Department of State Hospitals
2020-21 Governor's Budget Estimates
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CALIFORNIA DEPARTMENT OF STATE HOSPITALS
PROGRAM OVERVIEW

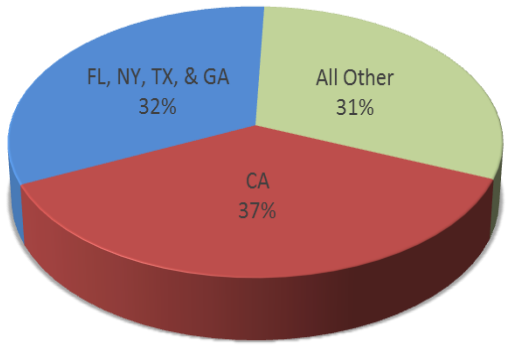
DSH Program Background

The mission of the California Department of State Hospitals (DSH) is to provide evaluation and treatment to patients in a safe and responsible manner, while seeking innovation and excellence in hospital operations across a continuum of care and settings. 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 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, 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. Additionally, DSH provides services in jail-based competency treatment (JBCT) programs and conditional release (CONREP) programs throughout the 58 counties. In FY 2018-19, DSH served 11,752 patients within state hospitals and jail-based facilities, with average daily censuses of 6,122 and 290 respectively. The CONREP program maintains an average daily census of approximately 661.

According to the National Association of State Mental Health Program Directors (NASMHD), California comprises 37 percent of all forensic mental health patients served in the United States. By comparison, the next four largest states – Florida, New York, Texas and Georgia – collectively comprise less than a third (32 percent) of the population. The following graph illustrates the distribution of the United States' forensic mental health population per the 2013 National Association of State Mental Health Program Directors, State Profiles.

Figure 1: Percentage of Forensic Mental Health Population Served in the United States



[1] Effective January 1, 2020 the term referring to the patient population Mentally Disordered Offender (MDO) is changed to Offender with a Mental Health Disorder (OMD) per SB 591 (Statutes of 2019).

Over the past 25 years, the Department's population demographic has shifted from primarily civil court commitments to a forensic population referred through the criminal court system. For the forensic patients it serves, DSH treats patients and the courts decide when they can be discharged. DSH cannot admit or discharge patients without a court's consent order nor refuse to treat patients. More than 90 percent of the patient population is forensic, including *Coleman* patients referred from CDCR. The remaining 10 percent of the population are patients admitted per the *Lanterman-Petris-Short* (LPS) Act.

With nearly 13,000 employees located in headquarters and five facilities throughout the state, every staff member's efforts at DSH focuses on the provision of mental health treatment in a secure setting while maintaining the safety of patients and staff. Approximately half of the Department's employees are in nursing classifications, including psychiatric technicians and registered nurses.

DSH is funded through the General Fund and reimbursements from counties for the care of LPS patients. All DSH facilities are licensed through the California Department of Public Health 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.

DSH State Hospitals

DSH-Atascadero: Opened in 1954, DSH-Atascadero is located on the Central Coast of California in Atascadero (San Luis Obispo County). The hospital is a forensic mental health hospital and is a self-contained psychiatric hospital constructed within a security perimeter. The majority of the all-male patient population is remanded for treatment by county superior courts or by CDCR pursuant to various sections of the California Penal Code (PC) and the Welfare and Institutions Code (WIC).

DSH-Atascadero primarily serves the following four patient types: Offender with a Mental Health Disorder (OMD)[1], *Coleman* patients 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. The hospital is California's newest 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 Penal Code and the Welfare and Institutions Code.

DSH-Coalinga primarily serves the following three patient types: ODM[1], *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

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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.

DSH-Metropolitan's operational bed capacity is restricted due to multiple units within two areas of the hospital that are located outside of the secured treatment area (STA). The units outside of the STA are unable to house PC forensically committed patients. In order to properly house the PC patients and provide additional capacity, a secured fence surrounding the remaining non-STA area is required and would increase the operational capacity to 1,062.

DSH-Metropolitan primarily serves the following four patient types: LPS, IST, ODM[1], 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. This hospital opened due to overcrowded conditions at the Stockton Asylum. 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 types: LPS, IST, ODM[1], 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 types: LPS, IST, ODM[1], and NGI.

For additional information on the specific state hospitals, please reference the DSH Hospital Profiles located within Section E2.

[1] Effective January 1, 2020 the term referring to the patient population Mentally Disordered Offender (MDO) is changed to Offender with a Mental Health Disorder (OMD) per SB 591 (Statutes of 2019).

POSITION SUMMARY
CURRENT YEAR 2019-20

	Authorized Positions Budget Act 2019	Authorized Blanket Positions 2019	Electronic Health Record within Clinical Assessments, Reports and Evaluation System-Phase 2	Treatment Team Staffing Study	Protecitive Services Staffing Study	Quality Improvement and Internal Auditing, Monitoring, Risk Management and Hospital Support	Post-Incident Debriefing and Support	Cooperative Electronic Document Management System (CEDMS)	Increase Resources for Regulation Promulgation	DSH-Metro Incresed Secure Bed Capacity	Enhanced Treatment Program Adjustment	Community Care Collaborative Pilot Program	Total November Estimate Adjustments	Total Positions CY 2019-20	Total CY Adjustments
Headquarters Admin	247.9	2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	249.9	0.0
Hospital Admin	246.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	246.3	0.0
DSH-Atascadero	2,188.2	30.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-26.7	0.0	-26.7	2,191.6	-26.7
DSH-Coalinga	2,324.0	28.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2,352.0	0.0
DSH-Metropolitan	2,166.6	67.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-51.1	0.0	0.0	-51.1	2,182.7	-51.1
DSH-Napa	2,476.9	47.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2,524.4	0.0
DSH-Patton	2,428.1	81.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-5.6	0.0	-5.6	2,503.7	-5.6
State Hospital Police Academy	7.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	7.0	0.0
CONREP	9.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	9.7	0.0
CONREP SVP	4.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.9	0.0
AES	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0
JBCT	3.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.6	0.0
Other Contracted Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Evaluation and Forensic Services	73.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	73.3	0.0
2019-20 Established Position Totals	12,177.5	256.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-51.1	-32.3	0.0	-83.4	12,350.1	-83.4

POSITION SUMMARY
BUDGET YEAR 2020-21

	Authorized Positions Budget Act 2019	Authorized Blanket Positions 2019	Electronic Health Record within Clinical Assessments, Reports and Evaluation System-Phase 2	Treatment Team Staffing Study	Protecitive Services Staffing Study	Quality Improvement and Internal Auditing, Monitoring, Risk Management and Hospital Support	Post-Incident Debriefing and Support	Cooperative Electronic Document Management System (CEDMS)	Increase Resources for Regulation Promulgation	DSH-Metro Incresed Secure Bed Capacity	Enhanced Treatment Program Adjustment	Community Care Collaborative Pilot Program	Total November Estimate Adjustments	Total Positions BY 2020-21	Total BY Adjustments
Headquarters Admin	247.3	2.0	18.0	14.0	1.0	11.0	5.0	0.0	3.0	0.0	0.0	0.0	52.0	301.3	52.0
Hospital Admin	243.3	0.0	0.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0	0.0	2.0	245.3	2.0
DSH-Atascadero	2,241.5	30.1	0.0	11.6	9.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	20.6	2,292.2	20.6
DSH-Coalinga	2,353.5	28.0	0.0	9.2	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	10.2	2,391.7	10.2
DSH-Metropolitan	2,228.3	67.2	0.0	14.4	9.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0	25.4	2,320.9	25.4
DSH-Napa	2,524.5	47.5	0.0	18.7	25.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	44.0	2,616.0	44.0
DSH-Patton	2,485.3	81.2	0.0	13.0	1.0	0.0	0.0	0.0	0.0	0.0	-1.5	0.0	12.5	2,579.0	12.5
State Hospital Police Academy	7.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	7.0	0.0
CONREP	9.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	9.7	0.0
CONREP SVP	5.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.0	0.0
AES	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0
JBCT	3.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.6	0.0
Other Contracted Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.0	3.0	3.0	3.0
Evaluation and Forensic Services	73.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	73.3	0.0
2020-21 Established Position Totals	12,423.3	256.0	18.0	80.9	46.3	11.0	5.0	2.0	3.0	2.0	-1.5	3.0	169.7	12,849.0	169.7

Detailed Funding Summary - All Programs
2020-21 Governor's Budget Detail of Adjustments

Department of State Hospitals
2020-21 Governor's Budget Estimates

				2020-21 Governor's Budget: Baseline Adjustments							
Fund	**Reference**	**Program**	**Current Service Level**	**Allocation for Employee Compensation**	**Allocation for Other Post-Employment Benefits**	**Allocation for Staff Benefits**	**Lease Revenue Debt Service Adjustment**	**Lottery Fund Technical Adjustment**	**Section 3.60 Pension Contribution Adjustment**	**Attorney General Services Rate Increase**	**BBA Subtotal**
0001-General Fund	RF 003	4410010-Atascadero	$3,670,000				$2,000				$2,000
		4410020-Coalinga	$30,856,000				$682,000				$682,000
		4410030-Metropolitan	$2,193,000				$5,000				$5,000
		4410040-Napa	$2,246,000				-$8,000				-$8,000
		4410050-Patton	$963,000				$9,000				$9,000
	RF 003 Total		**$39,928,000**				**$690,000**				**$690,000**
	RF 011	4400010-Headquarters Administration	$59,205,000	$683,000	$205,000	$345,000			$341,000	$1,506,000	$3,080,000
		4400020-Hospital Administration	$98,998,000	$718,000	$225,000	$379,000			$335,000		$1,657,000
		4410010-Atascadero	$287,614,000	$3,806,000	$1,923,000	$1,909,000			$2,432,000		$10,070,000
		4410020-Coalinga	$306,290,000	$4,079,000	$2,028,000	$2,129,000			$2,661,000		$10,897,000
		4410030-Metropolitan	$234,737,000	$3,896,000	$1,783,000	$1,902,000			$2,371,000		$9,952,000
		4410040-Napa	$291,523,000	$4,736,000	$2,093,000	$2,395,000			$2,724,000		$11,948,000
		4410050-Patton	$354,542,000	$4,397,000	$2,094,000	$2,177,000			$2,703,000		$11,371,000
		4410060-State Hospital Police Academy	$6,373,000	$32,000	$8,000	$15,000			$19,000		$74,000
		4420010-Conditional Release Program	$14,389,000	$26,000	$11,000	$14,000			$17,000		$68,000
		4420020-Conditional Release Program - SVP	$34,423,000	$14,000	$6,000	$8,000			$10,000		$38,000
		4430010-Admission, Evaluation, Stabilization Center	$10,772,000	$3,000	$1,000	$2,000			$2,000		$8,000
		4430020-Jail Based Competency Treatment	$57,493,000	$5,000	$2,000	$2,000			$2,000		$11,000
		4430030-Other Contracted Services	$15,570,000	$3,000	$1,000	$2,000			$2,000		$8,000
		4440-Evaluation and Forensic Services	$22,868,000	$202,000	$90,000	$111,000			$144,000		$547,000
	RF 011 Total		**$1,794,797,000**	**$22,600,000**	**$10,470,000**	**$11,390,000**			**$13,763,000**	**$1,506,000**	**$59,729,000**
	RF 017	4400010-Headquarters Administration	$413,000	$6,000	$2,000	$3,000			$4,000		$15,000
		4400020-Hospital Administration	$852,000	$18,000	$6,000	$10,000			$8,000		$42,000
	RF 017 Total		**$1,265,000**	**$24,000**	**$8,000**	**$13,000**			**$12,000**		**$57,000**
	RF 502	4410010-Atascadero	$46,000								
		4410020-Coalinga	$101,000								
		4410030-Metropolitan	$150,000								
		4410040-Napa	$480,000								
		4410050-Patton	$323,000								
	RF 502 Total		**$1,100,000**								
0001-General Fund Total			**$1,837,090,000**	**$22,624,000**	**$10,478,000**	**$11,403,000**	**$690,000**		**$13,775,000**	**$1,506,000**	**$60,476,000**
Lottery Education Fund	RF 511	4410010-Atascadero	$8,000					$2,000			$2,000
		4410030-Metropolitan	$8,000					$2,000			$2,000
		4410040-Napa	$8,000					$3,000			$3,000
		4410050-Patton	$8,000					$3,000			$3,000
	RF 511 Total		**$32,000**					**$10,000**			**$10,000**
0814-California State Lottery Education Fund Total			**$32,000**					**$10,000**			**$10,000**
0995-Reimbursements	RF 511	4400020-Hospital Administration	$3,412,000								
		4410010-Atascadero	$2,532,000								
		4410020-Coalinga	$32,000								
		4410030-Metropolitan	$80,882,000								
		4410040-Napa	$57,639,000								
		4410050-Patton	$25,328,000								
	RF 511 Total		**$169,825,000**								
0995-Reimbursements Total			**$169,825,000**								
Grand Total			**$2,006,947,000**	**$22,624,000**	**$10,478,000**	**$11,403,000**	**$690,000**	**$10,000**	**$13,775,000**	**$1,506,000**	**$60,486,000**

Detailed Funding Summary - All Programs
2020-21 Governor's Budget Detail of Adjustments

Department of State Hospitals
2020-21 Governor's Budget Estimates

			2020-21 Governor's Budget: Budget Change Proposals												
Fund	**Reference**	**Program**	**Electronic Health Record within Clinical Assessments, Reports and Evaluation System-Phase 2**	**Statewide Roof Repairs and Replacement**	**Quality Improvement and Internal Auditing, Monitoring, Risk Management and Hospital Support**	**Post-Incident Debriefing and Support**	**Increase Resources for Regulation Promulgation**	**Mission-Based Review - Treatment Team**	**Statewide Integrated Health Care Provider Network**	**Relocation to the Clifford L. Allenby Building-Phase 2**	**Pharmacy Modernization-Phase 2**	**Statewide Ligature Risk Special Repair Funding**	**Mission-Based Review - Protective Services**	**Cooperative Electronic Document Management System**	**BCP Subtotal**
0001-General Fund	RF 003	4410010-Atascadero													
		4410020-Coalinga													
		4410030-Metropolitan													
		4410040-Napa													
		4410050-Patton													
	RF 003 Total														
	RF 011	4400010-Headquarters Administration	$9,588,000	$49,438,000	$1,539,000	$826,000	$480,000	$754,000	$2,206,000	$2,692,000			$283,000	$441,000	$68,247,000
		4400020-Hospital Administration	$18,000	$5,000	$11,000	$5,000	$3,000	$77,000	$4,106,000	$3,808,000	$5,378,000		$46,000	$5,202,000	$18,659,000
		4410010-Atascadero						$5,718,000				$1,281,000	$1,513,000		$8,512,000
		4410020-Coalinga						$6,886,000					$288,000		$7,174,000
		4410030-Metropolitan						$5,786,000				$910,000	$1,557,000		$8,253,000
		4410040-Napa						$6,825,000				$3,659,000	$3,856,000		$14,340,000
		4410050-Patton						$5,974,000				$4,661,000	$357,000		$10,992,000
		4410060-State Hospital Police Academy													
		4420010-Conditional Release Program													
		4420020-Conditional Release Program - SVP													
		4430010-Admission, Evaluation, Stabilization Center													
		4430020-Jail Based Competency Treatment													
		4430030-Other Contracted Services													
		4440-Evaluation and Forensic Services													
	RF 011 Total		**$9,606,000**	**$49,443,000**	**$1,550,000**	**$831,000**	**$483,000**	**$32,020,000**	**$6,312,000**	**$6,500,000**	**$5,378,000**	**$10,511,000**	**$7,900,000**	**$5,643,000**	**$136,177,000**
	RF 017	4400010-Headquarters Administration													
		4400020-Hospital Administration													
	RF 017 Total														
	RF 502	4410010-Atascadero													
		4410020-Coalinga													
		4410030-Metropolitan													
		4410040-Napa													
		4410050-Patton													
	RF 502 Total														
0001-General Fund Total			**$9,606,000**	**$49,443,000**	**$1,550,000**	**$831,000**	**$483,000**	**$32,020,000**	**$6,312,000**	**$6,500,000**	**$5,378,000**	**$10,511,000**	**$7,900,000**	**$5,643,000**	**$136,177,000**
Lottery Education Fund	RF 511	4410010-Atascadero													
		4410030-Metropolitan													
		4410040-Napa													
		4410050-Patton													
	RF 511 Total														
0814-California State Lottery Education Fund Total															
0995-Reimbursements	RF 511	4400020-Hospital Administration													
		4410010-Atascadero													
		4410020-Coalinga													
		4410030-Metropolitan													
		4410040-Napa													
		4410050-Patton													
	RF 511 Total														
0995-Reimbursements Total															
Grand Total			**$9,606,000**	**$49,443,000**	**$1,550,000**	**$831,000**	**$483,000**	**$32,020,000**	**$6,312,000**	**$6,500,000**	**$5,378,000**	**$10,511,000**	**$7,900,000**	**$5,643,000**	**$136,177,000**

Detailed Funding Summary - All Programs
2020-21 Governor's Budget Detail of Adjustments

Department of State Hospitals
2020-21 Governor's Budget Estimates

			2020-21 Governor's Budget: Enrollment, Caseload and Population Adjustments										
Fund	**Reference**	**Program**	**Enhanced Treatment Program**	**Metropolitan State Hospital Increased Secure Bed Capacity**	**Community Care Collaborative Pilot Program**	**Admission, Evaluation, and Stabilization Center Expansion**	**Jail-Based Competency Treatment Program**	**Patient-Driven Operating Expenses**	**Conditional Release Program for Non-Sexually Violent Predators Provider Contract Funding**	**Incompetent to Stand Trial "Off-Ramp" Services**	**Lanterman-Petris-Short Population and Personal Services Adjustment**	**ECP Subtotal**	**Governor's Budget**
0001-General Fund	RF 003	4410010-Atascadero											$3,672,000
		4410020-Coalinga											$31,538,000
		4410030-Metropolitan											$2,198,000
		4410040-Napa											$2,238,000
		4410050-Patton											$972,000
	RF 003 Total												**$40,618,000**
	RF 011	4400010-Headquarters Administration			$15,000							$15,000	$130,547,000
		4400020-Hospital Administration	$638,000	$2,000	$3,000							$643,000	$119,957,000
		4410010-Atascadero	$0					$603,000				$603,000	$306,799,000
		4410020-Coalinga						$882,000				$882,000	$325,243,000
		4410030-Metropolitan		$292,000				$299,000				$591,000	$253,533,000
		4410040-Napa						$477,000				$477,000	$318,288,000
		4410050-Patton	-$253,000					$1,273,000				$1,020,000	$377,925,000
		4410060-State Hospital Police Academy											$6,447,000
		4420010-Conditional Release Program							$2,200,000			$2,200,000	$16,657,000
		4420020-Conditional Release Program - SVP											$34,461,000
		4430010-Admission, Evaluation, Stabilization Center				$5,283,000						$5,283,000	$16,063,000
		4430020-Jail Based Competency Treatment					$1,626,000					$1,626,000	$59,130,000
		4430030-Other Contracted Services			$24,545,000					$2,000,000		$26,545,000	$42,123,000
		4440-Evaluation and Forensic Services											$23,415,000
	RF 011 Total		**$385,000**	**$294,000**	**$24,563,000**	**$5,283,000**	**$1,626,000**	**$3,534,000**	**$2,200,000**	**$2,000,000**		**$39,885,000**	**$2,030,588,000**
	RF 017	4400010-Headquarters Administration											$428,000
		4400020-Hospital Administration											$894,000
	RF 017 Total												**$1,322,000**
	RF 502	4410010-Atascadero											$46,000
		4410020-Coalinga											$101,000
		4410030-Metropolitan											$150,000
		4410040-Napa											$480,000
		4410050-Patton											$323,000
	RF 502 Total												**$1,100,000**
0001-General Fund Total			**$385,000**	**$294,000**	**$24,563,000**	**$5,283,000**	**$1,626,000**	**$3,534,000**	**$2,200,000**	**$2,000,000**		**$39,885,000**	**$2,073,628,000**
Lottery Education Fund	RF 511	4410010-Atascadero											$10,000
		4410030-Metropolitan											$10,000
		4410040-Napa											$11,000
		4410050-Patton											$11,000
	RF 511 Total												**$42,000**
0814-California State Lottery Education Fund Total													**$42,000**
0995-Reimbursements	RF 511	4400020-Hospital Administration											$3,412,000
		4410010-Atascadero									$114,000	$114,000	$2,646,000
		4410020-Coalinga											$32,000
		4410030-Metropolitan									$3,226,000	$3,226,000	$84,108,000
		4410040-Napa									$2,076,000	$2,076,000	$59,715,000
		4410050-Patton									$1,374,000	$1,374,000	$26,702,000
	RF 511 Total										**$6,790,000**	**$6,790,000**	**$176,615,000**
0995-Reimbursements Total											**$6,790,000**	**$6,790,000**	**$176,615,000**
Grand Total			**$385,000**	**$294,000**	**$24,563,000**	**$5,283,000**	**$1,626,000**	**$3,534,000**	**$2,200,000**	**$2,000,000**	**$6,790,000**	**$46,675,000**	**$2,250,285,000**

STATE HOSPITALS POPULATION

	CURRENT YEAR 2019-20				
	July 1, 2019 Actual Census	Previously Approved Adjustments CY 2019-20	2020-21 November Adjustment CY 2019-20	2020-21 May Revision Adjustment CY 2019-20	June 30, 2020 Projected Census
POPULATION BY HOSPITAL					
ATASCADERO	1,132	-50	0	0	1,082
COALINGA	1,392	0	0	0	1,392
METROPOLITAN	795	236	0	0	1,031
NAPA	1,255	0	0	0	1,255
PATTON	1,530	-43	0	0	1,487
TOTAL BY HOSPITAL	**6,104**	**143**	**0**	**0**	**6,247**
POPULATION BY COMMITMENT					
Coleman - PC 2684[1]	187	0	0	0	187
IST - PC 1370	1,480	170	0	0	1,650
LPS & PC 2974	733	6	0	0	739
OMD - PC 2962[2]	556	-12	0	0	544
OMD - PC 2972[2]	776	0	0	0	776
NGI - PC 1026	1,411	-21	0	0	1,390
SVP - WIC 6602/6604	961	0	0	0	961
TOTAL BY COMMITMENT	**6,104**	**143**	**0**	**0**	**6,247**
CONTRACTED PROGRAMS					
AES KERN CENTER	59	1	30	0	90
REGIONAL JBCT	181	91	-33	0	239
SINGLE COUNTY JBCT	81	33	0	0	114
SMALL COUNTY MODEL JBCT: MENDOCINO, MARIPOSA[3]	N/A	N/A	N/A	N/A	N/A
TOTAL - CONTRACTED PROGRAMS	**321**	**125**	**-3**	**0**	**443**
CY POPULATION AND CONTRACTED TOTAL	**6,425**	**268**	**-3**	**0**	**6,690**

Note: DSH contracts with community based programs to provide IST restoration and conditional release services. These services are provided through the Los Angeles IST Restoration Program, which operates 210 beds and through the Conditional Release Program, which operates an average of 646 beds.

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.

[2] Effective January 1, 2020 the term referring to the patient population Mentally Disordered Offender (MDO) is changed to Offender with a Mental Health Disorder (OMD) per SB 591 (Statutes of 2019).

[3] Mendocino and Mariposa JBCT do not have a set number of beds and instead focus on the number of patients served. As such, the annual population change total does not include these additional beds.

STATE HOSPITALS POPULATION

	BUDGET YEAR 2020-21				
	July 1, 2020 Projected Census	Previously Approved Adjustments BY 2020-21	2020-21 November Adjustment BY 2020-21	2020-21 May Revision Adjustment BY 2020-21	June 30, 2021 Projected Census
POPULATION BY HOSPITAL					
ATASCADERO	1,082	13	0	0	1,095
COALINGA	1,392	0	0	0	1,392
METROPOLITAN	1,031	0	0	0	1,031
NAPA	1,255	0	0	0	1,255
PATTON	1,487	10	0	0	1,497
TOTAL BY HOSPITAL	**6,247**	**23**	**0**	**0**	**6,270**
POPULATION BY COMMITMENT					
Coleman - PC 2684[1]	187	0	0	0	187
IST - PC 1370	1,650	8	0	0	1,658
LPS & PC 2974	739	3	0	0	742
OMD - PC 2962[2]	544	6	0	0	550
OMD - PC 2972[2]	776	0	0	0	776
NGI - PC 1026	1,390	6	0	0	1,396
SVP - WIC 6602/6604	961	0	0	0	961
TOTAL BY COMMITMENT	**6,247**	**23**	**0**	**0**	**6,270**
CONTRACTED PROGRAMS					
AES KERN CENTER	90	0	0	0	90
REGIONAL JBCT	239	0	27	0	266
SINGLE COUNTY JBCT	114	0	21	0	135
SMALL COUNTY MODEL JBCT: MENDOCINO, MARIPOSA, EL DORADO, SISKIYOU, TUOLUMNE [3]	N/A	N/A	N/A	N/A	N/A
TOTAL - CONTRACTED PROGRAMS	**443**	**0**	**48**	**0**	**491**
BY POPULATION AND CONTRACTED TOTAL	**6,690**	**23**	**48**	**0**	**6,761**

Note: DSH contracts with community based programs to provide IST restoration and conditional release services. These services are provided through the Los Angeles IST Restoration Program, which operates 210 beds and through the Conditional Release Program, which operates an average of 646 beds.

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.

[2] Effective January 1, 2020 the term referring to the patient population Mentally Disordered Offernder (MDO) is changed to Offender with a Mental Health Disorder (OMD) per SB 591 (Statutes of 2019).

[3] Mendocino, Mariposa, El Dorado, Siskiyou and Tuolumne JBCT Programs do not have a set number of beds and instead focus on the number of patients served. As such, the annual population change total does not include these additional beds.

PROGRAM UPDATE
STATE HOSPITALS
POPULATION AND PERSONAL SERVICES ADJUSTMENTS
(Informational Only)

POPULATION

1) 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.

a. Methodology

In the 2016-17 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. Moving forward this methodology will be used as the standard forecasting tool to project the pending placement list for the Incompetent to Stand Trial (IST), Lanterman–Petris–Short (LPS), Offender with a Mental Health Disorder (OMD), Not Guilty by Reason of Insanity (NGI) and Sexually Violent Predator (SVP) populations. 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 as well as 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. 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, less the correlating average of monthly admissions, which are offset accordingly 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, 2020 and June 30, 2021. Variables are specific to patient legal class and are calculated using actual data for the recent 12-month period ending August 31, 2019.

The table 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, 2019 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, 2019. The projected census for June 30, 2020 (for CY) and June 30, 2021 (for BY) reflects the actual census as well as the approved and proposed census adjustments.

Census and Pending Placement List Projections			
CURRENT YEAR			
Legal Class	**July 1, 2019 Actual Census**	**June 30, 2020 Projected Census**	**June 30, 2020 Projected Pending Placement List[2]**
IST *(with JBCT/AES)*	1,801	2,093	676
LPS	733	739	287
OMD2962	556	544	30
OMD2972	776	776	3
NGI	1,411	1,390	18
SVP	961	961	3
Subtotal	6,238	6,503	1,017
Coleman[1]	187	187	
Total	6,425	6,690	1,017
BUDGET YEAR			
Legal Class	**July 1, 2020 Projected Census**	**June 30, 2021 Projected Census**	**June 30, 2021 Projected Pending Placement List[2]**
IST *(with JBCT/AES)*	2,093	2,149	182
LPS	739	742	373
OMD2962	544	550	45
OMD2972	776	776	4
NGI	1,390	1,396	10
SVP	961	961	6
Subtotal	6,503	6,574	620
Coleman[1]	187	187	
Total	6,690	6,761	620

[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 in accordance with data de-identification guidelines.

[2] Projected pending placement list forecast assumes an average referral rate and an average admission rate based on the most recent 12-month period ending August 2019.

b. Census and Referrals

In FY 2018-19 DSH has observed a decrease in referral rates for the PC2684, the PC2962 and the NGI populations but continues to observe a growth in IST referrals, causing a shift in the in-patient census composition to accommodate the growing IST referrals. In comparison to the prior year IST referrals increased by 8.3 percent in FY 2018-19. Similarly, the IST in-patient census increased by 10.2 percent as compared to the in-patient census on June 30, 2018.

Admission requirements and wait times for PC2684 patients are set forth by federal court orders (Coleman v. Brown), generated to address the need for treatment of mentally-ill prisoners. Pursuant to these court orders 336 beds are required to be available to Coleman patients for referrals of these patients from CDCR.

PC2962 patients are committed to a state hospital to receive treatment as a condition of parole. Qualifications for PC2962 patients are defined by the OMD Act (Penal Code sections 2960 et seq.), which requires PC2962 patients to receive mental health treatment as a condition of parole. Pursuant to the OMD Act PC2962 patients are committed and transferred to DSH on their parole release date.

The table below presents DSH's census and average monthly referrals by legal class.

CENSUS				
	June 30, 2018	June 30, 2019	Difference	% Change
IST *(with JBCT/AES)*	1,644	1,811	167	10.2%
LPS	700	736	36	5.1%
OMD2962	646	559	-87	-13.5%
OMD2972	779	778	-1	-0.1%
NGI	1,414	1,416	2	0.1%
SVP	953	962	9	0.9%
CDCR[1]	230	185	-45	-19.6%
	6,366	**6,447**	**81**	**1.3%**
AVERAGE MONTHLY STATE HOSPITAL REFERRALS				
	FY 2017-18	FY 2018-19	Difference	% Change
IST *(with JBCT/AES)*	371.8	402.5	30.8	8.3%
LPS	18.1	17.0	-1.1	-6.0%
OMD2962	49.3	48.7	-0.6	-1.2%
OMD2972	9.8	12.7	2.9	29.9%
NGI	18.4	13.8	-4.7	-25.3%
SVP	3.9	3.9	0.0	0.0%
CDCR[1]	46.3	35.6	-10.8	-23.2%
	517.5	**534.1**	**16.6**	**3.2%**

[1]FY 2018-19 referral data includes JBCT/AES transfers.

DJJ census and referral data is not displayed in accordance with data de-identification guidelines.

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)

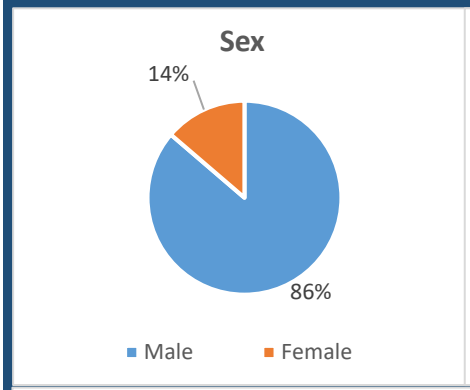
***** Items marked with an asterisk were previously captured in the "Other PC" category

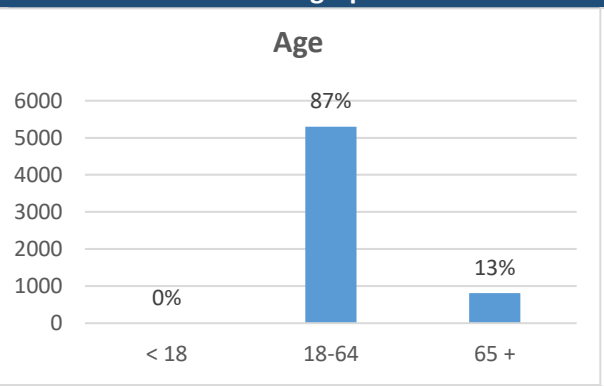
Department of State Hospitals

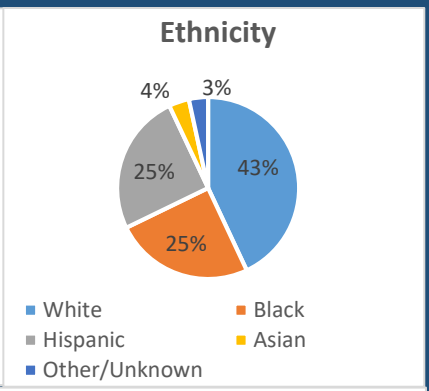
Demographic Snapshot: All Commitment Types

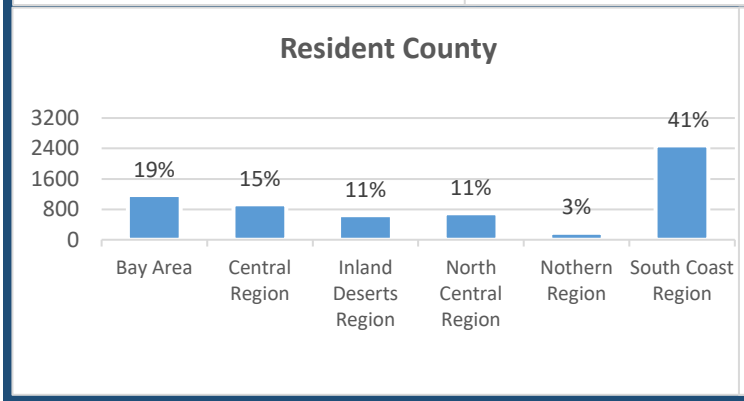
July 1, 2019; Census: 6,107

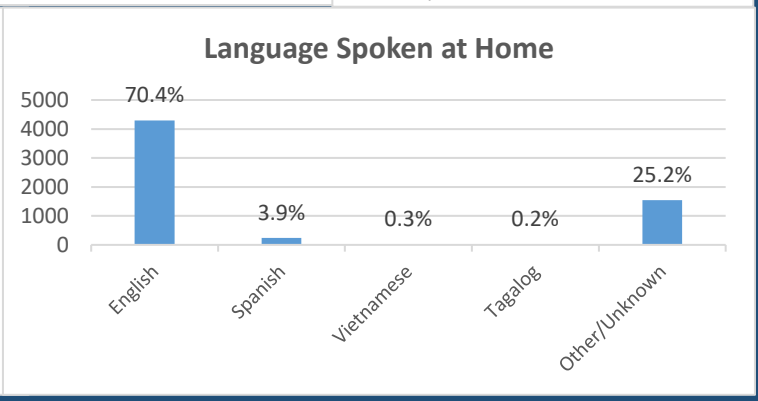
Basic Demographics



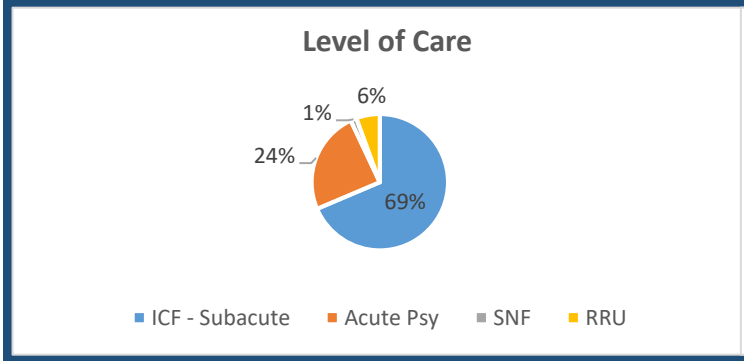


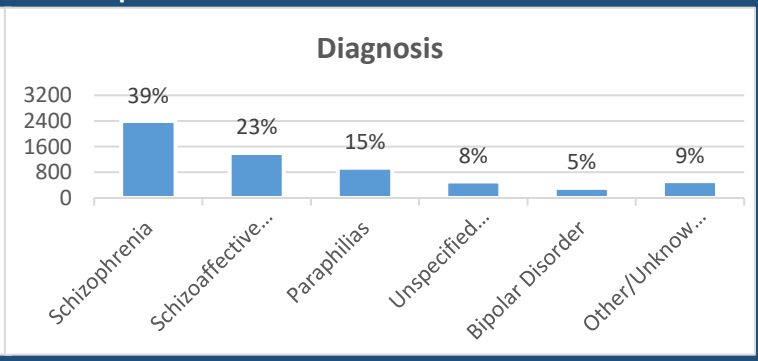






While at a State Hospital





Summary

The DSH population is composed of 86% males and 14% females; a majority of this population is between the ages of 18 and 64. Approximately 43% identify as White, 25% Black, and 25% 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 69% of the time, followed by 24% at an Acute level of care, 6% at an RRU level of care, and 1% at an SNF level of care. Schizophrenia, Schizoaffective, and Paraphilia-type disorders are the three most common diagnoses for the DSH population, accounting for 77% of the population.

To view BCP information, please click on this link: https://esd.dof.ca.gov/dofpublic/viewBcp.html.

This will take you to The Department of Finance BCP search page.

STATE HOSPITALS
LANTERMAN-PETRIS-SHORT (LPS)
POPULATION AND PERSONAL SERVICES ADJUSTMENT

Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	***0.0***	***0.0***	***0.0***	***0.0***	***$6,790***	***$6,790***
One-time	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Reimbursement Authority	*0.0*	*0.0*	*0.0*	*$0*	*$6,790*	*$6,790*

BACKGROUND:

The 2019 Budget Act increased the Department of State Hospitals (DSH) LPS reimbursement authority based on bed usage collections by $3,346,097 from $156,746,470 to $160,092,754[1]. In Fiscal Year (FY) 2018-19, DSH's budgeted capacity for LPS patients was 694. As of July 1, 2019, DSH had a total LPS census of 736.

Due to the increasing LPS population, DSH's reimbursement authority has not been sufficient for the services provided to counties. The estimated LPS collections methodology used is a combination of actual bed collections received in FY 2018-19 and a projection of anticipated collections for the remaining months. DSH utilized a weighted average of current year collections and applied it to the remaining months of the fiscal year. The trend from FY 2017-18 displayed a continued general increase in actual bed use, which justified the request for increased reimbursement authority for 2018-19.

These collections also included patients admitted under Penal Code Section 1370.01 (Misdemeanor Incompetent to Stand Trial – MIST). MIST patients were identified within the current LPS Memorandum of Understanding (MOU) as patients who could receive inpatient psychiatric care and treatment services; the MIST population as of March 2019 is 36. County reimbursements for patients admitted pursuant to Penal Code Section 1370.01 (MISTs) are realized through the same mechanism as reimbursements for patients admitted under the LPS Act - monthly reductions of each county's respective Health and Welfare Realignment fund appropriation; these monthly reductions reflect each county's total patient bed use but are not separated by commitment type.

In addition, DSH is currently contracting with the Public Consulting Group (PCG) to review and update DSH's bed rates. The contract began on June 1, 2018 and is scheduled to end December 30, 2019. The contractor is responsible for updating DSH's bed rates and providing DSH with the methodology so DSH may independently update the bed rates annually. PCG is actively reviewing numerous reports containing DSH service use costs and frequencies from prior months. The Department anticipates having an estimate of new bed rates in January 2020 and anticipates implementation of the bed rates on July 1, 2020.

[1] FY 2019-20 was a projected figure based on available data from collections through January 2019.

DESCRIPTION OF CHANGE:

DSH is projecting LPS collections of $166,882,555[2] in FY 2019-20, a difference of $6,789,801 from the current reimbursement authority. DSH is requesting an increase in reimbursement authority of $6,789,801 from what was originally approved via the 2019 Budget Act ($160,092,754) in FY 2020-21 ongoing. As the department continues to collect LPS reimbursements from counties on a monthly basis, DSH will have more data to update its caseload projections and reimbursement authority, as well as an update on the new bed rates in the 2020-21 May Revision.

FY	LPS Reimbursement Authority	LPS Collections	Difference
2019-20	$160,092,754	$166,882,555	+$6,789,801
2018-19	$156,746,470	$161,567,304[3]	+$4,820,834
2017-18	$136,627,657	$155,826,584	+19,198,927
2016-17	$137,539,100	$147,447,785	+$9,908,685
2015-16	$135,072,112	$141,964,866	+$6,892,754
2014-15	$123,419,000	$124,580,524	+$1,161,524
2013-14	$123,635,294	$123,635,294	0
2012-13	$115,991,452	$118,858,565	+$2,867,113
PPYs			+$8,477,440

[2] FY 2019-20 is a projected figure based on available data from collections through August 2019.
[3] Updated FY 2018-19 collection amount based on actual reimbursement received.

BCP Fiscal Detail Sheet

BCP Title: Lanterman-Petris-Short (LPS) Population and Personal Services Adjustment **BR Name: 4440-019-ECP-2020-GB**

Budget Request Summary

	FY20					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
539X - Other	0	6,790	6,790	6,790	6,790	6,790
Total Operating Expenses and Equipment	**$0**	**$6,790**	**$6,790**	**$6,790**	**$6,790**	**$6,790**
Total Budget Request	**$0**	**$6,790**	**$6,790**	**$6,790**	**$6,790**	**$6,790**

Fund Summary

Fund Source - State Operations						
0995 - Reimbursements	0	6,790	6,790	6,790	6,790	6,790
Total State Operations Expenditures	**$0**	**$6,790**	**$6,790**	**$6,790**	**$6,790**	**$6,790**
Total All Funds	**$0**	**$6,790**	**$6,790**	**$6,790**	**$6,790**	**$6,790**

Program Summary

Program Funding						
4410010 - Atascadero	0	114	114	114	114	114
4410030 - Metropolitan	0	3,226	3,226	3,226	3,226	3,226
4410040 - Napa	0	2,076	2,076	2,076	2,076	2,076
4410050 - Patton	0	1,374	1,374	1,374	1,374	1,374
Total All Programs	**$0**	**$6,790**	**$6,790**	**$6,790**	**$6,790**	**$6,790**

STATE HOSPITALS
PATIENT-DRIVEN OPERATING EXPENSES
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**$0**	**$3,534**	**$3,534**
One-time	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$3,534*	*$3,534*

BACKGROUND:

Between fiscal year (FY) 2012-13 and FY 2018-19, the Department of State Hospitals' (DSH) patient population increased significantly because of newly activated beds within the five state hospitals. For the bed activations, DSH received funding for positions and associated staff operating expenses and equipment (OE&E) but did not receive funding for patient related OE&E. DSH managed to absorb the increase costs due to savings in other areas; however, this model was not sustainable in the long-term to adequately support OE&E costs driven by patient care. As such, DSH can no longer absorb these operational costs.

The 2019 Budget Act included a standardized patient OE&E cost estimate methodology based on updated census estimates for 2019-20 and estimated costs per patient based on past year actual expenditures for several budget categories. As a result, the 2019 Budget Act included funding for a projected 2019-20 census of 6,317 and a cost per patient of $19,534 for a total patient-driven OE&E cost of $123.4 million in FY 2019-20.

DESCRIPTION OF CHANGE:

Estimated patient-driven OE&E costs for FY 2020-21 are based on updated census figures and updated costs per patient using FY 2018-19 actual expenditures. The 2020-21 methodology excludes patient wages from the budget categories included to calculate patient-drive OE&E, as patient wages will be adjusted in a separate proposal beginning in 2019-20 and annually thereafter. DSH has adjusted the current budget of $123.4 million in 2019-20 for patient-driven OE&E to $122,127,000 to reflect this change.

In FY 2018-19, DSH hospitals spent $129.1 million in patient-driven OE&E with a census count of 6,104 patients. This results in a cost-per-patient of $21,154.

$$\$129.1\ million/6{,}104\ patients = \$21{,}154\ per\ patient$$

This cost per patient was $1,818 more than the cost per patient in FY 2017-18, a 9.4% increase. Please see Figure 1 below for a breakdown of the current budget and actual costs for FY 2017-18 and FY 2018-19 by category.

Department of State Hospitals - Updated Patient-Driven OE&E Methodology - Governor's Budget 2020-21										
Background - Analysis of 2017-18 and 2018-19 Actuals										
Budget Categories	2019-20 Budgeted Amount	2017-18 Actuals	2018-19 Actuals	17-18 to 18-19 change	% change	2017-18 Cost Per Patient	2018-19 Cost Per Patient	17-18 to 18-19 change	% change	2018-19 Actual Census
Utilities	$ 16,894,000	$ 16,332,298	$ 17,984,110	$ 1,651,812	10.1%	2,674	2,946	$ 272	10.2%	6,104
Outside Hospitalization	$ 32,260,000	$ 31,187,615	$ 36,505,643	$ 5,318,028	17.1%	5,107	5,981	$ 874	17.1%	6,104
Clothing/Personal Supplies	$ 2,266,000	$ 2,190,825	$ 3,067,894	$ 877,069	40.0%	359	503	$ 144	40.1%	6,104
Recreation & Religion	$ 458,000	$ 442,767	$ 334,892	$ (107,875)	-24.4%	73	55	$ (18)	-24.3%	6,104
Foodstuffs	$ 19,038,000	$ 18,404,628	$ 18,606,834	$ 202,206	1.1%	3,014	3,048	$ 35	1.1%	6,104
Quartering & Housekeeping	$ 4,722,000	$ 4,564,861	$ 4,644,426	$ 79,565	1.7%	747	761	$ 13	1.8%	6,104
Patient Wages	$ 1,273,000	$ -	$ -	$ -	0.0%	-	-	$ -	0.0%	6,104
Laundry	$ 3,359,000	$ 3,247,663	$ 4,454,616	$ 1,206,953	37.2%	532	730	$ 198	37.2%	6,104
Miscellaneous Client Services	$ 428,000	$ 428,000	$ 428,000	$ -	0.0%	70	70	$ 0	0.0%	6,104
Chemicals, Drugs and Lab Supplies	$ 4,312,000	$ 4,168,739	$ 4,462,006	$ 293,267	7.0%	683	731	$ 48	7.1%	6,104
Pharmaceuticals	$ 38,302,000	$ 37,028,599	$ 38,571,835	$ 1,543,236	4.2%	6,063	6,319	$ 256	4.2%	6,104
Educational Supplies	$ 88,000	$ 85,191	$ 61,322	$ (23,869)	-28.0%	14	10	$ (4)	-28.0%	6,104
TOTALS	**$ 123,400,000**	**$ 118,081,186**	**$ 129,121,578**	**$ 11,040,392**	**9.3%**	**19,335**	**21,154**	**$ 1,818**	**9.4%**	

Figure 1: Current budget and actual expenditures.

Beginning in 2020-21, building off of the baseline allocation established in the 2019 Budget Act, the patient-driven OE&E adjustment will reflect targeted augmentations to specific budget categories that are historically large cost-drivers. The 2020-21 budget identifies outside hospitalization and pharmaceuticals as budget categories to be adjusted.

For outside hospitalization, DSH assumes growth of 2.7 percent in FY 2019-20 and 5.5 percent in FY 2020-21 based on the 2020-21 Price Letter estimate for Medical Care inflation. For pharmaceuticals, estimated growth is based on US Bureau of Labor Statistics Consumer Price Index data series for prescription drugs in U.S. city average, all urban consumers, not seasonally adjusted. The average percent monthly change over the last 12 months yielded no growth. This is consistent with the Department of Corrections and Rehabilitation's methodology for estimating pharmaceutical costs. Based on these assumptions, DSH estimates an increased cost of $3,047,674 in FY 2020-21. Please see Figure 2 below for detail.

Estimated Growth of Select Budget Categories						
Budget Categories	2018-19 Actuals	Inflator from Price Letter	2019-20 Projected Cost	Inflator from Price Letter	2020-21 Projected Cost	2020-21 Projected Cost compared to 2018-19 actuals
Outside Hospitalization	$ 36,505,643	2.7%	$ 37,491,295	5.5%	$ 39,553,317	$ 3,047,674
Pharmaceuticals	$ 38,571,835	0.0%	$ 38,571,835	0.0%	$ 38,571,835	$ -

Figure 2: Growth assumptions by category.

In addition to the assumed increase in costs for Outside Hospitalization, DSH expects the increase in patient population to increase costs. DSH estimates a census count for FY 2019-20 of 6,247 patients and for FY 2020-21, 6,270 patients; an increase of 23. This increase, multiplied by a cost per patient of $21,154, results in an estimated increased cost of $486,533 in FY 2020-21. This is consistent with the Department of Corrections and Rehabilitation's methodology for estimating OE&E costs. Please see Figure 3 below.

Adjustment for Census Increase				
2019-20	**2020-21**		**2018-19**	**2020-21**
Projected Census	Projected Census	Difference	Cost Per Patient	Cost For Increased census
6,247	6,270	23	$ 21,154	**$ 486,533**

Figure 3: Adjustment for patient increase.

The total proposed increase to DSH's budget for Patient Driven Operating Expenses is the sum of the estimated growth in the budget categories and the growth due to patient population increase. The total request for FY 2020-21 is $3,534,206.

$$FY\ 2019-20:\ \$3{,}047{,}674 + \$486{,}533 = \$3{,}534{,}206$$

BCP Fiscal Detail Sheet

BCP Title: Patient-Driven Operating Expenses **BR Name: 4440-055-ECP-2020-GB**

Budget Request Summary

	FY20					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5326 - Utilities	0	67	67	67	67	67
5340 - Consulting and Professional Services - External	0	3,185	3,185	3,185	3,185	3,185
539X - Other	0	282	282	282	282	282
Total Operating Expenses and Equipment	**$0**	**$3,534**	**$3,534**	**$3,534**	**$3,534**	**$3,534**
Total Budget Request	**$0**	**$3,534**	**$3,534**	**$3,534**	**$3,534**	**$3,534**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	0	3,534	3,534	3,534	3,534	3,534
Total State Operations Expenditures	**$0**	**$3,534**	**$3,534**	**$3,534**	**$3,534**	**$3,534**
Total All Funds	**$0**	**$3,534**	**$3,534**	**$3,534**	**$3,534**	**$3,534**

Program Summary

Program Funding						
4410010 - Atascadero	0	603	603	603	603	603
4410020 - Coalinga	0	882	882	882	882	882
4410030 - Metropolitan	0	299	299	299	299	299
4410040 - Napa	0	477	477	477	477	477
4410050 - Patton	0	1,273	1,273	1,273	1,273	1,273
Total All Programs	**$0**	**$3,534**	**$3,534**	**$3,534**	**$3,534**	**$3,534**

STATE HOSPITALS
DSH-METROPOLITAN INCREASED SECURE BED CAPACITY
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**-51.1**	**2.0**	**2.0**	**-$7,928**	**$294**	**$294**
One-time	*-53.1*	*0.0*	*0.0*	*-$8,222*	*$0*	*$0*
Ongoing	*2.0*	*2.0*	*2.0*	*$294*	*$294*	*$294*

BACKGROUND:

To provide additional capacity to address the ongoing system-wide forensic waitlist with particular focus on the continuing Incompetent to Stand Trial (IST) patient waitlist, the Budget Act of 2016 included capital outlay construction funding for the Increased Secure Bed Capacity project at Department of State Hospital (DSH) Metropolitan. This project added security fencing and infrastructure for existing patient buildings, which had primarily been used to house civilly committed Lanterman-Petris-Short (LPS) patients at DSH-Metropolitan. With the new security infrastructure, these buildings can now be used for the treatment of forensic patients. Specifically, this project included:

- Enclosing the Continuing Treatment West (CTW) Building with fencing to secure 376 beds;
- Enclosing the Skilled Nursing Facility (SNF) Building with fencing to secure 129 beds;
- Enclosing the adjacent park next to the CTW Building for recreation activities;
- Renovating and increasing the square footage of the existing visitor center as well as expand parking facilities;
- Installing required sally-ports, security kiosks, security alarms, security cameras, security lighting, and perimeter roads to ensure surveillance and access for emergency response vehicles around newly secured areas.

The Budget Act of 2015 included capital outlay construction funding for Fire Alarm System Upgrades at DSH-Metropolitan, which included upgrading the system for the 100s Building. The 100s Building preparations and fire alarm upgrades were completed in 2018, then DSH completed LPS patient and staff movement from the CTW to 100s Building in October 2018. The LPS patient movement was necessary from the CTW to the non-secured 100s Building to allow DSH to backfill the newly secured CTW vacant beds from the IST waitlist. The net impact of the CTW and 100s Building renovations will be the activation of up to 236 additional beds at DSH-Metropolitan[1].

The Budget Act of 2017 included 22.2 positions and $7.8 million in 2017-18 and 38.5 positions and $12.4 million in 2018-19 to prepare for the Increased Secure Bed Capacity at DSH-Metropolitan, which consisted of:

1. Preparing the 100s Building for the transfer of LPS patients from the CTW, requiring information technology installation (phones, Personal Duress Alarm System (PDAS), computers, equipment), minor facility repairs, and cleaning and stocking the units.
2. Expanding DSH's capacity to hire and train Hospital Police Officers in advance of activation to provide security for the 100s Building and convert the CTW to a secure treatment area in FY 2018-19 for ISTs.
3. Transferring LPS patients and staff from the CTW Building to the 100s Building.

[1] There is no impact to DSH-Metropolitan's Licensed Bed Capacity.

The Budget Act of 2018 included a reduction of 10.1 positions and savings of $1.1 million in 2017-18 due to delays in the CTW activations, the 100s Building preparations and fire alarm upgrades. The Budget Act of 2018 also included 162.8 positions and $24.8 million for 2018-19 and 342.2 positions and $50.6 million for 2019-20 for patient movement and the activation of Units 404, 406 and 408.

The Budget Act of 2019 included a reduction of 22.5 positions and a savings of $3.4 million in 2018-19 as a result of minor delays (two months) due to an initial delay in the contract award, and to a new State Fire Marshal requirement for fire sprinkler pipe fitter companies to have certified workers. The Budget Act of 2019 also included 99.2 positions and $15.5 million for 2019-20 and 1.5 positions and $267,000 in 2020-21 for the activation of Units 408,412 and 414. The funding and positions support the activation of the newly secured units at DSH-Metropolitan to provide increased capacity for the treatment of ISTs.

Provided below is the breakdown of total requests, by year and ongoing, for the DSH-Metropolitan 100s Activations and Increased Secure Bed Capacity.

DSH-Metropolitan State Hospital Secure Bed Capacity Increase

DSH-Metropolitan 100s Activations and Patient Movement					DSH-Metropolitan Increased Bed Capacity			
	FY 17-18	FY 18-19	FY 19-20	FY 20-21		FY 18-19	FY 19-20	FY 20-21
FY 2017-18 May Revision					**FY 2018-19 Governor's Budget**			
Positions	22.2	35.5	35.5	35.5	Positions	346.1	473.4	473.4
Funding	$7,827	$12,370	$5,222	$5,222	Funding	$53,085	$68,953	$68,953
FY 2018-19 May Revision					**FY 2018-19 May Revision**			
Positions	12.1	35.5	35.5	35.5	Positions	162.8	342.2	472.2
Funding	$7,149	$12,370	$5,222	$5,222	Funding	$24,781	$50,579	$68,970
FY 2019-20 Governor's Budget					**FY 2019-20 Governor's Budget**			
Positions	0.0	0.0	0.0	0.0	Positions	0.0	119.3	130.0
Funding	$0	$0	$0	$0	Funding	$0	$18,589	$20,117
FY 2019-20 May Revision					**FY 2019-20 May Revision**			
Positions	0.0	0.0	0.0	0.0	Positions	-22.5	-20.1	-128.5
Funding	$0	$0	$0	$0	Funding	-$3,476	-$3,055	-$19,850
Total Request by Year Ongoing					**Total Request by Year Ongoing**			
Positions	12.1	35.5	35.5	35.5	Positions	-22.5	99.2	1.5
Funding	$7,149	$12,370	$5,222	$5,222	Funding	-$3,476	$15,534	$267

DESCRIPTION OF CHANGE:

Changes to Unit Activation Timelines

DSH has experienced minor construction delays in the DSH-Metropolitan Increased Secure Bed Capacity project due to delays in the CTW Fire Alarm project related to obtaining State Fire Marshall final approval on doors and smoke seals. Fire alarm upgrades have been completed on four of the eight units in CTW. Three of these units are currently housing existing LPS patients and the fourth was activated on September 23, 2019 as the first Increased Secured Bed Capacity IST unit. Activation of the remaining four Increased Secured Bed Capacity IST units is dependent on completion of the fire alarm upgrades on those units which is anticipated to be completed in November 2019. Please see the updated activation timelines below.

Unit Activation	Number of Beds	Scheduled Activation as of 2020-21 Governor's Budget
IST Unit 404	48	Activated September 23, 2019
IST Unit 406	48	November 2019
IST Unit 408	48	November 2019
IST Unit 412	46	January 2020
IST Unit 414	46	March 2020

DSH does not anticipate a savings for the first three IST Units as the first unit activated in September 2019 and the second and third units are expected in November 2019 contingent upon the completion of the Fire Alarm Project. Staff are currently being hired, onboarded, and trained to serve DSH patients. DSH is, however, proposing a one-time current year staffing adjustment of 53.1 and associated savings of $8.2 million to account for a two-month delay in the activation of the fourth and fifth IST units.

The adjustments described in the 2020-21 Governor's Budget are due to current year delays and do not impact the ongoing position and funding needs previously authorized, as all units are anticipated to be activated by March 2020. An update will be provided in the 2020-21 May Revision.

DSH-Metropolitan Increased Secure Bed Capacity Additional Staffing Needs

To support the additional 236 beds activated in the expanded secure treatment area, DSH-Metropolitan requests 2.0 positions and the redirection of $294,000 in FY 2019-20 and ongoing for 1.0 Pharmacist I and 1.0 Pharmacy Technician. Due to the increase of DSH-Metropolitan's patients, the hospital will reopen a Satellite Pharmacy to support the five IST units. These positions were unforeseen in prior budget requests.

Attachment A is a description of the positions being requested.

DISCRETIONARY? Y/N: N

Attachment A: Position Description

Pharmacist I
The primary duties of a Pharmacist I, are to prepare, manufacture, and dispense drugs and pharmaceuticals, and supervise the work of nonprofessional assistants. Essential functions include, but are not limited to, providing medication histories, drug allergy assessments, maintaining complete patient profiles, monitor laboratory values, etc., in keeping with departmental policies and procedures. Provide patient counseling, including patient information, patient interviews and medication groups. Assure the accurate distribution of unit dose and floor stock medication to the units for which his/her satellite is responsible. Assure proper drug storage, stock levels, and accurate record keeping in the satellite. Responsible for the monthly ward inspections and Emergency Box inspections on the units. Using clinical knowledge, screen all drug orders for potential problems and provide appropriate solution to these problems.

Pharmacy Technician
The primary duties of a Pharmacy Technician are to perform basic services in a Pharmacy and technical pharmaceutically related duties, which do not require licensure and to do other related work. Essential functions include, but are not limited to, inputting Physician orders into the Pharmacy computer system, preparing the unit dose cassettes & exchange process, maintains the unit dose area, keeping it clean, neat and appropriately stocked, and clerical work.

BCP Fiscal Detail Sheet

BCP Title: DSH-Metropolitan Increased Secure Bed Capacity Current Year Takedown **BR Name: 4440-021-ECP-2020-GB**

Budget Request Summary

	FY20					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	-53.1	0.0	0.0	0.0	0.0	0.0
Total Positions	**-53.1**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Salaries and Wages						
Earnings - Permanent	-4,949	0	0	0	0	0
Total Salaries and Wages	**$-4,949**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-2,423	0	0	0	0	0
Total Personal Services	**$-7,372**	**$0**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-425	0	0	0	0	0
5304 - Communications	-53	0	0	0	0	0
5320 - Travel: In-State	-53	0	0	0	0	0
5324 - Facilities Operation	-266	0	0	0	0	0
5346 - Information Technology	-53	0	0	0	0	0
Total Operating Expenses and Equipment	**$-850**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-8,222**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-8,222	0	0	0	0	0
Total State Operations Expenditures	**$-8,222**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-8,222**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4400020 - Hospital Administration	-53	0	0	0	0	0
4410030 - Metropolitan	-8,169	0	0	0	0	0
Total All Programs	**$-8,222**	**$0**	**$0**	**$0**	**$0**	**$0**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
2011 - Custodian				-1.0	0.0	0.0	0.0	0.0	0.0
7552 - Physician & Surgeon (Safety)				-0.7	0.0	0.0	0.0	0.0	0.0
7619 - Staff Psychiatrist (Safety)				-3.0	0.0	0.0	0.0	0.0	0.0
8094 - Registered Nurse (Safety)				-12.5	0.0	0.0	0.0	0.0	0.0
8104 - Unit Supvr (Safety)				-0.8	0.0	0.0	0.0	0.0	0.0
8252 - Sr Psych Techn (Safety)				-4.4	0.0	0.0	0.0	0.0	0.0
8253 - Psych Techn (Safety)				-21.7	0.0	0.0	0.0	0.0	0.0
8324 - Rehab Therapist (Recr-Safety)				-3.0	0.0	0.0	0.0	0.0	0.0
9872 - Clinical Soc Worker (Hlth/CF)-Safety				-3.0	0.0	0.0	0.0	0.0	0.0
9873 - Psychologist (Hlth Facility-Clinical-Safety)				-3.0	0.0	0.0	0.0	0.0	0.0
Total Positions				**-53.1**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
2011 - Custodian	-33	0	0	0	0	0
7552 - Physician & Surgeon (Safety)	-159	0	0	0	0	0
7619 - Staff Psychiatrist (Safety)	-813	0	0	0	0	0
8094 - Registered Nurse (Safety)	-1,290	0	0	0	0	0
8104 - Unit Supvr (Safety)	-75	0	0	0	0	0
8252 - Sr Psych Techn (Safety)	-334	0	0	0	0	0
8253 - Psych Techn (Safety)	-1,430	0	0	0	0	0
8324 - Rehab Therapist (Recr-Safety)	-240	0	0	0	0	0
9872 - Clinical Soc Worker (Hlth/CF)-Safety	-255	0	0	0	0	0
9873 - Psychologist (Hlth Facility-Clinical-Safety)	-320	0	0	0	0	0
Total Salaries and Wages	**$-4,949**	**$0**	**$0**	**$0**	**$0**	**$0**
Staff Benefits						
5150200 - Disability Leave - Industrial	-68	0	0	0	0	0
5150210 - Disability Leave - Nonindustrial	-24	0	0	0	0	0
5150350 - Health Insurance	-342	0	0	0	0	0
5150450 - Medicare Taxation	-72	0	0	0	0	0

5150500 - OASDI	-2	0	0	0	0	0
5150600 - Retirement - General	-1,068	0	0	0	0	0
5150700 - Unemployment Insurance	-5	0	0	0	0	0
5150800 - Workers' Compensation	-223	0	0	0	0	0
5150900 - Staff Benefits - Other	-619	0	0	0	0	0
Total Staff Benefits	**$-2,423**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$-7,372**	**$0**	**$0**	**$0**	**$0**	**$0**

BCP Fiscal Detail Sheet

BCP Title: DSH-Metropolitan Increased Secure Bed Capacity Request **BR Name: 4440-027-ECP-2020-GB**

Budget Request Summary

	FY20					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	2.0	2.0	2.0	2.0	2.0	2.0
Total Positions	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**
Salaries and Wages						
Earnings - Permanent	173	173	173	173	173	173
Total Salaries and Wages	**$173**	**$173**	**$173**	**$173**	**$173**	**$173**
Total Staff Benefits	89	89	89	89	89	89
Total Personal Services	**$262**	**$262**	**$262**	**$262**	**$262**	**$262**
Operating Expenses and Equipment						
5301 - General Expense	16	16	16	16	16	16
5304 - Communications	2	2	2	2	2	2
5320 - Travel: In-State	2	2	2	2	2	2
5324 - Facilities Operation	10	10	10	10	10	10
5346 - Information Technology	2	2	2	2	2	2
Total Operating Expenses and Equipment	**$32**	**$32**	**$32**	**$32**	**$32**	**$32**
Total Budget Request	**$294**	**$294**	**$294**	**$294**	**$294**	**$294**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	294	294	294	294	294	294
Total State Operations Expenditures	**$294**	**$294**	**$294**	**$294**	**$294**	**$294**
Total All Funds	**$294**	**$294**	**$294**	**$294**	**$294**	**$294**

Program Summary

Program Funding						
4400020 - Hospital Administration	2	2	2	2	2	2
4410030 - Metropolitan	292	292	292	292	292	292
Total All Programs	**$294**	**$294**	**$294**	**$294**	**$294**	**$294**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
7658 - Pharmacy Techn				1.0	1.0	1.0	1.0	1.0	1.0
7659 - Pharmacist I				1.0	1.0	1.0	1.0	1.0	1.0
Total Positions				**2.0**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
7658 - Pharmacy Techn	45	45	45	45	45	45
7659 - Pharmacist I	128	128	128	128	128	128
Total Salaries and Wages	**$173**	**$173**	**$173**	**$173**	**$173**	**$173**
Staff Benefits						
5150200 - Disability Leave - Industrial	2	2	2	2	2	2
5150210 - Disability Leave - Nonindustrial	1	1	1	1	1	1
5150350 - Health Insurance	8	8	8	8	8	8
5150450 - Medicare Taxation	3	3	3	3	3	3
5150600 - Retirement - General	39	39	39	39	39	39
5150800 - Workers' Compensation	8	8	8	8	8	8
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	5	5	5	5	5	5
5150900 - Staff Benefits - Other	23	23	23	23	23	23
Total Staff Benefits	**$89**	**$89**	**$89**	**$89**	**$89**	**$89**
Total Personal Services	**$262**	**$262**	**$262**	**$262**	**$262**	**$262**

STATE HOSPITALS
ENHANCED TREATMENT PROGRAM (ETP) STAFFING
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**-32.3**	**-1.5**	**0.0**	**-$5,330**	**$385**	**$0**
One-time	*-32.3*	*-1.5*	*0.0*	*-$5,330*	*$385*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*

BACKGROUND:

The Enhanced Treatment Program (ETP) will accept patients who are at the highest risk of violence and who cannot be safely treated in a standard treatment environment. The ETP will provide treatment intended to return the patient to a standard treatment environment, with supports that prevent future aggression while increasing safety in the facility and protecting patients and staff from harm. As such, the ETP will provide enhanced treatment, staffing, security and implement an admissions and treatment planning process that identifies and addresses the patients' violence risk factors.

Per Assembly Bill (AB) 1340, the admissions process is established in statute and designed to identify patients at the highest risk of violence and address their risk factors. Admission into the ETP will be initiated by the referring state hospital psychiatrist or psychologist. The patient will then be assessed by a dedicated forensic psychologist who makes an initial determination of the appropriateness of the referral. If the referral is appropriate, the patient will be assessed by a Forensic Needs Assessment Panel (FNAP) comprised of a state hospital medical director, psychiatrist, and psychologist. If the FNAP certifies the patient for admission into the ETP, the patient will be referred to a Forensic Needs Assessment Team (FNAT) psychologist. The FNAT will then conduct an in-depth violence risk assessment and develop a treatment plan in coordination with the multi-disciplinary team assigned to the unit. The FNAT psychologists are dedicated to the ongoing management and treatment of ETP patients.

Per AB 1340, treatment is the ETP's focus, and every patient will receive treatment from a multi-disciplinary team comprised of a psychiatrist, two psychologists, a registered nurse, a clinical social worker, two rehabilitation therapists, and a psychiatric technician. A treatment team will be assigned to each unit. Due to the acuity of the patient population, the ETP will be staffed at a higher level than the Department's standard state hospital units. A nursing ratio of 1:1.5 was established for AM and PM shifts as necessary to allow for focused treatment, constant assessment of violence risk, and response in cases of an incident. A staff-to-patient ratio of 1:3 was established for the NOC shift. The direct care staff are a combination of registered nurses and psychiatric technicians. Enhanced security will also be provided by hospital police officers (HPO). There will be two to three HPOs on each unit across all shifts and will be available to provide additional support and assistance in cases of emergency.

The staffing ratios were established by an interdisciplinary workgroup which included participation from Medical Directors, Clinical and Nursing Administrators, Psychiatrists, Psychologists, Rehabilitation Therapists, Psychiatric Technicians, Clinical Social Workers, Hospital Protective Services, Clinical Operations and fiscal and program staff. To establish the staffing for the ETPs, the workgroup reviewed the nursing activities performed on the Enhanced Treatment Unit at DSH-Atascadero and ran staffing scenarios based on the program and treatment schedule that would be established on the ETP.

The Budget Act of 2018 included a total savings of 35.8 positions and $4.8 million for fiscal year (FY) 2017-18, 56.9 positions and $4.6 million in FY 2018-19 for the first two 13-bed unit activations, ETP Units 29 and 33 at DSH-Atascadero. The savings is due to delays in securing all required regulatory reviews and approvals of the ETP working plans. The Budget Act of 2018 also included 60.3 positions and $8.3 million in FY 2019-20 and ongoing for the staff, operating expenses and equipment needed for the activation of the third and fourth ETP units.

The Budget Act of 2019 included a one-time deduction of $2.34 million and 10.4 positions in 2019-20 due to delays in construction. The reasons for the delays were various, including existing site conditions, code issues, and resulting changes required by the State Fire Marshal. In addition, DSH redirected $139,000 of the savings reported due to critical needs identified for DSH-Patton's ETP unit activations, including U-06 courtyard improvements/fence security upgrade, shower room conversion to a housekeeping closet, and conversion of south wing rooms to staff offices and clinical treatment space.

DESCRIPTION OF CHANGE:

ETP Activation Timeline

DSH-Atascadero ETP construction at Unit 29 has been delayed due to existing site conditions, code issues and resulting changes required by the State Fire Marshal. Unforeseen conditions such as unknown regular and low voltage electrical conduits, materials damage and unexpected ductwork have also contributed to delays. Furthermore, the contractor has had challenges with the availability of labor, material deliveries, and subcontractor scheduling; all of which exacerbates the already existing construction delays.

DSH-Patton ETP construction at Unit U-06 has been delayed due to an extended regulatory review process and an unsuccessful initial bid process as reported in the 2019-20 May Revision. DSH-Patton ETP was successfully bid in August 2019 and construction is currently underway

DSH will activate the four ETP units in phases. Construction for the first unit at DSH-Atascadero (Unit 29) began in September 2018 and is expected to be completed in January 2020. Construction of the second unit at DSH-Atascadero (Unit 33) is now scheduled to begin in January 2020 and is expected to be completed in May 2020. Construction of DSH-Atascadero's third unit (Unit 34) is scheduled to begin in May 2020 and is expected to be completed in August 2020. DSH Patton's unit (Unit U-06) is scheduled to begin construction in June 2020 and is expected to be completed in November 2020. Each ETP unit will be activated after construction is completed. Below is an updated chart showing the units and when the construction will be initiated and completed.

Units/Hospital	Construction Scheduled Initiation	Construction Scheduled Completion	Delay from 2019-20 May Revision
DSH-Atascadero Unit 29	September 24, 2018 (Actual)	January 10, 2020	5-month delay
DSH-Atascadero Unit 33	January 11, 2020	May 10, 2020	5.5-month delay
DSH-Atascadero Unit 34	May 11, 2020	August 10, 2020	6-month delay
DSH-Patton Unit U-06	June 15, 2020	November 27, 2020	5-month delay

ETP Funding and Position Authority

Due to the delays identified above, DSH anticipates a one-time savings of $5.3 million in FY 2019-20 and a reduction of 32.3 positions and a request of $385,000 in FY 2020-21 and a reduction of 1.5 positions. Please see the chart below for a breakdown of ETP funding and position authority as of the 2020-21 November Estimate.

ETP Cost Breakdown
Dollars in Thousands

Timeframe	2017-18	2018-19	2019-20	2020-21	2021-22
2017 Budget Act	*$7,990*	*$15,228*	*$15,249*	*$15,249*	*$15,249*
2018-19 Governor's Budget	($4,953)	$2,835	$8,350	$8,350	$8,350
2018-19 May Revision	($4,883)	($4,571)	$8,300	$8,782	$8,782
Total as of 2018 Budget Act	*$3,107*	*$10,657*	*$23,549*	*$24,031*	*$24,031*
2019-20 Governor's Budget	$ -	$ -	($1,765)	$ -	$ -
2019-20 May Revision	$ -	($2,616)	($716)	$ -	$ -
Total as of 2019 Budget Act	$ -	*($2,616)*	*($2,481)*	*$ -*	*$ -*
2020-21 Governor's Budget	$ -	$ -	($5,330)	$385	$ -
Total:	**$3,107**	**$8,041**	**$15,738**	**$24,416**	**$24,031**

ETP Position Authority Breakdown

DSH-Atascadero Units 29 & 33	2017-18	2018-19	2019-20	2020-21	2021-22
FY 2017-18 Governor's Budget	44.7	115.1	115.1	115.1	115.1
FY 2018-19 Governor's Budget	-35.8	0.0	0.0	0.0	0.0
FY 2018-19 May Revision	0.0	-57.9	0.0	0.0	0.0
FY 2019-20 Governor's Budget	0.0	0.0	0.0	0.0	0.0
FY 2019-20 May Revision	0.0	-7.1	-3.4	0.0	0.0
FY 2020-21 Governor's Budget	0.0	0.0	-26.7	0.0	0.0
Total Authority Ongoing	**8.9**	**50.1**	**85.0**	**115.1**	**115.1**
DSH-Atascadero Unit 34 & DSH-Patton Unit U-06	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**2021-22**
FY 2017-18 Governor's Budget	0.0	0.0	0.0	0.0	0.0
FY 2018-19 Governor's Budget	0.0	23.2	65.7	65.7	65.7
FY 2018-19 May Revision	0.0	-22.2	-5.4	0.0	0.0
FY 2019-20 Governor's Budget	0.0	0.0	-12.7	0.0	0.0
FY 2019-20 May Revision	0.0	0.0	5.7	0.0	0.0
FY 2020-21 Governor's Budget	0.0	0.0	-5.6	-1.5	0.0
Total Authority Ongoing	**0.0**	**1.0**	**47.7**	**64.2**	**65.7**

While this aspect of the proposal still yields an increase in savings, DSH is taking a more systematic approach to adjusting staffing when activation timelines change. In previous updates when savings were scored, DSH would delay every position associated with the proposal. However, the Department has already filled certain positions with the emphasis on those necessary in developing the infrastructure for the ETP. The positions DSH does not anticipate scoring savings on are related to management, supervisors, information technology, human resources, and protective services. DSH

does not propose adjusting the management and supervisory positions because those positions are primarily responsible for establishing the ETP units, developing policies and procedures, and setting-up program objectives/goals. In addition, management and supervisors are responsible for staffing the units, security coordination, and assisting with preparing the units and licensing efforts once construction is complete. DSH's staffing and associated funding that is being scored relates to positions directly tied to unit-activations such as the treatment team and other unit-based staffing.

Information Technology Equipment and Services

The Budget Act of 2018 included $2.1 million to purchase and install surveillance cameras, workstations, cabling/wiring, and Public Announcement intercoms in the ETP units, and to reconfigure the Personal Duress Alarm System. This adjustment is needed as there have been physical modifications related to the new construction at DSH-Atascadero and DSH-Patton. The contracts executed for installation of cabling for data/voice, intercom and surveillance cameras will expire August 31, 2020. Due to construction delays, DSH anticipates cabling installation will not be completed in Units 33, 34 or Unit 06 until after that date, resulting in current year savings of approximately $581,037. Therefore, DSH requests to re-appropriate these unspent funds plus account for an additional unforeseen increase in cost. The Department requests $640,000 in one-time funds 2020-21 for a service contract proposed for the completion of cabling installation and materials in Unit 33, 34 and Unit U-06.

DISCRETIONARY? Y/N: No

BCP Fiscal Detail Sheet

BCP Title: Enhanced Treatment Program (ETP) Staffing **BR Name: 4440-022-ECP-2020-GB**

Budget Request Summary

	FY20					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	-32.3	-1.5	0.0	0.0	0.0	0.0
Total Positions	**-32.3**	**-1.5**	**0.0**	**0.0**	**0.0**	**0.0**
Salaries and Wages						
Earnings - Permanent	-2,834	-150	0	0	0	0
Total Salaries and Wages	**$-2,834**	**$-150**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-1,398	-80	0	0	0	0
Total Personal Services	**$-4,232**	**$-230**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-256	-12	0	0	0	0
5304 - Communications	-33	-2	0	0	0	0
5320 - Travel: In-State	-33	-2	0	0	0	0
5324 - Facilities Operation	-162	-7	0	0	0	0
5346 - Information Technology	-33	-2	0	0	0	0
Total Operating Expenses and Equipment	**$-517**	**$-25**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-4,749**	**$-255**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-4,749	-255	0	0	0	0
Total State Operations Expenditures	**$-4,749**	**$-255**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-4,749**	**$-255**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4400020 - Hospital Administration	-33	-2	0	0	0	0
4410010 - Atascadero	-4,626	0	0	0	0	0
4410050 - Patton	-90	-253	0	0	0	0
Total All Programs	**$-4,749**	**$-255**	**$0**	**$0**	**$0**	**$0**

BCP Title: Enhanced Treatment Program (ETP) Staffing **BR Name: 4440-022-ECP-2020-GB**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
1138 - Office Techn (Gen)				-0.5	-0.3	0.0	0.0	0.0	0.0
4588 - Assoc Accounting Analyst				-0.3	-0.1	0.0	0.0	0.0	0.0
5393 - Assoc Govtl Program Analyst				-0.8	-0.4	0.0	0.0	0.0	0.0
7619 - Staff Psychiatrist (Safety)				-0.1	0.1	0.0	0.0	0.0	0.0
8094 - Registered Nurse (Safety)				-14.8	-1.4	0.0	0.0	0.0	0.0
8252 - Sr Psych Techn (Safety)				-2.4	0.0	0.0	0.0	0.0	0.0
8253 - Psych Techn (Safety)				-9.2	1.4	0.0	0.0	0.0	0.0
8324 - Rehab Therapist (Recr-Safety)				-1.8	-0.3	0.0	0.0	0.0	0.0
9699 - Hlth Svcs Spec (Safety)				-0.5	-0.3	0.0	0.0	0.0	0.0
9872 - Clinical Soc Worker (Hlth/CF)-Safety				-0.1	0.1	0.0	0.0	0.0	0.0
9873 - Psychologist (Hlth Facility-Clinical-Safety)				-1.8	-0.3	0.0	0.0	0.0	0.0
Total Positions				**-32.3**	**-1.5**	**0.0**	**0.0**	**0.0**	**0.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
1138 - Office Techn (Gen)	-20	-12	0	0	0	0
4588 - Assoc Accounting Analyst	-21	-7	0	0	0	0
5393 - Assoc Govtl Program Analyst	-54	-27	0	0	0	0
7619 - Staff Psychiatrist (Safety)	-27	27	0	0	0	0
8094 - Registered Nurse (Safety)	-1,527	-144	0	0	0	0
8252 - Sr Psych Techn (Safety)	-183	0	0	0	0	0
8253 - Psych Techn (Safety)	-606	92	0	0	0	0
8324 - Rehab Therapist (Recr-Safety)	-144	-24	0	0	0	0
9699 - Hlth Svcs Spec (Safety)	-52	-31	0	0	0	0
9872 - Clinical Soc Worker (Hlth/CF)-Safety	-8	8	0	0	0	0
9873 - Psychologist (Hlth Facility-Clinical-Safety)	-192	-32	0	0	0	0
Total Salaries and Wages	**$-2,834**	**$-150**	**$0**	**$0**	**$0**	**$0**
Staff Benefits						
5150200 - Disability Leave - Industrial	-39	-2	0	0	0	0
5150210 - Disability Leave - Nonindustrial	-13	-1	0	0	0	0

5150350 - Health Insurance	-196	-10	0	0	0	0
5150450 - Medicare Taxation	-42	-2	0	0	0	0
5150500 - OASDI	-6	-3	0	0	0	0
5150600 - Retirement - General	-617	-36	0	0	0	0
5150700 - Unemployment Insurance	-2	0	0	0	0	0
5150800 - Workers' Compensation	-128	-7	0	0	0	0
5150900 - Staff Benefits - Other	-355	-19	0	0	0	0
Total Staff Benefits	**$-1,398**	**$-80**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$-4,232**	**$-230**	**$0**	**$0**	**$0**	**$0**

BCP Fiscal Detail Sheet

BCP Title: Enhanced Treatment Program (ETP) IT Funding **BR Name: 4440-030-ECP-2020-GB**

Budget Request Summary

	FY20					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5346 - Information Technology	-581	640	0	0	0	0
Total Operating Expenses and Equipment	**$-581**	**$640**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-581**	**$640**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-581	640	0	0	0	0
Total State Operations Expenditures	**$-581**	**$640**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-581**	**$640**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4400020 - Hospital Administration	-581	640	0	0	0	0
Total All Programs	**$-581**	**$640**	**$0**	**$0**	**$0**	**$0**

STATE HOSPITALS
DSH-PATTON OVER-BEDDING
PROPOSED TRAILER BILL LEGISLATION
New Item

BACKGROUND:

Under existing law, Welfare & Institutions Code (WIC) 4107 states that the Department of State Hospitals (DSH) Patton may house up to 1,530 patients until September 2020. This language was most recently amended by AB 1470, the Mental Health Trailer Bill (Section 83, Chapter 24, Statutes of 2012) which increased the allowable number of patients housed at DSH-Patton by 194 patients. This amendment to AB 1470 is the most recent of several previous changes to legislation extending the date to allow 1,530 patients to be housed at DSH-Patton.

DESCRIPTION OF CHANGE:

DSH is proposing trailer bill legislation to extend the upcoming sunset date from September 2020 to September 2030 to continue the operation of 1,530 beds at DSH-Patton. Without this amendment, DSH will lose the authority to operate the current 194 patient-occupied beds at DSH-Patton.

Summary of Arguments in Support

- The original legislation was intended to appropriately expand the capacity of the DSH system to admit forensic patients.
- DSH has a significant waitlist for patient admissions, particularly in Incompetent to Stand Trial patients.
- The waitlist for felony Incompetent to Stand Trial commitments cannot be properly addressed without maximizing DSH's bed capacity in conjunction with the ongoing establishment of county diversion programs and the expansion of jail-based treatment programs.

Proposed Trailer Bill Legislation

Section 4107 of the Welfare and Institutions Code is amended to read:
4107. (a) The security of patients committed pursuant to Section 1026 of, and Chapter 6 (commencing with Section 1367) of Title 10 of Part 2 of, the Penal Code, and former Sections 6316 and 6321, at Patton State Hospital shall be the responsibility of the Secretary of the Department of Corrections and Rehabilitation.

(b) The Department of Corrections and Rehabilitation and the State Department of Mental Health shall jointly develop a plan to transfer all patients committed to Patton State Hospital pursuant to the provisions in subdivision (a) from Patton State Hospital no later than January 1, 1986, and shall transmit this plan to the Senate Committee on Judiciary and to the Assembly Committee on Criminal Justice, and to the Senate Health and Welfare Committee and Assembly Health Committee by June 30, 1983. The plan shall address whether the transferred patients shall be moved to other state hospitals or to correctional facilities, or both, for commitment and treatment. (c) Notwithstanding any other provision of law, the State Department of State Hospitals shall house no more than 1,336 patients at Patton State Hospital. However, until September ~~2020~~ *2030*, up to 1,530 patients may be housed at the hospital.(d) This section shall remain in effect only until all patients committed, pursuant to the provisions enumerated in subdivision (a), have been removed from Patton State Hospital and shall have no force or effect on or after that date.

STATE HOSPITALS
COURT EVALUATIONS AND REPORTS
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**-$3,251**	**$0**	**$0**
Evaluations, Court Reports and Testimony	*0.0*	*0.0*	*0.0*	*-$734*	*$0*	*$0*
Forensic Case Management and Tracking	*0.0*	*0.0*	*0.0*	*-$1,341*	*$0*	*$0*
Neuropsychological Services	*0.0*	*0.0*	*0.0*	*-$1,176*	*$0*	*$0*

BACKGROUND:

The 2019 Budget Act included 94.6 permanent full-time positions and $40,227,000 phased in over three years to implement a staffing standard to support the forensic services workload associated with court-directed patient treatment. The standard establishes population-driven methods for calculating staffing needs for the following forensic functions: Evaluations, Court Reports and Testimony; Forensic Case Management and Data Tracking; and Neuropsychological Services (Neuropsychological Assessments and Cognitive Remediation Pilot Program).

DESCRIPTION OF CHANGE:

Evaluations, Court Reports and Testimony
The Forensic Evaluator positions are responsible for keeping the courts apprised of the status of the Department of State Hospitals (DSH) patients, whether through statutorily-mandated reports, or as requested through court appearances or additional written communication. The proposal included 53.1 forensic evaluator positions and $24,042,000, phased in over three years. As of October 1, 2019, 25.0 positions have been filled.

Future updates will include population data (average daily census, admissions, etc.) which will be used to refine Forensic Evaluator workload methodology calculations.

Forensic Case Management and Data Tracking
The Case Management and Data Tracking team within Forensic Services is responsible for processing, reviewing, communication and scheduling associated with all forensic commitments as it relates to court documentation, paperwork filings, and coordination with all entities involved with the forensic commitment process. A total of 16.3 positions and $5,031,000 were allocated for this function, phased in over two years. As of October 1, 2019, 1.0 position has been filled.

Delays in recruitment and hiring for this component are due to a variety of factors including noticing unions and more traditional hiring delays, including limited candidate pools which often require the hospital to re-advertise positions and repeat the screening and interview process.

The forensic case management and data tracking workload is driven based on the number of patients admitted and the average census (by commitment type) maintained within each hospital annually. Future updates will include applying the methodologies to current population data which will be used to refine hearing data across all commitment types.

STATE HOSPITALS
DIRECT CARE NURSING
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**-$3,594**	**$0**	**$0**
Medication Pass Psychiatric Technicians	*0.0*	*0.0*	*0.0*	*-$1,824*	*$0*	*$0*
Afterhours Supervising Registered Nurses	*0.0*	*0.0*	*0.0*	*-$1,770*	*$0*	*$0*

BACKGROUND:

The 2019 Budget Act included a total of 379.5 positions and $46 million, phased in across a three year period, to support the workload of providing 24-hour care nursing services within the Department of State Hospitals (DSH).

DESCRIPTION OF CHANGE:

Medication Pass Psychiatric Technicians
The function of medication pass is to prepare, administer, document and ultimately manage the medication administration process within each hospital unit. Each hospital staffs their medication rooms with a licensed psychiatric technician or licensed vocational nurse on both AM and PM shifts. The Budget Change Proposal (BCP) added 335.0 psychiatric technician positions to be phased in over three years across the five hospitals. These positions, which include relief, will add one 12-hour post for medication rooms on 128 units. This psychiatric technician must be fully dedicated to this function to maintain compliance with medication pass procedures, controlled substance handling requirements, and to complete meticulous documentation requirements regarding medication inventory, patient medication compliance, and pharmacy medication records reconciliation.

The department has established a nursing proposal implementation workgroup to direct the implementation of this proposal consistently across all five hospitals and to develop standardized data metrics to evaluate the impacts of these resources.

As of October 1, 2019, DSH-Napa and DSH-Coalinga will activate posts on twelve units across both hospitals. Recruitment has been delayed at DSH-Metropolitan and DSH-Patton because they could not notice the Service Employees International Union (SEIU) during active bargaining. DSH-Atascadero has delayed implementation while they prioritize hiring Enhanced Treatment Program (ETP) positions.

As of October 1, 2019, 17.0 medication room positions have been filled. DSH continues to actively recruit and hire these positions. In the May Revision (Enrollment, Caseload, Population) ECP, the budgeted funding for these positions will be adjusted to reflect the projected implementation timeline.

Afterhours Supervising Registered Nurses
Unit supervisors and supervising registered nurses are the first-line supervisors on the units. Current hospital staffing practices for unit supervisory positions allocate one unit supervisor or supervising registered nurse to each unit. These supervisors work five days per week during the day shift; however, they are responsible for the continuous management and supervision of their unit on a 24-hour basis. The BCP added 44.5 supervising registered nurse positions (including relief) to address

supervision coverage during the PM and NOC shifts. The PM/NOC shift supervising registered nurses range from three to four 12-hour posts per hospital for a total of 17 12-hour posts per night.

The nursing proposal implementation workgroup has prioritized implementing the Medication Pass Psychiatric Technician positions as they are the most critical need for the hospital units. The workgroup is currently developing a standardized Afterhours Supervising Registered Nurse duty statement and identifying data metrics that can be used to determine the effectiveness of expanding supervision coverage as well as utilization of 12-hour shifts for this purpose.

Future updates will report on the progress of activating the 12-hour Afterhours Supervising Registered Nurse shifts. The 17 posts identified for afterhours supervision was a conservative estimate of the need. This provides for a relatively high supervisor to staff ratio of 1:40. Depending on the workload experienced of these added supervisors, the total number of positions may need to be adjusted.

Temporary Help and Contracted Help Hours

Temporary help position authority is used to meet intermittent nursing staffing needs. The Direct Care Nursing BCP added 254.0 temporary help position authority to better align budgeted levels with the levels used during FY 2017-18.

Future updates to report on the temporary help position authority will include reporting on FY 2018-19 temporary help initial allocations, as well as adjusted temporary help authority based on actual usage.

Alignment of Position Authority

The proposal reallocated position authority between the hospitals so that DSH-Metropolitan and DSH-Napa have authorized positions to meet the need identified by the proposal. The redistribution will allow all hospitals to staff between 88 percent and 93 percent of need. This effort redistributes position authority only and does not reallocate funding.

As of October 1, 2019, DSH-Atascadero had shifted 112.0 positions out of 132.0, DSH-Coalinga had shifted 55.0 positions out of 76.1, and DSH-Patton had shifted all 27.4 positions to DSH-Metropolitan and DSH-Napa. This equates to a total gain of 142.5 positions for DSH-Metropolitan and 93.0 positions for DSH-Napa. Due to current filled positions and recruitment efforts in process, some of the vacant positions originally identified in the BCP to shift were no longer vacant, and therefore unavailable to be shifted to a different facility. The department will continue to work with the hospitals to identify remaining positions to be shifted to the other hospitals as vacancies are identified. To date, 26.0 of the shifted positions have been filled and recruitment and hiring efforts continue at DSH-Napa and DSH-Metropolitan to fill these positions.

Future updates will report on the total number of shifted positions as well as the status of the backfill. DSH anticipates overtime levels to decrease at DSH-Metropolitan and DSH-Napa once they can fill and utilize the shifted positions.

DSH continuously recruits and hires for all nursing positions and will increase efforts as needed to fill new positions and backfill vacated positions. To serve as a point of reference, from April 2019 to October 2019 DSH received over 2,370 applications and hired over 520 nursing personnel. The table below displays the total number hired by hospital and classification.

Total Hired	DSH-A	DSH-C	DSH-M	DSH-N	DSH-P	Total
Psych Techs & LVNs	55	61	58	31	62	267
Psych Tech Assistants	52	8	22	11	1	94
Registered Nurses	23	34	36	31	39	163
Total	**130**	**103**	**116**	**73**	**102**	**524**

Redirected Off-Unit Positions

DSH identified 50.0 nursing classification positions to be redirected from administrative functions back to providing nursing services on the units. As part of this redirection of off-unit nursing staff, DSH established 50.0 administrative positions, primarily Staff Services Analysts, in order to redirect 50.0 nursing positions back to the units.

As of October 1, 2019, all 50.0 positions have been shifted back to the units or are in the process of being shifted. The hospitals are currently recruiting for the administrative positions to backfill the duties for the positions redirected to the units.

Future updates to report on the redirected off-unit positions will include evaluating whether there are additional opportunities to redirect nursing positions back to the units.

FORENSIC CONDITIONAL RELEASE PROGRAM (CONREP)
GENERAL/NON-SEXUALLY VIOLENT PREDATOR (NON-SVP) PROGRAM
Community Program Director
New Item

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**$0**	**$2,200**	**$2,420**
One-time	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$2,200*	*$2,420*

BACKGROUND:

The Forensic Conditional Release Program (CONREP) is the Department of State Hospital's (DSH) statewide system of community-based services for specified court-ordered forensic individuals. Mandated as a State responsibility by the Governor's Mental Health Initiative of 1984, the program began operations on January 1, 1986 and operates pursuant to statutes in Welfare and Institutions Code (WIC) 4360 (a) and (b). The goal of CONREP is to promote greater public protection in California's communities via an effective and standardized community outpatient treatment system.

The CONREP population includes: Not Guilty by Reason of Insanity Penal Code (PC) 1026, Offender with a Mental Health Disorder (both PC 2964 parolees who have served a prison sentence and PC 2972 parolees who are civilly committed for at least one year after their parole period ends), Felony Incompetent to Stand Trial (PC 1370) patients who have been court-approved for outpatient placement in lieu of state hospital placement), and Offender with a Mental Health Disorder (WIC 6316). CONREP services are also offered to Sexually Violent Predators (WIC 6604). Individuals suitable for CONREP may be recommended by the state hospital Medical Director to the courts for outpatient treatment. Currently, DSH contracts with seven county-operated and three private organizations to provide outpatient treatment services to clients in all 58 counties in the state with non-SVP commitments.

As specified in PC 1600-1615 and 2960-2972, the CONREP Community Program Director, with the Court's approval (or in the case of Offender with a Mental Health Disorder, the Board of Parole Hearings' approval), assesses and makes the recommendation for individuals' placement in CONREP. CONREP delivers an array of mental health services to individuals during their period of outpatient treatment. In conjunction with the court-approved treatment plan, contractors coordinate and provide a wide array of 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, and psychological assessments. DSH has developed standards for these services which set minimum treatment and supervision levels for individuals court-ordered to CONREP. Regular evaluations and assessments on treatment progress are completed by contractors during the period of state hospitalization and while receiving treatment in CONREP.

When a DSH patient is discharged to CONREP, the goal is to provide an independent living environment in the least restrictive setting. However, if a CONREP-eligible patient has not demonstrated the ability to live in the community without direct staff supervision, the patient is referred to a Statewide Transitional Residential Program (STRP). The STRPs are a cost-effective resource used by CONREP to provide patients with the opportunity to learn and demonstrate appropriate community living skills in a controlled setting with 24 hours per day, seven days per week (24/7)

supervision while they transition from a state hospital to a community site. The STRP is limited to a 90 to 120-day stay as residential treatment. Once the patient has made the necessary adjustments and is ready to live in the community without structured 24/7 services provided by the STRP, the patient is able to live in a Board & Care, Room & Board, or other independent living arrangements without direct staff supervision.

DESCRIPTION OF CHANGE:

PC 1026 (b) and PC 1370 (a) (2) (A) requires the court to order the Community Program Director (CPD) or the CPD's designee to evaluate Not Guilty by Reason of Insanity (NGI) and Incompetent to Stand Trial (IST) defendants and provide a written recommendation to the court within fifteen (15) days of the order as to whether the defendant should be required to undergo outpatient treatment, or be committed to a State Hospital or to any other treatment facility. The CPD position is a role established as part of CONREP. Court orders to conduct a placement recommendation require time to review jail medical and mental health records, travel to local jails to interview clients, development and submission of court reports and responding to inquiries from the court and other criminal justice stakeholders about the placement opinions rendered as well as to explore potential outpatient placement options. The increase in numbers of IST and NGI cases referred to CPDs across the state requiring a placement recommendation has increased significantly over the years as evidenced primarily by the annual growth in the rate of IST commitments referred to DSH. In addition, implementation of the new mental health diversion law through Assembly Bill 1810, Statutes of 2018 has introduced options for CPDs to consider when Felony IST defendants are being evaluated for diversion participation. This has resulted in the need for CPDs to coordinate with county diversion program staff. While DSH has focused its efforts on increasing bed capacity and expanding programming options to serve IST defendants, the department has not addressed the workload increases impacting the CPDs. The impact of the increased placement evaluation workload has resulted in CONREP providers shifting clinical resources from other core treatment and hospital in-reach services necessary to grow and maintain CONREP outpatient census and service levels. DSH proposes to increase its CONREP provider contract funding to support the increased workload associated with CPD placement recommendations for Felony IST and NGI defendants.

METHODOLOGY:

Utilizing FY 2013-14 as a baseline, CPDs conducted approximately 3,000 IST and NGI placement evaluations in total. Since this data was not tracked during FY 2013-14, the rate of IST and NGI referrals for admission to DSH was used as a proxy for this estimate. As of 2018-19, the number of IST and NGI placement evaluations increased to approximately 5,000 evaluations. Of the total number of placement evaluations conducted, approximately 93-95% support IST workload and 5-7% supports NGI workload. Using these assumptions, DSH estimates a need for additional contract dollars to support a net increase of 2,000 placement evaluations at a cost of $1,000 per evaluation. Cost assumptions applied are further detailed below under the "Cost Per Evaluation" section.

Given the annual growth in the rate of IST referrals to DSH, a projected 10 percent annual increase in the rate of placement evaluations is assumed in the Budget Year and ongoing. As such, DSH is requesting an augmentation of $2.2 million in Budget Year to support 2,200 placement evaluations and $2.4 million ongoing. DSH will reevaluate the growth rate in placement evaluations annually to determine if funding levels are sufficient to support this workload.

Jail Evaluations Completed	Number of Evaluations
FY 2013-14	3,000
Increase in Evaluations	2,000
FY 2018-19	5,000

IST and NGI Jail Evaluations*	Number of Evaluations	Cost Per Evaluation	Total Cost
FY 2020-21	2,200	$1,000	$2,200,000
FY 2021-22	2,420	$1,000	$2,420,000

*Assumes a 10% annual increase in placement evaluations

COST PER EVALUATION:

The total estimated time to complete a jail evaluation ranges from 5.5 to 8.5 hours, which includes criminal, medical and mental health record review, court report writing, administrative time to process the evaluation and or coordinate with local county and criminal justice stakeholders and for a portion of the total evaluations conducted, travel and interview time. Approximately 40 percent of placement evaluations require travel time to and from the jail and time to conduct an in-person interview with the defendant. The other 60 percent of the jail evaluations are typically completed through a record review. These percentages are applied to an hourly rate of $175 per hour for Forensic Psychologist services for an average cost of $963 per evaluation plus administrative time at a cost of $38 per evaluation for a total average cost per evaluation of $1,000.

Estimated Time to Complete a Jail Evaluation Represented in Hours					
Report Writing	Record Review	Interview (40% of Evals)	Travel (40% of Evals)	Admin Time	Total Time
3.0	1.0	1.5	1.5	1.5	**8.5**

Average Cost for Evaluation	Hours Per Evaluation	Hourly Rate	Cost Per Evaluation	Average Cost
60% of Evaluations excluding travel and interview time	4.0	$175	$700	$963
40% of Evaluations requiring travel & interview time	7.0	$175	$1,225	
Administrative Support	1.5	$25	$38	$38
			Total Average Cost	**$1,000**

BCP Fiscal Detail Sheet

BCP Title: CONREP Non-SVP **BR Name: 4440-028-ECP-2020-GB**

Budget Request Summary

	FY20					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	0	2,200	2,420	2,420	2,420	2,420
Total Operating Expenses and Equipment	**$0**	**$2,200**	**$2,420**	**$2,420**	**$2,420**	**$2,420**
Total Budget Request	**$0**	**$2,200**	**$2,420**	**$2,420**	**$2,420**	**$2,420**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	0	2,200	2,420	2,420	2,420	2,420
Total State Operations Expenditures	**$0**	**$2,200**	**$2,420**	**$2,420**	**$2,420**	**$2,420**
Total All Funds	**$0**	**$2,200**	**$2,420**	**$2,420**	**$2,420**	**$2,420**

Program Summary

Program Funding						
4420010 - Conditional Release Program	0	2,200	2,420	2,420	2,420	2,420
Total All Programs	**$0**	**$2,200**	**$2,420**	**$2,420**	**$2,420**	**$2,420**

CONTRACTED PATIENT SERVICES
JAIL-BASED COMPETENCY TREATMENT (JBCT) PROGRAMS
EXISTING PROGRAMS AND ACTIVATION UPDATES
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**-$237**	**-$1,944**	**-$1,944**
One-Time	*0.0*	*0.0*	*0.0*	*-$237*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*-$1,944*	*-$1,944*

BACKGROUND:

DSH admits Incompetent to Stand Trial (IST) patients under Penal Code (PC) 1370, which 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. DSH contracts with county jail facilities to provide restoration of competency services in jail. Jail-Based Competency Treatment (JBCT) programs are designed to treat IST patients with lower acuity and to quickly restore them to trial competency, generally within 90 days. If a JBCT program is unable to restore a patient's competency quickly, the patient is referred to a state hospital for longer-term IST treatment.

The Budget Act of 2019 included an augmentation of $6.2 million in FY 2019-20 and $12.9 million ongoing to support cost increases in JBCT contracts and continued bed expansion to support growing capacity. The information below reflects an update on current programs and planned activations in the current year as well as the budget year (BY), as well as the ongoing impact of the proposed changes.

DESCRIPTION OF CHANGE FOR EXISTING PROGRAMS AND ACTIVATION UPDATES:

Existing JBCT Program Cost Increase

Sacramento Male JBCT Program – 32 Beds (CY $161,000; $140,000 BY and Ongoing)
This program's male 32-bed contract expired on July 31, 2019 and a new contract was negotiated that resulted in a $35 increase to the daily bed rate (from $400 to $435). The newly negotiated contract reflects cost increases in the following categories: $7/day increase for each contracted staff's salary commensurate with contract salary increases; $3/day increase for each county health staff's salary commensurate with bargained salary increases; and a $5/day increase in the jail facility's daily rate. DSH received funding to increase the daily bed rate to $420 effective August 1, 2019 and $440 in FY 2020-21. This deficit in funding equates to $15 per day, per patient in FY 2019-20. The current year cost is approximately $161,000.

As a result of this unanticipated rate increase, DSH was unable to commit to securing a contract with Sacramento County beyond the current extension to June 30, 2020 and cannot maintain future contract costs within the program's maximum budget of $440 per bed, per day beginning in FY 2020-21. The county has indicated that overall jail and JBCT clinical costs are expected to increase to a rate of approximately $452 per day, per patient. This deficit in funding equates to $12 per day, per patient. While DSH is actively working with the county to understand all JBCT cost drivers, DSH requests placeholder funding to support this anticipated cost increase of approximately $140,000 in the budget year and ongoing.

Existing JBCT Program Activation Updates

The Budget Act of 2019 included an augmentation of $5.1 million in FY 2019-20 and $11.2 million ongoing to expand existing JBCT program capacity and establish five new JBCT programs. The following outlines activation updates by county.

Mendocino: Small County Model (Informational Only)
DSH estimated that a new small county JBCT program would be activated in Mendocino County with an annual budget of $450,000, which will serve IST patients from that county. DSH anticipated startup activities would begin April 2019 and program activation would occur in May 2019. Due to extended contract negotiations, program activation occurred in July 2019.

San Luis Obispo: 5-Bed Program (Informational Only)
DSH estimated that a new five-bed JBCT program would be activated in San Luis Obispo County at a daily bed rate of $425 to serve IST patients from that county, with startup activities beginning in April 2019. Startup activities began in April 2019 as planned and program activation occurred in July 2019.

Monterey: 10-Bed Program (Informational Only)
DSH estimated that a new 10-bed JBCT program would be activated in Monterey County at a daily bed rate of $420, which will serve male IST patients from multiple neighboring counties. DSH assumed a 60-day startup period would begin in April 2019 and patient admissions would begin in June 2019. Due to extended contract negotiations, this contract is still in process of being executed and was approved by the county's Board of Supervisors on September 10, 2019. Startup activities began in June 2019 to begin renovating the treatment space. Due to anticipated delays in completing the necessary renovations and recruiting their clinical staff, DSH now estimates that patient admissions will begin in January 2020. However, this delayed activation does not yield any one-time cost savings in the current year due to the need to fund their startup activities.

San Joaquin: 10-Bed Program (Informational Only)
DSH estimated that a new 10-bed JBCT program would be activated in San Joaquin County at a daily bed rate of $420 in July 2019, which will serve IST patients from that county. This contract has been executed with the county and startup activities began in June 2019. Due to significant recruitment delays, DSH now estimates that patient admissions will begin in October 2019. However, this delayed activation does not yield any one-time cost savings in the current year due to the need to fund their startup activities.

San Bernardino: 20-Bed Expansion (CY -$242,000 One-Time Savings)
DSH estimated this program would increase its capacity by an additional 20 beds in July 2019 at a daily bed rate of $390.34, increasing the program's total capacity to 146 beds available to multiple counties across the state. This 20-bed expansion was deferred to August 2019, netting a total one-time cost savings of approximately $242,000 in the current year.

Stanislaus: 6-Bed Expansion (CY -$464,000 One-Time Savings)
DSH estimated the Stanislaus JBCT program would increase its capacity by an additional six beds in July 2019 at a daily bed rate of $420, increasing the program's total capacity to 18 beds to serve IST patients from that county. Due to extended contract negotiations, DSH now estimates this 6-bed expansion will be deferred to January 2020, netting a total one-time cost savings of approximately $464,000 in the current year.

Shasta: 6-Bed Program (CY -$464,000 One-Time Savings)
DSH estimated that a new 6-bed JBCT program would be activated in Shasta County at a daily bed rate of $420 in July 2019, which will serve IST patients from multiple counties across Northern California. Due to extended contract negotiations, DSH now estimates that program activation will occur in January 2020, netting a total one-time cost savings of approximately $464,000 in the current year.

Kings: 5-Bed Program (CY -$128,000 One-Time Savings)
DSH estimated that a new 5-bed JBCT program would be activated in Kings County at a daily bed rate of $420 in October 2019, which will serve IST patients from that county. Due to extended contract negotiations, DSH now estimates that program activation will occur in December 2019, netting a total one-time cost savings of approximately $128,000 in the current year.

Santa Barbara: 10-Bed Program (CY -$769,000 One-Time Savings)
DSH estimated that a new 10-bed JBCT program would be activated in Santa Barbara County at a daily bed rate of $420 in October 2019, which will serve IST patients from that county. Due to extended delays in the county negotiating their clinical provider subcontract, DSH now estimates that program activation will occur in April 2020, netting a total one-time cost savings of approximately $769,000 in the current year.

Alameda: 48-Bed Program (CY -$1.8 Million; BY and Ongoing -$7.4 Million Savings)
DSH estimated that a new 48-bed JBCT program would be activated in Alameda County at a daily bed rate of $420 to serve IST patients from multiple counties in the Bay Area region. DSH anticipated startup activities would begin in April 2020 with patient admissions beginning in June 2020. In June 2019, the county closed their Glenn E. Dyer jail facility located in Oakland as a cost-saving measure, which was the jail facility being considered to house this JBCT program. Due to this unanticipated closure, DSH will net a total cost savings of approximately $1.8 million in the current year and $7.4 million in the budget year and ongoing.

Admission, Evaluation and Stabilization (AES) Center (CY $3.5 Million; BY and Ongoing $5.3 million)
In FY 2017-18, DSH activated a 60-bed Admission, Evaluation and Stabilization (AES) Center located in the Lerdo Pre-Trial Facility in Bakersfield, California. Managed by the Kern County Sheriff's Office, the AES Center receives IST patients committed to DSH directly from various catchment counties. DSH received $10.7 million ongoing to support the operations of the AES Center. In addition, Assembly Bill 103 (Committee on Budget) Statutes of 2017 authorized DSH to directly admit patients into the AES Center. Of the $10.7 million authorized, DSH received $40,000 to support 1.0 Patients' Rights Advocate contracted position with a 60-patient caseload annually and $14,000 to support involuntary medication hearing costs that DSH incurs in contracting with the Office of Administrative Hearings (OAH) to conduct Administrative Law Judge (ALJ) hearings. The AES Center activated in April 2018 and full capacity was achieved in March 2019.

The rate of IST referrals continues to exceed the Department's available capacity. In FY 2018-19, DSH received a total of 4,200 IST referrals which represents a 4 percent increase compared to FY 2017-18. Based on current trends, DSH anticipates continued growth in its IST caseload. DSH continues to seek alternative solutions to increase current capacity in order to meet this ongoing pressure to the state hospital system.

The Kern County Sheriff has agreed to serve IST patients statewide and the AES Center has maintained full capacity in the last several months. To help meet the increased demand in IST referrals, DSH has identified an opportunity to increase the AES Center's capacity by an additional 30 beds in an adjacent unit that is ready to activate upon recruitment of additional staffing. DSH

assumes startup activities for this 30-bed expansion will begin in November 2019 with patient admissions beginning in January 2020. To support this current year activation, DSH proposes to utilize approximately $3.5 million in available one-time current year savings due to delayed JBCT program activations and ongoing funding that is available due to the closure of the jail in Alameda County. The estimated annual, ongoing cost for this 30-bed expansion is $5.3 million.

To support this 30-bed expansion, DSH also requests an augmentation of approximately $20,000 in the budget year and ongoing to fund an additional 0.5 Patients' Rights Advocate contracted position for a 30-patient caseload. In addition, DSH assumes six involuntary medication hearings per year will need to be conducted with an administrative law judge at an estimated cost of $1,150 per hearing. DSH requests an augmentation of approximately $7,000 in the budget year and ongoing to support these hearing costs.

Change from 2019 Budget Act						
	Bed Capacity in FY 2019-20	**Bed Capacity in FY 2020-21**	**Per Diem Rate**	**2019-20**	**2020-21**	**2021-22**
Sacramento JBCT (Males)[1]	32	32	$435-$452	$161,000	$140,000	$140,000
San Bernardino JBCT	146	146	$390.34	($242,000)	$0	$0
Stanislaus JBCT	18	18	$420.00	($464,000)	$0	$0
Shasta JBCT	6	6	$420	($464,000)	$0	$0
Kings JBCT	5	5	$420	($128,000)	$0	$0
Santa Barbara JBCT	10	10	$420	($769,000)	$0	$0
Alameda JBCT	48	48	$420	($1,830,000)	($7,379,000)	($7,379,000)
AES Center	90	90	$480	$3,499,000	$5,283,000	$5,283,000
Total:	**355**	**355**		**($237,000)**	**($1,956,000)**	**($1,956,000)**

[1]The Sacramento Male JBCT program's per diem rate is increasing from $400 to $435 in FY 2019-20 and to $452 in FY 2020-21.

Patients' Rights Advocates Funding

The Budget Act of 2019 included an augmentation of $259,000 in FY 2019-20 and ongoing to fund 6.5 contracted Patients' Rights Advocate positions to support the JBCT programs in order to comply with Assembly Bill 103 (Statutes of 2017) which requires that all DSH patients have equal access to Patients' Rights Advocacy resources, including IST patients who are admitted to JBCT programs. The methodology used to determine the number of contracted Patients' Rights Advocate positions needed and estimated cost is based on a 60-patient caseload with an annual salary of $40,000.

In FY 2020-21, DSH proposes to activate eight new JBCT programs with an estimated total capacity of 66 beds. However, DSH is no longer activating a 48-bed JBCT program in Alameda County, which DSH already received Patients' Rights Advocacy resources to support. After offsetting with the Alameda JBCT resources, DSH requests $12,000 in the budget year and ongoing to fund an additional 0.3 contracted Patients' Rights Advocate position.

The table below provides a breakdown of how the request supports the expanded JBCT caseload.

JBCT	CASELOAD	PRA POSITION	ANNUAL COSTS
FY 2020-21 New Programs Requested - Dedicated Beds	63	1.1	$42,000
FY 2020-21 New Programs Requested - Small County Models*	3	0.1	$2,000
Less Alameda JBCT Program - *No Longer Activating*	-48	-0.8	-$32,000
TOTAL:	**18**	**0.3**	**$12,000**

*Small county programs are estimated to serve an approximate total of 15 patients annually or an average of one patient at any given time.

CONTRACTED PATIENT SERVICES
JAIL-BASED COMPETENCY TREATMENT (JBCT) PROGRAMS
NEW PROGRAM UPDATES
New Item

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**$231**	**$8,853**	**$11,159**
One-Time	*0.0*	*0.0*	*0.0*	*$231*	*$4,593*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$4,260*	*$11,159*

DESCRIPTION OF CHANGE FOR NEW PROGRAM UPDATES:

DSH continues to build out its continuum of care to support IST patients by working with a number of counties to develop new JBCT programs in their local jails and secure contracts to activate these programs in the budget year. The target range of beds for each county is based on an analysis of the county's monthly trend of Felony IST referrals. Negotiations and contract development are at various stages for each location and the proposals below reflect the programs furthest along in the process. DSH requests authority to establish funding as a placeholder to allow contract and program development to continue moving forward. DSH assumes an estimated daily bed rate of $420, which is consistent with the rates established for recent JBCT program activations. In addition, DSH is Proposing Trailer Bill Language (TBL) to update the IST commitment packet contents. This will provide DSH the documents necessary to make fully informed placement evaluations for defendants committed to DSH as IST under Penal Code section 1370. This will contribute to the reduction in wait times.

New JBCT Programs with Dedicated JBCT Beds/Treatment Milieu

DSH is actively working with several counties to establish dedicated JBCT beds. The target range of beds for each county is based on an analysis of the monthly trend of Felony IST referrals tracked by DSH and the county's interest in establishing a local or regional program. DSH assumes an estimated daily bed rate of $420, which is consistent with the rates established for recent JBCT program activations.

June 2020 Proposed Activation:

- Northern California County A: Request to Establish 15 to 30-Bed Program (CY $189,000; BY $2.9 Million; Ongoing $4.6 Million)
  DSH proposes to establish a regional JBCT program in a Northern California county that will provide 15 beds, initially, for IST patients from multiple counties across the state. DSH anticipates activating this new program in June 2020. At a daily bed rate of $420, the one-time cost in the current year is approximately $189,000 to fund this 15-bed program activation.

  DSH estimates this program will increase its capacity by an additional 15 beds in April 2021, increasing the program's total capacity to 30 beds for IST patients from multiple counties. This expansion is dependent upon completion of the county jail's new mental health unit construction. At a daily bed rate of $420, the budget year cost for the initial 15 beds and 15-bed expansion planned for April 2021 is approximately $2.9 million. The estimated annual cost to support all 30 beds ongoing is approximately $4.6 million.

July 2020 Proposed Activations:

- Northern California County B: Request to Establish 6-Bed Program (BY and Ongoing $920,000)
  DSH proposes to establish a JBCT program in a Northern California county that will provide six beds for IST patients from that county. At a daily bed rate of $420, the estimated annual cost to support all six beds in the budget year and ongoing is approximately $920,000.

- Central California County C: Request to Establish 12-Bed Program (BY and Ongoing $1.8 Million)
  DSH proposes to establish a regional JBCT program in a Central California county that will provide 12 beds for male IST patients from multiple counties across the state. At a daily bed rate of $420, the estimated annual cost to support all 12 beds in the budget year and ongoing is approximately $1.8 million.

October 2020 Proposed Activations:

- Northern California County D: Request to Establish 5-Bed Program (BY $573,000; Ongoing $767,000)
  DSH proposes to establish a JBCT program in a Northern California county that will provide five beds for IST patients from that county. Assuming program activation will occur in October 2020 at a daily bed rate of $420, the estimated cost to support all five beds in the budget year is approximately $573,000. The annual, ongoing cost is approximately $767,000.

- Southern California County E: Request to Establish 10-Bed Program (BY $1.1 Million; Ongoing $1.5 Million)
  DSH proposes to establish a JBCT program in a Southern California county that will provide 10 beds for IST patients from that county. Assuming program activation will occur in October 2020 at a daily bed rate of $420, the estimated cost to support all 10 beds in the budget year is approximately $1.1 million. The annual, ongoing cost is approximately $1.5 million.

New Small County JBCT Models

DSH is also working with two Northern California counties to establish JBCT programs that are flexible in size and scope to serve their limited number of felony IST referrals. The payment model assumes a fixed cost for county administrative and medical costs, and variable costs to compensate for the daily jail rate and competency services delivered when IST patients are ordered into the program. Because these programs will serve a small annual total of patients, the program costs will be reduced in comparison to the JBCT programs that designate a specific number of beds.

June 2020 Proposed Activation:

- Northern California County F: Small County (CY $42,000; BY and Ongoing $500,000)
  DSH proposes to activate a new small county JBCT program in a Northern California county in June 2020 with a one-time cost in the current year of approximately $42,000. The estimated annual cost is approximately $500,000 in the budget year and ongoing.

July 2020 Proposed Activations:

- Northern California County G: Small County (BY and Ongoing $500,000)
  DSH proposes to activate a new small county JBCT program in a Northern California county with an estimated annual cost of approximately $500,000 in the budget year and ongoing.

- Central California County H: Small County (BY and Ongoing $500,000)
  DSH proposes to activate a new small county JBCT program in a Central California county with an estimated annual cost of approximately $500,000 in the budget year and ongoing.

Change from 2019 Budget Act						
	Bed Capacity in FY 2019-20	**Bed Capacity in FY 2020-21**	**Per Diem Rate**	**2019-20**	**2020-21**	**2021-22**
Northern California A JBCT	15	30	$420	$189,000	$2,873,000	$4,599,000
Northern California B JBCT	0	6	$420	$-	$920,000	$920,000
Central California C JBCT	0	12	$420	$-	$1,840,000	$1,840,000
Northern California D JBCT	0	5	$420	$-	$573,000	$767,000
Southern California E JBCT	0	10	$420	$-	$1,147,000	$1,533,000
Northern California F Small County JBCT[1]	N/A	N/A	N/A	$42,000	$500,000	$500,000
Northern California G Small County JBCT[1]	N/A	N/A	N/A	$-	$500,000	$500,000
Central California H Small County JBCT[1]	N/A	N/A	N/A	$-	$500,000	$500,000
Total:	**15**	**63**		**$231,000**	**$8,853,000**	**$11,159,000**

[1]Specific to the small county models, due to the payment model with both fixed and variable costs, a per diem rate is not applicable for these programs. Additionally, each small county model will serve up to 15 IST patients annually.

BCP Fiscal Detail Sheet

BCP Title: Jail-Based Competency Treatment New Activations **BR Name: 4440-029-ECP-2020-GB**

Budget Request Summary

	FY20					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	231	8,853	11,159	11,159	11,159	11,159
Total Operating Expenses and Equipment	**$231**	**$8,853**	**$11,159**	**$11,159**	**$11,159**	**$11,159**
Total Budget Request	**$231**	**$8,853**	**$11,159**	**$11,159**	**$11,159**	**$11,159**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	231	8,853	11,159	11,159	11,159	11,159
Total State Operations Expenditures	**$231**	**$8,853**	**$11,159**	**$11,159**	**$11,159**	**$11,159**
Total All Funds	**$231**	**$8,853**	**$11,159**	**$11,159**	**$11,159**	**$11,159**

Program Summary

Program Funding						
4430020 - Jail Based Competency Treatment	231	8,853	11,159	11,159	11,159	11,159
Total All Programs	**$231**	**$8,853**	**$11,159**	**$11,159**	**$11,159**	**$11,159**

BCP Fiscal Detail Sheet

BCP Title: Jail-Based Competency Treatment Existing Program Activation Updates **BR Name: 4440-031-ECP-2020-GB**

Budget Request Summary

	FY20					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	-3,736	-7,239	-7,239	-7,239	-7,239	-7,239
Total Operating Expenses and Equipment	**$-3,736**	**$-7,239**	**$-7,239**	**$-7,239**	**$-7,239**	**$-7,239**
Total Budget Request	**$-3,736**	**$-7,239**	**$-7,239**	**$-7,239**	**$-7,239**	**$-7,239**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-3,736	-7,239	-7,239	-7,239	-7,239	-7,239
Total State Operations Expenditures	**$-3,736**	**$-7,239**	**$-7,239**	**$-7,239**	**$-7,239**	**$-7,239**
Total All Funds	**$-3,736**	**$-7,239**	**$-7,239**	**$-7,239**	**$-7,239**	**$-7,239**

Program Summary

Program Funding						
4430020 - Jail Based Competency Treatment	-3,736	-7,239	-7,239	-7,239	-7,239	-7,239
Total All Programs	**$-3,736**	**$-7,239**	**$-7,239**	**$-7,239**	**$-7,239**	**$-7,239**

BCP Fiscal Detail Sheet

BCP Title: Admission Evaluation and Stabilization (AES) **BR Name: 4440-032-ECP-2020-GB**

Budget Request Summary

	FY20					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	3,499	5,283	5,283	5,283	5,283	5,283
Total Operating Expenses and Equipment	**$3,499**	**$5,283**	**$5,283**	**$5,283**	**$5,283**	**$5,283**
Total Budget Request	**$3,499**	**$5,283**	**$5,283**	**$5,283**	**$5,283**	**$5,283**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	3,499	5,283	5,283	5,283	5,283	5,283
Total State Operations Expenditures	**$3,499**	**$5,283**	**$5,283**	**$5,283**	**$5,283**	**$5,283**
Total All Funds	**$3,499**	**$5,283**	**$5,283**	**$5,283**	**$5,283**	**$5,283**

Program Summary

Program Funding						
4430010 - Admission, Evaluation, Stabilization Center	3,499	5,283	5,283	5,283	5,283	5,283
Total All Programs	**$3,499**	**$5,283**	**$5,283**	**$5,283**	**$5,283**	**$5,283**

BCP Fiscal Detail Sheet

BCP Title: Jail-Based Competency Treatment Patients' Rights **BR Name: 4440-033-ECP-2020-GB**

Budget Request Summary

	FY20					
	CY	BY	BY+1	BY+2	BY+3	BY+4
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	0	12	12	12	12	12
Total Operating Expenses and Equipment	**$0**	**$12**	**$12**	**$12**	**$12**	**$12**
Total Budget Request	**$0**	**$12**	**$12**	**$12**	**$12**	**$12**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	0	12	12	12	12	12
Total State Operations Expenditures	**$0**	**$12**	**$12**	**$12**	**$12**	**$12**
Total All Funds	**$0**	**$12**	**$12**	**$12**	**$12**	**$12**

Program Summary

Program Funding						
4430020 - Jail Based Competency Treatment	0	12	12	12	12	12
Total All Programs	**$0**	**$12**	**$12**	**$12**	**$12**	**$12**

CONTRACTED PATIENT SERVICES
INCOMPETENT TO STAND TRIAL (IST) "OFF-RAMP" SERVICES
New Item

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**$0**	**$2,000**	**$2,000**
One-Time	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$2,000*	*$2,000*

BACKGROUND:

The Department of State Hospitals (DSH) has continued to expand bed capacity and its program options to serve the felony IST population. However, the number of felony IST defendants awaiting placement to a DSH program for restoration of competency services continues to outpace the Department's ability to serve this population in a timely manner. On average, IST defendants pending placement to DSH programs wait longer than 60 to 90 days. While a defendant is progressing through the court process and being evaluated as IST, as well as while they are awaiting transfer to a state hospital if found IST, they receive mental health treatment in jail. During that time, by being stabilized on medications, some individuals may regain competency before being admitted to a DSH restoration of competency treatment program. However, county jails and existing Jail-Based Competency Treatment (JBCT) programs lack sufficient mental health staff to monitor and reassess for restored IST defendants.

The Budget Act of 2019 included funding for an "IST Off-Ramp" team in Los Angeles (LA) County to assess felony ISTs committed by LA County in the jail for restoration of competency prior to placement in a DSH program. If an IST is assessed and found to be competent, the team psychiatrically stabilizes the defendant to ensure competency is maintained and submits a restoration of competency report to the court to allow the defendant to proceed with their case rather than having to be transferred to a DSH program. This effort has proven successful thus far and, as of September 30, 2019, 159 IST patients in LA County have been successfully "off-ramped" and removed from the Department's waitlist.

DESCRIPTION OF CHANGE:

Implementing "off-ramp" services in additional counties can prevent additional IST defendants from being transferred unnecessarily to a treatment program if they are restored to competency. DSH proposes to implement four "off-ramp" programs in the following regions: Bay Area, Northern California, Central California, and Southern California. For each of these four regions, DSH proposes to deploy 2.0 forensically trained psychologists in contracted positions to monitor felony IST defendants for restoration of competency who are incarcerated in county jails located within each assigned region. The contracted psychologists will initiate medication protocols, assessment, and treatment while in jail; perform evaluations and court reports; and provide court testimony. The estimated annual cost is $500,000 per program to reimburse for the 2.0 contracted position salaries, benefits, increased travel costs associated with traveling to each county jail within the assigned region, and the counties' operating expenses. DSH requests placeholder funding of approximately $2.0 million in the budget year and ongoing to support a total of 8.0 contracted positions.

DSH is actively working with interested counties within the four regions to implement "off-ramp" programs by incorporating the 8.0 contracted positions and "off-ramp" workload into existing JBCT program contracts as an extension of competency restoration services provided by the counties and reimbursed by DSH. Thus, the proposed staffing would be based at the identified JBCT program counties (the "hubs") and deployed to neighboring counties (the "spokes") within their assigned region as a "hub and spoke" program model. As DSH is continuing to explore this new model with interested counties, updated estimated costs will be presented in the 2020-21 May Revision.

BCP Fiscal Detail Sheet

BCP Title: Incompetent to Stand Trial (IST) "Off-Ramp" Services **BR Name: 4440-025-ECP-2020-GB**

Budget Request Summary

	FY20					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	0	2,000	2,000	2,000	2,000	2,000
Total Operating Expenses and Equipment	**$0**	**$2,000**	**$2,000**	**$2,000**	**$2,000**	**$2,000**
Total Budget Request	**$0**	**$2,000**	**$2,000**	**$2,000**	**$2,000**	**$2,000**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	0	2,000	2,000	2,000	2,000	2,000
Total State Operations Expenditures	**$0**	**$2,000**	**$2,000**	**$2,000**	**$2,000**	**$2,000**
Total All Funds	**$0**	**$2,000**	**$2,000**	**$2,000**	**$2,000**	**$2,000**

Program Summary

Program Funding						
4430030 - Other Contracted Services	0	2,000	2,000	2,000	2,000	2,000
Total All Programs	**$0**	**$2,000**	**$2,000**	**$2,000**	**$2,000**	**$2,000**

CONTRACTED PATIENT SERVICES
COMMUNITY FORENSIC PROGRAMS
COMMUNITY CARE COLLABORTIVE PILOT
New Item

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**3.0**	**3.0**	**$0**	**$24,563**	**$33,338**
One-time	*0.0*	*0.0*	*0.0*	*$0*	*$23,903*	*$32,678*
Ongoing	*0.0*	*3.0*	*3.0*	*$0*	*$660*	*$660*

BACKGROUND:

The number of Felony Incompetent to Stand Trial (FIST) defendants referred to the Department of State Hospitals (DSH) has continued to increase year-over-year and in response DSH added nearly 450 state hospital beds, over 300 jail-based treatment beds, and reduced lengths of stay achieved through systems improvements. From FY 2013-14 to FY 2018-19, the monthly average number of FIST referrals increased by 51%. The rapid, exponential growth in this population triggered simultaneous growth in the number of FIST patients waiting for placement in a DSH bed. In FY 2007-08, the number of FISTs pending placement in a state hospital bed was between 200 and 300 patients; and as of November 25, 2019, that number has dramatically increased to 839. Over the past several years, DSH has taken multiple steps to respond to the demand for more beds and treatment alternatives to serving the FIST population. However, the increasing referral rates are creating enormous legal pressure with the possibility that the California Superior Court may mandate admission timelines.

DSH has worked to better understand the ongoing increase in demand by looking at the criminal histories of patients upon admission and recidivism data post-release from DSH. Restoration services for FISTs is little more than stabilizing their mental health symptoms and teaching them basic information about court processes and roles. With the limited focus on competency restoration, treatment at DSH does not have long-term impact on their mental health and criminal outcomes. Using patient data from FY 2014-15, DSH found that 45% of FISTs admitted to its system of care had 15 or more previous arrests. For comparison, in FY 2009-10, only 18% of FISTs had similar arrest histories. In addition, DSH's review of Department of Justice data on all FISTs discharged in FY 2014-15 found 69% were rearrested and 49.8% were convicted of new crimes within three years. This data shows that creating more capacity for restoration services at DSH cannot solve this problem when a major component of the cause of ongoing IST referrals is happening in the community between restoration at a state hospital and the next arrest. Continuing to build new capacity for state hospital restoration is not the answer for reducing the IST waiting list and so the State must look to long-term solutions in the community.

DESCRIPTION OF CHANGE:

DSH requests 3.0 positions and $24.6 million in budget year with an incrementally increased annual appropriation over a six-year period to support the Community Care Collaborative Pilot (CCCP) program. The proposed program will provide funding through an incentive program to three (3) pilot counties with the following goals:

- To incentivize counties to significantly reduce the overall rate of felony defendants declared incompetent to stand trial (FIST) and the rate of FIST defendants referred to DSH.

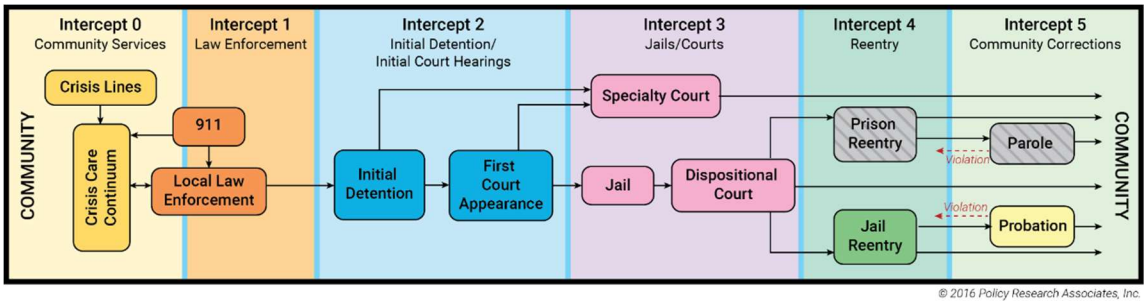
- To demonstrate effective strategies to treat and house a high risk and high need population–those with complex behavioral health issues who are often homeless or at risk of homelessness, have multiple interactions with law enforcement, and are often high utilizers of emergency room services.
- To incentivize building a full and appropriate continuum of care in the community to serve this population so they are no longer cycling in and out of institutions, including jail and prison, and homelessness.
- To incentivize greater investment in funding effective pre-arrest and pre-booking programs or strategies to reduce the rate of arrests and re-arrests.
- To promote increased flexibility within existing funding streams to reduce a siloed approach to the delivery of treatment and services to this population.

With the success of these pilots, more individuals will be treated and restored in the community, thereby reducing the waitlist for ISTs and ultimately freeing up state hospital beds for individuals who need 24-hour care that is not available through community programs. Existing and future litigation may be mitigated and avoided through the success of these pilots as the state demonstrates its goal to build toward a long-term solution to a problem that will continue without such an intervention.

Differences from DSH Diversion Pilot

The CCCP program has similar goals to DSH's Diversion program initiated in 2019-20 but is different from the Diversion program in important ways. Like Diversion, DSH designed the CCCP to reduce the annual number of FISTs referred to DSH, to establish additional long-term care options in the community, and to divert people with serious mental illness from criminal justice and institutional settings. However, the CCCP will allow the pilot communities much more flexibility in programing, selecting a target population, and outcomes than the current Diversion pilot.

The Diversion pilot requires counties to divert defendants who are in the post-booking, pre-trial stage of the criminal justice system (Intercept 2 and 3 of the Sequential Intercept Model (SIM) displayed below). In comparison, the CCCP allows counties the flexibility to use the funding to develop programs at any point on the SIM, which broadens the scope of the pilot to include pre-arrest (Intercept 0 and 1), post-conviction and re-entry programs, as well as during IST commitment. By allowing for these other types of programs, the CCCP provides upstream and downstream treatment options that, if deployed successfully, should reduce the rate of arrests in this population and overall FIST designations. Upstream efforts include the development or expansion of crisis response centers, law enforcement assisted diversion (LEAD) programs, crisis intervention teams, and additional mental health training for 911 dispatchers. Programs such as these are designed to divert individuals into treatment before an arrest by training police and other responders how to recognize and de-escalate a mental health crisis and develop the resources needed to take individuals to treatment instead of jail. Downstream programs should be designed to ensure an individual's success after release from jail by immediately providing housing, ongoing access to medication and behavioral health treatment, case management, and employment services.



In addition to a broader range of services, the CCCP will also allow counties to serve a broader pool of potential candidates. The Diversion program is limited to serving FISTs, or those likely to be found FIST and have a current mental health diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder. The CCCP will not have the same restrictions, thereby allowing counties to serve individuals suffering from PTSD, major depressive disorder, and other illnesses.

The program outcomes and payment mechanisms of the two programs are also different. Penal Code 1001.36, an authorizing statute for the Diversion program, requires that the charges against FIST participants in the Diversion program are dropped if a client completes the treatment program successfully. As the CCCP will employ different strategies to reduce the rate of IST referrals to DSH, such as at the pre-arrest stage or through community-based restoration for FISTs, there will not be a requirement to drop charges. Finally, payments in the Diversion program and CCCP will be structured differently. In the Diversion program, counties agree to a set target population to serve over three years (typically equivalent to 20-30% of the counties' total referrals to DSH in FY 2016-17) and payments to the county are triggered when the county serves a pre-determined population benchmark within their program. In comparison, a portion of the CCCP funding is based on an incentive model where payments will be based on reducing FIST referrals and FIST designations from the county over the course of the year as compared to the baseline year.

Community Care Collaborative Pilot Program Elements

DSH will implement a tiered incentive program with select counties that will provide funding to serve FIST patients in community-based restoration programs, and offer additional fiscal incentives when the county achieves its annual benchmark goals – a reduction to the number of FIST referrals to DSH and an overall reduction to the number of FIST designations as compared to a baseline year. Targeted FIST reductions will incrementally increase over the course of a 6-year pilot period, as will the value of incentive funding offered to the counties to encourage participation, thoughtful planning, and a focused approach to implementing creative and collaborative solutions to stem the tide of the increase in IST referrals.

The first year goal is set at a 15% reduction in the number of FIST referrals. For example, if a county referred 1,000 FISTs to DSH in 2018-19, the county's 2020-21 goal for the reduction in FIST referrals would be 150. The goal set for the number of referrals reduced also becomes the targeted reduction for FIST designations. By the sixth year, goal is increased to a 60% reduction in FIST referrals compared to 2018-19.

Annual reduction goals can be achieved through: 1) diversion of FIST defendants by treating them in a community-based restoration program; 2) "off-ramping" FIST defendants that have restored competency in jail; 3) upstream efforts, such as effective pre-arrest and pre-booking diversion programs and other strategies to reduce the rate of arrests and re-arrests; and/or 4) downstream efforts, such as programs designed to support individuals immediately upon release from custody by providing housing, ongoing behavioral health treatment, case management, and other wrap-around services.

Funding Structure:

DSH proposes a two-pronged funding structure where the cost of treating FIST patients in a community-based restoration program is compensated by the state, plus tiered incentive payments when specified reduction benchmarks and related goals are achieved.

- Start-Up Funds – Start-up funds for planning, implementation activities, and capital costs will be available and released upon submission of a detailed county plan and acknowledgement of support from county stakeholders (deliverable-based payment) in support of Year 1. The initial payment will equal 10% of the amount allotted for Progress

Payments (see below). Counties will have the opportunity to seek additional start-up funds in each subsequent year to assist with program and housing expansion projects. An updated plan and budget outlining the additional start-up costs will be required as a deliverable for payment.

- Progress Payments – Progress payments of $60,225 are provided for each FIST served by the County in a community-based restoration program during the year, up to the number that has been set as the benchmark goal. For example, the county with a referral reduction goal of 150 would be able to receive progress payments up to $9,033,750 in the first year. If the county serves fewer than 150 FISTs in community-based restoration programs, any remaining funds available will roll-over into the incentive payments available to the county for reaching the reduction goals.

    - Progress payments will be paid on a quarterly basis in accordance with the actual number of FIST patients served by the county in a community-based restoration program during the quarterly reporting period, up to the established goal.
    - An annual average cost of $60,225 ($15,056 per quarter or $165 per day) per FIST patient is used to calculate the amount due to the county for progress payments.
    - The average cost per FIST patient is increased by 3% every year after to account for annual increases to local service costs.
    - Any remaining funds from the budget for progress payments will be applied to the total budgeted incentive available to reach and, ideally, exceed annual reduction benchmarks specified for each participating county.

- Incentive Payments – The structure for incentive payments has the following components:

    - Annual Benchmark Reduction Goals – Incentive payments are available to the County when it achieves a specified level of reduction in progress towards its annual benchmark goals of: 1) a reduction in the number of FIST designations; or 2) a reduction to the number of FISTs referred to DSH as compared to the baseline year of 2018-19. A county does not need to meet its benchmark goal to be eligible to receive incentive payments, which is described below under 'Tiered Incentive Payments.'
    - Incentive Payments- The incentive payment available for a reduction in FIST referrals is 15% of the total available for progress payments and for a reduction in FIST designations, it is 25% of the total available for progress payments. For the example county, this results in an incentive of $1,355,063 (150 * $60,225 * 15%) for meeting the referral reduction benchmark and an incentive of $2,258,438 (150 * $60,225 * 25%) for meeting the designation reduction benchmark.
    - Tiered Incentive Payments – If the County achieves progress towards its benchmark reduction goals by the end of each year, a percentage of the total available for incentive payments will be distributed to the County to support its progress and encourage continued growth toward meeting its benchmark goals. After a county meets the minimum threshold reduction for an incentive payment, the funding available increases the closer the reduction is to the benchmark goal, as demonstrated in the table below. Incentive payments for an overall reduction to FIST designations are made available starting at a lower threshold (25% or higher), as compared to the reduction to DSH referrals (65% or higher) because achieving an overall reduction in FIST designations will take greater collaboration by all county and criminal justice partners to implement the changes that will be

necessary to measurably impact the rate of FIST designations. It is conceivably easier to achieve a reduction to the number of FISTs referred to DSH by redirecting patients into a community-based restoration program.

Tiered Incentive Payment Schedule

Reduction to Overall FIST Designations		Reduction to DSH Referrals	
% Progress Toward Goal	% of Incentive Payment Provided	% Progress Toward Goal	% of Incentive Payment Provided
10%	0%	10%	0%
20%	0%	20%	0%
25%	10%	25%	0%
30%	15%	30%	0%
40%	25%	40%	0%
50%	35%	50%	0%
60%	45%	60%	0%
65%	55%	65%	40%
70%	65%	70%	50%
80%	75%	80%	65%
90%	85%	90%	80%
100%	100%	100%	100%

- Benchmark Achievement "Timeline" Incentive – The County will receive an additional incentive payment equal to 15% of the amount allotted for the Progress Payments ($60,225 x 150 x 15% for our example county) if it reaches the benchmark goal for reducing FIST designations.

Continuing with our example County, the tables below list the incentive payments the County would be eligible to receive. Of the total available, $1.4 million is available for incentives supporting a reduction to DSH referrals and $2.3 million for incentives supporting an overall reduction in FIST designations. Below, the County achieves a reduction of 120 FIST referrals to DSH (80% of goal) by serving the patients in a community-based restoration program. However, the County ultimately deemed 135 more felony defendants as IST as compared to the baseline year. As a result, the County will receive 65% of the incentive available to reduce the number of FIST referrals to DSH ($0.9 million) and none of the incentives available to reduce the overall number of FIST designations.

Sample Incentive Payment Schedule

Reduction to Overall FIST Designations			
Benchmark Reduction:	150		
Total Available Incentive:	$2,258,438		
# of FISTs Reduced	% Reduction Achieved	Incentive Multiplier	Incentive Payment
15	10%	0%	$ -
30	20%	0%	$ -
38	25%	10%	$ 225,844
45	30%	15%	$ 338,766
60	40%	25%	$ 564,610
75	50%	35%	$ 790,453
90	60%	45%	$ 1,016,297
98	65%	55%	$ 1,242,141
105	70%	65%	$ 1,467,985
120	80%	75%	$ 1,693,829
135	90%	85%	$ 1,919,672
150	100%	100%	$ 2,258,438

Reduction to DSH Referrals			
Benchmark Reduction:	150		
Total Available Incentive:	$1,355,063		
# of FISTs Reduced	% Reduction Achieved	Incentive Multiplier	Incentive Payment
15	10%	0%	$ -
30	20%	0%	$ -
38	25%	0%	$ -
45	30%	0%	$ -
60	40%	0%	$ -
75	50%	0%	$ -
90	60%	0%	$ -
98	65%	40%	$ 542,025
105	70%	50%	$ 677,532
120	80%	65%	$ 880,791
135	90%	80%	$ 1,084,050
150	100%	100%	$ 1,355,063

If all incentive goals are achieved, the available funding for each FIST designation/referral reduced is $99,371 in the first year and is increased to $115,500 by year six as displayed in the chart below.

Total Max Incentive Per FIST Reduction

Incentive Payment	Year 1 Value	Year 6 Value
Start Up Funds (10% x Annual Progress Payment)	**$ 6,023**	**$ 7,000**
Progress Payments (Base Cost per Patient)	**$ 60,225**	**$ 70,000**
Additional Incentives per FIST Reduction	**$ 33,124**	**$ 38,500**
Incentive: Reduce FIST Referrals to DSH - Goal Met (15% x Progress Payment)	*$ 9,034*	*$ 10,500*
Incentive: Reduce Total FIST Commitments - Goal Met 25% x Progress Payment)	*$ 15,056*	*$ 17,500*
Incentive: Timeline Goal Met (15% x Progress Payment)	*$ 9,034*	*$ 10,500*
Maximum Annual Incentive Available Per FIST Reduction	**$ 99,371**	**$ 115,500**

Timely Discharge – To encourage timely conservatorship investigation proceedings and timely discharge to community-based services for FISTs referred to DSH and ultimately found non-restorable, the County will be charged the daily bed rate for any days a non-restorable FIST remains in a state hospital bed beyond 10 days.

Additional Example – County A:

In the example below, the Year 1 benchmark goal for County A is to reduce both overall FIST designations and FIST referrals to DSH by 198 (15% of 1,319 – total County A referrals to DSH in baseline year). The County serves 165 FIST patients in Community Based Restoration (CBR) and receives $9.9 million in progress payments. County A additionally off ramps another 135 FISTs from the DSH waitlist because they restored competency while in jail. Because the county only treated 165 FISTs in the community, the amount left available for Progress Payments (33 x $60,225 = $1,987,425) is redistributed to the incentives available to reach established benchmark goals for the County and prorated between the two categories of incentive payments. The County's overall FIST designations have increased by 91 over the baseline year; however, the net impact to DSH referrals was a

reduction of 206 FISTs. In this scenario, the County would be eligible for a partial incentive payment tied to achieving the goal of reducing the number of FIST referrals to DSH, but would not be eligible for an incentive payment for an overall reduction in FIST designations. In addition, we assume the County provides a detailed plan for program implementation in order to receive program implementation funds. At the end of the year, County A would receive the following payments:

	Count	Payment
FISTs served in Community	165	$9,937,125
Plan Submitted	198	$1,192,455
FIST Referral Reduction	198	$1,788,683
Rollover Progress Payments (40%)	33	$794,970
		$13,713,233

If the County achieved all benchmark goals, the county is eligible for a maximum payout of $19.7 million.

				Benchmark Goal Met			
County A	Year 1	Progress Payments (# Served x $60k Annual Cost per FIST)	Start Up Funds (10% x Progress)	Reduction to DSH Referrals (15% x Progress)	Overall FIST Reduction (25% x Progress)	Timeline Goal Met (15% x Progress)	**Total Payments**
Benchmark Goal / Incentive Payment Available:	**198**	$ 11,924,550	$ 1,192,455	$ 1,788,683	$ 2,981,138	$ 1,788,683	**$ 19,675,508**
Progress During Year:							
# of FISTs Treated in Community[1]	165	$9,937,125					
# of FISTs Off-Ramped from DSH Waitlist[2]	135	$0					
# of FISTs Diverted[3] - (reduce by amount paid for by DSH Diversion)	0	$0					
Total FISTs served during the year/Total Progress Payments	**300**	$9,937,125					
Final Outcome After Year Ends - OVERALL FIST COMMITMENTS:							
# of FIST Referrals during Baseline Year (2017-18)	1319						
# of FIST Commitments during Incentive Year by June 30, 2018 (2018-19)	1410						
Difference - Total # of FISTs Reduced Compared to Baseline Year	**-91**						
% of Benchmark Reduction Achieved	-46%						
Final Outcome After Year Ends - DSH REFERRALS							
# of FIST Referrals during Baseline Year (2017-18)	1319						
# of FIST Referrals to DSH by June 30, 2018 (2018-19)	1113						
Difference - Total # of FISTs Reduced Compared to Baseline Year	**206**						
% of Benchmark Reduction Achieved	104%						
Surplus/Deficit from progress payments applied to or reduced from benchmark goal incentives				*$794,970*	*$1,192,455*		
SUMMARY OF INCENTIVE PAYMENTS:							
Total Progress Payments for # of FISTs Served in CBR		$9,937,125					$9,937,125
Plan Submitted for Start Up? (Yes/No)	Yes		$1,192,455				$1,192,455
Did County achieve 65% or more of goal to reduce DSH Referrals by June 30? (Yes/No)	Yes			$2,583,653			$2,583,653
Did County achieve 65% or more of goal for overall FIST reduction by June 30? (Yes/No)	No				$0	$0	$0
TOTAL FUNDS DISTRIBUTED TO THE COUNTY		**$9,937,125**	**$1,192,455**	**$2,583,653**	**$0**	**$0**	**$13,713,233**

[1]Community-based program or facility. Annual cost of $60,225 per FIST patient treated in the community.

[2]FISTs "off-ramped" are those who are awaiting placement to DSH program but have competency restored prior to admission. The off-ramp program assesses for competency and writes reports to the courts when the FIST has regained competency. DSH currently budgets $750k annually to perform this service.

[3]FISTs diverted to the community as part of DSH Diversion program are paid for through separate funding source. Amount paid from DSH Diversion program deducted from available funding for incentives.

Leverage Other Funding Sources

In addition to the incentive funding available to support the reduction of FIST designations and referrals to DSH, counties will be encouraged to maximize the use of other available funding sources to effectively support community placement and services including, but not limited to, Medi-Cal (FFP) reimbursement, Social Security Disability, Supplemental Security Income and other eligible benefits that clients may be entitled to. Counties will be required to report on the funding sources that are accessed to support FIST patients served in the CCCP.

Proposed FIST Reduction Benchmarks

DSH proposes an annual reduction of FISTs as compared to total number of referrals DSH received in FY 2018-19 (baseline year), which is the most complete fiscal year dataset available for purposes of estimating FIST reduction goals and funding. DSH plans to work with three counties across the state that, combined, referred a net total of 1,580 FISTs to DSH programs In FY 2018-19. The benchmark goals will incrementally increase annually over a 6-year period as displayed in the chart below for the proposed pilot counties:

Program Reduction Goals		
Year	% Reduction	Benchmark Reduction Goal
Year 1	15%	237
Year 2	20%	316
Year 3	25%	395
Year 4	35%	553
Year 5	45%	711
Year 6	60%	949

In the first year of the incentive program, the benchmark reduction begins at 15% of the total referred in the baseline year. The percentage is based on actual experience in contracting with the Los Angeles County Office of Diversion and Re-entry to establish a 150-bed community-Based Restoration (CBR) and an Off-Ramp program. CBR transitions FIST defendants from jail to an outpatient competency restoration program for treatment and evaluation, and often leads to release from the criminal justice system into community-based housing and treatment. The Off-Ramp program provides treatment while a FIST defendant is in jail. If an assessment finds the FIST has restored to competency, a PC 1372 court report is written, and the defendant is "off-ramped" from the DSH IST waiting list.

In 2017-18, there were a total of 1,319 FIST designations in Los Angeles County and all were referred to DSH. In 2018-19, Los Angeles County had 1,410 FIST designations, however, the activation of the CBR/Off-Ramp program meant that not all of these designations were referred to DSH. In 2018-19, DSH experienced a net decrease in FIST referrals to 1,113 which represents a year-over-year difference of -15.6% (206 FISTs). In total, the CBR program served about 165 FIST patients during that year and another 135 defendants were off-ramped from their FIST commitment.

An analysis of data collected on FIST patients, conducted in collaboration with the University of California, Davis, found that since 2008-09, approximately 20% of those admitted to the state hospitals were already competent and 17%-20% were malingering[1]. Given the results of this research and experience with the Los Angeles program, a 15% reduction in Year 1 is a reasonable goal.

County Stakeholder Support: Collaborative planning and support from stakeholders will be required. Collaborative partners should include, but not be limited to: County Administrator, Public Health, Behavioral Health, specialized county diversion programs, Presiding Judge or delegate, District Attorney, Public Defender, Sheriff, Probation, Public Guardian/Conservator, and any other stakeholder critical to the success of the program.

[1] Malingering refers to producing false symptoms or exaggerating existing symptoms in order to avoid criminal prosecution.

County Plan: Participating counties will be required to submit a detailed plan to DSH outlining how the benchmark goals for reducing FIST referrals to DSH will be achieved and what efforts to decrease future ISTs altogether, not just to DSH, will be implemented; how incentive payments will be applied; and how all other available funding sources will be leveraged (i.e. Medi-Cal, MHSA, realignment, one-time state funding given for homelessness interventions, etc.).

- DSH Diversion Program: The County's plan will not replace an existing DSH Diversion pilot program. However, the Diversion program Diversion may be referenced as an option that will be leveraged to achieving the County's benchmark goal in reducing FIST referrals and/or designations.
- CBR Program: As part of the plan to serve FIST patients in a CBR program envisioned by the CCCP, the County will be required to place patients in stable housing and make treatment providers available to patients to address all of their needs, 24/7. In addition to the elements above, the plan must reflect:
  - How care will be coordinated, including parties responsible for coordination
  - The continuum of care that will be available to serve the target population including housing, competency restoration, treatment, medication and supportive services
  - The expansion of existing programs and establishment of new programs that will meet the demand in that county, and a timeline for implementation
  - How the County will mitigate the patient's risk of recidivating
  - If and how community supervision will be provided
  - Long term plan for housing and treatment of the population
  - Timeline of key milestones addressing the above elements and estimated activation date for services to commence
- FIST Designation Reduction: Equally important, the plan must outline the efforts that will be made to reduce the rate of FIST designations overall. This can include programs such as pre-arrest and pre-booking diversion, systems improvements, or other efforts.

Outcomes Reporting

In addition to regular reporting to DSH on the number and demographics of FIST patients served in the community, participating counties will be required to report, annually at a minimum, how and where the county spent funds received through the CCCP program. This will include actual costs to treat FIST patients, other funding sources leveraged, and investments made to support efforts towards reducing the overall rate of FIST designations and referrals to DSH.

Proposed Pilot Counties:

The counties that DSH proposes contracting with for this program each represent a different region of the state – Southern California, Northern California, and the Central Valley – and have some of the highest FIST referral rates to DSH in the state. Each of the counties DSH is considering also has worked with DSH in the past, in various capacities, to resolve the IST issue. DSH estimates its cost of treating nearly 1600 FIST patients from these three counties in FY 2018-19 was approximately $152.1 million, including treatment provided in a state hospitals and jail-based competency treatment programs.

Proposed Incentive Payment Budget:

The following chart reflects the total budget proposed for incentive payments to support participating pilot counties, based on the assumptions outlined in the sections above:

Proposed County Incentive Budget

Year	% Reduction	FIST Reduction Benchmark	Annual Cost Per Patient (Base Amount for Progress Payments)*	Start Up Funds (@ 10% x Progress Payment Budget)	Progress Payments (Base Funding)	Benchmark Goal & Timeline Incentives	**Annual Maximum Incentive Payments**
Year 1	15%	237	$ 60,225	$ 1,428,000	$ 14,274,000	$ 7,851,000	**$ 23,553,000**
Year 2	20%	316	$ 62,000	$ 1,959,000	$ 19,592,000	$ 10,777,000	**$ 32,328,000**
Year 3	25%	395	$ 64,000	$ 2,528,000	$ 25,280,000	$ 13,904,000	**$ 41,712,000**
Year 4	35%	553	$ 66,000	$ 3,650,000	$ 36,498,000	$ 20,075,000	**$ 60,223,000**
Year 5	45%	711	$ 68,000	$ 4,835,000	$ 48,348,000	$ 26,591,000	**$ 79,774,000**
Year 6	60%	949	$ 70,000	$ 6,643,000	$ 66,430,000	$ 46,502,000	**$ 119,575,000**

*Annual cost per patient of $60,225 with annual 3% cost inflator (rounded to nearest thousand)

Total 6-Year Budget: $ 357,165,000

Program Administration

To manage the program requirements, including tracking the rate of IST reductions, distribution of incentive payments and evaluating the effectiveness of the pilot project, DSH will require 3.0 positions, and additional funding for contracted research support, technical assistance funding, travel costs, and the standard complement of operating expenses and equipment (OE&E) . To ensure implementation starting at year 1, DSH requests these resources in FY 2020-21 and ongoing. Below is a breakdown of those resources.

- Chief Psychologist – Program Support and Oversight ($256,000 GF)
  The incumbent would be forensically trained with expertise in ISTs and community care to 1) review county proposals and approve funding; 2) provide ongoing technical assistance to counties and stakeholder education (county behavioral health, law enforcement, judges, district attorneys, etc.) and support; 3) consult on measuring program effectiveness; 4) monitor programs and perform onsite visits to ensure best practices are implemented; 5) monitor programmatic compliance with the contract scope of work; 6) work collaboratively with the contracted research analyst to utilize collected data for ongoing program improvement; and 7) serve in a statewide advisory capacity.

- Staff Services Manager II (Specialist) – Program Support and Oversight ($166,000 GF)
  The incumbent would be a highly skilled technical program consultant that will 1) develop and administer the community care incentive program, in conjunction with the Chief Psychologist; 2) develop and oversee a payment system compliant with the benchmark goals, including close monitoring of metrics; 3) support the review of county incentive proposals and provide technical assistance to county administrative and fiscal staff; 4) develop county contracts, including scopes of work and program budgets; and 5) manage county contracts, including monitoring compliance.

- Associate Governmental Program Analyst – Program Support ($133,000 GF)
  The incumbent would be highly skilled and will provide support to the program by 1) performing in-house data collection and analysis; 2) progress reporting; 3) coordinating planning and development; 4) scheduling meetings, conference calls and webinars; 5) performing webpage maintenance and communications to external stakeholders; 6) coordinating travel, including gaining access to various community facilities; 7) overseeing the distribution of county incentive payments and reconciliation of financial reports; 8) coordination of the county contract process.

- Operating Expenses and Equipment (OE&E) (BY $255,000 GF)
  DSH requests to fund the standard complement of operating expenditures to support the purchase of general supplies and equipment for the positions requested. In addition, DSH

requests an additional $35,000 per position each year to support the higher-than-typical travel required to support the implementation of this program, as well as ongoing county support and compliance monitoring. In addition, DSH requests $150,000 for technical assistance for counties, which will allow for trainings and consultations to be provided on various topics from subject matter experts, using technology, in-person presentations and specialty software.

- Research, Outcomes and Evaluation Contract ($200,000 GF)
  To monitor program effectiveness through research and development of outcomes and evaluation reports, DSH requests $200,000 in budget year and ongoing to support research and evaluation activities for the community care collaborative pilot program.

- Merge Other Existing County Program Resources
  A county under consideration for this program may have a current DSH-funded program that would be absorbed by the CCCP. In addition to the funding requested in this proposal, DSH estimates shifting approximately $15.5 million to the CCCP program, in addition to the augmentation requested to support the CCCP.

Total Request:

In the budget year, DSH is requesting an augmentation of $24.6 million in addition to merging any current authorized budgets for DSH-funded programs (approximately $15.5 million) to the CCCP. The total funds requested to support the CCCP proposal over the 6-year term of the pilot is reflected below.

Summary of Incentive Budget							
	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26	TOTAL
County Programs	$ 23,553,000	$ 32,328,000	$ 41,712,000	$ 60,223,000	$ 79,774,000	$ 119,575,000	**$ 357,165,000**
Community Care Collaborative Pilot (CCCP) Budget							
	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26	TOTALS
County Incentives Budget	**$ 23,553,000**	**$ 32,328,000**	**$ 41,712,000**	**$ 60,223,000**	**$ 79,774,000**	**$ 119,575,000**	**$ 357,165,000**
State Operations Budget							
Personnel	$ 555,000	$ 555,000	$ 555,000	$ 555,000	$ 555,000	$ 555,000	**$ 3,330,000**
OE&E	$ 255,000	$ 255,000	$ 255,000	$ 255,000	$ 255,000	$ 255,000	**$ 1,530,000**
Research/Evaluation Contract	$ 200,000	$ 200,000	$ 200,000	$ 200,000	$ 200,000	$ 1,175,000	**$ 2,175,000**
State Ops Budget	**$ 1,010,000**	**$ 1,010,000**	**$ 1,010,000**	**$ 1,010,000**	**$ 1,010,000**	**$ 1,985,000**	**$ 7,035,000**
TOTAL - CCCP	**$ 24,563,000**	**$ 33,338,000**	**$ 42,722,000**	**$ 61,233,000**	**$ 80,784,000**	**$ 121,560,000**	**$ 364,200,000**
Existing County Contract - move existing contract resources to CCCP							
County Contract Value	(15,523,000)	(15,523,000)	(15,523,000)	(15,523,000)	(15,523,000)	(15,523,000)	**(93,138,000)**
GRAND TOTAL - CCCP	**$ 40,086,000**	**$ 48,861,000**	**$ 58,245,000**	**$ 76,756,000**	**$ 96,307,000**	**$ 137,083,000**	**$ 457,338,000**

BCP Fiscal Detail Sheet

BCP Title: Community Care Collaborative Pilot Program **BR Name: 4440-059-ECP-2020-GB**

Budget Request Summary

	FY20					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	0.0	3.0	3.0	3.0	3.0	3.0
Total Positions	**0.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
Salaries and Wages						
Earnings - Permanent	0	318	318	318	318	318
Total Salaries and Wages	**$0**	**$318**	**$318**	**$318**	**$318**	**$318**
Total Staff Benefits	0	187	187	187	187	187
Total Personal Services	**$0**	**$505**	**$505**	**$505**	**$505**	**$505**
Operating Expenses and Equipment						
5301 - General Expense	0	24	24	24	24	24
5304 - Communications	0	3	3	3	3	3
5320 - Travel: In-State	0	108	108	108	108	108
5324 - Facilities Operation	0	15	15	15	15	15
5340 - Consulting and Professional Services - Interdepartmental	0	23,903	32,678	42,062	60,573	80,124
5346 - Information Technology	0	3	3	3	3	3
5368 - Non-Capital Asset Purchases - Equipment	0	2	2	2	2	2
Total Operating Expenses and Equipment	**$0**	**$24,058**	**$32,833**	**$42,217**	**$60,728**	**$80,279**
Total Budget Request	**$0**	**$24,563**	**$33,338**	**$42,722**	**$61,233**	**$80,784**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	0	24,563	33,338	42,722	61,233	80,784
Total State Operations Expenditures	**$0**	**$24,563**	**$33,338**	**$42,722**	**$61,233**	**$80,784**
Total All Funds	**$0**	**$24,563**	**$33,338**	**$42,722**	**$61,233**	**$80,784**

Program Summary

Program Funding						
4400010 - Headquarters Administration	0	15	15	15	15	15
4400020 - Hospital Administration	0	3	3	3	3	3
4430030 - Other Contracted Services	0	24,545	33,320	42,704	61,215	80,766

Total All Programs	**$0**	**$24,563**	**$33,338**	**$42,722**	**$61,233**	**$80,784**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
4801 - Staff Svcs Mgr II (Supvry)				0.0	1.0	1.0	1.0	1.0	1.0
5393 - Assoc Govtl Program Analyst				0.0	1.0	1.0	1.0	1.0	1.0
9859 - Chief Psychologist - CF				0.0	1.0	1.0	1.0	1.0	1.0
Total Positions				**0.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
4801 - Staff Svcs Mgr II (Supvry)	0	90	90	90	90	90
5393 - Assoc Govtl Program Analyst	0	70	70	70	70	70
9859 - Chief Psychologist - CF	0	158	158	158	158	158
Total Salaries and Wages	**$0**	**$318**	**$318**	**$318**	**$318**	**$318**
Staff Benefits						
5150200 - Disability Leave - Industrial	0	4	4	4	4	4
5150210 - Disability Leave - Nonindustrial	0	1	1	1	1	1
5150350 - Health Insurance	0	15	15	15	15	15
5150450 - Medicare Taxation	0	5	5	5	5	5
5150500 - OASDI	0	10	10	10	10	10
5150600 - Retirement - General	0	86	86	86	86	86
5150800 - Workers' Compensation	0	15	15	15	15	15
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	0	9	9	9	9	9
5150900 - Staff Benefits - Other	0	42	42	42	42	42
Total Staff Benefits	**$0**	**$187**	**$187**	**$187**	**$187**	**$187**
Total Personal Services	**$0**	**$505**	**$505**	**$505**	**$505**	**$505**

PROGRAM UPDATE

Informational Only

Vocational Services and Patient Wages Caseload

The Budget Act of 2019 included $3.2 million in ongoing funding beginning in fiscal year 2019-20 for DSH to implement a new and uniform wage structure for DSH's Vocational Rehabilitation Program. This allows DSH to pay a standardized wage rate of federal minimum wage for its patients, who are not CDCR inmates, and are participating in vocational rehabilitation programs across the five state hospitals.

As of July 1, 2019 DSH, has implemented the new wage structure of $7.25. In addition, DSH has applied workers compensation benefits to all DSH patients. Patient wages will fluctuate year-to-year based on the patient-worker population and number of hours worked. DSH is working on a methodology to adjust the budget year projections based on prior year figures and will provide an update in the 2020-21 May Revision.

Incompetent to Stand Trial Diversion Program

The 2018 Budget Act included $100 million to be used over fiscal years (FY) 2018-19 through 2022-23 to contract with counties to develop new, or expand existing, diversion programs for individuals with serious mental illness who are diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder with potential to be found IST on felony charges.

A total of $91 million was allocated for the counties with the highest referrals of felony ISTs to DSH: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, Santa Barbara, Santa Clara, Solano, Sonoma, and Stanislaus. Of this available funding, $8.5 million has been awarded to the "Round 2" counties which consist of: Del Norte, Marin, Placer, San Francisco, San Luis Obispo, Santa Cruz, and Yolo. The following table shows the contract status, funding and target number of diversions to be served for each county as of November 2019:

County Contract Status		
Executed Contracts		
County	**Funding**	**Population**
Del Norte	$426,000	9
Kern	$7,891,400	56
Los Angeles	$25,864,100	200
San Luis Obispo	$1,278,000	9
Santa Cruz	$1,362,536	45
Subtotal	**$36,822,036**	**319**
Contracts Pending County Approval		
County	**Funding**	**Population**
Marin	$531,476	12
San Bernardino	$7,464,800	53
San Francisco	$2,300,400	30
Sonoma	$3,839,100	27
Subtotal	**$14,135,776**	**122**
Contracts in Negotiation		
County	**Funding**	**Population**

Alameda	$3,114,100	22
Contra Costa	$3,114,100	22
Fresno	$5,843,700	42
Placer	$1,065,000	21
Riverside	$6,910,100	48
Sacramento	$4,478,900	50
San Diego	$4,970,000	35
San Joaquin	$2,986,000	21
Santa Barbara	$2,644,500	18
Santa Clara	$2,840,000	20
Solano	$3,242,300	23
Yolo	$1,100,000	8
Subtotal	**$42,308,700**	**330**
Contracts Not Started		
County	**Funding**	**Population**
Stanislaus[1]	N/A	N/A
Grand Total	**$93,266,512**	**771**

In November 2019, DSH released a second request for application (Round 3) to counties not included in Round 1 (Top 15) or awarded funds in the first competitive application round (Round 2). Round 3 will allocate remaining county funds to new county programs. Applications are due in January 2020 and awardees will be selected in Spring 2020.

Of the $100 million, $500,000 was dedicated for staffing, operating expenses and research contract funding. With a fully staffed IST Diversion team, DSH has been able to work closely with the Council of State Governments Justice Center (CSG) and the Council on Criminal Justice and Behavioral Health (CCJBH). Both DSH and CCJBH have contracts with CSG to develop technical assistance trainings, learning materials and program templates for county use, and to connect DSH and CCJBH with experts in other states who have prior experience implementing diversion programs. The DSH team also recently joined the CSG California Stepping Up Initiative Partners group which brings together stakeholders in criminal justice and behavioral health to discuss potential solutions to the issue of the seriously mentally ill in the criminal justice system.

Additional opportunities that DSH has successfully pursued over the past year include a technical assistance grant for counties from the SAMHSA GAINS Center and a grant supporting the development of an impact evaluation of the diversion program through the Abdul Latif Jameel Poverty Action Lab (J-PAL) North America at the Massachusetts Institute of Technology. In July 2019 Drs. Deb Pinals and Lisa Calahan, both national experts in the intersection of mental illness and criminal justice, traveled to California through the SAMHSA grant and led a two-day training conference with DSH's county partners. In September 2019 DSH was informed that it had also received the J-PAL State and Local Initiative award which will support the development of an impact evaluation of the diversion program in partnership with a national academic research team.

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*

[1] As of November 2019 Stanislaus, County is still in the program development stage and so has not entered into formal contract negotiations with DSH.

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 request, DSH is working with the Judicial Council to ensure the requested data collected from the Superior Courts of California can be transmitted to DSH and incorporated into the data sets collected from counties participating in pre-trial diversion as outlined in WIC 4361. In October 2019 DSH met with the Judicial Council to discuss the current status of their data collection efforts. Courts will be required to submit quarterly data reports beginning in the third quarter of fiscal year 2019-20. DSH and the Judicial Council will meet again in Spring 2020 to determine how the collected data will be transmitted to DSH and to coordinate completion of a report for inclusion in the 2021-22 Governor's Budget.

Forensic Conditional Release Program – Sexually Violent Predator Program

Effective January 1, 1996, Sexually Violent Predators (SVP) were added to the Forensic Conditional Release Program (CONREP) population (WIC 6604). Prior to the conditional release of the first SVP in 2003, existing CONREP providers did not have treatment services to accept SVPs as patients, requiring DSH to enter into an annual contract with a single private provider serving all 58 counties. Current statute requires that SVPs be conditionally released to their county of domicile and sufficient funding be available to provide treatment and supervision services when an SVP is conditionally released into the community by court order.

Similar to the general/non-SVP program, the CONREP-SVP program offers clients with direct access to an array of mental health services with a forensic focus. Additionally, required services for SVPs in CONREP include regularly scheduled sex offender risk assessments, polygraph testing, and the review of Global Position System (GPS) data and surveillance.

In recent years, DSH has experienced significant challenges that have impacted the cost of operating the CONREP-SVP program. The most notable issues include locating appropriate housing and public resistance of the placement of SVPs within their communities. Once the Court has ordered an SVP be released from a DSH hospital into the community via CONREP, it takes an average of 12 months to secure court-approved housing, resulting in increased preplacement services and costs. There are two types of accommodations CONREP SVP's are residing in; house and motel.

In response to public resistance to SVP placement and ensuring both patient and public safety, the need for heightened 24/7 security and monitoring has also resulted in significant cost increases. As the courts approve additional petitions for release, the lack of housing options has resulted in more SVPs being ordered and released into their communities as transients, further increasing costs.

DSH is not requesting a caseload adjustment in the 2020-21 Governor's Budget for the current year or budget year. DSH assumes a total of 21 SVPs, which includes two transient releases, will be conditionally released in the community.

Hospital Police Officers/Office of Protective Services (OPS) Police Academy

The 2019 Budget Act created a new sub-program for the Hospital Police Officer (HPO) Academy, under the program of 4410-State Hospitals, which allows for better transparency and overall management of Academy resources. This transferred all budget and position authority from DSH-Atascadero to its own program – the State Hospital Police Academy. Having the HPO Academy separate from other facilities allows DSH to track this budget independently and report on funding, costs, and outcomes specifically. Additionally, the 2019 Budget Act approved the conversion of 3.0 positions from limited term to permanent full-time to support DSH's Academy and graduate up to 150 HPO cadets annually. This expanded the Academy resources to 7.0 positions.

The 2019 Budget Act added 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 2020-21 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 2019-20 fiscal year, the projected attrition rate for the 2020-21 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

As of October 1, 2019, the following is the status of HPO Authorized positions:

HPO Authorized Positions[1]				
Hospitals	**Filled**	**Vacant**	**FTE[2]**	**Vacancy Rate**
Atascadero	123.0	3.5	126.5	2.77%
Coalinga	204.0	11.5	215.5	5.34%
Metropolitan	106.0	33.0	139.0	23.74%
Napa	102.0	4.0	106.0	3.77%
Patton	60.0	3.0	63.0	4.76%
Total	**595.0**	**55.0**	**650.0**	**8.08%**

[1] Only Includes classification 1937 - Hospital Police Officer

[2] Authorized Positions as of DSH Budget Management Branch (BMB) Hospital Position Report FY 2019-20 October, Rev B

Please note, DSH-Metropolitan shows a higher vacancy rate due to the approval of the Increased Secure Bed Capacity significant increase in HPO positions that were phased-in the beginning of FY 2019-20. DSH continues to actively recruit for these positions.

HOSPITAL POLICE OFFICER ATTRITION RATE

As of October 1, 2019, the following is the projected attrition rate based on FY 2017-2018 and FY 2018-19 actual attrition rates and trends:

HPO Attrition Rate					
Facilities	**FY 2019-20 FTE[1]**	**FY 19-20 Attrition Rate[1]**	**Avg Estimated Pos.**	**FY 20-21 Attrition Rate[2]**	**Avg Estimated Pos.**
Atascadero	126.5	1.24%	1.6	1.36%	1.7
Coalinga	215.5	0.46%	1.0	0.83%	1.8
Metropolian	139.0	1.40%	1.9	1.92%	2.7
Napa	106.0	0.47%	0.5	0.57%	0.6
Patton	63.0	0.66%	0.4	1.39%	0.9
Total	**650.0**	**0.85%**	**5.4**	**1.22%**	**7.7**

[1] Authorized Positions as of DSH Budget Management Branch (BMB) Hospital Position Report FY 2019-20 October, Rev B

[2] Projected attrition rate based on FY 19-20 data

CADET GRATUDUATE RATE

Below are the actual graduation rates as of FY 2018-19 to current cadet Academy cohort:

Cadet Graduate Rates			
Academy	**Number of Cadets Attended**	**Number of Cadets**	**Graduate Rate**
Academy 27 February 12, 2018 – May 18, 2018	50	44	88.00%
Academy 28 August 13, 2018 - November 16, 2018	49	42	85.71%
Academy 29 October 1, 2019 – January 10, 2019	38	32	84.21%
Academy 30 February 11, 2019 – May 31, 2019	33	31	93.94%
Academy 31 August 12, 2019 – November 22, 2019	43	34	79.07%
Academy 32 December 2, 2019 – March 20, 2020	19	TBD	TBD
TOTAL:	**213**	**183**	**86.19%**

Unfortunately, Academy 32 has a lower than anticipated cadet attendance. This is largely due to the unexpected resignation of the retired annuitant physician at DSH-Metropolitan, who was performing the medical screenings for all recruits. DSH-Metropolitan is actively working to hire a replacement physician prior to the commencement of Academy 33.

2014 South Napa Earthquake Repairs

DSH worked with the Department of General Services (DGS), the California Office of Emergency Services (OES), and the Federal Emergency Management Agency (FEMA) to determine the estimated project costs for the repairs associated with the damage at DSH-Napa resulting from the South Napa earthquake in August 2014. DSH prioritized the repairs to DSH-Napa's buildings into the following three projects:

- ***Project 1:*** Repair the three buildings that have been identified as historically significant (Electric Shop Building 147, Manor House Building 181, and Central Nursing Building 183)
- ***Project 2*****:** Repair the 23 buildings located outside the Secure Treatment Area (STA)
- ***Project 3*****:** Repair the 13 buildings located within the STA and patient housing

Project 1 Update – Per DGS, this project is scheduled to go out to bid on October 4, 2019. DSH will provide an updated construction cost estimate following DGS' award of the contract later this calendar year.

Project 2 Update **–** Project is nearly complete, apart from the work to be done for Building 331 (Central Plant), which is anticipated to be completed in mid-November 2019. To date, DSH has expended a total of $1,906,026 from the authorized construction budget of $3,675,000, with additional expenditures pending completion of Building 331.

Project 3 Update – Due to ongoing challenges and delays in the availability and hiring of casual labor, DSH was not able to make significant efforts towards completing Project 3 repairs, which were comprised of minor cosmetic repairs including plaster repairs and painting. Further complicating the issue, those repairs are within patient occupied areas which involves moving furniture within patient rooms, allowing for proper ventilation so plaster and paint can dry, and providing needed "swing space" (living space used to move patients to during moves, repairs, etc.) that DSH-Napa did not have available. As such, the Department cancelled the Project 3 deliverables to allow for further analysis through an enterprise-wide Infrastructure Master Plan, which will consider the prioritization and appropriateness of all repairs at DSH-Napa; not just those specific to the damage related to the 2014 South Napa Earthquake. The 2019-20 May Revise reported a savings of $1,138,958 in FY 2018-19 and $608,479 in FY 2019-20 because DSH will not be proceeding with completion of the Project 3 repairs.

The 2020-21 May Revision will provide the revised cost estimate for Project 1 and updated project status and costs for Project 2.

POPULATION PROFILE
Penal Code 2684 (*Coleman*) Patients

Description of Legal Class:

The Department of State Hospitals (DSH) admits *Coleman* patients under Penal Code (PC) 2684: Mentally Disordered Prisoners. The *Coleman* patients are California Department of Corrections and Rehabilitation (CDCR) patients, who are found to be mentally ill while in prison and 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 if they meet the criteria under PC 2962, or PC 2974 parolees with a mental health disorder who do not meet the provisions under PC 2962, or as a Lanterman-Petris-Short 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.
PC 2684A	Prisoner from CDCR, under approval by the Board of Parole Hearings, that referred to a state hospital for mental health treatment at an Acute level of care.

Legal Requirements/Legal Statute for Discharge:

The goal of DSH is to provide each *Coleman* patient with the appropriate treatment to 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, current treatment goals and objectives, and appropriate continued care can be arranged. A new policy was implemented, through Policy Directive 3609, to allow DSH to discharge patients directly into the community when they are institutionally released from CDCR.

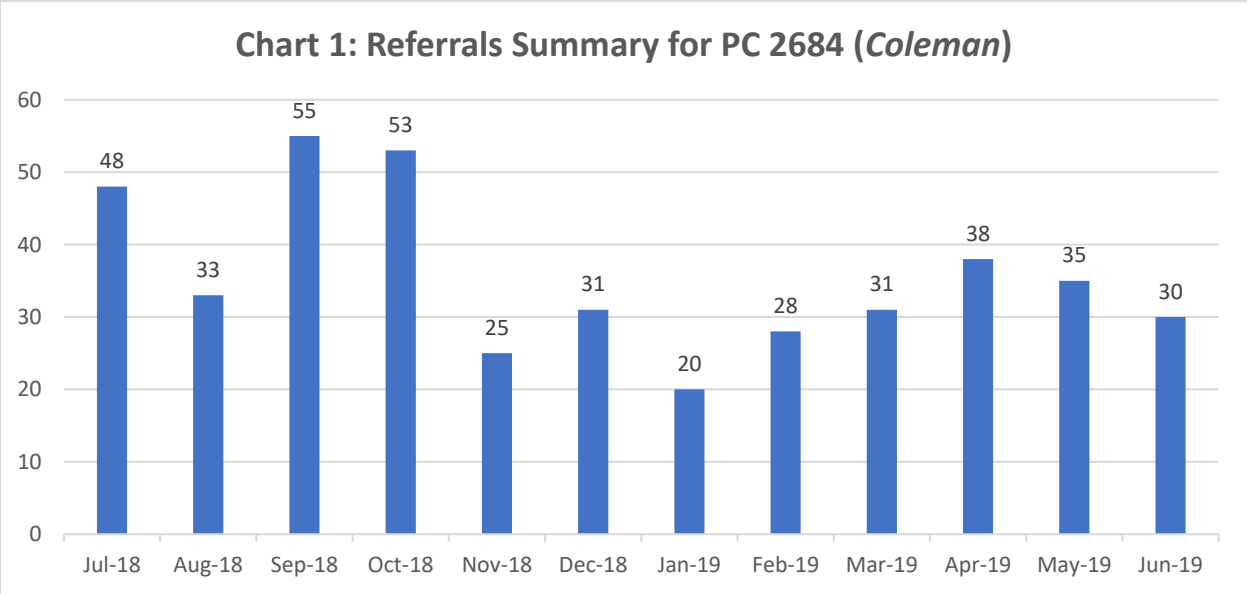
Treatment:

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

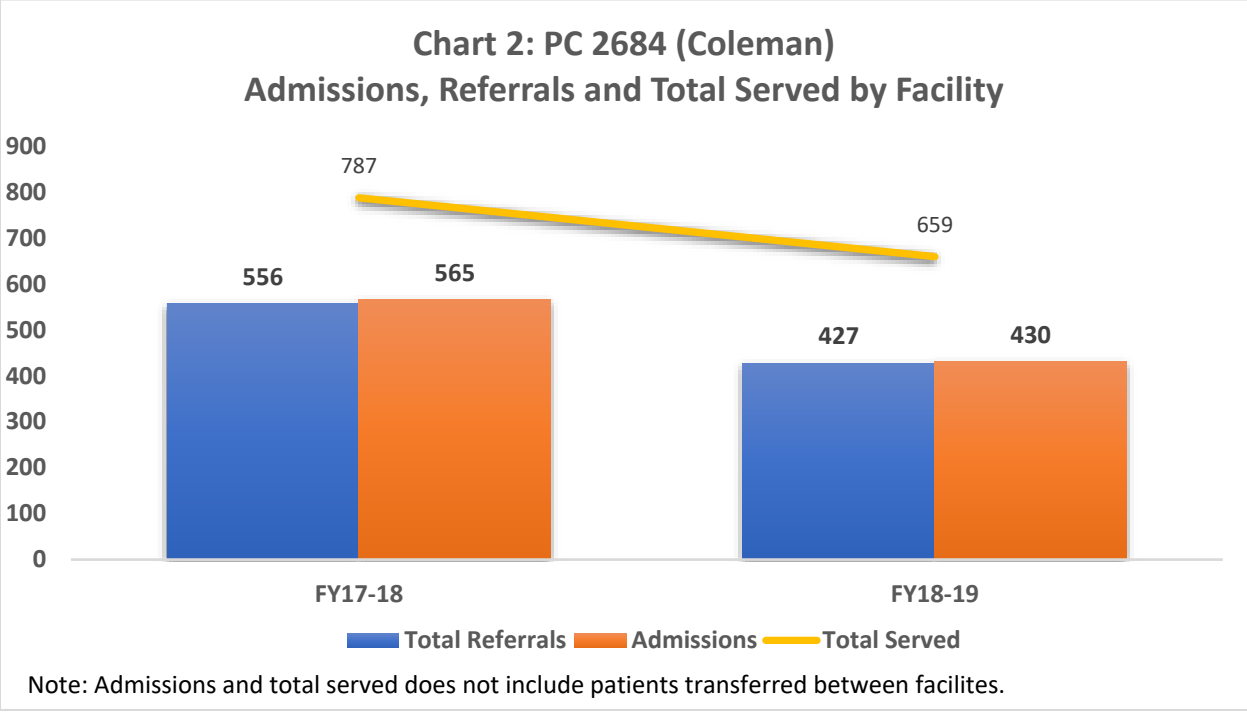
The *Coleman* population is tracked to the specific level of care detail that the individual patients are receiving at any given time; *Coleman* patients can be referred to either acute or intermediate care, and their full length of stay may include several referrals in both levels of care.

Population Data:

In FY 2018-19, 427 *Coleman* patients were committed to the state hospitals, a 25 percent decrease from FY 2017-18.

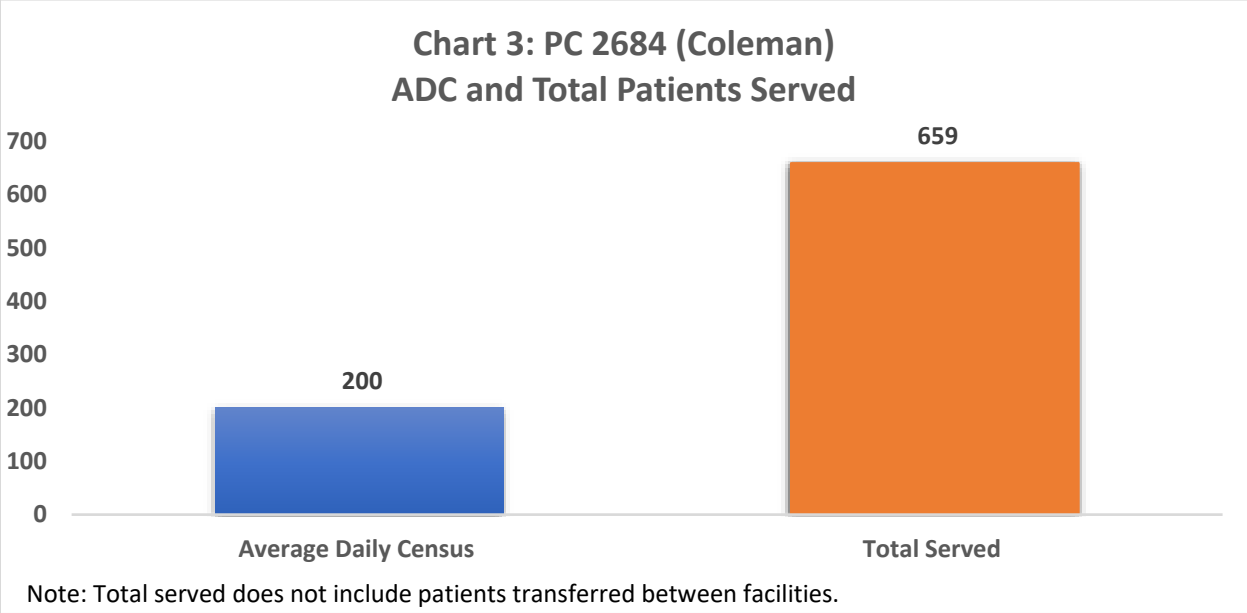


Over the course of FY 2018-19, 430 *Coleman* patients were admitted into a state hospital. Chart 2 displays the admission, referrals, and total patients served systemwide for the *Coleman* population in FY 2018-19.



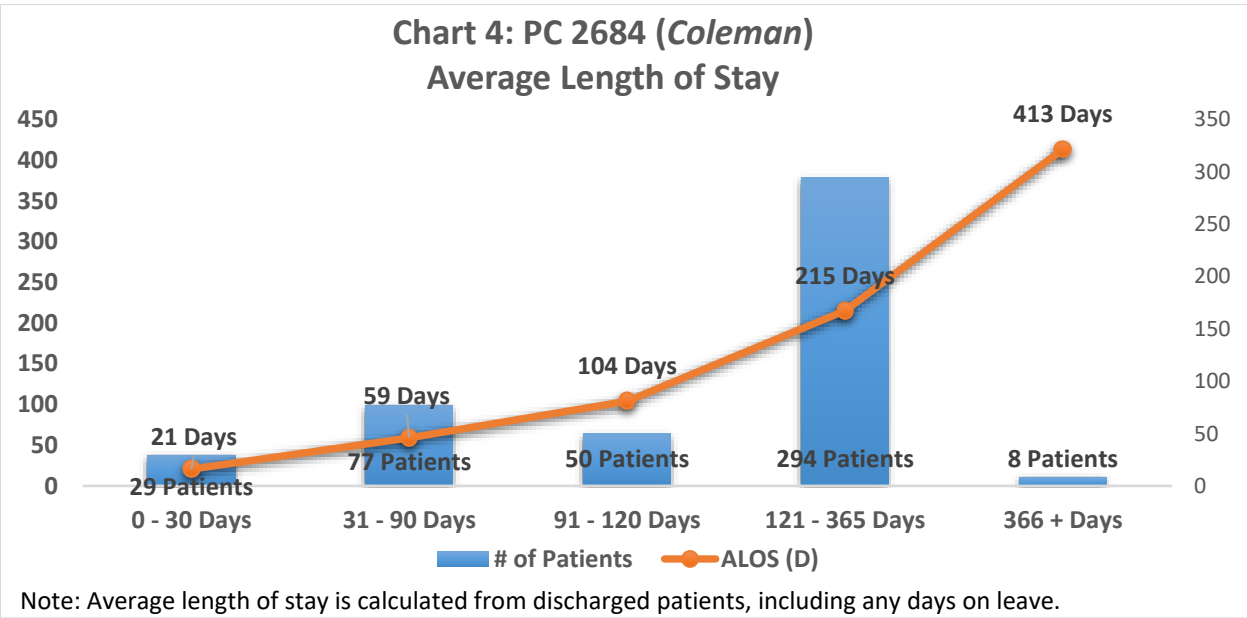
Note: Admissions and total served does not include patients transferred between facilites.

On average, 200 *Coleman* patients are treated daily in the state hospitals, representing 3 percent of the overall patient population in FY 2018-19. Chart 3 displays the average daily census (ADC) and total number of patients served for the *Coleman* population in FY 2018-19. As of June 30, 2019, the system-wide *Coleman* census was 185 patients.



Note: Total served does not include patients transferred between facilities.

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 2018-19, 458 *Coleman* patients were discharged with an average length of stay of 168 days, a little less than half a year. Chart 4 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. These defendants are then committed by the court to DSH for treatment specifically designed to enable the defendant to proceed with 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. IST patients committed to DSH mostly include felony criminal charges, and occasionally include misdemeanor charges.

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 no longer incompetent to stand trial, but who requires continued, involuntary treatment in a state hospital to maintain competency while awaiting trial and during the course of trial
PC 1370(b)(1)	Unlikely to regain competency; may apply to PC 1370, PC 1370.01, or PC 1370.1. The treating facility may recommend to the court that an individual is unlikely to regain competency regardless of length of treatment or resources available at the state hospital level of care, and if the court agrees with that recommendation, the committing county must pick up the individual within 10 days of notification by DSH.
PC 1370(c)(1)	IST that remains at DSH within 90 days of their maximum term commitment; may apply to PC 1370, PC 1370.01, or PC 1370.1. These patients are required to be picked up by their committing county 90 days prior to the expiration of their IST commitment.
PC 1610	Temporary admission while waiting for court revocation of PC 1370 (IST)

Legal Requirements/Legal Statute 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

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

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 he or she has 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. 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 or if meets specified criteria, can be hospitalized further under a civil commitment.

As defined in PC 1370(b)(1), a patient may be deemed by the treatment team as unlikely to regain competency, and upon notification of the county of commitment, the patient must be picked up within 10 days. Often, the county will pursue other means to ensure the patient is receiving treatment and care, usually by ways of securing a conservatorship and referring the individual back to the state hospital. In the event a patient is nearing their maximum term of commitment, the state hospital, pursuant to PC 1370(c)(1) must notify the county, who must pick up the patient at least 90 days prior to the expiration of the commitment term. On occasion, a county does not retrieve their committed patients in a timely manner or pursues conservatorship without discharging the individual in question, and the patient remains on census. In FY 2017-18, when applying the average length of stay for an IST patient, this practice resulted in a loss of 54.3 patients served between PC 1370(b)(1) and PC 1370(c)(1) individuals.

Misdemeanor IST commitments are only committed to DSH if there are no less restrictive placements for competency treatment and the county enters into a contract with DSH for cost of competency treatment.

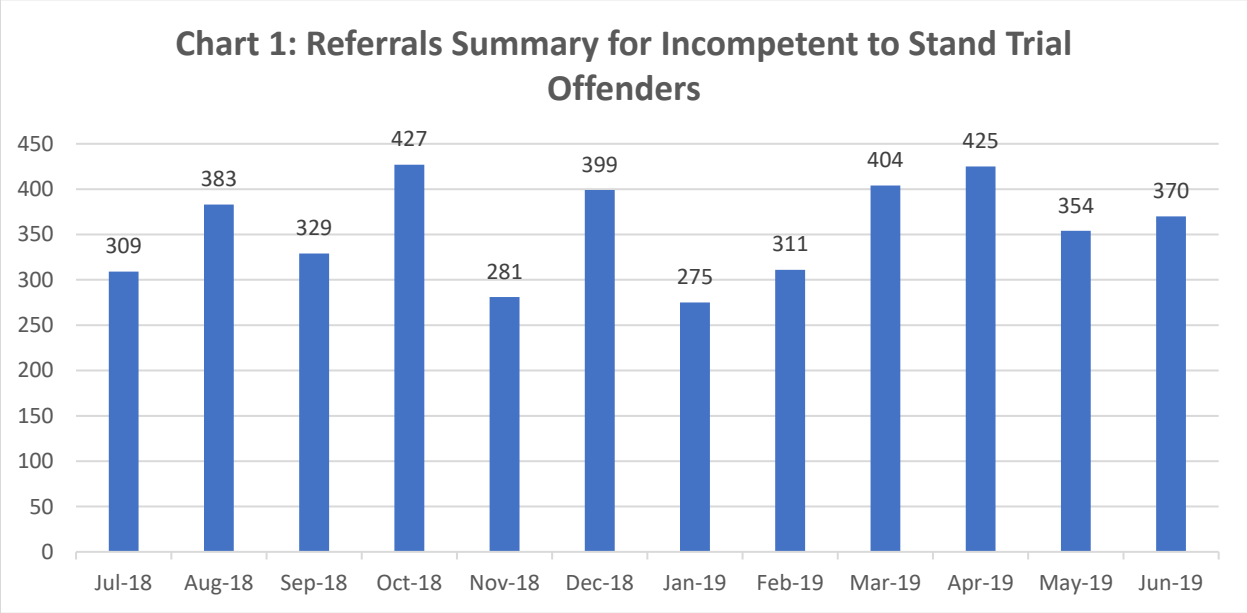
Treatment:

The focus of treatment for the IST population is on restoration of trial competency in the most expeditious manner. To this end, IST patients are treated in one treatment program so the training of criminal procedures can be constantly 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 court.

Throughout treatment, patients are regularly evaluated and, 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.

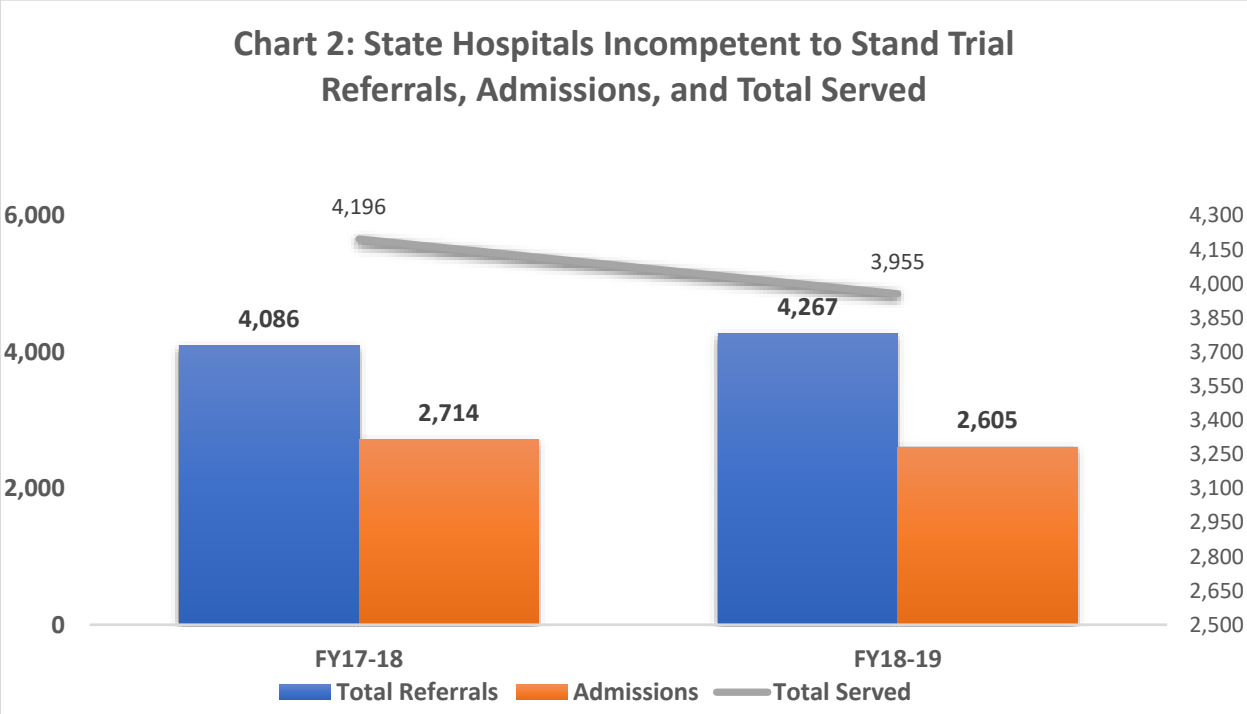
Population Data:

In FY 2018-19, 4,267 IST patients were committed to DSH, a 4 percent decrease from FY 2017-18.



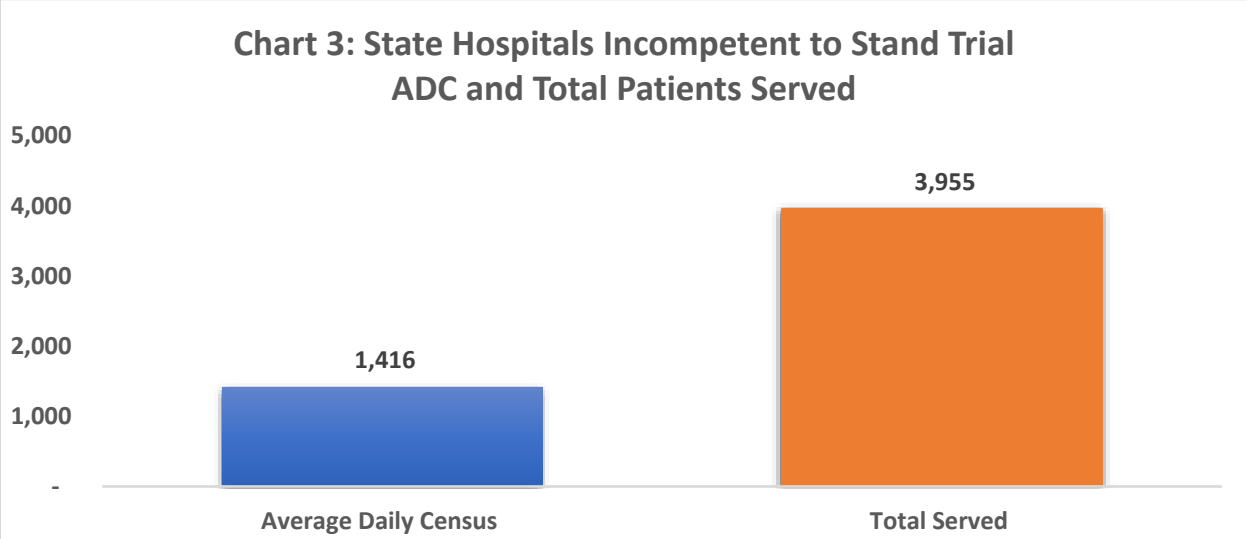
State Hospital Data

Over the course of FY 2018-19, 2,605 IST patients were admitted into a state hospital. Chart 2 displays referrals, admissions, and total patients served systemwide for the IST population in FY 2018-19.



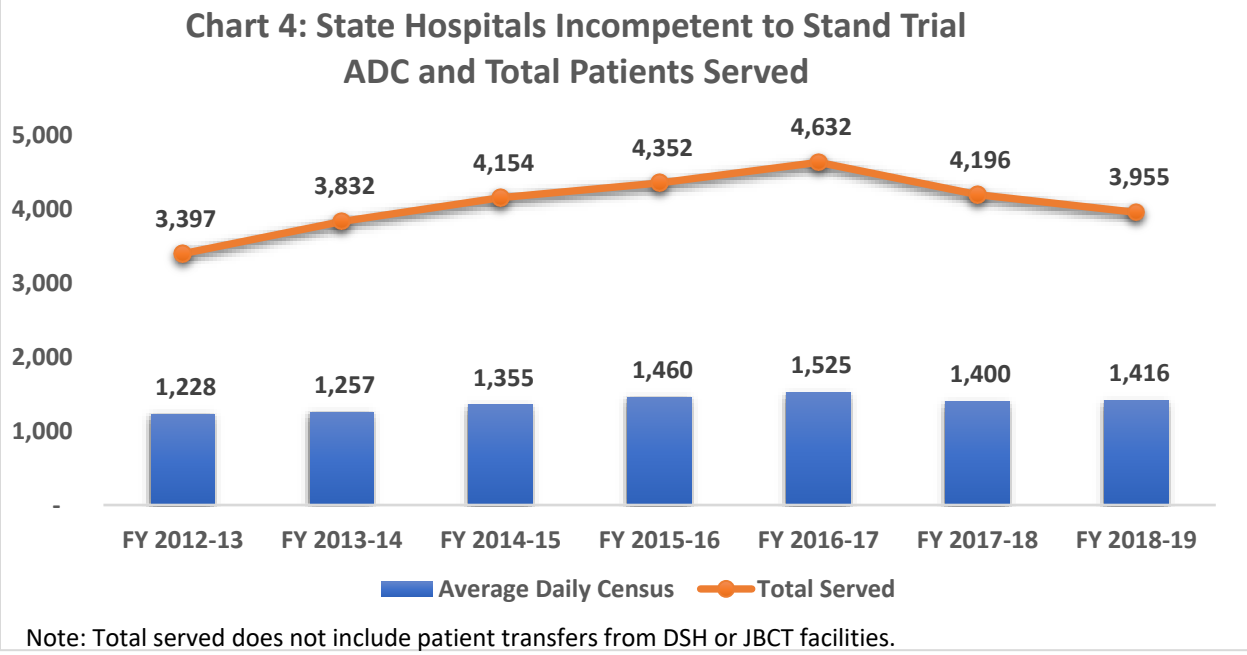
Note: Total admissions and total served do not include patient transfers from DSH or JBCT facilities.

On average, 1,416 IST patients are treated daily in the state hospitals, representing 15 percent of the overall patient population in FY 2018-19. Chart 3 displays the average daily census (ADC) and total number of patients served in state hospital facilities for the IST population in FY 2018-19. As of June 30, 2019, the state hospital system-wide IST census is 1,490 patients.



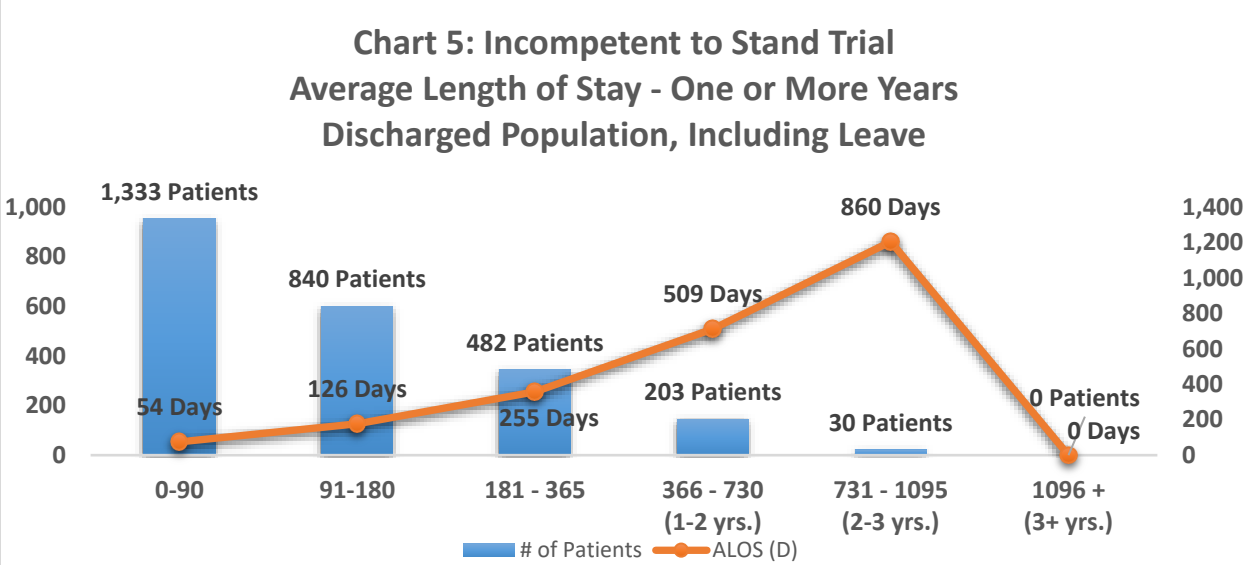
Note: Total admissions and total served do not include patient transfers from DSH or JBCT facilities.

The IST population at the state hospitals in both ADC and total number of patients served has declined since FY 2016-17. Due to the increasing availability of jail-based programs, the Department's IST census continues to balance between state hospitals and jail-based facilities, though overall the impact of ISTs continues to rise.



Note: Total served does not include patient transfers from DSH or JBCT facilities.

In FY 2018-19, 2,888 IST patients were discharged from state hospitals with an average length of stay of 149 days, 0.4 years. Chart 5 displays the distribution of lengths of stay for all discharged IST patients.



Note: During FY 2018-19, 53 EISTs were excluded from this ALOS calculation.

Jail-Based Competency Treatment Program Data

Over the course of FY 2018-19, 1,476 IST patients were admitted into a JBCT facility or the Admission, Evaluation, and Stabilization (AES) Center. Chart 6 displays the admission and total patients served distribution by AES/JBCT facility for the IST population in FY 2018-19.

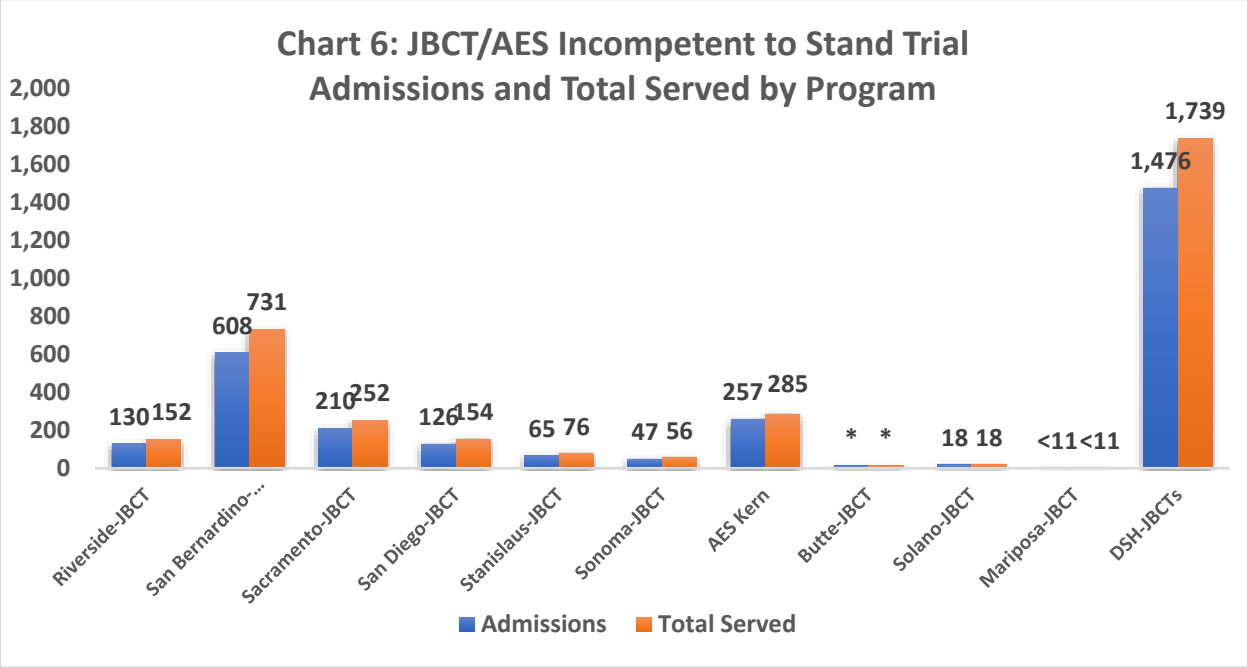
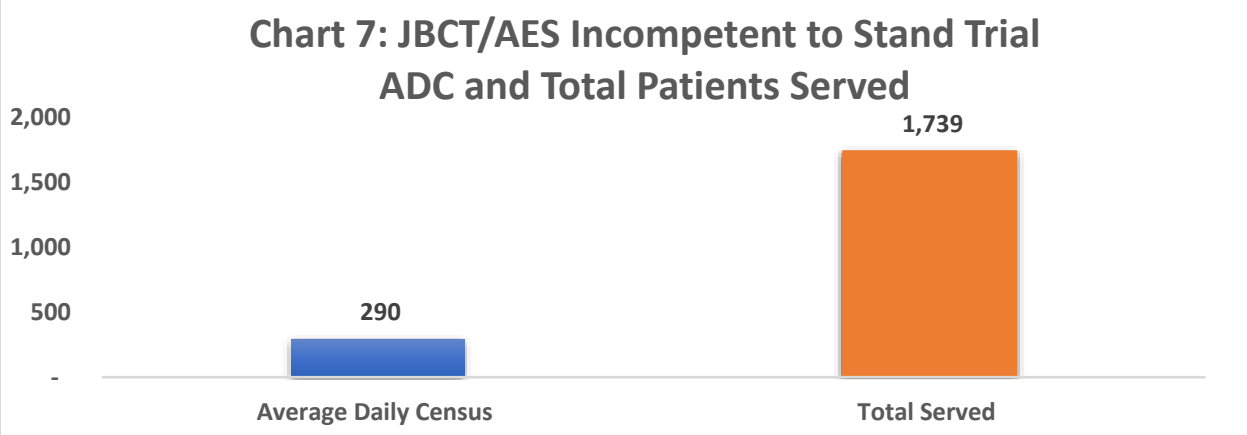
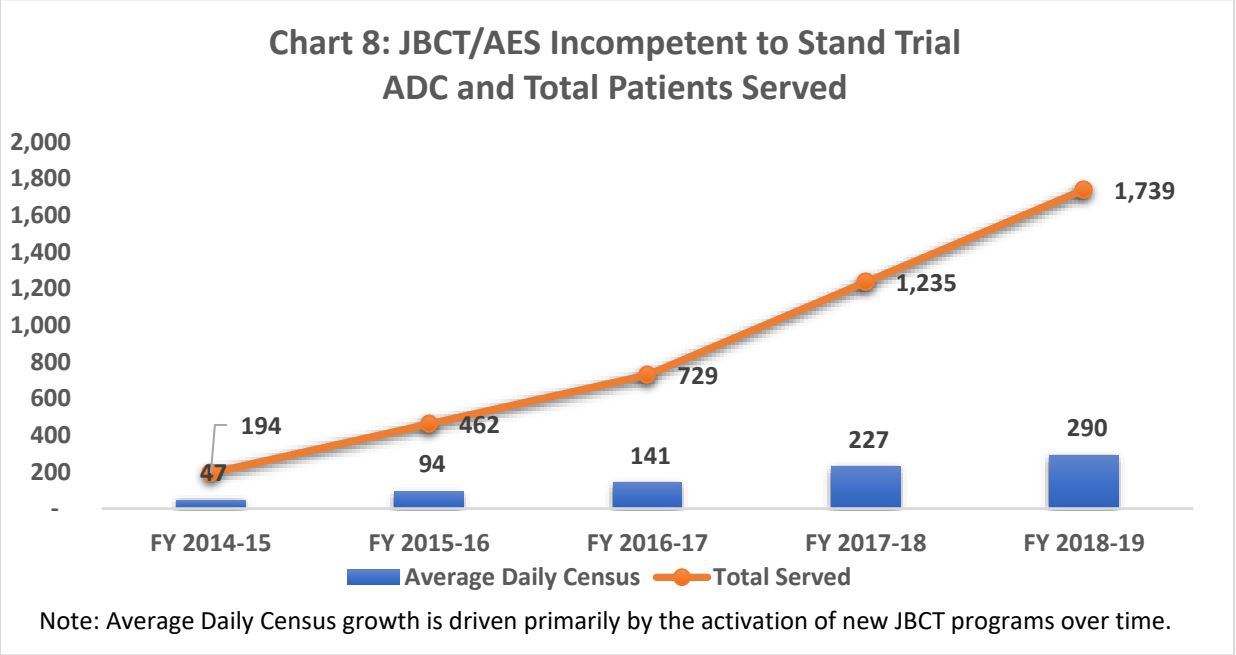


Chart 6. Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines.

On average, 290 IST patients are treated daily in the AES/JBCTs, a 28 percent increase from FY 2017-18. Chart 7 displays the ADC and total number of patients served in the AES/JBCTs for the IST population in FY 2018-19. As of June 30, 2019, the AES/JBCT system-wide IST census is 323 patients.

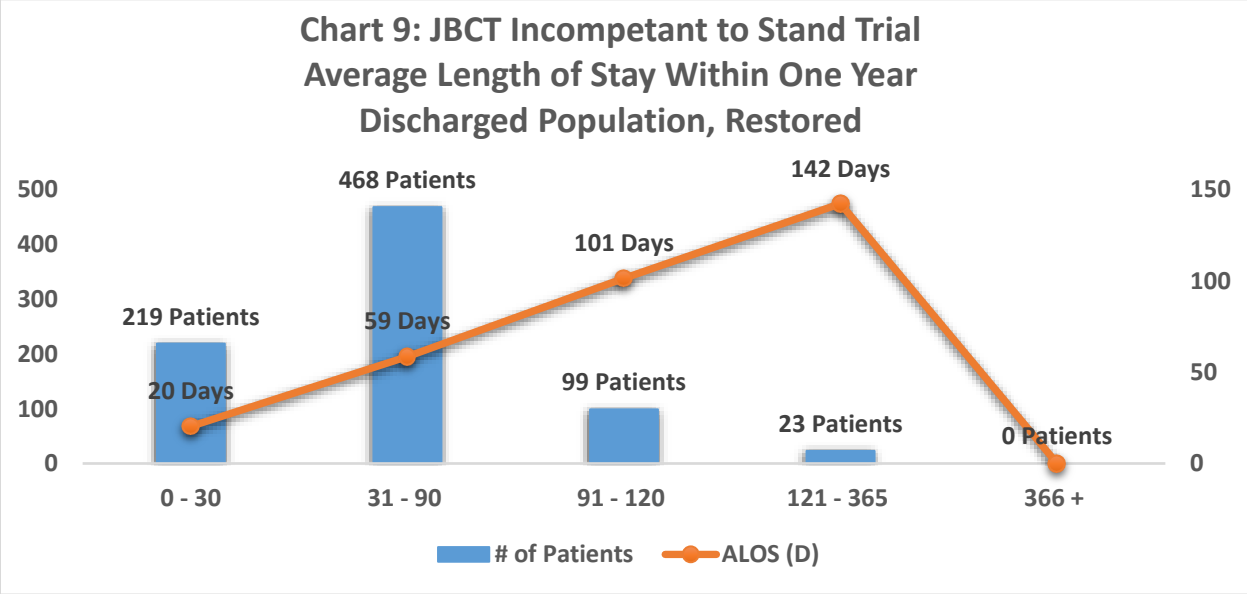


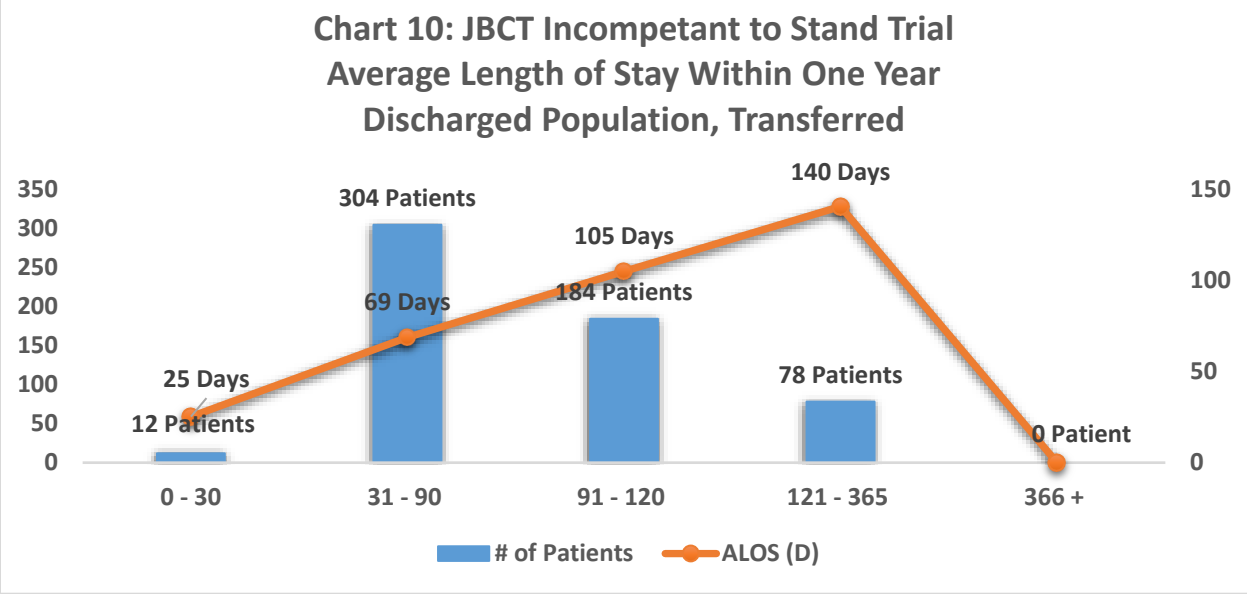
Year over year, the IST population at the jail-based programs in both ADC and total number of patients served has steadily increased, with a significant surge between FY 2016-17 and FY 2018-19. Due to the increasing availability of jail-based programs, the Department's IST census has balanced between state hospitals and jail-based facilities, though overall the impact of ISTs continues to rise.



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 who had a stronger likelihood of quick restoration of competency, generally under 90 days from admission. If, during the course of 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 continuation of restoration care. In FY 2018-19, 809 IST patients were restored and discharged with an average length of stay of 56 days. During that same period, 578 IST patients were discharged from the AES/JBCT program and transferred to a state hospital, with an average length of stay of 89 days. Chart 9 displays the distribution of lengths of stay for all discharged IST patients that were restored. Chart 10 displays the distribution of lengths of stay for all discharged IST patients that transferred to state hospital facilities.





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 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 150+ 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 2018-19, CBR successfully off-ramped 135 patients. Chart 11 displays the number of patients found competent monthly in CBR's off-ramp assessment.

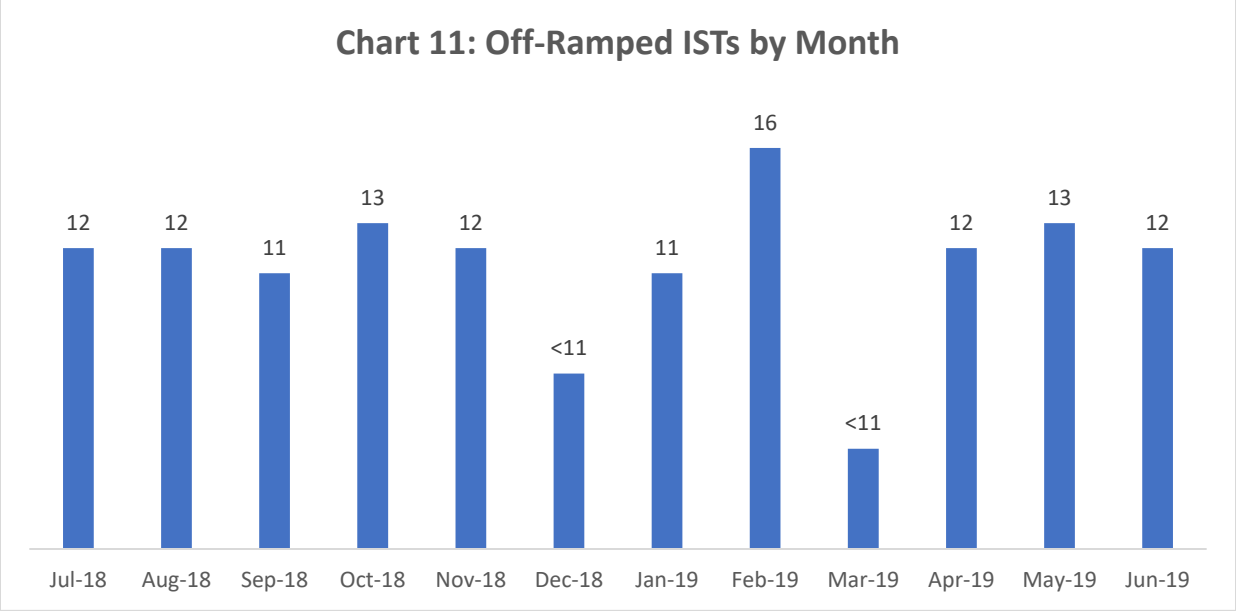
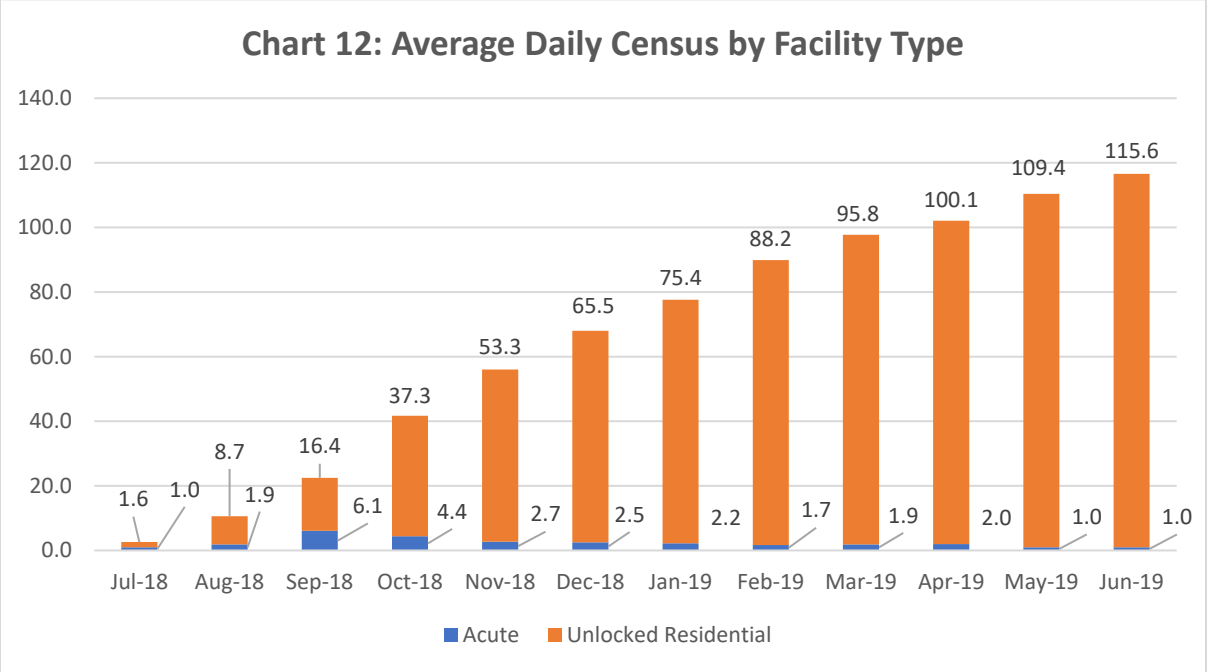


Chart 11. Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines.

Upon assessment of Los Angeles 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 conditional release is approved by the court, the matched provider arranges pickup of the patient and admits into their community facility to begin treatment. In FY 2018-19, 165 patients were conditionally released to CBR, and were subsequently admitted into community beds at either an acute level of care, or in an unsecured residential facility. Chart 12 displays the Average Daily Census by month in the various levels of care.



Through the end of FY 2018-19, three patients have been successfully restored with an Average Length of Treatment of 194 days.

In the absence of this program, the Los Angeles County patients who have been served by CBR either through competency assessment and off-ramp petition (n = 135), or conditional release and admission to a community facility (n = 165), would have continued as referrals to DSH and awaited an available bed in existing capacity.

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, 86 percent of all LPS patients treated 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 13 percent were conserved under WIC 5008(h)(1)(B) (Murphy Conservatorship). The remaining LPS population within DSH was comprised of the other 13 legal statutes under the LPS Act.

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

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 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 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 5304(a)[1]	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 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 5250	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 5150	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 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	A temporary hold for an individual with a developmental disability while awaiting a hearing pursuant to WIC 6503.
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 6552[1]	Voluntary application as Juvenile court ward to be treated for a mental disorder at a state hospital (VJCW)
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)
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.

[1]During Fiscal Year (FY) 2018-19, this population was not served in the state hospitals.

Legal Requirements/Legal Statute 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.

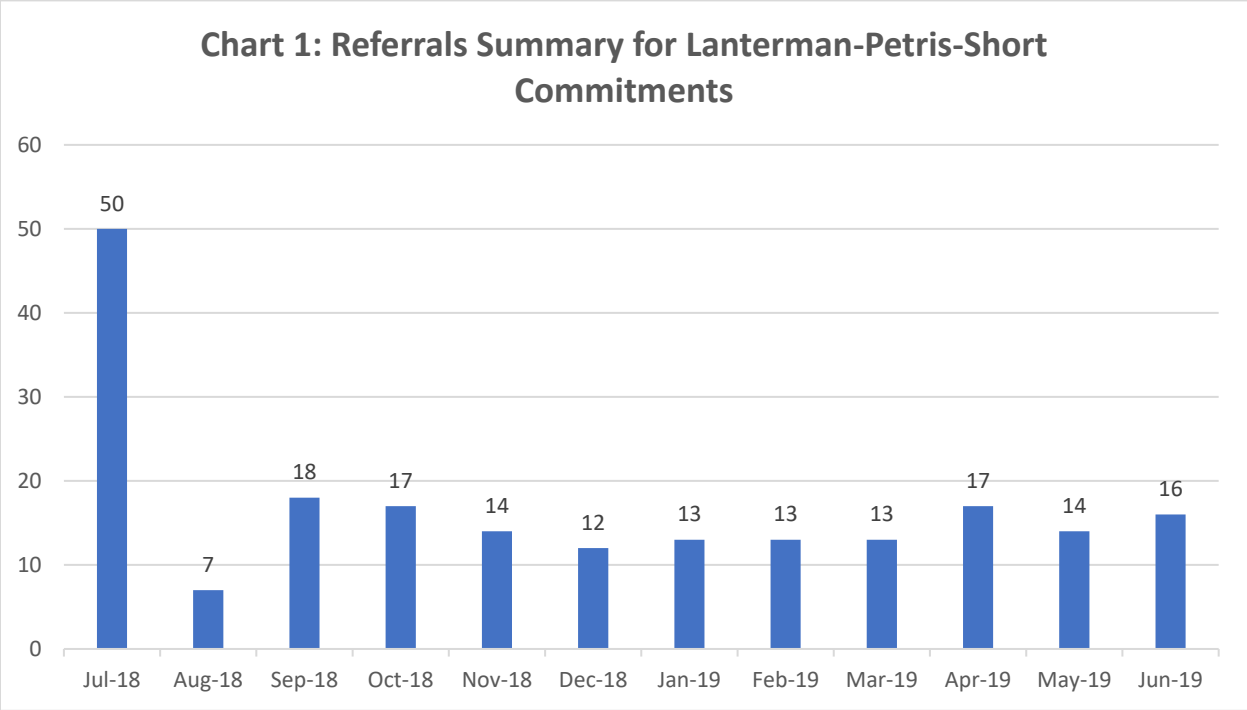
Treatment:

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.

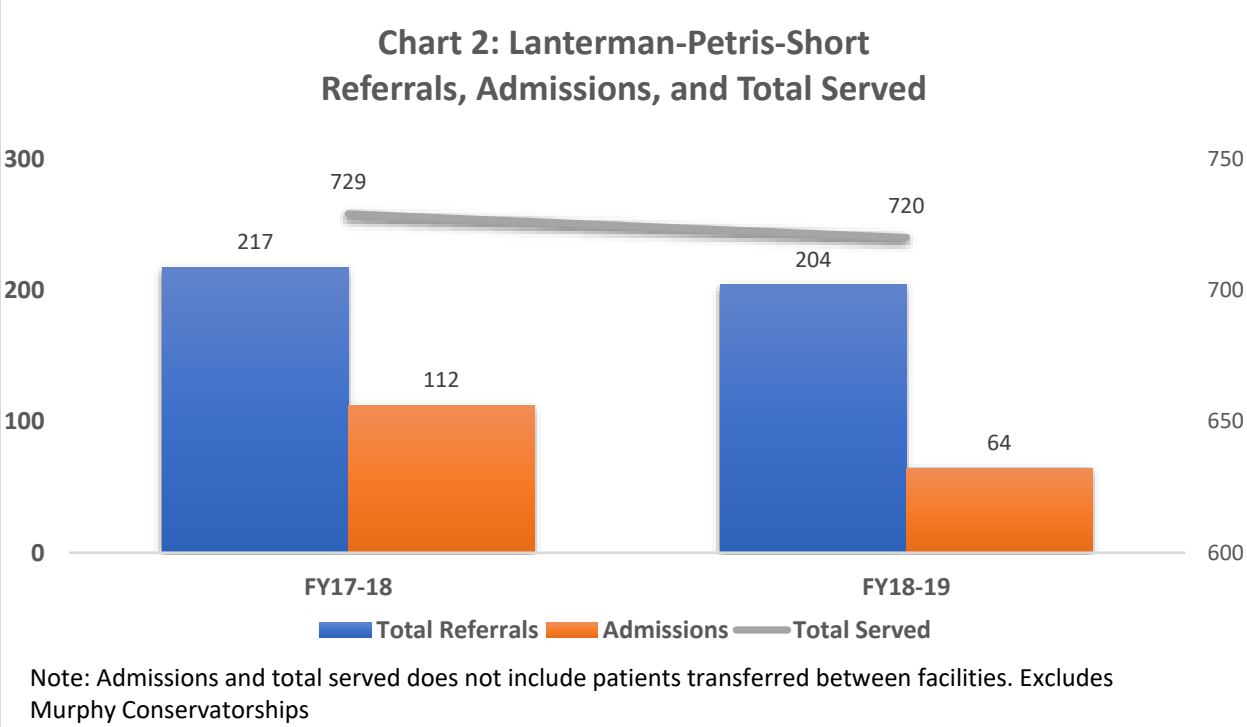
The focus of treatment for the LPS population is on psychiatric stabilization and psychosocial treatments to reduce the risk of danger to themselves or others and develop basic life skills to function optimally in a lower level of care in the community. Because of the wide diversity of patients under 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:

In Fiscal Year (FY) 2018-19, 204 LPS patients were committed to the state hospitals, a 6 percent decrease from FY 2017-18.

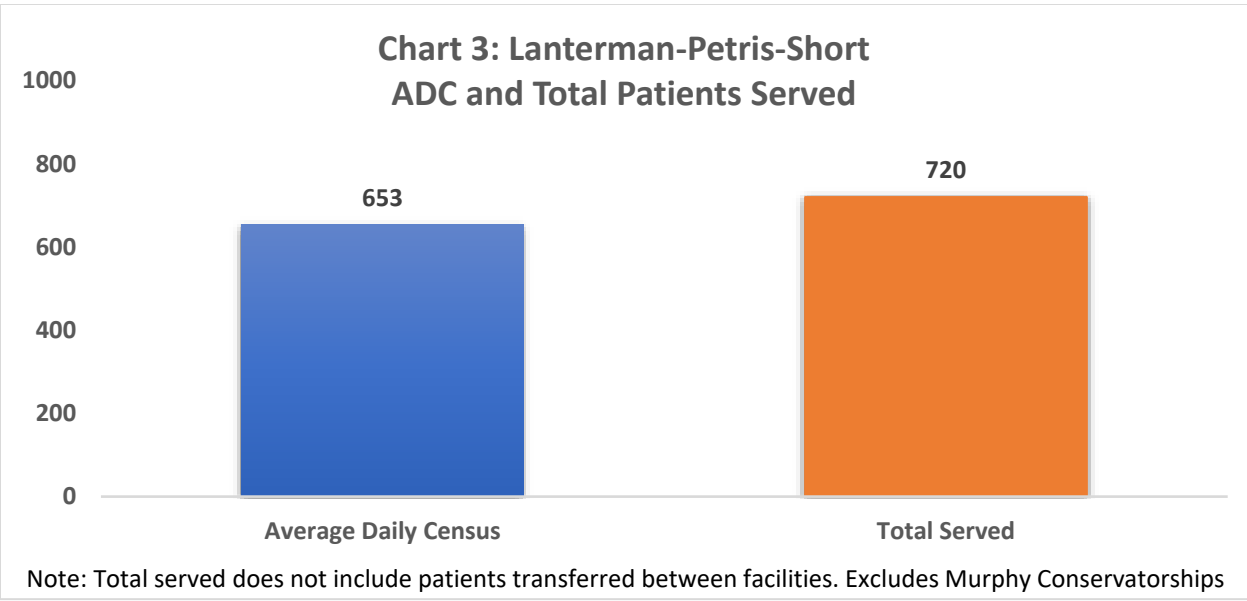


Over the course of FY 2018-19, 64 LPS patients were admitted into a state hospital. Chart 2 displays the referrals, admissions, and total patients served for the LPS population in FY 2018-19.



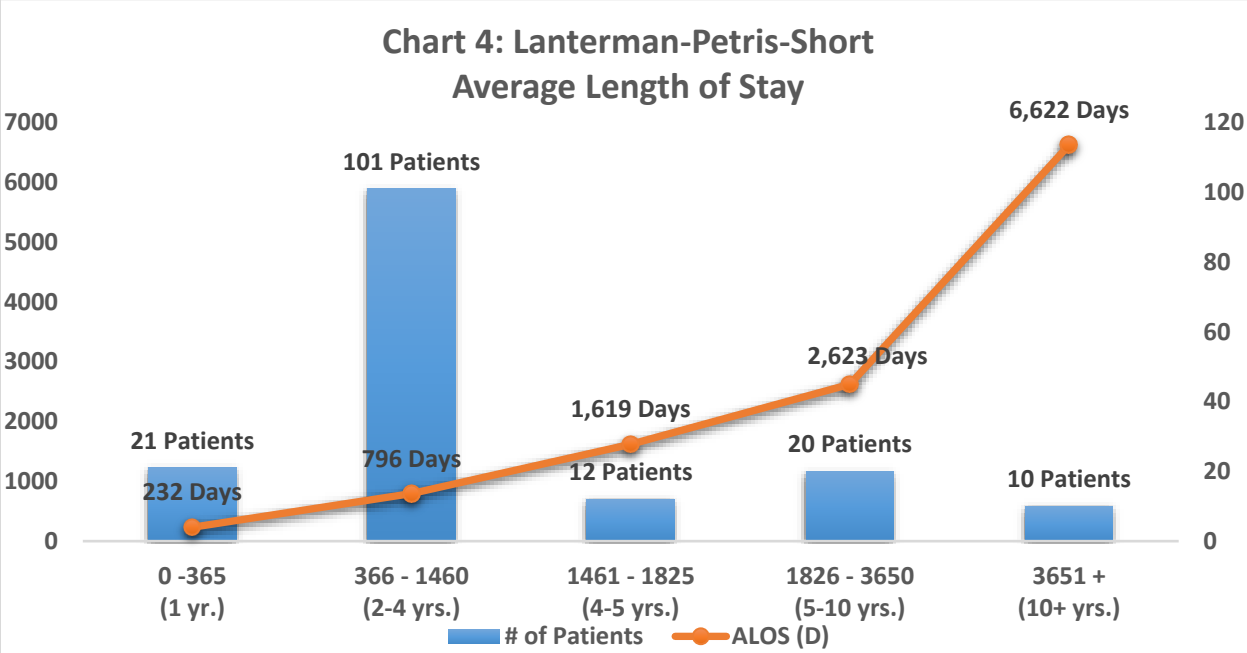
Note: Admissions and total served does not include patients transferred between facilities. Excludes Murphy Conservatorships

Chart 3 displays the average daily census (ADC) and total number of patients served for the LPS population in FY 2018-19. On average, 653 LPS patients are treated daily in the state hospitals, representing 10 percent of the overall patient population. As of June 30, 2019, the system-wide LPS census was 626.

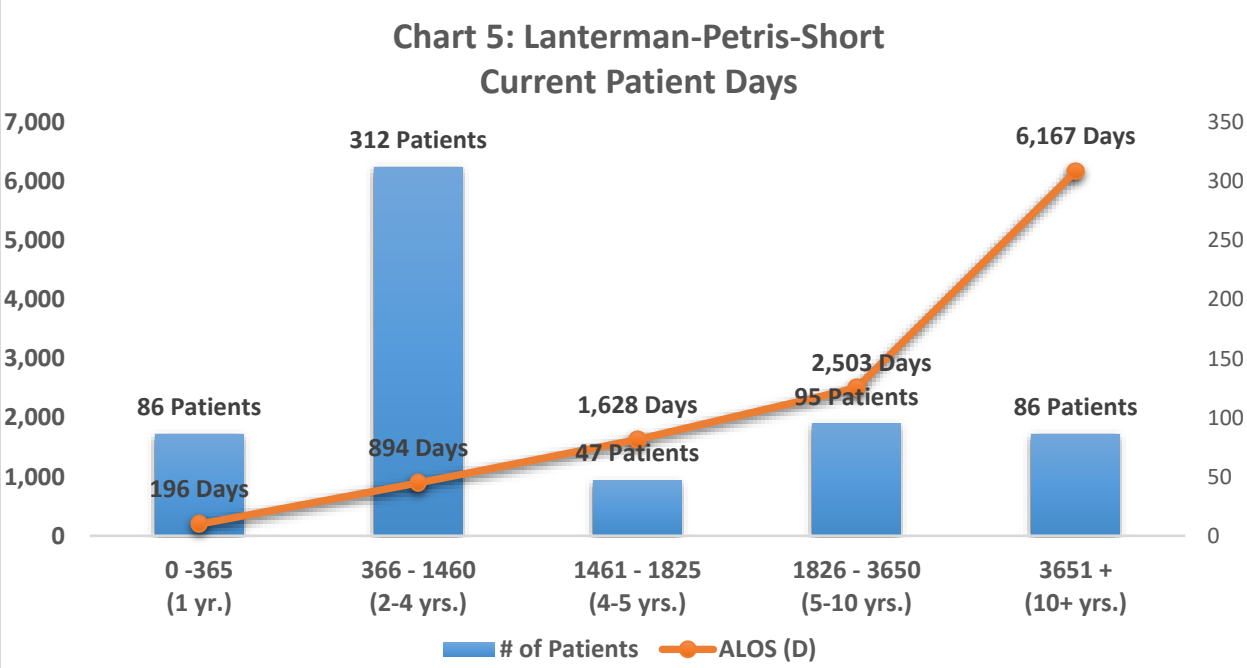


Note: Total served does not include patients transferred between facilities. Excludes Murphy Conservatorships

In FY 2018-19, 164 LPS patients were discharged with an average length of stay of 3.7 years. Chart 4 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, 2019.



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

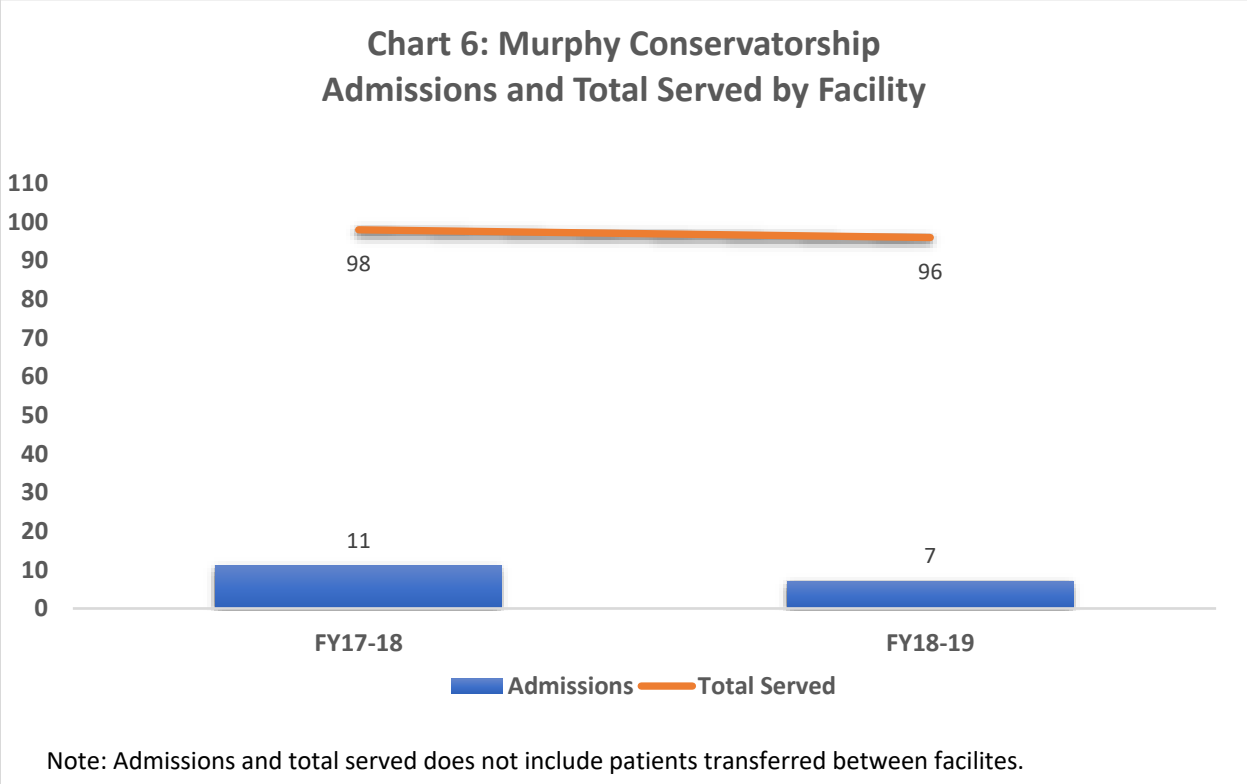


Note: Current patient days is, as of a particular point in time, the number of days residents-on-unit have spent in the state hospital, including leave.

Murphy Conservatorships

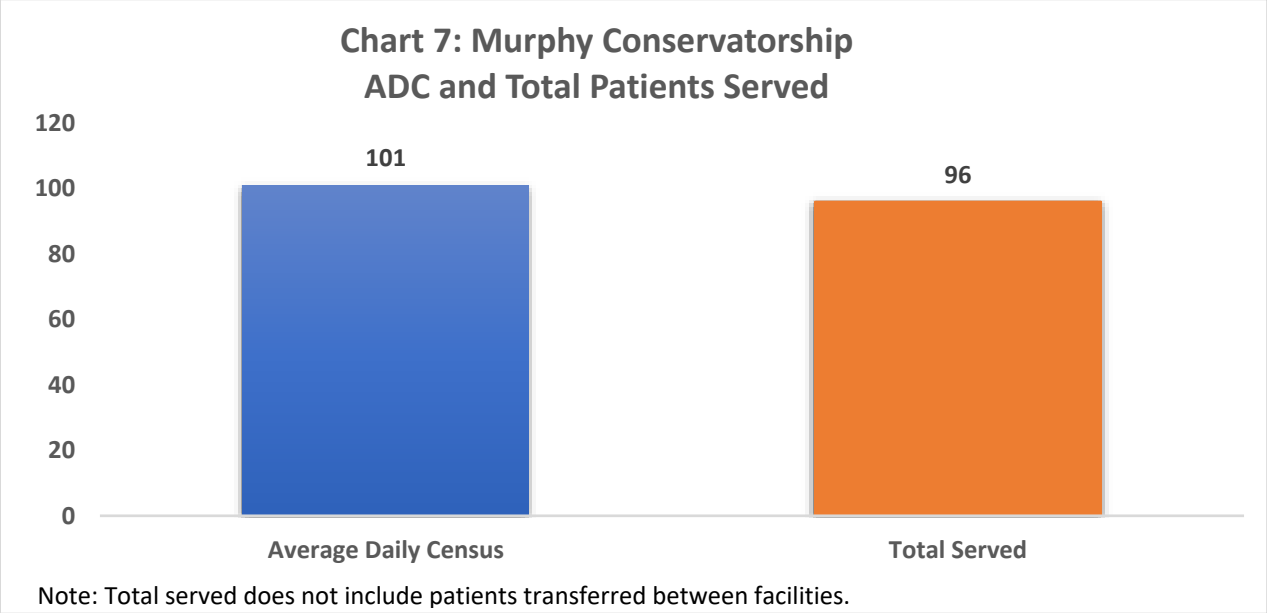
Murphy conservatorships (MURCON) are patients that have been previously found to be IST, and at the end of the IST commitment period the patient has been retained for further treatment because (1) the patient is subject to a pending indictment or information charging the individual with a felony involving 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 2018-19, 7 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 2018-19.



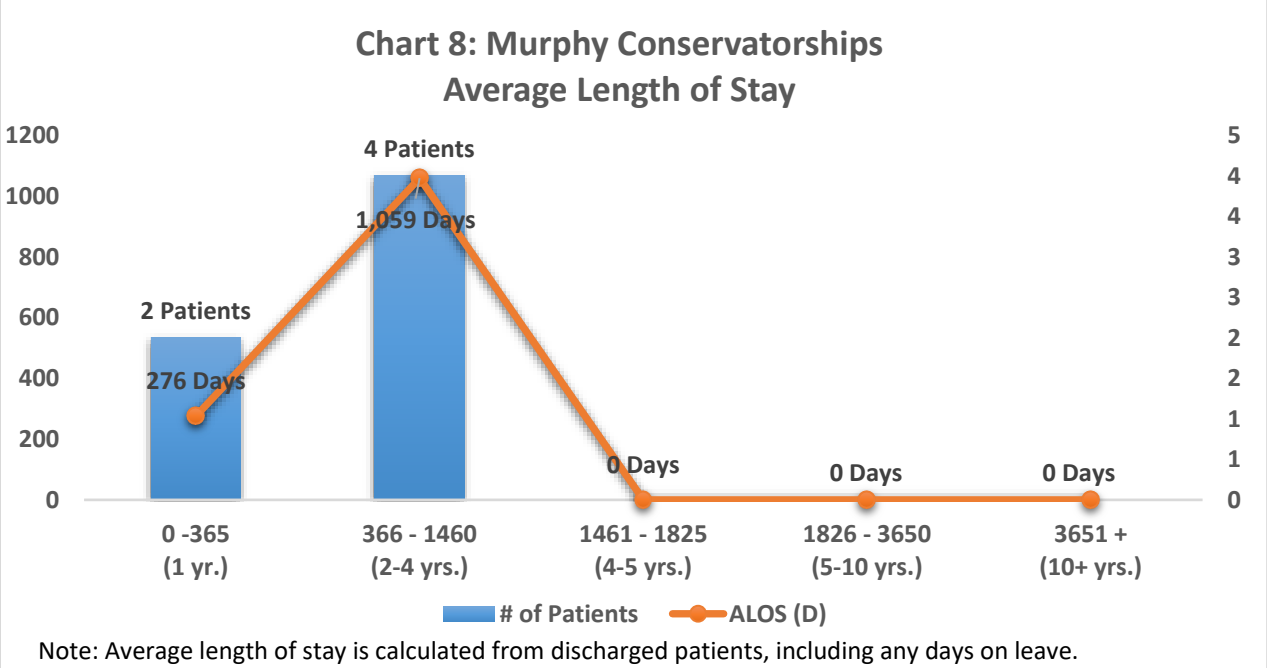
Note: Admissions and total served does not include patients transferred between facilites.

On average, 101 Murphy Conservatorship patients are treated daily in the state hospitals, representing 2 percent of the overall patient population in FY 2018-19. Chart 7 displays the average daily census (ADC) and total number of patients served for the MURCON population in FY 2018-19. As of June 30, 2019, the system-wide MURCON census was 110.

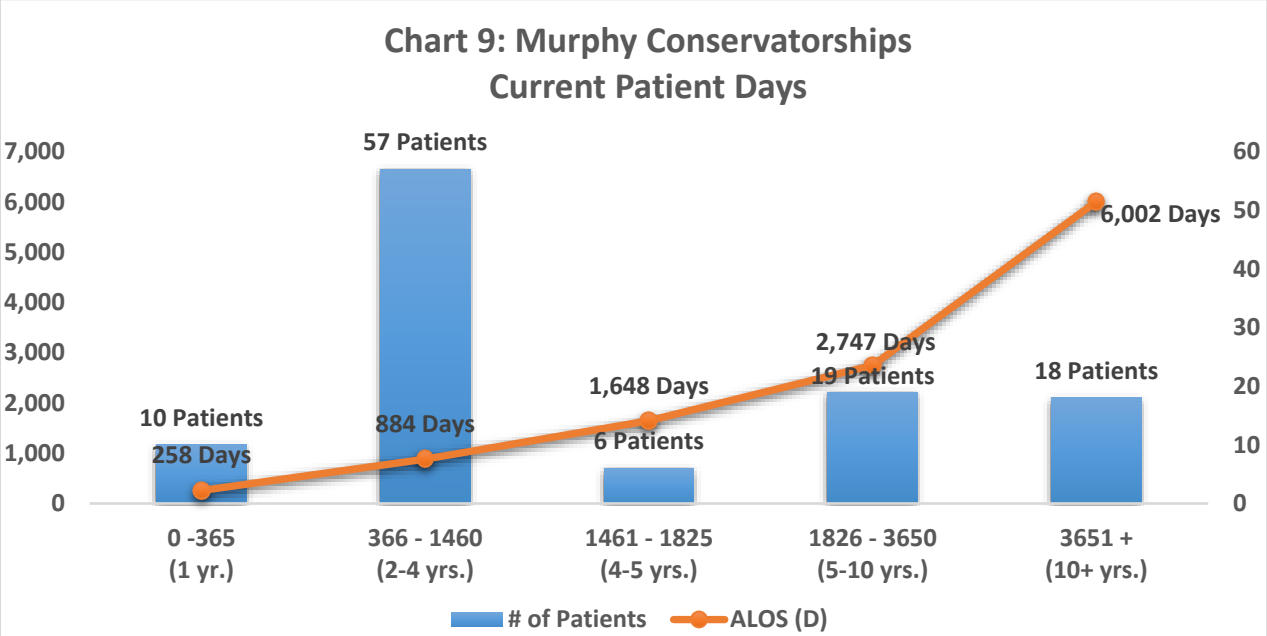


Note: Total served does not include patients transferred between facilities.

In FY 2018-19, 6 MURCON patients were discharged with an average length of stay of 2.2 years. Chart 8 displays the distribution of lengths of stay for all discharged MURCON patients, and Chart 9 displays the distribution of patient days for those MURCON patients who remain residents on unit as of June 30, 2019.



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



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[1]

Description of Legal Class:

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

Parolees who committed one of a specified list of crimes and who were treated for a severe mental disorder connected to their original crime can be committed to a state hospital as a condition of parole for a period not to exceed the length of their parole term; these patients are committed under PC 2962. If the person still requires treatment at the end of their parole term, they can be committed under PC 2972 if it is determined 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 Statute for Discharge:

After one year, a parolee is entitled to an annual review hearing conducted by 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:

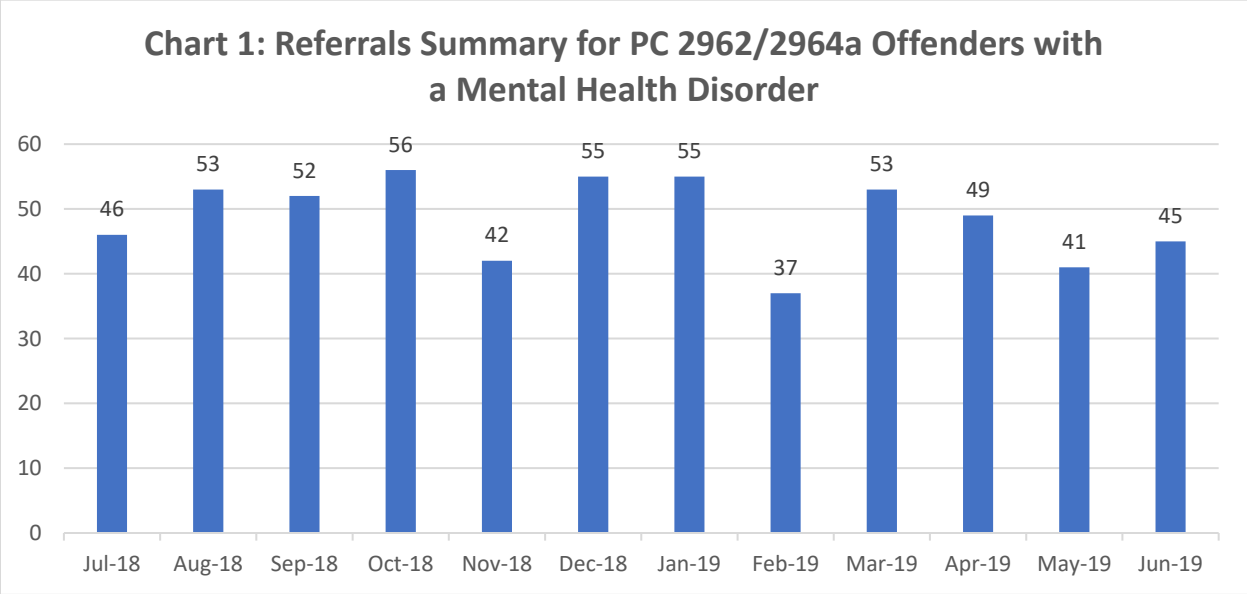
OMD patients have unique needs and challenges. Because their crimes involve violence, many have spent years in prison and need specialized psychosocial treatments to aid in their reintegration back into society. Due to the seriousness and long-term nature of their mental illness, as well as a history 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 Conditional Release Program (CONREP). Another area of focus is substance abuse treatment since a history of substance abuse is prevalent in most OMD patients. The 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.

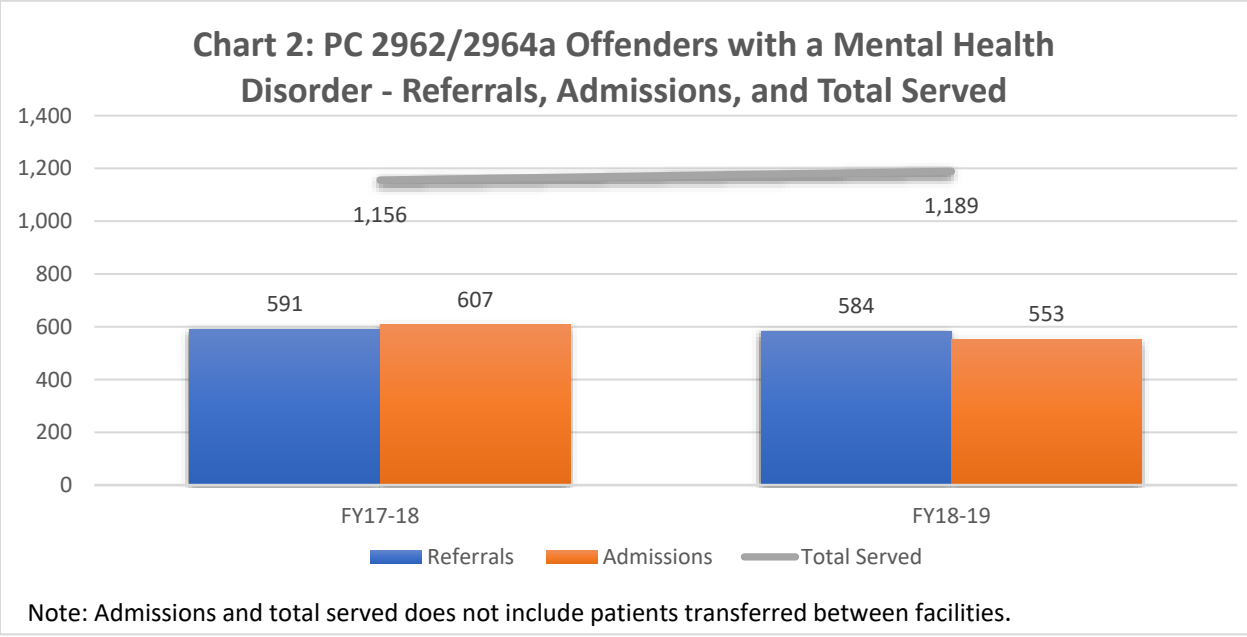
Population Data:

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

In Fiscal Year (FY) 2018-19, 584 PC 2962/2964a OMD patients were committed to the state hospitals, a 2 percent decrease from FY 2017-18.

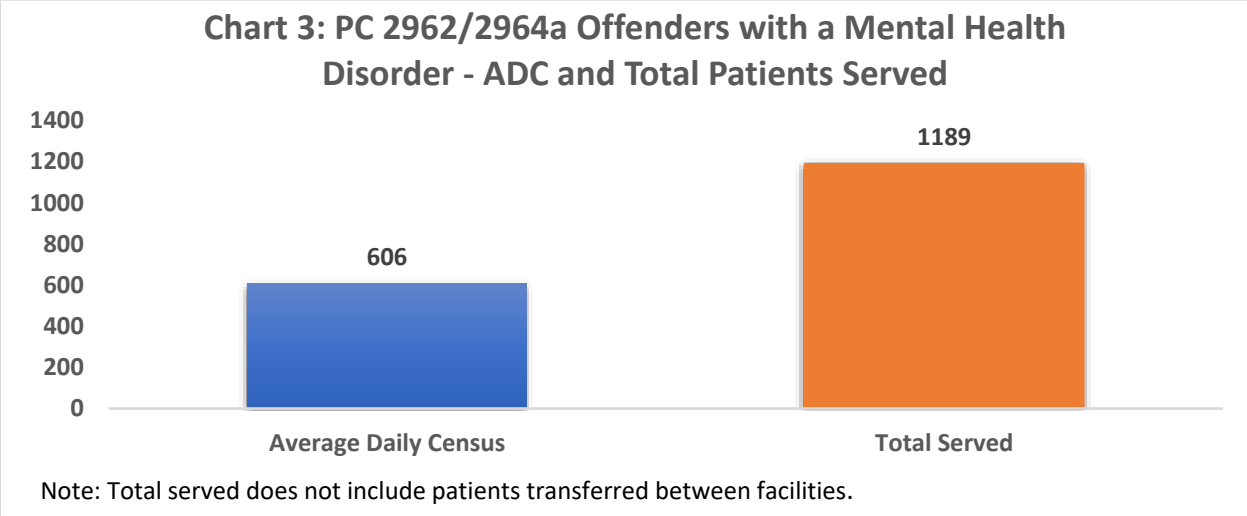


Over the course of FY 2018-19, 553 PC 2962/2964a OMD patients were admitted into a state hospital. Chart 2 displays the referrals, admissions and total patient served for the PC 2962/2964a OMD population in FY 2018-19.



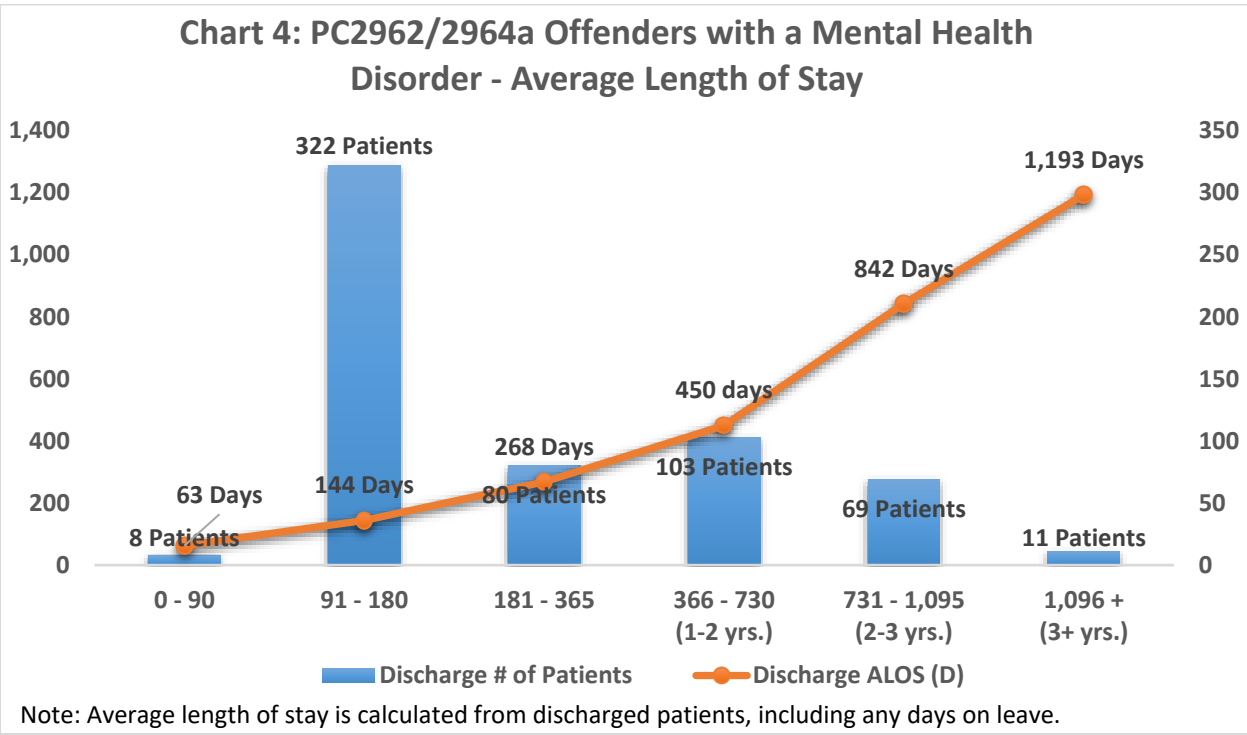
Note: Admissions and total served does not include patients transferred between facilities.

Chart 3 displays the average daily census (ADC) and total number of patients served for the PC 2962/2964a OMD population in FY 2018-19. On average, 606 PC 2962/2964a OMD patients are treated daily in the state hospitals, representing 6 percent of the overall patient population. As of June 30, 2019, the system-wide PC 2962/2964a OMD census was 559 patients.



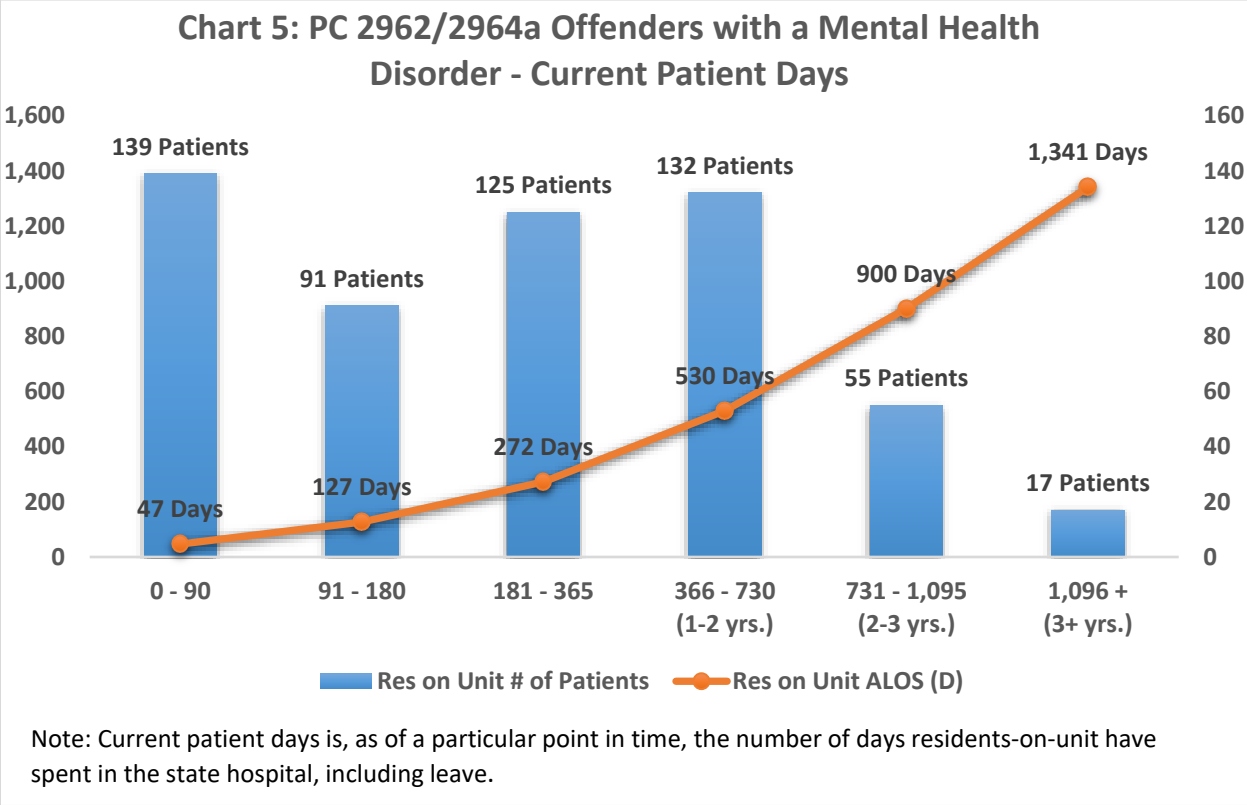
Note: Total served does not include patients transferred between facilities.

Chart 4 displays the distribution of lengths of stay for all discharged PC 2962/2964a OMD patients. In FY 2018-19, 593 PC 2962/2964a OMD patients were discharged with an average length of stay of 313 days, a little less than one year.



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

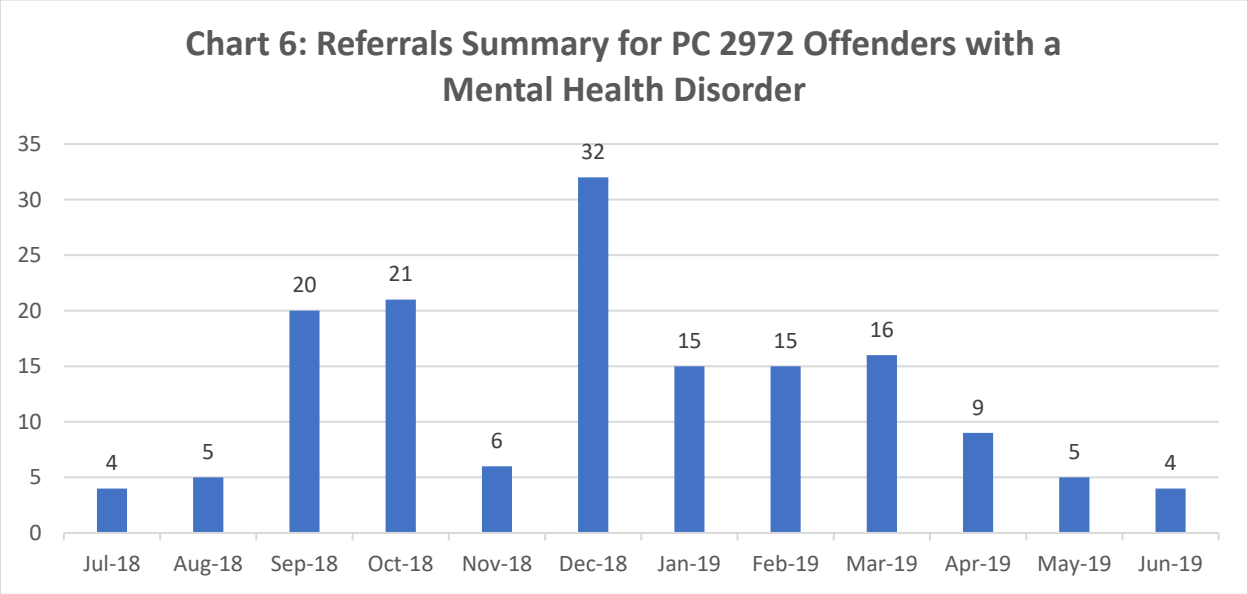
Chart 5 displays the distribution of patient days for all PC 2962/2964a OMD residents on unit as of June 30, 2019. On average, the 559 PC 2962/2964a OMD patients who continue to reside at DSH as of June 30, 2019 have been there for 348 days, a little less than a year; these days will continue to accrue until the individual PC2962/2964a OMD patients have been discharged.



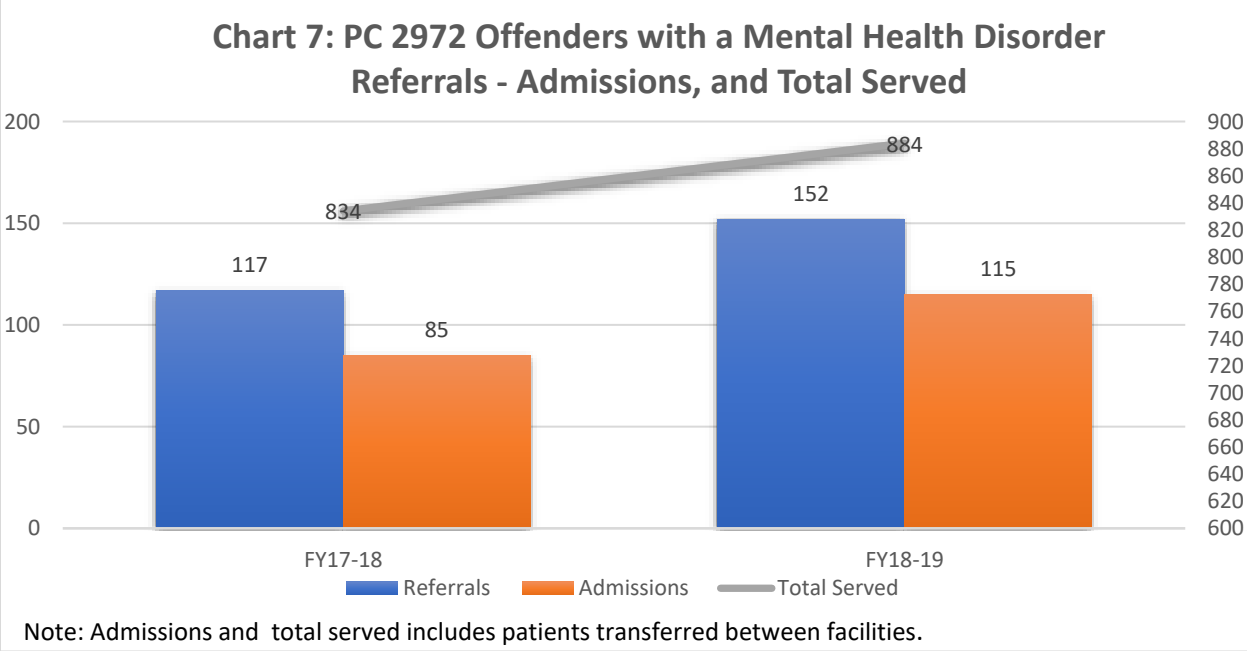
Note: Current patient days is, as of a particular point in time, the number of days residents-on-unit have spent in the state hospital, including leave.

PC 2972 Offenders with a Mental Health Disorder (OMD)

In Fiscal Year (FY) 2018-19, 152 PC 2972 OMD patients were committed to the state hospital, a 30 percent increase from FY 2017-18.

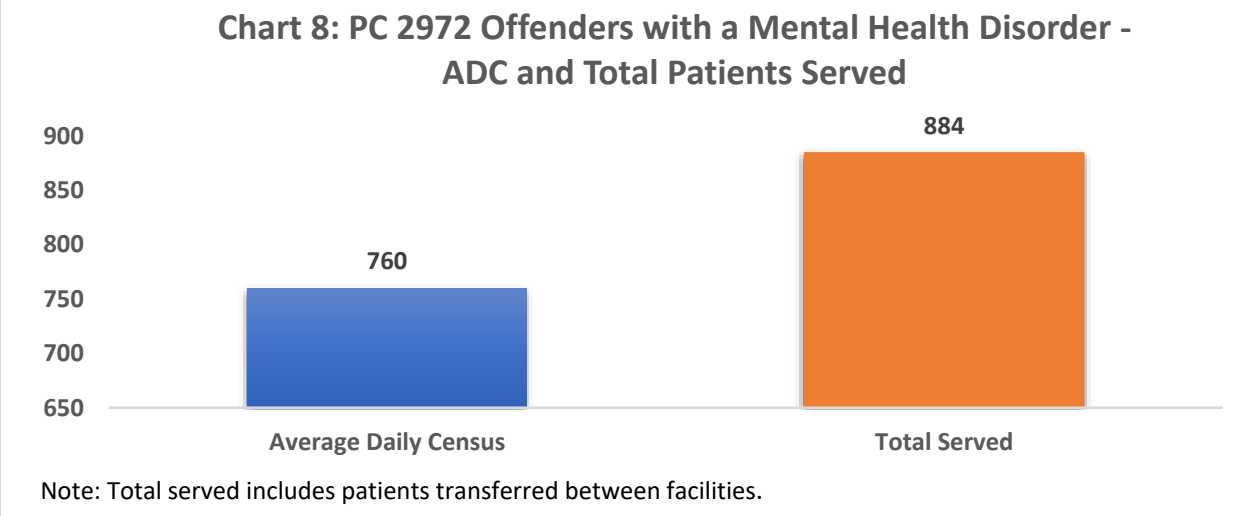


Over the course of FY 2018-19, 115 PC 2972 OMD patients were admitted (including transfer admissions) to a state hospital. Chart 7 displays the referrals, admissions and total patient served for the PC 2972 OMD population in FY 2018-19.



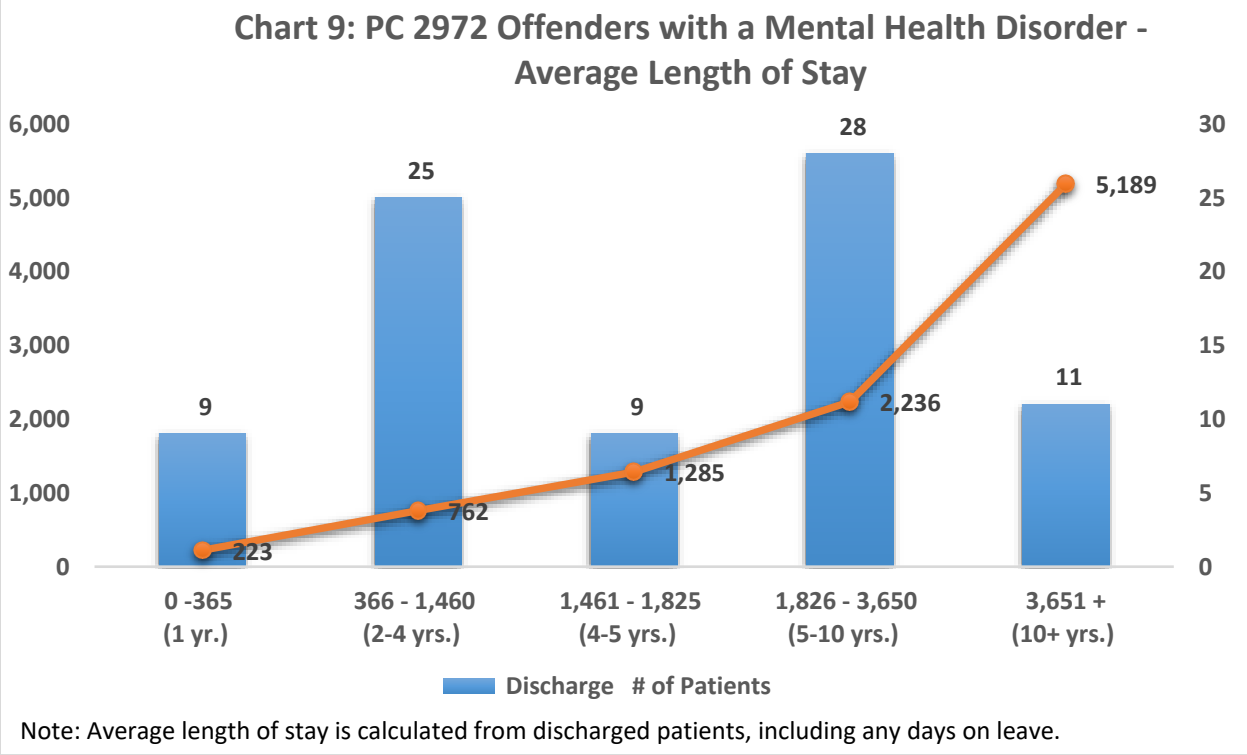
Note: Admissions and total served includes patients transferred between facilities.

Chart 8 displays the average daily census (ADC) and total number of patients served for the PC 2972 OMD population in FY 2018-19. On average, 760 PC 2972 OMD patients are treated daily in the state hospitals, representing 12 percent of the overall patient population. As of June 30, 2019, the system-wide PC 2972 OMD census was 762 patients.



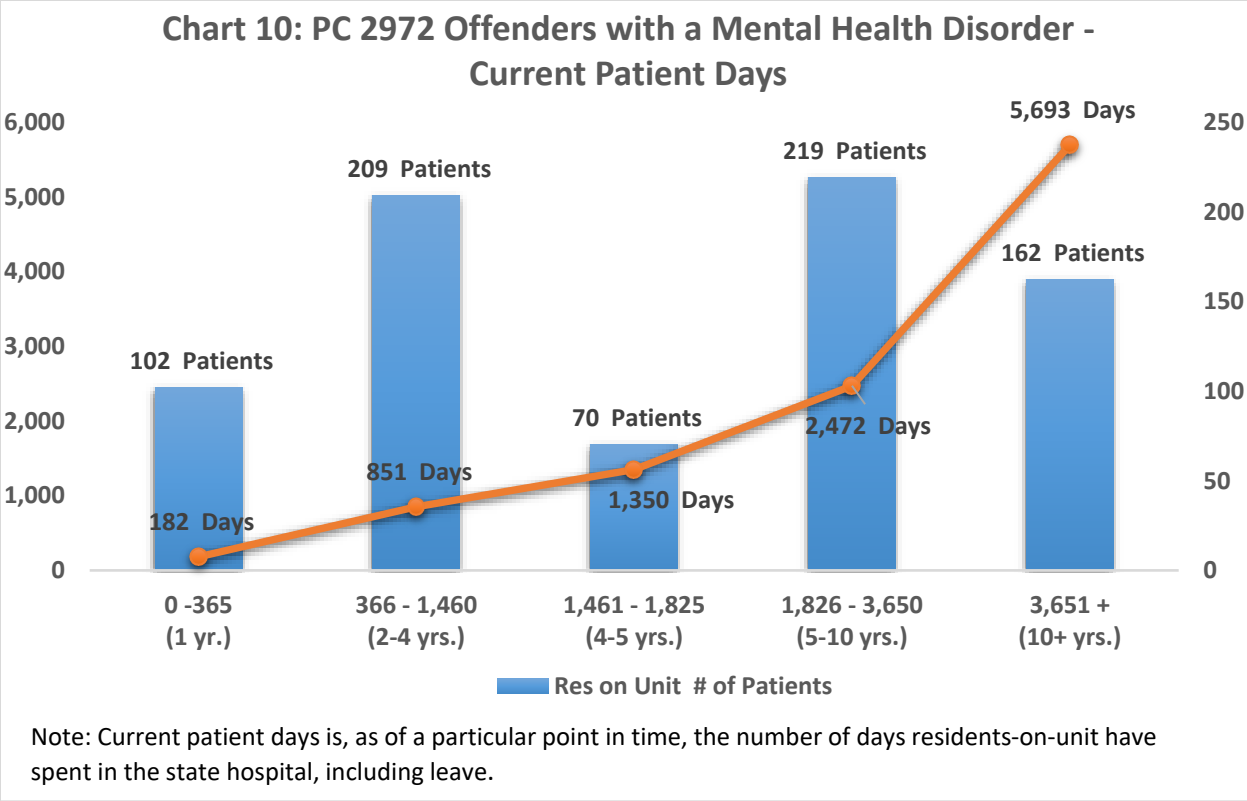
Note: Total served includes patients transferred between facilities.

In FY 2018-19, 82 PC 2972 OMD patients were discharged with an average length of stay of five years. Chart 9 displays the distribution of lengths of stay for all discharged PC 2972 OMD patients.



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

Chart 10 displays the distribution of patient days for all PC 2972 OMD residents on unit as of June 30, 2019. On average, the 762 PC 2972 OMD patients who continue to reside at DSH as of June 30, 2019 have been there for 2,302 days or six years; these days will continue to accrue until the individual PC 2972 OMD patients have been discharged.

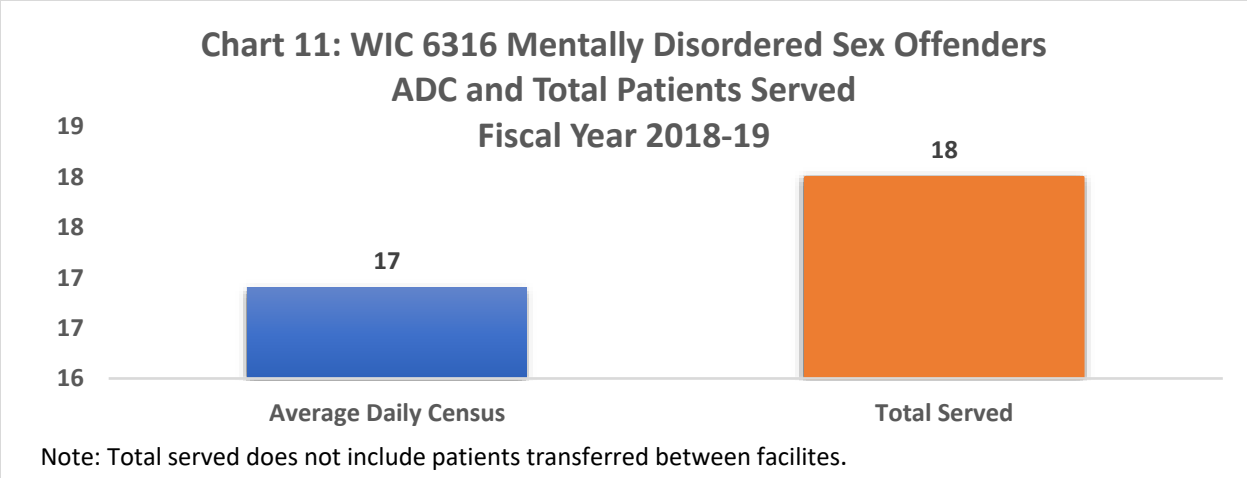


Note: Current patient days is, as of a particular point in time, the number of days residents-on-unit have spent in the state hospital, including leave.

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 11 displays the average daily census (ADC) and total number of patients served for the WIC 6316 MDSO population in FY 2018-19. On average, 17 WIC 6316 MDSO patients are treated daily in the state hospitals, representing 0.3 percent of the overall patient population. As of June 30, 2019, the system-wide WIC 6316 MDSO census was 16 patients.



In FY 2018-19, WIC 6316 MDSO patients that discharged had an average length of stay of six years. For the 16 WIC 6316 MDSO patients who continue to reside at DSH, they have been there for 3,155 days, or nine years; these days will continue to accrue until the individual WIC 6316 MDSO patients have been discharged.

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 Statute 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 that the NGI patient has achieved long-term stabilization and low risk of dangerousness to ensure the court that the patient 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

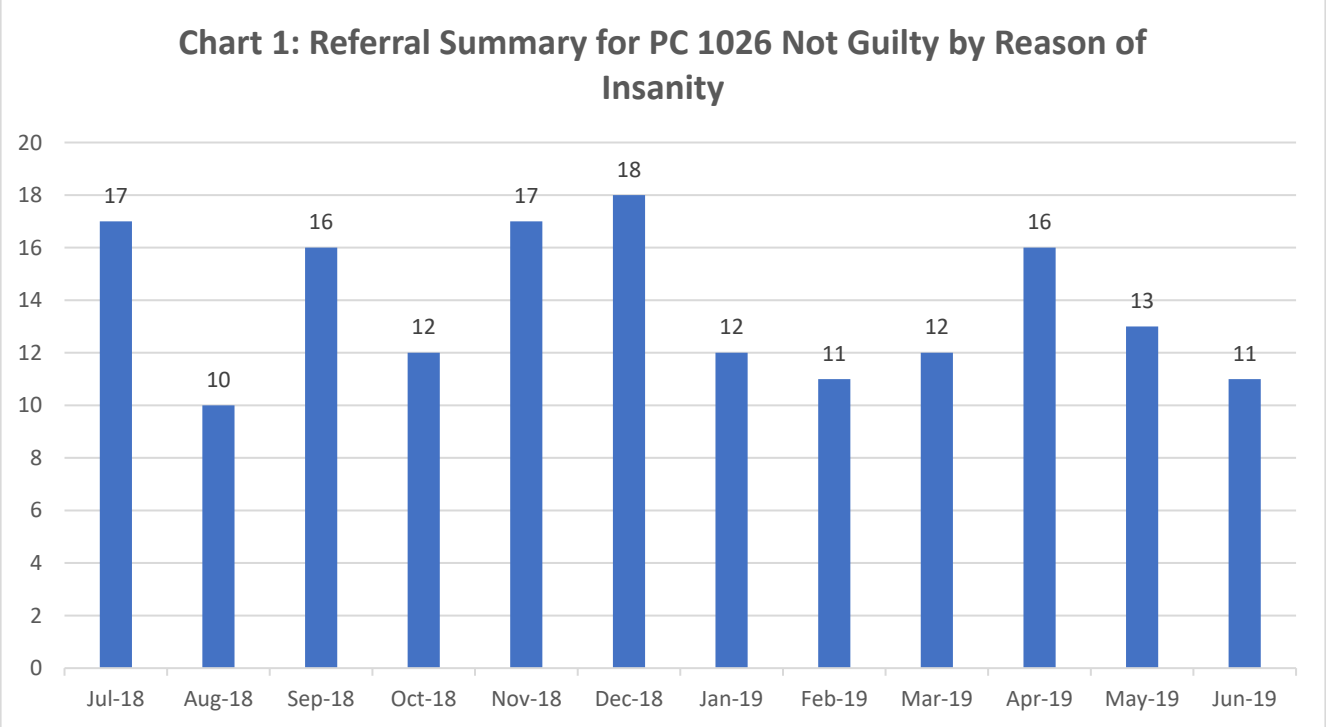
that exacerbate their mental illness. Each NGI patient's progress in treatment is evaluated and submitted to the court via an annual report completed by the DSH treatment team and medical director of the state hospital. In the event that the maximum term approaches and the treatment team does not feel discharge would be appropriate, the hospital can pursue an extension of the NGI sentence in order to extend the stay of the individual, pursuant to Penal Code (PC) 1026.5. In Fiscal Year (FY) 2018-19, 440 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 and similar 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.

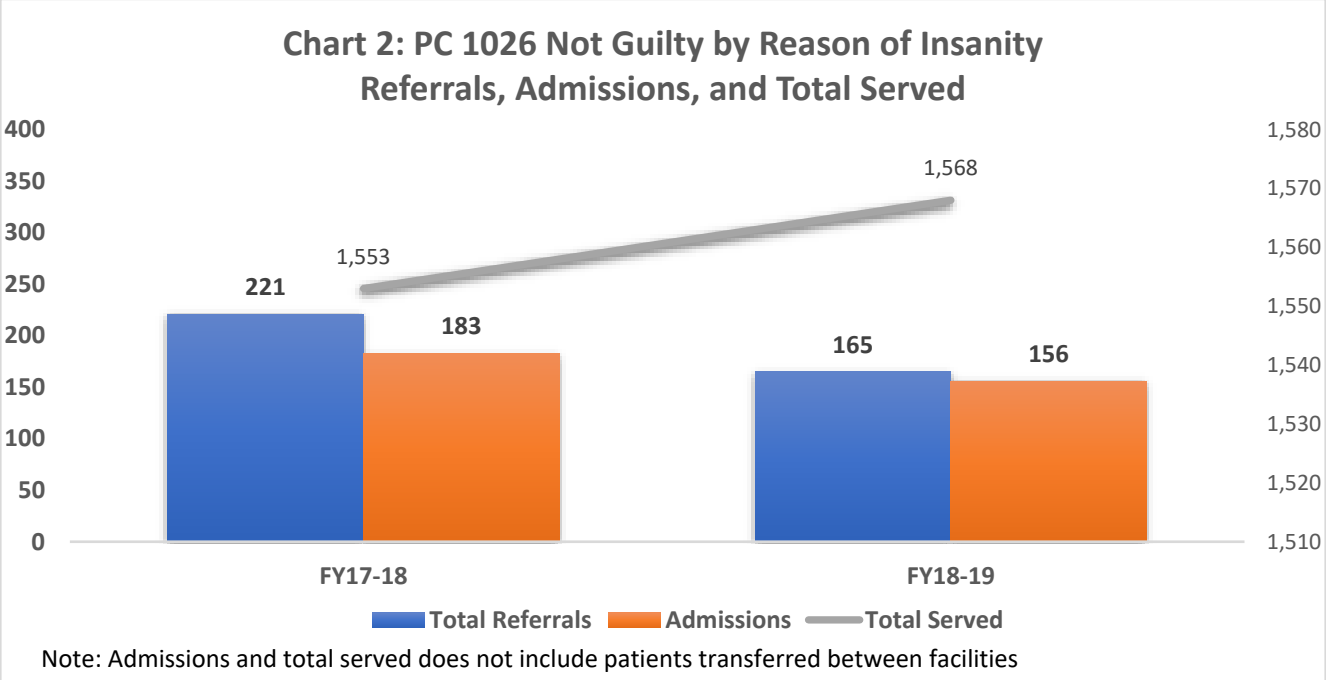
Although NGI patients are admitted to DSH because of severe mental illness and dangerousness, NGI patients have the right to refuse treatment unless that right is removed by case law or regulation, as guided by the *Greenshields* involuntary medication order process. This can effectively lengthen the 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 2018-19, 165 NGI patients were committed to the state hospitals, a 25 percent decrease from FY 2017-18. Chart 1 depicts the monthly referrals of NGI patients to DSH.

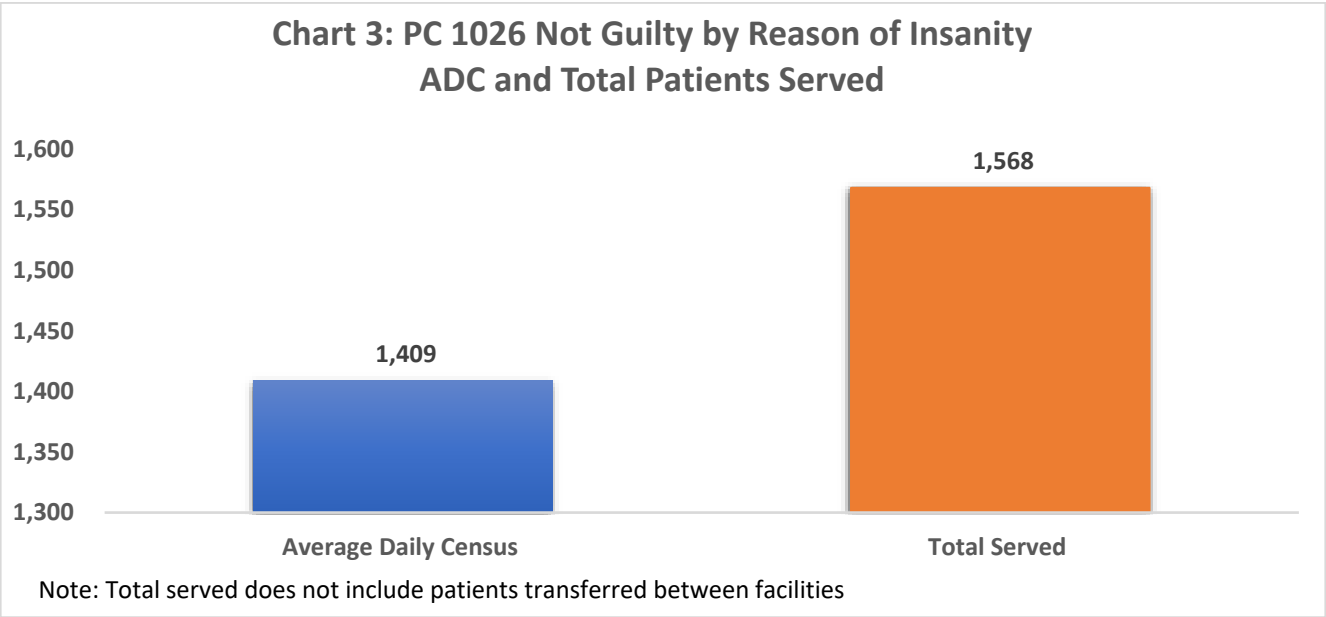


Over the course of FY 2018-19, 156 NGI patients were admitted into a state hospital. Chart 2 displays the referrals, admissions and total patients served for the NGI population in FY 2018-19.



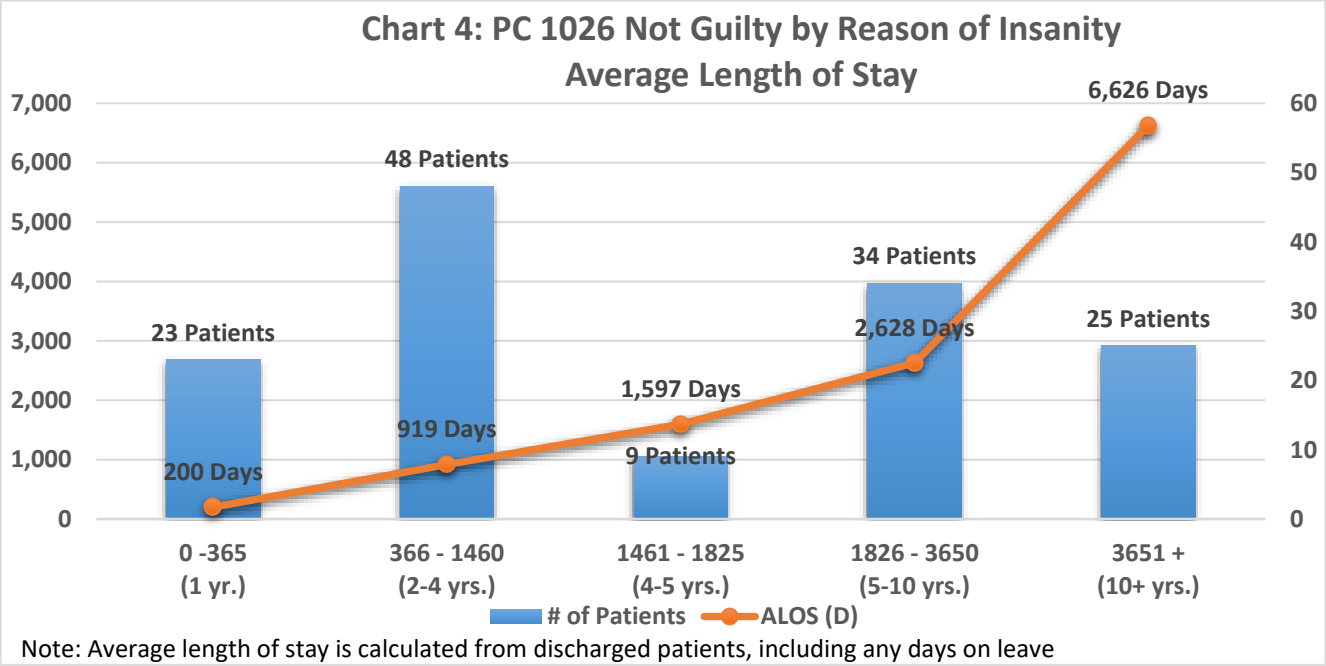
Note: Admissions and total served does not include patients transferred between facilities

Chart 3 displays the average daily census (ADC) and total number of patients served for the NGI population in FY 2018-19. On average, 1,409 NGI patients are treated daily in the state hospitals, representing 22 percent of the overall patient population. As of June 30, 2019, the system-wide NGI census was 1,416 patients.



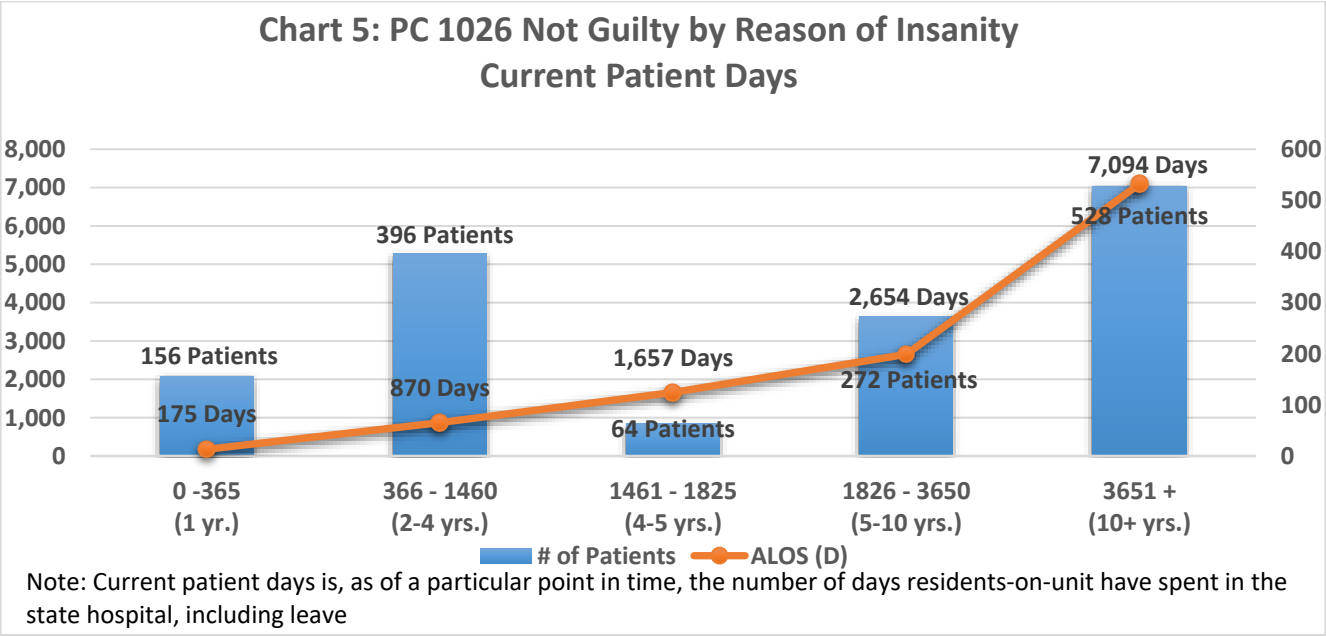
Note: Total served does not include patients transferred between facilities

In FY 2018-19, 139 NGI patients were discharged with an average length of stay of 6 years. Chart 4 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 1,416 NGI patients who continue to reside at DSH as of June 30, 2019 have been there for 3,492.4 days, or 9.6 years; these days will continue to accrue until the individual NGI patients have been discharged. Chart 5 displays the distribution of patient days for all NGI residents on unit as of June 30, 2019.



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
Sexually Violent Predator Patients

Description of Legal Class:

The Department of State Hospitals (DSH) admits Sexually Violent Predator (SVP) patients under Welfare and Institutions Code (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 has 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 at which point a determination of WIC 6604 will be made.
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 a SVP
PC 1610	Temporary admission while waiting for court revocation of Sexually Violent Predator commitment

[1]During Fiscal Year (FY) 2018-19, this population was not served in the state hospitals.

Legal Requirements/Legal Statute 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 and 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.

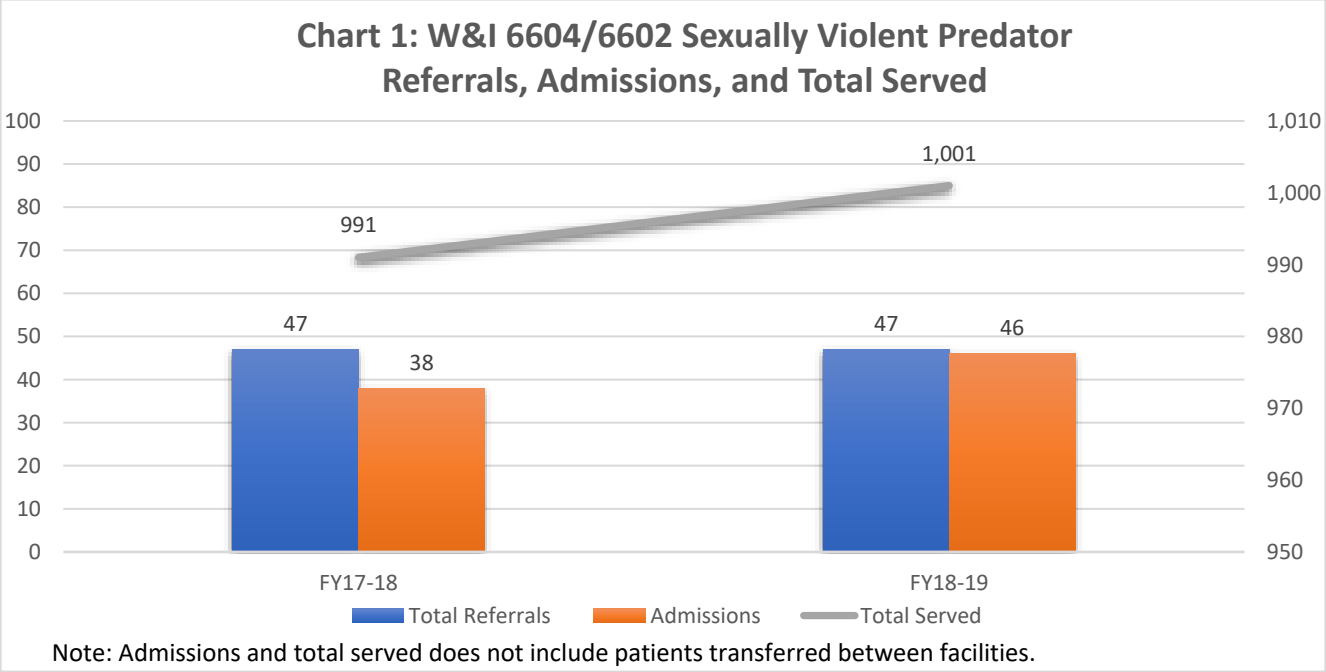
DSH must submit an annual report to the court of the SVP patient's mental condition, a review of whether they still meet the SVP criteria, whether conditional release to a less restrictive environment or unrestricted discharge would be in the best interest of the individual, and whether conditions could 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 long-term 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 understand their sexual violence risk factors and 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.

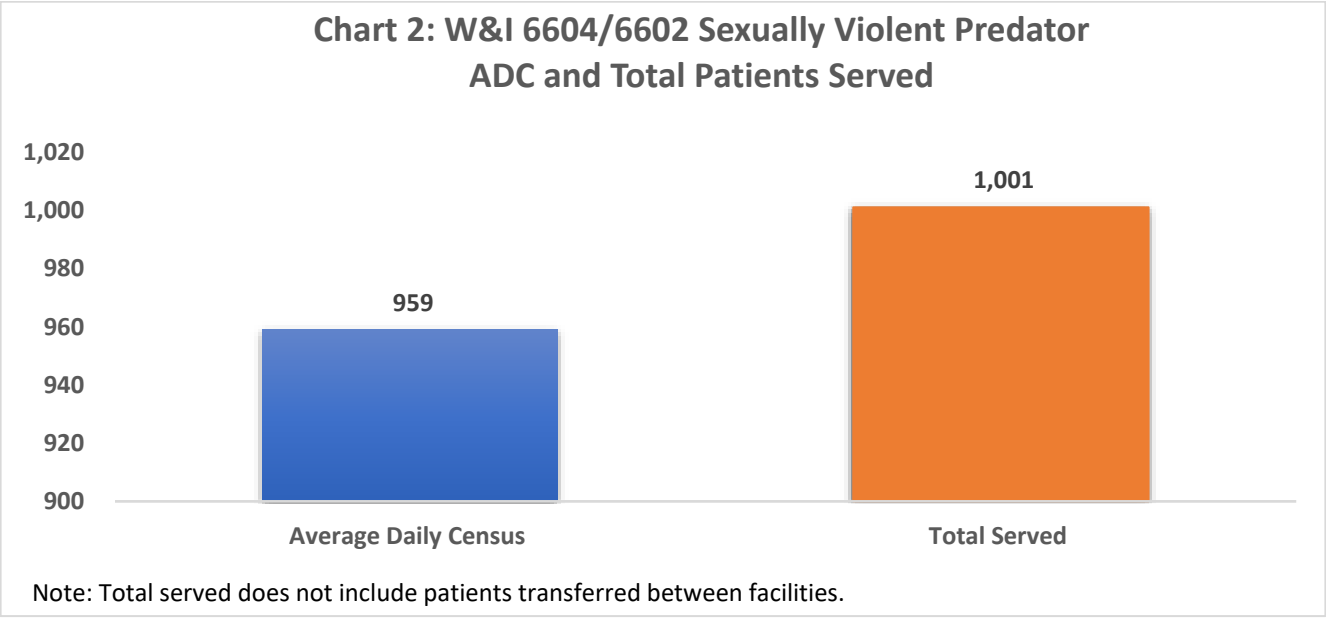
Population Data:

In Fiscal Year (FY) 2018-19, 47 SVP patients were committed, of which 46 SVP patients were admitted into a state hospital. Chart 1 displays the referrals, admissions, and total patients served for the SVP population in FY 2018-19.



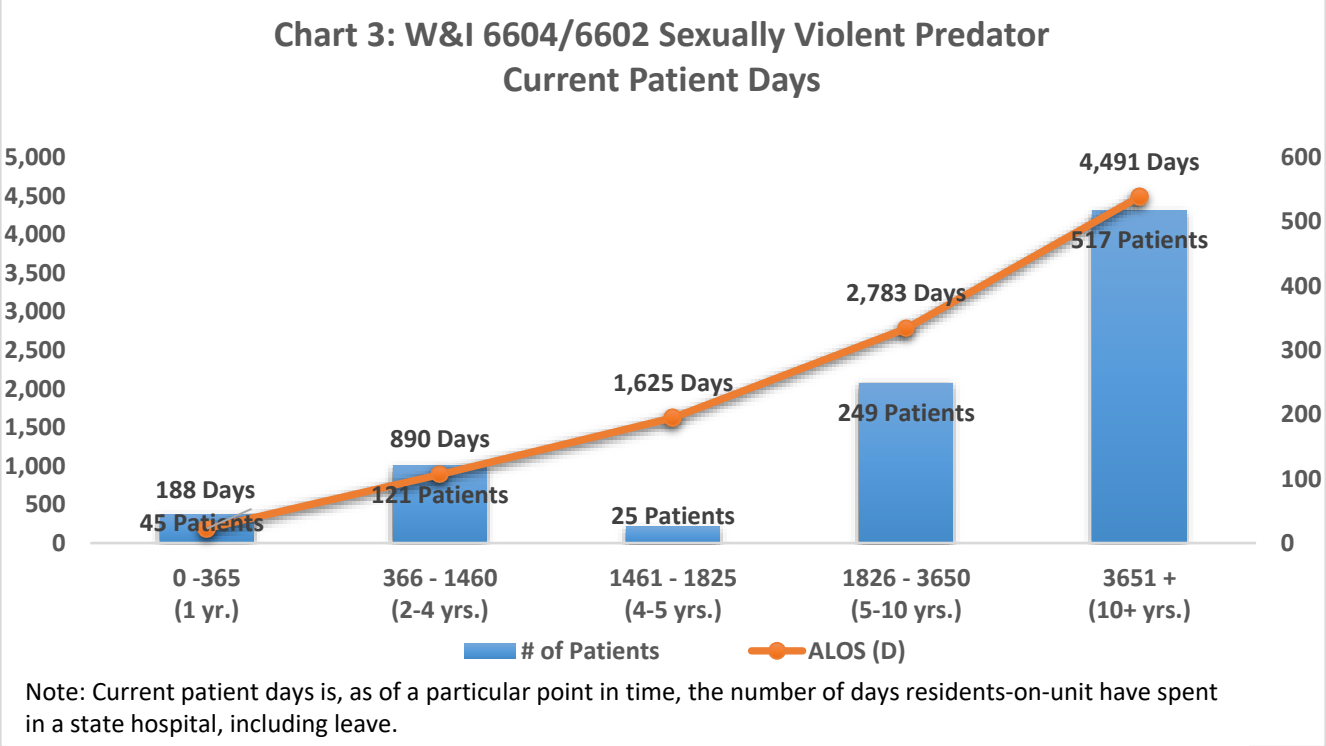
Note: Admissions and total served does not include patients transferred between facilities.

Chart 2 displays the average daily census (ADC) and total number of patients served for the SVP population in FY 2018-19. On average, 959 SVP patients are treated daily in the state hospitals, representing 15 percent of the overall patient population. As of June 30, 2019, the system-wide SVP census was 958 patients.



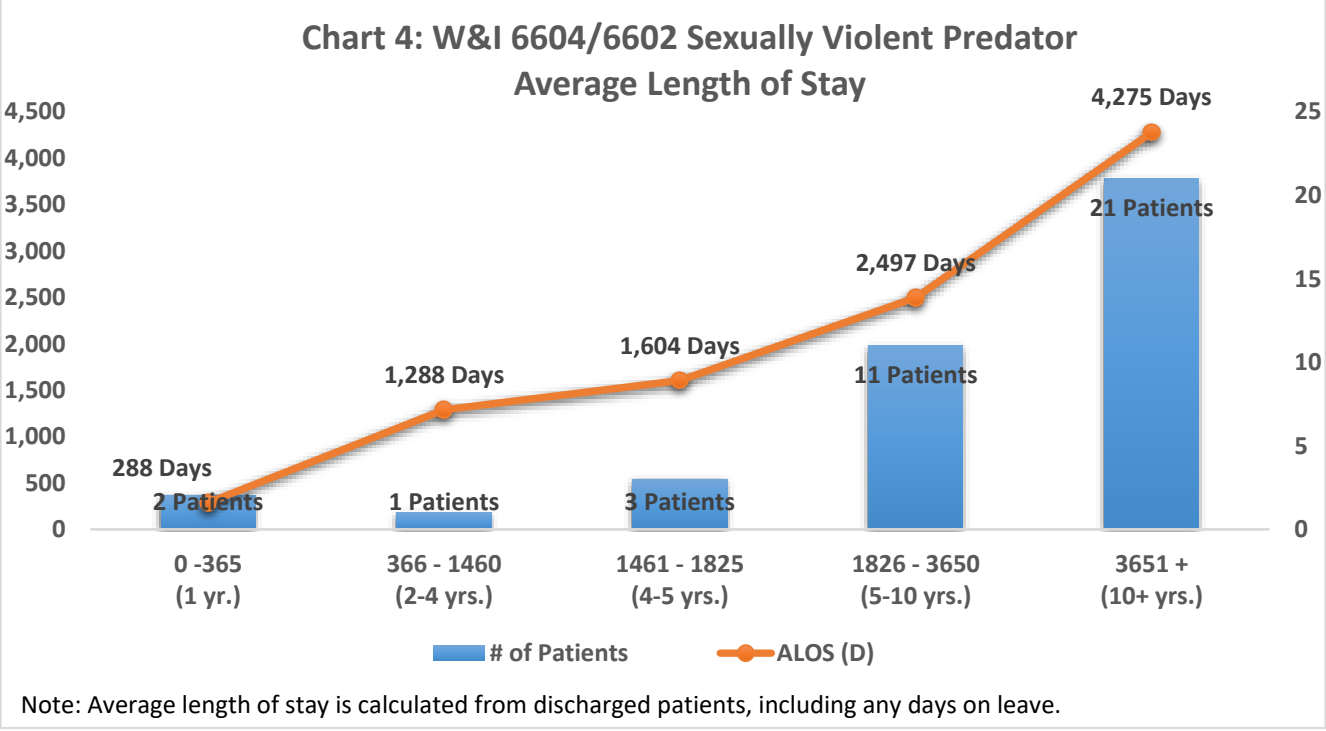
Note: Total served does not include patients transferred between facilities.

Chart 3 displays the patient days for all SVP patients that remained on census as of June 30, 2019.



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.

In FY 2018-19, 38 SVP patients were discharged with an average length of stay of 9 years. Chart 4 displays the distribution of lengths of stay for all discharged SVP patients.



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

Department of State Hospitals – Atascadero

HISTORY

The Department of State Hospitals-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) 2018-19, DSH-Atascadero served 2,465 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	-
Offender with a Mental Health Disorder	2962 / 2972
Coleman/CDCR	2684
Not Guilty by Reason of Insanity	1026

HOSPITAL STAFF

Approximately 2,111 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 GED, or pursue advanced independent studies.

Program management is responsible to ensure a safe and therapeutic environment through the appropriate management of resources and the provision of recovery-based treatment and rehabilitation services specific to the patients' needs.

When indicated, 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 his 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) who will be responsible for outpatient services 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 centralized approach to delivering services where the patients and the staff from throughout the hospital come together to participate in services. RMS represents more of a centralized system of programming rather than a reference to a specific building or certain location. RMS interventions are provided, as much as possible, in the context of real-life functioning and in the rhythm of life of the patient. Thus, an RMS 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.

RMS are designed to ensure that each patient receives individualized services to promote increased wellness and ability to thrive in the community upon discharge. All decisions regarding what is offered through each mall are driven by the needs of the patients served. Services are provided in an environment that is culturally sensitive and strengths based.

Services facilitated through the mall include courses and activities designed to help with symptom management, personal development and life skills. The mall capitalizes on human and staff resources from the entire hospital to provide a larger diversity of interaction and experiences for all patients in the mall.

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. CMS also clinically supervises nursing staff who provide occupational health services to employees.

ACCREDITATION AND LICENSURE

This facility is accredited by The Joint Commission (TJC). 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 deal with organization quality, safety of care issues and the safety of the environment in which care is provided.

DSH-Atascadero is licensed by the California Department of Public Health. DSH-Atascadero 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 on the following page for a brief description of DSH-Atascadero's training programs.

DSH-Atascadero Training Programs

DISCIPLINE	PROGRAM TYPE
Nursing	• Registered Nursing Programs Clinical Rotation • Nursing Students Preceptorship
Pharmacy [1]	•Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools.
Physician and Surgeon [2]	•Accepts Contracted Students
Psychiatric Technicians [3]	•Psychiatric Technician Trainee •Pre-Licensed Psychiatric Technician •20/20 Psychiatric Technician Training Program
Psychology	•American Psychological Association Approved Pre-Doctoral Internship
Registered Dietitians	•Accredited Dietetic Internship •Contracted Cal-Poly San Luis Obispo Dietetic Internship
Rehabilitation Therapy	•Recreation Therapy (Student Assistants) •Music Therapy (Student Assistants)
Social Work	•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-Coalinga is California's newest state mental health hospital 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. 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) 2018-19, DSH-Coalinga served 1,464 patients. The commitment categories of patients treated at DSH-Coalinga are as follows:

Patient Commitments	Penal Code
Lanterman-Petris Short	-
Offender with a Mental Health Disorder	2962 / 2972
Coleman/CDCR	2684
Not Guilty by Reason of Insanity	1026
Sexually Violent Predators	6602/6604

HOSPITAL STAFF

Approximately 2,426 employees work at DSH-Coalinga 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 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 individual 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 individual's self-regulation skills to prepare him 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 individual'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; 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 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 also has seven Residential Recovery Units (RRU), 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 on the following page 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	•Recreation Therapy (Student Assistants) •Recreation Therapy Internship Program •Music Therapy (coming soon)
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 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.

Department of State Hospitals – Metropolitan

HISTORY

The Department of State Hospitals-Metropolitan opened in 1916, this state hospital was once a self-sufficient facility with its own farm, dairy and animals. Today, DSH-Metropolitan is located in Norwalk in Los Angeles County. The hospital has an open campus within a security perimeter. Due to the close proximity of schools and residential housing, DSH-Metropolitan has made an agreement with the community to not accept patients with criminal history that includes murder, sex crimes, or 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) 2018-19, DSH-Metropolitan served 1,482 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	-
Offender with a Mental Health Disorder	2972
Not Guilty by Reason of Insanity	1026

HOSPITAL STAFF

Approximately 2,111 employees work at DSH-Metropolitan providing around-the-clock care, including psychologists, psychiatrists, social workers, rehabilitation therapists, psychiatric technicians, 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, 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 comprehensive, cognitive-behavioral treatment for complex, difficult-to-treat mental disorders founded in the late 1970s by psychologist Marsha Linehan.

Research indicates DBT to be effective in reducing:

- Suicidal and self-injurious behaviors
- Chronic feeling of emptiness and depression
- Intense anger or difficulty controlling anger
- Impulsive behaviors that are potentially self-damaging (e.g., substance abuse)
- Psychiatric hospitalizations

DSH- Metropolitan has a specialized unit dedicated to DBT as a treatment modality for individuals who have emotional responses that are poorly modulated and does not fall within the conventionally accepted range. It is also for patients who demonstrate maladaptive behavior such as suicidal actions, aggression towards others, self-harm and substance use.

Each individual 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

ACCREDITATION AND LICENSURE

This facility is accredited by The Joint Commission (TJC). 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 deal with 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 on the following page for a brief description on those training programs.

DSH-Metropolitan Training Programs

DISCIPLINE	PROGRAM TYPE
Nursing [1]	• Registered Nursing Programs Clinical Rotation • 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	•Recreation Therapy (Volunteer Positions) •Music Therapy (Volunteer Positions) •Loyola Marymount University - Art Therapy (Practicum Students)
Social Work	•Unpaid Masters of Social Work Internships

[1] **Nursing:** Preceptorship for BSN and 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 Hospital building. The Hospital originated in response to overcrowding at Stockton Asylum, the first State Hospital. Department of State Hospitals-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. Treatment programs for developmentally disabled residents were available from October 1968 to August 1987 and from October 1995 to March 2001. The hospital does not accept voluntary admissions.

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,418 beds. In Fiscal Year (FY) 2018-19, DSH-Napa served 2,017 patients. The commitment categories of patients treated at DSH-Napa are as follows:

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

HOSPITAL STAFF

Approximately 2,495 employees work at DSH-Napa, 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 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 outside the Security Treatment Area (STA) for primarily civil commitments and four programs are inside for forensic commitments. On arrival at the residential unit, staff orients the patient to the unit and 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, California Forensic Conditional Release Program (CONREP), and the courts may play a role as the patient moves through the continuum of care from admission to discharge.

Units have a focus on a particular population and treatment. In addition to the living units there are other service sites. Mall services provides a variety of off unit services for patients. Mall services are a centralized approach to delivering services where the patients and the 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, the mall 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 provide opportunities for patients to develop job skills and habits, as well as earn funds. Educational services enable 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 whole patient in wellness and improved quality of life. Medical ancillary services provide clinics to provide a number of medical services including but not limited to physical, occupational and speech therapies as well as 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

This facility is accredited by The Joint Commission (TJC). 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 deal with organization quality, safety of care issues and the safety of the environment in which care is provided.

DSH-Napa is licensed by the California Department of Public Health. DSH-Napa 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 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. 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 on the following page 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
Psychiatry	•UC Davis, Psychiatry and Law •CA North State University •Touro University •Clinical Clerkships for Medical School Graduates
Psychology	•American Psychological Association Approved Pre-Doctoral Internship
Registered Dietitians	•Accredited Dietetic Internship
Rehabilitation Therapy	•Recreation Therapy (Volunteer Positions) •Occupational Therapy (Volunteer Positions) •Music Therapy (Volunteer Positions) •Dance Movement Therapy Internship
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 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 Apprentice - This class is limited term and designed for entrance and performance in an apprentice program leading to status as a licensed Psychiatric Technician. Persons in this class receive training under the provisions of apprenticeship standards and written apprentice agreements under Chapter 4, Division 3, California Labor Code. 2. Pre-Licensed Psychiatric Technicians are graduates from Psychiatric Technician School but have not yet passed the state licensing exam. They are limited to 9 months in that role (test must be passed within the 9 months) and work full time with some limitations on their job responsibilities.

Department of State Hospitals – Patton

HISTORY

The Department of State Hospitals-Patton is a secure forensic psychiatric hospital located in Patton, CA, 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 a secure treatment area. 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) 2018-19, DSH-Patton served 2,585 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	-
Offender with a Mental Health Disorder	2962 / 2972
Coleman/CDCR	2684
Not Guilty by Reason of Insanity	1026

HOSPITAL STAFF

Approximately 2,455 employees work at DSH-Patton providing around-the-clock 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, groundskeepers, information technology staff, plant operations staff, spiritual leaders, and other administrative staff.

TREATMENT AND PROGRAMS

The Trial Competency Program is for patients admitted to the hospital under Penal Code (PC) 1370 as Incompetent to Stand Trial. These patients receive a specialized program 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 our Mentally Disordered Offender (MDO) and Not Guilty by Reason of Insanity (NGI) population emphasizes the potential for each patient to learn new skills and adaptive coping mechanisms to enhance the quality of the patient's life at the hospital and prepare them for eventual transfer to Community Outpatient Treatment (COT). Other goals are to motivate patients for treatment, develop greater self-autonomy and independence, and the mastery of Activities of Daily Living (ADL) skills and self-discipline.

All treatment programs at DSH-Patton utilize the recovery philosophy 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.

ACCREDITATION AND LICENSURE

This facility is accredited by The Joint Commission (TJC). TJC conducts unannounced surveys 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 deal with organization quality, safety of care issues and the safety of the environment in which care is provided.

DSH-Patton has 12 units designated as acute. An acute psychiatric facility means having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code , including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary services. DSH-Patton also has 21 units designated as an Intermediate Care Facility (ICF). An ICF means a health facility that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care.

DSH-PATTON MUSEUM

The DSH-Patton Museum examines the history of psychiatry and treatment of mental illness in California state-run facilities. The museum offers a glimpse of the evolution of the treatment of mental illness during the last 125 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 items. 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.

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.

TRAINING AND PARTNERSHIPS

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

DSH-Patton 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.
Psychiatry	•Loma Linda •UC Riverside •Kaiser Permanente
Psychology	•Practicum •American Psychological Association Approved Pre-Doctoral Internship •Post-Doctoral Fellowship
Registered Dietitians	•Accredited Dietetic Internship
Rehabilitation Therapy	•Recreation Therapy (Student Assistants)
Social Work	•Masters of Social Work and Bachelors 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.

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

BACKGROUND:
The Forensic Conditional Release Program (CONREP) is the Department of State Hospital's (DSH) statewide system of community-based services for specified court-ordered forensic individuals. Mandated as a State responsibility by the Governor's Mental Health Initiative of 1984, the program began operations on January 1, 1986 and operates pursuant to statutes in Welfare and Institutions Code (WIC) 4360(a) and (b). The goal of CONREP is to promote greater public protection in California's communities via an effective and standardized community outpatient treatment system. DSH contracts with county-operated and private organizations who administer direct treatment and supervision services to DSH patients.

The CONREP population includes:

- Not Guilty by Reason of Insanity (NGI), Penal Code (PC) 1026
- Offender with a Mental Health Disorder (OMD) (both PC 2964 parolees who have served a prison sentence and PC 2972s who are civilly committed for at least one year after their parole period ends)
- Felony Incompetent to Stand Trial (IST) (PC 1370s who have been court-approved for outpatient placement in lieu of state hospital placement)
- Mentally Disordered Sex Offenders (MDSO) (WIC 6316).

CONREP services are also offered to Sexually Violent Predators (WIC 6604) as discussed in greater detail in the CONREP-SVP Program Update.

As of September 23, 2019, there are 635 clients in CONREP Non-SVP.

TREATMENT:

Individuals suitable for CONREP may be recommended by the state hospital Medical Director to the courts for outpatient treatment. Currently, DSH contracts with seven county-operated and three private organizations to provide outpatient treatment services to clients in all 58 counties in the state with non-SVP commitments.

As specified in PC 1600-1615 and 2960-2972, the CONREP Community Program Director, with the Court's approval (or, in the case of OMDs, the Board of Parole Hearings' approval), assesses and makes the recommendation for individuals' placement in CONREP. CONREP delivers an array of mental health services to individuals during their period of outpatient treatment. In conjunction with the court-approved treatment plan, contractors coordinate and provide a wide array of 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, and psychological assessments. DSH has developed standards for these services which set minimum treatment and supervision levels for individuals court-ordered to CONREP. Regular evaluations and assessments on treatment progress are completed by contractors during the period of state hospitalization and while receiving treatment in CONREP.

When a DSH patient is discharged to CONREP, the goal is to provide an independent living environment in the least restrictive setting. However, if a CONREP-eligible patient has not demonstrated the ability to live in the community without direct staff supervision, the patient is referred to a Statewide Transitional Residential Program (STRP).

The STRPs are a cost-effective resource used by CONREP to provide patients with the opportunity to learn and demonstrate appropriate community living skills in a controlled setting with 24 hours per day, seven days per week (24/7) supervision while they transition from a state hospital to a community site. Alternatively, patients placed in an independent living situation and are having difficulties adjusting can be placed in a STRP, in lieu of re-hospitalization, to help re-stabilize them when their psychiatric symptoms increase or if they are non-compliant with their treatment plan. The STRP is limited to a 90 to 120-day stay as residential treatment. Once the patient has made the necessary adjustments and is ready to live in the community without structured 24/7 services provided by the STRP, the patient is able to live in a Board & Care, Room & Board, or other independent living arrangements and without direct staff supervision.

PROGRAM PROFILE
EVALUATION AND FORENSIC SERVICES
SOCP AND OMD PRE-COMMITMENT PROGRAM

BACKGROUND:
The Department of State Hospitals (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 a Offender with a Mental Health Disorder (OMD) as a condition of parole or as a Sexually Violent Predator (SVP). DSH administers these services through the OMD Program and the Sex Offender Commitment Program (SOCP). DSH currently employs 3.0 Chief Psychologists, 24.5 Consulting Psychologists, and 19.0 SVP Evaluators in addition to contracted psychologists to perform psychological evaluations, develop forensic evaluation reports, provide expert witness court testimony and consultation related to these evaluation services, as well as maintain up-to-date training associated with these programs. These services must be performed at a variety of locations throughout California, but not limited to, state prisons, state hospitals, jails, and courts. The forensic evaluations are time-sensitive and must be completed and referred to the District Attorney's Office no less than 20 days prior to the inmate's release from prison for those individuals determined to meet the criteria as an SVP to comply with a statutory requirement.

This program profile reflects the forensic evaluator staffing levels required to support the volume of interviews, evaluations, forensic report development, and expert witness and court testimony services driven by the number of CDCR referrals for potential SVP and OMD commitments to the state hospitals. Additional workload may include, but is not limited to: completing SVP update evaluations required in preparation for court; developing and maintaining a robust quality assurance program, including data analytics to target training and/or support needs to evaluators and CDCR stakeholders; participating in a mentorship program that pairs highly experienced evaluators with less experienced evaluators; developing and implementing standardized assessment protocols; and maintaining licensure requirements. Failure to perform these forensic services accurately and timely could result in the inappropriate release of an OMD or SVP into the community, compromising public safety.

Sex Offender Commitment Program (SOCP)

The SOCP was established in 1996 pursuant to the Sexually Violent Predator Act, Welfare and Institutions Code (WIC) 6600, et seq. In accordance with WIC 6601(b), the Board of Parole Hearings (BPH) performs the clinical aspects of screening CDCR inmates to determine whether the individual is likely to be an SVP and warrants two forensic psychological evaluations by DSH.

CDCR and BPH are responsible for performing a two-part screening process of CDCR inmates[1]. This consists of: (1) identifying whether the individual committed qualifying offenses for commitment as an SVP; and, if so, (2) BPH conducts a clinical review of the individual's qualifying offense(s) and social, criminal, and institutional history to determine whether the individual is likely to be an SVP. If CDCR and BPH determine an individual is likely to be an SVP, CDCR refers the individual to DSH for a full evaluation of whether the person meets the criteria. For the period between August 2018 and July 2019, approximately 535 cases were referred to DSH for full evaluations. DSH is required to complete two forensic psychological evaluations to determine if the individual meets the statutory criteria for civil commitment as an SVP. When there is a difference of opinion (DOP) by the two forensic evaluators initially assigned by DSH to perform full evaluations, DSH is statutorily required to assign

[1] Welfare and Institutions Code 6601 (b)

two additional independent evaluators who are not state government employees to assess the individuals. For the period between August 2018 and July 2019, approximately 50 DOPs were completed by DSH.

Forensic evaluations require travel to the inmate's location for an in-person interview, perform case records reviews including criminal and medical history, develop a written evaluation report and provide expert witness testimony once the case goes to trial. Updated forensic evaluations may be required as part of the preparation for court.

Offender with a Mental Health Disorder (OMD) Program

The OMD commitment was created to provide a mechanism to detain and treat severely mentally ill prisoners who have reached the end of their determinate prison terms and are dangerous to others as a result of a severe mental disorder. The law became effective July 1, 1986 and is codified in Penal Code (PC) 2960 – 2981.

The OMD commitment is a two-phase process:

The first phase is a certification by CDCR's Chief Psychiatrist that an inmate meets the OMD criteria. The certification process consists of CDCR conducting the initial file review and performing one clinical evaluation prior to referring to DSH. DSH then receives the OMD referral from the applicable CDCR institution and sends a clinician to the appropriate CDCR facility to conduct the second forensic psychological evaluation and determine if the inmate meets the OMD statutory criteria prior to release from prison. For the period between August 2018 and July 2019, DSH received approximately 2,772 referrals from CDCR to perform an OMD evaluation for potential commitment to a state hospital. Of these, 409 DSH evaluations were positive and 2,363 DSH evaluations were negative. Of the referral total, 546 were admitted to a state hospital based on DSH evaluations and DOP evaluations conducted by BPH. When there is a DOP between the CDCR and DSH forensic evaluators based on criteria outlined in PC 2962, BPH is responsible for conducting two additional, independent evaluations. BPH conducts approximately 300 DOPs annually.

The second phase consists of a statutory mandate requiring BPH to commit inmates who are found to meet OMD criteria to a state hospital for treatment as a special condition of parole. After a parolee is discharged from CDCR to DSH, the individual is civilly committed as an OMD for involuntary treatment.

CALIFORNIA DEPARTMENT OF STATE HOSPITALS

REPORT ON STATE HOSPITAL FINANCIAL ACTIVITY

California Department of State Hospitals

FISCAL YEAR 2019-20

January 10, 2020






DIRECTOR
Stephanie Clendenin

Department of State Hospitals

Report on State Hospital Financial Activity: FY 2019-20

EXECUTIVE SUMMARY

Pursuant to the Fiscal Year (FY) 2019-20 Budget, 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 2019 Budget Act which requires DSH to provide a year-end summary and an operating budget for each state hospital with the FY 2020-21 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 2018-19 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

THE 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, 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. Additionally, DSH provides services in jail-based competency treatment (JBCT) programs and conditional release (CONREP) programs throughout the 58 counties. In FY 2018-19, DSH served 11,752 patients within state hospitals and jail-based facilities, with average daily censuses of 6,122 and 290 respectively. The CONREP program maintains an average daily census of approximately 661.

SUMMARY OF AUTHORIZED AND VACANT POSITIONS

Department of State Hospitals

Report on State Hospital Financial Activity: FY 2019-20

The following table provides a summary of the authorized and vacant positions for the state hospital system as of November 1, 2019.

State Hospital	Authorized Positions[1]	Vacant as of 11/1/19	Percent Vacant
Atascadero	2,225.3	379.9	17.1%
Coalinga	2,352.0	261.0	11.1%
Metropolitan	2,233.8	597.7	26.8%
Napa	2,524.4	282.5	11.2%
Patton	2,509.3	244.8	9.8%
Totals	**11,844.8**	**1,765.9**	**14.9%**

[1]Includes authorized Temporary Help per the Schedule 7A.

AUTHORIZED VERSUS VACANT POSITIONS BY CLASSIFICATION

As of November 1, 2019, DSH's vacancy rate is 14.9 percent. Item 4440-011-0001, Provision 9 requires DSH to provide the number of authorized and vacant classifications, including psychiatric technicians, nurses, physicians, psychiatrists, social workers, and rehabilitation therapists. The following table provides a summary of the authorized and vacant positions for those classifications.

		Atascadero		Coalinga		Metropolitan		Napa		Patton	
Class Title	Class Code	Authorized	Vacant	Authorized	Vacant	Authorized	Vacant	Authorized	Vacant	Authorized	Vacant
Staff Psychiatrist	7619	24.3	13.3	21.6	3.6	50.8	18.8	53.4	10.4	66.5	20.8
Psychologist	9873	51.7	12.7	38.5	14.5	46.8	17.8	47.4	1.0	59.3	18.7
Senior Psychiatric Technician	8252	103.2	25.2	88.0	0.0	82.3	31.3	84.0	9.0	83.0	0.0
Rehabilitation Therapist	Various	55.0	7.0	46.5	8.5	56.5	16.0	59.1	2.0	69.1	3.1
Registered Nurse	8094	247.8	52.8	232.0	10.8	304.6	108.2	420.2	25.8	362.1	26.1
Clinical Social Worker	9872	45.1	4.1	45.1	6.1	58.8	14.8	52.2	0.2	69.0	1.0
Psychiatric Technician	8253	617.8	85.8	692.5	54.4	488.2	161.2	458.5	74.2	688.6	45.6
Physician/Surgeon	7552	16.0	3.0	12.4	4.4	25.1	3.1	22.5	0.0	26.0	4.3

TEMPORARY HELP BLANKET POSITIONS

Temporary help blanket positions are temporary help positions 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, 2019. 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

DSH recently transitioned to FI$Cal for budgeting functions and restructured its programmatic structure to individually break out each hospital's budget. FY 2018-19 was the first budget-year developed in FI$Cal with the new program structure. The department, along with the Department of Finance, focused on the establishment of accurate budgets for each hospital at the item/program level that appears in the 2018 Budget Act, but did not further break those amounts down into the various line items in which the expenditures were projected to occur. As a result, the final FY 2018-19 allocations to each hospital in Hyperion, while correct in total (at the item/program level), do not exactly match each hospital's internal operating budget by line item. Beginning in FY 2019-20, DSH will update its budget in Hyperion each year to match the budget line items with planned 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 2018-19. For FY 2019-20 and FY 2020-21, 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.

Department of State Hospitals

Report on State Hospital Financial Activity: FY 2019-20

Exhibit I—All Hospitals

Category2	FI$Cal Category	2018-19 Budget	2018-19 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$847,275,000	$735,724,000
	5100150-Earnings - Temporary Civil Service Employees	$25,094,000	$35,081,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$105,182,000	$124,574,000
Salaries and Wages Total		**$977,551,000**	**$895,379,000**
Staff Benefits	5150150-Dental Insurance	$0	$1,214,000
	5150200-Disability Leave - Industrial	$8,845,000	$225,000
	5150210-Disability Leave - Nonindustrial	$3,077,000	$295,000
	5150350-Health Insurance	$0	$21,539,000
	5150400-Life Insurance	$0	$61,000
	5150450-Medicare Taxation	$0	$12,855,000
	5150500-OASDI	$8,289,000	$7,787,000
	5150600-Retirement - General	$163,606,000	$186,326,000
	5150620-Retirement - Public Employees - Safety	$0	$0
	5150630-Retirement - Public Employees - Miscellaneous	$0	$0
	5150700-Unemployment Insurance	$681,000	$792,000
	5150750-Vision Care	$0	$229,000
	5150800-Workers' Compensation	$32,077,000	$45,028,000
	5150820-Other Post-Employment Benefits (OPEB) Employer Contributions	$0	$0
	5150900-Staff Benefits - Other	$139,884,000	$143,739,000
Staff Benefits Total		**$356,459,000**	**$420,090,000**
Operating Expenses and Equipment	5301400-Goods - Other	$9,031,000	$3,962,000
	5302900-Printing - Other	$960,000	$1,109,000
	5304800-Communications - Other	$2,872,000	$2,614,000
	5306700-Postage - Other	$0	$186,000
	5308900-Insurance - Other	$881,000	$975,000
	5320490-Travel - In State - Other	$1,596,000	$1,264,000
	5322400-Training - Tuition and Registration	$698,000	$854,000
	5324350-Rents and Leases	$14,165,000	$29,504,000
	5324550-Special Repairs and Deferred Maintenance	$11,597,000	$0
	5326900-Utilities - Other	$13,307,000	$17,986,000
	5340330-Consulting and Professional Services - Interdepartmental - Other	$2,906,000	$4,697,000
	5340580-Consulting and Professional Services - External - Other	$1,060,000	$66,792,000
	5342600-Departmental Services - Other	$0	$50,000
	5344000-Consolidated Data Centers	$0	$94,000
	5346900-Information Technology - Other	$0	$73,000
	5368115-Office Equipment	$14,011,000	$8,263,000
	5390900-Other Items of Expense - Miscellaneous	$116,592,000	$78,364,000
	5395000-Unallocated Operating Expense and Equipment	$18,339,000	$0
	5415000-Claims Against the State	$0	$9,000
	5490000-Other Special Items of Expense	$0	$2,892,000
Operating Expenses and Equipment Total		**$208,015,000**	**$219,688,000**
Total		**$1,542,025,000**	**$1,535,157,000**

Department of State Hospitals

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Exhibit I—Atascadero State Hospital

Category2	FI$Cal Category	2018-19 Budget	2018-19 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$144,554,000	$132,969,000
	5100150-Earnings - Temporary Civil Service Employees	$6,625,000	$8,474,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$16,218,000	$14,891,000
Salaries and Wages Total		**$167,397,000**	**$156,334,000**
Staff Benefits	5150150-Dental Insurance	$0	$174,000
	5150200-Disability Leave - Industrial	$1,584,000	$33,000
	5150210-Disability Leave - Nonindustrial	$718,000	$77,000
	5150350-Health Insurance	$0	$3,530,000
	5150400-Life Insurance	$0	$12,000
	5150450-Medicare Taxation	$0	$2,260,000
	5150500-OASDI	$1,738,000	$1,357,000
	5150600-Retirement - General	$34,043,000	$34,229,000
	5150620-Retirement - Public Employees - Safety	$0	$0
	5150630-Retirement - Public Employees - Miscellaneous	$0	$0
	5150700-Unemployment Insurance	$99,000	$112,000
	5150750-Vision Care	$0	$39,000
	5150800-Workers' Compensation	$8,813,000	$11,061,000
	5150820-Other Post-Employment Benefits (OPEB) Employer Contributions	$0	$0
	5150900-Staff Benefits - Other	$27,084,000	$25,653,000
Staff Benefits Total		**$74,079,000**	**$78,537,000**
Operating Expenses and Equipment	5301400-Goods - Other	$1,451,000	$543,000
	5302900-Printing - Other	$101,000	$115,000
	5304800-Communications - Other	$311,000	$425,000
	5306700-Postage - Other	$0	$30,000
	5308900-Insurance - Other	$11,000	$12,000
	5320490-Travel - In State - Other	$459,000	$433,000
	5322400-Training - Tuition and Registration	$132,000	$229,000
	5324350-Rents and Leases	$2,242,000	$10,098,000
	5324550-Special Repairs and Deferred Maintenance	$7,897,000	$0
	5326900-Utilities - Other	$2,533,000	$2,866,000
	5340330-Consulting and Professional Services - Interdepartmental - Other	$576,000	$766,000
	5340580-Consulting and Professional Services - External - Other	$291,000	$15,946,000
	5342600-Departmental Services - Other	$0	$23,000
	5344000-Consolidated Data Centers	$0	$27,000
	5346900-Information Technology - Other	$0	$18,000
	5368115-Office Equipment	$2,007,000	$1,366,000
	5390900-Other Items of Expense - Miscellaneous	$23,431,000	$10,574,000
	5395000-Unallocated Operating Expense and Equipment	$18,339,000	$0
	5415000-Claims Against the State	$0	$1,000
	5490000-Other Special Items of Expense	$0	$10,000
Operating Expenses and Equipment Total		**$59,781,000**	**$43,482,000**
Total		**$301,257,000**	**$278,353,000**

Department of State Hospitals

Report on State Hospital Financial Activity: FY 2019-20

Exhibit I—Coalinga State Hospital

Category2	FI$Cal Category	2018-19 Budget	2018-19 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$151,995,000	$147,785,000
	5100150-Earnings - Temporary Civil Service Employees	$731,000	$447,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$22,673,000	$21,310,000
Salaries and Wages Total		**$175,399,000**	**$169,542,000**
Staff Benefits	5150150-Dental Insurance	$0	$216,000
	5150200-Disability Leave - Industrial	$1,260,000	$25,000
	5150210-Disability Leave - Nonindustrial	$823,000	$52,000
	5150350-Health Insurance	$0	$3,825,000
	5150400-Life Insurance	$0	$13,000
	5150450-Medicare Taxation	$0	$2,425,000
	5150500-OASDI	$1,837,000	$1,662,000
	5150600-Retirement - General	$36,040,000	$37,754,000
	5150620-Retirement - Public Employees - Safety	$0	$0
	5150630-Retirement - Public Employees - Miscellaneous	$0	$0
	5150700-Unemployment Insurance	$236,000	$313,000
	5150750-Vision Care	$0	$43,000
	5150800-Workers' Compensation	$4,945,000	$5,030,000
	5150820-Other Post-Employment Benefits (OPEB) Employer Contributions	$0	$0
	5150900-Staff Benefits - Other	$29,339,000	$28,286,000
Staff Benefits Total		**$74,480,000**	**$79,644,000**
Operating Expenses and Equipment	5301400-Goods - Other	$1,620,000	$556,000
	5302900-Printing - Other	$126,000	$159,000
	5304800-Communications - Other	$943,000	$661,000
	5306700-Postage - Other	$0	$26,000
	5308900-Insurance - Other	$124,000	$138,000
	5320490-Travel - In State - Other	$574,000	$358,000
	5322400-Training - Tuition and Registration	$90,000	$103,000
	5324350-Rents and Leases	$2,299,000	$1,947,000
	5324550-Special Repairs and Deferred Maintenance	$1,050,000	$0
	5326900-Utilities - Other	$3,338,000	$3,698,000
	5340330-Consulting and Professional Services - Interdepartmental - Other	$642,000	$806,000
	5340580-Consulting and Professional Services - External - Other	$242,000	$24,402,000
	5342600-Departmental Services - Other	$0	$4,000
	5344000-Consolidated Data Centers	$0	$5,000
	5346900-Information Technology - Other	$0	$23,000
	5368115-Office Equipment	$2,201,000	$780,000
	5390900-Other Items of Expense - Miscellaneous	$32,024,000	$15,356,000
Operating Expenses and Equipment Total		**$45,273,000**	**$49,022,000**
Total		**$295,152,000**	**$298,208,000**

Department of State Hospitals

Report on State Hospital Financial Activity: FY 2019-20

Exhibit I—Metropolitan State Hospital

Category2	FI$Cal Category	2018-19 Budget	2018-19 Expenditures
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$164,051,000	$114,146,000
	5100150-Earnings - Temporary Civil Service Employees	$2,876,000	$6,153,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$11,157,000	$17,876,000
Salaries and Wages Total		**$178,084,000**	**$138,175,000**
Staff Benefits	5150150-Dental Insurance	$0	$252,000
	5150200-Disability Leave - Industrial	$717,000	$12,000
	5150210-Disability Leave - Nonindustrial	$250,000	$53,000
	5150350-Health Insurance	$0	$4,088,000
	5150400-Life Insurance	$0	$10,000
	5150450-Medicare Taxation	$0	$1,952,000
	5150500-OASDI	$1,196,000	$1,472,000
	5150600-Retirement - General	$21,700,000	$29,003,000
	5150620-Retirement - Public Employees - Safety	$0	$0
	5150630-Retirement - Public Employees - Miscellaneous	$0	$0
	5150700-Unemployment Insurance	$48,000	$44,000
	5150750-Vision Care	$0	$42,000
	5150800-Workers' Compensation	$5,486,000	$6,807,000
	5150820-Other Post-Employment Benefits (OPEB) Employer Contributions	$0	$0
	5150900-Staff Benefits - Other	$16,814,000	$20,280,000
Staff Benefits Total		**$46,211,000**	**$64,015,000**
Operating Expenses and Equipment	5301400-Goods - Other	$2,048,000	$887,000
	5302900-Printing - Other	$77,000	$127,000
	5304800-Communications - Other	$481,000	$187,000
	5306700-Postage - Other	$0	$33,000
	5308900-Insurance - Other	$188,000	$240,000
	5320490-Travel - In State - Other	$260,000	$136,000
	5322400-Training - Tuition and Registration	$82,000	$134,000
	5324350-Rents and Leases	$4,757,000	$1,647,000
	5324550-Special Repairs and Deferred Maintenance	$697,000	$0
	5326900-Utilities - Other	$1,403,000	$2,903,000
	5340330-Consulting and Professional Services - Interdepartmental - Other	$310,000	$547,000
	5340580-Consulting and Professional Services - External - Other	$75,000	$3,920,000
	5342600-Departmental Services - Other	$0	$23,000
	5344000-Consolidated Data Centers	$0	$10,000
	5346900-Information Technology - Other	$0	$0
	5368115-Office Equipment	$542,000	$1,487,000
	5390900-Other Items of Expense - Miscellaneous	$12,224,000	$11,130,000
	5415000-Claims Against the State	$0	$6,000
	5490000-Other Special Items of Expense	$0	$308,000
Operating Expenses and Equipment Total		**$23,144,000**	**$23,725,000**
Total		**$247,439,000**	**$225,915,000**

Department of State Hospitals

Report on State Hospital Financial Activity: FY 2019-20

Exhibit I—Napa State Hospital

Category2	FI$Cal Category	2018-19 Budget	2018-19 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$188,578,000	$166,358,000
	5100150-Earnings - Temporary Civil Service Employees	$7,965,000	$5,962,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$25,173,000	$32,697,000
Salaries and Wages Total		**$221,716,000**	**$205,017,000**
Staff Benefits	5150150-Dental Insurance	$0	$325,000
	5150200-Disability Leave - Industrial	$2,408,000	$110,000
	5150210-Disability Leave - Nonindustrial	$449,000	$26,000
	5150350-Health Insurance	$0	$5,652,000
	5150400-Life Insurance	$0	$13,000
	5150450-Medicare Taxation	$0	$2,991,000
	5150500-OASDI	$1,693,000	$1,722,000
	5150600-Retirement - General	$32,894,000	$42,300,000
	5150620-Retirement - Public Employees - Safety	$0	$0
	5150700-Unemployment Insurance	$155,000	$237,000
	5150750-Vision Care	$0	$56,000
	5150800-Workers' Compensation	$5,239,000	$11,398,000
	5150820-Other Post-Employment Benefits (OPEB) Employer Contributions	$0	$0
	5150900-Staff Benefits - Other	$33,850,000	$35,552,000
Staff Benefits Total		**$76,688,000**	**$100,382,000**
Operating Expenses and Equipment	5301400-Goods - Other	$3,129,000	$1,248,000
	5302900-Printing - Other	$430,000	$430,000
	5304800-Communications - Other	$820,000	$784,000
	5306700-Postage - Other	$0	$42,000
	5308900-Insurance - Other	$493,000	$536,000
	5320490-Travel - In State - Other	$147,000	$152,000
	5322400-Training - Tuition and Registration	$257,000	$210,000
	5324350-Rents and Leases	$2,470,000	$12,807,000
	5324550-Special Repairs and Deferred Maintenance	$831,000	$0
	5326900-Utilities - Other	$3,642,000	$5,175,000
	5340330-Consulting and Professional Services - Interdepartmental - Other	$859,000	$1,711,000
	5340580-Consulting and Professional Services - External - Other	$286,000	$9,338,000
	5344000-Consolidated Data Centers	$0	$36,000
	5346900-Information Technology - Other	$0	$32,000
	5368115-Office Equipment	$2,195,000	$2,864,000
	5390900-Other Items of Expense - Miscellaneous	$23,620,000	$19,899,000
	5415000-Claims Against the State	$0	$1,000
	5490000-Other Special Items of Expense	$0	$1,001,000
Operating Expenses and Equipment Total		**$39,179,000**	**$56,266,000**
Total		**$337,583,000**	**$361,665,000**

Department of State Hospitals

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Exhibit I—Patton State Hospital

Category2	FI$Cal Category	2018-19 Budget	2018-19 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$198,097,000	$174,466,000
	5100150-Earnings - Temporary Civil Service Employees	$6,897,000	$14,045,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$29,961,000	$37,800,000
Salaries and Wages Total		**$234,955,000**	**$226,311,000**
Staff Benefits	5150150-Dental Insurance	$0	$247,000
	5150200-Disability Leave - Industrial	$2,876,000	$45,000
	5150210-Disability Leave - Nonindustrial	$837,000	$87,000
	5150350-Health Insurance	$0	$4,444,000
	5150400-Life Insurance	$0	$13,000
	5150450-Medicare Taxation	$0	$3,227,000
	5150500-OASDI	$1,825,000	$1,574,000
	5150600-Retirement - General	$38,929,000	$43,040,000
	5150620-Retirement - Public Employees - Safety	$0	$0
	5150630-Retirement - Public Employees - Miscellaneous	$0	$0
	5150700-Unemployment Insurance	$143,000	$86,000
	5150750-Vision Care	$0	$49,000
	5150800-Workers' Compensation	$7,594,000	$10,732,000
	5150820-Other Post-Employment Benefits (OPEB) Employer Contributions	$0	$0
	5150900-Staff Benefits - Other	$32,797,000	$33,968,000
Staff Benefits Total		**$85,001,000**	**$97,512,000**
Operating Expenses and Equipment	5301400-Goods - Other	$783,000	$728,000
	5302900-Printing - Other	$226,000	$278,000
	5304800-Communications - Other	$317,000	$557,000
	5306700-Postage - Other	$0	$55,000
	5308900-Insurance - Other	$65,000	$49,000
	5320490-Travel - In State - Other	$156,000	$185,000
	5322400-Training - Tuition and Registration	$137,000	$178,000
	5324350-Rents and Leases	$2,397,000	$3,005,000
	5324550-Special Repairs and Deferred Maintenance	$1,122,000	$0
	5326900-Utilities - Other	$2,391,000	$3,344,000
	5340330-Consulting and Professional Services - Interdepartmental - Other	$519,000	$867,000
	5340580-Consulting and Professional Services - External - Other	$166,000	$13,186,000
	5344000-Consolidated Data Centers	$0	$16,000
	5346900-Information Technology - Other	$0	$0
	5368115-Office Equipment	$7,066,000	$1,766,000
	5390900-Other Items of Expense - Miscellaneous	$25,293,000	$21,405,000
	5415000-Claims Against the State	$0	$1,000
	5490000-Other Special Items of Expense	$0	$1,573,000
Operating Expenses and Equipment Total		**$40,638,000**	**$47,193,000**
Total		**$360,594,000**	**$371,016,000**

Department of State Hospitals

Report on State Hospital Financial Activity: FY 2019-20

Exhibit II—All Hospitals

Hospital	2019-20 Budget	2019-20 Projected Expenditure	2020-21 Budget	2020-21 Projected Expenditure
4410010-Atascadero	$294,331,000	$291,388,000	$309,445,000	$306,351,000
4410020-Coalinga	$312,638,000	$309,512,000	$325,275,000	$322,022,000
4410030-Metropolitan	$316,215,000	$313,053,000	$337,641,000	$334,265,000
4410040-Napa	$360,116,000	$356,515,000	$378,003,000	$374,223,000
4410050-Patton	$383,919,000	$380,080,000	$404,627,000	$400,581,000
Grand Total	**$1,667,219,000**	**$1,650,547,000**	**$1,754,991,000**	**$1,737,441,000**