	45	4	6	3
PC 1001.36 Petitions Granted	47	2	6	3
PC 1001.36 Petitions Granted (Felony)	46	3	6	3
PC 1001.36 Petitions Denied	45	4	6	3
PC 1001.36 Petitions Denied (Felony)	44	5	6	3
PC 1001.36 Petitions Denied due to Statute	41	8	6	3
PC 1001.36 Petitions Denied due to Statute (Felony)	40	9	6	3
PC 1001.36 Successful Completions	46	3	6	3
PC 1001.36 Successful Completions (Felony)	45	4	6	3
PC 1001.36 Unsuccessful Terminations	47	2	6	3
PC 1001.36 Unsuccessful Terminations (Felony)	45	3	7	3
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	0	0
WIC 4361 Diversion Started	24	0	0	0
WIC 4361 Unsuccessful Terminations	24	0	0	0
WIC 4361 Successful Completions	24	0	0	0

April - June 2022				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	39	3	3	13
PC 1001.36 Petitions Received (Felony)	40	3	2	13
PC 1001.36 Petitions Granted	40	2	3	13
PC 1001.36 Petitions Granted (Felony)	39	3	3	13
PC 1001.36 Petitions Denied	39	3	3	13
PC 1001.36 Petitions Denied (Felony)	38	4	3	13
PC 1001.36 Petitions Denied due to Statute	35	7	3	13
PC 1001.36 Petitions Denied due to Statute (Felony)	35	7	3	13
PC 1001.36 Successful Completions	39	3	3	13
PC 1001.36 Successful Completions (Felony)	38	4	3	13
PC 1001.36 Unsuccessful Terminations	40	2	3	13
PC 1001.36 Unsuccessful Terminations (Felony)	39	3	3	13
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	0	0
WIC 4361 Diversion Started	24	0	0	0
WIC 4361 Unsuccessful Terminations	24	0	0	0
WIC 4361 Successful Completions	24	0	0	0