Department of State Hospitals

2022-23

Governor's Budget
Proposals and Estimates

Submitted to:
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Department of State Hospitals
2022-23 Governor's Budget
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DEPARTMENT OF STATE HOSPITALS
PROGRAM OVERVIEW
Informational Only

BACKGROUND

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

DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton) and employs nearly 13,000 staff. In addition to state hospital treatment, DSH provides services in contracted jail-based competency treatment (JBCT), community-based restoration (CBR) and pre-trial felony mental health diversion programs, and the conditional release program (CONREP). DSH is responsible for the daily care to over 7,000 patients, and in FY 2020-21, DSH served 7,813 across the state hospitals, 2,403 in JBCT and CBR contracted programs and 841 in CONREP programs. In addition, as of December 31, 2020, a total of 276 individuals were diverted into county programs funded by DSH.

With nearly 13,000 employees located across its Sacramento headquarters and five state hospitals 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 Lanterman-Petris-Short (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.

STATE HOSPITALS

DSH-Atascadero

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

DSH-Coalinga

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

DSH-Metropolitan

Opened in 1916, DSH-Metropolitan is located in Norwalk (Los Angeles County). The hospital is an "open" style campus within a security perimeter. Due to concerns raised by the community, DSH-Metropolitan maintains a formal agreement with the City of Norwalk and the Los Angeles County Sheriff not to accept patients charged with murder or a sex crime, or at high risk for escape. This agreement has limited the total number of patients that DSH-Metropolitan can treat below the licensed bed capacity. Until 2019, DSH-Metropolitan's operational bed capacity was restricted due to multiple units that were located outside of the hospital's secured treatment area (STA). The units outside of the STA were unable to house forensic patients. To provide additional capacity to serve forensic patients, a secured fence surrounding the housing units located next to the existing secure treatment area. To provide additional capacity to address an ongoing system-wide forensic waitlist, the 2016 Budget Act included the capital outlay construction funding for the Increased

Secure Bed Capacity project, which is now complete. DSH-Metropolitan primarily serves the following four patient commitment types: LPS, IST, OMD and NGI.

DSH-Napa

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

DSH-Patton

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

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

DEPARTMENT OF STATE HOSPITALS
FUNCTIONAL VACANCY DISPLAY
Informational Only

BACKGROUND

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

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

- Departmental Regular/Ongoing Authorized Positions ties to the 4440-fiscal year (FY) 2021-22 Schedule 7A, 2020-21 Authorized Positions
- Temporary Help includes employees working second positions, retired annuitants, limited term, and permanent intermittent
- Total Authorized Positions contain specific classifications, and the totals tie to the Schedule 7A
- Contracted Full-Time Equivalent (FTE) and Overtime FTE contain FTE positions which have been converted from contract hours and overtime hours
- Total Filled FTE is the grand total of Total Filled Civil Service Positions, Temp Help Filled, Contracted FTE, and Overtime FTE
- Functional Vacancy FTE is the calculated difference between Total Filled Civil Service Positions and Total Filled FTE
- Functional Vacancy Rate is calculated by dividing Functional Vacancy FTE by Total Authorized Positions

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

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

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

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

Department of State Hospitals	Hospital Position Report Average of FY 20-21									
Classifications	**Departmental Regular/Ongoing Authorized Positions (1)**	**Temporary Help**	**Total Authorized Positions**	**Total Filled Civil Service Positions (1)**	**Temp Help Filled**	**Contracted FTE**	**Overtime FTE (2)**	**Total Filled FTE**	**Functional Vacancy FTE (3)**	**Functional Vacancy Rate**
Clinical Services -Treatment Team and Primary Care										
Social Worker (9872, 9874)	270.9	0.0	270.9	242.1	3.2	1.2	0.3	246.8	24.1	8.9%
Rehab Therapist - Safety (8321, 8323, 8324, 8420, 8422)	277.6	0.0	277.6	249.9	1.1	0.0	6.8	257.8	24.3	8.8%
Psychologist-Clinical-Safety (9873)	231.3	0.0	231.3	192.5	4.7	6.9	0.0	204.1	27.9	12.1%
Staff Psychiatrist-Safety (7619)	236.7	0.0	236.7	128.3	4.6	55.0	0.0	187.9	62.6	26.4%
Nurse Practitioner-Safety (9700)	43.0	0.0	43.0	33.9	0.6	0.0	0.3	34.8	8.2	19.1%
Physician & Surgeon-Safety (7552)	104.9	0.0	104.9	89.9	2.4	6.3	0.0	98.6	8.9	8.5%
Total: Clinical Services - Treatment Team and Primary Care	**1,164.4**	**0.0**	**1,164.4**	**936.6**	**16.6**	**69.4**	**7.4**	**1,030.0**	**156.0**	**13.4%**
Clinical Services - Nursing										

Psychiatric Technician (8236, 8253, 8254, 8274)	3,425.3	137.6	3,562.9	2,921.7	244.5	3.6	585.6	3,755.4	75.9	2.1%
Registered Nurse-Safety (8094)	1,568.4	115.2	1,683.6	1,354.2	73.7	2.8	273.4	1,704.1	91.1	5.4%
Senior Psych Tech-Safety (8252)	368.6	1.3	369.9	368.2	3.3	0.0	91.8	463.3	0.0	0.0%
Total: Clinical Services - Nursing	**5,362.3**	**254.1**	**5,616.4**	**4,644.1**	**321.5**	**6.4**	**950.8**	**5,922.8**	**167.0**	**3.0%**
Protective Services										
Hosp Police Lieut (1935)	26.4	0.0	26.4	24.0	2.0	0.0	6.4	32.4	0.0	0.0%
Hosp Police Sgt (1936)	100.6	0.0	100.6	77.8	2.0	0.0	15.5	95.3	10.5	10.4%
Hosp Police Ofcr (1937)	692.0	0.0	692.0	589.2	33.9	0.0	119.0	742.1	12.7	1.8%
Total: Protective Services	**819.0**	**0.0**	**819.0**	**691.0**	**37.9**	**0.0**	**140.9**	**869.8**	**23.2**	**2.8%**

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

STATE HOSPITALS POPULATION

	2021-22 May Revision Projection	CURRENT YEAR 2021-22				
	June 30, 2021 Projected Census	July 1, 2021 Actual Census[1]	Previously Approved Adjustments CY 2021-22	2022-23 November Adjustment CY 2021-22	2022-23 May Revision Adjustment CY 2021-22	June 30, 2022 Projected Census
POPULATION BY HOSPITAL						
ATASCADERO	*1,040*	987	13	0	0	1,000
COALINGA	*1,365*	1,311	0	0	0	1,311
METROPOLITAN	*797*	808	0	0	0	808
NAPA	*1,090*	1,122	0	0	0	1,122
PATTON	*1,445*	1,349	0	0	0	1,349
TOTAL BY HOSPITAL	***5,737***	**5,577**	**13**	**0**	**0**	**5,590**
POPULATION BY COMMITMENT						
Coleman - PC 2684[2]	*280*	169	0	0	0	169
IST - PC 1370	*1,029*	1,193	4	0	0	1,197
LPS & PC 2974	*775*	801	0	0	0	801
OMD[3] - PC 2962	*549*	414	3	0	0	417
OMD[3] - PC 2972	*752*	729	3	0	0	732
NGI - PC 1026	*1,410*	1,340	3	0	0	1,343
SVP - WIC 6602/6604	*942*	931	0	0	0	931
TOTAL BY COMMITMENT	***5,737***	**5,577**	**13**	**0**	**0**	**5,590**
CONTRACTED PROGRAMS						
AES KERN CENTER	*60*	58	2	0	0	60
STATEWIDE/REGIONAL JBCT	*237*	219	58	0	0	277
SINGLE COUNTY JBCT	*138*	142	93	0	0	235
SMALL COUNTY MODEL JBCT: MARIPOSA[4]	*N/A*	N/A	N/A	N/A	N/A	N/A
LOS ANGELES CBR	*415*	415	100	0	0	515
OTHER COUNTIES CBR	*0*	0	54	0	0	54
TOTAL - CONTRACTED PROGRAMS	***850***	**834**	**307**	**0**	**0**	**1,141**
POPULATION AND CONTRACTED TOTAL	***6,587***	**6,411**	**320**	**0**	**0**	**6,731**

Note: DSH contracts with community based programs to provide conditional release services. These services are provided through the Conditional Release Program, which operates an average of 650 beds.

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

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

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

[3] 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).

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

STATE HOSPITALS POPULATION

	2021-22 May Revision Projection	BUDGET YEAR 2022-23				
	June 30, 2022 Projected Census	July 1, 2022 Projected Census	Previously Approved Adjustments BY 2022-23	2022-23 November Adjustment BY 2022-23	2022-23 May Revision Adjustment BY 2022-23	June 30, 2023 Projected Census
POPULATION BY HOSPITAL						
ATASCADERO	*1,066*	1,000	0	0	0	1,000
COALINGA	*1,365*	1,311	0	0	0	1,311
METROPOLITAN	*937*	808	140	0	0	948
NAPA	*1,090*	1,122	0	0	0	1,122
PATTON	*1,455*	1,349	10	0	0	1,359
TOTAL BY HOSPITAL	***5,913***	**5,590**	**150**	**0**	**0**	**5,740**
POPULATION BY COMMITMENT						
Coleman - PC 2684[2]	*280*	169	0	0	0	169
IST - PC 1370	*1,433*	1,197	144	0	0	1,341
LPS & PC 2974	*523*	801	0	0	0	801
OMD[3] - PC 2962	*558*	417	3	0	0	420
OMD[3] - PC 2972	*758*	732	3	0	0	735
NGI - PC 1026	*1,419*	1,343	0	0	0	1,343
SVP - WIC 6602/6604	*942*	931	0	0	0	931
TOTAL BY COMMITMENT	***5,913***	**5,590**	**150**	**0**	**0**	**5,740**
CONTRACTED PROGRAMS						
AES KERN CENTER	*90*	60	30	0	0	90
REGIONAL JBCT	*257*	277	0	3	0	280
SINGLE COUNTY JBCT	*260*	235	5	54	0	294
SMALL COUNTY MODEL JBCT: MARIPOSA[4]	*N/A*	N/A	N/A	N/A	N/A	N/A
LOS ANGELES CBR	*515*	515	0	0	0	515
OTHER COUNTIES CBR	*54*	54	168	0	0	222
TOTAL - CONTRACTED PROGRAMS	***1,176***	**1,141**	**203**	**57**	**0**	**1,401**
POPULATION AND CONTRACTED TOTAL	***7,089***	**6,731**	**353**	**57**	**0**	**7,141**

Note: DSH contracts with community based programs to provide conditional release services. These services are provided through the Conditional Release Program, which operates an average of 650 beds.

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

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

[3] 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).

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

POPULATION DATA
STATE HOSPITALS
POPULATION AND PERSONAL SERVICES ADJUSTMENTS
Informational Only

COVID-19 IMPACT ON CENSUS AND REFERRALS

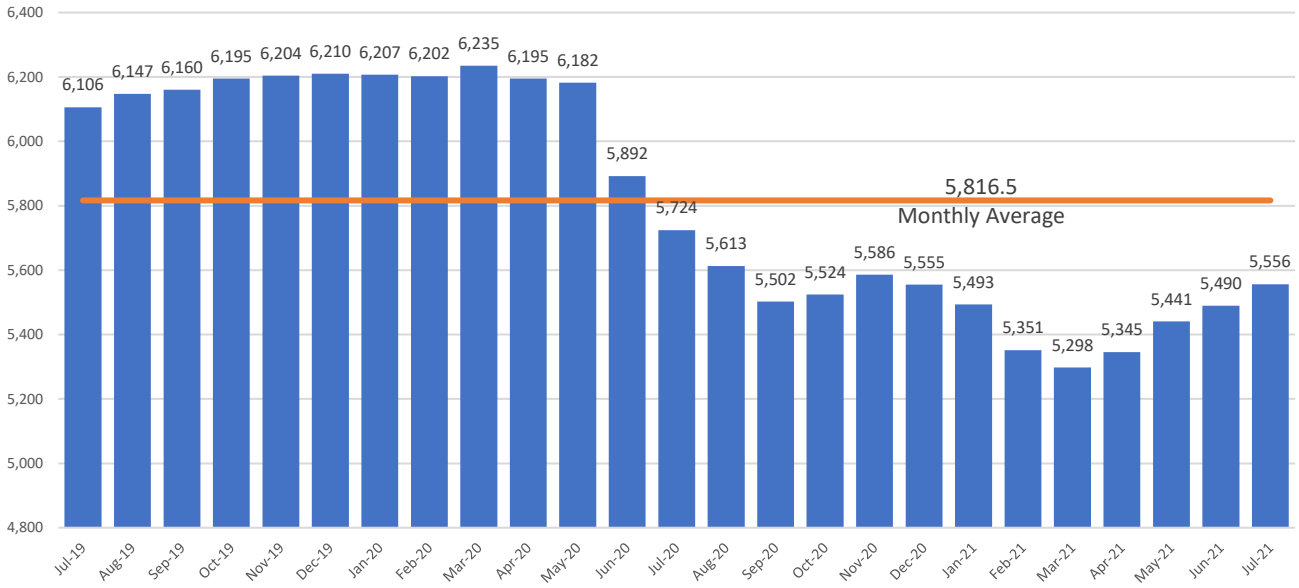
Temporary Census Reduction due to COVID-19

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

As DSH resumed admissions at the end of May 2020, in order to maintain the safety of patients and staff, it created Admission Observation Units (AOUs) to safely admit new patients and isolation units to mitigate the impacts of COVID-19 outbreaks. To establish these units, hospitals reduced census to empty occupied housing units and convert them to AOUs and Isolation units. This not only reduced DSH's overall inpatient census but also slowed admission rates. Housing units that normally served multiple patients in dorm rooms, when converted to AOU's, housed individual patients in each of the dorm rooms for an observation period of 10 days while DSH tested the admission cohort of patients to ensure they do not have COVID-19. After the admission observation and testing period the patients were transferred to their treatment unit. Further testing and quarantine procedures were observed when positive COVID-19 cases were identified in an admission cohort or when hospitals experienced an outbreak.

Due to the need to create AOUs and isolation units and other impacts of COVID-19 on admissions, DSH's census reduced by approximately 11 percent from 6,235 on March 1, 2020 to 5,556 on July 1, 2021. This census reduction caused DSH's occupancy rates to decrease down to 90 percent from the pre-COVID-19 occupancy rate of 96 percent. DSH anticipates this decrease to be temporary until AOUs and isolation units are no longer needed for COVID-19 response.

State Hospitals Monthly Census Trend: July 2019 – July 2021



Staffing Needs

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

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

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

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

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

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

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

Referral and Census Trends

Since the inception of COVID-19 and the implementation of the SIP order, followed by the implementation of a safe admission process into AOUs, the Incompetent to Stand Trial (IST) waitlist has increased by 90 percent to 1,649 as of August 30, 2021. Although DSH observed a 56 percent decrease in weekly IST referral rates associated with county court closures following the SIP order, the IST waitlist increased following DSH's temporary suspension of admissions. Similar referral trends were observed with the Lanterman–Petris–Short (LPS), Not Guilty by Reason of Insanity (NGI), OMD 2972, Sexually Violent Predator (SVP), and *Coleman* legal classes following the SIP order. Weekly referral rates decreased by the following rates: 23 percent for LPS population, 43 percent for the NGI population, 57 percent for the OMD 2972 population, 51 percent for the SVP population and 77 percent for the *Coleman* population. As county courts have begun resuming court proceedings, DSH's referral rates have steadily increased.

Pre and Post SIP Order Waitlist and Weekly Referral Averages*

CA Statewide Shelter-in-Place Order: **March 19, 2020**							
	IST	LPS	OMD 2962	OMD 2972	NGI	SVP	*Coleman*
Pre-SIP Waitlist: 3/16/2020	869	241	54	<11	24	0	<11
Post-SIP Waitlist: 5/25/2020	1144	196	97	11	38	<11	<11
Current Waitlist: 8/30/2021	1649	303	17	<11	14	12	<11
Pre-SIP Average Weekly Referrals (7/1/19 – 3/21/20)	78.5	<11	<11	<11	<11	<11	12.8
Post-SIP Average Weekly Referrals (3/22/20 – 5/30/20)	34.9	<11	11.7	<11	<11	<11	<11
% Change (Referrals):	*-56%*	*-23%*	*23%*	*-57%*	*-43%*	*-51%*	*-77%*
Current Average Weekly Referrals[1]	107.6	<11	<11	<11	<11	<11	<11

*Referral data excludes JBCT Transfers, State Hospital Transfers and Court Returns.
[1]Current average weekly referrals reflect most recent referral data from August 2021 through September 2021.

Prior to the onset of COVID-19 in March 2020, DSH's average monthly IST referrals were trending close to fiscal year (FY) 2018-19 averages and overall DSH referrals were almost one percent higher. Due to COVID-19, average monthly referrals have generally declined with an overall 11.8 percent decrease from FY 2018-19 to FY 2019-20, with *Coleman* being the only population to have an increase in average monthly referrals (+30.8%). As county courts have begun resuming court proceedings, IST referral rates have been steadily increasing in FY 2020-21, specifically in the second half of the FY with average monthly referral rates reaching 344.2 (+8.2% increase from prior year).

Average Monthly Referrals*

	FY 2018-19	**FY 2019-20** (Pre-COVID-19)[1]	**FY 2019-20** (Post-COVID-19)[2]	**FY 2019-20**	**FY 2020-21**	**% Change** FY 2019-20 to FY 2020-21
IST *(with JBCT/AES)*	372.0	367.5	219.3	318.1	315.3	-0.9%
LPS	15.8	<11	<11	<11	***	52.2%
OMD2962	46.4	40.6	46.5	42.6	25.8	-39.4%
OMD2972	<11	<11	<11	<11	<11	27.3%
NGI	11.3	11.8	<11	<11	<11	-32.8%
SVP	<11	<11	<11	<11	<11	117.8%
CDCR	35.3	56.1	26.3	46.2	15.8	-65.8%
	487.7	**490.3**	**310.8**	**430.3**	**384.6**	**-10.6%**

[1]FY 2019-20 pre-COVID-19 referral data reflects averages from July 2019 through February 2020.
[2]FY 2019-20 post-COVID-19 referral data reflects averages from March 2020 through June 2020.
Referral data excludes JBCT Transfers, State Hospital Transfers, Court Returns and includes CBR referrals/off-ramps.
DJJ census and referral data is not displayed to protect confidentiality of the individuals.

* Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or "less than 11" within the narrative. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

Patient Census*

	6/30/2019	2/29/2020 (Pre-COVID-19)	6/30/2020	6/30/2021	% Change 6/30/2020 to 6/30/2021
IST *(with JBCT/AES)*	1,811	1,894	1,324	1,603	21.07%
LPS	736	747	776	789	1.68%
OMD2962	559	508	533	415	-22.14%
OMD2972	778	760	748	716	-4.28%
NGI	1,416	1,415	1,407	1,338	-4.9%
SVP	962	943	942	939	-0.32%
CDCR	185	296	281	169	-39.86%
	6,447	**6,563**	**6,011**	**5,969**	**-0.70%**

*DJJ census and referral data is not displayed to protect confidentiality of the individuals.

POPULATION PROJECTIONS

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

Methodology

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

This methodology utilizes four main measures, as well as expected systemwide capacity expansions, to forecast the pending placement list. These measures include pending admissions, average referrals, average admissions and average length of stay (ALOS). A projected pending placement list is generated by adding a point-in-time pending placement list value to an average of monthly new patient referrals. This value is then reduced by the correlating average of monthly admissions, which are offset to incorporate any bed decreases. Expected

systemwide capacity increases, augmented by the appropriate ALOS, are then subtracted from the projected pending placement list to yield a modified pending placement list projection for future months.

The projected pending placement list for CY and BY is based on the modified pending placement list value calculated for June 30, 2022 and June 30, 2023. Variables are specific to patient legal class and are typically calculated using actual data for the most recent 12-month period. Variables had to be adjusted for the FY 2022-23 Governor's Budget Estimate to incorporate COVID-19-related circumstances for admissions and referrals.

To ensure that admission and referral variables reflect current conditions, pending placement projections are calculated based on the trends observed April 2021 through September 2021 for the IST, NGI, LPS and SVP populations. OMD variables continue to be based on the most recent 12-month period ending September 30, 2021 as OMD admissions were not suspended. As such, referral rates for this patient type were not impacted by court closures.

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, 2021 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, 2021. The projected census for June 30, 2022 (for CY) and June 30, 2023 (for BY) reflects the actual census as well as the approved and proposed census adjustments.

FY 2021-22 Census and Pending Placement List Projections

Legal Class	July 1, 2021 Actual Census	June 30, 2022 Projected Census	June 30, 2022 Projected Pending Placement List
IST[1] *(with JBCT/AES)*	1,612	1,769	1,921
LPS	801	801	356
OMD2962	414	417	29
OMD2972	729	732	6
NGI	1,340	1,343	8
SVP	931	931	13
Subtotal	*5,827*	*5,993*	*2,334*
Coleman[2]	169	169	-
Total	**5,996**	**6,162**	**2,334**

FY 2022-23 Census and Pending Placement List Projections

Legal Class	July 1, 2022 Projected Census	June 30, 2023 Projected Census	June 30, 2023 Projected Pending Placement List
IST[1] *(with JBCT/AES)*	1,769	2,005	1,049
LPS	801	801	424
OMD2962	417	420	32
OMD2972	732	735	8
NGI	1,343	1,343	7
SVP	931	931	9
Subtotal	*5,993*	*6,235*	*1,529*
Coleman[2]	169	169	-
Total	**6,162**	**6,404**	**1,529**

[1] Current and projected IST census does not include Community-Based Restoration Program patients being treated in a community mental health treatment setting.
[2] The projected pending place list is not calculated for the Coleman and DJJ populations within the DSH forecasting model. Projections for the Coleman population is developed by CDCR; the DJJ population is based on contracted beds agreed to between CDCR and DSH. DJJ census is not displayed to protect confidentiality of the individuals.

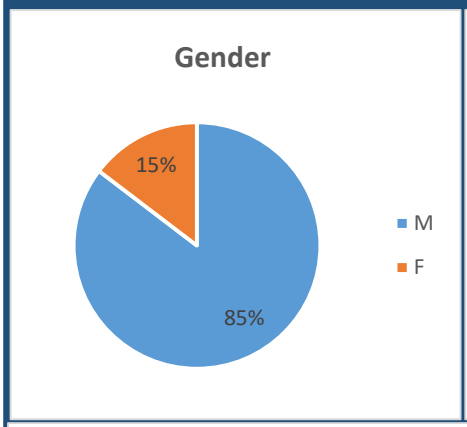
COMMITMENT CODES			
Legal Category	**Legal Class Text**	**Code Section**	**Description**
NGI	NGI PC1026	PC 1026	Not Guilty by Reason of Insanity
Other NGI*	RONGI, RO1026	PC 1610	Temporary Admission while waiting for Court Revocation of a PC 1026 (NGI)
Other NGI	MNGI	WIC 702.3	Minor Not Guilty by Reason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

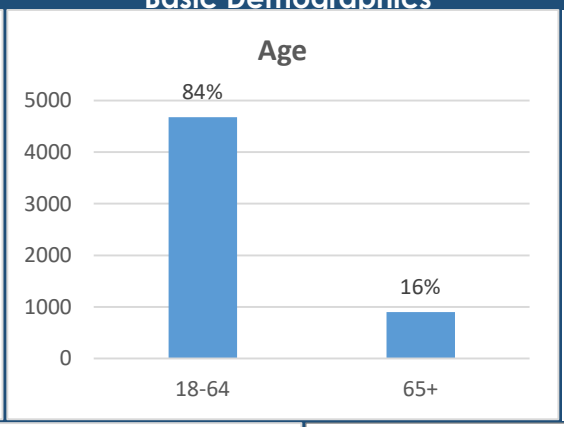
***** Items marked with an asterisk were previously captured in the "Other PC" category

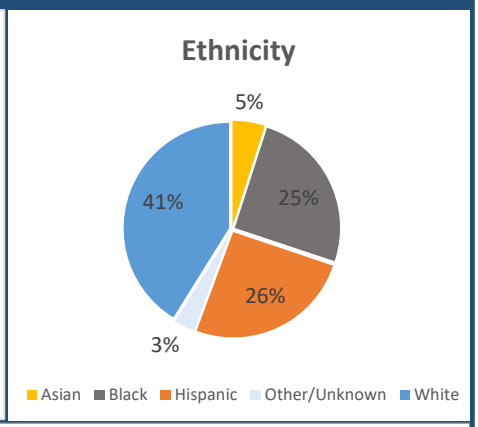
Demographic Snapshot: All Commitment Types

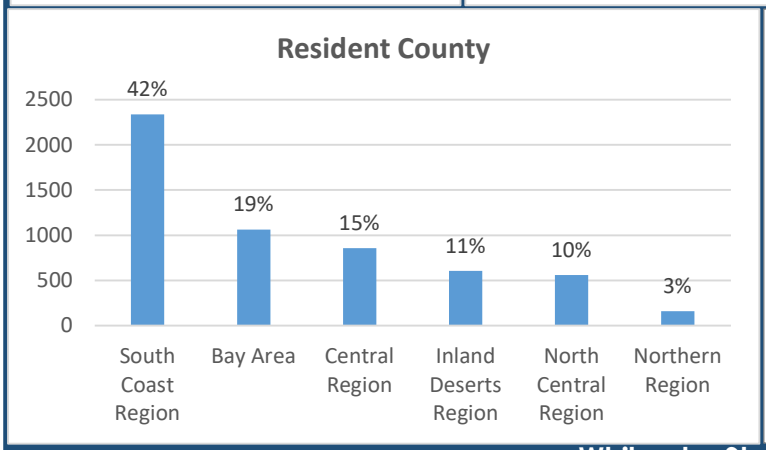
July 1, 2021; Census: 5,580

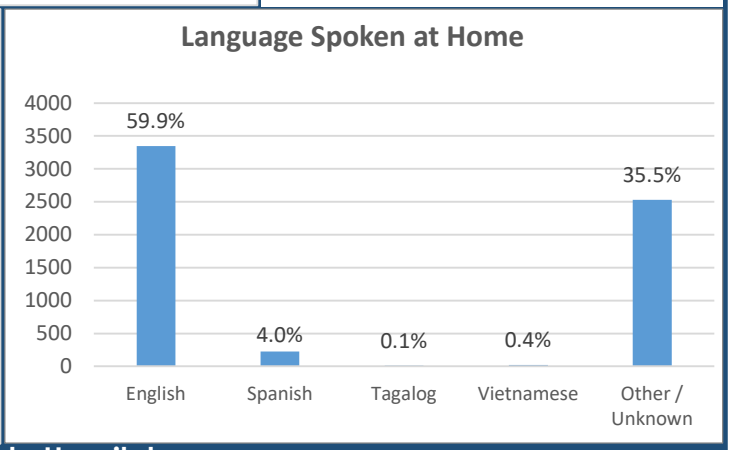
Basic Demographics



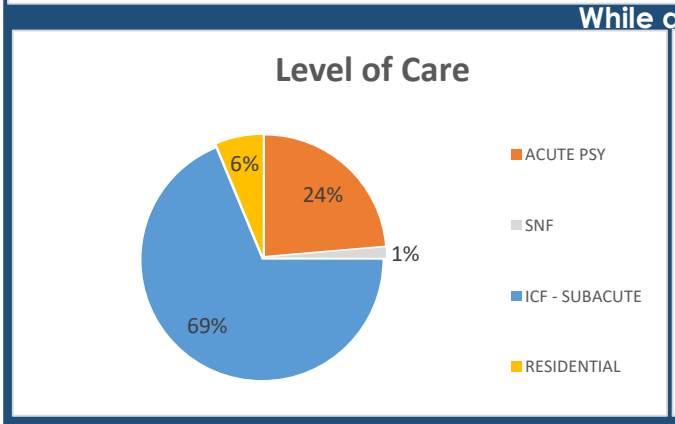


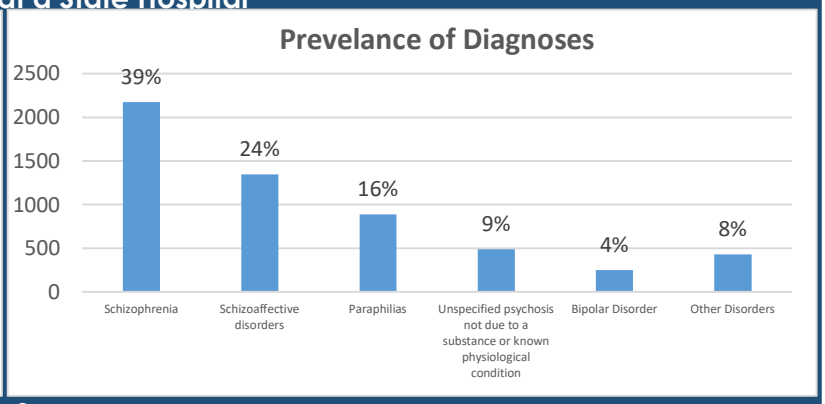






While at a State Hospital





Summary

The DSH population is composed of 85% males and 15% females; a majority of this population is between the ages of 18 and 64. Approximately 41% identify as White, 25% Black, and 26% 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 79% of the population.

DIVISION OF HOSPITAL STRATEGIC PLANNING AND IMPLEMENTATION
RESEARCH, EVALUATION, AND DATA

Patients Served by Ethnicity

Fiscal Year 2020-2021

		CDCR	IST	LPS	NGI	OMD[4]	SVP	**Grand Total**
State Hospitals and JBCT Patients Served by Count[1]	*White*	***	1,437	276	733	609	574	3,795
	Hispanic or Latino	***	1,359	237	326	462	147	2,687
	Black or African American	124	1,113	218	309	506	225	2,495
	Asian	<11	144	46	62	28	<11	293
	Unknown	15	100	***	***	30	17	202
	Native Hawaiian or Other Pacific Islander	<11	53	21	43	20	<11	146
	American Indian or Alaska Native	<11	36	<11	<11	19	15	87
	TOTAL	***	4,242	817	1,505	1,674	991	**9,705**

		CDCR	IST	LPS	NGI	OMD[4]	SVP	**Grand Total**	**2019 State of California[2]**	**2020 State of California[3]**
State Hospitals and JBCT Patients Served by Percentage[1]	*White*	34.9%	33.9%	33.8%	48.7%	36.4%	57.9%	39.1%	36.3%	34.7%
	Hispanic or Latino	32.8%	32.0%	29.0%	21.7%	27.6%	14.8%	27.7%	39.1%	39.4%
	Black or African American	26.1%	26.2%	26.7%	20.5%	30.2%	22.7%	25.7%	5.8%	5.4%
	Asian	***	3.4%	5.6%	4.1%	1.7%	***	3.0%	14.6%	15.1%
	Unknown	3.2%	2.4%	***	***	1.8%	1.7%	2.1%	0.3%	0.6%
	Native Hawaiian or Other Pacific Islander	***	1.2%	2.6%	2.9%	1.2%	***	1.5%	0.4%	0.3%
	American Indian or Alaska Native	1.3%	0.8%	***	***	1.1%	1.5%	0.9%	0.4%	0.4%
	TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	**100.0%**		

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

[2]Taken from U.S. Census Bureau 2019 American Community Survey (ACS). Does not include 3.1% labeled "two or more races".

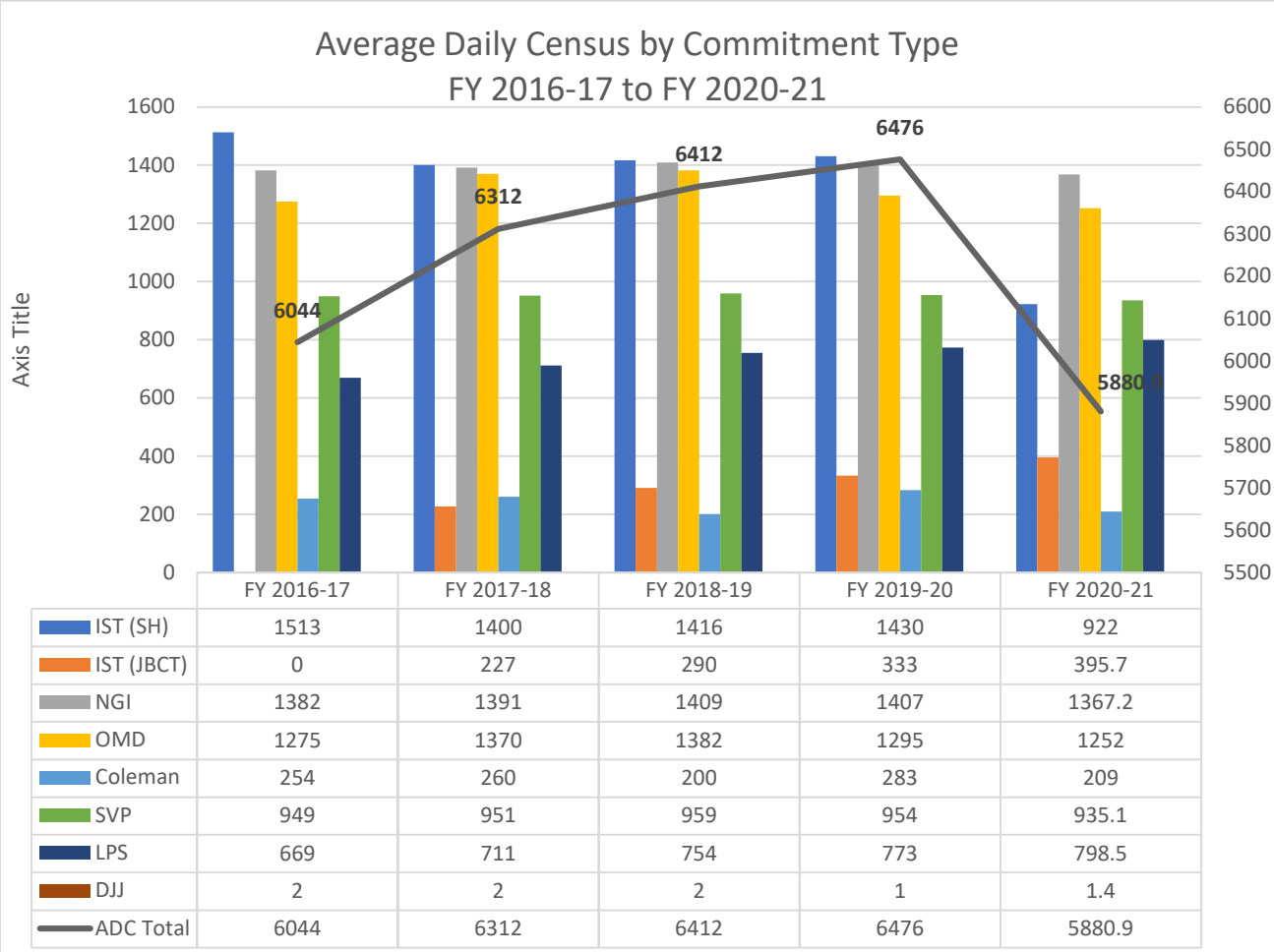
[3]Taken from U.S. Census Bureau 2020 American Community Survey (ACS). Does not include 4.1% labeled "two or more races".

[4]Includes MDSO.

[5]DJJ is excluded and accounts for less than 11 total patient served, 60% White and 40% Hispanic or Latino.

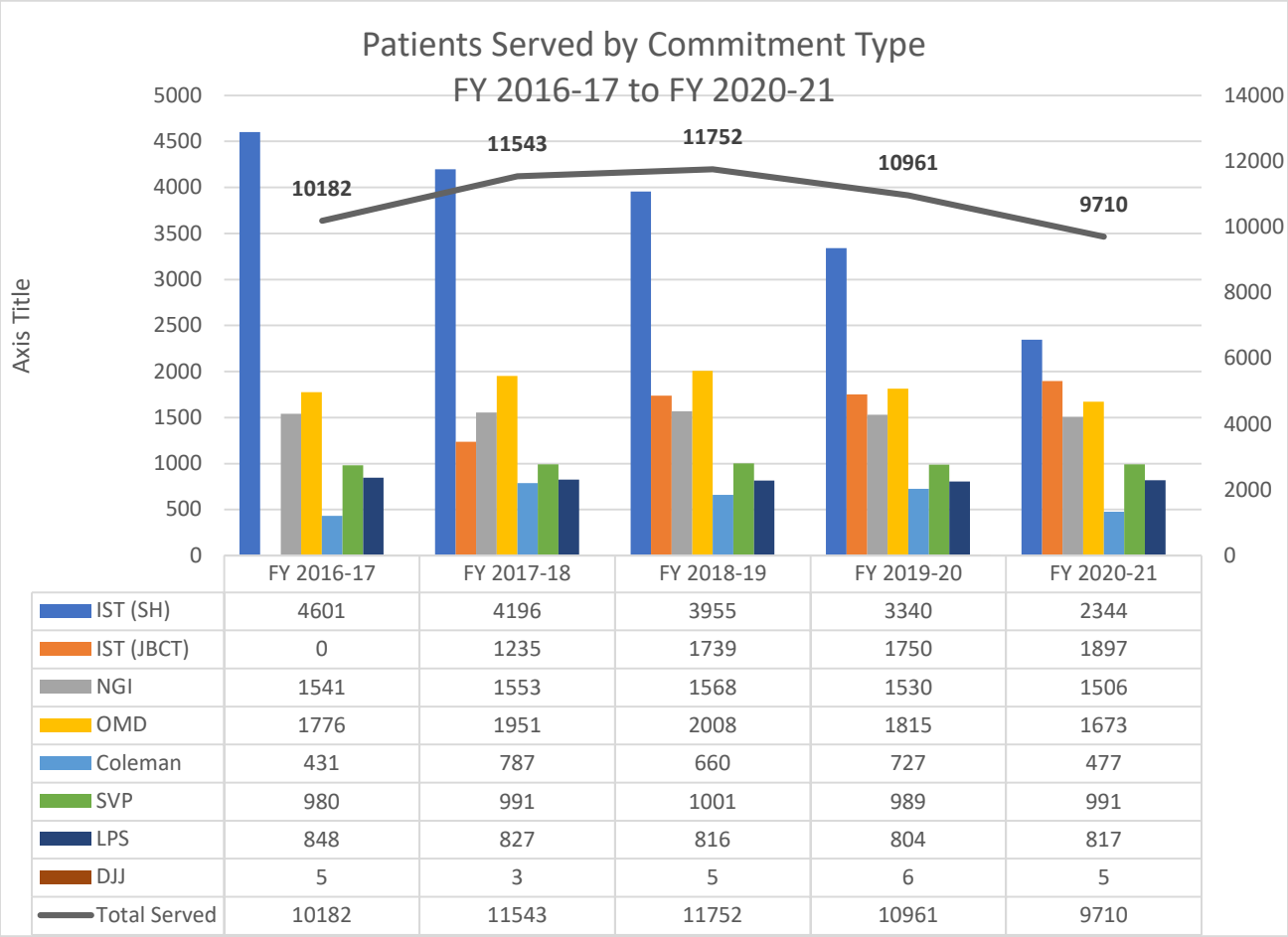
Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data.

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



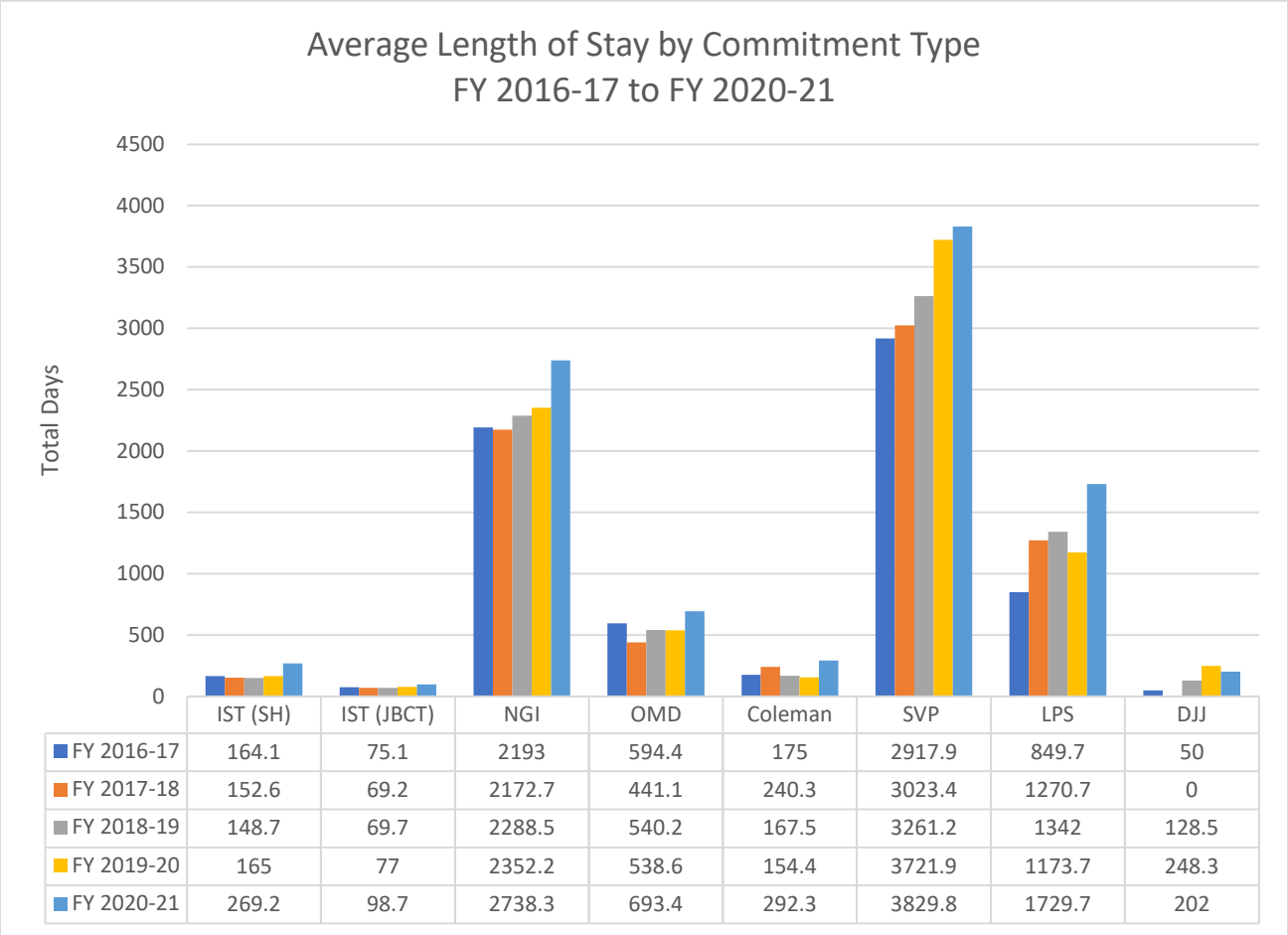
	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
IST (SH)	1513	1400	1416	1430	922
IST (JBCT)	0	227	290	333	395.7
NGI	1382	1391	1409	1407	1367.2
OMD	1275	1370	1382	1295	1252
Coleman	254	260	200	283	209
SVP	949	951	959	954	935.1
LPS	669	711	754	773	798.5
DJJ	2	2	2	1	1.4
ADC Total	6044	6312	6412	6476	5880.9

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



	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
IST (SH)	4601	4196	3955	3340	2344
IST (JBCT)	0	1235	1739	1750	1897
NGI	1541	1553	1568	1530	1506
OMD	1776	1951	2008	1815	1673
Coleman	431	787	660	727	477
SVP	980	991	1001	989	991
LPS	848	827	816	804	817
DJJ	5	3	5	6	5
Total Served	10182	11543	11752	10961	9710

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



	IST (SH)	IST (JBCT)	NGI	OMD	Coleman	SVP	LPS	DJJ
FY 2016-17	164.1	75.1	2193	594.4	175	2917.9	849.7	50
FY 2017-18	152.6	69.2	2172.7	441.1	240.3	3023.4	1270.7	0
FY 2018-19	148.7	69.7	2288.5	540.2	167.5	3261.2	1342	128.5
FY 2019-20	165	77	2352.2	538.6	154.4	3721.9	1173.7	248.3
FY 2020-21	269.2	98.7	2738.3	693.4	292.3	3829.8	1729.7	202

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

Department of Finance (ca.gov)

STATE HOSPITALS

STATE HOSPITALS
COUNTY BED BILLING REIMBURSEMENT AUTHORITY
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**	**$0**	**$0**
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	$0	$0

BACKGROUND

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

LPS Population

The LPS population includes multiple civil commitment patients who have been admitted to the Department of State Hospitals (DSH) under the LPS Act (Welfare and Institutions Code (WIC) section 5000 et seq.). WIC section 5358 specifies DSH as one treatment option, however, there are multiple treatment options for the LPS population including a medical, psychiatric, nursing, or other state-licensed facility, or a county hospital, hospital operated by the Regents of the University of California, a United States government hospital, or other nonmedical facility approved by the State Department of Health Care Services or an agency accredited by the State Department of Health Care Services. These patients require mental health treatment and are committed through civil court proceedings if legal criteria concerning a danger to themselves or others, or grave disability, are met. The LPS population is referred to DSH by local community mental health programs through involuntary civil commitment procedures pursuant to the LPS Act. WIC section 4330 requires counties to reimburse DSH for their use of hospital beds and services provided pursuant to the LPS Act.

In the 2021 Budget Act, DSH adjusted the reimbursement authority by adding an additional $8.1 million ongoing to account for the increasing LPS population, bringing the ongoing LPS reimbursement authority budget to $181,625,000. On average, 798 LPS patients are treated daily in the state hospitals, representing 14

percent of the overall patient population. As of June 30, 2021, the system-wide LPS census was 798.

IST Non-Restorable and Maximum Term IST Defendants Return to County

Pursuant to PC §1372, DSH is authorized to bill counties for IST patients who have been restored to competency and not picked up by their committing county within 10 days following the filing of a certificate of restoration with the court. Pursuant to PC §1370, when the state hospital issues a progress report that there is no substantial likelihood that the defendant will regain mental competence in the foreseeable future, the committing county is required to return the defendant to court within 10 days to initiate the LPS conservatorship process.

Prior to 2015, state law required counties to return unrestorable defendants to court and to initiate the conservatorship process but did not provide a required timeline for doing so. AAB 2625, Achadjian, Chapter 742, Statutes of 2014 created the 10-day timeline for return after notice to the court of a patient having no substantial likelihood that the defendant will regain mental competence in the foreseeable future.

The 2021 Budget Act included trailer bill language (TBL) authorizing DSH to charge the county a daily bed rate for the treatment of defendants, committed to DSH as IST, who are not timely transported and returned by and to the committing county under specific statutory circumstances. The daily bed rate billed to the county will be consistent with current rates for patients committed to DSH pursuant to the LPS Act. Per AB 133, Chapter 143, billing will commence if the County Sheriff does not pick-up the relevant IST defendant from a DSH facility and return them to county custody within ten (10) days' notice to the committing court that the IST defendant (1) has no substantial likelihood of regaining mental competence in the foreseeable future or (2) is within 90 days of reaching their maximum commitment term. This bill also included corresponding statutory changes to WIC section 17601 to allow DSH to collect reimbursement from counties.

DESCRIPTION OF CHANGE

LPS Population

No change is proposed to DSH's reimbursement authority at this time. DSH is currently in negotiations with counties regarding a proposed increase in the daily bed rate based on DSH's actual costs. The current bed rates charged the counties, per the current LPS Memorandum of Understanding (MOU) have not been updated since FY 2012-13. DSH currently charges a daily bed rate of $775 for Skilled Nursing Facility (SNF) and $626 for a blended rate for an Acute or

Intermediate Care Facility bed type (blended rate went into effect FY 2014-15 based on the per diem bed rates that were already in place). DSH has notified the counties that it intends to increase the LPS bed rates beginning July 1, 2022.

In FY 2018-19 DSH partnered with the Public Consulting Group (PCG) to review and update the DSH bed rates. PCG provided DSH with a methodology based on service use costs and frequencies from prior fiscal years. DSH is currently working with California Mental Health Services Authority's (CalMHSA) to reach an agreement regarding the newly proposed rates. However, if an agreement is unsuccessful between both parties, WIC section 4331, subdivision (d) authorizes DSH to set bed rates to recover the cost of care for LPS patients. DSH will provide the final bed rates and its impact of DSH's reimbursement authority in the 2022-23 May Revision based on the outcome of ongoing negotiations with the counties.

IST Non-Restorable

In addition to LPS reimbursements, the IST reimbursement collections will be drawn from the same Mental Health Subaccount of the Sales Tax Account in the Local Revenue Fund in accordance with Schedule B as authorized in WIC section 17601.

DSH is currently reviewing the impacts to its reimbursement authority based on the implementation of billing counties for the statutory changes included in AB133. County billing is set to begin as of October 1, 2021 and occurs monthly in arrears. An update will be provided in the 2022-23 May Revision on the reimbursement authority needed.

STATE HOSPITAL
DSH - METROPOLITAN INCREASED SECURE BED CAPACITY
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**-$21,830**	**$0**	**$0**
One-time	*0.0*	*0.0*	*0.0*	*-$21,830*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*

BACKGROUND

To provide additional capacity to address the ongoing system-wide forensic waitlist, particularly focusing on the Incompetent to Stand Trial (IST) patient waitlist, the 2016 Budget Act included capital outlay construction funding for the Increased Secure Bed Capacity (ISBC) project at Department of State Hospital (DSH) Metropolitan. This project added security fencing and infrastructure for existing patient buildings at the hospital, which had primarily been used to house civilly committed Lanterman-Petris-Short (LPS) patients. These patients were transferred from the Continuing Treatment West (CTW) to the non-secured 100s Building in October 2018. With the new security infrastructure, these buildings can now be used for the treatment of forensic patients.

In the 2021 Budget Act, COVID-19 prompted a delay in the activation of the remaining three units of a five-unit secured bed capacity expansion to provide additional bed capacity to treat IST patients committed to DSH. During this time, DSH-Metropolitan prioritized using the three inactive units for its COVID-19 response. One unit was utilized for isolation of patients testing positive for COVID-19 while the other two units were used as Admission Observation Units (AOUs).

DESCRIPTION OF CHANGE

As of the 2022-23 Governor's Budget, there continue to be delays in the activation of the remaining three units for ISTs resulting in a one-time savings in FY 2021-22 of $21.8 million associated with personal services savings. The activation of the three units to serve ISTs continue to be delayed due to the following challenges:

1. COVID-19 - One of the three units is currently serving as a COVID-19 isolation unit.

2. Skilled Nursing Facility Swing Space – In July 2021, the SNF Building at DSH-Metropolitan sustained significant damage due to water intrusion that

occurred as a result of rain that occurred while the roof was being replaced. The SNF patients had to be relocated to two of these units that had been previously been being used as an Admission Observation Unit and Isolation Unit for COVID-19 response.

3. Chronic Treatment East (CTE) Fire Alarm Upgrade Project – This project is to upgrade the fire alarm system across all patient housing units in the CTE building and is further impacting bed capacity at DSH-Metropolitan. Patient housing units must be vacated when the fire alarm construction is being performed on the unit. The initial plan was to utilize units from the ISBC project as swing space for the CTE Fire Alarm Upgrade Project before the CTW units were opened to ISTs. The fire alarm project was initially expected to be completed in September 2021. The project is still underway due to delays in construction related to resolving deficiencies identified by the State Fire Marshall during final inspections in the first units receiving the fire alarm upgrades. Due to the SNF building damage and the unavailability of the CTW units for swing space, DSH-Metropolitan had to reduce census in order to accommodate swing space for this project. The CTE Fire Alarm Upgrade Project is contributing to the overall challenges in activating additional units for ISTs and is projected to be complete early 2022.

Due to all three impacts, the activation of the three remaining units continue to experience delays. An update will be provided in the 2022-23 May Revision.

Activation Timeline Adjustment

Unit	Number of Beds	Scheduled Activation as of 2021-22 May Revision	Scheduled Activation as of 2022-23 Governor's Budget	Change from 2021-22 May Revision
Unit 1	48	September 23, 2019	September 23, 2019	No change - Activated
Unit 2	48	January 29, 2020	January 29,2020	No change - Activated
Unit 3	48	September 2021	July 2022	10-month delay
Unit 4	46	September 2021	July 2022	10-month delay
Unit 5	46	September 2021	July 2022	10-month delay

The table below displays a position and funding summary of the project by fiscal year, showing the adjustments made throughout the life of the project. DSH will provide further updates in the 2022-23 May Revision.

DSH-Metropolitan Increased Secure Bed Capacity					
	FY 18-19	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**
FY 2018-19 Governor's Budget					
Positions	346.1	473.4	473.4	473.4	473.4
Funding	$53,085	$68,953	$68,953	$68,953	$68,953
FY 2018-19 May Revision					
Positions	-183.3	-131.2	-1.2	0.0	0.0
Funding	-$28,304	-$18,374	$17	$0	$0
FY 2019-20 Governor's Budget					
Positions	0.0	119.3	130.0	130.0	130.0
Funding	$0	$18,589	$20,117	$20,117	$20,117
FY 2019-20 May Revision					
Positions	-22.5	-20.1	-128.5	-128.5	-128.5
Funding	-$3,476	-$3,055	-$19,850	-$19,850	-$19,850
FY 2020-21 Governor's Budget					
Positions	0.0	-51.1	2.0	2.0	2.0
Funding	$0	-$7,928	$294	$294	$294
FY 2020-21 May Revision					
Positions	0.0	-171.3	-43.7	0.0	0.0
Funding	$0	-$26,455	-$6,758	$0	$0
FY 2021-22 Governor's Budget					
Positions	0.0	0.0	-120.6	0.0	0.0
Funding	$0	$0	-$18,617	$0	$0
FY 2021-22 May Revision					
Positions	0.0	0.0	0.0	-1.2	-1.2
Funding	$0	$0	$0	$17	$17
FY 2022-23 Governor's Budget					
Positions	0.0	0.0	0.0	0.0	-127.3
Funding	$0	$0	0.0	$0	-$21,830
Total Request by Year Ongoing					
Positions	**140.3**	**219.0**	**311.4**	**475.7**	**346.4**
Funding	**$21,305**	**$31,730**	**$44,156**	**$69,531**	**$47,701**

BCP Fiscal Detail Sheet

BCP Title: DSH - Metropolitan Increased Secure Bed Capacity **BR Name: 4440-041-ECP-2022-GB**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Salaries and Wages						
Earnings - Permanent	-13,330	0	0	0	0	0
Total Salaries and Wages	**$-13,330**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-6,464	0	0	0	0	0
Total Personal Services	**$-19,794**	**$0**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-1,018	0	0	0	0	0
5304 - Communications	-127	0	0	0	0	0
5320 - Travel: In-State	-127	0	0	0	0	0
5324 - Facilities Operation	-637	0	0	0	0	0
5346 - Information Technology	-127	0	0	0	0	0
Total Operating Expenses and Equipment	**$-2,036**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-21,830**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-21,830	0	0	0	0	0
Total State Operations Expenditures	**$-21,830**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-21,830**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4400020 - Hospital Administration	-127	0	0	0	0	0
4410030 - Metropolitan	-21,703	0	0	0	0	0
Total All Programs	**$-21,830**	**$0**	**$0**	**$0**	**$0**	**$0**

Personal Services Details

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
2011 - Custodian I	-193	0	0	0	0	0
7552 - Physician & Surgeon (Safety)	-564	0	0	0	0	0
7619 - Staff Psychiatrist (Safety)	-2,702	0	0	0	0	0
8094 - Registered Nurse (Safety)	-3,037	0	0	0	0	0
8104 - Unit Supvr (Safety)	-256	0	0	0	0	0
8252 - Sr Psych Techn (Safety)	-1,112	0	0	0	0	0
8253 - Psych Techn (Safety)	-2,891	0	0	0	0	0
8420 - Rehab Therapist (Art-Safety)	-758	0	0	0	0	0
9872 - Clinical Soc Worker (Hlth/CF)-Safety	-806	0	0	0	0	0
9873 - Psychologist (Hlth Facility-Clinical-Safety)	-1,011	0	0	0	0	0
Total Salaries and Wages	**$-13,330**	**$0**	**$0**	**$0**	**$0**	**$0**
Staff Benefits						
5150200 - Disability Leave - Industrial	-173	0	0	0	0	0
5150210 - Disability Leave - Nonindustrial	-53	0	0	0	0	0
5150350 - Health Insurance	-613	0	0	0	0	0
5150450 - Medicare Taxation	-200	0	0	0	0	0
5150600 - Retirement - General	-2,666	0	0	0	0	0
5150700 - Unemployment Insurance	-13	0	0	0	0	0
5150800 - Workers' Compensation	-613	0	0	0	0	0
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	-373	0	0	0	0	0
5150900 - Staff Benefits - Other	-1,760	0	0	0	0	0
Total Staff Benefits	**$-6,464**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$-19,794**	**$0**	**$0**	**$0**	**$0**	**$0**

STATE HOSPITALS
ENHANCED TREATMENT PROGRAM (ETP) STAFFING
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**-56.5**	**-56.5**	**-$9,613**	**-$8,902**	**-$8,902**
One-time	*0.0*	*0.0*	*0.0*	*-$3,580*	*$0*	*$0*
Ongoing	*0.0*	*-56.5*	*-56.5*	*-$6,033*	*-$8,902*	*-$8,902*

BACKGROUND

The Enhanced Treatment Program (ETP) was developed to accept patients who are at the highest risk of violence and cannot be safely treated in a standard treatment environment. The ETP will provide treatment intended to return patients 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 processes that identify and address patients' violence risk factors.

Assembly Bill (AB) 1340, Statutes of 2014, established the admissions process in statute. It is designed to identify patients at the highest risk of violence and address their risk factors. Admission into the ETP is initiated by the referring state hospital Psychiatrist or Psychologist. The patient will then be assessed by a dedicated Forensic Psychologist who makes an initial assessment of the appropriateness of the referral. If the referral is determined to be appropriate, the patient will be evaluated 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 one Psychiatrist, two Psychologists, one Registered Nurse, one Clinical Social Worker, two Rehabilitation Therapists, and one 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 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 nocturnal (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 2018 Budget Act authorized DSH to construct four ETP units; three 13-bed units at DSH-Atascadero to serve male patients and one 10-bed unit at DSH-Patton to serve female patients.

In the 2021 Budget Act, DSH experienced further activation delays in all four units. The continued delays were due to existing site conditions, code issues, unforeseen conditions such as unknown regular and low voltage electrical conduits, materials damage, unexpected ductwork, and uncertainties related to COVID-19.

DESCRIPTION OF CHANGE

DSH-Atascadero ETP construction at Unit 29 was completed in July 2021. The State Fire Marshal issued the Certificate of Occupancy on July 16, 2021. The California Department of Public Health conducted a licensing survey on August 4, 2021 and issued the license on August 18, 2021. FNAP certification of referred patients began on August 25, 2021 and first patients were admitted to the ETP on September 14, 2021. The four-year pilot project was initiated with the opening of the first ETP unit and will end effective September 13, 2025 under current statute.

DSH-Atascadero ETP construction at Units 33 and 34 was planned to begin in October and November 2021, respectively. Due to the shared infrastructure between these two upstairs and downstairs units, both units, which are currently occupied, would need to be taken off-line for construction at the same time reducing DSH's available bed capacity. These two units total 92 beds. DSH's bed capacity needs have been greatly impacted by COVID-19 and the need to have isolation units and admission observation units and the *Stiavetti v. Clendenin* lawsuit regarding timely access to treatment for the Incompetent to Stand Trial (IST). Due to these considerations, DSH recommends postponement of the capital outlay project and associated staffing necessary to activate the last two ETP units at DSH-Atascadero until current IST bed pressures are resolved. DSH is projecting a savings of $6 million in FY 2021-22 and $8.5 million and 56.5 positions in FY 2022-23 and ongoing. Once bed capacity pressures are alleviated, DSH would request the associated capital outlay funding and associated staffing to reinitiate the remaining two units.

At May Revision, the DSH-Patton ETP was scheduled to resume the U Building fire sprinkler project in July 2021, followed by ETP construction on U-06 beginning in January 2022. The fire alarm project was reinitiated in July 2021, however unforeseen fire sprinkler installation design changes, the need to survey for potential asbestos containing materials, and discovery of gaps in the existing smoke barrier have extended the anticipated length of the project. While a total of 43-beds will need to be taken offline, DSH recommends that construction to convert U-06 to a 10-bed ETP unit for females continues, to provide equal access to ETP treatment for both male and female patients. DSH anticipates construction to be complete in October 2022 for this expansion. DSH is projecting a savings of $3 million in FY 2021-22 due to these delays.

Position Funding Gap

DSH has recognized an oversight in the phase-in process of positions that are tied to ETP. When each proposal was created, DSH costed each position at the current salary range recognized by CalHR. At the time of development, only the positions in current year and budget year would be included in the DOF annual Employee Compensation and Employer Contribution Retirement drills. Any positions requested in the outyears would not be included in the Employee Compensation and Retirement drills until they appear on the Schedule 8. Due to the fact these outyear unestablished positions do not reflect the updated bargaining unit contract negotiations or pay differentials for qualified positions, DSH developed a process to mitigate this issue going forward until all positions are established.

DSH has determined the additional funding for positions that are going to be phased-in for the outyears and requests $43,000 in FY 2022-23 and ongoing.

ETP Activation Timeline

Units/Hospital	Construction Scheduled Initiation	Construction Scheduled Completion	Delay from 2021- 22 May Revision
DSH-Atascadero Unit 29	September 24, 2018 (Actual)	July 2021	3-month delay
DSH-Atascadero Unit 33	Suspended	Suspended	Unknown
DSH-Atascadero Unit 34	Suspended	Suspended	Unknown
DSH-Patton Unit U-06	April 2022	October 2022	3-month delay

DGS Suspension Fees

With postponement, DSH will not incur further suspension fees and will have an opportunity to bid for a new construction contractor in the future for the two remaining ETP units. Numerous challenges were encountered with the current contractor which caused many delays in Unit 29 construction. DSH will incur $306,000 in costs for FY 2021-22 associated with cancelation of the contract and there is a possibility the contractor could make a claim for additional funding.

Information Technology (IT) Funding

As of the FY 2022-23 Governor's Budget, construction on Units 33 and 34 at DSH-Atascadero have been postponed until bed capacity pressures are resolved. As a result, DSH will remit the funding received for IT support costs related to those unit activations. This included telepresence equipment, speakers, and intercoms, in addition to the ongoing service and maintenance costs for repairs, software and hardware updates, servers, etc. DSH is projecting a savings of $915,000 in FY 2021-22 and $446,000 in FY 2022-23 and ongoing.

Summary of Changes

Due to the postponement of the ETP project at DSH-Atascadero and construction delays at DSH-Patton, DSH will recognize a significant savings on the ETP based on not requiring the enhanced staffing to support Units 33 and 34. The delays anticipated for DSH-Patton's Unit 06 will score a one-time savings of $3.6 million in FY 2021-22, whereas the cessation of the planned construction for Units 33 and 34 at DSH-Atascadero will result in a savings of $6 million in FY 2021-22 and $8.5 million and 56.5 positions in FY 2022-23 and ongoing.

Funding and Position Summary

The tables below display the positions and funding received in support of the ETP unit activations.

ETP Cost Breakdown (Dollars in Thousands)						
Timeframe	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**2021-22**	**2022-23**
2017 Budget Act	***$7,990***	***$15,228***	***$15,249***	***$15,249***	***$15,249***	***$15,249***
2018-19 Governor's Budget	($4,953)	$2,835	$8,350	$8,350	$8,350	$8,350
2018-19 May Revision	$70	($7,406)	($50)	$432	$432	$432
Total as of 2018 Budget Act	***$3,107***	***$10,657***	***$23,549***	***$24,031***	***$24,031***	***$24,031***
2019-20 Governor's Budget	$0	$0	($1,765)	$0	$0	$0
2019-20 May Revision	$0	($2,616)	($716)	$0	$0	$0
Total as of 2019 Budget Act	***$3,107***	***$8,041***	***$21,068***	***$24,031***	***$24,031***	***$24,031***
2020-21 Governor's Budget	$0	$0	($5,330)	$385	$0	$0
2020-21 May Revision	$0	$0	($3,085)	($1,385)	$0	$0
Total as of 2020 Budget Act	***$3,107***	***$8,041***	***$12,653***	***$23,031***	***$24,031***	***$24,031***
2021-22 Governor's Budget	$0	$0	$0	($4,711)	($1,776)	$0
2021-22 May Revision	$0	$0	$0	($3,715)	$329	$1,015
Total as of 2021 Budget Act	***$3,107***	***$8,041***	***$12,653***	***$14,605***	***$22,584***	***$25,046***
2022-23 Governor's Budget	$0	$0	$0	$0	($9,613)	($8,902)
Total as of 2022-23 Governor's Budget	***$3,107***	***$8,041***	***$12,653***	***$14,605***	***$12,971***	***$16,144***

ETP Position Breakdown						
DSH-Atascadero Units 29 & 33	**17-18**	**18-19**	**19-20**	**20-21**	**21-22**	**22-23**
2017-18 Governor's Budget	44.7	115.1	115.1	115.1	115.1	115.1
2018-19 Governor's Budget	-35.8	0.0	0.0	0.0	0.0	0.0
2018-19 May Revision	0.0	-57.9	0.0	0.0	0.0	0.0
2019-20 Governor's Budget	0.0	0.0	0.0	0.0	0.0	0.0
2019-20 May Revision	0.0	-7.1	-3.4	0.0	0.0	0.0
2020-21 Governor's Budget	0.0	0.0	-26.7	0.0	0.0	0.0
2020-21 May Revision	0.0	0.0	-21.1	-6.0	0.0	0.0
2021-22 Governor's Budget	0.0	0.0	0.0	-21.1	-5.0	-5.0
2021-22 May Revision	0.0	0.0	0.0	-23.0	-2.4	-2.4
2022-23 Governor's Budget	0.0	0.0	0.0	0.0	0.0	-22.3
Total Authority Ongoing	**8.9**	**50.1**	**63.9**	**65**	**107.7**	**85.4**
DSH-Atascadero Unit 34 & DSH-Patton Unit U-06	**17-18**	**18-19**	**19-20**	**20-21**	**21-22**	**22-23**
2017-18 Governor's Budget	0.0	0.0	0.0	0.0	0.0	0.0
2018-19 Governor's Budget	0.0	23.2	65.7	65.7	65.7	65.7
2018-19 May Revision	0.0	-22.2	-5.4	0.0	0.0	0.0
2019-20 Governor's Budget	0.0	0.0	-12.7	0.0	0.0	0.0
2019-20 May Revision	0.0	0.0	5.7	0.0	0.0	0.0
2020-21 Governor's Budget	0.0	0.0	-5.6	-1.5	0.0	0.0
2020-21 May Revision	0.0	0.0	0.0	-2.4	0.0	0.0
2021-22 Governor's Budget	0.0	0.0	0.0	-9.0	-6.6	-6.6
2021-22 May Revision	0.0	0.0	0.0	0.0	-5.8	-5.8
2022-23 Governor's Budget	0.0	0.0	0.0	0.0	0.0	-34.2
Total Authority Ongoing	**0.0**	**1.0**	**47.7**	**52.8**	**53.3**	**19.1**

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

EXECUTIVE SUMMARY

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

DSH has been authorized to establish four ETP units totaling 49 beds. Three 13-bed units will be provided at DSH-Atascadero and one 10-bed treatment unit will be at DSH-Patton. One unit at DSH-Atascadero began admitting patients on September 14, 2021. As the remaining three units are not yet completed or activated, this report covers activity for the first month of operation of the first activated ETP unit at DSH-Atascadero in accordance with reporting requirements established in AB 1340. An update on the status of the construction and activation of each unit is provided in DSH's annual Governor's Budget and May Revision Population and Caseload Estimates.

This report encompasses data collected between September 14, 2021 and October 15, 2021. The data shows patient characteristics including gender, ethnicity, age on admission, legal group, and years at DSH. Data also includes information on staffing requirements and staff-to-patient ratios, as well as staff turnover. Data on restraint and seclusion use and serious injuries is also provided. The report also includes information regarding patients' rights complaints received as provided by the Disability Rights California, California Office of Patients' Rights and the resolution to these issues. Finally, the report includes information regarding the training that ETP staff received, as well the training provided to staff who may primarily work elsewhere but could be asked to provide treatment in the ETP.

This first annual report does not include any findings or recommendations, as this report is for the first month of a single ETP unit and there is not sufficient data to draw conclusions currently. More detailed findings and recommendations are anticipated in future reports.

BACKGROUND

Assembly Bill 1340 (Achadjian, Statutes of 2014) authorized DSH to establish pilot enhanced treatment programs (ETP) for those patients determined to be at high risk for most dangerous behavior against other patients and hospital staff. The ETP was developed to accept patients who are at the highest risk of violence and cannot otherwise be safely treated in a standard treatment environment. The ETP will provide treatment intended to return patients 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 admissions and treatment planning processes that identify and address patients' violence risk factors.

DSH has been authorized to establish four ETP treatment units totalling 49 beds. Three 13-bed treatment units are to be located at DSH-Atascadero; and one 10-bed treatment unit will be located at DSH-Patton. Construction of the first ETP treatment unit at DSH-Atascadero has completed and the unit began admitting patients on September 14, 2021. The remaining three units are not yet completed or activated. An update on the status of the construction and activation of each unit is provided in DSH's annual Governor's Budget and May Revision Population and Caseload Estimates.
This report covers activity for the first month of operation of the first activated ETP unit at DSH-Atascadero, in accordance with reporting criteria established in AB 1340. Specifically, *Section 4145 of the Welfare and Institutions Code reads:*

4145. (a) The State Department of State Hospitals shall monitor the pilot enhanced treatment programs (ETP), evaluate outcomes, and report on its findings and recommendations. This report shall be provided to the fiscal and policy committees of the Legislature annually, beginning on January 10 of the first year after which the first ETP is opened and services have commenced, and shall be in compliance with Section 9795 of the Government Code. The evaluation shall include, but is not limited to, all of the following:
(1) Comparative summary information regarding the characteristics of the patients served.
(2) Compliance with staffing requirements.
(3) Staff classification to patient ratio.
(4) Average monthly occupancy.
(5) Average length of stay.
(6) The number of residents whose length of stay exceeds 90 days.
(7) The number of patients with multiple stays.
(8) The number of patients whose discharge was delayed due to lack of available beds in a standard treatment environment.

(9) Restraint and seclusion use, including the number of incidents and duration, consistent with paragraph (3) of subdivision (d) of Section 1180.2 of the Health and Safety Code.
(10) Serious injuries to staff and residents.
(11) Serious injuries to staff and residents related to the use of seclusion and restraints as defined under Section 1180 of the Health and Safety Code.
(12) Staff turnover.
(13) The number of patients' rights complaints, including the subject of the complaint and its resolution.
(14) Type and number of training provided for ETP staff.
(15) Staffing levels for ETPs.

In response to the reporting requirements as identified in Section 4145, the Department of State Hospitals (DSH) has established data tracking and collection methodologies to capture the information required. This report details the methodology used and describes the data captured for the collection period ending on October 15, 2021. The data contained in this report is limited to what is permitted under the Health Insurance Portability and Accountability Act (HIPAA), and state privacy laws, when disclosure of health information is required by law. (45 CFR 164.512(a); Civ. Code, § 56.10, subd. (b)(9).)

I. Methodology

This reporting period encompasses data collected between September 14, 2021 and October 15, 2021. Data may be limited due to the first patient being served on an ETP unit on September 14, 2021. Existing DSH enterprise data collection practices were relied upon for reporting of items identified in Section 4145(a) (1-12) and (14-15). The requested information was operationalized considering current DSH policy and procedures. Data were collected using existing software and were independently verified using tracking sheets developed specifically for this reporting requirement.

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

II. Summary of Data

Patient Characteristics

Gender	**N (%)**
Male	8 (100%)
Female	0 (0%)

Ethnicity	**N (%)**
American Indian or Alaska Native	0 (0%)
Asian	0 (0%
Black or African American	1 (12.5%)
Hispanic or Latino	3 (37.5%)
Native Hawaiian or Other Pacific Islander	1 (12.5%)
White	3 (37.5%)

Age on Admission	**N (%)**
18-29	1 (12.5%)
30-41	2 (25%)
42-53	5 (62.5%)
54-65	0 (0%)
66-77	0 (0%)
78-90	0 (0%)
Mean Age:	43.1

Legal Group	**N (%)**
Incompetent to Stand Trial	1 (12.5%)
Not Guilty by Reason of Insanity	2 (25%)
Offender with a Mental Disorder	2 (25%)
Lanterman-Petris Short Act	3 (37.5%)
Sexually Violent Predator	0 (0%)
Coleman[a]	0 (0%)

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

Years at DSH – Current Admission[a]	N (%)
0-5	4 (50%)
6-10	2 (25%)
11-15	0
15 -20	2 (25%)
20-25	0
25+	0
Mean:	7.17

[a] "Current admission" includes hospital years during most recent commitment that did not result in a discharge from DSH.

Years at DSH – Overall[a]	N (%)
0-5	3 (37.5%)
6-10	2 (25%)
11-15	0
15 -20	3 (37.5%)
20-25	0
25+	0
Mean:	9.11

[a] "Overall" includes hospital years during all DSH commitments. Individuals committed to DSH may have had multiple commitment periods during their lifetime.

All patients (residents) currently admitted to the ETP are male. Their mean age is 43.1 years. Patients (residents) come from African American, Hispanic, Pacific Islander, and White ethnic backgrounds. Patients (residents) in the ETP belong to one of the following legal groups: Not Guilty by Reason of Insanity, Offenders with Mental Disorders, Incompetent to Stand Trial, and Lanterman-Petris Short Act Conservatees. Since their most recent DSH admission, they have spent an average of 7.17 years at DSH. However, as some patients (residents) have been admitted to DSH on multiple occasions, the combined average time spent in DSH is 9.11 years.

Compliance with Staffing Requirements

According to Health and Safety Code 1265.9(d)(1), the ETP shall maintain a staff-to-patient ratio of one to five. Health and Safety Code 1265.9(g) defines staff as licensed nurses and psychiatric technicians providing direct patient care.

During the reporting period from September 14, 2021 through October 15, 2021, the ETP maintained a staff-to-patient ratio of one to five or lower.

Staff Classification to Patient Ratio

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

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

Staff Classification	**Staff-to-Patient Ratio During Reporting Period**
Level-of-Care Staff[a]	
AM Shift	1 : 1.5
PM Shift	1 : 1.5
NOC Shift	1 : 3
Hospital Police Officer	1 : 4
Rehabilitation Therapist	1 : 4
Psychologist	1 : 4
Psychiatrist	1 : 8
Social Worker	1 : 8
FNAT Psychologist	1 : 2.7

[a] Level of Care staff include Psychiatric Technicians and Registered Nurses.

Occupancy

Average Monthly Occupancy	**N**
September 2021	3.29
October 2021	6.67
Mean	4.98

Average Length of Stay	**Days[a]**
DSH-Atascadero Unit 29	19.5 (± 10.6)

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

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

The ETP began accepting patients on September 14, 2021. Admissions were staggered over several weeks. Thus, there were 8 patients (residents) residing on the unit at the end of this reporting period. No patients' (residents') length of stay exceeded 90 days since there were only 32 days in the reporting period. No patient (resident) had multiple stays. No patients (residents) were discharged during the reporting period.

Restraint and Seclusion Use

Over the reporting period from September 14, 2021 to October 15, 2021, there were four incidents of seclusion and five incidents of restraints.

Patients (residents) may be placed in seclusion or restraint for being an imminent danger to themselves or to others. All incidents of seclusion or restraint during the reporting period were related to patients (residents) being deemed an imminent danger to others.

For the purpose of this report, incidents have been separated into two categories, those that occurred while the patient (resident) was physically located on the ETP Unit, where they have the benefit of specially trained staff and environmental controls; and those that occurred while the patient (resident) was receiving care outside the ETP Unit in other areas of the hospital.
A total of four incidents of seclusion occurred on the ETP Unit and involved one patient for a total of 5.88 hours. The four episodes of seclusion occurred within the first two weeks of unit activation, when ETP staff were still becoming familiar with using clinical locked door status as a tool for least restrictive containment.

Four incidents of 5-point bed restraint occurred on the ETP unit and were related to three patients. Restraint usage lasted for a combined 6.75 hours.

There was one incident of wrist-to-waist restraint use due to danger to others that occurred while the patient was receiving care outside the ETP Unit. This incident

occurred while the patient was examined in the DSH-A Admissions Suite, upon arrival to the hospital. The admission process is lengthy and includes multiple assessments by a psychiatrist, registered nurse and general medical practitioner.

Restraint and Seclusion Use on ETP[a]	n[b]	Duration[c]
Incidents and Duration of Seclusion Use	4	5.88
Incidents and Duration of Restraint Use	4	6.75

[a] Restraint and Seclusion while the patient was physically located on the ETP Unit
[b] Number of distinct incidents that required seclusion or restraint of a patient
[c] Total Time in hours

Reason for Restraint and Seclusion Use on ETP[a]	n[b]	Duration[b]
Danger to Other	8	12.63
Danger to Self	0	0

[a] Restraint and Seclusion while the patient located on the ETP Unit.
[b] Number of distinct incidents that required seclusion or restraint of a patient
[c] Time in hours

Restraint and Seclusion Use outside ETP[a]	n[b]	Duration[c]
Incidents and Duration of Seclusion Use	0	NA
Incidents and Duration of Restraint Use	1	2.75

[a] Restraint and Seclusion while the patient was located outside the ETP Unit.
[b] Number of distinct incidents that required seclusion or restraint of a patient
[c] Time in hours

Reason for Restraint and Seclusion Use outside the ETP	n[a]	Duration[b]
Danger to Other	1	2.75
Danger to Self	0	0

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

Serious Injuries to Staff and Patients (Residents)

Per Health and Safety Code 1180.1 (g), "*Serious injury" means significant impairment of the physical condition as determined by qualified medical personnel, and includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, or injuries to internal organs*." There were no incidents that resulted in serious injuries to staff or patients (residents) during the review period, and there were no serious injuries to staff or patients (residents) related to the use of seclusion or restraints.

Serious Injuries[a]	n
Serious Injuries to Staff	0
Serious Injuries to Patients (Residents)	0
Serious injuries to Staff related to the use of seclusion and restraints	0
Serious injuries to Patients (Residents) related to the use of seclusion and restraints	0

[a] Serious injury is defined as requiring medical care beyond first aid, or overnight stay in a hospital.

Staff Turnover

During the reporting period from September 14, 2021 through October 15, 2021, two registered nurses left the ETP. Both staff departures were unrelated to working on the ETP. One retired and the other nurse left state service to accept a job in an area closer to where their family lives. These vacancies were filled after the reporting period.

Patients' Rights Complaints

The Disability Rights California, California Office of Patients' Rights provided information pertaining to patients' rights complaints they received during the reporting period of September 14, 2021 through October 15, 2021. A total of 5 complaints were made by 3 patients (residents).

Problem Code	Complaints
Access / Use of Personal Possessions	1
Keep / Spend Reasonable Sum of Money / Personal Funds	1
Social Interaction / Participation	2
Telephones / Confidential Use	1
Total	5

Access to Telephones / Social Interaction

3 complaints were submitted regarding the unit phones not working and patients (residents) not being able to get in touch with their family after arriving to the ETP. These were classified as Social Interaction/Participation and Telephones/Confidential Use.

- Resolution: The complaints were received the second week of October. Incoming phone lines were still functioning but the ability to place an outside call was affected. The phone was repaired the following week. 1 of the 3 patients (residents) was able to establish regular family phone calls within the reporting period. The other 2 patients (residents) worked with the Patients' Rights Advocate (PRA) and Social Worker to re-establish contact with their family following the reporting period. Social

Work, as the designated family and community support systems liaison, can facilitate calls through the employee phone system when considered a viable treatment approach.

Access / Use to Personal Funds and Personal Possessions

2 complaints were submitted regarding patients (residents) not being able to access their money or property that was transferred with them to the ETP from another State Hospital.

- Resolution: The PRA was able to help both patients gain access to their money within approximately 1 week of being transferred. At the end of the reporting period, the PRA was working with DSH-A to address facility-wide delays in processing patient property due to a staff vacancy in the property room. This vacancy is temporary, and hiring is in process. 1 of the 2 patients who filed a complaint was able to access their property during the reporting period. Access was pending for the second patient.

ETP Staff Training

In addition to mandated training provided to all hospital staff, those providing care on the ETP receive specialized training. Employees whose primary work assignment is elsewhere in the hospital, but who may be asked to provide treatment coverage on the ETP also receive an orientation to working on the ETP.

In anticipation of ETP activation, 57 ETP staff participated in a six-week in-person training academy in April and May 2019 aimed at providing specialized skills to address the needs of the patient populations served through the ETP. Training was offered with a focus on evidence-based treatments to address common risk factors for violence. Due to delays in activation, and the COVID-19 pandemic, another abbreviated two-week training academy was held virtually in April 2021 for 57 staff. The data below details the training topics presented during that most recent training academy from April 13, 2021 to April 30, 2021.

Training Name
ETP Background, Philosophy & Culture
ETP Positive Psychology
ETP Trauma Informed Care
ETP Motivational Interviewing
ETP Sensory Modulation
ETP Admission and Discharge Process
ETP New Admission Orientation Process
ETP Cognitive Remediation
ETP Milieu Management Skills (DBT)

ETP Treatment of Criminogenic Risk
ETP Transdisciplinary Approach
ETP Discipline Specific Duties
ETP Writing a Behavior Plan
ETP Coping Skills and Unit Privileges
ETP Specific Charting Requirements
ETP Incident Management Overview
ETP Risk Assessment Process & Application
ETP Patient's Rights
ETP Therapeutic Options
ETP Therapeutic Strategies and Interventions Theory
ETP Social Skills Training for Schizophrenia
ETP Operational Processes

In addition, an abbreviated videotaped training was created for staff whose primary work assignment is the ETP, but who did not have the opportunity to attend the full ETP academy. Seven staff completed this video training.

ETP Academy Video Training
ETP Positive Psychology
ETP Trauma Informed Care
ETP Motivational Interviewing
ETP Therapeutic Options
ETP Transdisciplinary Approach
ETP Social Skills Training for Schizophrenia
ETP Risk Assessment Process & Application
ETP Specific Charting Requirements
ETP Operational Processes

Lastly, a one-hour orientation to working on the ETP was developed for those whose primary work assignment is elsewhere, but who may be asked to provide treatment coverage on the ETP. 957 level-of-care (e.g., licensed nurses and psychiatric technicians) and clinical (e.g., psychiatrists, psychologists, social workers, rehabilitation therapists) staff completed this training. This includes 392 staff who completed this training during the reporting period of September 14, 2021 through October 15, 2021.

ETP Orientation Training
ETP Positive Philosophy
ETP Trauma Informed Care
ETP Sensory Modulation

ETP Milieu Management Plan
ETP Structure and Processes

Staffing Levels for ETPs

The table below summarizes staff classification and number of staff who are permanently assigned to the ETP. Only staff providing direct patient care are included.

ETP Permanent[a] Staff	**Number**
Registered Nurse	14
Psychiatric Technician (includes Senior Psychiatric Technician)	24
Licensed Vocational Nurse	1
Psychiatrist	1
Psychologist	2
Social Worker	1
Rehabilitation Therapist	2
FNAT Psychologist	3
Hospital Police Officers	9
Unit Supervisor	1

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

FINDINGS AND RECOMMENDATIONS

The data in this report reflects the first month of ETP operations, consequently there is not sufficient data to draw conclusions and formulate recommendations at this time. DSH is closely monitoring ETP operations and data during this transition period from program planning to full implementation to identify any adjustments that may be needed to process, protocols, and training. More detailed findings and recommendations are anticipated in future reports.

BCP Fiscal Detail Sheet

BCP Title: Enhanced Treatment Program (ETP) Staffing **BR Name: 4440-040-ECP-2022-GB**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	0.0	-56.5	-56.5	-56.5	-56.5	-56.5
Total Positions	**0.0**	**-56.5**	**-56.5**	**-56.5**	**-56.5**	**-56.5**
Salaries and Wages						
Earnings - Permanent	-5,076	-4,872	-4,872	-4,872	-4,872	-4,872
Total Salaries and Wages	**$-5,076**	**$-4,872**	**$-4,872**	**$-4,872**	**$-4,872**	**$-4,872**
Total Staff Benefits	-2,950	-2,681	-2,681	-2,681	-2,681	-2,681
Total Personal Services	**$-8,026**	**$-7,553**	**$-7,553**	**$-7,553**	**$-7,553**	**$-7,553**
Operating Expenses and Equipment						
5301 - General Expense	-489	-450	-450	-450	-450	-450
5304 - Communications	-61	-57	-57	-57	-57	-57
5320 - Travel: In-State	-61	-57	-57	-57	-57	-57
5324 - Facilities Operation	-306	-282	-282	-282	-282	-282
5340 - Consulting and Professional Services - External	306	0	0	0	0	0
5346 - Information Technology	-976	-503	-503	-503	-503	-503
Total Operating Expenses and Equipment	**$-1,587**	**$-1,349**	**$-1,349**	**$-1,349**	**$-1,349**	**$-1,349**
Total Budget Request	**$-9,613**	**$-8,902**	**$-8,902**	**$-8,902**	**$-8,902**	**$-8,902**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-9,613	-8,902	-8,902	-8,902	-8,902	-8,902
Total State Operations Expenditures	**$-9,613**	**$-8,902**	**$-8,902**	**$-8,902**	**$-8,902**	**$-8,902**
Total All Funds	**$-9,613**	**$-8,902**	**$-8,902**	**$-8,902**	**$-8,902**	**$-8,902**

Program Summary

Program Funding						
4400020 - Hospital Administration	-976	-503	-503	-503	-503	-503
4410010 - Atascadero	-5,606	-8,442	-8,442	-8,442	-8,442	-8,442
4410050 - Patton	-3,031	43	43	43	43	43
Total All Programs	**$-9,613**	**$-8,902**	**$-8,902**	**$-8,902**	**$-8,902**	**$-8,902**

BCP Title: Enhanced Treatment Program (ETP) Staffing **BR Name: 4440-040-ECP-2022-GB**

Personal Services Details

Positions			Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
1139	-	Office Techn (Typing)				0.0	0.0	0.0	0.0	0.0	0.0
1303	-	Personnel Spec				0.0	0.0	0.0	0.0	0.0	0.0
1935	-	Hosp Police Lieut				0.0	0.0	0.0	0.0	0.0	0.0
1936	-	Hosp Police Sgt				0.0	-5.3	-5.3	-5.3	-5.3	-5.3
1937	-	Hosp Police Officer				0.0	-26.4	-26.4	-26.4	-26.4	-26.4
4588	-	Assoc Accounting Analyst				0.0	0.0	0.0	0.0	0.0	0.0
5393	-	Assoc Govtl Program Analyst				0.0	0.0	0.0	0.0	0.0	0.0
7619	-	Staff Psychiatrist (Safety)				0.0	0.8	0.8	0.8	0.8	0.8
8094	-	Registered Nurse (Safety)				0.0	-15.2	-15.2	-15.2	-15.2	-15.2
8096	-	Supvng Registered Nurse (Safety)				0.0	-2.4	-2.4	-2.4	-2.4	-2.4
8104	-	Unit Supvr (Safety)				0.0	2.4	2.4	2.4	2.4	2.4
8252	-	Sr Psych Techn (Safety)				0.0	-0.2	-0.2	-0.2	-0.2	-0.2
8253	-	Psych Techn (Safety)				0.0	-2.6	-2.6	-2.6	-2.6	-2.6
8324	-	Rehab Therapist (Recr-Safety)				0.0	-1.6	-1.6	-1.6	-1.6	-1.6
9699	-	Hlth Svcs Spec (Safety)				0.0	0.0	0.0	0.0	0.0	0.0
9839	-	Sr Psychologist (Hlth Facility) (Spec)				0.0	-5.0	-5.0	-5.0	-5.0	-5.0
9872	-	Clinical Soc Worker (Hlth/CF)-Safety				0.0	0.7	0.7	0.7	0.7	0.7
9873	-	Psychologist (Hlth Facility-Clinical-Safety)				0.0	-1.7	-1.7	-1.7	-1.7	-1.7
VR00	-	Various				0.0	0.0	0.0	0.0	0.0	0.0
Total Positions						**0.0**	**-56.5**	**-56.5**	**-56.5**	**-56.5**	**-56.5**

Salaries and Wages			CY	BY	BY+1	BY+2	BY+3	BY+4
1139	-	Office Techn (Typing)	-5	0	0	0	0	0
1303	-	Personnel Spec	32	0	0	0	0	0
1935	-	Hosp Police Lieut	-102	0	0	0	0	0
1936	-	Hosp Police Sgt	-556	-415	-415	-415	-415	-415
1937	-	Hosp Police Officer	-2,895	-1,934	-1,934	-1,934	-1,934	-1,934
4588	-	Assoc Accounting Analyst	8	0	0	0	0	0
5393	-	Assoc Govtl Program Analyst	-7	0	0	0	0	0
7619	-	Staff Psychiatrist (Safety)	87	232	232	232	232	232
8094	-	Registered Nurse (Safety)	-356	-1,696	-1,696	-1,696	-1,696	-1,696

8096	-	Supvng Registered Nurse (Safety)	-459	-306	-306	-306	-306	-306
8104	-	Unit Supvr (Safety)	369	246	246	246	246	246
8252	-	Sr Psych Techn (Safety)	-16	-16	-16	-16	-16	-16
8253	-	Psych Techn (Safety)	-102	-174	-174	-174	-174	-174
8324	-	Rehab Therapist (Recr-Safety)	-32	-130	-130	-130	-130	-130
9699	-	Hlth Svcs Spec (Safety)	-117	0	0	0	0	0
9839	-	Sr Psychologist (Hlth Facility) (Spec)	-843	-602	-602	-602	-602	-602
9872	-	Clinical Soc Worker (Hlth/CF)-Safety	27	70	70	70	70	70
9873	-	Psychologist (Hlth Facility-Clinical-Safety)	-109	-174	-174	-174	-174	-174
VR00	-	Various	0	27	27	27	27	27
Total Salaries and Wages			**$-5,076**	**$-4,872**	**$-4,872**	**$-4,872**	**$-4,872**	**$-4,872**
Staff Benefits								
5150200	-	Disability Leave - Industrial	-66	-64	-64	-64	-64	-64
5150210	-	Disability Leave - Nonindustrial	-22	-20	-20	-20	-20	-20
5150350	-	Health Insurance	-233	-225	-225	-225	-225	-225
5150450	-	Medicare Taxation	-78	-76	-76	-76	-76	-76
5150500	-	OASDI	2	1	1	1	1	1
5150600	-	Retirement - General	-1,459	-1,259	-1,259	-1,259	-1,259	-1,259
5150700	-	Unemployment Insurance	-4	-5	-5	-5	-5	-5
5150800	-	Workers' Compensation	-233	-225	-225	-225	-225	-225
5150820	-	Other Post-Employment Benefits (OPEB) Employer Contributions	-186	-164	-164	-164	-164	-164
5150900	-	Staff Benefits - Other	-671	-644	-644	-644	-644	-644
Total Staff Benefits			**$-2,950**	**$-2,681**	**$-2,681**	**$-2,681**	**$-2,681**	**$-2,681**
Total Personal Services			**$-8,026**	**$-7,553**	**$-7,553**	**$-7,553**	**$-7,553**	**$-7,553**

STATE HOSPITALS
VOCATIONAL SERVICES AND PATIENT MINIMUM WAGE CASELOAD
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**-$279**	**$0**	**$0**
One-time	*0.0*	*0.0*	*0.0*	*-$279*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*

BACKGROUND

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

The program consists of clinicians evaluating the patient's current health to determine if the patient meets the preliminary criteria to participate in the program, including medical clearance and approval, determining the patient is not a danger to themselves or others and the program will be beneficial for the patient's treatment and care. The program allows patients to be paid an hourly wage for the work performed. Patient work consists of the following type of jobs:

- Custodial
- Kitchen Worker
- Product Assembler
- Laundry Attendant
- Landscaper
- Painter
- Plumbing
- Barber
- Horticulture
- Multimedia Production
- Peer Mentor
- Office Clerk
- Repair Technician
- Car Wash
- Beauty Shop
- Craft
- Graphic Arts
- Gym
- Grooming Cart
- Library
- Maintenance
- Supported Employment
- Carpentry
- Print Shop
- Recycling
- Sewing
- Teacher Assistant
- Upholstery

The Vocational Rehabilitation Program strives to build and enhance patient skills through direct physical experiences in the hospital or community for employment stabilization and reduction of recidivism.

During fiscal year (FY) 2020-21, the COVID-19 pandemic impacted each hospital's ability to host patient workers due to restrictions on patient movement throughout the hospital to protect the overall health and safety of both patients and staff. As a result, the Vocational Services Program experienced a decline of roughly 30 percent capacity. DSH projected standard operations would resume in January 2022 as COVID-19 cases decrease and vaccination rates increase, allowing patients to resume work on the units.

DESCRIPTION OF CHANGE

DSH is requesting a one-time estimated current year (CY) savings of $279,000. During COVID-19 vocational referrals have been impacted by restrictions on patient work as job sites and activities have had to limit the amount of patient workers at a time. However, as vaccination rates have increased and the number of patient and staff cases have decreased, DSHs patient worker programs are slowly resuming normal activities. DSH will provide an update on the status of patient workers and vocational referrals in the FY 2022-23 May Revision.

FY 2020-21 Actual Data

The table below reflects FY 2020-21 actual data including expenditures, average hours worked and average number of patient workers.

FY 2020-21 Actuals			
State Hospitals	**Avg Hours Worked Per Patient**	**Avg Number of Patient Workers**	**Expenditures**
Atascadero	47	117	$473,342
Coalinga	33	480	$1,366,062
Metropolitan	9	163	$133,447
Napa	8	156	$112,404
Patton	14	60	$71,048
Sacramento	N/A	N/A	$334,000
Total:	**111**	**976**	**$2,490,304**

Current Year Projections

As stated above, hospitals are gradually beginning to resume pre-COVID-19 activities in the Patient Worker Programs. Updates on the status of the Patient Worker Programs will be provided in the 2022-23 May Revision.

Adjustment

Comparing the program allocation to the FY 2021-22 projected expenditures reflecting the planned gradual recommencement of pre-COVID-19 activities, the table below displays a total scored savings of $279,000 in FY 2021-22.

FY 2021-22 Vocational Services Program Projections			
State Hospitals	**FY 2021-22 Allocation**	**FY 2021-22 Projected Expenditures**	**FY 2021-22 Adjustment**
Atascadero	$624,000	$561,000	-$63,000
Coalinga	$1,607,000	$1,493,000	-$114,000
Metropolitan	$133,000	$125,000	-$8,000
Napa	$167,000	$126,000	-$41,000
Patton	$328,000	$275,000	-$53,000
Sacramento	$334,000	$334,000	$0
Total:	**$3,193,000**	**$2,914,000**	**-$279,000**

Fusion II Payroll System

The Fusion II system was fully implemented at DSH-Atascadero and DSH-Napa in May 2021, DSH-Metropolitan in July 2021, and DSH-Coalinga in September 2021. The Fusion II system is scheduled to be deployed at DSH-Patton in November 2021, completing the implementation of this software across all state hospitals.

BCP Fiscal Detail Sheet

BCP Title: Vocational Services and Patient Minimum Wage Caseload **BR Name: 4440-037-ECP-2022-GB**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	-279	0	0	0	0	0
Total Operating Expenses and Equipment	**$-279**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-279**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-279	0	0	0	0	0
Total State Operations Expenditures	**$-279**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-279**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4410010 - Atascadero	364	427	427	427	427	427
4410020 - Coalinga	-213	-99	-99	-99	-99	-99
4410030 - Metropolitan	86	94	94	94	94	94
4410040 - Napa	-632	-591	-591	-591	-591	-591
4410050 - Patton	116	169	169	169	169	169
Total All Programs	**$-279**	**$0**	**$0**	**$0**	**$0**	**$0**

STATE HOSPITALS
MISSION-BASED REVIEW Combined
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**41.0**	**41.0**	**-$17,248**	**$4,210**	**$3,924**
One-time	*0.0*	*0.0*	*0.0*	*-$18,520*	*$286*	*$0*
Ongoing	*0.0*	*41.0*	*41.0*	*$1,272*	*$3,924*	*$3,924*

BACKGROUND:

In 2013, the Department of State Hospitals (DSH) initiated a comprehensive effort to evaluate staffing practices amongst the five state hospitals. This study, identified as DSH's Clinical Staffing Study, was assembled to perform a thorough analysis of past practices and staffing methodologies, and ensure they continue to be adequate and appropriate for the department's growing and evolving populations across all DSH facilities. DSH's population served has grown by 34 percent since fiscal year (FY) 2007-08, including Jail Based Competency Programs (JBCT). In both FY 2019-20 and FY 2020-21 DSH's population served has dropped from impacts of COVID-19, resulting in a growth of 11 percent as comparted to FY 2007-08. In addition to this growth, the composition of the population has changed, becoming increasingly more forensic and geriatric. These dynamics, along with the application of new treatment modalities, over time necessitate the review and analysis of current staffing models.

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

Court Evaluations and Reports

As part of DSH's staffing study efforts and in collaboration with the Department of Finance (DOF) Research and Analysis Unit through a Mission-Based Review, the process for completing all forensic services workload within each hospital's Forensic Services Department was examined. This examination involved review of all statutory language directing the commitment and treatment of patients, depiction of the forensic process (i.e., flow charts) from commitment to discharge for each commitment type, review of datasets available to document the throughput of the process and convening a multitude of subject matter expert interviews to document current practices and challenges. This in-depth review led to the proposed methodologies for staffing each component of Forensic Services.

Direct Care Nursing

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

Workforce Development

Although not a proposal identified through the Staffing Studies, this proposal works in conjunction with the Direct Care Nursing proposal as a means to attract and retain a sufficient workforce of trained medical professionals. While DSH employs a large number of psychiatrists, many positions remain vacant. DSH and other state employers of these disciplines are experiencing difficulties in filling these positions largely due to nationwide shortages. In addition, successful recruitment is also challenged by the high-risk work environment.

While nursing level of care classifications vary at DSH, this request focused primarily on recruitment for registered nurses (RNs) and psychiatric technicians (PTs). These two nursing classifications reflect most of the authorized nursing positions at DSH and have some of the highest vacancy rates. In California, a medical doctor specializing in the diagnosis, treatment, and prevention of mental health illness must complete a four-year residency program in psychiatry to become a licensed psychiatrist.

Protective Services

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

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

The Protective Services component focuses entirely on three key elements:

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

Treatment Team and Primary Care Services

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

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

The following sections will provide specific updates on implementation and outcomes for all five core areas listed above.

STATE HOSPITALS
MISSION-BASED REVIEW – 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**	**-$1,522**	**$0**	**$0**
One-time	*0.0*	*0.0*	*0.0*	*-$1,522*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*

BACKGROUND:

The 2019 Budget Act included 94.6 permanent full-time positions and $40.2 million, 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).

The 2020 Budget Act shifted some of the approved resources into the outyears in response to the economic impact of the COVID-19 pandemic. The positions were shifted based on need and revised to be phased-in across a four-year period.

The 2021 Budget Act recognized a funding oversight in the position phase-in process; the positions phased-in during 2021-22 and ongoing were underfunded. The adjustment will continue annually until all phase-ins are complete.

DECRIPTION OF CHANGE:

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

As of September 30, 2021, a total of 37.7 positions have been established and 30.9 positions have been filled. DSH is actively recruiting to fill these positions, however not all positions have been filled. As a result, DSH is projecting a savings in FY 2021-22 of $705,000.

Evaluations, Court Reports and Testimony	Total	Filled
Senior Psychiatrist Supervisor	2.0	0.0
Senior Psychiatrist Specialist	5.1	1.0
Staff Psychiatrist	-0.5	-0.5
Senior Psychologist Supervisor	5.9	3.7
Senior Psychologist Specialist	45.2	32.3
Psychologist - Clinical	-10.5	-10.5
Consulting Psychologist	4.9	3.9
Research Data Specialist II	1.0	1.0
TOTAL	**53.1**	**30.9**

Outcomes

Due to impacts of COVID-19, reporting of outcomes will be delayed as DSH continues to focus our efforts on COVID-19 response. However, below are the workload measures that DSH anticipates reporting on in the future for this section:

1. Conduct forensic evaluations and complete court reports on all forensic patients within the prescribed timelines.
2. Provide expert forensic testimony upon subpoena.
3. Establish process for collecting and tracking all subpoena and hearing data across all commitment types, identifying key elements such as hearing type, travel and time at court

Forensic Case Management and Data Tracking

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

As of September 30, 2021, a total of 16.3 positions have been established and 10.3 positions have been filled. DSH is actively recruiting to fill these positions, however not all positions have been filled. As a result, DSH is projecting a savings in FY 2021-22 of $425,000.

Case Management and Data Tracking	Total	Filled
Staff Services Manager I	1.0	1.0
Correctional Case Records Supervisor	-1.0	-1.0
Psychiatric Technician	-6.0	-6.0
Associate Governmental Program Analyst	19.1	15.9
Correctional Case Records Analyst	-14.5	-14.5
Staff Services Analyst	17.7	14.9
TOTAL	**16.3**	**10.3**

Outcomes

Due to impacts of COVID-19, reporting of outcomes will be delayed as we continue to focus our efforts on COVID-19 response. However, below are the workload measures that DSH anticipates reporting on in the future for this section:

1. Initiate data cohort studies to document the full process from admission to discharge, assessing all potential datasets and identifying methods for improved tracking.
2. Collaborate with the DSH Technology Services Division and hospital staff to implement additional data tracking methods using existing DSH systems (or DSH systems currently under development).
3. Coordinate all findings through DSH's data governance committee and use finding to inform methodology changes.

Neuropsychological Services

A total of 25.2 positions were allocated to support neuropsychological services, phased-in over two years. This included 11.2 positions for conducting Neuropsychological Assessments and 14.0 positions in a Cognitive Remediation Pilot Program at DSH-Metropolitan and DSH-Napa. In the FY 2020-21 May Revision, recruitment efforts were paused, and resources shifted to focus on managing COVID-19 priorities and minimizing exposure. DSH adjusted the 25.2 positions to be phased-in over three years. The final position phase-in for Neuropsychological Services has been completed as of January 1, 2021.

As of September 30, 2021, a total of 25.2 positions have been established and 21.5 positions have been filled. DSH is actively recruiting to fill these positions, however not all positions have been filled. As a result, DSH is projecting a savings in FY 2021-22 of $392,000.

Neuropsychological Services	Total	Filled
Neuropsychological Assessments and Treatment		
Senior Psychologist Supervisor	3.5	3.0
Senior Psychologist Specialist	7.7	4.5
Cognitive Remediation Pilot Program		
Senior Psychologist Specialist	4.0	4.0
Psychiatric Technician	10.0	10.0
TOTAL	**25.2**	**21.5**

Outcomes

Neuropsychological Services consists of a small staff that provide neuropsychological consultation and evaluation for any patient at the hospital. The increase in positions is intended to assist with decreasing wait time for completion of referrals and increase the number of patients seen monthly.

- DSH-Atascadero was delayed in hiring due to recruitment challenges and has yet to assess any outcomes.
- DSH-Coalinga was delayed in hiring due to recruitment challenges and has yet to assess any outcomes.
- DSH-Metropolitan has completed 54 reports year to date and currently have no patients on the waitlist.
- DSH-Napa has received 84 referrals and has completed 71 assessments starting July 1, 2020 to date.
- DSH-Patton Neuropsychological assessments and treatment have been timelier with the addition of staff. As of July 1, 2021, the team has completed 120 referrals, 30 full evaluations and 63 brief evaluations.

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

Participation in the program has doubled at each location as well. Patient data being collected is pre-treatment and post-treatment data related to violence and aggression. However, quantitative data is still being collected and not yet readily available. However, qualitative data suggests a reduction in aggression and improvements in overall unit functioning (e.g., some patients have received Patient of the Week status).

DSH-Patton has re-tooled their cognitive rehabilitation programs:

- FREE – Functional Rehabilitation and Education Experience for patients who are incompetent to stand trial
- RISE – Recovery Inspired Skills Enhancement for patients who have cognitive impairments and behavior problems

The FREE neuropsychologists developed a computer program to assist with trial competency and the program was installed on several Chrome Books which are taken to their unit-based groups. Despite COVID-19, the FREE program provides services on the units to small groups of patients or on an individual basis.

FREE had 21 patients enrolled from July 2021 to September 2021, six achieved competency and six were deemed NSL. The RISE program was able to expand their unit groups and they now have 37 patients enrolled on nine different groups.

The FREE program has developed a mentoring program where unit clinicians are trained to run the FREE cognitive rehab groups on the units. Outreach to psychologists and other clinical staff has been done to get the mentoring program up and running.

BCP Fiscal Detail Sheet

BCP Title: Mission Based Review: Court Evaluations and Reports **BR Name: 4440-027-ECP-2022-GB**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Salaries and Wages						
Earnings - Permanent	-916	0	0	0	0	0
Total Salaries and Wages	**$-916**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-471	0	0	0	0	0
Total Personal Services	**$-1,387**	**$0**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-66	0	0	0	0	0
5304 - Communications	-9	0	0	0	0	0
5320 - Travel: In-State	-9	0	0	0	0	0
5324 - Facilities Operation	-43	0	0	0	0	0
5346 - Information Technology	-8	0	0	0	0	0
Total Operating Expenses and Equipment	**$-135**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-1,522**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-1,522	0	0	0	0	0
Total State Operations Expenditures	**$-1,522**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-1,522**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4400020 - Hospital Administration	-8	0	0	0	0	0
4410010 - Atascadero	-746	0	0	0	0	0
4410020 - Coalinga	-374	0	0	0	0	0
4410030 - Metropolitan	-197	0	0	0	0	0
4410040 - Napa	-18	0	0	0	0	0
4410050 - Patton	-179	0	0	0	0	0
Total All Programs	**$-1,522**	**$0**	**$0**	**$0**	**$0**	**$0**

BCP Title: Mission Based Review: Court Evaluations and Reports **BR Name: 4440-027-ECP-2022-GB**

Personal Services Details

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
5157 - Staff Svcs Analyst (Gen)	87	0	0	0	0	0
5393 - Assoc Govtl Program Analyst	138	0	0	0	0	0
7609 - Sr Psychiatrist (Supvr)	155	0	0	0	0	0
7616 - Sr Psychiatrist (Spec)	31	0	0	0	0	0
9831 - Sr Psychologist (Hlth Facility) (Supvr)	132	0	0	0	0	0
9839 - Sr Psychologist (Hlth Facility) (Spec)	373	0	0	0	0	0
Total Salaries and Wages	**$916**	**$0**	**$0**	**$0**	**$0**	**$0**
Staff Benefits						
5150200 - Disability Leave - Industrial	-10	0	0	0	0	0
5150210 - Disability Leave - Nonindustrial	-2	0	0	0	0	0
5150350 - Health Insurance	-42	0	0	0	0	0
5150450 - Medicare Taxation	-14	0	0	0	0	0
5150500 - OASDI	-14	0	0	0	0	0
5150600 - Retirement - General	-201	0	0	0	0	0
5150800 - Workers' Compensation	-42	0	0	0	0	0
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	-25	0	0	0	0	0
5150900 - Staff Benefits - Other	-121	0	0	0	0	0
Total Staff Benefits	**$-471**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$445**	**$0**	**$0**	**$0**	**$0**	**$0**

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

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**32.0**	**32.0**	**-$4,572**	**$735**	**$735**
One-time	*0.0*	*0.0*	*0.0*	*-$4,572*	*$0*	*$0*
Ongoing	*0.0*	*32.0*	*32.0*	*$0*	*$735*	*$735*

BACKGROUND:

The 2019 Budget Act included a total of 379.5 positions and $46 million, phased-in over three years, to implement a staffing standard to support the workload of providing 24-hour care nursing services within DSH.

The 2020 Budget Act shifted resources in response to the economic impacts of the COVID-19 pandemic. The positions were shifted based on need and updated to be phased-in across a four-year period.

The 2021 Budget Act recognized a funding oversight in the position phase-in process; the positions phased-in during 2021-22 and ongoing were underfunded. The adjustment will continue annually until all phase-in's are complete.

DESCRIPTION OF CHANGE:

Medication Pass Psychiatric Technicians

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

As of September 30, 2021, a total of 152.5 positions have been established and 104.0 positions have been filled. DSH is actively recruiting to fill these positions, however not all positions have been filled. As a result, DSH is projecting a savings in FY 2021-22 of $2,993,000.

Medication Pass Psychiatric Technicians Phase-ins		
Fiscal Year	**Total**	**Filled**
2019-20	51.5	51.5
2020-21	101.0	52.5
2021-22	102.0	0.0
2022-23	80.5	0.0
TOTAL	**335.0**	**104.0**

Recruiting for these PT positions has proven to be challenging due to lack of candidates available and the need to fill other vacant PT positions on-unit. DSH has been evaluating other nursing classifications that may assist in completing the duties dedicated to this function. Licensed Vocational Nurses (LVN) have been identified as a classification that may be more accessible and easier to recruit. LVN's have the same qualifications as a PT to work withing the dedicated Medication Pass rooms. If hospitals have been unsuccessful in their recruiting efforts with the PT classification, they have been given the opportunity to reclass vacant positions into LVNs to assist in getting vacancies filled. DSH will provide a report on in the 2021-22 May Revision on the status of filling these positions with either classifications.

Outcomes

Due to impacts of COVID-19, reporting of quantitative outcomes will be delayed as DSH continues to focus efforts on COVID-19 response. Since the implementation of the Medication Room Psychiatric Technicians having the Medication Room Psychiatric Technician position out of the count allows more time dedicated to medication administration. This contributes to a lower number of medication errors. Quality Improvement reviews of Medication Room operations at a few DSH locations reflected zero California Department of Public Health (CDPH) licensing deficiencies or citations during this reporting period.

<u>Afterhours Supervising Registered Nurses (SRNs)</u>

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

As of September 30, 2021, a total of 44.5 positions have been established and 26.9 positions have been filled. DSH is actively recruiting to fill these positions, however

not all positions have been filled. As a result, DSH is projecting a savings in FY 2021-22 of $1,579,000.

Afterhours Supervising Registered Nurses Phase-ins		
Fiscal Year	**Total**	**Filled**
2019-20	3.0	3.0
2020-21	6.0	6.0
2021-22	35.5	17.9
TOTAL	**44.5**	**26.9**

Outcomes

Due to impacts of COVID-19, reporting of quantitative outcomes will be delayed as DSH continues to focus efforts on COVID-19 response. These positions are hard to fill due to COVID-19, hospital geographic location and staffing shortages within the hospital. However, for the few hospitals that have successfully hired for these positions, there is anecdotal evidence to suggest these positions have been a true value-add to the hospitals. After hours SRNs have been instrumental in setting up and/or supporting multiple special projects and initiatives such as staffing COVID-19 testing sites; oversight, monitoring and issue resolution on COVID-19 isolation units; addressing and resolving staff conflict regarding assignments/responsibilities; observing unit staff and assessing competency on an ongoing, timely basis via rounds and conducting audits; providing regular and comprehensive feedback to Program Management and other SRNs regarding observations and rounds, actions initiated, and effectiveness of corrective action taken via email hand off reports, in person reports, and attendance of staff and Program Management meetings. Other highlighted duties completed by the SRN include completing workplace injury report, training of plans of corrections for deficiencies, following up on audits results with staff, assisting with developing nursing policies and procedures, ensuring infection prevention and control on the units, conducting in-services including hands on training and participating in hiring interviews.

<u>Redirected Off-Unit Positions</u>

In the original BCP, 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 using classifications Staff Services Analysts (SSA) or Associate Governmental Program Analysts (AGPA), in order to redirect 50.0 nursing positions back to the units. All 50.0 positions have been shifted back to the units, and all 50.0 of the administrative positions received have been filled.

DSH has completed a second analysis of off-unit level of care positions to assess which should be redirected back to on unit and what administrative positions would be needed to complete these functions. In the FY 2022-23 Governor's Budget, DSH is requesting position authority (no funding) for 15.0 Medical Assistant positions, 9.0 AGPA interchangeable positions and 8.0 Psychiatric Technician Assistant (PTA) positions. With these positions added, DSH will be able to put 25.0 Psych Techs, 2.0 RN's, 1.0 LVN and 4.0 PLPT's back on-unit. Similar to the first phase, funding for these positions will be covered by the anticipated decrease in overtime needed to staff on-unit positions.

Alignment of Position Authority

The proposal reallocated position authority between the hospitals to provide DSH-Metropolitan and DSH-Napa authorized positions to meet the need identified by the Direct Care Nursing Budget Change Proposal (BCP). The hospital position shifts are listed below:

- DSH-Atascadero to shift 132.0 positions
- DSH-Coalinga to shift 76.1
- DSH-Patton to shift 27.4
- Once all position shifts are complete, this will equate 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 move between hospitals are no longer vacant, and therefore unavailable to be shifted to a different location. DSH will continue to work with the hospitals to identify remaining positions to be shifted as vacancies are identified.

As of September 30, 2021, 217.5 positions have been shifted and recruitment and hiring efforts continue at DSH-Napa and DSH-Metropolitan to fill all the positions received. This effort redistributed position authority only and did not reallocate funding, so there are no savings associated with the unfilled positions.

Temporary Help and Contracted Help Hours

Temporary help position authority is used to meet intermittent nursing staffing needs. The BCP added 254.0 temporary help position authority to better align budgeted levels with the levels used during FY 2017-18. As of the FY 2022-23 Governor's Budget, DSH will not be requesting additional temporary help resources. DSH will reevaluate the temporary help needs in the 2022-23 May Revision to determine if additional authority is needed. As stipulated in the original

BCP, future requests may include increasing the temporary help authority to better align with hospital staffing needs and reduce overtime usage.

Position Funding Gap

DSH has recognized an oversight in the phase-in process of positions that are tied to MBR – Direct Care Nursing. When each proposal was created, DSH costed each position at the current salary range recognized by CalHR. At the time of development, only the positions in current year (CY) and budget year (BY) would be included in the DOF annual Employee Compensation and Employer Contribution Retirement drills. Any positions requested in the outyears would not be included in the Employee Compensation and Retirement drills until they appear on the Schedule 8. Due to the fact these outyear unestablished positions do not reflect the updated bargaining unit contract negotiations or pay differentials for qualified positions, DSH developed a process to mitigate this issue going forward until all positions are established.

DSH has determined the additional funding for positions that are going to be phased-in for the outyears and requests $735,000 in BY and ongoing.

BCP Fiscal Detail Sheet

BCP Title: Mission Based Review: Direct Care Nursing **BR Name: 4440-028-ECP-2022-GB**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	0.0	32.0	32.0	32.0	32.0	32.0
Total Positions	**0.0**	**32.0**	**32.0**	**32.0**	**32.0**	**32.0**
Salaries and Wages						
Earnings - Permanent	-2,732	634	634	634	634	634
Total Salaries and Wages	**$-2,732**	**$634**	**$634**	**$634**	**$634**	**$634**
Total Staff Benefits	-1,310	99	99	99	99	99
Total Personal Services	**$-4,042**	**$733**	**$733**	**$733**	**$733**	**$733**
Operating Expenses and Equipment						
5301 - General Expense	-265	1	1	1	1	1
5304 - Communications	-33	0	0	0	0	0
5320 - Travel: In-State	-33	0	0	0	0	0
5324 - Facilities Operation	-166	1	1	1	1	1
5346 - Information Technology	-33	0	0	0	0	0
Total Operating Expenses and Equipment	**$-530**	**$2**	**$2**	**$2**	**$2**	**$2**
Total Budget Request	**$-4,572**	**$735**	**$735**	**$735**	**$735**	**$735**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-4,572	735	735	735	735	735
Total State Operations Expenditures	**$-4,572**	**$735**	**$735**	**$735**	**$735**	**$735**
Total All Funds	**$-4,572**	**$735**	**$735**	**$735**	**$735**	**$735**

Program Summary

Program Funding						
4400020 - Hospital Administration	-33	0	0	0	0	0
4410010 - Atascadero	-2,170	218	218	218	218	218
4410020 - Coalinga	-1,474	68	68	68	68	68
4410030 - Metropolitan	-611	91	91	91	91	91
4410040 - Napa	-35	142	142	142	142	142
4410050 - Patton	-249	216	216	216	216	216
Total All Programs	**$-4,572**	**$735**	**$735**	**$735**	**$735**	**$735**

BCP Title: Mission Based Review: Direct Care Nursing **BR Name: 4440-028-ECP-2022-GB**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
5393 - Assoc Govtl Program Analyst				0.0	9.0	9.0	9.0	9.0	9.0
7374 - Medical Assistant				0.0	15.0	15.0	15.0	15.0	15.0
8253 - Psych Techn (Safety)				0.0	8.0	8.0	8.0	8.0	8.0
VR00 - Various				0.0	0.0	0.0	0.0	0.0	0.0
Total Positions				**0.0**	**32.0**	**32.0**	**32.0**	**32.0**	**32.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
5393 - Assoc Govtl Program Analyst	0	0	0	0	0	0
7374 - Medical Assistant	0	0	0	0	0	0
8253 - Psych Techn (Safety)	0	0	0	0	0	0
VR00 - Various	-2,732	634	634	634	634	634
Total Salaries and Wages	**$-2,732**	**$634**	**$634**	**$634**	**$634**	**$634**
Staff Benefits						
5150200 - Disability Leave - Industrial	-36	6	6	6	6	6
5150210 - Disability Leave - Nonindustrial	-10	2	2	2	2	2
5150350 - Health Insurance	-126	30	30	30	30	30
5150450 - Medicare Taxation	-40	10	10	10	10	10
5150600 - Retirement - General	-532	-80	-80	-80	-80	-80
5150700 - Unemployment Insurance	-2	0	0	0	0	0
5150800 - Workers' Compensation	-126	30	30	30	30	30
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	-77	17	17	17	17	17
5150900 - Staff Benefits - Other	-361	84	84	84	84	84
Total Staff Benefits	**$-1,310**	**$99**	**$99**	**$99**	**$99**	**$99**
Total Personal Services	**$-4,042**	**$733**	**$733**	**$733**	**$733**	**$733**

STATE HOSPITALS
WORKFORCE DEVELOPMENT
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**-$415**	**$0**	**$0**
One-time	*0.0*	*0.0*	*0.0*	*-$415*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*

BACKGROUND:

The 2019 Budget Act included a total of 8.0 positions and $1.5 million to develop and implement a Psychiatric Residency Program and expand resources for Nursing Recruitment to meet the mission of providing mental health services to patients and reduce vacancy rates for mental health providers. Of the positions allotted, 2.0 are for the Residency Program and 5.0 are for expanding Nursing Recruitment.

In the 2021 Budget Act, DSH reported that the Psychiatric Residency Program anticipated its first cohort in July 2021. For the Nursing Recruitment, DSH reported that DSH-Atascadero and DSH-Napa expanded their cohorts. As reported in the 2021-22 May Revision, DSH-Coalinga is no longer moving forward with the West Hills Community College (WHCC) contract to expand their cohorts. As a result, DSH reclassed the Nurse Instructor to an Associate Governmental Program Analyst (AGPA) to be a Recruitment Outreach Specialist focused on addressing nursing recruitment challenges.

DESCRIPTION OF CHANGE:

<u>Residency Program Update</u>

The Residency Program at St. Joseph Medical Center (SJMC) received accreditation from the Accreditation Council for Graduate Medical Education (ACGME) in February 2021, which enabled recruitment for residents. Since that time, both DSH positions of an Associate Program Director and Hospital Administration Resident II have been filled and the Residency Program has matched its first cohort of seven residents which began in July 2021. With the current contract in place, 28 residents will be in the program by post graduate year four. Of those no more than eight will be onsite at any given time.

When DSH originally put forward the Residency Program as part of the Workforce Development Budget Change Proposal (BCP) in the 2019 Budget Act, estimates were made on the number of residents and when the program would begin. When the final number of residents were provided by SJMC, it was higher than what DSH had projected in the original request (7 residents versus 4 residents per program year). However, due to the year delay in implementation due to COVID-19, sufficient funding remains from the original BCP until fiscal year (FY) 2024-25 to fund the additional residents. In current year, DSH is anticipating a savings of $363,000 due to the delay in beginning the Residency Program.

Given the success of recruiting the first cohort, DSH is currently working with SJMCs on potentially increasing the number of residents participating in the Residency Program. Per the ACGME, any expansions to a program should occur within the first five years of the program being established. DSH will provide more information on the status of the proposed program expansion and potential number of residents in the 2022-23 May Revision.

Nursing Recruitment Update

DSH-Atascadero:

DSH-Atascadero and Cuesta College had expanded their cohort sizes to accommodate 45 students per cohort. However due to COVID-19 this has temporarily been reduced to 30 per cohort. DSH-Atascadero and Cuesta College anticipate returning to 45 students per cohort beginning in January 2022. As of September 30, 2021, all Nurse Instructor positions are filled.

Cohorts from 2019 started with 90 students and graduated 73. Cohorts from 2020 started with 75 students and graduated 61. Cohorts for 2021 so far have started with 60 students and graduated 53. DSH will provide more information on the number of students who graduate from the 2021 cohorts in the 2022-23 May Revision.

DSH-Coalinga:

DSH-Coalinga originally planned to expand on existing contracts with WHCC and Porterville College in the Central Valley to train PTs and RNs to bring on larger cohorts. At this time, WHCC is no longer moving forward with the expansion of cohort sizes. Porterville College is also not planning to expand. As a result of the expansions not moving forward, the allocated Nurse Instructor position was reclassed to an AGPA to assist with outreach and recruitment efforts of the nursing positions. As of September 30, 2021, this position has not been filled and interviews

are being held in early October. As a result, DSH recognizes savings in FY 2021-22 of $52,000 due to delays in hiring.

DSH-Napa:

DSH-Napa and Napa Valley College have executed a contract which includes the existing two cohorts per year and added an additional six students each, for a total cohort size of 36 students per cohort. This varies from the original plan of adding an additional cohort at Napa Valley College. The Nurse Instructor position began teaching at Napa Valley College in April of 2021. Since then, the position has become vacant again. DSH is in the process of filling this vacant position but has had issues due to finding qualified candidates and ones who are able to have flexible schedules to work within the different start and end dates to accommodate the semester courses and clinicals.

The first cohort from 2020 started with 30 students and due to COVID-19 three graduated in May 2021. Two graduates obtained employment at DSH-Napa in August 2021. The second cohort from 2020 started with 30 students and is expecting to graduate 15 students in December of 2021. DSH will provide more information on the number of students who graduate and potential number of hires for DSH in the 2022-23 May Revision.

BCP Fiscal Detail Sheet

BCP Title: Mission Based Review: Workforce Development **BR Name: 4440-026-ECP-2022-GB**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Salaries and Wages						
Earnings - Permanent	-29	0	0	0	0	0
Total Salaries and Wages	**$-29**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-18	0	0	0	0	0
Total Personal Services	**$-47**	**$0**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-3	0	0	0	0	0
5324 - Facilities Operation	-2	0	0	0	0	0
5340 - Consulting and Professional Services - External	-363	0	0	0	0	0
Total Operating Expenses and Equipment	**$-368**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-415**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-415	0	0	0	0	0
Total State Operations Expenditures	**$-415**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-415**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4410020 - Coalinga	-52	0	0	0	0	0
4410040 - Napa	-363	0	0	0	0	0
Total All Programs	**$-415**	**$0**	**$0**	**$0**	**$0**	**$0**

Personal Services Details

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
5393 - Assoc Govtl Program Analyst	-29	0	0	0	0	0
Total Salaries and Wages	**$-29**	**$0**	**$0**	**$0**	**$0**	**$0**
Staff Benefits						
5150350 - Health Insurance	-1	0	0	0	0	0
5150500 - OASDI	-2	0	0	0	0	0
5150600 - Retirement - General	-9	0	0	0	0	0
5150800 - Workers' Compensation	-1	0	0	0	0	0
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	-1	0	0	0	0	0
5150900 - Staff Benefits - Other	-4	0	0	0	0	0
Total Staff Benefits	**$-18**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$-47**	**$0**	**$0**	**$0**	**$0**	**$0**

STATE HOSPITALS
MISSION-BASED REVIEW – PROTECTIVE SERVICES
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**10.0**	**10.0**	**-$1,589**	**$2,298**	**$2,012**
One-time	*0.0*	*0.0*	*0.0*	*-$2,265*	*$286*	*$0*
Ongoing	*0.0*	*10.0*	*10.0*	*$676*	*$2,012*	*$2,012*

BACKGROUND:

The Budget Change Proposal (BCP) contained within the fiscal year (FY) 2020-21 Governor's Budget included a total request of 94.1 positions and $12 million, phased in across a two-year period, to support a standardized staffing approach to support the workload of providing protective services functions to DSH employees and patients.

Due to COVID-19, the 2020 Budget Act reflected the approved methodologies that were presented in the BCP; however, no dollars or positions were authorized. DSH utilized overtime budget for off-grounds custody to administratively establish 12.0 additional Hospital Police Officer (HPO) positions.

The 2021 Budget Act included 94.1 positions and $11.4 million, phased in over two years to support the full implementation in alignment with the methodology previously approved in the 2020 Budget Act.

The total staffing needs included in the Protective Services proposal as part of the 2021 Budget Act are noted in the following table:

Classification	Total Need	Current Resources	Remaining Need
OPS: Chief of Law Enforcement	1.0	1.0	0.0
OPS: Assistant Chief of Law Enforcement	1.0	0.0	1.0
Chief of Police	5.0	0.0	5.0
Assistant Chief of Police	0.0	0.0	0.0
Hospital Police Lieutenant	6.0	3.0	3.0
Hospital Sergeant	18.6	14.3	4.3
Hospital Police Officer	212.2	131.4	80.8
TOTAL	**243.8**	**149.7**	**94.1**

DESCRIPTION OF CHANGE:

Support and Operations Division

A total of 88.1 positions were allocated to support the Support and Operations Division to be phased in over two years. As result of the OPS Police Academy schedule, DSH has determined a phase-in schedule for the requested positions which aligns with cohorts in an effort to maximize funding and recruitment. The Support and Operations division personnel are responsible for the security of main sally-ports, visiting centers, package centers, transportation, admission units, off-grounds custody, perimeter kiosks, hospital patrol (i.e., corridor and building patrol, grounds and patient services patrol, perimeter patrol), investigations and the communication and dispatch centers at the hospitals. Personnel in this division include Hospital Police Lieutenant, Hospital Police Sergeant, and Hospital Police Officers.

As of September 30, 2021, a total of 24.0 positions have been established and none have been filled. Of the 24.0, 12.0 were established in prior year and 12.0 were established in August 2021 to align with the most recent graduating class of the DSH academy. DSH anticipates recruits to apply for and fill these positions, however, due to timing of this update, that information is not available yet. The next DSH academy has started and is scheduled to finish in December 2021. As a result, DSH is projecting a savings in FY 2021-22 of $1,377,000.

Classification	Total	Filled
Hospital Police Lieutenant	3.0	0.0
Hospital Sergeant	4.3	0.0
Hospital Police Officer	80.8	0.0
TOTAL	**88.1**	**0.0**

During the Staffing Study, DSH-Coalinga's Main Courtyard Expansion was still in progress and the staffing needs had not been reviewed. The Department of Police Services (DPS) already has substantial overtime costs and there are an insufficient number of officers to staff the new courtyard, which is scheduled to open January 2022. The physical layout, geographic location, and number of patients that can be accommodated in the main courtyard expansion require officers posted on the yard during all hours of operation. There are two officer positions needed to staff this expansion on two shifts a day for seven days a week. The workload analysis is included in Attachment A below. In FY 2022-23, DSH requests to redirect $671,000 in savings and administratively establish 10.0 HPOs effective January 1, 2022 (when an academy is scheduled to graduate) for current year. DSH requests $1.34 million and 10.0 positions in FY 2022-23 and ongoing for the Courtyard Expansion to be fully staffed.

Executive Leadership Structure

A total of 6.0 positions were allocated to support the Executive Leadership Structure in the beginning of FY 2021-22. The OPS leadership strives to streamline processes and procedures on an enterprise level and provide ongoing training, supervision, and guidance to law enforcement personnel to ensure the safety and security of the patients, staff and community.

As of September 30, 2021, a total of 6.0 positions have been established and none have been filled. DSH has developed the duty statements for these new positions, and they have been advertised. As a result, DSH is projecting a savings in FY 2021-22 of $671,000.

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

Field Training Overtime Funding

Once HPO cadets complete the OPS Police Academy coursework and graduate, it is mandatory to perform four months of field training with another officer. Because of these field training requirements, two HPOs will be assigned to the same post, resulting in overtime. These overtime costs will only be required during the implementation of the Protective Services proposal. Due to the delays in hiring, the table below displays the adjustments to the one-time funding needed by location per FY:

Overtime Funding Adjustment				
Hospital	**2021-22**	**2022-23**	**2023-24**	**Total**
Atascadero	-$65,000	$65,000	$0	**$0**
Metropolitan	-$51,000	$51,000	$0	**$0**
Napa	-$170,000	$170,000	$0	**$0**
TOTAL	**-$286,000**	**$286,000**	**$0**	**$0**

Position Funding Gap

DSH has recognized an oversight in the phase-in process of positions that are tied to MBR – Protective Services. When each proposal was created, DSH costed each position at the current salary range recognized by CalHR. At the time of development, only the positions in current year (CY) would be included in the

DOF annual Employee Compensation and Employer Contribution Retirement drills. Any positions requested in the outyears would not be included in the Employee Compensation and Retirement drills until they appear on the Schedule 8. Due to the fact these outyear unestablished positions do not reflect the updated bargaining unit contract negotiations or pay differentials for qualified positions, DSH developed a process to mitigate this issue going forward until all positions are established. DSH has determined the additional funding for positions that are going to be phased-in for the outyears and requests $660,000 in FY 2022-23 and ongoing.

Attachment A: Workload Analysis

WORKLOAD ANALYSIS FOR:

Hospital Police Officer	***Hours Required to Accomplish***	***Frequency of Task***	**Months**	***Total Hours Projected (Annually)***
The officers would be required to provide safety and security for the main courtyard expansion (courtyard) when it opens. The courtyard is connected to the main courtyard as the only access in or out of the courtyard. The courtyard is 19,680 square feet. The main courtyard connects to the El Camino Real Hallway. As the main courtyard officer and the El Camino Real Officers are responsible for their work areas two officers are required at a minimum to provide officer backup in case of disturbances until additional officers can arrive. The maximum capacity for this courtyard is 3,200. When the hospital is in full operation there can be up to an estimated 800 patients out on this yard at a time. The officers will monitor the patients physically by patrols and through a camera system in each of the two officer stations situated on opposite sides of the yard. The courtyard would operate from 0800 to 2100 hours each day with a few hour breaks in the day for patient counts. This time will cover two shifts of two officers each for seven days a week. This is 32 hours a day for four officers, seven days a week 365 days a year. To cover the	32 hours daily. Two shifts of two officers each.	Daily	12	17,760

yard and provide effective relief will take ten officers.				

The courtyard officers will be a uniformed presence to prevent physical disturbances between the patients. The officers will conduct occasional contraband searches of the patients, enforce state and federal laws, and enforce hospital administrative directives. The officers will be able to communicate via radio to each other and other officers in the facility to request assistance. The officers will summon assistance in case of medical emergencies and provide information to responding medical personnel. The officers will investigate any criminal activity and write appropriate crime reports and informational reports documenting crimes and non-criminal issues inside the courtyard.				

The officers will search the courtyard each day before it opens for contraband or any damage or hazards. The officers will monitor the environmental conditions in the courtyard. The officers would immediately report any environmental or infrastructure issues to the appropriate authorities. The officers will write work orders for any needed repairs. Officers would also be responsible for monitoring self-injurious or suicidal behaviors such as ligature risks due to all the exercise equipment in the courtyard.				
TOTAL HOURS PROJECTED ANNUALLY				**17,760**
TOTAL HOURS PROJECTED ANNUALLY: 1,776 (hours/1,776 = PYs)				
TOTAL POSITIONS NEEDED 10				

BCP Fiscal Detail Sheet

BCP Title: Mission Based Review: Protective Services **BR Name: 4440-025-ECP-2022-GB**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	0.0	10.0	10.0	10.0	10.0	10.0
Total Positions	**0.0**	**10.0**	**10.0**	**10.0**	**10.0**	**10.0**
Salaries and Wages						
Earnings - Permanent	-723	1,182	1,182	1,182	1,182	1,182
Overtime/Other	-286	286	0	0	0	0
Total Salaries and Wages	**$-1,009**	**$1,468**	**$1,182**	**$1,182**	**$1,182**	**$1,182**
Total Staff Benefits	-447	670	670	670	670	670
Total Personal Services	**$-1,456**	**$2,138**	**$1,852**	**$1,852**	**$1,852**	**$1,852**
Operating Expenses and Equipment						
5301 - General Expense	-65	80	80	80	80	80
5304 - Communications	-9	10	10	10	10	10
5320 - Travel: In-State	-9	10	10	10	10	10
5324 - Facilities Operation	-42	50	50	50	50	50
5346 - Information Technology	-8	10	10	10	10	10
Total Operating Expenses and Equipment	**$-133**	**$160**	**$160**	**$160**	**$160**	**$160**
Total Budget Request	**$-1,589**	**$2,298**	**$2,012**	**$2,012**	**$2,012**	**$2,012**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-1,589	2,298	2,012	2,012	2,012	2,012
Total State Operations Expenditures	**$-1,589**	**$2,298**	**$2,012**	**$2,012**	**$2,012**	**$2,012**
Total All Funds	**$-1,589**	**$2,298**	**$2,012**	**$2,012**	**$2,012**	**$2,012**

Program Summary

Program Funding						
4400010 - Headquarters Administration	-3	0	0	0	0	0
4400020 - Hospital Administration	-108	10	10	10	10	10
4410010 - Atascadero	-339	77	12	12	12	12
4410020 - Coalinga	578	1,342	1,342	1,342	1,342	1,342
4410030 - Metropolitan	-525	71	20	20	20	20
4410040 - Napa	-1,089	798	628	628	628	628

4410050 - Patton	-103	0	0	0	0	0
Total All Programs	**$-1,589**	**$2,298**	**$2,012**	**$2,012**	**$2,012**	**$2,012**

BCP Title: Mission Based Review: Protective Services **BR Name: 4440-025-ECP-2022-GB**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
1937 - Hosp Police Officer				0.0	10.0	10.0	10.0	10.0	10.0
7500 - - C.E.A. - A				0.0	0.0	0.0	0.0	0.0	0.0
OT00 - Overtime				0.0	0.0	0.0	0.0	0.0	0.0
VR00 - Various				0.0	0.0	0.0	0.0	0.0	0.0
Total Positions				**0.0**	**10.0**	**10.0**	**10.0**	**10.0**	**10.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
1937 - Hosp Police Officer	-381	732	732	732	732	732
7500 - - C.E.A. - A	-342	0	0	0	0	0
OT00 - Overtime	-286	286	0	0	0	0
VR00 - Various	0	450	450	450	450	450
Total Salaries and Wages	**$-1,009**	**$1,468**	**$1,182**	**$1,182**	**$1,182**	**$1,182**
Staff Benefits						
5150200 - Disability Leave - Industrial	-10	15	15	15	15	15
5150210 - Disability Leave - Nonindustrial	-3	5	5	5	5	5
5150350 - Health Insurance	-34	55	55	55	55	55
5150450 - Medicare Taxation	-11	17	17	17	17	17
5150600 - Retirement - General	-230	319	319	319	319	319
5150700 - Unemployment Insurance	-1	1	1	1	1	1
5150800 - Workers' Compensation	-34	55	55	55	55	55
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	-28	46	46	46	46	46
5150900 - Staff Benefits - Other	-96	157	157	157	157	157
Total Staff Benefits	**$-447**	**$670**	**$670**	**$670**	**$670**	**$670**
Total Personal Services	**$-1,456**	**$2,138**	**$1,852**	**$1,852**	**$1,852**	**$1,852**

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

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**-1.0**	**-1.0**	**-$9,150**	**$1,177**	**$1,177**
One-time	*0.0*	*0.0*	*0.0*	*-$9,746*	*$0*	*$0*
Ongoing	*0.0*	*-1.0*	*-1.0*	*$596*	*$1,177*	*$1,177*

BACKGROUND

The Budget Change Proposal (BCP) contained within the fiscal year (FY) 2020-21 Governor's Budget included a total request of 250.2 positions and $64.2 million, phased in across a five-year period, to support the workload of providing psychiatric and medical care treatment to patients committed to DSH.

Due to COVID-19, the 2020 Budget Act reflected the approved methodologies contained in the BCP but only provided funding and resources for the most critical portions of the proposal, approving 40.0 positions and $10 million in funding.

The 2021 Budget Act included 213.3 positions and $54.1 million, phased-in over five years to support full implementation in alignment with the methodology previously approved in the 2020 Budget Act.

The total staffing needs of the Treatment Team proposal as part of recent Budget Acts are reflected in the table below:

Classification	Total Need	Current Resources	Remaining Need
Assistant Director of Dietetics	1.0	0.0	1.0
Assistant Medical Director	1.0	0.0	1.0
Associate Personnel Analyst	6.0	0.0	6.0
Chief of Primary Care Services	5.0	0.0	5.0
Chief Physician & Surgeon	11.0	5.0	6.0
Clinical Social Worker	292.3	259.3	33.0
Medical Director	6.0	0.0	6.0
Pharmacist II	1.0	0.0	1.0
Physician & Surgeon	148.4	121.5	26.9
Program Director	1.0	0.0	1.0
Psychiatrist	287.3	224.7	62.6
Psychologist	287.3	227.6	59.7
Rehabilitation Therapist	288.4	256.3	32.1

Senior Psychiatrist Supervisor	1.0	0.0	1.0
Senior Psychologist Specialist	5.0	0.0	5.0
Senior Psychologist Supervisor	2.0	0.0	2.0
Supervising Registered Nurse	1.0	0.0	1.0
Supervising Rehab Therapist	1.0	0.0	1.0
Unit Supervisor	1.0	0.0	1.0
TOTAL	**1,346.7**	**1,094.4**	**252.3**

DESCRIPTION OF CHANGE:

The overall need for full implementation is 252.3 positions. DSH has recognized an oversight and established an additional 1.0 position in the 2021 Budget Act. DSH will return 1.0 positions and $137,000 in 2022-23 and ongoing.

Interdisciplinary Treatment Team

A total of 180.4 positions were allocated to support the Interdisciplinary Treatment Team to be phased in over five years. The Treatment Team is responsible for the planning and delivery of treatment, discipline-specific other workload, administrative and professional responsibilities, crisis prevention, unit milieu work and crisis and incident management.

As of September 30, 2021, a total of 16.2 positions have been established and none have been filled. DSH is actively recruiting to fill these positions, however not all positions have been filled. As a result, DSH is projecting a savings in FY 2021-22 of $1,891,000.

Interdisciplinary Treatment Team	Total	Filled
Psychiatrist	61.6	0.0
Psychologist	59.7	0.0
Clinical Social Worker	27.0	0.0
Rehabilitation Therapist	32.1	0.0
TOTAL	**180.4**	**0.0**

Primary Medical Care

A total of 31.9 positions were allocated to support Primary Medical Care to be phased in over three years. DSH provides medical services to its patients, encompassing routine preventative care and the treatment of non-life-threatening medical illness. Primary Care Departments are currently led by a Chief Physician and Surgeon who reports directly to the Medical Director. The Chief Physician and Surgeon is responsible for all medical services, dental services,

allied health (including radiology), public health, physical therapy, clinical laboratories, and pharmacy operations. Similar to the treatment team caseloads, primary care caseload is impacted by treatment categories and the medical workload associated with each category.

As of September 30, 2021, a total of 19.6 positions have been established and 3.2 positions have been filled. DSH is actively recruiting to fill these positions, however not all positions have been filled. As a result, DSH recognizes savings in FY 2021-22 of $3,246,000.

Primary Medical Care	Total	Filled
Chief Physician & Surgeon	6.0	1.0
Physician & Surgeon	25.9	2.2
TOTAL	**31.9**	**3.2**

Trauma-Informed Care

A total of 6.0 positions were allocated to support Trauma-Informed Care to be fully phased in beginning of FY 2021-22. Trauma-informed care is a comprehensive approach that shapes the wider culture of a hospital. It achieves sustainable organizational change through workforce training, trauma-informed policies and standards, and the provision of evidence-based, trauma-specific screening, assessment, referral, and treatment. Trauma-informed care is broadly associated with improved mental health outcomes, more effective behavior management, and reduced violence and aggression.

As of September 30, 2021, a total of 6.0 positions have been established and 1.0 positions has been filled. DSH is actively recruiting to fill these positions, however not all positions have been filled. As a result, DSH is projecting a savings in FY 2021-22 of $480,000.

Trauma-Informed Care	Total	Filled
Senior Psychologist Supervisor[1]	1.0	0.0
Senior Psychologist Specialist	5.0	1.0
TOTAL	**6.0**	**1.0**

[1] Position reclassed to a Program Director

Clinical Executive Structure

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

Administrative Support Positions

A total of 6.0 positions were allocated to support Administrative Services to be fully phased in beginning of FY 2021-22. The increase of staff within this proposal, as well as the complexities associated with filling these classifications, has created a need for additional personnel staff. To address this need, this proposal established additional Associate Personnel Analyst (APA) at each of the five hospitals and DSH-Sacramento. These APAs will be responsible for implementation efforts and providing ongoing personnel management support such as including classification and pay, recruitment, selection, retention, training, benefits, position control and organizational development. Subsequent to this approval, DSH evaluated if other classification may be better suited to achieving this additional workload. It was deemed that if a hospital chooses to do so, they can reclass this APA to a Staff Services Analyst (SSA)/Associate Governmental Program Analyst (AGPA) interchangeable position to better met operational need and to expand the pool of candidates. Filling as an interchangeable SSA/AGPA will aide in the recruitment process and longevity of an incumbent staying within the division/department. This option provides a promotional pathway and allows DSH to use the AGPA exam list as appropriate. The functions of these positions will generally remain unchanged.

As of September 30, 2021, a total of 6.0 positions have been established and none have been filled. DSH is actively recruiting to fill these positions. As a result, DSH is projecting a savings in FY 2021-22 of $379,000.

Administrative Support	Total	Filled
Associate Personnel Analyst	6.0	0.0
TOTAL	**6.0**	**0.0**

Clinical Executive Leadership

A total of 12.0 positions were allocated to support Clinical Executive Leadership to be fully phased in beginning FY 2021-22. The Clinical Executive Leadership positions provide leadership for various departments and disciplines. They are required to meet the legal requirements for the practice of medicine in California as determined by the Medical Board of California or the California Board of Osteopathic Examiners and must meet all legal requirements to practice psychiatry in California.

To be able to successfully recruit and fill the Medical Leadership positions (Medical Director, Assistant Medical Director, and Chief of Primary Care) there are several administrative approval processes to be pursued through the California Department of Human Resources (CalHR). These include Safety Retirement

approvals for these leadership positions and establishment and conversion of exempt positions. DSH has received approval for almost all of the positions.

In addition to the above challenges, DSH has experienced issues with pay compaction for the leadership positions. When these positions were first established in the proposal the pay ranges identified were less than the ranges of the positions they would oversee. Due to this issue, DSH has updated the pay ranges and this change results in a request in funding of $596,000 in FY 2021-22 and ongoing.

As of September 30, 2021, a total of 12.0 positions have been established and none have been filled. DSH is currently recruiting for all positions and advertising on LinkedIn, Psychiatric Times, CalCareers and the DSH external website. As a result, DSH is projecting a savings in FY 2021-22 of $3,298,000.

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

Discharge Strike Team

A total of 6.0 positions were allocated to support The Discharge Strike Team to be fully phased in beginning FY 2021-22. The Discharge Strike Team will focus on establishing and strengthening relationships with placement communities to improve knowledge of various community resources, address barriers to placement and improve communication in efforts to expedite placement. These efforts will allow DSH to increase the rate of patient discharge and patient placement into a lower level of care for eligible patients.

As of September 30, 2021, a total of 6.0 positions have been established and none have been filled. DSH has developed the duty statements for these new positions, and they have been advertised. As a result, DSH is projecting a savings in FY 2021-22 of $452,000.

Discharge Strike Team	Total	Filled
Program Director	1.0	0.0
Clinical Social Worker	5.0	0.0
TOTAL	**6.0**	**0.0**

Clinical Operations Advisory Council Positions (COAC)

A total of 10.0 positions were allocated to support the COAC team to be fully phased in beginning FY 2021-22. The Clinical Operations Division facilitates the development, evaluation and maintenance of clinical standards for DSH. Included as part of this division is COAC, an interdisciplinary leadership team of clinicians from across the system, which is responsible for developing interdisciplinary best practices that can be standardized and deployed systemwide. COAC serves a critical need as it provides leadership for the provision of quality clinical care and therapeutic services to DSH patients.

Position authority only was requested as these positions were originally either borrowed from other areas in the hospitals are established in the blanket. As of September 30, 2021, a total of 10.0 positions have been established in Sacramento and the staff are being redirected. The vacated hospital positions are being re-directed either back on unit or abolished if they were in the blanket.

Classification	Total
Senior Psychiatrist Supervisor	1.0
Clinical Social Worker	1.0
Psychiatrist	1.0
Supervising Rehab Therapist	1.0
Physician and Surgeon	1.0
Assistant Director of Dietetics	1.0
Pharmacist II	1.0
Unit Supervisor	1.0
Senior Psychologist Supervisor	1.0
Supervising Registered Nurse	1.0
TOTAL	**10.0**

Position Funding Gap

DSH has recognized an oversight in the phase-in process of positions that are tied to MBR – Treatment Team and Primacy Care Services. When each proposal was created, DSH costed each position at the current salary range recognized by CalHR. At the time of development, only the positions in current year (CY) would be included in the DOF annual Employee Compensation and Employer Contribution Retirement drills. Any positions requested in the outyears would not be included in the Employee Compensation and Retirement drills until they appear on the Schedule 8. Due to the fact these outyear unestablished positions do not reflect the updated bargaining unit contract negotiations or pay

differentials for qualified positions, DSH developed a process to mitigate this issue going forward until all positions are established. DSH has determined the additional funding for positions that are going to be phased-in for the outyears and requests $718,000 in FY 2022-23 and ongoing.

Equipment, Facilities, and Infrastructure Funding

With the large increase in staffing from the MBR Treatment Team BCP, DSH reviewed current resources and determined that additional modular/trailer office buildings, furnishings, and information technology (IT) infrastructure would be needed beyond the standard complement allocated per position. In order to fully implement this proposal, DSH requested one-time funding to support the purchase and installation of these office spaces and equipment.

As of September 30, 2021, DSH's internal planning efforts to identify its programmatic needs continues in conjunction with an assessment of the existing infrastructure to determine the extent of site preparations required at each facility. At this time, DSH does not anticipate any savings resulting in FY 2021-22.

BCP Fiscal Detail Sheet

BCP Title: Mission Based Review: Treatment Team **BR Name: 4440-029-ECP-2022-GB**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	0.0	-1.0	-1.0	-1.0	-1.0	-1.0
Total Positions	**0.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**
Salaries and Wages						
Earnings - Permanent	-5,761	851	851	851	851	851
Total Salaries and Wages	**$-5,761**	**$851**	**$851**	**$851**	**$851**	**$851**
Total Staff Benefits	-2,823	342	342	342	342	342
Total Personal Services	**$-8,584**	**$1,193**	**$1,193**	**$1,193**	**$1,193**	**$1,193**
Operating Expenses and Equipment						
5301 - General Expense	-268	-8	-8	-8	-8	-8
5304 - Communications	-43	-1	-1	-1	-1	-1
5320 - Travel: In-State	-43	-1	-1	-1	-1	-1
5324 - Facilities Operation	-178	-5	-5	-5	-5	-5
5346 - Information Technology	-34	-1	-1	-1	-1	-1
Total Operating Expenses and Equipment	**$-566**	**$-16**	**$-16**	**$-16**	**$-16**	**$-16**
Total Budget Request	**$-9,150**	**$1,177**	**$1,177**	**$1,177**	**$1,177**	**$1,177**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-9,150	1,177	1,177	1,177	1,177	1,177
Total State Operations Expenditures	**$-9,150**	**$1,177**	**$1,177**	**$1,177**	**$1,177**	**$1,177**
Total All Funds	**$-9,150**	**$1,177**	**$1,177**	**$1,177**	**$1,177**	**$1,177**

Program Summary

Program Funding						
4400010 - Headquarters Administration	-782	27	27	27	27	27
4400020 - Hospital Administration	-34	-1	-1	-1	-1	-1
4410010 - Atascadero	-1,585	58	58	58	58	58
4410020 - Coalinga	-2,041	403	403	403	403	403
4410030 - Metropolitan	-1,621	189	189	189	189	189
4410040 - Napa	-1,368	228	228	228	228	228
4410050 - Patton	-1,719	273	273	273	273	273

Total All Programs	**$-9,150**	**$1,177**	**$1,177**	**$1,177**	**$1,177**	**$1,177**

BCP Title: Mission Based Review: Treatment Team **BR Name: 4440-029-ECP-2022-GB**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
8324 - Rehab Therapist (Recr-Safety)				0.0	-1.0	-1.0	-1.0	-1.0	-1.0
VR00 - Various				0.0	0.0	0.0	0.0	0.0	0.0
Total Positions				**0.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
8324 - Rehab Therapist (Recr-Safety)	0	-82	-82	-82	-82	-82
VR00 - Various	-5,761	933	933	933	933	933
Total Salaries and Wages	**$-5,761**	**$851**	**$851**	**$851**	**$851**	**$851**
Staff Benefits						
5150200 - Disability Leave - Industrial	-78	11	11	11	11	11
5150210 - Disability Leave - Nonindustrial	-19	0	0	0	0	0
5150350 - Health Insurance	-267	42	42	42	42	42
5150450 - Medicare Taxation	-93	10	10	10	10	10
5150500 - OASDI	-11	0	0	0	0	0
5150600 - Retirement - General	-1,151	105	105	105	105	105
5150700 - Unemployment Insurance	-2	1	1	1	1	1
5150800 - Workers' Compensation	-267	42	42	42	42	42
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	-164	23	23	23	23	23
5150900 - Staff Benefits - Other	-771	108	108	108	108	108
Total Staff Benefits	**$-2,823**	**$342**	**$342**	**$342**	**$342**	**$342**
Total Personal Services	**$-8,584**	**$1,193**	**$1,193**	**$1,193**	**$1,193**	**$1,193**

STATE HOSPITALS
TELEPSYCHIATRY RESOURCES
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**	**$0**
One-time	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*

BACKGROUND

The Department of State Hospitals (DSH) has increased its use of telepsychiatry to provide psychiatric treatment remotely to patients at hospitals where it is historically difficult to hire psychiatrics due to geographical location. Telepsychiatry uses electronic communications and information technologies to provide clinical psychiatric care services to all patients, regardless if the patient is a penal code or civil commitment. In a conference room equipped with interactive videoconferencing equipment, treatment team staff and telepsychiatry coordinators (Psychiatric Technicians, PT) at the hospital can present patients and their treatment plans to a Staff Psychiatrist at a remote location also equipped with videoconferencing capability. This allows the provider to observe patient behavior and discuss their care with colleagues.

Although physically in another location, the remote telepsychiatrist maintains the same responsibilities as a psychiatrist physically located at the treating hospital. The telepsychiatrist actively participates in treatment conferences, serves as a member of the patient's treatment team, and performs the same duties as an onsite Staff Psychiatrist, with the exception of ordering seclusion and restraint in emergency situations.

The 2019 Budget Act authorized DSH to redirect 18.0 existing vacant Staff Psychiatrist positions as telepsychiatrists to be phased-in over two years. DSH also received authority for 18 Psychiatric Technicians based on a 1:1 staffing ratio to Staff Psychiatrist to coordinate telepsychiatry services.

The 2021 Budget Act reflected a one-time savings as a result of a hiring delay at DSH-Atascadero and a position redirection to DSH-Coalinga. Seven positions originally identified for telepsychiatry services at DSH-Atascadero were shifted to DSH-Coalinga where recruitment and hiring efforts had begun.

DESCRIPTION OF CHANGE

Telepsychiatry Staffing Update

Oversight

One position was allocated to provide oversight and guidance of the Staff Psychiatrists and telepsychiatry program overall.

As of September 30, 2021, 1.0 position has been established and 1.0 position has been filled.

Staff Psychiatrist

A total of 18.0 existing vacant Staff Psychiatrist positions were allocated to support telepsychiatry services to be phased-in over two years.

Hospital[1]	Total	Filled
DSH-Atascadero	0.0	0.0
DSH-Coalinga	13.0	9.0
DSH-Napa	5.0	3.0
TOTAL	**18.0**	**12.0**

[1]These positions will be physically located at various hospitals but will provide service remotely.

As of September 2021, a total of 18.0 positions have been established and 12.0 positions have been filled. DSH is reevaluating the Telepsychiatry needs and will provide an update on the status of these positions in the 2022-23 May Revision.

Coordinators

A total of 18.0 positions were allocated to support the Staff Psychiatrists in coordinating telepsychiatry services.

Hospital[1]	Total	Filled
DSH-Atascadero	0.0	0.0
DSH-Coalinga	13.0	5.0
DSH-Napa	5.0	5.0
TOTAL	**18.0**	**10.0**

[1]These positions will be physically located at various hospitals but will provide service remotely.

As of September 30, 2021, a total of 18.0 positions have been established and 10.0 have been filled. DSH is reevaluating the Telepsychiatry needs and will provide an update on the status of these positions in the 2022-23 May Revision.

STATE HOSPITALS
PATIENT-DRIVEN OPERATING EXPENSES & EQUIPTMENT
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**$0**	**$1,905**	**$2,100**
One-time	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$1,905*	*$2,100*

BACKGROUND

Between fiscal year (FY) 2012-13 and FY 2018-19, the DSH patient population increased significantly due to 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. Included in this category are items such as funding for outside medical care, pharmaceuticals, patient clothing, food stuffs, etc. DSH previously managed to absorb the increased costs with savings in other areas. However, this model was unsustainable to adequately support ongoing OE&E costs driven by patient care.

The 2019 Budget Act established ongoing funding of $11,080,000 each year to fund a 585 bed increase in State Hospital census since FY 2012-13. Also included was a standardized patient OE&E cost estimate methodology based on updated census estimates for FY 2019-20 and estimated costs per patient, derived from past year actual expenditures for outside medical care contracts. As a result, the 2019 Budget Act included funding for a projected FY 2019-20 census of 6,317 and a per patient cost of $19,534 (based on FY 2017-18 actuals) for a total patient-driven OE&E cost of $123.4 million in FY 2019-20.

This proposal was converted to an informational only proposal in the 2020 and 2021 Budget Acts due to difficulties projecting future patient driven costs and patient census during the COVID-19 pandemic. While DSH has continued to monitor and manage these expenditures closely through each budget year, it is no longer feasible for DSH to continue absorbing the cost of these expenditures. To account for Patient OE&E costs moving forward, DSH will utilize the methodology established in the Budget Act of 2019 to include a funding request in FY 2022-23 and ongoing.

DESCRIPTION OF CHANGE

Estimated patient-driven OE&E costs for FY 2022-23 are based on updated census figures and updated costs per patient using FY 2018-19 actual expenditures. In FY 2018-19, DSH spent $129.2 million in patient-driven OE&E with a census count of 6,126 patients. This resulted in a cost-per-patient of $21,085.

$$\$129.2\ million/6{,}126\ patients = \$21{,}085\ per\ patient$$

Per Patient Cost

Following the logic adopted in the 2019 Budget Act in which prior year actuals were used to derive the per patient cost, DSH captured the most recent set of actuals to develop a per patient cost. However, after comparing the growth year over year, it was apparent that some of the actuals being utilized had been skewed by expenditures related to COVID-19.

Deriving Per Patient Cost - All State Hospitals			
Budget Categories	**2017-18 Avg. Cost Per Patient**	**2018-19 Avg. Cost Per Patient**	**2019-20 Avg. Cost Per Patient**
	6,107 census	**6,126 census**	**6,289 census**
Utilities	$2,674	$2,936	$3,654
Outside Hospitalization	$5,107	$5,960	$22,284
Clothing/Personal Supplies	$359	$501	$414
Recreation & Religion	$73	$55	$69
Foodstuffs	$3,014	$3,040	$3,160
Quartering & Housekeeping	$747	$758	$899
Laundry	$532	$727	$657
Miscellaneous Client Services	$269	$74	$110
Chemicals, Drugs and Lab Supplies	$683	$728	$1,644
Pharmaceuticals	$6,063	$6,296	$6,064
Educational Supplies	$14	$10	$10
	$19,535	**$21,085**	**$38,963**

After reviewing the data above and noting the 46% increase within a single fiscal year - mostly attributed to Outside Hospitalization and Chemicals, Drugs and Lab Supplies – DSH is using FY 2018-19 data to create a Per Patient Cost that would provide the most accurate look at DSH's ongoing need.

Allotment Adjustment

To project the budgetary needs, the census from the year used to establish the previous Per Patient amount (6,107 in FY 2017-18) and the difference between the previous Per Patient Cost and the new ($21,085 - $19,535 = $1,550) were multiplied together. The figure below displays the total amount needed to fund Patient Driven OE&E for the census recognized in FY 2017-18.

Cost Adjustment for Existing Census		
2017-18 Census	Increase in Per Patient Cost between FY 2017-18 and FY 2018-19	Total
6,107	**$1,550**	**$9,463,335**

While this addresses the existing census, a second calculation is needed to obtain the amount for the projected patient census for FY 2022-23 (5,740). To project this amount, the difference in census from the year the last Per Patient Cost was established in FY 2017-18 and the projected census for FY 2022-23 (6,107 – 5,740 = -367) and multiplied that difference by the new Per Patient Cost. During the last several years, state hospitals have had to reduce census and limit admissions due to the space restrictions surrounding COVID-19, resulting in the decrease of 367 in the census. The figure below displays the total adjusted amount in Patient Driven OE&E due to the decrease in projected census recognized between FY 2017-18 and FY 2022-23.

Cost Adjustment for Updated Census		
Per Patient Cost based off FY 2018-19 Actuals	Increase in Patient Census between FY 2017-18 and FY 2022-23	Total
$21,085	**-367**	**-$7,738,044**

Based off the methodology adopted in the 2019 Budget Act, with updated Per Patient Costs and increased census, DSH requests $1,725,000 in FY 2022-23 and ongoing.

Cost Adjustment for Per Patient and Census Adjustments	
Cost Adjustment for Existing Census (Figure 2)	$9,463,335
Cost Adjustment for New Census (Figure 3)	-$7,738,044
Total	**$1,725,291**

Patients' Rights Advocacy

DSH is statutorily required per the Welfare Institutions Code (WIC) 5510(d) to provide patient advocacy services in the state hospitals and is therefore responsible for ensuring the observation and protection of mental health laws, regulations, and policies regarding the rights of mental health service recipients in state hospitals and licensed and community care facilities for the Department of Health Care Services (DHCS). This request is for the state hospital patients only, resources for the jail-based competency treatment (JBCT) programs are included in the JBCT narrative accordingly. To meet this requirement, DSH must contract with a third party to provide patients' rights advocacy and investigative services. As this contract is entirely related to DSH's patient population, it is proposed that funding for this contract be included as part of the Patient Driven OE&E request.

When DSH originally received the ongoing patient driven OE&E funding in FY 2019-20 associated with the 585 bed increase since FY 2012-13, the patients' rights advocacy services were not included in the calculation although the need for services has grown. As a result, DSH requests $180,000 in FY 2022-23 and $375,000 in FY 2023-24 and ongoing to continue providing patients' rights advocacy services as statutorily required.

BCP Fiscal Detail Sheet

BCP Title: Patient-Driven Operating Expenditures and Equipment **BR Name: 4440-042-ECP-2022-GB**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5326 - Utilities	0	521	521	521	521	521
5340 - Consulting and Professional Services - External	0	3,202	3,397	3,397	3,397	3,397
539X - Other	0	-1,818	-1,818	-1,818	-1,818	-1,818
Total Operating Expenses and Equipment	**$0**	**$1,905**	**$2,100**	**$2,100**	**$2,100**	**$2,100**
Total Budget Request	**$0**	**$1,905**	**$2,100**	**$2,100**	**$2,100**	**$2,100**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	0	1,905	2,100	2,100	2,100	2,100
Total State Operations Expenditures	**$0**	**$1,905**	**$2,100**	**$2,100**	**$2,100**	**$2,100**
Total All Funds	**$0**	**$1,905**	**$2,100**	**$2,100**	**$2,100**	**$2,100**

Program Summary

Program Funding						
4400010 - Headquarters Administration	0	180	375	375	375	375
4410010 - Atascadero	0	-1,713	-1,713	-1,713	-1,713	-1,713
4410020 - Coalinga	0	1,796	1,796	1,796	1,796	1,796
4410030 - Metropolitan	0	4,146	4,146	4,146	4,146	4,146
4410040 - Napa	0	-1,329	-1,329	-1,329	-1,329	-1,329
4410050 - Patton	0	-1,175	-1,175	-1,175	-1,175	-1,175
Total All Programs	**$0**	**$1,905**	**$2,100**	**$2,100**	**$2,100**	**$2,100**

STATE HOSPITALS
COVID-19 Update
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**$0**	**$64,600**	**$0**
One-time	*0.0*	*0.0*	*0.0*	*$0*	*$64,600*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*

BACKGROUND

The Department of State Hospital (DSH) executed a COVID-19 response plan across its system that followed guidance from the California Department of Public Health (CDPH), the Centers for Disease Control and Prevention (CDC) and other state and local partners. Under these circumstances, DSH took the following steps:

- In mid-March 2020, DSH activated its Emergency Operation Center. DSH hospitals activated their Incident Command Centers and developed incident action plans to better communicate and coordinate DSH's pandemic response efforts, including infection control and respiratory protection.
- Implemented policies and procedures for infection control, respiratory protection, COVID-19 testing and personal protective equipment and established isolation units at its hospitals.
- Implemented policies to reduce the risk of patients with COVID-19 entering DSH facilities by requiring updated health information related to COVID-19 from sending facilities; not accepting individuals currently positive for COVID-19, under investigation for COVID-19 or currently quarantined due to an exposure; and established Admission Observation Units to admit patients in cohorts to screen, observe and isolate cohorts as needed.
- Staff working in patient care areas have daily antigen testing at all hospitals. Hospital staff working in non-patient care areas are tested to two times per week by either PCR or antigen. The frequency of antigen testing of direct patient care staff may be adjusted down to two times per week during periods when COVID-19 infections are minimal.
- Vaccination Implementation – As vaccines were released in California in December 2020 to protect Californians from COVID-19, DSH began its vaccination campaign. On August 5th, 2021 a State Public Health Order was issued for all workers who provide services within specified health facilities, including state hospitals, have their first dose of a one-dose regimen or their second dose of a two-dose regimen by September 30,

2021. DSH has achieved a staff vaccination rate of 82% at the state hospitals. Some staff may have qualified for a medical or religious exemption from the mandatory COVID-19 vaccination. Additionally, federal regulators have recommended COVID-19 booster shots for certain groups of individuals, including healthcare workers and individuals who live and work in institutional settings. In late September, DSH began offering these booster shots to patients and employees who previously received two doses of the Pfizer-BioNTech vaccine. DSH has achieved a patient vaccination rate of 78% across its system.

As of the 2022-23 Governor's Budget DSH has the following updates:

- COVID-19 Cases and Hospital Updates – As of November 10, 2021, DSH performed 98,645 tests on 9,116 patients across all five hospitals, with 2,102 patients testing positive. DSH also performed 186,977 PCR staff tests statewide, 1,165,113 antigen tests statewide and with a total of 2,686 testing positive.
- Quarantine/Isolation/Surge Capacity – Each hospital continued to maintain quarantine and isolation plans, including COVID-19 pandemic emergency plans and supplemental procedures addressing management of isolation units and infection control methods. In addition, DSH is utilizing the Norwalk ACS site for Admission Observation Units (AOUs) for DSH-Metropolitan.
- Isolation and Testing – When a patient was actively displaying symptoms of COVID-19, nursing staff immediately isolated the patient in a private room and laboratory samples for COVID-19 are taken. Once the test confirmed that the patient had tested positive for COVID-19, the patient was transferred to the COVID-19 isolation unit for care and was isolated for a minimum of 14 days.
- Support – DSH continued to ensure that both Employees and Patients received support. Through efforts such as establishing an Employee Support line, making the California Chaplain Corps available, and collaborating with the state's Employee Assistance Program (EAP) and educating and providing updates on COVID-19, PPE and safety practices, sanitizing equipment, and the importance of testing.

DESCRIPTION OF CHANGE

DSH proposes $64.6 million one-time General Fund in fiscal year 2022-23 related to estimated direct response expenditure costs to continue responding to and mitigating the impacts of the COVID-19 Pandemic.

Proposed funding will be used for two main areas of response: personnel services and testing. Personnel services totals $50.6 million and captures costs for staff whose straight time is directly related to COVID-19 and overtime hours for additional cleaning/sanitization, staffing coverages, environmental projects, performing custody tasks, screening staff, isolation staff and testing staff whose time is directly related to COVID-19 response and mitigation efforts. Testing funding totals to $14 million and captures costs for staff and patient testing at all locations.

These cost estimates are based on the best available information at this time, it is anticipated this request will be updated as part of May Revision as additional information continues to be gathered and evaluated.

BCP Fiscal Detail Sheet

BCP Title: Fiscal Year 2022-23 COVID-19 Allocation **BR Name: 4440-059-ECP-2022-GB**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Salaries and Wages						
Earnings - Permanent	0	39,177	0	0	0	0
Overtime/Other	0	11,423	0	0	0	0
Total Salaries and Wages	**$0**	**$50,600**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$0**	**$50,600**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	0	14,000	0	0	0	0
Total Operating Expenses and Equipment	**$0**	**$14,000**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$0**	**$64,600**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	0	64,600	0	0	0	0
Total State Operations Expenditures	**$0**	**$64,600**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$0**	**$64,600**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4400020 - Hospital Administration	0	36	0	0	0	0
4410010 - Atascadero	0	9,126	0	0	0	0
4410020 - Coalinga	0	6,235	0	0	0	0
4410030 - Metropolitan	0	28,795	0	0	0	0
4410040 - Napa	0	7,587	0	0	0	0
4410050 - Patton	0	12,821	0	0	0	0
Total All Programs	**$0**	**$64,600**	**$0**	**$0**	**$0**	**$0**

BCP Title: Fiscal Year 2022-23 COVID-19 Allocation **BR Name: 4440-059-ECP-2022-GB**

Personal Services Details

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
VR00 - Various	0	50,600	0	0	0	0
Total Salaries and Wages	**$0**	**$50,600**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$0**	**$50,600**	**$0**	**$0**	**$0**	**$0**

STATE HOSPITALS
COST OF CARE AND TREATMENT/FINANCIAL ASSISTANCE POLICY SUPPLEMENTAL REPORT TO LEGISLATURE
Program Update

INTRODUCTION

The Department of State Hospitals (DSH) submits this supplemental report to the Legislature (SRL) to provide information and recommendations regarding patient cost of care and treatment in a state hospital and recommended financial assistance policies. The following was required as part of the 2021 Budget Act to be included in this SRL:

DSH shall report to legislative fiscal committees no later than January 10 , 2022 an assessment of existing law and guidance pertaining to patient and family member financial liability for the care and treatment at a state hospital facility, necessity of those laws in obtaining Medicare reimbursement including discussions with Centers for Medicare and Medicaid Services (CMS) regarding the development of financial assistance policies impact on federal reimbursement, recommendations regarding patient relief from financial impact and financial impact of recommendations.

In determining financial impact, include the following data by fiscal year:

- *Number of patients served each year from January 1, 2018, to present.*
- *Amounts collected directly from patients from January 1, 2018, to present.*
- *Amounts collected from individuals and estates other than directly from the patient, from January 1, 2018, to present.*
- *Amounts collected from Medicare, from January 1, 2018, to present.*
- *Amounts collected from other payers, from January 1, 2018, to present.*
- *Lawsuits filed against patients for collection of owed amounts, from January 1, 2018, to present.*
- *Existing financial assistance policy and criteria, including informal policies and criteria, by state hospital, used from January 1, 2018, to present.*
- *Number and percentage of individuals who requested financial assistance with their bills from January 1, 2018, to present, and the number and percentage of requests that were reduced, cancelled, or remitted*.

As described in the contents of this report, DSH recognizes the need to review and update the existing Welfare and Institutions Code that governs the financial liability for patient care and treatment at a state hospital facility. The statutory framework governing the DSH patient's cost of care has not been updated in a significant amount of time. As such, it does not currently align with DSH's current system of care, vision and mission. This report builds on statutory changes included

in the 2021 Budget Act that removed financial liability for family members of state hospital patients. In the 2021 Budget Act, Trailer Bill Language (TBL) was included to remove the financial liability of relatives of a DSH patient for care and treatment at a state hospital. The TBL amended WIC sections 7275, 7276, 7277.1, 7278 and 7282 to remove relatives, including spouse, father, mother, or children from financial liability.

BACKGROUND

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. In addition to state hospital treatment, DSH provides services in contracted jail-based competency treatment (JBCT), community-based restoration (CBR) and pre-trial felony mental health diversion programs, and the conditional release program (CONREP). DSH is responsible for the daily care to over 7,000 patients, in FY 2020-21, DSH served 7,813 patients across the state hospitals, 2,403 in JBCT and CBR contracted programs and 841 in CONREP programs. In addition, as of December 31, 2020, a total of 276 individuals were diverted into county programs funded by DSH. According to the National Association of State Mental Health Program Directors (NASMHPD) 2015 data, California reflects 44 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 of 36 percent of the population. 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.

DSH is statutorily required to seek and collect payments for cost of care from liable patients and their legal representatives through the Welfare and Institutions Code (WIC) sections 7275 – 7292. To assist in meeting this statutory requirement, the 2014 Budget Act authorized DSH to create the Patient Cost Recovery Section (PCRS) to develop and implement a standardized and streamlined third-party billing program that would include accounts management, billing and collection, asset determination, policies and procedures, compliance and auditing. PCRS acts as an intermediary to recoup charges related to a patient's cost of care from any applicable insurance or private pay parties. All moneys collected from the established third-party billing are remitted to the State General Fund. The intent of establishing PCRS was for DSH to assume the responsibility for all billing and collections functions previously performed by the Department of Developmental

Services (DDS) on behalf of DSH. DSH continues the process of assuming the third-party billing responsibilities from DDS with the goal of recouping cost of care from Medicare, private pay, and insurance collections by providing technical assistance to the state hospitals regarding billing, Medicare compliance reviews, managing patient trust accounts, performing patient benefit and insurance enrollment, and provider enrollment.

The table below displays the reimbursement totals, by source, for the most recent complete fiscal years (FY) from Medicare, private payors, and supplemental Medicare insurance. In addition, in Fiscal Year 2020-21, DSH received reimbursements through the Coronavirus Aid, Relief, and Economic Security (CARES) Act due to the coronavirus (COVID-19) pandemic. CARES Act reimbursements were for expenditures related to the prevention and treatment of COVID-19 which included, but was not limited to expenses for patients testing, vaccinations, and personal protection equipment. DSH also received reimbursements for the treatment and care of its uninsured patient population through a special fund as part of the CARES Act.

Source	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
Medicare Parts A/B	$838,397	$516,104	$471,776	$510,144
Medicare Part D	$1,091,620	$1,130,527	$1,045,330	$989,063
[1]Private Pay	$2,574,851	$2,538,219	$1,741,601	$2,044,477
[2]Other	$109,204	$117,971	$47,609	$125,167
Lanterman-Petris-Short (LPS)	$156,030,990	$160,656,436	$168,617,208	$166,076,215
Uninsured COVID-19 Reimbursements	N/A	N/A	N/A	$8,989,126
CARES Act	N/A	N/A	$491,882	$458,201
Totals	**$160,645,082**	**$164,959,257**	**$172,415,406**	**$179,192,393**

[1]Private Pay reimbursements include conservator, third party, patient, and legal settlement payments.

[2] "Other" reimbursements include Supplemental Medicare Insurance and excess fund payments from patient trust accounts (WIC section 7281)

DSH anticipates increased Medicare reimbursement based on recently approved resources to enhance DSH's current billing system. The Cost Recovery System (CRS) is housed within the Department of Developmental Services (DDS) and serves as the electronic billing system for DDS and DSH that is utilized for tracking, documenting, billing, and recovering funds for patient cost of care. CRS is outdated and creates substantial challenges preventing DSH from maximizing its Medicare reimbursement. As a result, DSH received resources in the 2021 Budget Act to enhance system functionality for CRS to capture, bill and recover eligible patient cost of care reimbursements. The enhancement of CRS will allow DSH to bridge the gap between the current CRS limitations and the implementation of a

full electronic health record solution while allowing for increased revenue collection during this interim period.

ASSESSMENT APPROACH

To meet the requirements of the supplemental report to the Legislature and make recommendations to provide patient relief from financial impact, the following provides a brief description of the steps DSH has taken to complete this report and inform recommendations.

- Environmental scan and review of financial liability related statutes and regulations
- Review and analysis of Medicare regulations
- Discussions with the Centers for Medicare and Medicaid Services
- Communication and information gathering with other public healthcare providers on financial assistance programs (County and other forensic state hospital)
- Review and analysis of historical and existing practices related to billing, collections, and financial liability
- Data collection of billing and reimbursement collected historically

REVIEW OF EXISTING LAW

DSH conducted a comprehensive review of state law and the following WIC sections apply to patients with the financial liability to pay for their cost of care and treatment, Medicare, and DSH's cost of care collection efforts and includes the recent changes implemented with Assembly Bill (AB) 133. Below provides a summary of statute as currently written and application to DSH's environment.

- WIC section 4025: Charges made by the department for the care and treatment of each patient in a facility maintained by the department shall not exceed the actual cost thereof as determined by the Director in accordance with standard accounting practices. The Director is not prohibited from including the amount of expenditures for capital outlay or the interest thereon, or both, in his determination of actual cost. As used in this section, the terms "care" and "care and treatment" include care, treatment, support, maintenance, and other services rendered by the department to a patient in the state hospital or other facility maintained by or under the jurisdiction of the department.
    - DSH Application: Authorizes and restricts DSH to only charge patients for the actual cost of their care and treatment at a DSH facility, not profit from it.

- WIC section 7275: A patient in a state hospital, their estate, and the guardian or conservator and administrator of the estate of the patient shall cause the patient to be properly and suitably cared for and maintained. The patient in a state hospital and the administrators of their estate, and the estate of the person shall be liable for their care, support, and maintenance in a state institution of which they are a patient. The liability shall exist whether the person has become a patient of a state institution pursuant to the provisions of this code or pursuant to the provisions of Sections 1026, 1368, 1369, 1370, and 1372 of the Penal Code.
    - DSH Application: Overarching governing authority identifying patient financial liability who owe for their cost of care and treatment while at a DSH facility. Patient liability is also specified based on legal class commitment. Additional liable legal classes not identified in WIC section 7275 includes but is not limited to: WIC section 6602 (sexually violent predators), and WIC section 5358 (LPS). This drives all collection activity to seek reimbursement from patients who are liable for their cost of care and treatment at a DSH facility, as well as meets Medicare's regulations by pursuing collection of the amounts owed in the same way and with the same vigor that it pursues the collection of other debts.

- WIC section 7276: The charge for the care and treatment of persons at state hospitals for whom there is liability to pay therefor shall be determined pursuant to Section 4025. The Director of state hospitals may reduce, cancel, or remit the amount to be paid by the estate liable for the care and treatment of a person who is a patient at a state hospital, on satisfactory proof that the estate is unable to pay the cost of that care and treatment or that the amount is uncollectible. If there has been a payment under this section, and the payment or any part thereof is refunded because of the death, leave of absence, or discharge of a patient of the hospital, that amount shall be paid by the hospital or the State Department of State Hospitals to the person who made the payment upon demand, and in the statement to the Controller the amounts refunded shall be itemized and the aggregate deducted from the amount to be paid into the State Treasury, as provided by law. If a person dies at any time while their estate is liable for their care and treatment at a state hospital, the claim for the amount due may be presented to the executor or administrator of their estate, and paid as a preferred claim, with the same rank in order of preference, as claims for expenses of last illness.
    - DSH Application: Provides the DSH Director the authority to reduce or eliminate the patient's cost of care account balance if the patient has been determined to be unable to pay.

- WIC section 7277: The State Department of State Hospitals shall collect all the costs and charges mentioned in Section 7275, and shall determine, pursuant to Section 7275, and collect the charges for care and treatment rendered to persons in community mental health clinics maintained by the department and may take action necessary to affect their collection within or without the state. The Director of State Hospitals may, at their discretion, refuse to accept payment of charges for the care and treatment in a state hospital of person with a mental health disorder or who has chronic alcoholism and who is eligible for deportation by the federal immigration authorities.
    - DSH Application: Grants DSH the ability to collect the charges for the cost of care and treatment for patients in a community health clinic. DSH does not operate public community mental health clinics but does, however, contract with county and private providers to operate outpatient clinics for DSH patients ordered to the Conditional Release Program (CONREP). DSH does not collect the cost of care and treatment for patients in CONREP but does offset living expenses (housing, food, clothing, incidentals) with any income or benefits available to the patients (i.e., Supplemental Security Income/Social Security Disability Income).

- WIC section 7277.1: In the case of liability for care arising under Section 7275 during the lifetime of a decedent, in which the decedent has been a patient in a state hospital preceding the date of decedent's death, a claim for costs and charges shall be mailed within four months after written request therefor, in the form required by the department, by the fiduciary of the estate or trust or by any other person liable for the claim or any portion thereof.
    - DSH Application: This section allows DSH to seek reimbursement for liable patients after they are deceased while also providing protection to the family of a deceased patient by imposing a time limit to file a claim.

- WIC section 7278: The State Department of State Hospitals shall, following the admission of a patient into a state hospital, investigate to determine the moneys, property, or interest in property, if any, the patient has, and whether the patient has a duly appointed and acting guardian to protect their property and their property interests.
    - DSH Application: DSH completes an asset determination for all patients liable for their cost of care and treatment while admitted to a DSH facility. This process primarily consists of communicating with patients during the admission process to determine if there are any

bank or trust accounts, property, or legal representation as well as inquiring about insurance coverage such as Medicare.

- WIC section 7279: If any person committed to a state hospital has sufficient estate for the purpose, the guardian or conservator of the person's estate shall pay for their care, support, maintenance, and necessary expenses at the state hospital to the extent of the estate. The payment may be enforced by the order of the judge of the superior court where the guardianship or conservatorship proceedings are pending. On the filing of a petition therein by the department showing that the guardian or conservator has failed, refused, or neglected to pay for such care, support, maintenance, and expenses, the court, by order, shall direct the payment by the guardian or conservator.
    - DSH Application: While not an existing business practice by DSH, this language allows the department to file a petition with the courts to affect conservators neglecting to make payments towards a patient's cost of care account balance, orders payments be made, or for the conservator to sell assets to make a payment. This law supports the collection of cost of care by holding conservators with the means to pay responsible for the care and treatment of the patient they are conserving.

- WIC section 7281: There is at each institution under the jurisdiction of the State Department of State Hospitals, a fund known as the patients' personal deposit fund. Any funds coming into the possession of the superintendent, belonging to any patient in that institution, shall be deposited in the name of that patient in the patients' personal deposit fund, except that if a guardian or conservator of the estate is appointed for the patient then they shall have the right to demand and receive the funds. Whenever the sum belonging to any one patient, deposited in the patients' personal deposit fund, exceeds the sum of five hundred dollars ($500), the excess may be applied to the payment of the care, support, maintenance, and medical attention of the patient. After the death of the patient any sum remaining in his or her personal deposit account in excess of burial costs may be applied for payment of care, support, maintenance, and medical attention. Any of the funds belonging to a patient deposited in the patients' personal deposit fund may be used for the purchase of personal incidentals for the patient or may be applied in an amount not exceeding five hundred dollars ($500) to the payment of his or her burial expenses.
    - DSH Application: Patients liable for their cost of care have their personal deposit fund account reviewed for balances over $500. Hospitals review if funds are eligible for payment towards cost of care and the excess funds in the account may be utilized to apply towards

their cost of care. In fiscal year 2020-21, $121,081 was collected from this procedure.

- WIC section 7281.1: A patient of an institution under the jurisdiction of the State Department of State Hospitals who participates in a sheltered workshop or vocational rehabilitation program shall not be required to return or remit any earnings received during the patient's participation to the institution for the cost of care, support, maintenance, and medical attention pursuant to Section 7281.
    - DSH Application: Although DSH may collect funds in excess of $500 in a patient's personal deposit fund pursuant to WIC section 7281, any wages received from participating in a sheltered workshop or vocational rehabilitation program are exempt from collections.

- WIC section 7282: The State Department of State Hospitals may in its own name bring an action to enforce payment for the cost and charges of transportation of a person to a state hospital against any person, guardian, or conservator liable for transportation. The department also may, in its own name, bring an action to recover for the use and benefit of any state hospital or for the state the amount due for the care, support, maintenance, and expenses of any patient therein, against any county, or officer thereof, or against any person, guardian, or conservator liable for the care, support, maintenance, or expenses.
    - DSH Application: If a patient has known property and/or a means to financially afford to make monthly payments, all reasonable attempts to collect reimbursement for their care and treatment in a DSH facility will be performed prior to legal action against the asset(s). Filing a claim to recover the costs for their care and treatment will be completed after notifying the patient they have a debt and affording the opportunity to make payments, but before the four-year statute of limitations expires.

- WIC section 7353: DSH shall pay the premium for third-party health coverage for Medicare beneficiaries who are patients at the state hospitals under the jurisdiction of DSH. The department shall, when a mental health state hospital patient's coverage would lapse due to lack of sufficient income or financial resources, or any other reason, continue the health coverage by paying the costs of continuation or group coverage pursuant to federal law or converting from a group to an individual plan.
    - DSH Application: Paying the Medicare premiums allows DSH to bill Medicare for covered services provided by or charged to the state hospitals for eligible patients. DSH is also statutorily mandated to seek all avenues of reimbursement for patients' cost of care and

treatment. Paying patients' Medicare premium costs allows DSH to recoup funds from Medicare. Liable patients with eligible services under Medicare will have all reimbursements applied to their cost of care account balance, thereby reducing their liability to the state. In addition, patients enrolled in Medicare may retain coverage after discharge allowing them to immediately seek any medically necessary treatment.

REVIEW OF FEDERAL RULES AND REGULATIONS

While in the course of DSH's research and analysis, there are no existing CMS regulations, WIC regulations, or CFR regulations that specifically states a discounted care program will negatively impact Medicare benefits or reimbursements that DSH identified, there are federal and state regulations that must be taken into consideration before implementing a program/policy that offers discounted care to patients.

- The Office of Inspector General (OIG) focuses on addressing issues of waste, fraud, and abuse and to improve the efficiency of Medicare, Medicaid, and over 100 other Department of Health and Human Services (HHS) programs. The HHS Anti-Kickback Statute (AKS) (42 U.S. Code section 1320a-7b(b)), in part, states where the Medicare and Medicaid program require patients to pay copays for services, providers are generally required to collect that money from their patients. Routinely waiving these copays could implicate the AKS and providers may not advertise that copayments will be forgiven. However, providers are free to waive a copayment if they make an individual determination that the patient cannot afford to pay or if reasonable collection efforts fail. It is also legal to provide free or discounted services to uninsured people.
    - DSH Application: DSH will remain in compliance with the Anti-Kickback Statute as the recommended policy addressing patient debt relief will apply to indigent patients and/or those without a means to pay for their cost of care and treatment.

- 42 Code of Federal Regulations (CFR) section 1001.952(k): This statute states remuneration does not include any reduction or waiver of a Federal health care program beneficiary's obligation to pay copayment, coinsurance or deductible amounts as long as the cost-sharing amounts are owed to a hospital for inpatient hospital services for which a Federal health care program pays under the prospective payment system. The hospital must: not later claim the amount reduced or waived as a bad debt for payment purposes or otherwise shift the burden of the reduction or waiver onto a Federal health care program, other payers, or individuals; offer to reduce

or waive the cost-sharing amounts without regard to the reason for admission, the length of stay of the beneficiary, or the diagnostic related group for which the claim for reimbursement is filed; and the offer to reduce or waive the cost-sharing amounts must not be made as part of a price reduction agreement between a hospital and a third-party payer (including a health plan), unless the agreement is part of a contract for the furnishing of items or services to a beneficiary of a Medicare supplemental policy.

  - DSH Application: Currently, DSH does not waive coinsurance or deductibles, however, this section will need to be considered should a patient financial assistance program be implemented.

- 42 CFR section 411.4(b): Individuals who are in custody include, but are not limited to, individuals who are under arrest, incarcerated, imprisoned, escaped from confinement, under supervised release, on medical furlough, required to reside in mental health facilities, required to reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule. Payment may be made for services furnished to individuals or groups of individuals who are in the custody of police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met: (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody. (2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts.
  - DSH Application: Compliance to this CFR is pursuant to WIC sections 7275 through 7282. DSH identifies patients liable for their cost of care and pursues all reimbursements using the same laws, regulations, policies, and resources regardless of the status of third-party coverage. Likewise, all reimbursement revenue received (i.e., Medicare, Excess Funds per WIC section 7281, private payors) is transferred into the state General Fund.

- Discussion with CMS Regarding Financial Assistance Programs: DSH met with Noridian, the Medicare Administrative Contractor (MAC) operating on CMS' behalf, to discuss parameters to a financial assistance program, CMS' laws and regulations governing over a financial assistance program, and potential impacts of offering financial assistance and its implications on participating in Medicare. Per DSH's conversation with Noridian, DSH can still submit claims to Medicare even if offering financial assistance.

CMS did not express concerns with a financial assistance program. DSH also reached out to the CMS Region 9 (California) office for additional insight on implementing a financial assistance program. Additional CMS research yielded the following findings:

- CMS does not prohibit a hospital from waiving collections of charges to any patients, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of an indigency policy.
- If a hospital can document that a Medicare patient is indigent or medically indigent, the hospital can forgo any collection effort aimed at the patient. If it's determined that no other person or source is legally responsible for the unpaid deductibles and coinsurance, the hospital may claim the amounts as Medicare bad debts.

FINANCIAL ASSISTANCE IN OTHER GOVERNMENTAL ENTITIES

In DSH's development of this report, DSH communicated with various other public behavioral health systems to evaluate how billing and patient financial assistance was operationalized by other governmental entities. Below provides a brief summary of DSH's findings.

- County Behavioral Health Services: DSH met with a County eligibility department to discuss their eligibility policies, procedures, and criteria for financial assistance. This specific County uses their electronic health record (EHR) system to capture patient information (i.e., third-party insurance, income, and financial responsibilities). Based on this information, the EHR system automatically applies the Uniform Method of Determining Ability to Pay to determine the patient liability with a sliding fee schedule that allows patients to afford the medical treatment they receive. The sliding fee schedule is based on income and patient financial responsibilities to estimate the amount of income available to make a payment. This monthly payment is considered to be paid in full after a set number of months regardless of what the total cost of care balance was prior to the adjustment.

- Other State Hospital: DSH met with representatives from another psychiatric state hospital system to discuss their indigent and charity care program. This particular state hospital also utilized an automated system to evaluate a patient's financial situation to determine charges utilizing a sliding fee scale to assist in determining cost of care for patients whose income level is at or below 200 percent of the current Federal Poverty Guidelines.

RECOMMENDATIONS

With the passage of the TBL removing liability from family members via the 2021 Budget Act, there may be additional opportunities to provide patient financial relief while meeting obligations to CMS. After a review of all WIC sections, federal regulations, discussion with CMS, and other laws and policies that apply to DSH and patient cost of care, the following recommendations are provided for consideration to the Legislature. As noted in the section immediately following the recommendations, implementation of these recommendations may result in lower cost of care reimbursements.

DSH's recommendations primarily reflect updating and/or removing outdated statutory language no longer applicable to DSH's current system of care and providing patient relief that DSH does not anticipate would jeopardize DSH's ability to collect Medicare. Most substantively, DSH is proposing to develop a statutory and policy framework for implementing a Financial Assistance/Discounted Care Program.

- WIC section 7276: Authorizes the Director to reduce, cancel, or remit the amount owed to the state for the care and treatment of a patient at a state hospital on satisfactory proof that there is an inability to pay or that the amount is uncollectible. DSH recommends a change to the WIC section to allow the Director to appoint a designee to approve the reduction or cancellation of a patient's cost of care debt. In addition, DSH recommends a change to the WIC section to provide factors for consideration for the reduction or cancellation of debt, which would serve as the statutory framework for implementing a financial assistance policy. Such factors for consideration should include patient and/or conservator information (i.e. public benefit program participation), employment and banking information, or other income to assess against the federal poverty level as well as liabilities such as child support, restitution, etc.

- WIC section 7279(b) and (c): DSH recommends repealing subsection (b) and (c), as DSH does not believe ordering a guardian or conservator over a patient's estate to sell any personal or real property, or both, to pay for the patient's care, support, maintenance, and expenses is a necessary collection effort and is not in alignment with DSH's mission or goals.

- WIC section 7281: Under the jurisdiction of the State Department of State Hospitals a fund known as the patients' personal deposit fund. Any funds coming into the possession of the superintendent, belonging to any patient in that institution, shall be deposited in the name of that patient in the patients' personal deposit fund. Whenever the sum exceeds five hundred

dollars, ($500), the excess may be applied to the payment of the care, support, maintenance, and medical attention of the patient. DSH recommends amending this section to eliminate DSH's authority to remove funds in excess of $500 from the patients' personal deposit fund for cost of care. Allowing patients to accumulate income in excess of $500 while admitted to a DSH facility will ease their transition into their respective communities upon discharge. They may be better situated as a result to financially secure housing and pay for basic living expenses following the completion of their treatment programs.

- WIC section 7284: Gives DSH the authority to apply to the superior court of the proper county for its appointment as guardian or conservator of the person's estate. Since DSH collects for cost of care pursuant to WIC section 7275, DSH considers this a conflict of interest and recommends repealing this section.

- WIC section 7285: Gives DSH authority to invest funds held as executor, administrator, guardian or conservator of estates, or trustee, in bonds or obligations issued or guaranteed by the United states or the State of California. DSH does not have certified investment counselors on staff or equivalent expertise to implement this process, collects for cost of care pursuant to WIC section 7275, which DSH would considers a conflict of interest. Therefore, DSH recommends repealing this section.

- WIC section 7286: Gives DSH authority to establish one or more common trusts for investment of funds held as executor, administrator, guardian or conservator of estates, or trustee and may designate from time to time the amount of participation of each estate in such trusts. DSH does not have certified investment counselors on staff or equivalent expertise to implement this process, collects for cost of care pursuant to WIC section 7275, which DSH would considers a conflict of interest. Therefore, DSH recommends repealing this section.

- WIC section 7287: Upon the death of an incompetent person over whom the State Department of State Hospitals has obtained jurisdiction pursuant to Section 7284, the department may make proper disposition of the remains, and pay for the disposition of the remains together with any indebtedness existing at the time of death of the person from the assets of the guardianship or conservatorship estate, and thereupon it shall file its final account with the court or otherwise close its administration of the estate of the person. DSH recommends repealing this language, consistent with the recommendation to appeal WIC Section 7284, as DSH does not

obtain jurisdiction as conservator or guardian of individuals deemed incompetent therefore this statute is unnecessary.

- WIC section 7290: Gives DSH authority to enter into a special agreement, secured by a properly executed bond with relatives, guardian, conservator, or friend of any patient therein, for his or her care, support, maintenance, or other expenses. DSH does not have certified investment counselors on staff or equivalent expertise to implement this process, collects for cost of care pursuant to WIC section 7275, which DSH would considers a conflict of interest. Therefore, DSH recommends amending this language to remove DSH from this section.

- WIC section 7291: The county from which each person has been committed to an institution shall pay the state the cost of the care of such person, for the time the person committed remains a patient of the institution, at the monthly rate therefor fixed as provided in Section 7292. The reference to "defective or psychopathic delinquents" in the statute is unclear and does not coincide with the various patient commitment types DSH currently serves. Furthermore, these terms are not in alignment with DSH's mission, goals, and values and not in alignment with practices of charging a daily bed rate, not a monthly rate. As a result, DSH recommends repealing.

- WIC section 7292: States the cost of such care shall be determined and fixed from time to time by the Director of State Hospitals, but in no case shall it exceed the rate of forty dollars ($40) per month. This section is outdated and does not coincide with WIC section 7275. Per WIC section 7291, it only applies to "defective or psychopathic delinquents" with the county of commitment paying up to $40 per month. The reference to "defective or psychopathic delinquents" in the statute is unclear and does not coincide with the various patient commitment types DSH currently serves. As a result, DSH recommends repealing.

Financial Assistance Program Development

The overarching purpose of the newly proposed financial assistance program is to provide a framework that allows for a patient to legally be relieved of their debt (in full or in part) for their cost of care and treatment in a state hospital. The mechanics of the financial assistance program are noted below from the perspective of a patient admission to discharge; however, the critical component of the proposed program is that patient relief will be measured against a patient's income compared to the Federal Poverty Level (FPL). Based on research from other financial assistance policies, patients at 300 percent of the FPL or below may be granted 100 percent debt relief. There will be a sliding scale of debt relief

in terms of the cost of care account balance owed for patients with an income more than 300 percent of FPL. Furthermore, federal regulations were also reviewed for eligibility, billing, and reimbursements as they relate to DSH patients to ensure a financial assistance program would not put the department at risk or be deemed ineligible to participate in Medicare.

Patient Admission Process or Shortly Thereafter

- Prior to eligibility and assessing a patient's participation in the financial assistance program, DSH, during the admission process will provide a patient notification of their liability for costs related to treatment and maintenance at the facility. Notification will be in the form of providing the policy on financial assistance and the Financial Assistance Program application.
- As part of the admission's process or shortly thereafter should the patient require time to acclimate to the DSH environment, included as part of the Financial Assistance Program application is a request for information related to health insurance coverage, all income sources, assets, financial account information, and living expenses (i.e., monthly bills, rent/mortgage, insurance premium payments, etc.) to be used in the determination of the amount of relief they may be eligible for. DSH also attempts to collect necessary information to enroll the patient into Medicare, when applicable, which could offset a portion of their cost of care.
- A final determination for financial assistance eligibility cannot be determined at the time of admission, as the discharge date would be unknown at that time to determine the final cost of care balance, however, DSH staff can begin working with the patient to collect information that will eventually be utilized to determine their participation in the financial assistance program to relieve them of a portion or all of their financial liability for care and treatment.

Patient Throughout Stay at DSH

- The policy and procedure for financial assistance will be posted appropriately in the hospital setting as well as availability of hospital Trust Offices to provide information to patients.
- Patient may wish to update information they previously provided during the admissions process or enroll for Medicare should they be eligible during the open enrollment or qualifying period.

Discharged Patient and Determination of Financial Assistance Eligibility

- Discharged patients would be sent a New Payor Letter noticing their liability of debt without a specific dollar amount given the feedback received related to the impact that receiving a large bill could have on a former patient. The New Pay Letter would state to contact DSH to discuss the

liability and payment options, to dispute the debt or to discuss an eligibility determination for the financial assistance program to reduce or eliminate their cost of care debt. The letter will also include website link and information to DSH financial assistance program and forms.

- When a request for financial assistance is received, PCRS will complete an account reconciliation of the patient's account to reflect a patient's finalized cost of care balance.
- DSH PCRS will also send the asset form and financial assistance application to requestors to complete. These forms will be used to determine a requestor's income and assets as well as other financial liabilities that will be considered in determining an ability to pay or not. PCRS will review the forms and documentation (i.e., prior year tax returns, bank statements, utility bills, etc.) to verify the patient's financial status.
- Based on the patient's documentation submitted, PCRS will work with the patient or legal representative to identify if a reasonable payment plan to apply towards their cost of care account balance is feasible.
    - "Reasonable payment plan" means monthly payments that are not more than a certain percent (i.e. 10 percent) of a patient's family income for a month, excluding deductions for essential living expenses.
- Patients at 300 percent of the Federal Poverty Level (FPL) or below may be granted 100 percent debt relief. There will be a sliding scale of debt relief in terms of the cost of care account balance owed for patients with an income more than 300 percent of FPL.

The above recommendation is based on DSH's assessment as part of the completion of this report and overarching statutory authority from WIC section 7276 authorizing the Director to reduce, cancel, or remit the amount owed to the state for the care and treatment of a patient at a state hospital. To effectively implement the patient financial assistance program, DSH proposes accompanying trailer bill language to update WIC to reflect the necessary authority to implement this program. While DSH proposes statutory changes to provide the overarching structure and broad categories DSH will consider in implementing a financial assistance program, DSH will need to further define the financial assistance program to interpret and make specific its proposed statue changes, if adopted. To enable DSH to implement the financial assistance program as quickly as possible in Fiscal Year 2022-23, DSH proposes to include in the trailer bill language proposal, language that authorizes DSH to implement, interpret, or make specific WIC Section 7276 by means of a departmental letter or other similar instruction, as necessary.

As DSH recommends developing a robust financial assistance program, the recommended program is not intended to waive or alter any contractual

provisions or rates negotiated by and between DSH and a third-party payer or provide discounts to a non-contracted third-party payer or other entities that are legally responsible to make payment on behalf of a beneficiary, covered person, or insured.

FINANCIAL IMPACT OF COST OF CARE REIMBURSEMENT:

The following data elements are requirements of this report and specific financial impacts should DSH's recommendations be implemented will be noted.

A. Number of patients served each year from January 1, 2018, to present.

1) FY 2017-2018: 8,430 patients
2) FY 2018-2019: 11,752 patients
3) FY 2019-2020: 10,961 patients
4) FY 2020-2021: 9,710 patients

B. Amounts collected directly from patients from January 1, 2018, to present.

1) FY 2017-2018: $100,916
2) FY 2018-2019: $107,985
3) FY 2019-2020: $43,742
4) FY 2020-2021: $122,935
5) FY 2021-2022: $43,283 through September 2021

Amounts are based on excess fund payments made from patients' trust account at the hospitals and payment plans directly established with the patient.

If DSH's recommendation to repeal WIC 7281 and move away from collecting excess funds were implemented, it would reduce revenue returned to the General Fund. However, the amounts DSH collects via excess funds are not significant as compared to its other collection efforts.

C. Amounts collected from individuals and estates other than directly from the patient, from January 1, 2018, to present.

1) FY 2017-2018: $1,503,026
2) FY 2018-2019: $2,538,219
3) FY 2019-2020: $1,741,061
4) FY 2020-2021: $2,048,979
5) FY 2021-2022: $441,018 through September 2021

Amounts are based on payments collected through the patients' conservators, fiduciaries, or representative payees, and payments received from legal settlements. The appointed party issues payments using the patient's estates. Legal settlement cases may have been filed prior to 2018 but the cases were

settled, and funds received in 2018 or after. There was no legal settlement revenue received for FY 2019-20.

D. Amounts collected from Medicare, from January 1, 2018, to present.

Supplemental Medicare Insurance

1) FY 2017-2018: $5,787
2) FY 2018-2019: $10,046
3) FY 2019-2020: $3,867
4) FY 2020-2021: $3,074
5) FY 2021-2022: $290 through September 2021

Medicare Part A and B

1) FY 2017-2018: $487,051
2) FY 2018-2019: $516,104
3) FY 2019-2020: $471,776
4) FY 2020-2021: $510,144
5) FY 2021-22: $170,161 through September 2021

Medicare Part D

1) FY 2017-2018: $507,755
2) FY 2018-2019: $1,130,527
3) FY 2019-2020: $1,045,330
4) FY 2020-2021: $989,063
5) FY 2021-22: $231,850 through September 2021

Total Medicare per Fiscal Year

1) FY 2017-2018: $1,000,593
2) FY 2018-2019: $1,656,677
3) FY 2019-2020: $1,520,974
4) FY 2020-2021: $1,502,270
5) FY 2021-2022: $402,302 through September 2021

COVID-19 Uninsured Funding

1) FY 2020-2021: $8,989,126
2) FY 2021-22: $2,043,812 through September 2021

CARES Act Stimulus Fund

1) FY 2019-2020: $491,882
2) FY 2020-2021: $458,201

The Medicare amounts exclude payments received under the CARES Act and the COVID-19 Uninsured Fund reimbursement.

E. Amounts collected from other payers, from January 1, 2018, to present.
No funds were collected from other third-party payers except from conservators, representative payees, and settlement cases, see (C).

F. Lawsuits filed against patients for collection of owed amounts, from January 1, 2018, to present.
DSH filed six lawsuits seeking collection from January 1, 2018 to present. DSH reviewed and/or investigated patient income and assets to determine if the patient, or their legal representative, possessed sufficient financial assets to recover cost of care and treatment. In FY 2020-2021, 617 patients were researched for potentially possessing assets. Of those, 50 had an asset, and one lawsuit was filed.

G. Existing financial assistance policy and criteria, including informal policies and criteria, by state hospital, used from January 1, 2018, to present.
Upon patient discharge, the PCRS determines if a patient is liable for their cost of care account balance while treated in a DSH facility. If a patient is liable for their cost of care, a New Payor Letter is sent to the patient or their legal representative notifying them there is a debt owed to the state and requesting to make arrangements for payment, including the establishment of a reasonable payment plan. If a payment plan is requested, DSH works with the individual to obtain financial information including income and liabilities and establish a reasonable plan reflective of the individual's current financial status. If no contact is made by the patient or legal representative within 30-days of the date on the New Payor Letter, or contact is made but a payment plan could not be established, the patient or their legal representative will receive a statement notifying them of their unadjusted cost of care account balance.

H. Number and percentage of individuals who requested financial assistance with their bills from January 1, 2018, to present, and the number and percentage of requests that were reduced, cancelled, or remitted.

1. Payment plans established since January 2018: four with monthly payments ranging from $10 - $100
2. Cost of Care write off requests from July 2020 through October 2021:

    a. 25 patients, relatives, or legal representatives requested for write off after receiving statements or a New Payor Letter regarding their account balance due. On average, 2,302 patients receive a monthly statement. This equates to 1.1% of patients requesting to write off their cost of care account balance.

b. As of October 2021, zero patient accounts were reduced, cancelled, or remitted. However, DSH has currently paused billings for patients who requested for financial assistance while DSH works towards implementing a financial assistance policy.

PCRS began tracking cost of care write off requests in July 2020 when the first request was received from a payor.

CONDITIONAL RELEASE PROGRAM (CONREP)

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

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**-$7,425**	**$4,563**	**$4,563**
One-time	*0.0*	*0.0*	*0.0*	*-$7,877*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$452*	*$4,563*	*$4,563*

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 Non-Sexually Violent Predator (Non-SVP) 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 2972 parolees who are civilly committed for at least one year after their parole period ends). This category also includes the Mentally Disordered Sex Offender (MDSO) commitment under WIC 6316 (repealed).
- Felony Incompetent to Stand Trial (IST) (PC 1370 patients who have been court-approved for outpatient placement in lieu of state hospital placement)

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

As specified in PC 1600-1615 and 2960-2972, the CONREP Community Program Director (CPD), with the Court's approval (or in the case of OMDs, the Board of Parole Hearings' (BPH) approval), assesses and makes the recommendation for individuals' placement in CONREP. 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 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. Historically, CONREP's model of care has been based on a centralized outpatient clinic setting where the majority of treatment services are delivered. In this treatment model, clients must seek transportation or walk to access these services. Thus, in order to access treatment timely and on a regular basis, clients must live in a residence within close proximity to the outpatient clinic or along a major bus route. Since it is impractical to place individuals in areas that would require a client to navigate multiple bus routes or obtain a costly taxi ride, the current type of service model limits the inventory of housing secured for placement of CONREP clients.

Step-Down Transitional Program

For CONREP-eligible patients that have not demonstrated the ability to live in the community without direct staff supervision, CONREP has limited availability through the level of care known as the Statewide Transitional Residential Program (STRP). The STRP is a cost-effective resource used to provide patients with the opportunity to learn and demonstrate appropriate community living skills while they transition from a state hospital to a community site. These patients are limited to 90- to 120-day stays as they reside in a controlled setting with 24 hours per day, seven days per week (24/7) supervision. Once the patient makes the necessary adjustments and is ready to live in the community without structured 24/7 services, the patient is able to live in a Board & Care, Room & Board, or other independent living arrangements without direct staff supervision.

There is a significant need for more placement options like the STRP. As a result, DSH is working to build out its continuum of treatment options available to better meet the needs of state hospital patients ready to step down to a lower level of care as part of their transition to CONREP.

DSH is partnering with several community-based providers to expand its continuum of care and increase the availability of placement options dedicated to CONREP clients. This will expand the number of community beds available for patients who

are ready for outpatient treatment but still need a higher level of direct care. These facilities allow patients to step down into a lower restrictive environment and focus on the skills necessary for independent living when transitioning to CONREP. The expansion of CONREP capacity and patient placement allows DSH to backfill vacated state hospital beds with pending IST placements who are not eligible for outpatient treatment. Expanding the availability of beds to treat DSH patients is critical to providing timely access to those requiring and awaiting treatment in higher acuity state hospital settings.

Forensic Assertive Community Treatment (FACT)

The CONREP Mobile Forensic Assertive Community Treatment (FACT) program establishes an additional level of care available to clients. Services are available 24/7 through a mobile treatment team who can respond to clients as needed to reduce the likelihood of rehospitalization through de-escalation and crisis intervention practices. DSH is currently working with a provider to establish 180 dedicated beds and staff resources for this new treatment option in CONREP across three regions of the state: 60 beds in Northern CA, 60 beds in the Bay Area, and 60 beds in Southern CA. In addition to increasing the placement options available for NGI and OMD patients transitioning from the state hospitals, the FACT model of care can be used to place ISTs ordered to CONREP where a community-based restoration program is not available.

Funding

Pursuant to WIC 4360 (a) and (b) and PC section 1615, DSH CONREP is responsible for 100 percent of the costs incurred by providers who deliver treatment and supervision services to CONREP patients. Any benefits that clients are eligible for help offset the cost of housing and personal incidentals.

Under the funding methodology, DSH negotiates a contracted per diem rate with the contractors for all required services based on prior year actual expenditures. Once the contract is executed, this rate is applied to the number of days a client receives services while in CONREP. Funding for other program expenses must either be approved in advance by DSH (i.e. supplemental services including life support, translation services, patient transportation, enhanced supervision, etc.) or be invoiced and paid in arrears. At the end of each fiscal year (FY), DSH will analyze the actual level of required services provided by the contractor.

The contract budget for the programs is calculated by multiplying the established per diem rate by the total bed capacity and the number of contract days in the FY.

The total contract budget is then determined by subtracting revenue offsets, such as Supplemental Security Income (SSI) from supplemental service costs.

In the 2021 Budget Act, DSH received resources to support a projected caseload increase and the increasing salary and operational expenses of the CONREP providers in FY 2021-22 and ongoing. The providers are obligated to provide salary increases as negotiated by the respective collective bargaining unit contracts. As a result, the providers requested the standard cost of living and operational cost increases.

Caseload Update

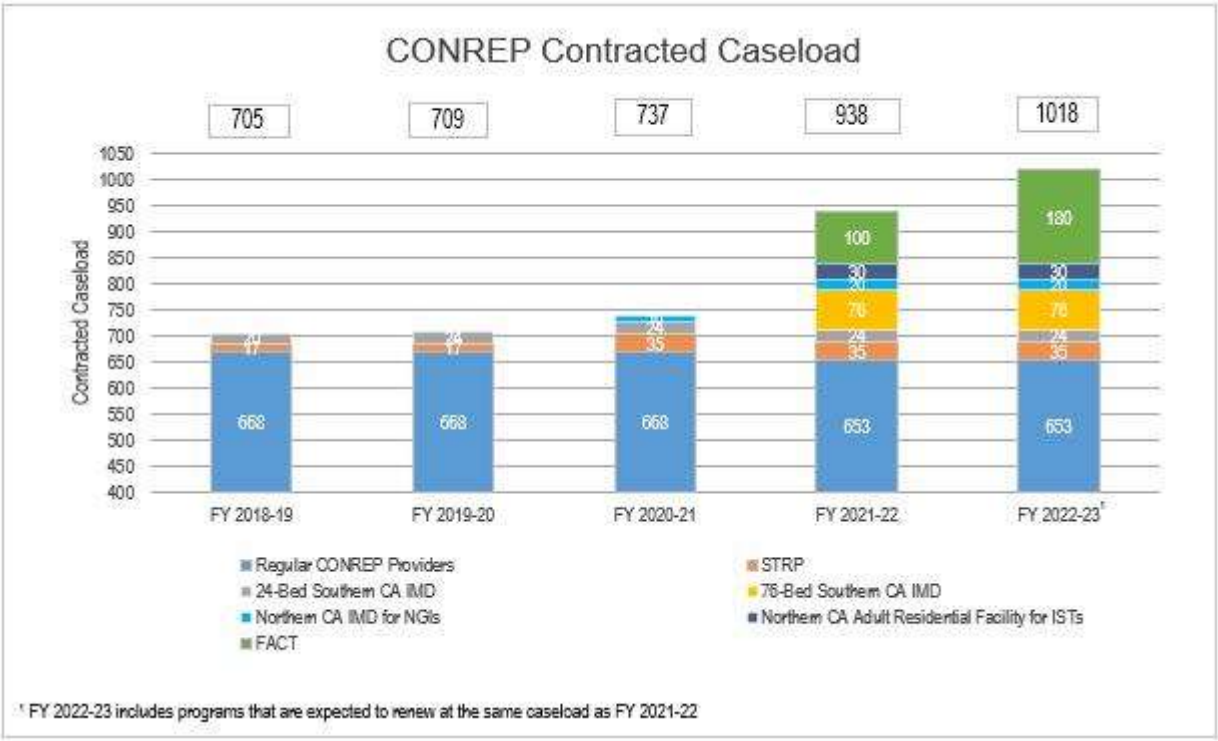
DSH anticipates a total contracted caseload of 938 CONREP clients in FY 2021-22 and 1,018 in FY 2022-23. This contracted caseload includes 653 regular CONREP clients who are currently placed in a variety of settings that do not offer dedicated beds to the program. In addition, CONREP's contracted caseload includes the following specialized beds dedicated to the program:

- 35 STRP beds in FY 2021-22

- 180 FACT beds
    - 100 in FY 2021-22
    - Additional 80 in FY 2022-23

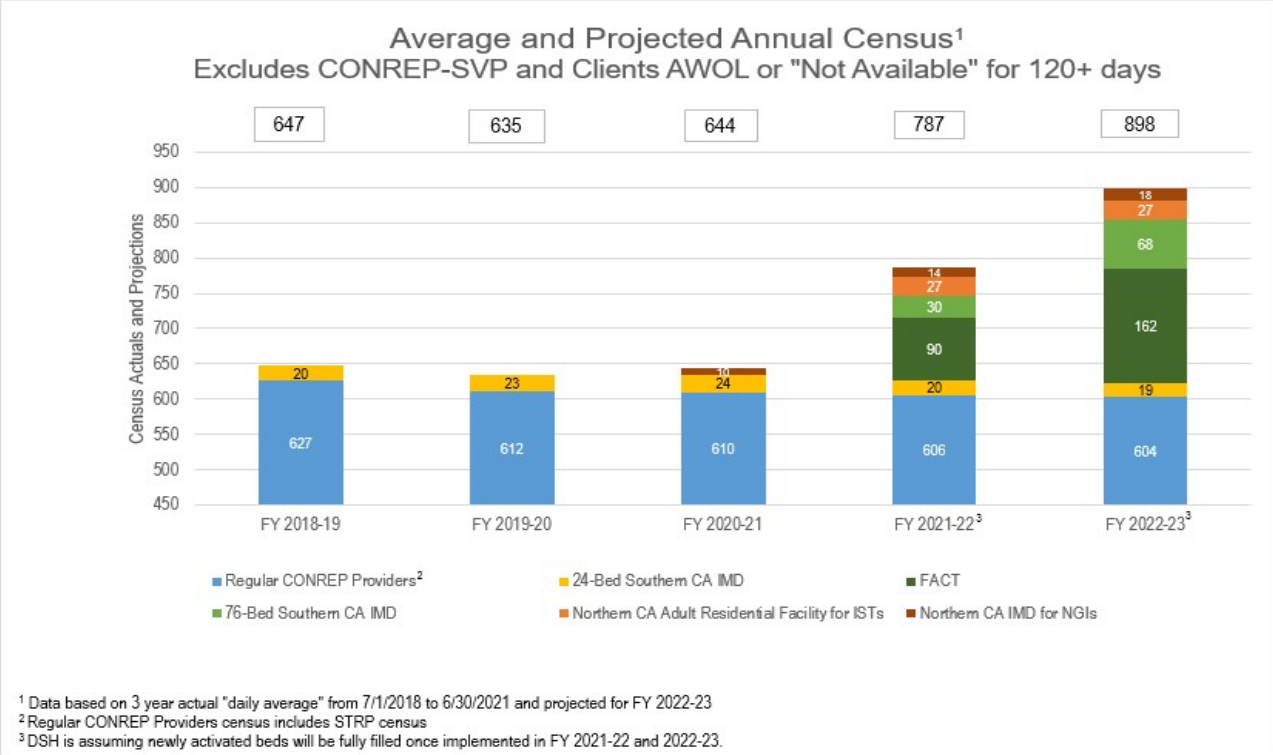
- 150 Institute of Mental Disorder (IMD)/Adult Residential Facility (ARF) beds in FY 2021-22
    - 76-bed Southern California (CA) IMD
    - 24-bed Southern CA IMD
    - 20-bed Northern CA IMD
    - 30-bed Northern CA ARF

The following chart illustrates DSH's previous, current, and projected CONREP contracted caseload for FY 2018-19 through FY 2022-23.



This contracted caseload reflects the total number of clients and beds available by the end of FY 2021-22 and FY 2022-23 which may vary based on activation delays. While DSH anticipates the activation of new beds dedicated to CONREP in FY 2022-23, the actual number of patients will be phased in and vary over the course of two years. Reflecting the projected patient phase-in, DSH estimates an average census of 787 in FY 2021-22 and 898 in FY 2022-23.

The following chart displays the average and projected annual census for FY 2018-19 through FY 2022-23.



[1] Data based on 3 year actual "daily average" from 7/1/2018 to 6/30/2021 and projected for FY 2022-23
[2] Regular CONREP Providers census includes STRP census
[3] DSH is assuming newly activated beds will be fully filled once implemented in FY 2021-22 and 2022-23.

As of October 2021, there are approximately 149 patients with court or BPH orders, or who have been referred by the state hospitals for placement to CONREP and are pending an order for release. A caseload update for the CONREP Non-SVP clients will be presented in the 2022-23 May Revision.

DESCRIPTION OF CHANGE

DSH reflects a one-time savings of $7.9 million in FY 2021-22 due to activation delays and an ongoing savings of $913,000 in FY 2021-22 for the 5-bed Northern CA MHRC. Additionally, DSH requests $1.4 million in FY 2021-22 and $5.5 million in FY 2022-23 and ongoing for CONREP Non-SVP to support the new 30-bed Northern CA Adult Residential Facility for ISTs. In total, DSH reflects a one-time current year (CY) savings of $7.4 million and requests $4.6 million in budget year (BY) and ongoing. The following sections will provide specific updates on programs and funding for all CONREP non-SVP programs.

Step-Down Transitional Programs

78-Bed Southern CA IMD Facility (Golden Legacy)

In partnership with Southern CA IMD facility, DSH developed a 78-bed step-down program for OMD and NGI state hospital patients ready for CONREP in 18 to 24 months. The existing space was licensed as a skilled nursing facility (SNF) and the provider received programmatic approval from Department of Health Care Services (DHCS), Mental Health and Substance Use Division (MHSUD) to establish a Special Treatment Program (STP) designation. The timing of activation is predicated on physical space modifications required to assure the safety and security of the patients.

Similar to what was reported in the 2021-22 May Revision, this program has not yet activated due to pending external approvals. Over the summer, an issue was raised by a surveyor of the Centers for Medicare & Medicaid Services (CMS) regarding a similar facility. The issue centered around serving a justice-involved population and the patients' rights related to freedom of movement (patient's right to come and go from facility at will). This issue raised concerns around the risk of decertifying the Golden Legacy facility. DSH is working with its contractor and the Department of Public Health (DPH) to seek assistance in connecting with CMS regarding a formal decision on the risk of decertification. DSH developed an alternative option to accommodate a partial decertification of the units that will host the 78-bed CONREP program allowing the remaining units of the facility to remain certified. As of November 2021, DSH is awaiting a new survey by DPH and the opportunity to present this plan to continue with program activation. DSH notes that the decision could result in the need for an alternative location to operate the new step-down program. DSH will continue to monitor the situation and provide updates in the 2022-23 May Revision.

While awaiting the CMS decision, DSH continues to work closely with Golden Legacy on program planning and startup activities. To avoid further delays, the program is expeditiously working on recruiting, hiring, and training the staff. Golden Legacy is developing a patient referral process and identifying prospective patients for transfer so placement can be facilitated immediately upon activation. In addition, due to COVID-19 isolation protocols, the facility must temporarily convert two double rooms to single occupancy for the duration of the pandemic, thereby reducing the bed capacity from 78 to 76. There are no savings associated with this temporary conversion, as this bed reduction does not reduce the staffing ratio.

As prospective state hospital patients have been identified for participating in the new 78-bed program, DSH's provider identified six beds available in their adjacent

Sylmar Health and Rehabilitation IMD facility for placement of OMD patients during this transition period. The utilization of these beds is temporary; once the 78-bed program has been activated, patients that were placed at Sylmar will be transferred to the new facility. DSH estimates the cost of care for these patients will be $567,000 in CY which will be covered through the existing authority for the 78-bed program.

Due to the pending external approvals, DSH now anticipates program activation to occur in March 2022. As a result of this delay and accounting for the cost of the additional beds located at Sylmar, DSH anticipates a one-time savings of $7.3 million in FY 2021-22.

20-bed Northern CA IMD Facility (Canyon Manor)

DSH established a 10-bed Northern CA IMD facility for NGI patients ready for step-down into a CONREP program in 18 to 24 months. Activation of the Northern CA 10-bed step-down IMD program began in July 2020, which included development of policies and procedures, training staff, and phased-in admissions. In July 2021, DSH extended this contract term and expanded this program by an additional 10 beds for a total of 20 beds. As of late November 2021, 13 of the 20 beds are either filled or reserved for patients ready for placement but pending a court ordered release from the state hospital. The provider continues to evaluate additional patients for admission. As a result of early implementation delays opening the expanded bed spaces, DSH reflects a one-time savings of $570,000 in FY 2021-22.

5-bed Northern CA MHRC

The 2021 Budget Act included funding to establish a 5-bed Northern CA Mental Health Rehabilitation Center (MHRC) for IST patients who have been ordered to CONREP. This facility operates several 24-hour residential care facilities for seriously mentally ill individuals. Its goal is to promote community re-entry by reducing inpatient hospitalizations and expedite client transition to lower levels of care. Program activation was expected to occur in July 2021. However, ongoing contract discussions have come to a halt and DSH has declined to move forward with program activation. As a result, DSH proposes to redirect the full savings of $913,000 in FY 2021-22 and ongoing to support activation of the 30-bed Northern CA Adult Residential Facility.

30-bed Northern CA Adult Residential Facility

DSH continues its efforts to expand its continuum of care and create additional placement options that serve patients discharged from the state hospitals. DSH is in active discussions with another Northern CA provider who has recently activated a 225-bed adult residential facility. This provider has committed to contracting with DSH

for a 30-bed Northern CA Adult Residential Facility and DSH is currently in negotiations to establish the 30-bed program in FY 2021-22 to serve ISTs ordered to CONREP. DSH expects contract execution and program activation to occur by April 2022. Its goal is to promote community re-entry by reducing inpatient hospitalizations and expedite client transition to lower levels of care. Services include supportive mental health programing for patients with dual diagnosis, 24/7 admissions, medication management, nursing care, life skills coaching, and in-county transportation to all necessary appointments. In total, DSH requests $1.4 million in FY 2021-22 and $5.5 million in FY 2022-23 and ongoing to support the new 30-bed Northern CA Adult Residential Facility.

FACT Program

DSH identified a single service provider for the new FACT level of care and is in the contract negotiation process. DSH anticipates program activation to begin in January 2022, consistent with the timeline originally anticipated. Currently, the contracted provider is in the process of locating and securing the housing required to implement this new program in Sacramento, San Diego, and Alameda counties. These counties are the prospective locations that will support regional FACT programs for CONREP clients. In accordance with the tentative schedule below, the projected program activation timeline plans a phased in approach to scaling up beds across all the three regions:

- Northern CA (CONREP FACT Regional Program – Sacramento) – early Winter 2022
- Southern CA (CONREP FACT Regional Program – San Diego) – early Spring 2022
- Bay Area (CONREP FACT Regional Program – Alameda) – early Fall 2022

The activation timeline assumes patient admissions for each program will be phased in at 10 individuals per month until all beds are full. The phase-in process provides the contractor with an increased time to find appropriate housing facilities for the clients and adjust them to the FACT level of care.

DSH is actively developing admission and discharge protocols for the program. Additionally, DSH is working with state hospital discharge planning staff and CONREP CPDs to assess which patients are best suited for placement within CONREP FACT. This will allow DSH to mitigate potential delays in filling beds when the new programs are ready to activate. In addition, the contractor is currently recruiting the necessary staff for success of each program. DSH will provide an update in the 2022-23 May Revision.

BCP Fiscal Detail Sheet

BCP Title: Conditional Release Program (CONREP) Non-Sexually Violent Predator (SVP) **BR Name: 4440-031-ECP-2022-GB**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	-7,425	4,563	4,563	4,563	4,563	4,563
Total Operating Expenses and Equipment	**$-7,425**	**$4,563**	**$4,563**	**$4,563**	**$4,563**	**$4,563**
Total Budget Request	**$-7,425**	**$4,563**	**$4,563**	**$4,563**	**$4,563**	**$4,563**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-7,425	4,563	4,563	4,563	4,563	4,563
Total State Operations Expenditures	**$-7,425**	**$4,563**	**$4,563**	**$4,563**	**$4,563**	**$4,563**
Total All Funds	**$-7,425**	**$4,563**	**$4,563**	**$4,563**	**$4,563**	**$4,563**

Program Summary

Program Funding						
4420010 - Conditional Release Program	-7,425	4,563	4,563	4,563	4,563	4,563
Total All Programs	**$-7,425**	**$4,563**	**$4,563**	**$4,563**	**$4,563**	**$4,563**

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

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**1.0**	**1.0**	**$0**	**$245**	**$245**
One-time	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Ongoing	*0.0*	*1.0*	*1.0*	*$0*	*$245*	*$245*

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

Similar to the general non-SVP program, CONREP-SVP offers clients 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 experienced significant challenges that impacted the operating cost of CONREP-SVP. The most notable issues include locating appropriate housing and public resistance to the placement of SVPs within their communities. Once the court orders an SVP be released from a state hospital into the community via CONREP, it takes an average of 12 months to secure court-approved housing. This results in increased pre-placement services and costs.

There are three types of accommodations that CONREP-SVPs typically reside in: a house, recreational vehicle (RV), and motel, with the latter two considered a transient release. In response to public resistance to SVP placement while ensuring both client and public safety, the need for heightened 24/7 security and monitoring also resulted in significant cost increases. As the courts approve additional petitions for release, the lack of housing options may result in some SVPs being released into their communities as transients, further increasing costs.

The number of SVPs in CONREP is limited and movement in and out of the program cannot be reliably projected utilizing historical census data. Caseload changes for CONREP-SVP are based on the most up-to-date information for each client including, but not limited to, court information regarding the status of those petitioning for conditional release from DSH-Coalinga, current CONREP clients petitions for unconditional release, status of clinical evaluations, client progress in the program, housing status, and historical experience with placement in the county of commitment. After accounting for these factors, current year (CY) and budget year (BY) caseload adjustments are made in accordance with the month projected for admission to or discharge from CONREP. Similarly, funding associated with projected caseload changes are prorated to reflect the partial-year value of phasing new clients in and out of the program.

In the 2021 Budget Act, DSH incorporated a different methodology of establishing the budget for CONREP-SVP services. Under this budget methodology, the contractor works with DSH to establish monthly cost per client rates in accordance with prior years actual expenditures for services and adjusted based on the number of individuals served. As a result, DSH presented an annual average cost of $344,000 per client and received $1.8 million in fiscal year (FY) 2021-22 and ongoing to cover the anticipated costs for a projected average of 25 CONREP-SVP clients.

DESCRIPTION OF CHANGE

DSH requests 1.0 position and $245,000 in FY 2022-23 and ongoing to support an Attorney III who will provide the necessary legal coverage for an increasing number of court hearings related CONREP-SVP clients. A CONREP-SVP caseload update has also been provided below.

Increased Court Hearing Resources

DSH has experienced an increased trend of county courts requesting a DSH attorney presence at placement hearings. In previous years, the average number of hearings per month had been roughly 15-18 hearings; during March 2020 to February 2021, the average monthly hearings attended was approximately 24-26 hearings. As a result, from March 2020 to February 2021, DSH's CONREP-SVP contracted provider attended 235 hearings regarding client placements. These placements are extremely sensitive, time consuming, and require extensive DSH Legal involvement. Even one individual client case can generate a large number of hearings. For example, a DSH attorney has attended 16 hearings for one CONREP-SVP candidate since October 2020. Most placements take one and a half years on average and a case goes to court every 30-60 days during preplacement activities, up to the date in which a residence is approved by the court for community notification. In addition, hearings occur approximately every two to four weeks up to the community notice.

For each client case, DSH estimates 24-26 hearings per case from order to placement. For each hearing, DSH Legal must attend multiple preparation meetings with DSH program staff, the CONREP-SVP contracted provider, District Attorneys, Public Defenders, and Superior Courts. DSH expects the number of placement hearings to increase as more individuals are engaging in treatment at DSH-Coalinga and being recommended for discharge into CONREP. Additionally, more clients are filing for conditional release which also requires increased DSH Legal resources. Currently, there are 15 clients at DSH-Coalinga awaiting placement in the community, for which DSH is in the process of finding housing. Given the estimate of typical hearings that occur for placement, this would result in approximately 360 to 390 hearings. In addition, in the process of finding housing, the Courts hold many hearings, including status updates on locating appropriate housing and statutorily mandated public hearings. These hearings may also require involvement by a DSH attorney in response to subpoenas and motions related to the client's placement. Below is a summary of responsibilities for the proposed position:

- Provide assistance interacting with criminal justice partners
- Attend court hearings for challenging and/or complex placements
- Provide legal advice to program staff
- Consult with the CONREP-SVP contractor
- Provide legal advice on the statutory requirements in response to community and media concerns

As the courts increasingly request for a DSH attorney to attend these hearings along with the CONREP-SVP contracted provider, DSH requests 1.0 Attorney III at an annual cost of $240,000 to provide the necessary legal coverage for the increased workload. Additionally, a high level of travel is expected in order to attend the significant number of hearings in person. Therefore, DSH requests an increase of $5,000 annually to support the increased travel costs. In total, DSH requests $245,000 in FY 2022-23 and ongoing.

Caseload Update

DSH assumes that a total caseload of 25 SVPs could be conditionally released into the community by June 30, 2022. There are currently 16 court-ordered clients participating in CONREP-SVP and 15 individuals with court-approved petitions awaiting placement into the community. Additionally, 11 more individuals have filed petitions for conditional release and are proceeding through the court process. Although it is possible that more than 25 SVP clients could be conditionally released to CONREP by the end of FY 2022-23, a conservative average caseload of 25 will be assumed, due to the unpredictable nature of the courts and the challenges surrounding housing availability for SVP clients, among other factors. No additional funding is being requested at this time, however, DSH will closely monitor this caseload and provide an update in the 2022-23 May Revision.

The following table provides a summary of the current and projected CONREP-SVP placement caseload. While the number of placements made in FY 2022-23 appears to be static, admissions and discharges occur throughout the year and should be considered when reviewing projected placements.

CONREP-SVP Caseload Update and Projection for FY 2022-23			
Status	Projected Caseload as of 2021-22 May Revise	Projected Placements by End of FY 2021-22[1]	Projected Placements by End of FY 2022-23[1]
Individuals currently in CONREP	16	17	18
Individuals approved for CONREP	11	13	13
TOTAL	**27**	**30**	**31**
Average Caseload[1]	**25**	**25**	**25**

[1]Accounts for admissions and discharges over the course of the FY.

BCP Fiscal Detail Sheet

BCP Title: Conditional Release Program (CONREP) Sexually Violent Predator (SVP) **BR Name: 4440-032-ECP-2022-GB**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	0.0	1.0	1.0	1.0	1.0	1.0
Total Positions	**0.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**
Salaries and Wages						
Earnings - Permanent	0	137	137	137	137	137
Total Salaries and Wages	**$0**	**$137**	**$137**	**$137**	**$137**	**$137**
Total Staff Benefits	0	87	87	87	87	87
Total Personal Services	**$0**	**$224**	**$224**	**$224**	**$224**	**$224**
Operating Expenses and Equipment						
5301 - General Expense	0	8	8	8	8	8
5304 - Communications	0	1	1	1	1	1
5320 - Travel: In-State	0	1	1	1	1	1
5324 - Facilities Operation	0	5	5	5	5	5
5340 - Consulting and Professional Services - External	0	5	5	5	5	5
5346 - Information Technology	0	1	1	1	1	1
Total Operating Expenses and Equipment	**$0**	**$21**	**$21**	**$21**	**$21**	**$21**
Total Budget Request	**$0**	**$245**	**$245**	**$245**	**$245**	**$245**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	0	245	245	245	245	245
Total State Operations Expenditures	**$0**	**$245**	**$245**	**$245**	**$245**	**$245**
Total All Funds	**$0**	**$245**	**$245**	**$245**	**$245**	**$245**

Program Summary

Program Funding						
4400010 - Headquarters Administration	0	6	6	6	6	6
4400020 - Hospital Administration	0	1	1	1	1	1
4420020 - Conditional Release Program - Sexually Violent Predators	0	238	238	238	238	238
Total All Programs	**$0**	**$245**	**$245**	**$245**	**$245**	**$245**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
5795 - Atty III				0.0	1.0	1.0	1.0	1.0	1.0
Total Positions				**0.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
5795 - Atty III	0	137	137	137	137	137
Total Salaries and Wages	**$0**	**$137**	**$137**	**$137**	**$137**	**$137**
Staff Benefits						
5150200 - Disability Leave - Industrial	0	2	2	2	2	2
5150210 - Disability Leave - Nonindustrial	0	1	1	1	1	1
5150350 - Health Insurance	0	6	6	6	6	6
5150450 - Medicare Taxation	0	2	2	2	2	2
5150500 - OASDI	0	8	8	8	8	8
5150600 - Retirement - General	0	40	40	40	40	40
5150800 - Workers' Compensation	0	6	6	6	6	6
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	0	4	4	4	4	4
5150900 - Staff Benefits - Other	0	18	18	18	18	18
Total Staff Benefits	**$0**	**$87**	**$87**	**$87**	**$87**	**$87**
Total Personal Services	**$0**	**$224**	**$224**	**$224**	**$224**	**$224**

CONTRACTED PATIENT SERVICES

CONTRACTED PATIENT SERVICES
JAIL-BASED COMPETENCY TREATMENT PROGRAMS AND ADMISSION, EVALUATION, AND STABILIZATION CENTER (JBCT/AES)
Program Summary

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**-$6,989**	**$11,620**	**$11,839**
One-time	*0.0*	*0.0*	*0.0*	*-$6,989*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$11,620*	*$11,839*

BACKGROUND

The Department of State Hospitals (DSH) contracts with a number of California counties to provide restoration of competency services to Incompetent to Stand Trial (IST) patients in county jail facilities. Jail-Based Competency Treatment (JBCT) programs are designed to treat IST patients with lower acuity and quickly restore them to trial competency, generally within 90 days. In fiscal year (FY) 2020-21, IST patients had an average length of stay of 99.1 days in a JBCT program which is an increase over prior years due to operational impacts resulting from the COVID-19 pandemic. If a JBCT program is unable to restore an IST patient to trial competency quickly, the patient can be referred to a state hospital for longer-term IST treatment. DSH currently operates four JBCT program models:

1. Single county model – serves IST patients from one specific county with an established number of dedicated program beds.
2. Regional model - serves IST patients from surrounding counties with an established number of dedicated program beds.
3. Statewide model - serves IST patients from multiples counties statewide with an established number of dedicated program beds.
4. Small county model – services are delivered on an individual basis to a small number of IST patients, generally 12 to 15 annually. These programs do not have dedicated treatment beds.

The number of dedicated beds or total number of patients served annually for each county is based on an analysis of the county's actual monthly trend of felony IST referrals. Negotiations and contract development are at various stages for each location, and the proposals in the following sections reflect the counties furthest along in the process. DSH also continues to identify ways to reduce wait times and access to treatment services, including the expansion of existing jail in-reach contracted services. These services provide early access to psychotropic medication including long-acting injectable medication, clinical one to one contact, and basic

competency education services to IST patients pending placement to a DSH program. In addition to treatment services, contracted patients' rights advocacy services are also included in accordance with the assumed timelines and caseload for new program activations or existing program expansions.

Over the last few years, DSH has assumed an estimated average daily bed rate of $420 to develop the funding request proposed for new programs, which has been consistent with the rates established for prior JBCT program activations. However, DSH has received requests from multiple counties to cover higher costs incurred by the jails and their treatment providers due to increases in salaries and operating expenses. Additionally, the final per diem rate ultimately negotiated to by the county and DSH may vary by program, based on multiple factors including the size of the program, physical layout of the jail, and geographical location as it relates to recruitment and retention of qualified healthcare staff. Furthermore, per diem rates are anticipated to increase over time commensurate with inflation and a variety of economic factors. DSH aims to negotiate contract rate increases within existing resources, while balancing the increasing demand for IST beds and treatment services.

DESCRIPTION OF CHANGE

DSH reflects a one-time current year (CY) savings of approximately $7.0 million due to contract negotiation delays amid the COVID-19 pandemic. In addition, DSH requests $11.6 million in 2022-23 and $11.8 million in 2023-24 and ongoing to support the expansion of the existing JBCT programs including expansion of early access/jail-in reach services to IST patients pending placement, the addition of new JBCT programs, and associated program support funding for patients' rights advocacy services. DSH is looking into utilizing the CY savings to offset increased costs incurred by the jails due to supporting increased salaries, expanding the current JBCT service footprint and supporting new JBCT programs. The following sections will provide additional information and funding adjustments anticipated as of the Governor's Budget for all existing JBCT program activations and refer to Attachment A for an itemized list of adjustments.

Existing AES and JBCT Program Cost Increase and Expansion Updates

Kern AES Center: 60-Beds (-$2,606,000 in FY 2021-22)

In the 2021-22 May Revision, DSH assumed the expansion of the additional 30 male beds would occur in December 2021. As the Kern AES Center continues to face recruitment challenges and experience delays in procuring the necessary renovation service contracts, DSH will defer the expansion request until July 2022. As a result, DSH expects a CY savings of $2.6 million.

Existing Program Bed Capacity Update Requests and Operational Expenditures Cost Increases (-$4,383,000 in FY 2021-22; $3,529,000 in FY 2022-23; $3,748,000 in FY 2023-24 and ongoing)

As of the 2022-23 Governor's Budget, the following adjustments to currently funded and existing programs include:

- Eight currently funded county programs pending activation are experiencing delays and some bed capacity levels are being adjusted due to a change in the proposed JBCT location in the jail
- Four existing JBCT programs experienced increasing level of IST referrals and can support a bed capacity expansion: Humboldt, Kings, Monterey, Sonoma
- One currently funded program pending activation (Northern California County H) will increase its capacity by an additional 20 beds and serve as a statewide program
- A five percent rate increase is anticipated for: Humboldt, Kings, Sonoma, Sacramento, San Luis Obispo, Shasta, Stanislaus, Ventura, Northern CA County H and Northern California County N

Service Expansion to Provide Early Access to IST Treatment ($2,636,000 in FY 2022-23 and ongoing)

DSH proposes to utilize CY savings to expand JBCT services to perform early access to treatment services to support IST defendants while pending placement to a DSH program and are currently housed in or near a county jail that hosts a JBCT program. The Incompetent to Stand Trial Solutions Workgroup established pursuant to Welfare and Institutions Code (WIC) 4147, has identified potential solutions to treatment in jail settings to support the stabilization of felony IST defendants and ultimately increase treatment opportunities for IST patients (See C17 – IST Solutions Workgroup the Program Update – IST Solutions Workgroup). The funding will support the expansion of current jail medical and behavioral health provider contracts. Below reflects a preliminary estimate of the services to be provided:

- Psychiatry – psychiatric nurse practitioners and/or psychiatrists
- Mental Health clinicians to deliver one to one clinical engagement and initiate competency restoration services
- Nursing to administer and monitor medications

DSH proposes to absorb the CY cost by repurposing a portion of savings experienced from delayed or deferred activations and anticipates having an executed contract and these services in place by late March 2022. Based on the program outcomes, the ongoing challenges related to increased referral rates of ISTs and associated waitlists, and the recommendations of the IST Solutions Workgroup, DSH will provide updates in the 2022-23 May Revision of any recommended changes and ongoing funding needed for JBCT.

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 the actual monthly trend of felony IST referrals and the county's interest in establishing a local or regional program. DSH assumes an estimated daily bed rate of $420, consistent with the rates established for recent JBCT program activations. Refer to Attachment A for an itemized list of costs by proposed JBCT location. An update will be provided in the 2022-23 May Revision.

Activation Updates ($5,366,000 in FY 2022-23 and ongoing)

DSH requests $5.4 million in FY 2022-23 and ongoing for JBCT to support an additional two new programs adding 35 beds.

Patients' Rights Advocacy Funding ($89,000 in FY 2022-23 and ongoing)

DSH requests $49,000 in FY 2022-23 and ongoing to fund contracted patients' rights advocacy services to support the proposed new JBCT programs in order to comply with Assembly Bill (AB) 103 (Statutes of 2017). AB 103 requires that all DSH patients have equal access to patients' rights advocacy resources, including IST patients who are admitted to JBCT programs. In addition, DSH requests $40,000 in BY and ongoing to support previously unanticipated travel costs associated with the PRAs.

CONTRACTED PATIENT SERVICES
JAIL-BASED COMPETENCY TREATMENT PROGRAMS AND ADMISSION, EVALUATION, AND STABILIZATION CENTER (JBCT/AES)
Attachment A

The following table demonstrates the funding requested in the fiscal year (FY) 2022-23 Governor's Budget for the Jail Based Competency Treatment (JBCT) Program's total capacity, activation dates, per diem rates and projected funding for existing and new JBCT programs.

Total JBCT Capacity and Projected Funding									
Existing JBCT Capacity and Projected Funding									
Program	**FY 21-22 Bed Capacity**	**FY 22-23 Bed Capacity**	**FY 21-22 Activation**	**FY 22-23 Activation**	**Existing Per Diem Rate**	**Proposed Per Diem Rate**	**FY 21-22[1]**	**FY 22-23[1]**	**FY 23-24[1]**
Butte	5	5	N/A	N/A	$420	$420	-	-	-
Calaveras	10	10	N/A	N/A	$420	$420	-	-	-
Humboldt	6	8	N/A	N/A	$419	$441	-	$368	$368
Kern AES	60	90	N/A	N/A	$480	$480	-$2,606	-	-
Kings	5	8	N/A	N/A	$420	$441	$189	$303	$521
Mariposa	N/A	N/A	N/A	N/A	N/A	N/A	-	-	-
Mendocino	6	6	N/A	N/A	$420	$420	-	-	-
Monterey	10	11	N/A	N/A	$441	$441	-	$161	$161
Placer	15	15	N/A	N/A	$374	$374	-	-	-
Riverside	25	25	N/A	N/A	$402	$402	-	-	-
Sacramento	44	44	N/A	N/A	$474	$499	-	$385	$385
San Bernardino	146	146	N/A	N/A	$472	$472	-	-	-
San Diego	30	40	N/A	N/A	$391	$391	$630	$1,533	$1,533
San Joaquin	12	12	N/A	N/A	$403	$403	-	-	-
San Luis Obispo	5	5	N/A	N/A	$424	$446	-	$39	$40

Program	FY 21-22 Bed Capacity	FY 22-23 Bed Capacity	FY 21-22 Activation	FY 22-23 Activation	Existing Per Diem Rate	Proposed Per Diem Rate	FY 21-22[1]	FY 22-23[1]	FY 23-24[1]
Santa Barbara	10	10	N/A	N/A	$418	$418	-	-	-
Shasta	6	6	N/A	N/A	$374	$441	-	$46	$46
Solano	10	10	N/A	N/A	$418	$418	-	-	-
Sonoma	12	14	N/A	N/A	$431	$462	$132	$434	$434
Stanislaus	18	18	N/A	N/A	$375	$441	-	-	-
Ventura	8	8	N/A	N/A	$415	$441	-	$61	$61
Central CA County B	9	10	Dec 2021	May 2022	$420	$420	-$340	$153	$153
Central CA County C	15	15	Sept 2021	April 2022	$420	$420	-$4,300	-$3,900	-$3,900
Northern CA Small County D	N/A	N/A	Dec 2021	Dec 2022	N/A	N/A	-$84	-	-
Northern CA County E	N/A	5	Sept 2021	Dec 2022	N/A	N/A	-$160	$267	$267
Northern CA County F	5	5	Dec 2021	Dec 2022	$420	$420	-$189	-	-
Northern CA County G	7	7	Dec 2021	Jan 2022	$420	$420	-	-	-
Northern CA County H	40	40	Mar 2022	Feb 2022	$441	$441	$1,076	$3,219	$3,219
Northern CA County I	15	15	Dec 2021	Mar 2023	$420	$420	-$567	-	-
Northern CA County J	15	15	Dec 2021	Mar 2023	$420	$420	-$567	-	-

Program	FY 21-22 Bed Capacity	FY 22-23 Bed Capacity	FY 21-22 Activation	FY 22-23 Activation	Existing Per Diem Rate	Proposed Per Diem Rate	FY 21-22[1]	FY 22-23[1]	FY 23-24[1]
Central CA County K	4	7	Dec 2021	Mar 2023	$420	$420	-$203	$460	$460
Northern CA County N	19	19	Apr 2022	Feb 2022	$420	$420	-	-	-
Jail In-Reach Services	N/A	N/A	N/A	N/A	N/A	N/A	-	$2,636	$2,636
Existing Subtotal	**572**	**629**					**-$6,989**	**$6,165**	**$6,384**
New JBCT Capacity and Projected Funding									
Program	**FY 21-22 Bed Capacity**	**FY 22-23 Bed Capacity**	**FY 21-22 Activation**	**FY 22-23 Activation**	**Existing Per Diem Rate**	**Proposed Per Diem Rate**	**FY 21-22[1]**	**FY 22-23[1]**	**FY 23-24[1]**
Central CA County L	0	12	N/A	July 2022	N/A	$420	-	$1,840	$1,840
Southern CA County M	0	23	N/A	Mar 2023	N/A	$420	-	$3,526	$3,526
Patients' Rights Advocacy	N/A	N/A	N/A	N/A	N/A	N/A	-	$49	$49
PRA Travel	N/A	N/A	N/A	N/A	N/A	N/A	-	$40	$40
New Subtotal	**0**	**35**					**$0**	**$5,455**	**$5,455**
TOTAL	**572**	**664**					**-$6,989**	**$11,620**	**$11,839**

[1] Dollars in Thousands

BCP Fiscal Detail Sheet

BCP Title: Jail Based Competency Treatment - Existing Programs **BR Name: 4440-035-ECP-2022-GB**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	-6,989	6,165	6,384	6,384	6,384	6,384
Total Operating Expenses and Equipment	**$-6,989**	**$6,165**	**$6,384**	**$6,384**	**$6,384**	**$6,384**
Total Budget Request	**$-6,989**	**$6,165**	**$6,384**	**$6,384**	**$6,384**	**$6,384**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-6,989	6,165	6,384	6,384	6,384	6,384
Total State Operations Expenditures	**$-6,989**	**$6,165**	**$6,384**	**$6,384**	**$6,384**	**$6,384**
Total All Funds	**$-6,989**	**$6,165**	**$6,384**	**$6,384**	**$6,384**	**$6,384**

Program Summary

Program Funding						
4430020 - Jail Based Competency Treatment	-6,989	0	0	0	0	0
4430050 - Jail Based Competency Treatment Programs	0	6,165	6,384	6,384	6,384	6,384
Total All Programs	**$-6,989**	**$6,165**	**$6,384**	**$6,384**	**$6,384**	**$6,384**

BCP Fiscal Detail Sheet

BCP Title: Jail Based Competency Treatment - New Programs **BR Name: 4440-036-ECP-2022-GB**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	0	5,455	5,455	5,455	5,455	5,455
Total Operating Expenses and Equipment	**$0**	**$5,455**	**$5,455**	**$5,455**	**$5,455**	**$5,455**
Total Budget Request	**$0**	**$5,455**	**$5,455**	**$5,455**	**$5,455**	**$5,455**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	0	5,455	5,455	5,455	5,455	5,455
Total State Operations Expenditures	**$0**	**$5,455**	**$5,455**	**$5,455**	**$5,455**	**$5,455**
Total All Funds	**$0**	**$5,455**	**$5,455**	**$5,455**	**$5,455**	**$5,455**

Program Summary

Program Funding						
4430050 - Jail Based Competency Treatment Programs	0	5,455	5,455	5,455	5,455	5,455
Total All Programs	**$0**	**$5,455**	**$5,455**	**$5,455**	**$5,455**	**$5,455**

CONTRACTED PATIENT SERVICES
FELONY MENTAL HEALTH DIVERSION PROGRAM
Informational Only

BACKGROUND

The Department of State Hospitals (DSH) contracts with various counties throughout California to develop new, or expand existing, Felony Mental Health Diversion (Diversion) Programs. These county programs serve individuals with serious mental illnesses who are diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder with potential to be found Incompetent to Stand Trial (IST) on felony charges. The Diversion program (formerly known as the IST Diversion program) was established in the 2018 Budget Act which included $100 million one-time General Fund, available for expenditure between from fiscal year (FY) 2018-19 through FY 2022-23, and 2.0 positions with limited-term funding.

In the 2021 Budget Act, DSH received an additional 12 months to expend the FY 2018-19 funding of $46.4 million one-time General Fund to expand the Diversion program for existing and new counties, in addition to $1.2 million ongoing to support the 2.0 positions established in FY 2018-19. Additionally, the 2021 Budget Act authorized ongoing funding for 1.0 additional analyst position, an increased appropriation for data collection and research, and technical assistance contracts to support DSH's county partners.

Funding for Existing County Programs

Of the $100 million appropriated in FY 2018-19, $99.5 million was allocated to fund county Diversion programs. By June 30, 2021, $93.1 million of the $99.5 million was encumbered for contracts with the following 24 counties:

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

The 2021 Budget Act extended the funding received in FY 2018-19 by 12 months, which grants DSH and participating counties enough time to complete the full pilot program. Remaining unallocated program funding will be available to counties with the capacity to serve more individuals through this program.

DESCRIPTION OF CHANGE

The original Diversion pilot project was scheduled to end in FY 2021-22Although DSH was approved to expand the pilot by one year to account for delays caused by the COVID-19 pandemic, the Department anticipates it will have sufficient data and enough individuals who have completed the program to begin tracking post-diversion outcomes. Additionally, the Incompetent to Stand Trial Solutions Workgroup established pursuant to Welfare and Institutions Code (WIC) 4147, has identified potential solutions to increase the utilization of diversion for felony ISTs (See C17 – IST Solutions Workgroup). Based on the program outcomes, the ongoing challenges related to increased referral rates of ISTs and associated waitlists, and the recommendations of the IST Solutions Workgroup, DSH will provide updates in the 2022-23 May Revision of any recommended changes and ongoing funding needed for Diversion.

The 24 counties with contracts in place also have the option to expand their current DSH Diversion programs by up to 20% utilizing $17.4 million in FY 2021-22 funding. Counties that choose to participate in this expansion will be required to divert defendants who have been found felony IST. In addition, DSH opened the diagnostic criteria for entry into the program to include any mental health diagnosis allowed under Penal Code (PC) 1001.36 and waived the requirement for additional county match funding.

Letters of Intent (LOI) from interested counties were submitted to DSH in September 2021. Sixteen counties – Alameda, Contra Costa, Humboldt, Kern, Los Angeles, Marin, Riverside, Sacramento, San Diego, San Francisco, San Mateo, Santa Barbara, Santa Clara, Solano, Ventura, and Yolo – submitted an LOI to expand their existing programs and are currently working with DSH to plan their expansions.

Funding for New County Programs

The 2021 Budget Act expanded the Diversion program by an additional $29.0 million to contract with new counties across the state. New county programs established under this expansion will follow the requirements of the original pilot launched in FY 2018-19:

- Eligible clients must have a felony charge
- Eligible clients must have a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder
- Eligible clients must not pose an unreasonable safety risk to the community

- There must be a connection established between the alleged crime and either the defendant's symptoms of mental illness or conditions of homelessness
- The county must provide matching funds in local dollars (10-20% of contract depending on county size)

In fall 2021, six new counties submitted LOIs to establish new Diversion programs. DSH is currently providing intensive technical assistance, including a five-session Diversion Academy featuring national field experts, to assist counties in developing their programs. DSH will provide a status update in the 2022-23 May Revision.

County Program Implementation Status

As of September 30, 2021, DSH has executed contracts with 24 counties and all 24 have activated their Diversion programs. These programs aim to divert a total of 820 felony ISTs over the course of their program. The chart below displays the funding, population and start date per county.

County Program Status - FY 2018-19 Funding			
Activated Programs			
County	**Funding**	**Population**	**Program Start Date**
Alameda	$3,114,100	22	3/2/2021
Contra Costa	$3,114,100	22	7/1/2020
Del Norte	$426,000	9	6/1/2020
Fresno	$5,843,700	42	3/15/2021
Humboldt	$979,800	23	7/1/2020
Kern	$7,891,400	56	1/13/2020
Los Angeles	$25,864,100	200	3/1/2019
Marin	$531,476	12	6/12/2020
Placer	$1,065,000	21	2/1/2021
Riverside	$6,910,100	48	6/15/2021
Sacramento	$4,478,900	32	3/8/2021
San Bernardino	$7,464,800	53	1/1/2020
San Diego	$3,328,000	30	10/27/2020
San Francisco	$2,300,400	30	7/1/2020
San Luis Obispo	$1,278,000	9	8/20/2019
San Mateo	$835,757	12	4/19/2021
Santa Barbara	$2,644,500	18	9/22/2020
Santa Clara	$2,840,000	20	7/1/2020
Santa Cruz	$1,362,536	45	10/1/2020

Siskiyou	$194,000	40	6/1/2021
Solano	$3,242,300	23	2/12021
Sonoma	$3,839,100	27	1/1/2020
Ventura	$2,428,200	18	3/2/2021
Yolo	$1,100,000	8	2/3/2021
Subtotal	**$93,076,269**	**820**	

Diversion Program Data Collection Efforts and Research

Pursuant to WIC 4361, DSH is actively performing data collection from every county with a Diversion program. Data is collected quarterly in arrears on all county Diversion program participants. As of June 30, 2021, 458 eligible individuals have been diverted to a county-run program. DSH continues to work one-on-one with all counties to ensure the quality of the data collected. The following table displays a high-level snapshot of the Diversion program participants.

Diversion Program Participant Descriptive Data		
Program Information	**Total Number**	**Percentage**
Total Diverted as 6/30/2021	479	100%
Total ISTs Diverted Prior to Referral to DSH I[1]	197	41.1%
Total Eligible for Diversion[2]	458	95.6%
Total Found Likely to Be IST Prior to Diversion	282	58.9%
Total ISTs Diverted Directly from DSH Waitlist	52	10.8%
Diagnosis	**Total Number**	**Percentage**
Schizophrenia	196	40.9%
Schizoaffective Disorder	167	34.9%
Bipolar Disorder	110	23.0%
Nonqualifying Disorder[3]	<11[4]	***%
Ethnicity	**Total Number**	**Percentage**

[1] In some counties the courts are committing ISTs directly to the county Diversion program instead of committing them to DSH and then ordering them into Diversion; consequently, these ISTs do not have a commitment order to DSH and do not become part of the waitlist.
[2] DSH works directly with each county when it identifies diversion participants who do not meet all eligibility requirements of the program.
[3] DSH works directly with each county when it identifies diversion participants who do not meet all eligibility requirements of the program.
[4] Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or "less than 11" within the narrative. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

Black	174	36.3%
Hispanic	143	29.9%
White	125	26.1%
Other	37	7.7%
Gender	**Total Number**	**Percentage**
Male	319	66.6%
Female	157	32.8%
Other	3	0.6%
Living Situation at Arrest	**Total Number**	**Percentage**
Homeless	386	80.6%
Not Homeless	93	19.4%
Felony Charges	**Total Number**	**Percentage**
Arson	36	7.5%
Assault/ Battery	149	31.1%
Criminal Threats	38	7.9%
Kidnapping	15	3.1%
Robbery	73	15.2%
Theft	83	17.3%
Other	85	17.7%

Abdul Lateef Jameel Poverty Action Lab North America Grant

In September 2019, DSH was awarded an incubation grant of $39,600 from the Abdul Lateef Jameel Poverty Action Lab (J-PAL) North America of the Massachusetts's Institute of Technology. J-PAL North America supports the development and implementation of randomized control trials (RCTs) in public health and welfare programs. DSH Diversion was awarded the use of J-PAL academicians and funding to determine if an RCT of the Diversion program is feasible. Regular meetings with the J-PAL team began in October 2019 but have been on hold due to COVID-19 since spring 2020. Due to these unavoidable delays, J-PAL approved a no-cost extension of this grant to DSH through June 30, 2022.

Program Administration Update

The DSH team works closely with the Council of State Governments Justice Center (CSG) and the Council on Criminal Justice and Behavioral Health (CCJBH) to implement the Diversion program. Both DSH and CCJBH have contracts with CSG to develop technical assistance trainings, learning materials, and program templates for county use. In addition, the contracts connect DSH and CCJBH with experts in other states with prior experience implementing Diversion programs. DSH received an annual appropriation of $100,000 to support technical assistance contracts with CSG and other national experts in community treatment for individuals with serious mental illness and criminal justice involvement.

DSH continues to provide all counties participating in the Diversion program with technical assistance and training opportunities. As of September 1, 2021, DSH has provided counties with 132 hours of in-person and web-based training. In FY 2018-19 and 2019-20, DSH technical assistance focused primarily on supporting county planning and initial implementation efforts. Topics for FY 2020-21 focused on supporting counties as their programs were activated and established, such as:

- Appropriate medications and psychopharmacology considerations for prescribers in Diversion programs
- How to use risk assessments to inform client treatment plans
- Case plan review sessions with DSH psychiatrists, external experts, and other county staff to assist counties in evaluating more difficult cases
- 1:1 assistance with producing required fiscal reports

In the coming year, DSH plans to focus county technical assistance into two tracks. The first track is designated for all new counties contracting with DSH to implement a new Diversion program. As referenced above, DSH developed and released a five-session Diversion Academy for new counties. The Diversion Academy provides 20 hours of targeted assistance to counties in developing their Diversion programs and completing the program plans required by DSH. Leveraging prior experience with working with counties currently participating in the Diversion program, DSH developed the Academy with the goal of helping new counties stand up programs more quickly and efficiently.

The second track will be targeted at existing county programs and will focus on ongoing risk management strategies, continued learning opportunities related to psychopharmacology, and the specific risks that co-occurring substance use disorders (SUDs) cause when working with this population. For example, DSH has identified that training counties on how to differentiate between an individual suffering from a psychotic disorder with a co-occurring SUD or someone suffering primarily from a SUD with psychotic *symptoms* is of particular importance for the success of this program. This approach is designed to optimize current programs and provide better patient outcomes.

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

BACKGROUND

The Budget Act of 2019 added the following Provisional Language: *Item 4440-011-0001—Department of State Hospitals 1. Incompetent to Stand Trial Diversion Program. Trial courts shall work with the Judicial Council to provide data pursuant to mental health diversion programs set forth in Penal Code section 1001.36 including the number of petitions that were granted. When possible, the courts shall also report the (1) number of petitions that were denied (2) number of petitions denied because the defendant did not meet the statutory requirements for eligibility, (3) number of individuals who successfully completed the diversion program, and (4) number of individuals that were terminated from the program. The Judicial Council will make this data available to the Legislature and the Department of State Hospitals on an annual basis commencing July 1, 2020. The Department of State Hospitals shall include this report in the data elements it receives from counties that have contracted with the department for mental health diversion programs funded pursuant to Chapter 6.5 (commencing with Section 4361) of the Welfare and Institutions Code.*

In response to the Provisional Language request, the Department of State Hospitals (DSH) and the Judicial Council worked to ensure the Superior Courts of California data related to Penal Code (PC) section 1001.36 is transmitted and incorporated into the county data sets collected from the pre-trial diversion program (per Welfare and Institutions Code (WIC) 4361). This report describes the methodologies employed by both departments to collect the data required by WIC 4361 and the Provisional Language, as well as challenges encountered. Additionally, a high-level summary of the data collected as of June 30, 2021 is provided.

2022-23 GOVERNOR'S BUDGET REPORT

Judicial Council Data Collection Methodology

Pursuant to the Supplemental Report of the 2019 Budget Act by the Legislative Analyst's Office regarding Assembly Bill 1810 (Stats. 2018, Ch. 34), trial courts are required to work with the Judicial Council of California to provide data pursuant to mental health diversion programs set forth in PC 1001.36. The Judicial Council is to make this data available to the Legislature and DSH on an annual basis, beginning January 1, 2020. In response to those requirements, the Judicial Council amended its quarterly superior court data surveys to include requests for totals of petitions for

mental health diversion, petition outcomes, and program outcomes. These items were further amended to distinguish between petitions and diversions for cases including at least one felony charge and total petitions and diversions.

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

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

Judicial Council Data Collection Challenges

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

DSH Data Collection Methodology

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

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

DSH operationalized the collection of these data points via a master data dictionary and workbook. As counties complete the contracting process with DSH, the DSH data team collaborates with the county data teams to individualize the master data dictionary and workbook for each county. Typically, adjustments to the data dictionary occur in the section capturing services provided as each program has a different combination of available treatment opportunities.

Once counties begin to send defendants to Diversion, they have 90 days after the end of each quarter to submit data reports to DSH. The department provides each county with access to a secure online file transfer system through which the reports are uploaded. DSH established reporting quarters in alignment with the state fiscal year (FY):

- Quarter 1 – July 1 through September 30
- Quarter 2 – October 1 through December 31
- Quarter 3 – January 1 through March 31
- Quarter 4 – April 1 through June 30

[1] This information shall be confidential and shall not be open to public inspection

Data Collection Challenges

DSH has encountered two main issues related to the collection of data for this project to date. The first issue is challenges to DSH's authority to collect patient-level data from certain County Counsels and county information security departments. DSH released a Department Letter (DL 19-001) in October 2019 establishing its authority to collect this information as a "health oversight agency" as defined by the Health Insurance Portability and Accountability Act of 1996 (42 C.F.R. part 164.501) and as a program evaluator and auditor per 42 C.F.R. part 2.53. Clarifying this authority to the counties allowed DSH to require the submission of patient-level mental health and substance use disorder treatment for the purposes of evaluating these programs.

In FY 2019-20, data collection for this program was also impacted by COVID-19. Numerous counties which had planned to activate programs and begin diverting individuals before June 30, 2020 were delayed due to the numerous impacts of the pandemic, including court closures, and resource constraints in the county, mass releases of inmates at the local jails and virus outbreaks at the jails. These delays reduced the number of counties reporting to DSH in FY 2019-20. As of Spring 2021 all current DSH-contracted programs have been activated and reported data as of June 30, 2021.

SUMMARY OF REPORTED DATA

The following tables display high-level summaries of the data reported to DSH and the Judicial Council per the requirements of the above referenced Provisional Language.

FY 2018-19

DSH began collecting county data in FY 2018-19 as the first two county programs activated. The Judicial Council, however, was not required to collect data from counties prior to Quarter 1 of FY 2019-20.

FY 2018-19 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	N/A
PC 1001.36 Petitions Received (Felony)	N/A
PC 1001.36 Petitions Granted	N/A
PC 1001.36 Petitions Granted (Felony)	N/A
PC 1001.36 Petitions Denied	N/A
PC 1001.36 Petitions Denied (Felony)	N/A
PC 1001.36 Petitions Denied due to Statute	N/A

PC 1001.36 Petitions Denied due to Statute (Felony)	N/A
PC 1001.36 Successful Completions	N/A
PC 1001.36 Successful Completions (Felony)	N/A
PC 1001.36 Unsuccessful Terminations	N/A
PC 1001.36 Unsuccessful Terminations (Felony)	N/A
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	34
WIC 4361 Diversion Started	29
WIC 4361 Unsuccessful Terminations	0
WIC 4361 Successful Completions	0

FY 2019-20

During this period DSH collected data on existing programs and activated three additional county programs. The Judicial Council officially began collecting data in the third quarter of the FY. However, courts were able to voluntarily submit data prior to the required compliance date.

FY 2019-20 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	1,924
PC 1001.36 Petitions Received (Felony)	563
PC 1001.36 Petitions Granted	680
PC 1001.36 Petitions Granted (Felony)	222
PC 1001.36 Petitions Denied	246
PC 1001.36 Petitions Denied (Felony)	99
PC 1001.36 Petitions Denied due to Statute	93
PC 1001.36 Petitions Denied due to Statute (Felony)	48
PC 1001.36 Successful Completions	78
PC 1001.36 Successful Completions (Felony)	30
PC 1001.36 Unsuccessful Terminations	62
PC 1001.36 Unsuccessful Terminations (Felony)	7
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	114
WIC 4361 Diversion Started	115
WIC 4361 Unsuccessful Terminations	< 11
WIC 4361 Successful Completions	0

FY 2020-21

DSH collected data throughout the FY and activated three additional county programs. All 24 contracted programs activated by Spring 2021 and all programs reported data by Quarter 4 (April-June).

FY 2020-21 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	2,168
PC 1001.36 Petitions Received (Felony)	1,268
PC 1001.36 Petitions Granted	1,319
PC 1001.36 Petitions Granted (Felony)	582
PC 1001.36 Petitions Denied	732
PC 1001.36 Petitions Denied (Felony)	453
PC 1001.36 Petitions Denied due to Statute	413
PC 1001.36 Petitions Denied due to Statute (Felony)	269
PC 1001.36 Successful Completions	635
PC 1001.36 Successful Completions (Felony)	213
PC 1001.36 Unsuccessful Terminations	156
PC 1001.36 Unsuccessful Terminations (Felony)	81
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	258
WIC 4361 Diversion Started	259
WIC 4361 Unsuccessful Terminations	38
WIC 4361 Successful Completions	44

Number of Counties Reporting by Quarter

The first table below provides a summary of the total number of counties reporting data each quarter. The following tables display a more detailed count of the total number of counties reporting on each data element by FY quarter from 2018-19 through 2020-21.

Summary of Total Counties Reporting		
Numbers of Counties Reporting	**Judicial Council**	**DSH**
Q3 2018 (January - March)	**	2
Q4 2018 (April - June)	**	2
Q1 2019 (July through September)	25	3
Q2 2019 (October through December)	24	3
Q3 2020 (January through March)	40	4
Q4 2020 (April through June)	41	5

Q1 2020 (July through September)	43	11
Q2 2020 (October through December)	43	12
Q3 2021 (January through March)	42	19
Q4 2021 (April through June)	37	24

Fiscal Year 2018-19				
January - March 2019				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Received (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Granted	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Granted (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied due to Statute	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied due to Statute (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Successful Completions	N/A	N/A	N/A	N/A
PC 1001.36 Successful Completions (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Unsuccessful Terminations	N/A	N/A	N/A	N/A
PC 1001.36 Unsuccessful Terminations (Felony)	N/A	N/A	N/A	N/A
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	2	0	0	0
WIC 4361 Diversion Started	2	0	0	0
WIC 4361 Unsuccessful Terminations	2	0	0	0
WIC 4361 Successful Completions	2	0	0	0

April - June 2019				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Received (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Granted	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Granted (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied due to Statute	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied due to Statute (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Successful Completions	N/A	N/A	N/A	N/A
PC 1001.36 Successful Completions (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Unsuccessful Terminations	N/A	N/A	N/A	N/A
PC 1001.36 Unsuccessful Terminations (Felony)	N/A	N/A	N/A	N/A
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	2	0	0	0
WIC 4361 Diversion Started	2	0	0	0
WIC 4361 Unsuccessful Terminations	2	0	0	0
WIC 4361 Successful Completions	2	0	0	0

Fiscal Year 2019-20				
July - September 2019				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	25	16	15	2
PC 1001.36 Petitions Received (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Granted	25	16	15	2
PC 1001.36 Petitions Granted (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied	23	17	16	2
PC 1001.36 Petitions Denied (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied due to Statute	19	21	16	2
PC 1001.36 Petitions Denied due to Statute (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Successful Completions	22	18	16	2
PC 1001.36 Successful Completions (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Unsuccessful Terminations	22	18	16	2
PC 1001.36 Unsuccessful Terminations (Felony)	N/A	N/A	N/A	N/A
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	3	0	0	0
WIC 4361 Diversion Started	3	0	0	0
WIC 4361 Unsuccessful Terminations	3	0	0	0
WIC 4361 Successful Completions	3	0	0	0

October - December 2019				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	25	16	16	1
PC 1001.36 Petitions Received (Felony)	25	16	16	1
PC 1001.36 Petitions Granted	24	16	17	1
PC 1001.36 Petitions Granted (Felony)	24	16	17	1
PC 1001.36 Petitions Denied	23	17	17	1
PC 1001.36 Petitions Denied (Felony)	23	17	17	1
PC 1001.36 Petitions Denied due to Statute	21	19	17	1
PC 1001.36 Petitions Denied due to Statute (Felony)	20	20	17	1
PC 1001.36 Successful Completions	24	16	17	1
PC 1001.36 Successful Completions (Felony)	24	16	17	1
PC 1001.36 Unsuccessful Terminations	22	18	17	1
PC 1001.36 Unsuccessful Terminations (Felony)	22	18	17	1
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	3	0	0	0
WIC 4361 Diversion Started	3	0	0	0
WIC 4361 Unsuccessful Terminations	3	0	0	0
WIC 4361 Successful Completions	3	0	0	0

January - March 2020				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	40	11	7	0
PC 1001.36 Petitions Received (Felony)	39	12	7	0
PC 1001.36 Petitions Granted	40	10	8	0
PC 1001.36 Petitions Granted (Felony)	39	11	8	0
PC 1001.36 Petitions Denied	38	13	7	0
PC 1001.36 Petitions Denied (Felony)	37	13	8	0
PC 1001.36 Petitions Denied due to Statute	31	17	10	0
PC 1001.36 Petitions Denied due to Statute (Felony)	31	19	8	0
PC 1001.36 Successful Completions	39	11	8	0
PC 1001.36 Successful Completions (Felony)	39	11	8	0
PC 1001.36 Unsuccessful Terminations	38	12	8	0
PC 1001.36 Unsuccessful Terminations (Felony)	37	13	8	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	4	0	0	0
WIC 4361 Diversion Started	4	0	0	0
WIC 4361 Unsuccessful Terminations	4	0	0	0
WIC 4361 Successful Completions	4	0	0	0

April - June 2020				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	41	8	7	2
PC 1001.36 Petitions Received (Felony)	40	9	7	2
PC 1001.36 Petitions Granted	41	8	7	2
PC 1001.36 Petitions Granted (Felony)	40	8	8	2
PC 1001.36 Petitions Denied	39	10	7	2
PC 1001.36 Petitions Denied (Felony)	38	11	7	2
PC 1001.36 Petitions Denied due to Statute	33	16	7	2
PC 1001.36 Petitions Denied due to Statute (Felony)	32	17	7	2
PC 1001.36 Successful Completions	40	8	8	2
PC 1001.36 Successful Completions (Felony)	40	8	8	2
PC 1001.36 Unsuccessful Terminations	40	9	7	2
PC 1001.36 Unsuccessful Terminations (Felony)	40	9	7	2
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	5	0	0	0
WIC 4361 Diversion Started	5	0	0	0
WIC 4361 Unsuccessful Terminations	5	0	0	0
WIC 4361 Successful Completions	5	0	0	0

Fiscal Year 2020-21				
July - September 2020				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	41	10	4	3
PC 1001.36 Petitions Received (Felony)	40	11	4	3
PC 1001.36 Petitions Granted	43	8	4	3
PC 1001.36 Petitions Granted (Felony)	42	9	4	3
PC 1001.36 Petitions Denied	39	11	5	3
PC 1001.36 Petitions Denied (Felony)	40	11	4	3
PC 1001.36 Petitions Denied due to Statute	36	15	4	3
PC 1001.36 Petitions Denied due to Statute (Felony)	36	15	4	3
PC 1001.36 Successful Completions	41	10	4	3
PC 1001.36 Successful Completions (Felony)	39	11	5	3
PC 1001.36 Unsuccessful Terminations	41	9	5	3
PC 1001.36 Unsuccessful Terminations (Felony)	41	10	4	3
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	11	0	0	1
WIC 4361 Diversion Started	11	0	0	1
WIC 4361 Unsuccessful Terminations	11	0	0	1
WIC 4361 Successful Completions	11	0	0	1

October - December 2020				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	41	13	3	1
PC 1001.36 Petitions Received (Felony)	40	14	3	1
PC 1001.36 Petitions Granted	43	11	3	1
PC 1001.36 Petitions Granted (Felony)	42	12	3	1
PC 1001.36 Petitions Denied	41	13	3	1
PC 1001.36 Petitions Denied (Felony)	40	14	3	1
PC 1001.36 Petitions Denied due to Statute	35	19	3	1
PC 1001.36 Petitions Denied due to Statute (Felony)	34	20	3	1
PC 1001.36 Successful Completions	41	13	3	1
PC 1001.36 Successful Completions (Felony)	40	14	3	1
PC 1001.36 Unsuccessful Terminations	41	13	3	1
PC 1001.36 Unsuccessful Terminations (Felony)	40	14	3	1
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	12	0	0	1
WIC 4361 Diversion Started	12	0	0	1
WIC 4361 Unsuccessful Terminations	12	0	0	1
WIC 4361 Successful Completions	12	0	0	1

January - March 2021				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	41	7	5	5
PC 1001.36 Petitions Received (Felony)	40	8	5	5
PC 1001.36 Petitions Granted	42	6	5	5
PC 1001.36 Petitions Granted (Felony)	41	7	5	5
PC 1001.36 Petitions Denied	41	7	5	5
PC 1001.36 Petitions Denied (Felony)	40	8	5	5
PC 1001.36 Petitions Denied due to Statute	35	13	5	5
PC 1001.36 Petitions Denied due to Statute (Felony)	34	14	5	5
PC 1001.36 Successful Completions	41	7	5	5
PC 1001.36 Successful Completions (Felony)	40	8	5	5
PC 1001.36 Unsuccessful Terminations	41	7	5	5
PC 1001.36 Unsuccessful Terminations (Felony)	40	8	5	5
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	19	0	0	0
WIC 4361 Diversion Started	19	0	0	0
WIC 4361 Unsuccessful Terminations	19	0	0	0
WIC 4361 Successful Completions	19	0	0	0

April - June 2021				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	36	8	3	11
PC 1001.36 Petitions Received (Felony)	35	9	3	11
PC 1001.36 Petitions Granted	37	7	3	11
PC 1001.36 Petitions Granted (Felony)	36	8	3	11
PC 1001.36 Petitions Denied	34	9	4	11
PC 1001.36 Petitions Denied (Felony)	35	9	3	11
PC 1001.36 Petitions Denied due to Statute	30	14	3	11
PC 1001.36 Petitions Denied due to Statute (Felony)	29	15	3	11
PC 1001.36 Successful Completions	36	8	3	11
PC 1001.36 Successful Completions (Felony)	35	9	3	11
PC 1001.36 Unsuccessful Terminations	36	8	3	11
PC 1001.36 Unsuccessful Terminations (Felony)	35	9	3	11
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	0	0
WIC 4361 Diversion Started	24	0	0	0
WIC 4361 Unsuccessful Terminations	24	0	0	0
WIC 4361 Successful Completions	24	0	0	0

CONTRACTED PATIENT SERVICES
COMMUNITY-BASED RESTORATION (CBR) PROGRAM
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**$0**	**$2,975**	**$3,200**
One-time	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$2,975*	*$3,200*

BACKGROUND

The 2018 Budget Act included funding to support the Department of State Hospitals' (DSH) Community Based Restoration (CBR) program in partnership with Los Angeles (LA) county. This partnership treats LA county felony Incompetent to Stand Trial (IST) patients in community mental health treatment settings who would otherwise be treated in a state hospital or Jail Based Competency Treatment (JBCT) program.

In the 2021 Budget Act, DSH was authorized to expand the LA community-based treatment program and establish new programs in additional counties to support the development of a comprehensive continuum of care for felony ISTs. DSH was approved to establish up to 300 new beds in LA county and provide time-limited transitional resources to support the off-ramp of IST defendants to the community who may restore to competency while waiting in jail. DSH estimated activating all 300 beds by September 2021. Additionally, DSH was approved to add up to 252 beds in 17 additional counties activated over a three-year period. As a result of the expansion, the CBR program projected to have a new bed capacity of 771.

DESCRIPTION OF CHANGE

DSH requests $3 million in fiscal year (FY) 2022-23 and $3.2 million ongoing to correct a calculation error and fund the increased daily bed rates in the LA county CBR program. DSH will provide an update in the 2022-23 May Revision on expansion and activation updates along with any changes as a result of the IST Solutions Workgroup recommendations put forward.

Los Angeles (LA) County CBR Expansion Update

In Spring 2021, DSH and LA county executed an amended contract for an additional 200 beds in the LA program which were activated in Summer 2021, bringing the total number of beds in the LA CBR program to 415. Additionally, in early November 2021, DSH amended the contract with LA in Fall 2021 to increase the LA CBR program by another 100 beds for a total of 515 beds. ODR began activation of the remaining

beds in early November 2021. DSH will provide an update on the status of this expansion and activation of beds in the 2022-23 May Revision.

New County CBR Expansion Update

In Summer 2021, DSH began direct outreach to multiple counties and private treatment providers to discuss details of the new CBR opportunity with the State and began conversations about potential partnerships. DSH will continue with these outreach efforts through Fall 2021 and Winter 2021 and will provide an update on progress in the 2022-23 May Revision.

Program Administration Update

In Summer 2021, DSH reached out to multiple vendors and Subject Matter Experts to contract with DSH and provide technical assistance and training to counties and providers who elect to participate in the CBR program. Discussions are ongoing and DSH anticipates having consultant contracts executed by mid-Winter 2021.

DSH will provide updates on the status of consultant contracts, planned training and technical assistance, and recruitment in the 2022-23 May Revision.

Funding Correction

DSH requests a technical adjustment for a calculation error in the ongoing costs for the LA county CBR program expansion starting in FY 2022-23. This error undercounted the total number of beds funded in FY 2022-23 and ongoing by one acute bed ($600/day) and 33 unlocked residential beds ($175/day). Therefore, DSH is requesting an adjustment in the amount of $2.3 million in budget year (BY) and ongoing to correct this issue.

The following table displays the comparison between the total budget authorized in the 2021 Budget Act and the correct total budget for the 300 bed LA CBR program expansion.

Bed Type	BY and BY+1 Funding Costs Authorized in 2021 Budget Act	BY and BY+1 Corrected Funding Costs	Difference
Acute	$1,533,000	$1,752,000	$219,000
IMD	$7,321,900	$7,321,900	$0
Unlocked	$12,775,000	$14,882,875	$2,107,875
LA Expansion Total	**$21,629,900**	**$23,956,775**	**$2,326,875**

Bed Rate Adjustment

DSH requests an adjustment of $675,000 in BY and $900,000 in BY+1 and ongoing for the original 150 beds of the LA CBR program. The daily rates for Acute Psychiatric, Institute for Mental Disease (IMD), and Unlocked Residential beds in LA have increased since the initial appropriation in FY 2018-19 and the contract for the 150 beds at the old rate will expire in October 2022. The new contract for the 150 beds will reflect the updated bed rates and DSH will need additional funding to support the ongoing operations of this program. The following table outlines the updated daily bed rates by bed type.

Bed Type	Total Beds	FY 2018-19 Authorized Daily Rate	FY 2022-23 Governor's Budget Daily Rate
Acute Psychiatric	5	$500	$600
IMD	45	$325	$340
Residential	100	$165	$175
Total	**150**	**N/A**	**N/A**

The table below outlines the funding adjustment in BY and ongoing as a result of the updated daily bed rates.

Bed Type	FY 2018-19 Authorized Funding	BY Funding Request*	BY+1 Ongoing Funding Request
Acute Psychiatric	$900,000	$1,050,000	$1,100,000
IMD	$5,300,000	$5,525,000	$5,600,000
Residential	$6,000,000	$6,300,000	$6,400,000
Total Funding	**$12,200,000**	**$12,875,000**	**$13,100,000**
2022-23 Governor's Budget Adjustment	**N/A**	**$675,000**	**$900,000**

*New Daily Bed Rate Effective October 2022

BCP Fiscal Detail Sheet

BCP Title: Community Based Restoration Program **BR Name: 4440-034-ECP-2022-GB**

Budget Request Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
			FY22			
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	0	2,975	3,200	3,200	3,200	3,200
Total Operating Expenses and Equipment	**$0**	**$2,975**	**$3,200**	**$3,200**	**$3,200**	**$3,200**
Total Budget Request	**$0**	**$2,975**	**$3,200**	**$3,200**	**$3,200**	**$3,200**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	0	2,975	3,200	3,200	3,200	3,200
Total State Operations Expenditures	**$0**	**$2,975**	**$3,200**	**$3,200**	**$3,200**	**$3,200**
Total All Funds	**$0**	**$2,975**	**$3,200**	**$3,200**	**$3,200**	**$3,200**

Program Summary

Program Funding						
4430060 - Community-Based Restoration Programs	0	2,975	3,200	3,200	3,200	3,200
Total All Programs	**$0**	**$2,975**	**$3,200**	**$3,200**	**$3,200**	**$3,200**

CONTRACTED PATIENT SERVICES
INSTITUTE FOR MENTAL DISEASE (IMD) AND SUB-ACUTE BED CAPACITY FUNDING PROGRAM
Informational Only

BACKGROUND

The Department of State Hospitals' (DSH) Institute for Mental Disease (IMD) and Sub-Acute Bed Capacity funding program allows DSH to address significant Incompetent to Stand Trial (IST) waitlist challenges by contracting with counties or private providers to develop new or renovate existing facilities to provide alternative treatment options to state hospitals. As a result, this will increase the availability of IMDs, Mental Health Rehabilitation Centers (MHRC), Skilled Nursing Facilities (SNF) or other types of facilities appropriate for felony IST patients. DSH assists potential contracted providers with the construction and implementation costs associated with expanding or renovating existing facilities. These facilities will serve felony ISTs that can be safely treated in community settings that provide lower levels of care. If necessary, these facilities can also serve other DSH commitments to free up bedspace in the state hospitals for the felony IST population. This program will support building a community-based forensic behavioral health continuum to serve individuals committed to DSH.

Locating potential providers able to provide safe secure treatment to DSH's various patient commitment types has required DSH to be nimble in its approach. DSH's goal is to maximize the number of facilities that address the IST waitlist directly by either providing competency restoration services or diversion stabilization services. Additionally, DSH may consider a facility that can be used to step down Not Guilty by Reason of Insanity (NGI) and Offender with a Mental Health Disease (OMD) patients from a state hospital into a Conditional Release Program (CONREP). Similarly, a facility may be able to be used to step down Lanterman-Petris-Short (LPS) patients from secured state hospital beds and focus efforts on transitioning them back into the community upon discharge. This would allow DSH to backfill vacant hospital beds with IST patients from the waitlist. DSH currently assumes daily bed rates can range from $400 to more than $1,000 for the increased sub-acute beds. Given previous discussions with counties, DSH notes that a premium rate may be required to incentivize providers to serve the felony IST and other justice-involved populations.

In the 2021 Budget Act, DSH received $267.1 million and 22.0 permanent positions in fiscal year (FY) 2021-22, $88.5 million in FY 2022-23 and $146.0 million in FY 2023-24 and ongoing for the IMD and Sub-Acute-Bed Capacity funding program. Of the funding received, $255.9 million is one-time funding to establish the program which will serve one or more DSH commitment types. Of the positions received, 15.5 will support program development and oversight of the contracted providers, management of patient referrals and movement, hospital discharge planning and coordination,

information technology needs, and data and contract resources. The breakdown of positions is as follows:

- 1.0 Exempt Deputy Director
- 1.0 C.E.A. A
- 1.0 Staff Services Manager II
- 1.0 Executive Assistant
- 2.0 Consulting Psychologists
- 1.0 Health Program Specialist II
- 1.0 Health Program Specialist I
- 1.5 Associate Governmental Program Analysts
- 1.0 Attorney III
- 1.0 Research Data Analyst II
- 3.0 Informational Technology Specialist Is, and
- 1.0 Informational Technology Specialist II

The remaining 8.0 positions will be used to address the workload associated with the implications of the Stiavetti court-decision. In addition, the 2021 Budget Act included Trailer Bill Language (TBL) to add Welfare and Institutions Code Sections 4361.5 and 4361.6 to authorize DSH to contract with private or public entities to house and treat individuals committed to DSH.

DESCRIPTION OF CHANGE

DSH began engagement meetings with multiple private providers in Summer 2021 and continues to work with those providers to develop potential IMD and Sub-Acute Bed Capacity programs across the State. Through these discussions, DSH has identified the need to support acute level of care beds as a complement to IMD and sub-acute levels to promote stabilization for a portion of the FIST population who may require involuntary medications. Partnering with providers who can provide a blend of acute and sub-acute beds will allow more individuals to transition from jail to community settings and promote a broader continuum of care for this population. In addition, DSH is currently discussing this funding opportunity with targeted counties; specifically, those lacking the capacity to stabilize more FIST defendants to broaden the number of individuals who could be considered for and served in the diversion program. Further, DSH is engaging counties who have been limited by the lack of available sub-acute beds in their community, impacting that county's ability to participate in the DSH Diversion and Community-Based Restoration (CBR) programs. Lastly, DSH is strategizing the use of these funds to support recommendations resulting from the IST Solutions Workgroup, as authorized in WIC 4147, and concluded on November 19, 2021. Please refer to section C17 for information on the IST Solutions Workgroup. DSH will provide an update on the status of program implementation and planned number of beds in the 2022-23 May Revision.

CONTRACTED PATIENT SERVICES
STATEWIDE INCOMPETENT TO STAND TRIAL OFF-RAMP (SISTOR) PROGRAM
Program Update

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

BACKGROUND:

The Department of State Hospitals (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. The IST "Off-Ramp" team in Los Angeles (LA) county assesses felony ISTs committed by LA county in the jail for restoration of competency prior to placement in a DSH program. Under this program, if a felony IST is assessed and found to be competent, the team submits a restoration of competency report to the court to allow the defendant to proceed with their case rather than be transferred to a DSH program. This effort has proven successful and, as of November 15, 2021, 390 IST defendants have been off-ramped with 383 deemed to be restored to competency.

To replicate LA county's model in other areas of the state, DSH was authorized $2.0 million ongoing to implement IST "Off-Ramp" services in four additional counties. This would allow DSH to reduce the number of IST defendants from being unnecessarily transferred to a DSH treatment program if the individual's competency has been restored. The original vision for this program, prior to the COVID-19 pandemic, assumed centralizing evaluator staff at key regions across the state and then deploying the evaluators to neighboring counties to assess ISTs within the jails in their region. This service model was rebranded as the Statewide Incompetent to Stand Trial Off-Ramp (SISTOR) program. Ultimately, the original vision for the program was not executed because DSH could not secure a contract provider who could cover the entire state through a regional approach within the funding level authorized in the budget.

In the 2021 Budget Act, DSH reported the completion of the bidding process and the selection of a provider. As part of the negotiated contract, DSH secured a provider that can ramp up quickly and scale resources to offset much of the implementation delay by providing the sufficient staffing needed to complete a significant portion of the evaluation workload initially assumed. Additionally, as reported in the 2021 Budget Act, the annual costs of the SISTOR contract totaled approximately $1.0 million and the remaining $1.0 million of the $2.0 million approved in the 2020 Budget

Act will be used to support the Re-Evaluation Services for Felony IST program in fiscal year (FY) 2021-22 and ongoing.

DESCRIPTION OF CHANGE:

Subsequent to securing a contractor for the SISTOR program, DSH established the Re-Evaluation Services for Felony IST program as authorized under Assembly Bill (AB) 133 and Welfare and Institutions Code (WIC) Section 4335.2. This program establishes a process and resources for DSH to perform re-evaluations, primarily through telehealth evaluations, for IST defendants who are in jail for 60 days or more pending placement to a DSH facility. The re-evaluations performed under this program includes:

a) Assessing if the individual has been restored while in jail, is malingering or is non-restorable.
b) Filing a report to the court on the status of the patient (effectively the 90-day report); and if restored, file the PC 1372 report.
c) Assess whether the individual may be a good candidate for diversion or other outpatient treatment programs and inform the District Attorney, Public Defender, and the Diversion or Community-Based Restoration program if one is available in the county.

As DSH began to implement its Re-Evaluation Services for Felony ISTs program and through previous experience gained using existing civil service staff, DSH identified a need to develop and incorporate a standardized assessment process and evaluation report. However, under the SISTOR contract, the provider would use an independent assessment process to identify and prioritize which IST defendants to evaluate that does not correspond with the above criteria. Due to public contract rules, DSH was unable to amend the SISTOR contract to align with the requirements of the Re-Evaluation Services program. Rather than risk creating discrepancies in the re-evaluation referrals and reporting standards, DSH canceled the contract and is electing to dissolve the SISTOR program. As a result of this change, the remaining $1.0 million budgeted for the SISTOR program is reflected as an ongoing savings beginning in current year (CY).

BCP Fiscal Detail Sheet

BCP Title: Statewide Incompetent to Stand Trial Off-Ramp (SISTOR) Program **BR Name: 4440-033-ECP-2022-GB**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	-1,000	-1,000	-1,000	-1,000	-1,000	-1,000
Total Operating Expenses and Equipment	**$-1,000**	**$-1,000**	**$-1,000**	**$-1,000**	**$-1,000**	**$-1,000**
Total Budget Request	**$-1,000**	**$-1,000**	**$-1,000**	**$-1,000**	**$-1,000**	**$-1,000**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-1,000	-1,000	-1,000	-1,000	-1,000	-1,000
Total State Operations Expenditures	**$-1,000**	**$-1,000**	**$-1,000**	**$-1,000**	**$-1,000**	**$-1,000**
Total All Funds	**$-1,000**	**$-1,000**	**$-1,000**	**$-1,000**	**$-1,000**	**$-1,000**

Program Summary

Program Funding						
4430030 - Other Contracted Services	-1,000	-1,000	-1,000	-1,000	-1,000	-1,000
Total All Programs	**$-1,000**	**$-1,000**	**$-1,000**	**$-1,000**	**$-1,000**	**$-1,000**

CONTRACTED PATIENT SERVICES
INCOMPETENT TO STAND TRIAL (IST) SOLUTIONS WORKGROUP
Informational Only

BACKGROUND

Over the last decade, the State of California has seen significant growth in the number of individuals found Incompetent to Stand Trial (IST) on felony charges. The year-over-year growth in this commitment type to the Department of State Hospitals (DSH) has outpaced the Department's ability to create additional capacity in its system, leading to a large waitlist and long wait times for defendants pending placement to DSH. Furthermore, the impacts of the COVID-19 pandemic and necessary infection control measure put in place, resulted in slower admissions and reduced capacity for the treatment of felony ISTs at DSH's treatment facilities further exacerbating waitlists and wait times.

Assembly Bill 133 (2021) and the 2021 Budget Act established a statewide workgroup led by the California Health and Human Services Agency (CalHHS) and DSH to identify short, medium, and long-term solutions for the IST crisis. Additionally, the 2021 Budget Act included $75.0 million to support the immediate implementation of short-term solutions. The IST Solutions Workgroup was required to submit actionable solutions to CalHHS and the Department of Finance (DOF) by November 30, 2021 in accordance with the timeline outlined below:

- Short-term solutions achievable by April 1, 2022
- Medium-term solutions achievable by January 10, 2023
- Long-term solutions achievable by January 10, 2024, and January 10, 2025

DSH was charged with chairing and staffing the IST Solutions Workgroup. In August 2021, DSH entered into a contract with a vendor to assist with meeting planning, facilitation services, and documentation of the final workgroup recommendations for submission to CalHHS and DOF. In addition, DSH contracted with national experts in the field of forensic mental health with specialized experience and qualifications in forensic evaluation, competence to stand trial services, forensic mental health systems, workforce development, and training. This contracted team served as Subject Matter Experts for the IST Solutions Workgroup and to DSH in its implementation of IST programs and solutions.

The IST Workgroup convened between August 2021 and November 2021 and held five meetings and nine topic-focused sub-working group meetings, further described below, with a number of representatives and stakeholders from several state agencies, the Judicial Council, local government and criminal justice system representatives, and representatives of IST patients and their family members.

IST Solutions Workgroups[1]

In addition to the primary workgroup, three sub-workgroups were established to generate short, medium, and long-term solutions focused on specific areas of opportunity. The solutions proposed by these sub-workgroups would be considered by the IST Solutions Workgroup for inclusion in the final report to CalHHS and DOF.

Working Group 1: Early Access to Treatment and Stabilization for Felony ISTs

The goal of Working Group 1 was to identify short-term solutions to provide early access to treatment and stabilization in jail or via Jail Based Competency Treatment (JBCT) programs. The goal was to maximize re-evaluation, diversion or other community-based treatment opportunities and reduce IST length-of-stay in jails.

Working Group 2: Diversion and Community-Based Restoration for Felony ISTs

The goal of Working Group 2 was to identify short-term, medium-term, and long-term strategies to implement Felony Mental Health Diversion and Community-Based Restoration (CBR) programs across the state.

Working Group 3: Initial County Competency Evaluations

The goal of Working Group 3 was to identify solutions to reduce the overall number of individuals found IST by strengthening the quality of the initial competency evaluations ordered by the courts (also known as Alienist Evaluations).

IST Solutions Workgroup Report and Budget Request

The efforts of the IST Solutions Workgroup resulted in a compendium of recommended strategies and solutions summarized in the statutorily required IST Solutions Workgroup report released on November 30, 2021. A full copy of the *Incompetent to Stand Trial Solutions Workgroup - Report of Recommended Solutions* can be accessed on the CalHHS website.

The 2021 Budget Act included $75 million in 2021-22 and $175 million in 2022-23 to support the immediate implementation of actionable solutions proposed by the IST Solutions Workgroup. Informed by the deliberations of the IST Solutions Workgroup, the Governor's Budget includes statutory language authorizing the Department of Finance to augment DSH's budget by an additional $350 million General Fund, building on the $175 million already available in 2022-23 authorized by the 2021 Budget Act for the purposes of implementing solutions identified by the IST Workgroup. The 2022-23 Governor's Budget Proposed Budget Summary provides a high-level description of the proposed solutions. Additional details on the proposed

[1] For a complete list of workgroup members and materials please visit the CalHHS IST Solutions Workgroup website.

strategies identified in the Governor's Budget Summary are forthcoming and will be posted at the California Department of State Hospitals – DSH Budget Information website when available.

EVALUATION AND FORENSIC SERVICES

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

Caseload Update

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 an Offender with a Mental Health Disorder (OMD) or as a Sexually Violent Predator (SVP) as a condition of parole. DSH administers these services through the OMD Program and the Sex Offender Commitment Program (SOCP). Currently DSH employs 3.0 Chief Psychologists, 25.0 Consulting Psychologists (CP), and 19.0 SVP Evaluators (SVP-E) in addition to contracted psychologists to perform the following services:

- Psychological evaluations
- Developing forensic evaluation reports
- Providing expert witness court testimony and consultation related to these evaluation services
- Maintaining up-to-date training associated with these programs

These services are typically provided at a variety of locations throughout California, including state prisons, state hospitals, jails, and courts. During the COVID-19 pandemic, more opportunities to perform remote evaluation services have become readily available. For those individuals determined to meet the criteria as an SVP, the forensic evaluations are time-sensitive. To comply with the statutory requirement, the evaluations must be completed and referred to the District Attorney's Office no less than 20 days prior to the inmate's release from prison.

The forensic evaluator staffing described above reflects the required level 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 DSH. 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
- Maintaining licensure requirements

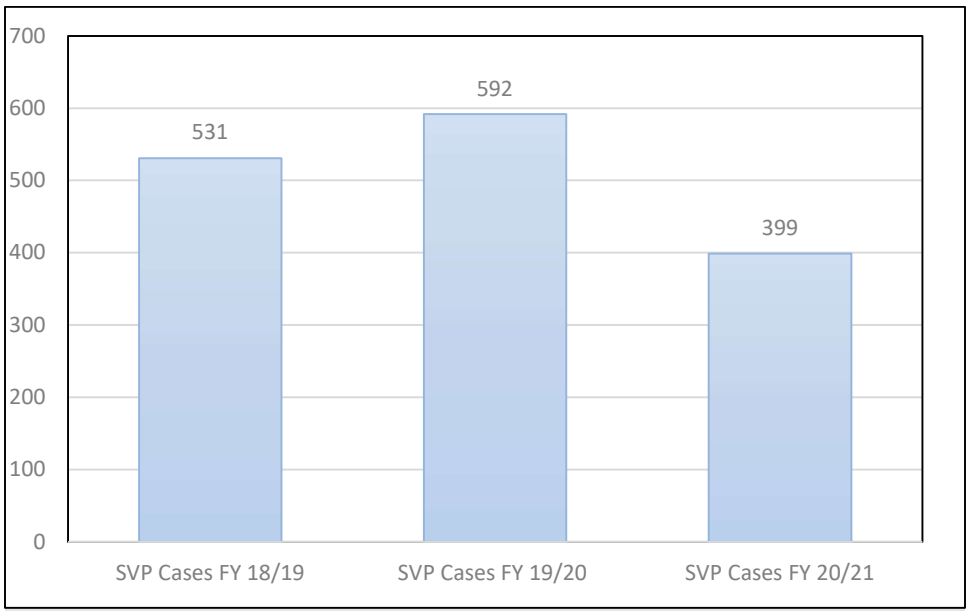
Failure to perform these forensic services accurately and timely could result in the inappropriate release of an OMD or SVP into the community, compromising public safety.

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.

Per WIC 6601(b), CDCR and BPH are responsible for performing a two-part screening process of CDCR inmates. This consists of identifying whether the individual committed qualifying offenses for commitment as an SVP. If so, BPH must conduct 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.

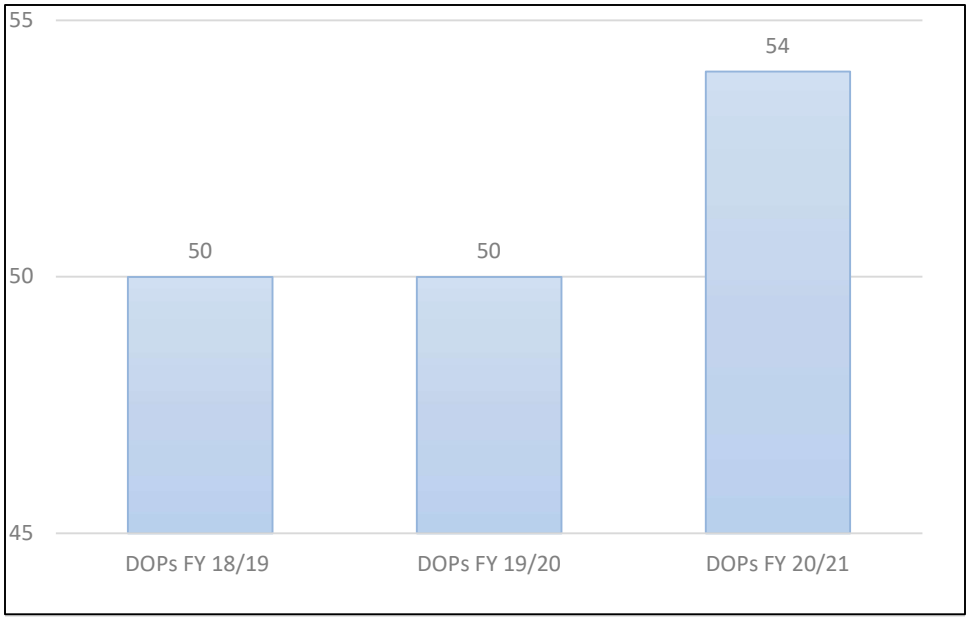
For the period between July 2020 and June 2021, approximately 399 cases were referred to DSH for full evaluations. The chart below illustrates the trends seen in the past three years:



For each referral, 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 civil service evaluators initially assigned by DSH to perform full evaluations, DSH is statutorily

required to assign two additional independent evaluators who are not state government employees to assess the individuals.

For the period between July 2020 and June 2021 approximately 54 DOPs were completed by DSH. As shown below, the number of DOPs stayed largely consistent in the past three years.

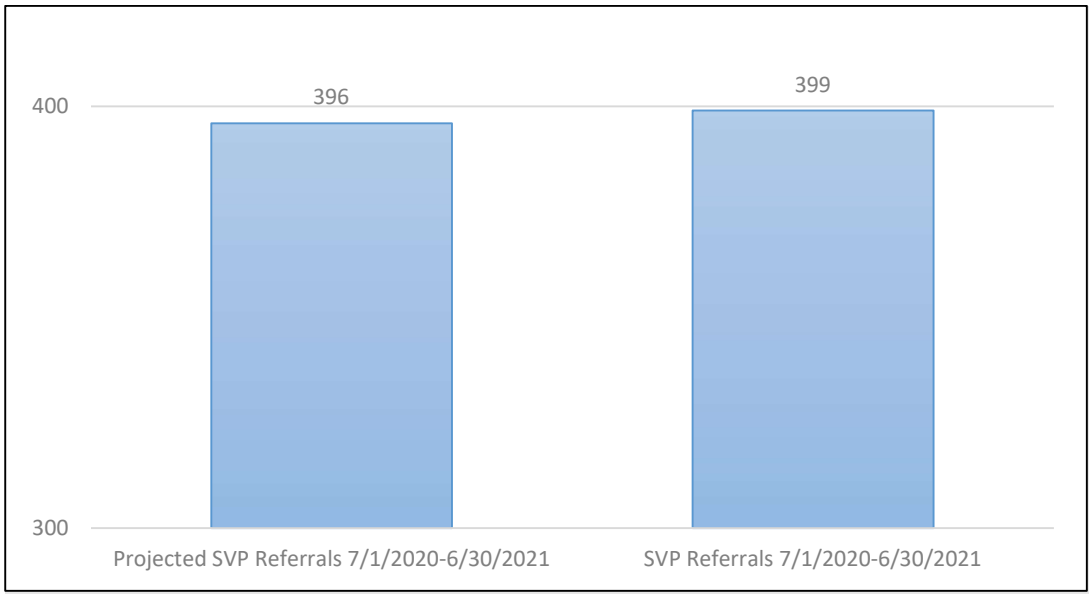


Prior to the COVID-19 pandemic, forensic evaluators typically were required to travel to the inmate's location to administer an in-person interview, perform case record reviews including criminal and medical history either in person or remotely through an electronic document sharing platform, develop a written evaluation report, update forensics evaluations, and provide expert witness testimony once the case goes to trial. Beginning March 2020, as a result of the COVID-19 pandemic, travel significantly declined with the increased use of telepsychology for conducting inmate interviews. This practice has continued in the jails and prisons where the technology, space, and the necessary support staff requirements are met.

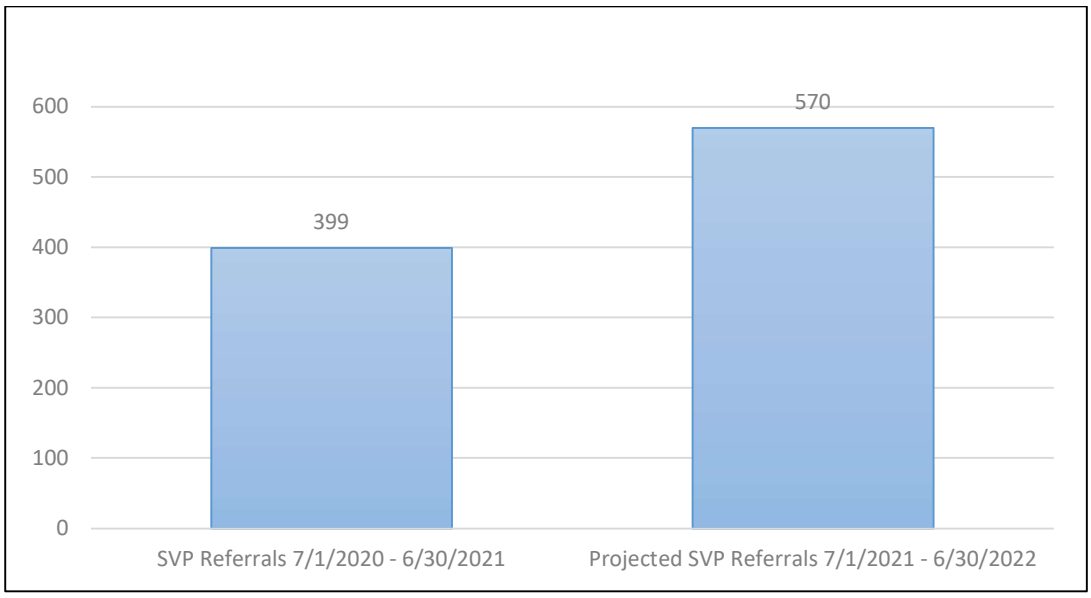
Per WIC 6600 statute, initial evaluations should be performed by civil servants. In certain instances when a civil service evaluator is not available, such as impending release dates, a contracted evaluator will evaluate the inmate. When a contractor is used, DSH incurs additional costs to pay the contracted rates. In the past three years, the use of contractors for initial SVP evaluations declined and rush referrals continue to make up only a small portion of the total referrals.

To calculate SVP referral projections for FY 2021-22, the average number of referrals in the previous six months was annualized. As of the 2021-22 May Revision, it was projected that DSH would receive 396 SVP referrals in FY 2020-21. The actual number of SVP referrals received in FY 2020-21 was 399. The chart below displays the

comparison between the projected SVP referrals and the SVP referrals received for FY 2020-21.



As of October 2021, DSH received 190 referrals for the first four months of FY 2021-22. By applying this trend to the next 8 months to project an annualized total, DSH estimates 570 SVP referrals will be received in FY 2021-22. The upward trend is most likely due to CDCR implementing credit recalculations at the end of FY 2020-21 and the beginning of FY 2021-22 which resulted in earlier release dates. The chart below displays the comparison between the SVP referrals received in FY 2020-21 and the projected SVP referrals for FY 2021-22.



DSH will continue to coordinate with CDCR/BPH to monitor the workload impact to SVP referrals.

Offender with a Mental Health Disorder (OMD) Program

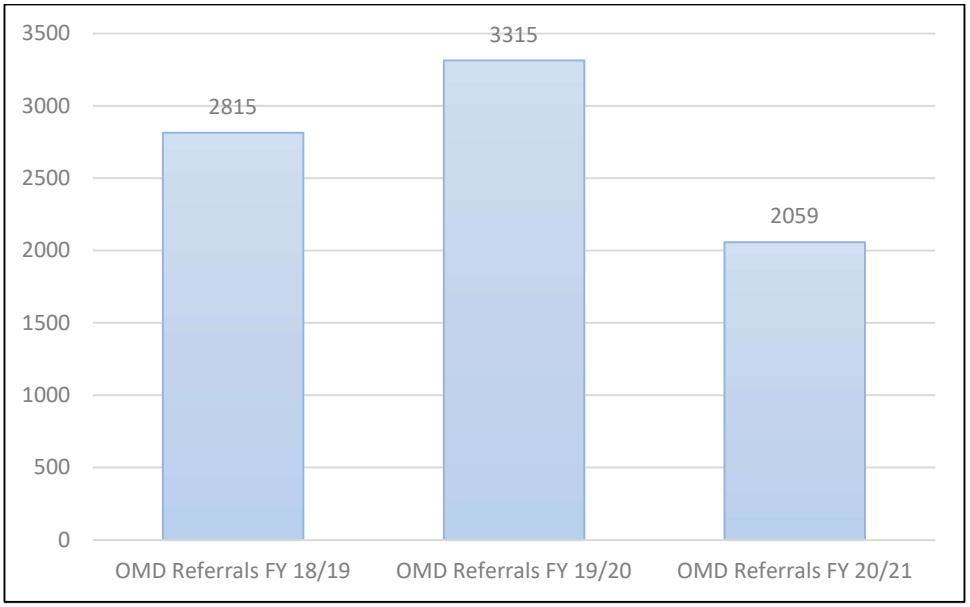
The OMD commitment was created to provide a mechanism to detain and treat prisoners who have reached the end of their determinate prison terms and are dangerous to others as a result of a severe mental disorder. The law became effective July 1, 1986 and is codified in Penal Code (PC) 2960 – 2981.

The OMD commitment is a two-phase process:

OMD Commitment - First Phase

The first phase requires certification by a CDCR 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 the inmate to DSH. DSH then receives the OMD referral and sends a clinician to the CDCR facility. There, the clinician conducts the second forensic psychological evaluation and determines if the inmate meets the OMD statutory criteria prior to release from prison. DSH utilized telepsychology to conduct most inmate interviews.

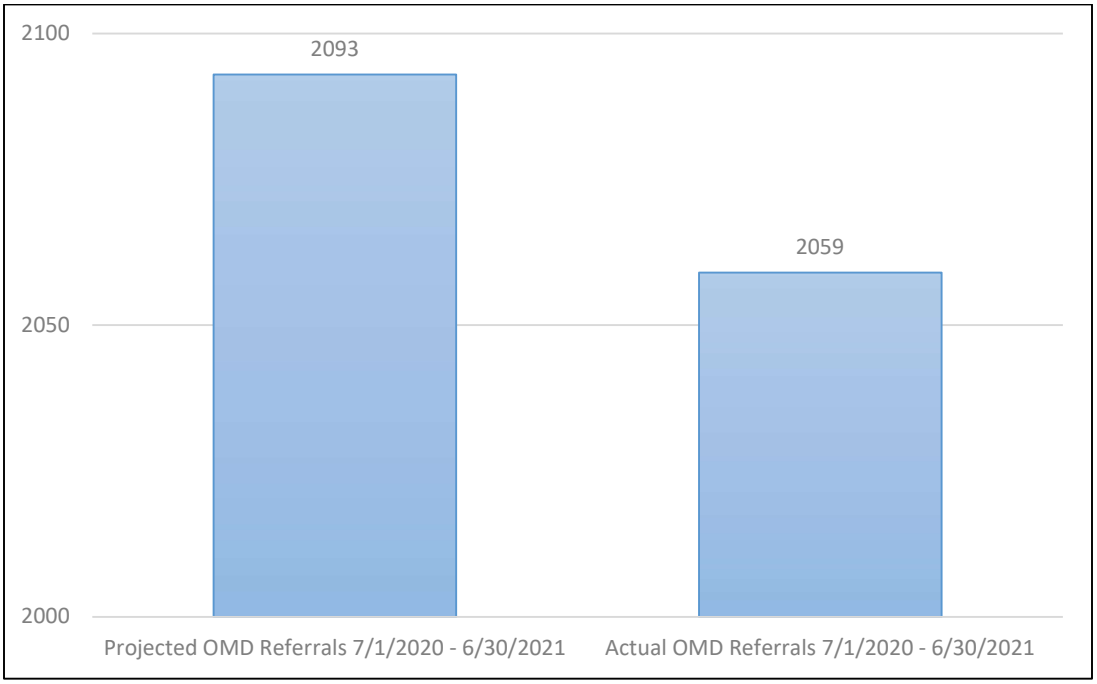
For the FY 2020-21, DSH received 2,059 referrals from CDCR to perform an OMD evaluation for potential commitment to a state hospital, each one requiring a designation of positive or negative. A positive evaluation means the individual was deemed a potential OMD commitment to a state hospital. If CDCR and DSH evaluators determine that the individual should be committed to DSH as an OMD, certification paperwork is submitted to the BPH hearing officer for review. If approved, the individual is sent to DSH to serve their parole. Of the 2,059 referrals from CDCR during FY 2020-21, 177 DSH evaluations were positive and 1,882 DSH evaluations were negative. The chart below illustrates the referrals received in FYs 2018-19 through 2020-21.



Beginning in June 2020, DSH experienced an increase in the number of OMD referrals with expedited release dates, largely due to CDCR's efforts to initiate early release dates during COVID-19. Shorter sentencing and early releases led to more referrals received, though many with a lower acuity (meaning that the inmate may not meet all OMD criteria) and a much shorter timeframe until the earliest possible release dates. This required DSH to perform parallel evaluations without waiting for the BPH assessment, differing from the typical referral process. In a typical assessment process, a BPH evaluator's positive referral would result in the referral to DSH to perform an evaluation and confirm the referral. Because not all BPH referrals resulted in a positive OMD confirmation by DSH, the number of FY 2020-21 referrals does not reflect the entire volume of workload performed by DSH evaluators.

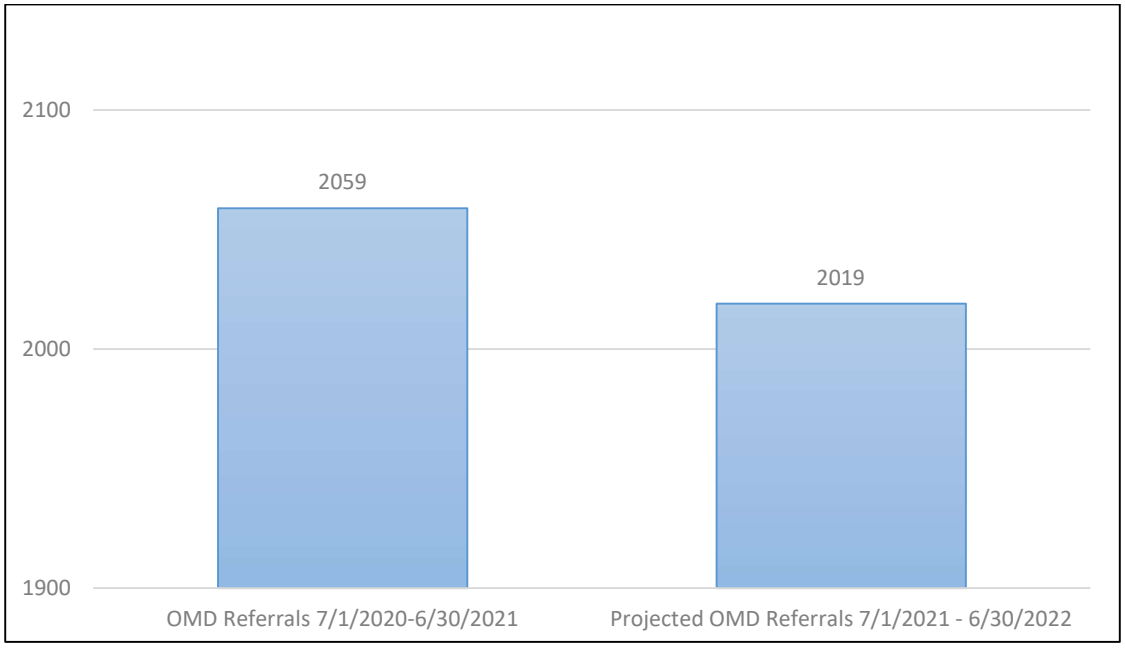
CDCR and BPH anticipate that the increase of OMD referrals with expedited release dates is temporary, and by Spring 2022 are expected to be closer to pre-pandemic levels with only minimal rushes due to unforeseen circumstances.

In the 2021-22 May Revision, DSH projected to receive 2,093 OMD referrals in FY 2020-21. The actual number of referrals received was 2,059. The chart below displays the comparison between the projected OMD referrals and the OMD referrals received for FY 2020-21.



Of the total referrals, 348 were admitted to a state hospital based on DSH evaluations and DOP evaluations conducted by BPH. In comparison, during FY 2019-20, 458 were admitted to a state hospital. 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.

As of October 2021, DSH has received 673 referrals in the first four months of FY 2021-22. By applying this trend to the next 8 months, DSH projects an annualized total of 2,019 OMD referrals will be received in FY 2021-22. The chart below displays the comparison between the OMD referrals received in FY 2020-21and the projected OMD referrals for FY 2021-22.



DSH will continue to closely monitor the trends in rush referral cases over the next fiscal year and provide an update in the 2022-23 May Revision.

OMD Commitment - Second Phase

The second phase is 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.

DSH will continue to work closely with CDCR and BPH to determine if there will be additional workload impacts to the OMD program. These may stem from referrals with impending release dates as a result of CDCR's programming calculations related to their efforts to reduce the number of inmates. DSH continues to monitor these referral trends, especially as they may result in a future budget adjustment to meet the demand and comply timely with statute.

EVALUATION AND FORENSIC SERVICES
RE-EVALUATION SERVICES FOR FELONY INCOMPETENT TO STAND TRIAL (IST)
Program Update

BACKGROUND

The Department of State Hospitals' (DSH) Re-evaluation Services for Felony Incompetent to Stand Trial (IST) program allows DSH to re-evaluate individuals deemed felony IST, who have been waiting in jail for 60 days or more pending transfer to a DSH restoration of competency program. The goal of this program is to assist in reducing the DSH IST waitlist by identifying individuals who have already restored to competency and no longer need to be transferred to a DSH treatment program or to help identify individuals who may be candidates for diversion or other outpatient treatment.
The workload and costs for this program fall into three main categories:

1) DSH contracted forensic evaluators and associated support to perform re-evaluations of IST defendants
2) DSH clinical, administrative, and operational staff to support coordination of service delivery
3) Reimbursement of jail information technology (IT) costs (including laptops and licenses).
    a. This helps facilitate the tele-evaluations and enacts a flat reimbursement rate per each IST defendant evaluated. The payment to the County Sheriffs covers the jail staff time to provide support and escort the patient for the evaluation.

Contracted IST forensic evaluators will:

a) Assess if the individual has been restored while in jail, is malingering or is non-restorable.
b) File a report to the court on the status of the patient (effectively the 90-day report) and if restored, file the Penal Code (PC) 1372 report.
c) Assess whether the individual may be a good candidate for diversion or other outpatient treatment program, and inform the District Attorney, Public Defender, and the IST Diversion or community-based restoration program if one is available in the county.

Assembly Bill (AB) 133, enacted July 1, 2021, authorized DSH to perform these re-evaluations, primarily through telehealth evaluations, for IST defendants in jail pending placement specified in Welfare and Institutions Code (WIC) Section 4335.2. Additionally, supporting PC Sections 1370, 1370.1 and 1372 were amended for consistency with the new WIC section.

The 2021 Budget Act

In the 2021 Budget Act, DSH received resources to implement the Re-Evaluation Services for Felony ISTs program. DSH established this program for a 4-year term beginning July 1, 2021 (FY 2021-22) to June 30, 2025 (FY 2024-25). After the third year of the program, DSH will assess the need to extend all or a portion of the resources on an ongoing basis and if necessary, submit a new budget request for the FY 2025-26 budget cycle. In addition, the 2021 Budget Act included a permanent redirection of $1.0 million from the Statewide Incompetent to Stand Trial Off-Ramp (SISTOR) program. An update on the implementation of this new program is reflected below.

DESCRIPTION OF CHANGE

DSH is reviewing the potential need for budget language that grants the authority to reimburse county jail partners without requiring an executed contract to help facilitate payments to the Sherriff's. No additional position authority or funding for the Re-Evaluation Services program is requested at this time. DSH will provide an update in the 2022-23 May Revision on implementation progress, language request and any changes as a result of the IST Solutions Workgroup recommendations put forward.

Program Implementation Updates

The IST Re-Evaluation contract for the evaluator panel was finalized and DSH executed contracts with new evaluators in December 2021. While the new contracts were in development, DSH temporarily redirected a limited number of existing civil service forensic evaluators to expedite the program and evaluate IST defendants currently on the waitlist. However, DSH anticipates continuing to utilize a portion of these redirected staff to support the Re-Evaluation Services program ongoing. As of mid-November 2021, 84 reports were completed by the DSH civil service evaluators. Of these, 24 (approximately 28%) have been determined to be competent.

DSH hosted an information session in October 2021, to provide the county sheriffs, jail administrative staff, and jail operations staff an overview of the program and the reimbursement funding available. As of early December 2021, DSH held individual meetings with 20 counties to establish central points of contact, address additional questions, and provide a draft reimbursement contract for review. Subsequent meetings will be scheduled as needed. Furthermore, DSH is scheduled to meet with five other counties by the end of December 2021and three counties have submitted reimbursement contracts DSH is in the process of finalizing.

Other internal coordination and process development activities are as follows:

- In coordination with Technology Services Division (TSD), Forensic Services Division (FSD) and Patient Management Unit (PMU) are developing an IST process workflow to identify the modifications needed for the Patient Reservation and Tracking System (PaRTS) to track IST referrals, caseload assignment and additional data elements needed to support program implementation and reporting metrics.
- FSD and PMU are collaborating to update and identify potential efficiencies of the case management process which include managing referrals, scheduling, court reporting, and outcomes tracking.
- FSD and Clinical Operations developed a standardized evaluation tool, training, and quality assurance process.

STATE HOSPITALS
HOSPITAL POLICE OFFICER/OFFICE OF PROTECTIVE SERVICES (OPS) POLICE ACADEMY
Informational Only

BACKGROUND

The 2019 Budget Act established a new sub-program for the Hospital Police Officer Academy (Academy), in turn, contributing to a higher level of transparency and improvement in the management of Academy resources. With this change, all budget and position authority were redirected from DSH-Atascadero to its own program – the State Hospital Police Officer Academy. Having the HPO Academy separate from other facilities allows DSH to track this budget independently and report on funding, costs, and outcomes specifically.

The 2021 Budget Act includes Provisional language stating:

"The State Department of State Hospitals shall provide a status update on the recruitment and retention of hospital police officers, to be included in the department's 2022–23 Governor's Budget estimate and subsequent May Revision estimate. The update shall include the number of authorized and vacant positions for each hospital, the actual attrition rate for the 2021–22 fiscal year, the projected attrition rate for the 2022–23 fiscal year, and the rate of success pertaining to the number of hospital police officer cadet graduates of the OPS Police Academy."

In the 2021 Budget Act, cadet attendance declined considerably due to COVID-19 and issues regarding the background investigations contract. The Office of Protective Services (OPS) has since moved away from contracted background investigators as they were unable to conduct background investigations for potential candidates in a timely and thorough manner. By transitioning away from the contracted investigators and moving towards in-house expertise, DSH has resolved its issues with the background investigations.

DESCRIPTION OF CHANGE

Hospital Police Officer Positions

As of August 1, 2021, the following is the status of Hospital Police Officers (HPO) authorized positions:

August 1, 2021 HPO Authorized Positions[1]				
Hospitals	**Filled**	**Vacant**	**FTE[2]**	**Vacancy Rate**
Atascadero	110.0	14.50	124.50	11.64%
Coalinga	202.0	8.5	210.50	4.03%
Metropolitan[3]	101.0	40.0	141.00	28.37%
Napa	101.0	8.0	109.0	7.33%
Patton	63.0	0.0	63.0	0.00%
Total	**577.0**	**71.0**	**648.0**	**10.96%**

[1] Only Includes classification 1937- Hospital Police Officer
[2] Authorized Positions as of DSH Budget Management Branch (BMB) Hospital Position Report FY 2020-21 February, Rev A
[3] Metropolitan FTEs include those positions for the Metro Increase Secure Bed Capacity project delayed due to COVID-19

Hospital Police Office Attrition Rate

As of August 1, 2021, the projected attrition rate based on actual attrition rates and trends for FYs 2017-2018, 2018-19, 2019-20, 2020-21, and 2021-22:

August 1, 2021 HPO Attrition Rate					
Hospitals	**FY 2021-22 FTE[1]**	**FY 2021-22 Attrition Rate[2]**	**Avg Estimated Monthly Pos.**	**FY 2022-23 Attrition Rate[3]**	**Avg Estimated Monthly Pos.**
Atascadero	124.5	1.14%	1.4	0.92%	1.1
Coalinga	210.5	0.87%	1.8	0.72%	1.5
Metropolitan	141.0	1.58%	2.2	1.55%	2.2
Napa	109.0	0.48%	0.5	0.54%	0.6
Patton	63.0	0.66%	0.4	0.97%	0.6
Total	**648.0**	**0.95%**	**6.3**	**0.94%**	**6.0**

[1] Authorized Positions as of DSH Budget Management Branch (BMB) Hospital Position Report FY 2021-22 August, Rev A
[2] Projected attrition rate based on FY 2017-18, 2018-19, 2019-20, 2020-21, and 2021-22 data
[3] Projected attrition rate based on FY 2018-19, 2019-20, 2020-21, and 2021-22 data

Cadet Graduation Rate

The tale below displays the actual graduation rates from FY 2018-19 through the current cadet Academy cohort.

Cadet Graduation Rates			
Academy	**Number of Cadets Attended**	**Number of Cadets Graduated**	**Graduation 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	88.88%
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	17	89.47%
Academy 33 February 10, 2020 – May 22, 2020	20	16	80.00%
Academy 34 August 24, 2020 – December 10, 2020	25	21	84.00%
Academy 35 December 28, 2020 – April 22, 2021	19	10	52.63%
Academy 36 May 3, 2021 – August 12, 2021	16	9	56.25%
Academy 37 August 23, 2021 – December 9, 2021	10	TBD	TBD
TOTAL:	**312**	**256**	**82.05%**

Academy 36

COVID-19 continued to impact the recruitment and hiring of cadets for the academy. Housing issues due to COVID-19 required OPS to identify additional housing options for the cadets within DSH-Atascadero's barracks and apartments. COVID-19 also impacted hiring as the rest of the country continued to experience worker shortages, potential employees not wanting to comply with testing policies and requirements, and applicants not meeting the hiring

requirements. The Academy 36 graduation was conducted virtually to reduce the number of individuals gathering and reduce any potential COVID-19 exposures.

Academy 37

COVID-19 continues to impact the hiring and recruitment for the academy for the same reasons listed above with the addition of vaccination policies and requirements. OPS is researching contracting with a vendor to assist with recruitment efforts to potentially increase the number of applications for HPOs.

STATE HOSPITALS
Stephanie Stiavetti, et al. v. Stephanie Clendenin, et al.
Informational Only

BACKGROUND

On August 25, 2021, the California Supreme Court denied the Department of State Hospitals (DSH) and the Department of Developmental Services (DDS) petition for review of the published opinion in the Stephanie Stiavetti, et al. v. Stephanie Clendenin, et al. (2021) 65 Cal.App.5th 691 (First District Court of Appeal, Division Two). DSH and DDS had petitioned the Court to review the imposition of a uniform, statewide 28-day deadline from commitment by which DSH and DDS must commence substantive competency restoration services of defendants found incompetent to stand trial (IST).

On December 15, 2021, on remand to the Alameda County Superior Court, the Court held that prior to the notice of appeal filed by DSH and DDS on June 13, 2019, a writ had not issued. Hence, the Court's compliance time periods had not gone into effect. On December 15, 2021, the Court issued an amended judgement adopting the prior Court's April 19, 2019 compliance time period, beginning to run effective August 27, 2021, the date of the remittitur. The compliance benchmarks are as follows:

- Within 12 months of August 27, 2021, the DSH and the DDS must commence substantive services for all IST defendants within 60 days from the transfer of responsibility date.
- Within 18 months of August 27, 2021, the DSH and the DDS must commence substantive services for all IST defendants within 45 days from the transfer of responsibility date.
- Within 24 months of August 27, 2021, the DSH and the DDS must commence substantive services for all 1ST defendants within 33 days from the transfer of responsibility date.
- Within 30 months of August 27, 2021, the DSH and the DDS must commence substantive services for all IST defendants within 28 days from the transfer of responsibility date.

DSH has made significant investments and actions to increase its capacity to serve IST patients, however, DSH continues to experience an increase in referrals. Since 2012-13, DSH's IST bed capacity has increased by 1,380, which includes state hospital beds, Jail Based Competency Treatment programs (JBCTs), and Community Based Restoration (CBR). Despite these significant efforts to increase capacity and address the wait times for IST patients, the average monthly referrals have increased from 305 to 394 from 2017 to 2021. Prior to the pandemic, DSH was making strides in reducing the IST waitlist. However, the COVID-19 pandemic has

reversed DSH's trajectory, and catapulted DSH into an IST crisis. Due to the need to develop admission observation units, isolation units, and space for persons under investigation in response to COVID-19, DSH's IST census in its hospital programs has significantly decreased. Furthermore, throughout the pandemic, DSH has had to halt admissions twice altogether and various outbreaks have also impacted admissions.

POTENTIAL COST PRESSURE

If DSH does not meet the above referenced court ordered admission timelines by the deadlines imposed by the court, DSH may be subject to future fines and penalties. At this time, DSH cannot project the value of any potential fines and penalties that may be incurred. The court will not establish enforcement actions unless they become necessary due to non-compliance with the order. Thus, DSH does not know what level of contempt fines will be levied at this time should it not meet the court-ordered timelines. Additionally, DSH's ability to meet the court timelines is dependent upon many factors, including referral rates and increasing CBR and sub-acute capacity, implementing its IST re-evaluation program, further expansions and new county implementations of IST Diversion programs, which are all dependent upon developing partnerships and the success of those partners in implementing the DSH-funded programs. Additionally, it is unknown what further future impacts COVID-19 may have on DSH admissions to state hospitals, JBCT's and CBR. However, DSH can reference a similar lawsuit in the state of Washington known as Trueblood v. Washington (2015). In the Trueblood lawsuit, similar to California, despite substantial increases in capacity, the IST referrals continued to increase. As a result, Washington has not been able to meet the court ordered timelines for admissions and experienced over $100,000,000 in contempt fines. California has a significantly larger population, so the cost could be significantly greater in California. The fine structure for Washington consisted of $750 a day per IST for the first 7 days past the court-ordered deadline and $1,500 per day for every day thereafter. In addition to penalties, DSH will incur costs associated with one-time and ongoing plaintiff's attorney fees, ongoing Deputy Attorney General costs, and potential Special Master court monitoring costs.

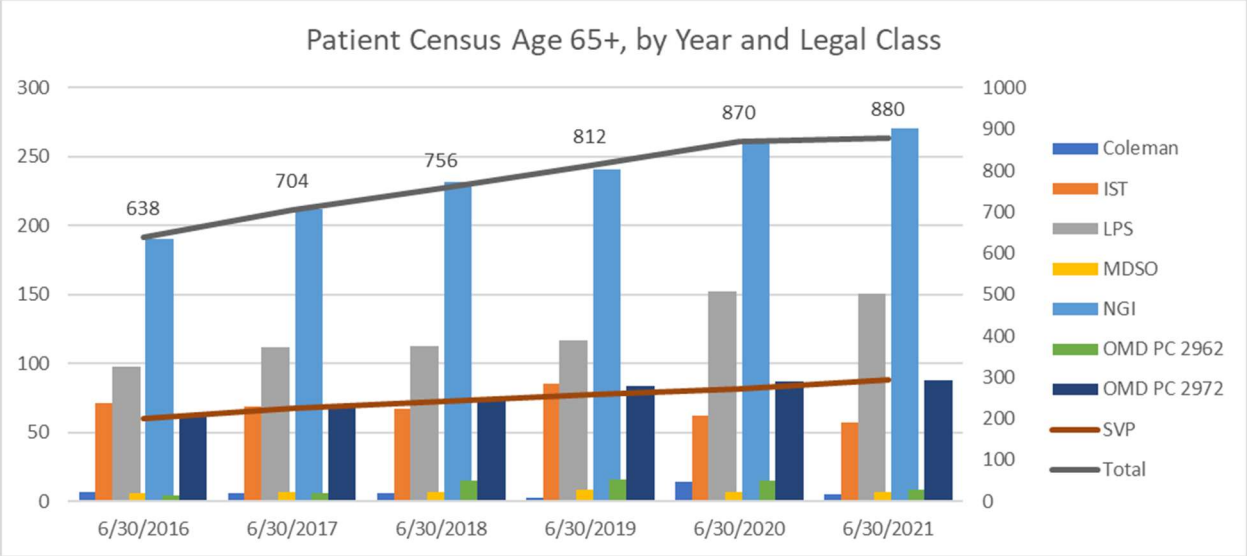
DSH continues to develop, implement, and expand a variety of solutions to the growing demand to serve IST patients with a goal of avoiding costly penalties. The below table reflects DSH's recent efforts and additional details on each program can be found in the individual narratives included in DSH's 2022-23 Governor's Budget publication:

- Jail Based Competency Treatment Programs
- Community Based Restoration Program
- Felony Mental Health Diversion Program (Diversion)

- CONREP Non-SVP: Mobile Forensic Assertive Community Treatment (FACT) Team
- CONREP Continuum of Care Expansion
- DSH-Metropolitan Increase Secured Bed Capacity
- Increase Sub-Acute Bed Capacity
- Re-Evaluation Services for Felony ISTs
- Non-Restorable and Maximum Term IST Defendants Return to County Requirement
- IST Solutions Workgroup

STATE HOSPITALS
Skilled Nursing Level of Care Needs
Informational Only

The Department of State Hospitals (DSH) has an aging population in need of higher levels of medical care. The number of patients age 65 and older has increased by 38 percent since June 30, 2016, as illustrated in the graph and table below.



June 30, 2021 Census, by Age Group		
Age Range	**Count of Patients**	**Percent to Total Census**
65-74	710	12%
75-84	156	3%
85-94	14	<1%
Systemwide	**880**	**15%**

Addressing the needs of the aging patient population will be a challenge for primary medical care in DSH in the years to come. Older patients have a higher prevalence for multiple medical conditions. Current research reveals that patients with schizophrenia experience accelerated aging and development of age-related illnesses 20 years earlier than expected and suffer from a dramatically decreased life expectancy. As of June 30, 2021, 39 percent of DSH's population had a diagnosis of schizophrenia. Moreover, mental illness, particularly psychotic spectrum disorders, bipolar disorders, depressive disorders, are associated with increased prevalence of chronic diseases that include asthma, arthritis, cardiovascular disease, cancer, diabetes and obesity. As of June 30,2021, 24 percent of DSH's population had a diagnosis of schizoaffective disorder and nine

percent had a diagnosis of bipolar disorder. Chronic medical conditions will continue to complicate DSH mental health care and create a need for closely coordinated care between primary medical care, psychiatry, nursing, pharmacy, Physical/Occupational/Speech Therapy (POST), dietary, environmental services, and other disciplines.

Many patients committed to DSH either due to the nature of their mental illness or the crimes that they commit have long lengths of stay. DSH provides mental, health and dental care for patients during the course of their stay with DSH. Their health care depending on a patient's length of stay may include geriatric and end-of-life care. During the course of their stay, medical care needs may increase over time, requiring either interim or long-term skilled nursing care. The following provides by commitment type, the average number of patient days for patients in census at the end of FY 2020-21.

Commitment Type	Average Patient Days
Coleman	185.8
IST	252.0
LPS	3,147.6
MDSO	3,314.6
NGI	6,084.7
OMD PC 2962	786.6
OMD PC 2972	3,971.9
SVP	4,443.5

Currently, DSH operates licensed Skilled Nursing Facility (SNF) beds to provide continuous nursing treatment and care for both forensically and civilly committed patients. This allows DSH patients to remain comfortably at DSH to receive the continuous care they need rather than be transferred to a community skilled nursing facility, where they will require 24-hour custodial supervision by either DSH law enforcement or CDCR correctional officers. However, DSH does not currently have enough SNF beds to meet existing and future patients' needs. SNF beds are licensed and regulated by the California Department of Public Health (CDPH) pursuant to California Code of Regulations (CCR) Title 22, Division 5, Chapter 3. DSH SNF beds are also federally certified by Centers for Medicare and Medicaid Services (CMS) and therefore must comply with CMS regulations and reporting requirements as well. SNF beds also require appropriate staffing levels are essential to meeting licensing and regulatory requirements.

DSH currently operates three SNF units, two at DSH-Metropolitan and one at DSH-Napa. As of June 30, 2021, there are 68 active SNF beds at DSH-Metropolitan and 29 active SNF beds at DSH-Napa. The SNF patients at DSH are on average

approximately 68 years old. The table below depicts age statistics of the SNF units for each hospital and systemwide. The majority of the patients currently housed within DSH's SNF units are longer-term commitment types. As of June 30, 2021, 33 percent of the SNF population consisted of Not Guilty by Reason of Insanity (NGI) and Offenders with a Mental Health Disorder (OMD) patients while 62 percent were Lanterman-Petris Short (LPS) patients.

Age Statistics for SNF Units: June 30, 2021 Census			
	Average Age	**Minimum Age**	**Maximum Age**
DSH-Metropolitan	68.6	37.9	90.4
DSH-Napa	67.4	56.5	78.4
Systemwide (SNF-only)	**68.2**	**37.9**	**90.4**

In addition to the limited number of existing licensed SNF beds DSH possesses, a system limitation is that the DSH skilled nursing facilities at DSH-Napa and DSH-Metropolitan are not able to serve patients committed to DSH-Coalinga as Sexually Violent Predators (SVP). As DSH-Coalinga's patient population ages, the SNF needs increase and DSH-Coalinga does not currently have and SNF beds. DSH-Coalinga's patient population reflects an average age between 9.3 years and 13.2 years older than DSH's other hospitals.

For the DSH facilities that do not have in-house options for SNF level-of-care, DSH may contract out with community facilities, when possible. However, there are a number of challenges with community options, which are noted below:

- Availability of community SNFs is minimal, if at all.
    - Based on the Centers for Medicare and Medicaid Services (CMS) rating system, facilities serving psychiatric patients on medications will lower their rating serving as a disincentive to serve DSH patients.
    - Many SNFs do not have a psychiatric wing or regularly employ psychiatrists to be able to serve DSH patients.
    - As California's population ages overall, DSH will be competing against already limited SNF capacity in the community. California's over-60 population is projected to grow to 25 percent by 2030.
- Forensic commitment types are challenging to place in the community, many SNF's will not accept forensic commitments, particularly those with sexual offenses.
- Most community SNFs do not have expertise to serve a forensic patient population and do not have the physical plant security features to provide a therapeutic environment for forensic patients (i.e., patients may be restrained to their bed and require close custodial supervision by CDCR or DSH officers).

Based on the DSH's patient medical needs and challenges described above, DSH is exploring short-term and long-term solutions to the meet the needs of DSH's aging and high acuity patient population. Current options being explored consist of the following

- Convert units within existing DSH facilities to SNF level of care.
- Identify community SNF facilities for DSH to partner with to provide services to DSH patients that are willing to exclusively serve DSH population and provide the necessary security modifications to provide a therapeutic environment for forensic patients.

As DSH explores the above options and others, DSH will evaluate cost effectiveness, COVID-19 uncertainties, bed capacity, timeframe, and availability of facilities. As DSH evaluates its options and their feasibility, DSH will provide an update through the annual budget process.

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

Department of Finance (ca.gov)

POPULATION PROFILE
Penal Code 2684 (*Coleman*) Patients

DESCRIPTION OF LEGAL CLASS

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

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

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

LEGAL REQUIREMENTS/LEGAL STATUE FOR DISCHARGE

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

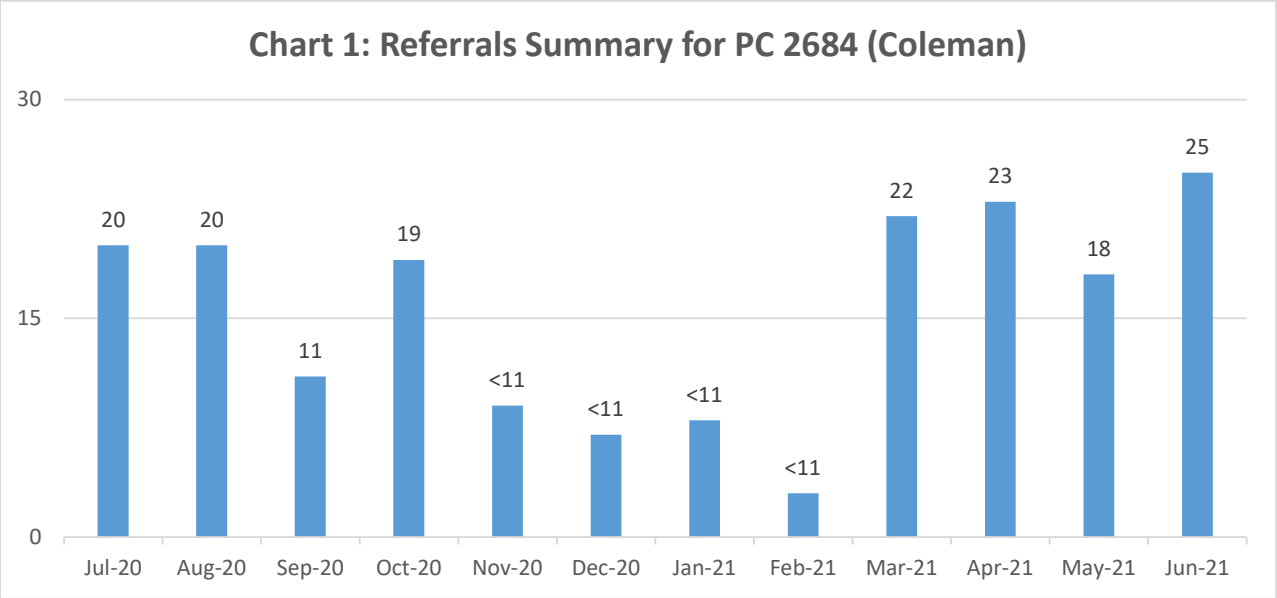
TREATMENT

The focus of treatment for the *Coleman* population is on psychiatric stabilization. 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

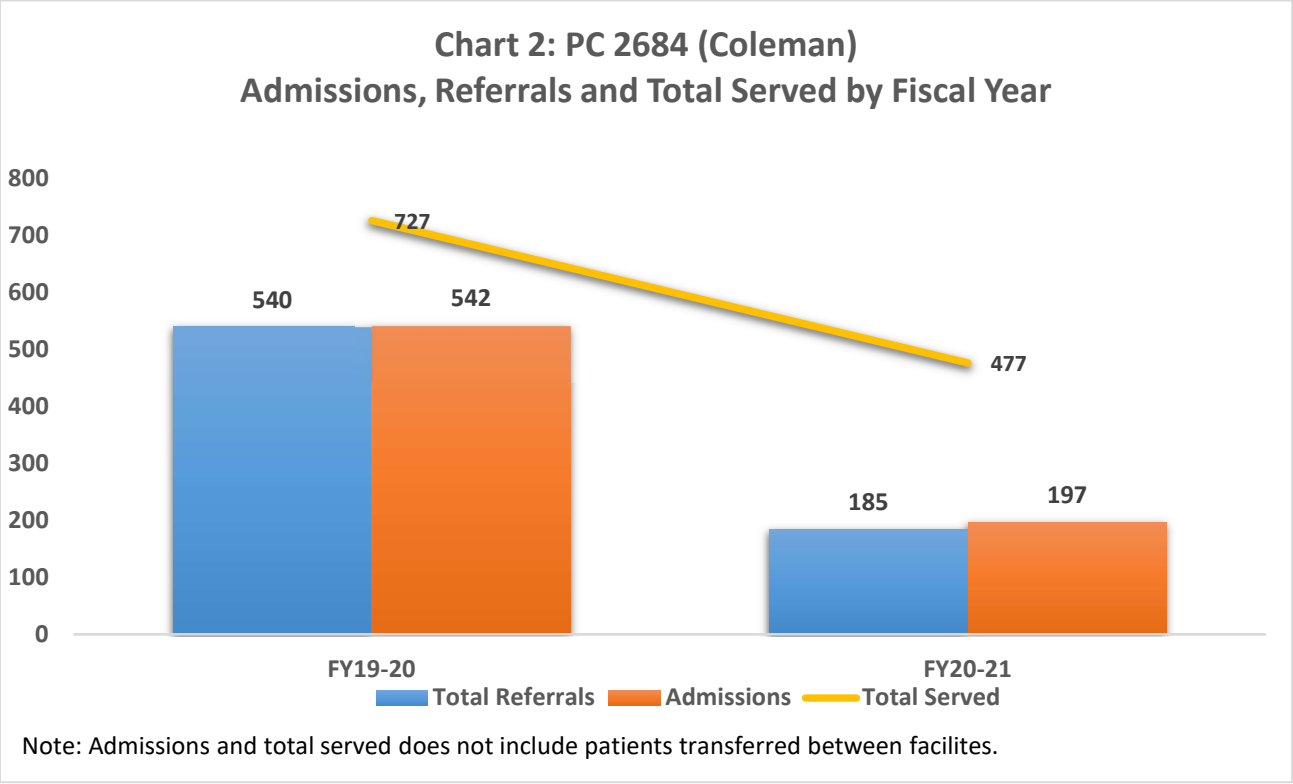
their mental illness symptoms and reintegrate back into a prison environment when discharged from the state hospital.

POPULATION DATA

In FY 2020-21, 185 *Coleman* patients were referred and accepted for admission to the state hospitals, excluding referrals rescinded by CDCR. This is a 66 percent decrease from FY 2019-20 and reflects the impacts of COVID-19 at both DSH and CDCR. At the start of the FY 2020-21, the July 1 census was 281 and on June 30, 2021, the census had decreased to 170, a 40 percent decrease.

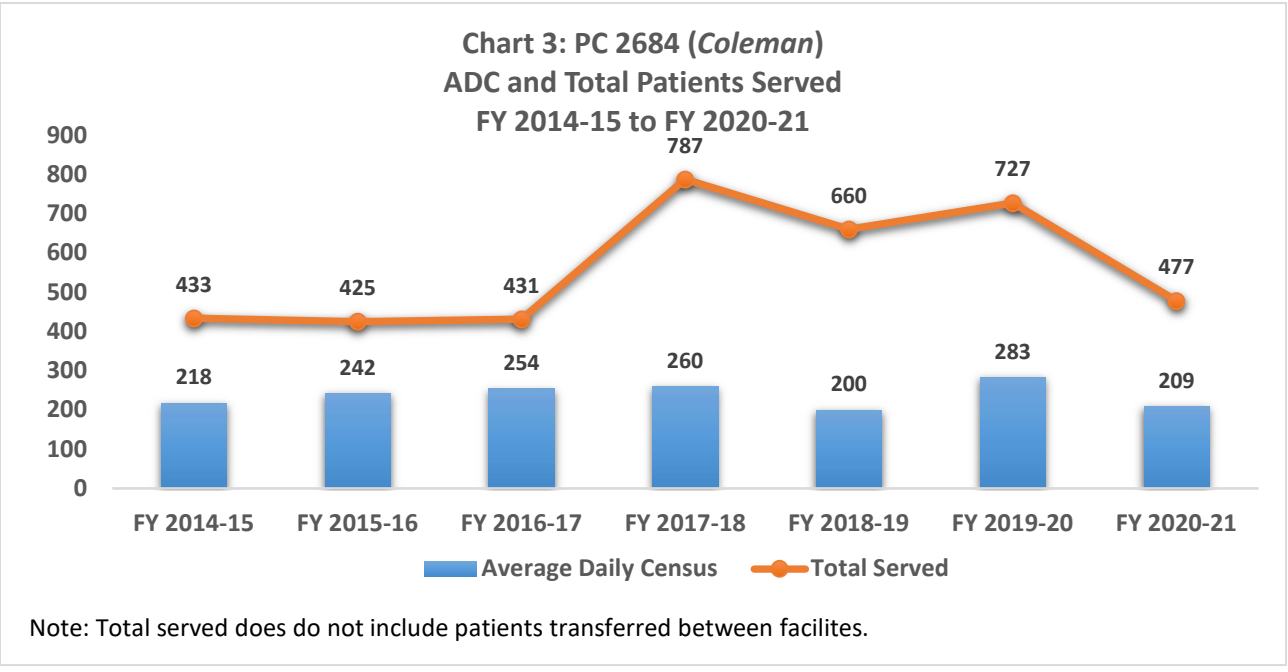


Over the course of FY 2020-21, 197 *Coleman* patients were admitted into a state hospital. Chart 2 displays the admission, referrals, and total patients served systemwide for the *Coleman* population in FY 2019-20 and FY 2020-21. The number of admissions decreased by 64 percent.



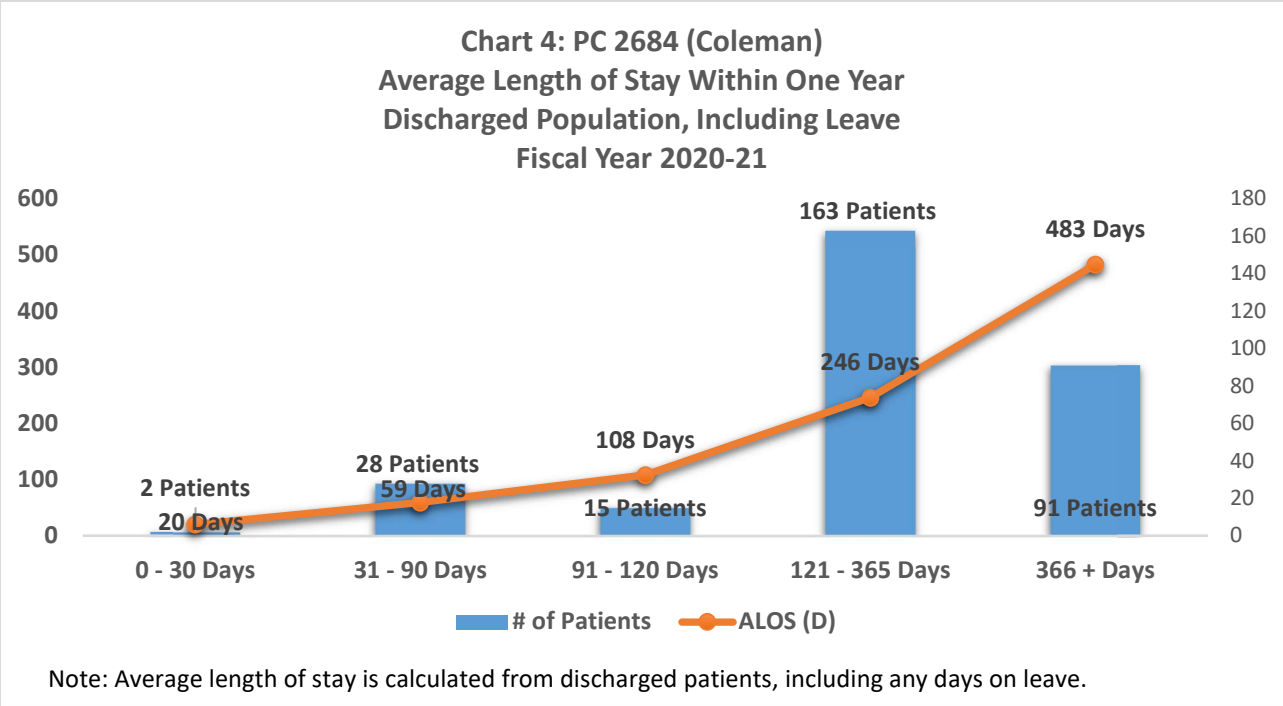
Note: Admissions and total served does not include patients transferred between facilites.

On average, 209 *Coleman* patients are treated daily in the state hospitals, representing 4 percent of the overall patient population in FY 2020-21. Chart 3 displays the average daily census (ADC) and total number of patients served for the *Coleman* population during FY 2014-15 to FY 2020-21. As of June 30, 2021, the system-wide *Coleman* census was 170 patients.



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

Because the focus of treatment is acute stabilization, the length of hospitalization for *Coleman* patients tends to be shorter than the other commitment types. In FY 2020-21, 299 *Coleman* patients were discharged with an average length of stay of 292 days. 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, are determined to be unlikely to be restored to competency in the foreseeable future or are within 90-days of their maximum commitment for competency treatment. IST patients committed to DSH mostly include felony criminal charges, and occasionally include misdemeanor charges. As of July 27, 2021, defendants only with misdemeanor commitment charges (1370.01) can no longer be committed to DSH. There are still 1370.01 commitments to DSH that were committed prior to July 27, 2021.

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

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

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

LEGAL REQUIREMENTS/LEGAL 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 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 and the commitment is vacated by the court, usually after a defendant is placed under a Lanterman-Petris-Short Act conservatorship. If a patient/defendant has not regained competency to stand trial by the end of their IST commitment term or is determined there is no substantial likelihood they will regain competency in the foreseeable future, the patient/defendant must be returned to the committing county.

As defined in PC 1370(b)(1), a patient may be deemed by the treatment team as unlikely to regain competency, and upon notification to the county of commitment Sheriff, the patient must be picked up within 10 days and returned to county custody. Often, the county will pursue other means to ensure the patient is receiving treatment and care, which may include securing a conservatorship and referring the individual back to the state hospital under a conservatorship commitment. In the event a patient is nearing their maximum term of commitment, the state hospital, pursuant to PC 1370(c)(1) must notify the Sheriff, who must pick up the patient who is within 90 days prior to the expiration of the commitment term within 10-days of notice by DSH. In prior years, DSH noted counties not consistently retrieving their patients in a timely manner, requiring patients to remain on census for longer periods of time. In FY 2020-21, when applying average length of stay for an IST patient, this practice resulted in a loss of 134.9 IST patients served between PC 1370 (b)(1) and PC 1370(c)(1) individuals. Per Assembly Bill 133, Chapter 143, billing will commence if the County Sheriff does not pick-up the relevant IST defendant from a DSH facility and return them to county custody within ten (10) days' notice to the committing court that the

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

IST defendant (1) has no substantial likelihood of regaining mental competence in the foreseeable future or (2) is within 90 days of reaching their maximum commitment term. AB133, Chapter 143 also includes corresponding statutory changes to Welfare and Institutions Code section 17601 to allow DSH to collect reimbursement from counties.

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

TREATMENT

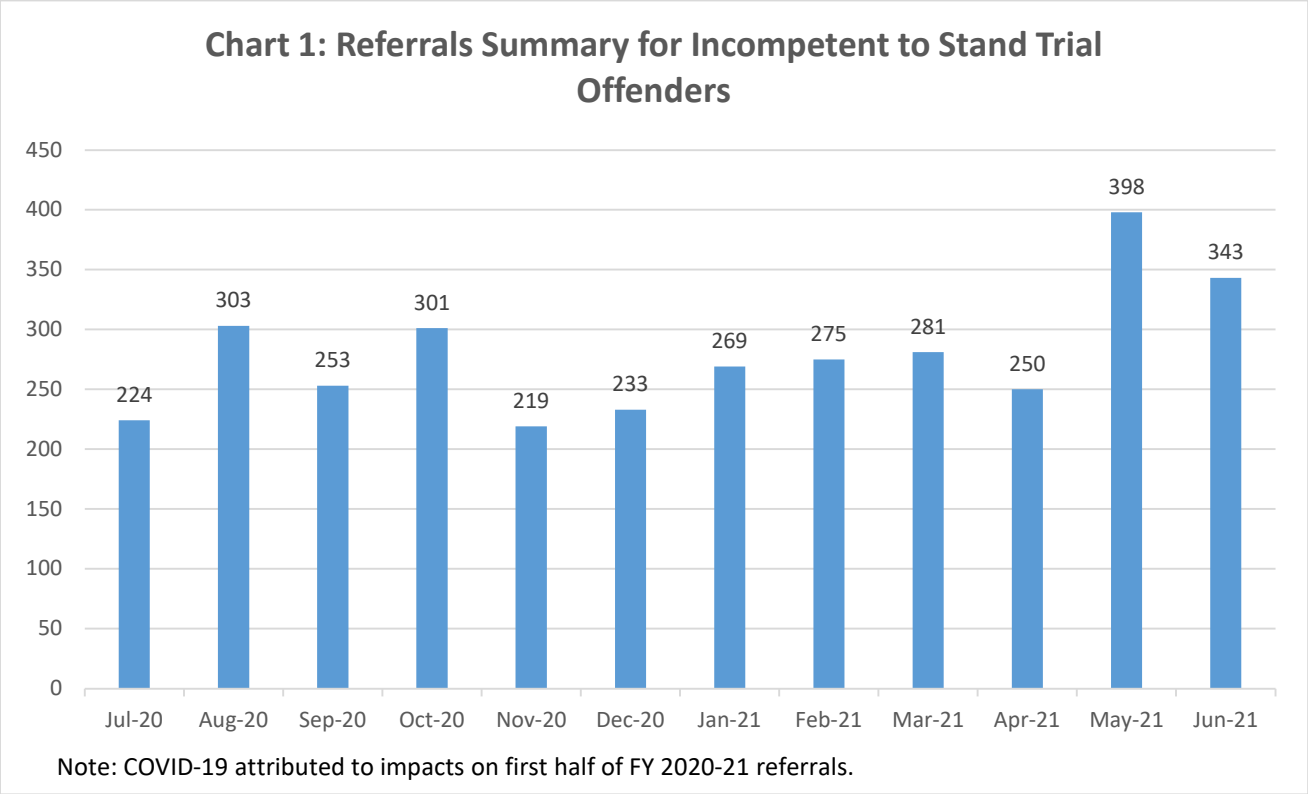
The focus of treatment for the IST population is on restoration of trial competency in the most expeditious manner. To this end, IST patients are treated in one treatment program so the training of criminal procedures can be constantly present in the treatment milieu. Once specific mental health issues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

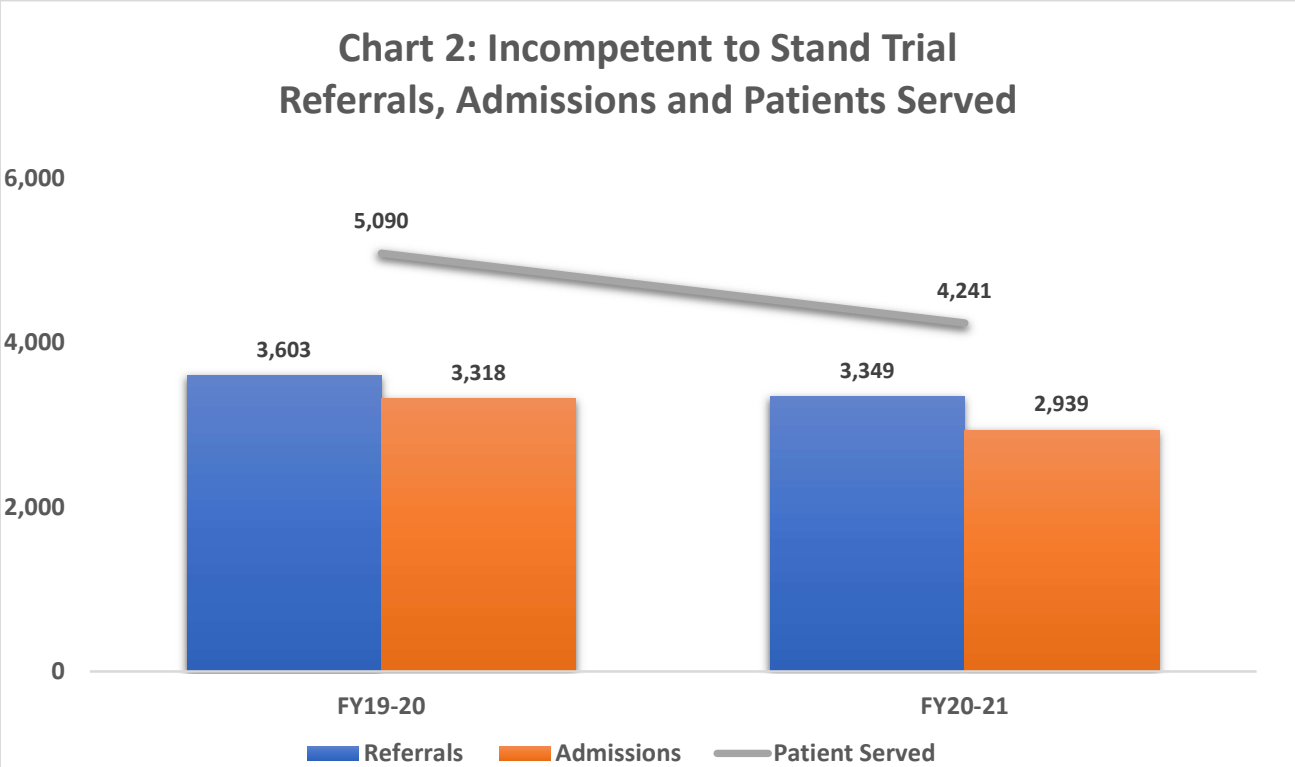
In FY 2020-21 3,349 IST patients were committed[2] to DSH, a 7 percent decrease from FY 2019-20. The COVID-19 pandemic directly impacted IST referral rates. As county courts began resuming court proceedings, IST referral rates have been steadily increasing, specifically in the second half of FY 2020-21 with average monthly referral rates reaching 303 referrals. Chart 1 displays referrals systemwide for the IST population in FY 2020-21.

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



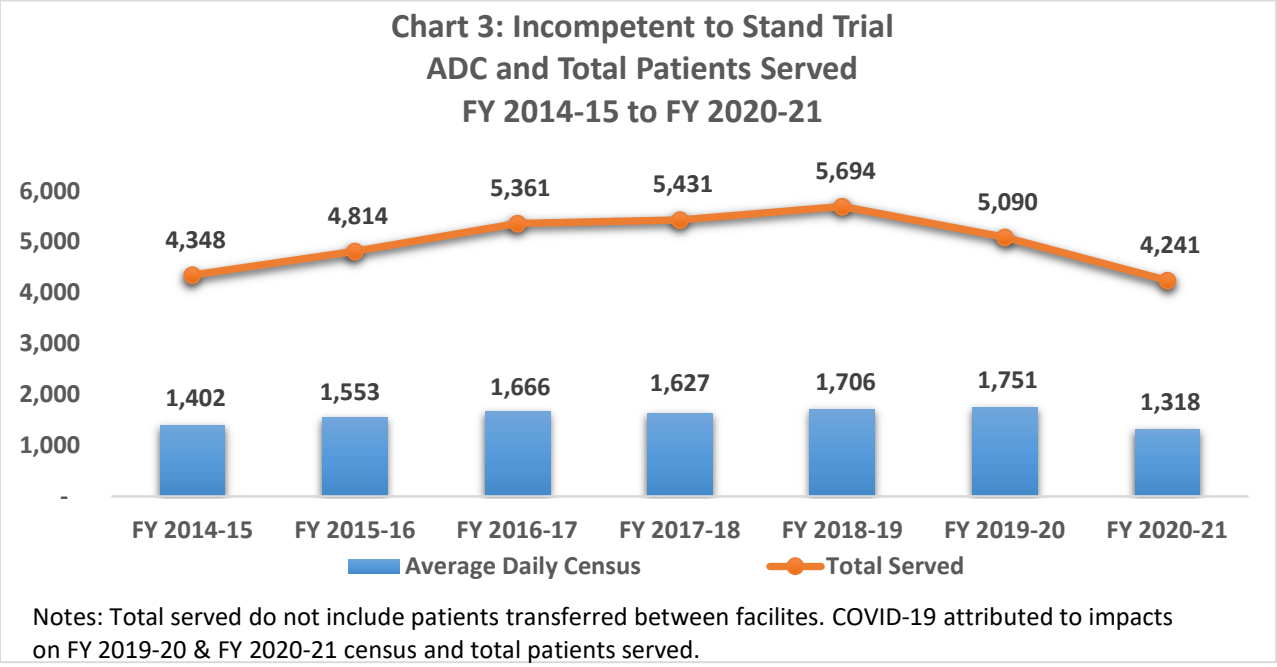
Incompetent to Stand Trial Data

Over the course of FY 2020-21, 2,939 IST patients were admitted into a state hospital and jail-based programs which is a decrease of 11 percent from the prior year. Admission rates remained impacted due to COVID-19. These impacts were due to restricted patient movement due to quarantine units and the continued need of Admission Observation Units (AOU). AOUs house patients arriving to the hospital for admission and in certain circumstances patients arriving from receiving outside care/services. Patients are isolated and tested for 10 days as a prevention measure for Routine Intake Quarantine. As admissions directly correlate to patients served, DSH served 17 percent less patients in FY 2020-21 than in the prior year. Chart 2 displays referrals, admissions, and total patients served systemwide for the IST population in FY 2019-20 and FY 2020-21.



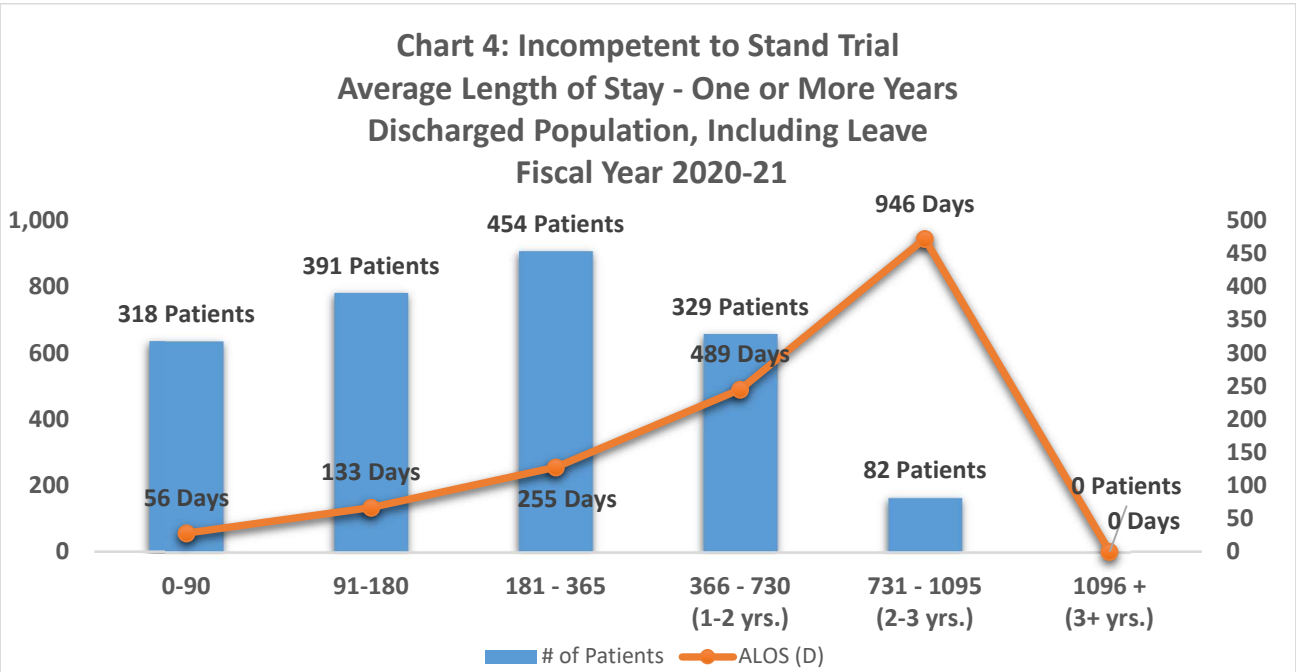
Notes: Total admissions and total served does not include patients transfers from DSH or JBCT facilities. COVID-19 attributed to impacts on first half FY 2020-21 referrals, admissions and total patients served.

On average, 1,318 IST patients are treated daily in the state hospitals and jail-based programs, representing 22 percent of the overall patient population in FY 2020-21. Chart 3 displays the average daily census (ADC) and total number of patients served in state hospital facilities and jail-based programs for the IST population from FY 2014-15 to FY 2020-21. As of June 30, 2021, the system-wide IST census is 1,596 patients.



Notes: Total served do not include patients transferred between facilites. COVID-19 attributed to impacts on FY 2019-20 & FY 2020-21 census and total patients served.

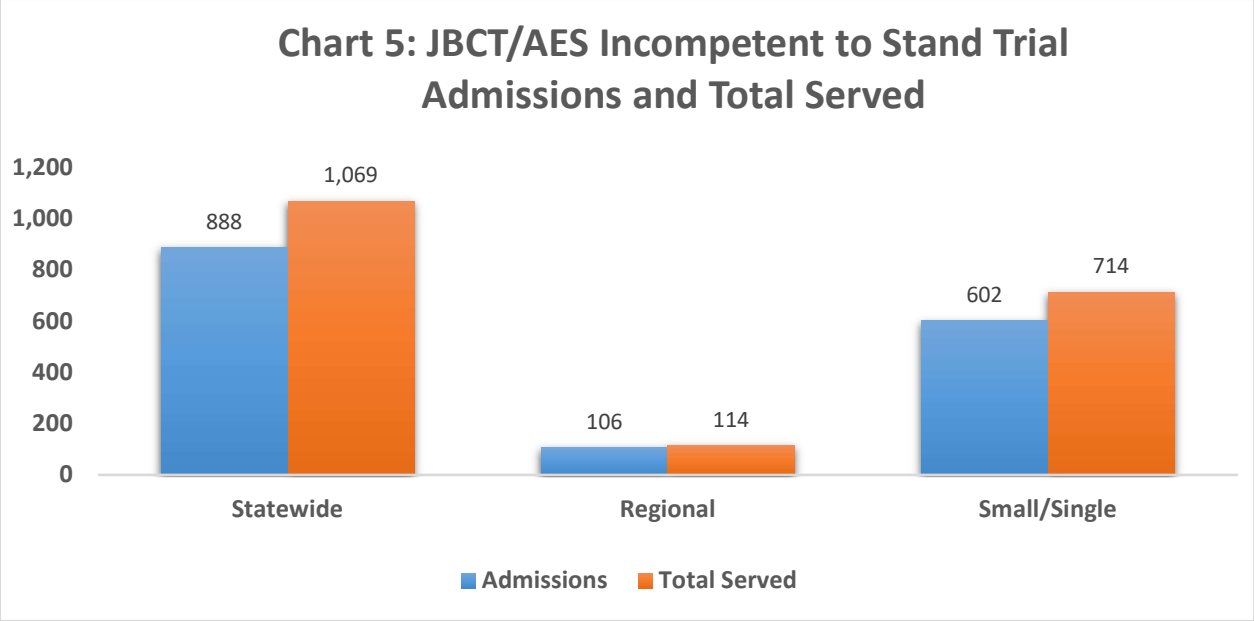
In FY 2020-21, 1,574 IST patients were discharged from state hospitals with an average length of stay of 269 days, 0.7 years. The State Hospital length of stay increased by 63 percent (or approximately 104 days) as compared to the prior year. This increase in the length of stay can be attributed to COVID-19 as DSH had to temporarily suspend IST admissions and discharges to mitigate the impacts of COVID-19 throughout its hospitals. Chart 4 displays the distribution of lengths of stay for all discharged IST patients.



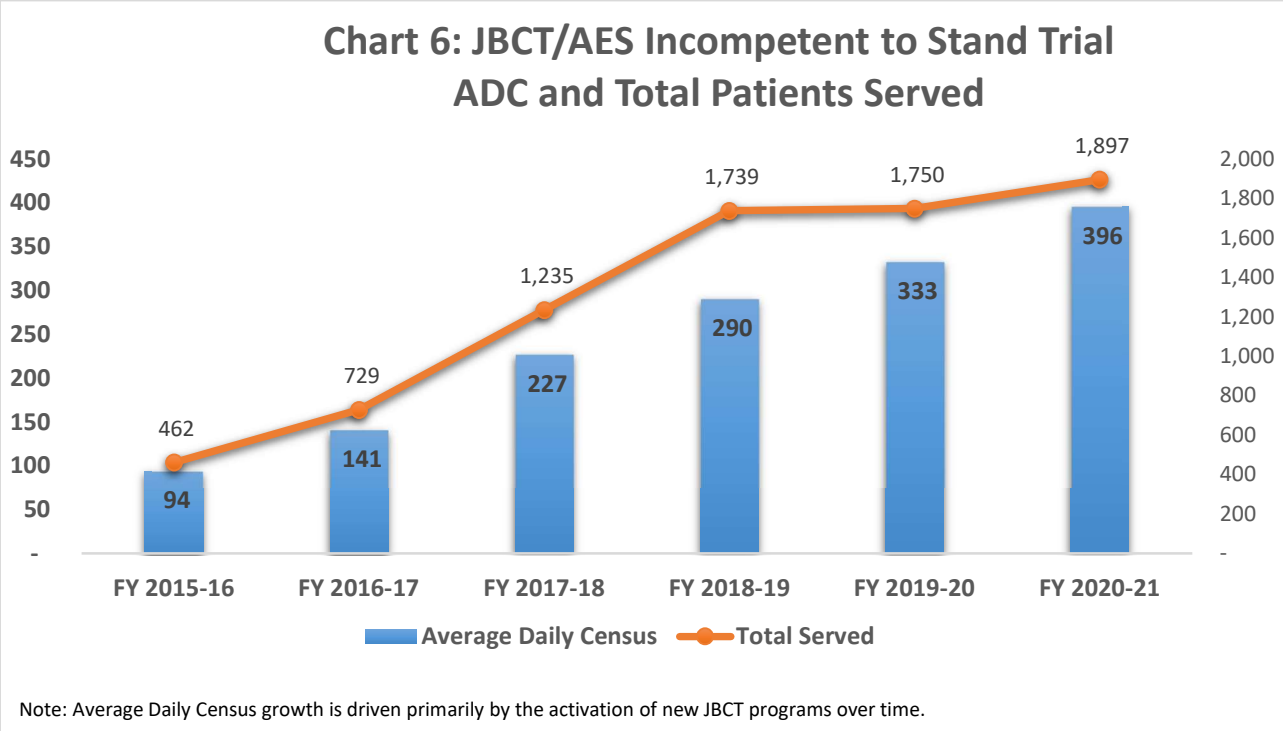
Notes: During FY2020-21, 3 EISTs were excluded from ALOS patient count. COVID-19 attributed to impacts on FY 2020-21 average length of stay.

Jail-Based Competency Treatment Program Data

Over the course of FY 2020-21, 1,596 IST patients were admitted into a JBCT facility or the Admission, Evaluation, and Stabilization (AES) Center which is an increase of eight percent from the prior year. This increase is attributed to facility expansions. Chart 5 displays the admission and total patients served distribution by AES/JBCT facility categories for the IST population in FY 2020-21.

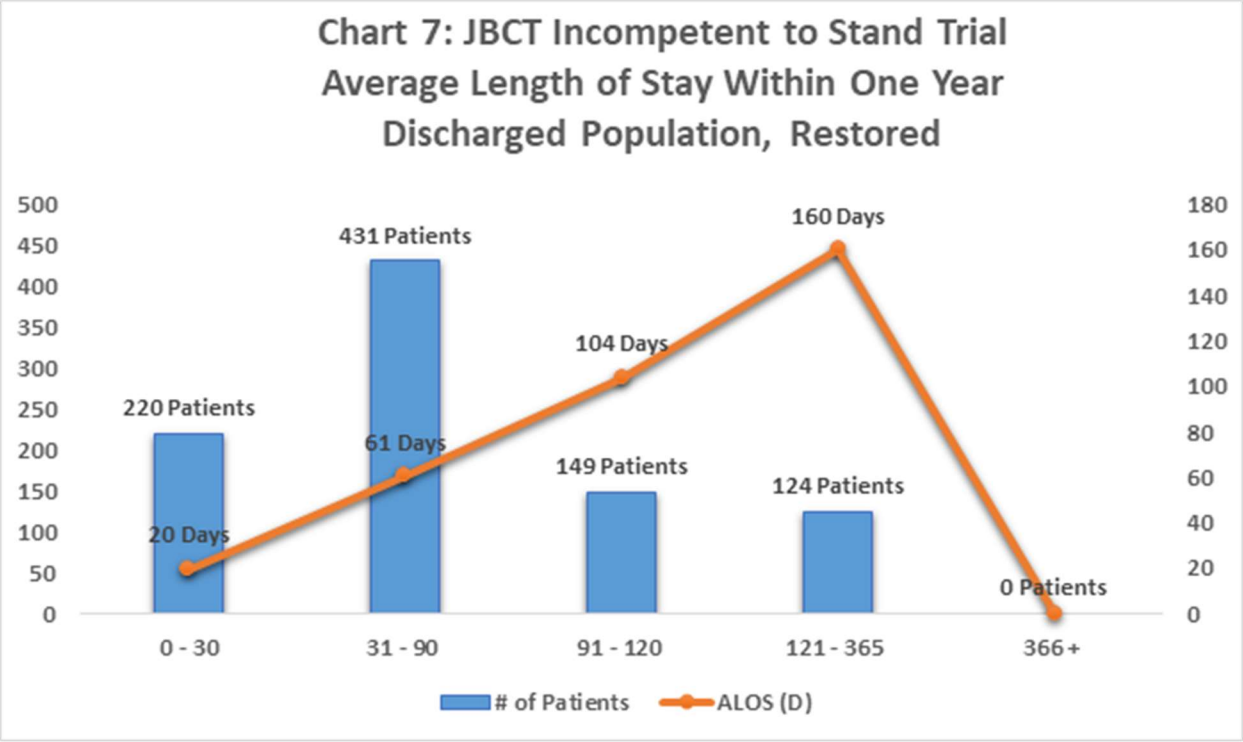


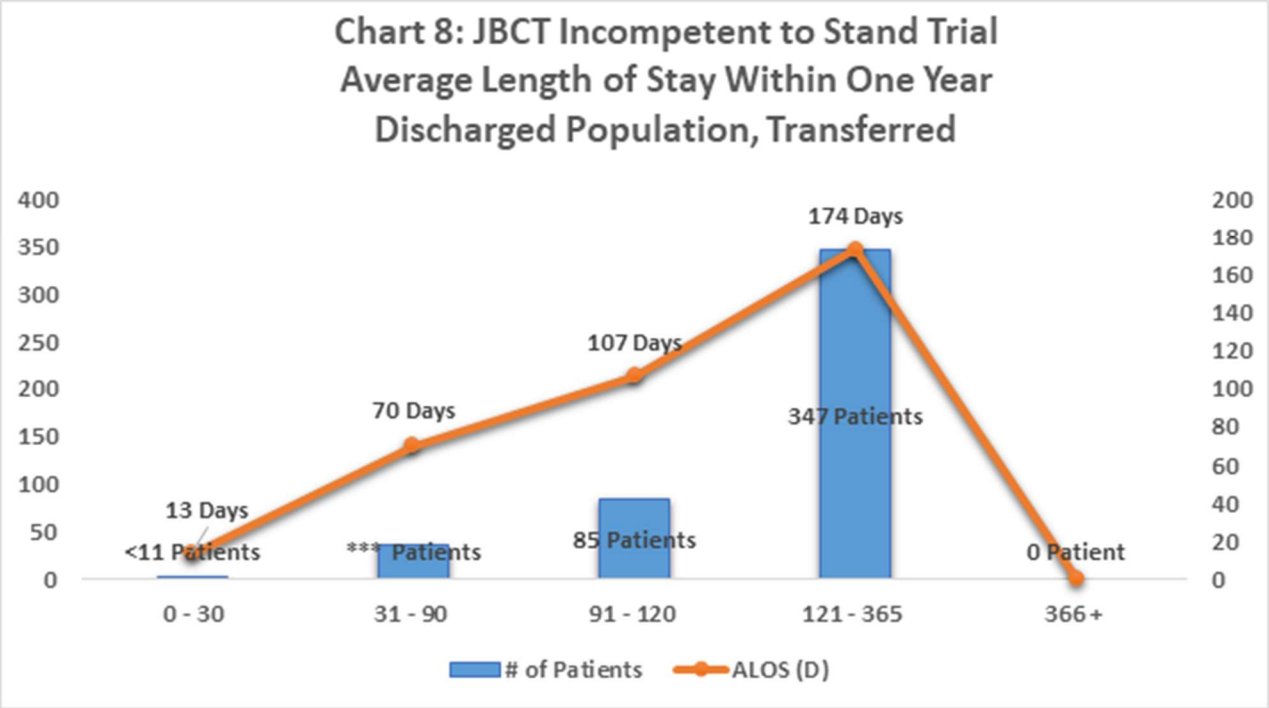
On average, 396 IST patients are treated daily in the AES/JBCTs, a 19 percent increase from FY 2019-20. Chart 6 displays the ADC and total number of patients served year over year in the AES/JBCTs for the IST population. As of June 30, 2021, the AES/JBCT system-wide IST census is 421 patients.



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

The JBCT and AES programs were designed to treat patients 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 2020-21, 924 IST patients were restored and discharged with an average length of stay of 71 days. During that same period, 528 IST patients were discharged from the AES/JBCT program and transferred to a state hospital, with an average length of stay of 153 days. Chart 7 displays the distribution of lengths of stay for all discharged IST patients that were restored. Chart 8 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 Los Angeles County-Office of Diversion and Re-entry, CBR aims to regularly assess committed IST patients while they wait for a bed at DSH to 1) re-evaluate

competency and the need for competency treatment ("off-ramp") and 2) identify suitability for a community-based treatment option in a network of 400+ beds.

As part of this two-prong approach, the off-ramp team monitors Felony ISTs in the jail for restoration of competency prior to placement in a state hospital or into the community restoration program. If competence is suspected, the team prepares court documentation and petitions the court to approve the determination of restored competence. Over the course of FY 2020-21, CBR successfully off-ramped 134 patients. Chart 9 displays the number of patients found competent monthly in CBR's off-ramp assessment.

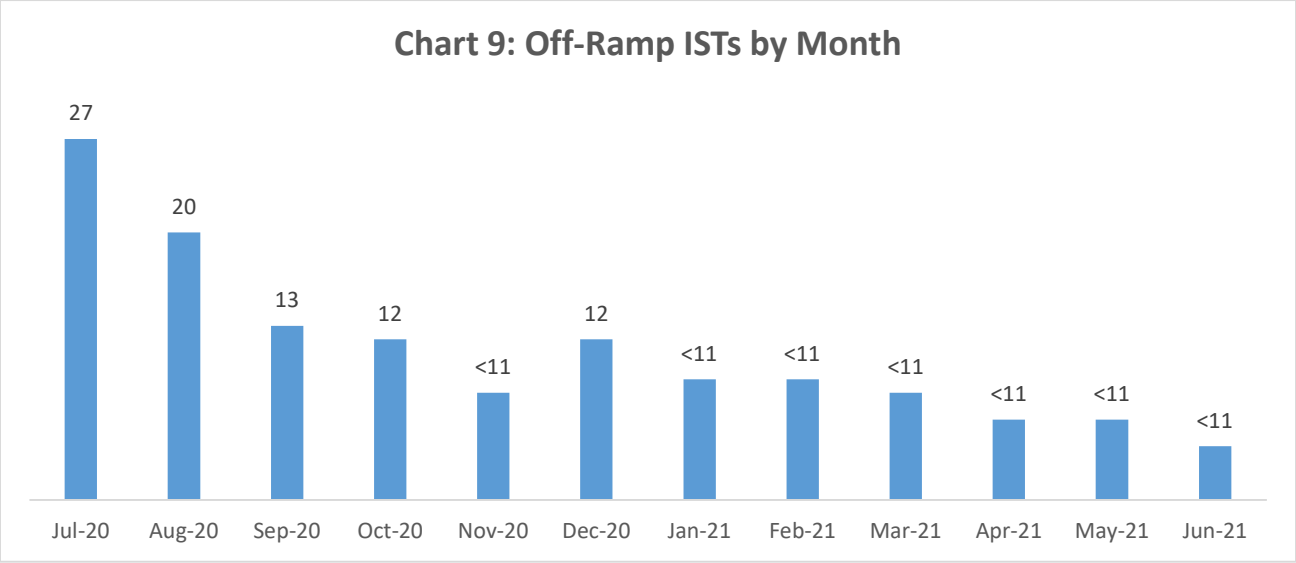


Chart 9. Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines.

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 2020-21, 301 patients were conditionally released to CBR, and were subsequently admitted into community beds at an acute level of care, subacute level of care, or in an unsecured residential facility. Chart 10 displays the Average Daily Census by month in the various levels of care.

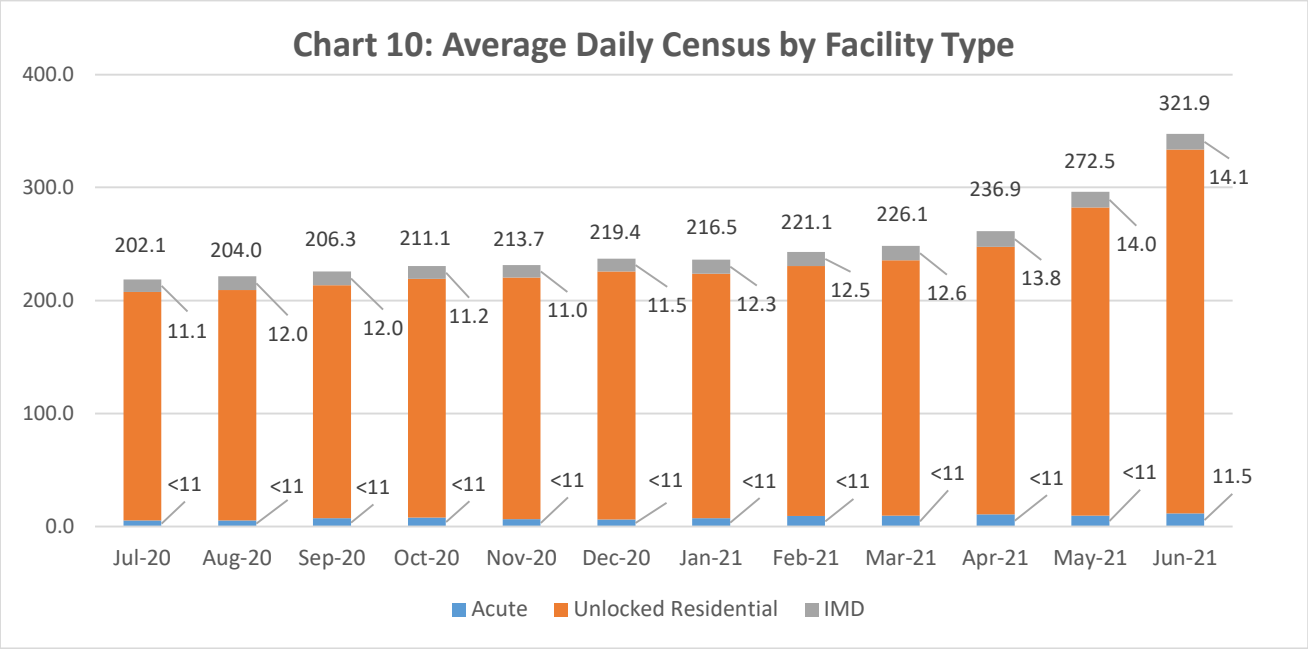


Chart 15. Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines.

In FY 2019-20, less than 11 patients were restored to competency with an Average Length of Treatment of 295 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 = 134), or conditional release and admission to a community facility (n = 301), would have continued as referrals to DSH and awaited an available bed in in a state hospital or JBCT.

POPULATION PROFILE
Lanterman-Petris-Short Patients

DESCRIPTION OF LEGAL CLASS

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

Over the past five years, 86 percent of all LPS patients served in state hospitals were committed under WIC 5353 or 5358 as conservatees. During the same period, approximately 1 percent was committed under Penal Code (PC) 2974, and 13 percent were conserved under WIC 5008(h)(1)(B) (Murphy Conservatorship). The remaining LPS population within DSH was comprised of the other 4 legal statutes under the LPS Act.

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

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

WIC 5304(b)	Additional 180-day post certification (ADD) in the event that the individual has attempted, inflicted, or a made a serious threat of physical harm upon another during post certification treatment.
WIC 5353	Temporary conservatorship (T.Cons), in which an appointed temporary conservator may make arrangements, sometimes at a state hospital, to provide the individual with food, shelter, and care pending a conservatorship determination.
WIC 5358	Conservatorship (CONS), in which the appointed conservator places the conservatee in an appropriate facility, such as a state hospital, and can require treatment to remedy or prevent the recurrence of the conservatee's mental illness.
WIC 6000	Voluntary application to a state hospital for treatment and care made by a competent adult; they may leave at any time after notifying, or their conservator notifying in the case of conservatorships, hospital staff and following hospital discharge procedures (VOL)
WIC 4825, 6000(a)[1]	Admission to a state hospital of a developmentally disabled individual by their conservator; if competent, the individual may apply for and receive services at a regional center instead.
WIC 5150[1]	72-hour detention (DET) for assessment, evaluation, and crisis intervention with probable cause that a person is a danger to themselves or others, as a result of a mental health disorder.
WIC 5250[1]	14-day certification (CERT) following detainment pursuant to WIC 5150 (72-hour detention), WIC 5200 (court ordered for evaluation, Article 2), or WIC 5225 (court ordered for evaluation, Article 3). The individual must be offered treatment on a voluntary basis but has been unwilling or unable to accept the recommended treatment, and no family, friend, or other individual has submitted in writing their willingness to provide for the person's basic personal needs.
WIC 5260[1]	Additional 14-day certification for suicidal persons who demonstrated this behavior via threats or attempts during the previous 14-day period or 72-hour evaluation period (SUIC)
WIC 5270.15[1]	30-day certification (A-Cert) upon completion of a 14-day certification pursuant to WIC 5250 in the event that the individual remains gravely disabled or is unwilling or unable to voluntarily accept treatment. A certification review hearing is conducted to determine suitability of commitment.
WIC 5303[1]	Pending court decision on 180-day post certification (PCD), the conservatee remains at the treatment facility until released by court or in the event the petition is withdrawn.
WIC 6500, 6509[1]	A person with a developmental disability committed to a state hospital if found to be a danger to themselves or others; this

	commitment expires after one year pursuant to WIC 6500(b)(1)(A).
WIC 6506[1]	A temporary hold for an individual with a developmental disability while awaiting a hearing pursuant to WIC 6503.
WIC 6552[1]	Voluntary application as Juvenile court ward to be treated for a mental disorder at a state hospital (VJCW)

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

LEGAL REQUIREMENTS/LEGAL STATUE FOR DISCHARGE

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

TREATMENT

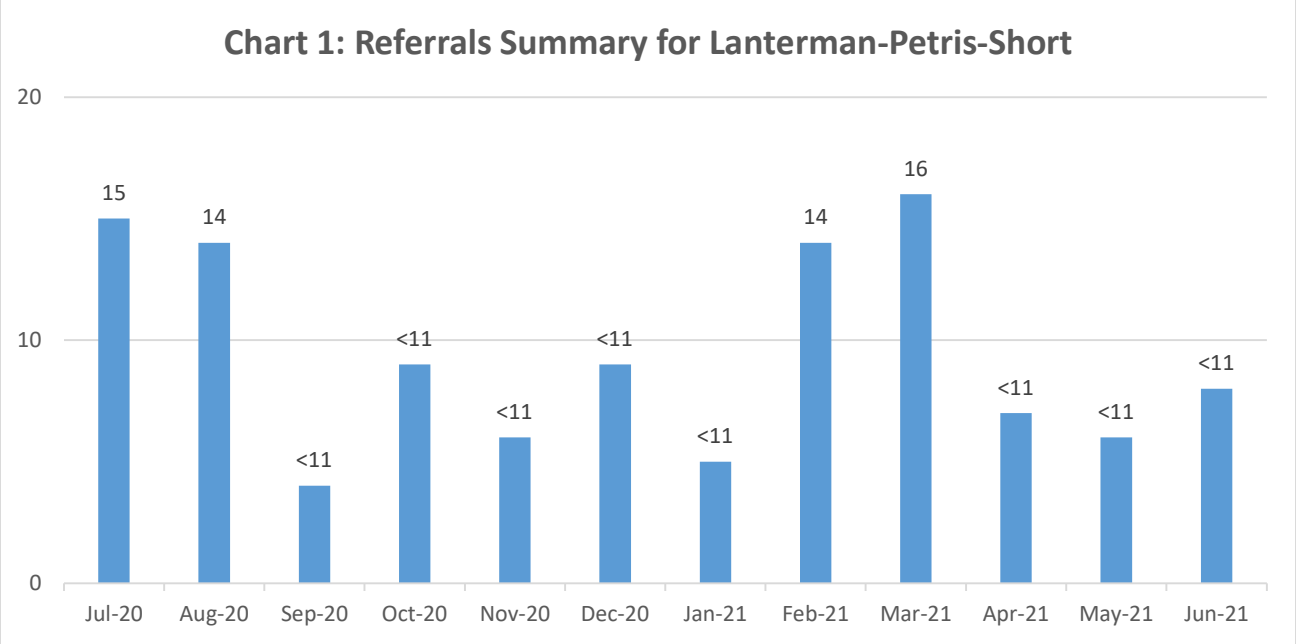
Under WIC 5150, an individual, on probable cause, can be taken into custody for mental health treatment for 72 hours. The individual can then be evaluated for an additional 14-day period of treatment pursuant to WIC 5250. After further evaluation and judicial review, the individual can then be placed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

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

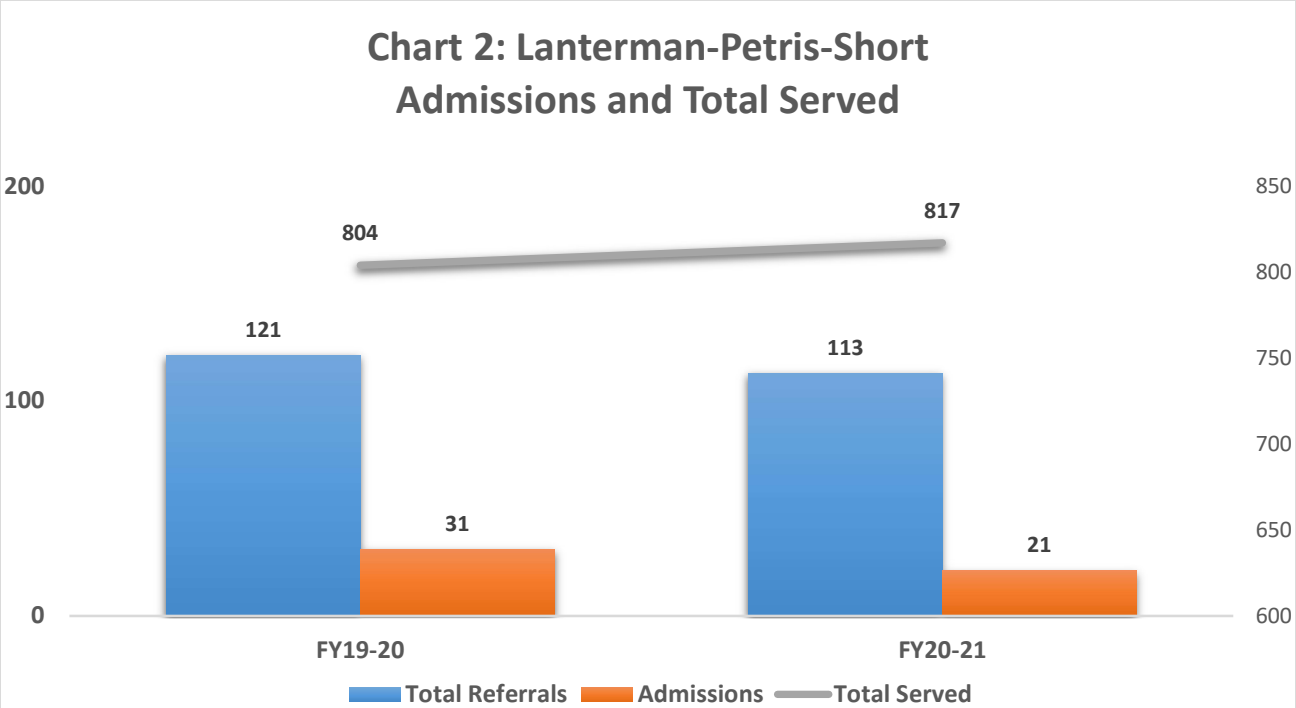
POPULATION DATA

LPS Population data in Charts 1 through 5 displays DSH LPS population including Murphy Conservatorship. A subset of Murphy Conservatorship data can be found

on page 6. In Fiscal Year (FY) 2020-21, 113 LPS patients were committed to the state hospitals, a 7 percent decrease from FY 2019-20.



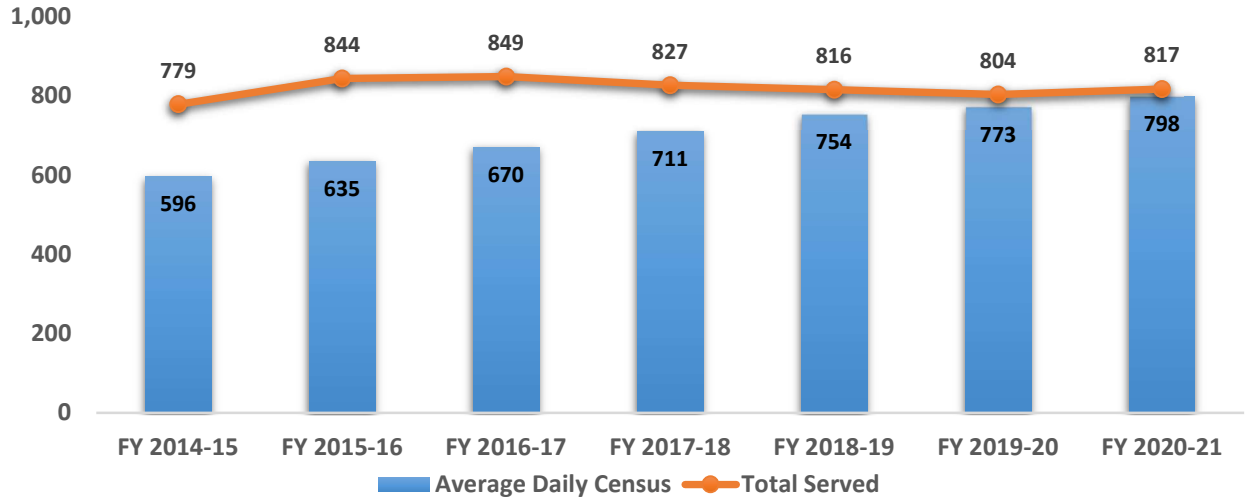
Over the course of FY 2020-21, 21 LPS patients were admitted into a state hospital. Chart 2 displays the referrals, admissions, and total patients served for the LPS population in FY 2019-20 and FY 2020-21.



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

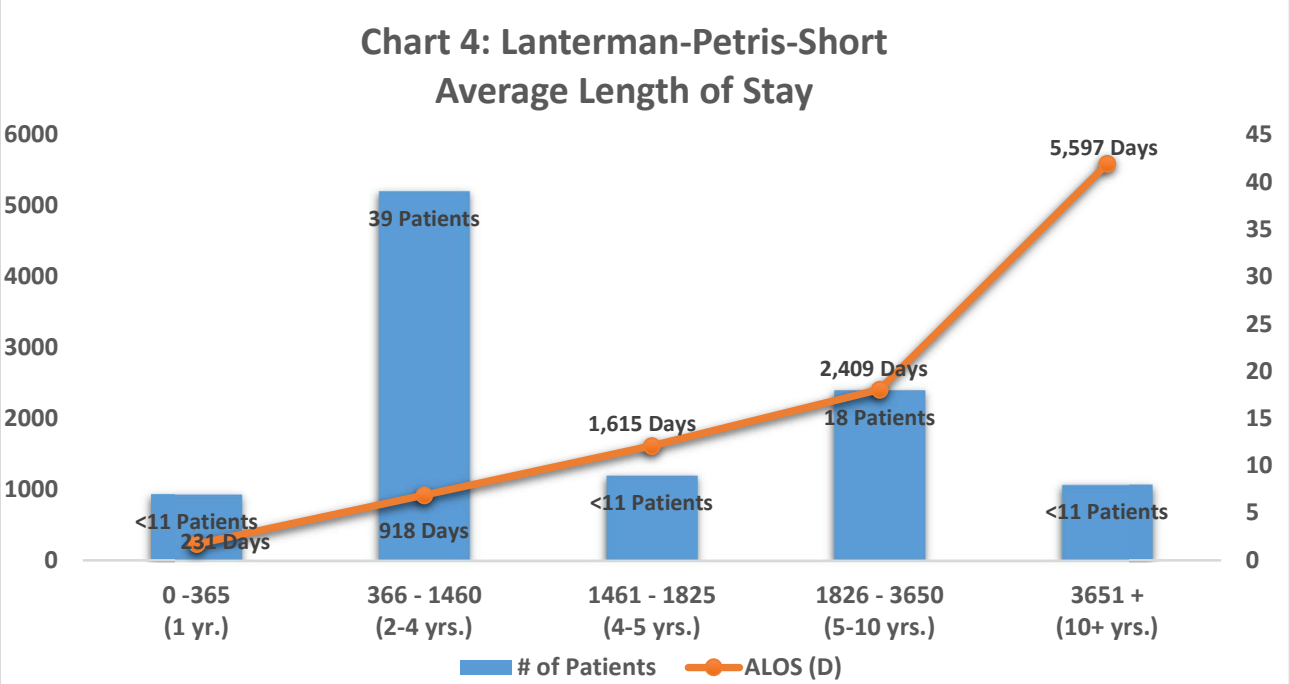
Chart 3 displays the average daily census (ADC) and total number of patients served for the LPS population during FY 2014-15 to FY 2020-21. On average, 798 LPS patients are treated daily in the state hospitals, representing 14 percent of the overall patient population. As of June 30, 2021, the system-wide LPS census was 798.

Chart 3: Lanterman-Petris-Short
ADC and Total Patients Served
FY 2014-15 to FY 2020-21

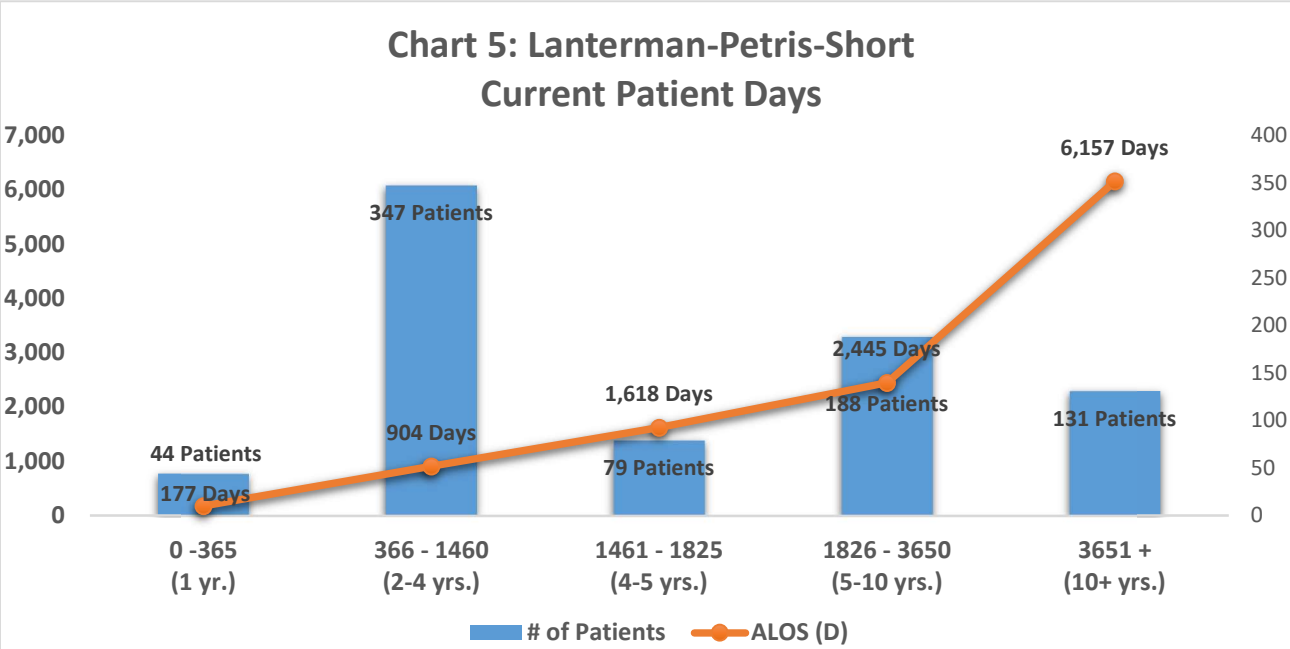


Note: Total served does do not include patients transferred between facilites.

In FY 2020-21, 81 LPS patients were discharged with an average length of stay of 4.7 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, 2021.



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

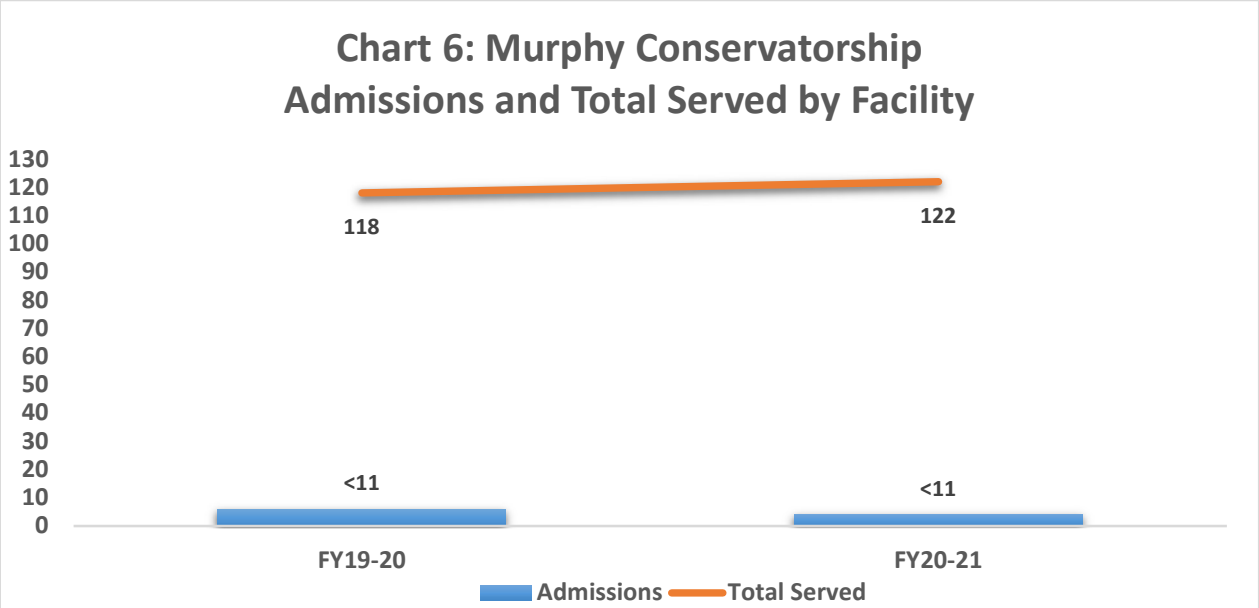


Note: Current patient days is, as of a particular point in time, the number of days residents-on-unit have spent in a state hospital, including leave.

Murphy Conservatorships

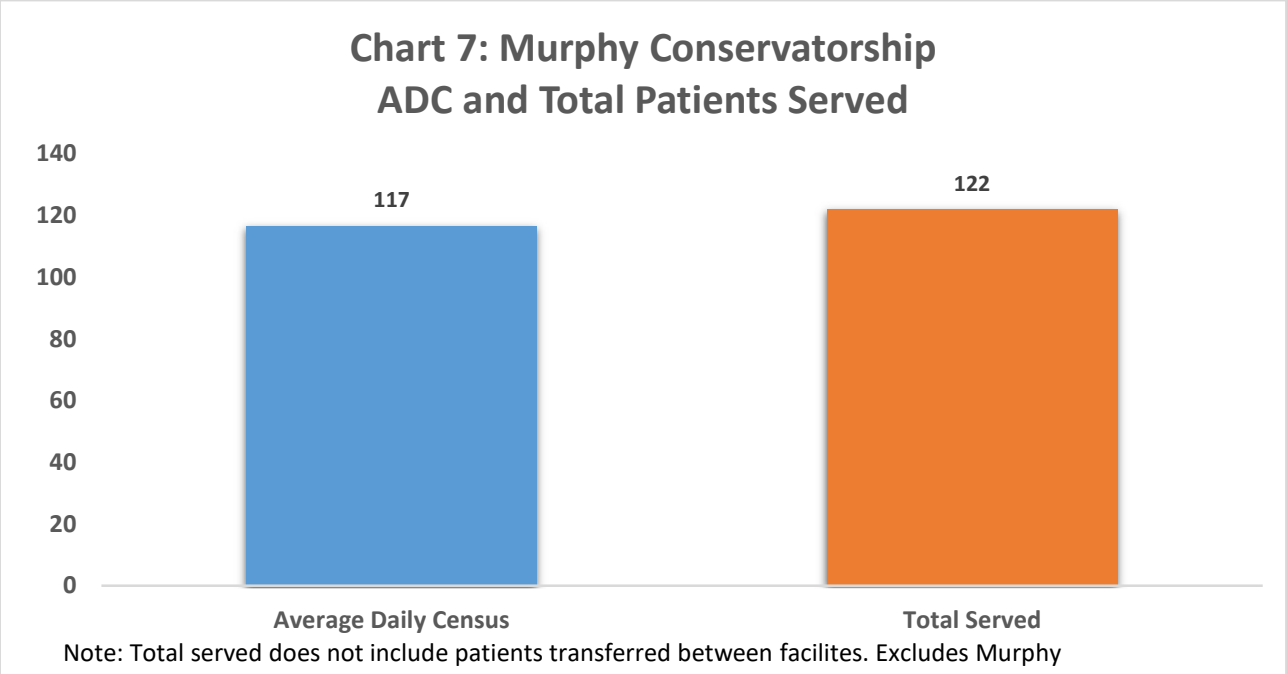
Murphy conservatorships (MURCON) are patients that have been previously found to be IST, and at the end of the IST commitment period the patient has been retained for further treatment if all of the following exist: (1) the patient is subject to a pending indictment or information charging the individual with a felony involving death, great bodily harm, or threat to the physical well-being of another; (2) as a result of a mental disorder, the patient continues to be unable to understand or meaningfully participate in the pending criminal proceedings; (3) the patient has been found incompetent pursuant to PC section 1370; and (4) the patient is currently dangerous as the result of a mental disorder, defect or disorder. The conservatorship lasts for one year, just like any other LPS conservatorship, and can be extended indefinitely if a new conservatorship is obtained each year. MURCON patients also have the right to a yearly court review and/or jury trial to petition the court to remove the conservatorship.

Over the course of FY 2020-21, less than 11 Murphy Conservatorship patients were admitted into a state hospital. Chart 6 displays the admissions and total served distribution by state hospital for the LPS Murphy Conservatorship population in FY 2019-20 and FY 2020-21.

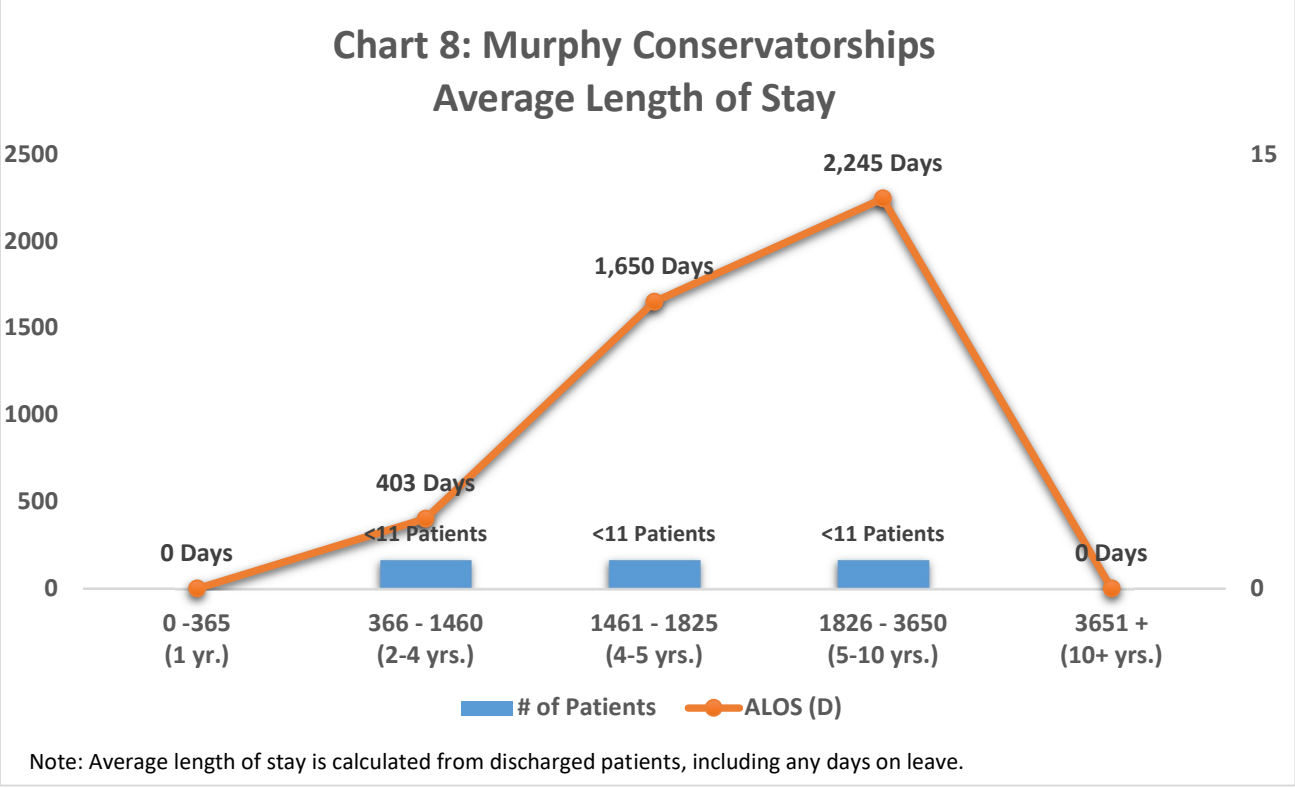


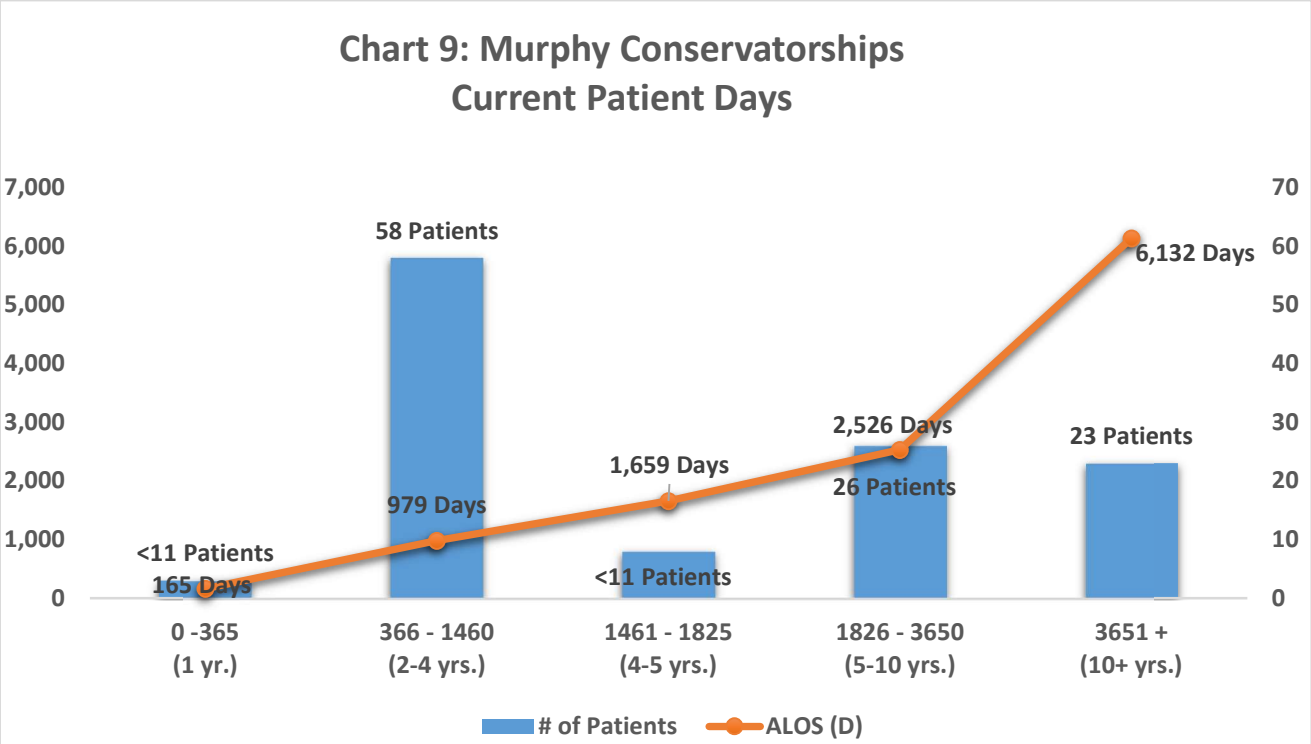
Note: Admissions and total served does not include patients transferred between facilites.

On average, 117 Murphy Conservatorship patients are treated daily in the state hospitals, representing 2 percent of the overall patient population in FY 2020-21. Chart 7 displays the average daily census (ADC) and total number of patients served for the MURCON population in FY 2020-21. As of June 30, 2021, the system-wide MURCON census was 118.



In FY 2020-21, less than 11 MURCON patients were discharged with an average length of stay of 3.9 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, 2021.





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.

POPULATION PROFILE
Not Guilty by Reason of Insanity Patients

DESCRIPTION OF LEGAL CLASS

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

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

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

LEGAL REQUIREMENTS/LEGAL STATUE FOR DISCHARGE

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

treatment in the community. During the second step of the process, the court must determine whether the patient has been fully restored to sanity. The court's finding of restoration will result in the patient's unconditional release from supervision. A patient may bypass the mandatory one-year of outpatient commitment and have an early restoration hearing in the event the conditional release program director recommends an early release.

TREATMENT

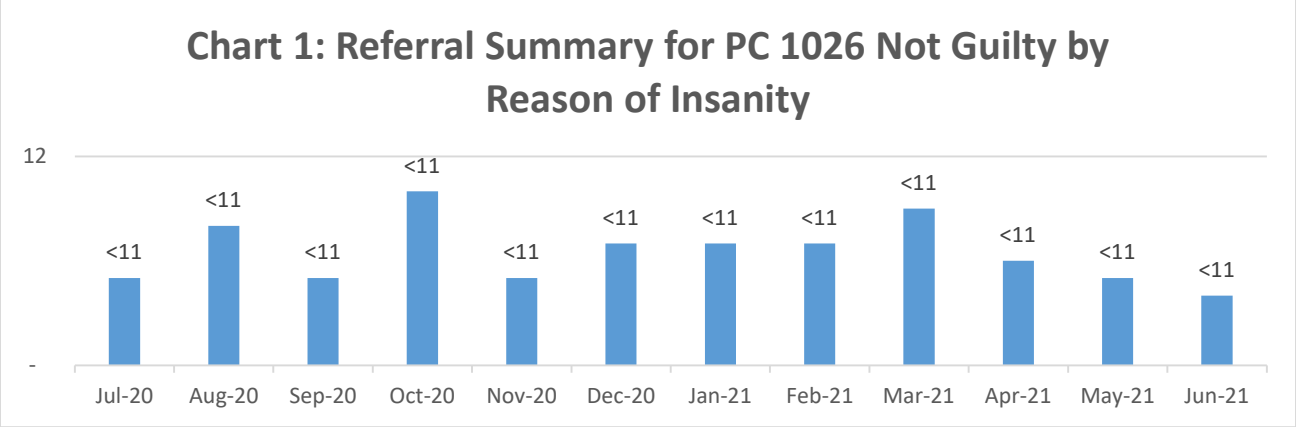
Because NGI patients tend to be severely mentally ill and their crimes involve severe violence, treatment requires substantial time resources. The treatment team must demonstrate to the court that the NGI patient has achieved long-term stabilization and no longer poses a danger due to their mental illness. Thus, the patient needs to demonstrate long-term symptom stability, long-term adherence to psychiatric treatments, and an understanding of the factors that exacerbate their mental illness. Each NGI patient's progress in treatment is evaluated and submitted to the court via an annual report completed by the DSH treatment team and medical director of the state hospital. 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 to extend the stay of the individual, pursuant to Penal Code (PC) 1026.5. In Fiscal Year (FY) 2020-21, 421 patients were served at the state hospitals under this extension option.

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

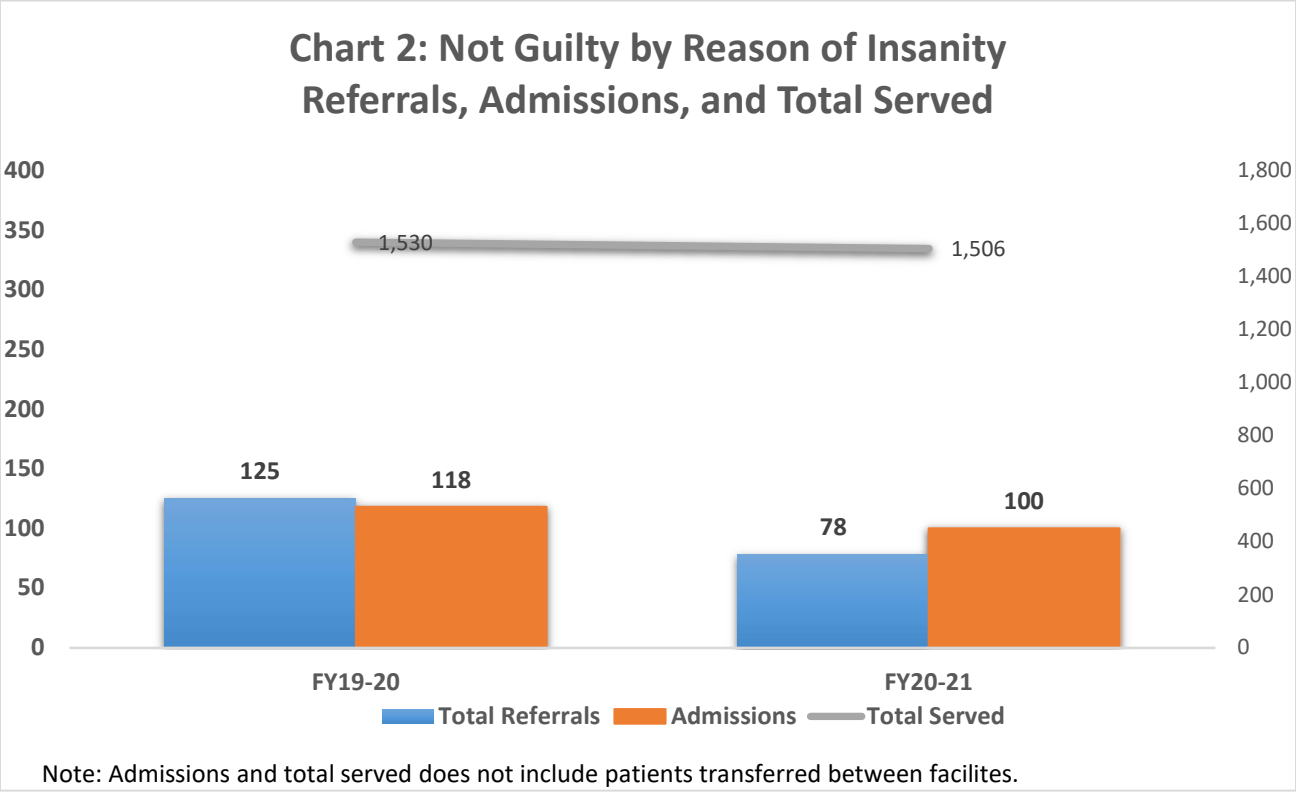
Although NGI patients are admitted to DSH because of severe mental illness and dangerousness, NGI patients have the right to refuse treatment unless that right is removed by case law or regulation, as guided by the *Greenshields* involuntary medication order process. This can effectively lengthen the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

POPULATION DATA

In FY 2020-21, 78 NGI patients were committed to the state hospitals, a 38 percent decrease from FY 2019-20. Chart 1 depicts the monthly referrals of NGI patients to DSH.

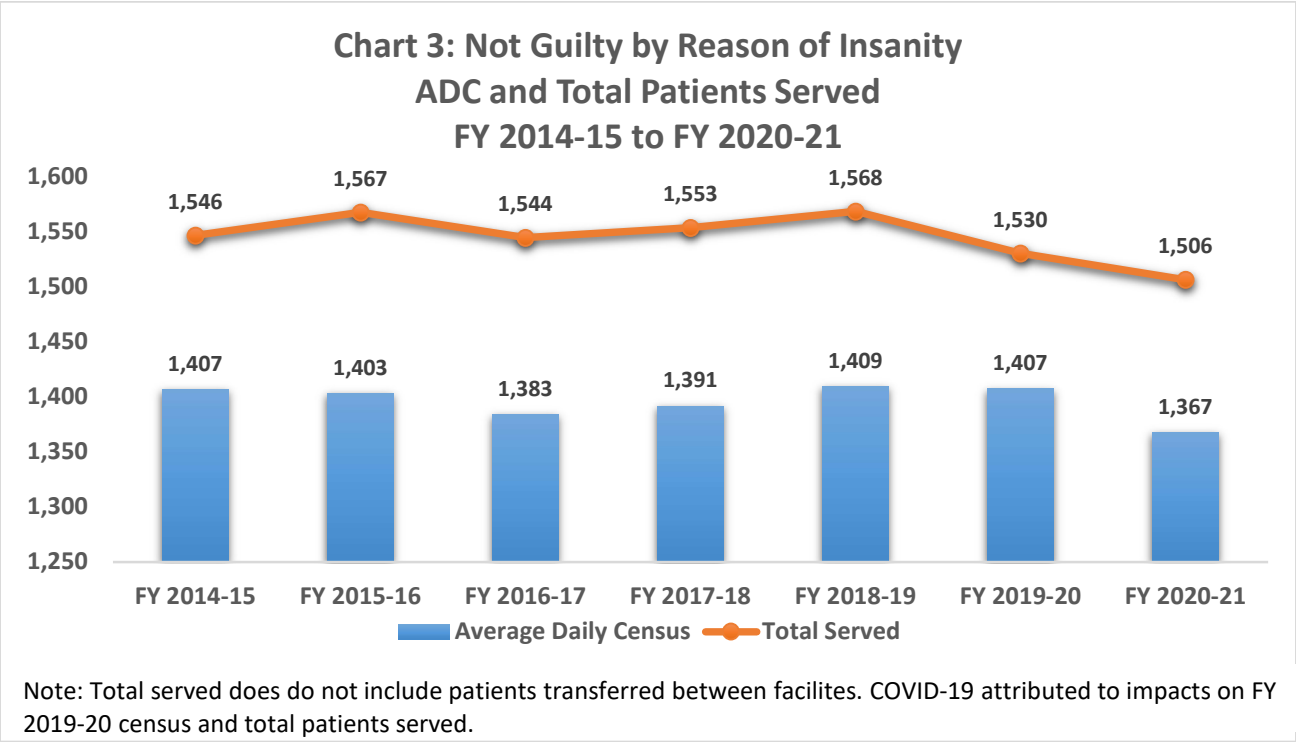


Over the course of FY 2020-21, 100 NGI patients were admitted into a state hospital which is a decrease of 15 percent from the prior year. Chart 2 displays the referrals, admissions and total patients served for the NGI population for FY 2019-20 and FY 2020-21.



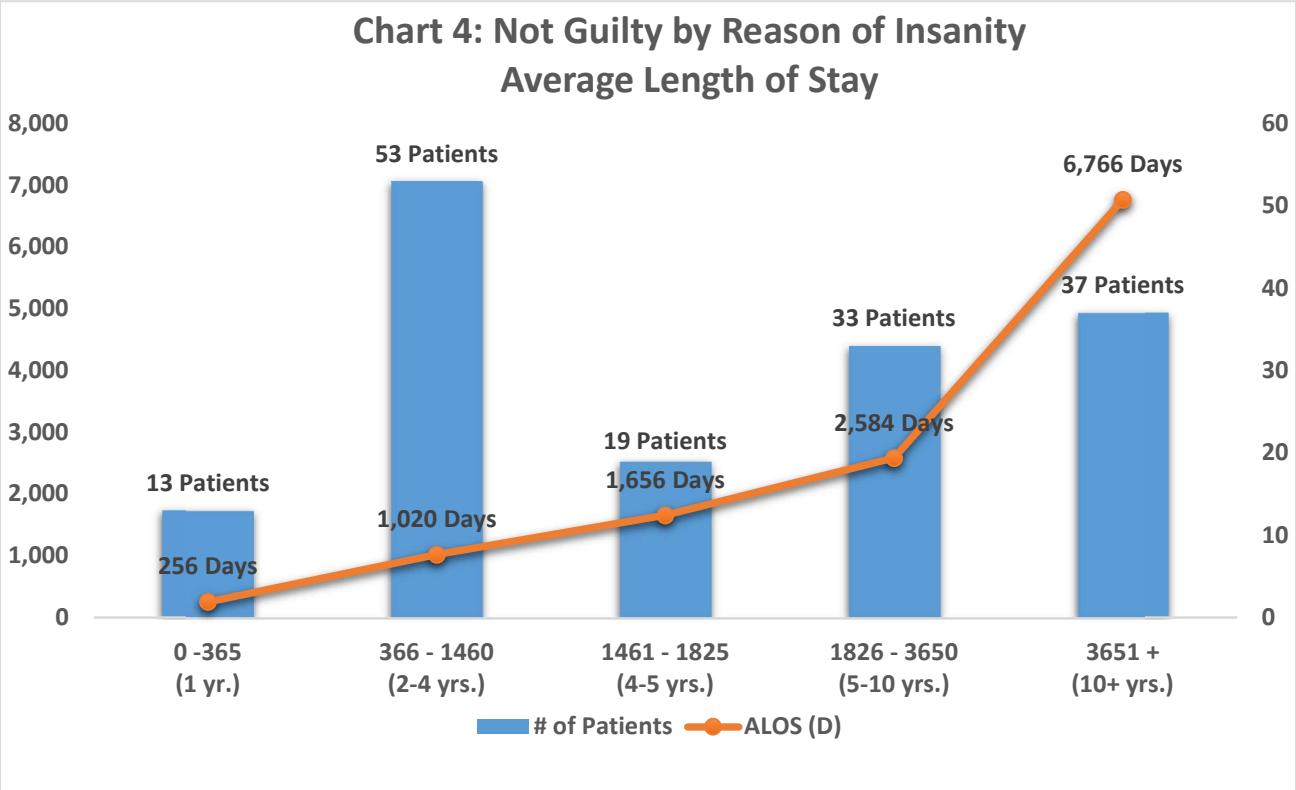
Note: Admissions and total served does not include patients transferred between facilites.

Chart 3 displays the average daily census (ADC) and total number of patients served for the NGI population during FY 2014-15 to FY 2020-21. On average, 1,367 NGI patients are treated daily in the state hospitals, representing 23 percent of the overall patient population. As admissions directly correlate to patients served, DSH served 2 percent less patients in FY 2020-21 than in the prior year. As of June 30, 2021, the system-wide NGI census was 1,336 patients.



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

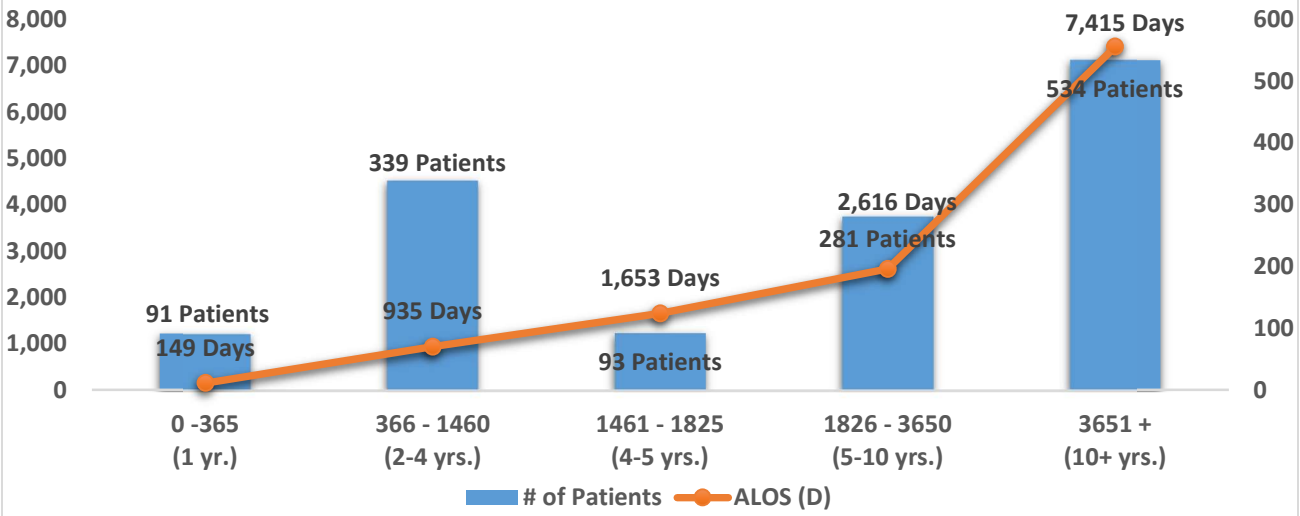
In FY 2020-21, 155 NGI patients were discharged with an average length of stay of 7.5 years. Chart 4 displays the distribution of lengths of stay for all discharged NGI patients.



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 1,338 NGI patients who continue to reside at DSH as of June 30, 2021 have been there for 3,871 days, or 10.6 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, 2021.

Chart 5: Not Guilty by Reason of Insanity
Current Patient Days



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

POPULATION PROFILE
Offenders with a Mental Health Disorder

DESCRIPTION OF LEGAL CLASS

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

Parolees who committed one of a specified 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 the Board of Parole Hearings (BPH) to determine if (1) the parolee still meets the six criteria for OMD classification and (2) whether the parolee can be treated on an outpatient basis. The length of a parole period is determined by statute and depends on the type of sentence imposed. Parole terms can extend beyond the maximum parole period due to revocation or escape attempts. A parole period can be waived at the discretion of BPT. 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

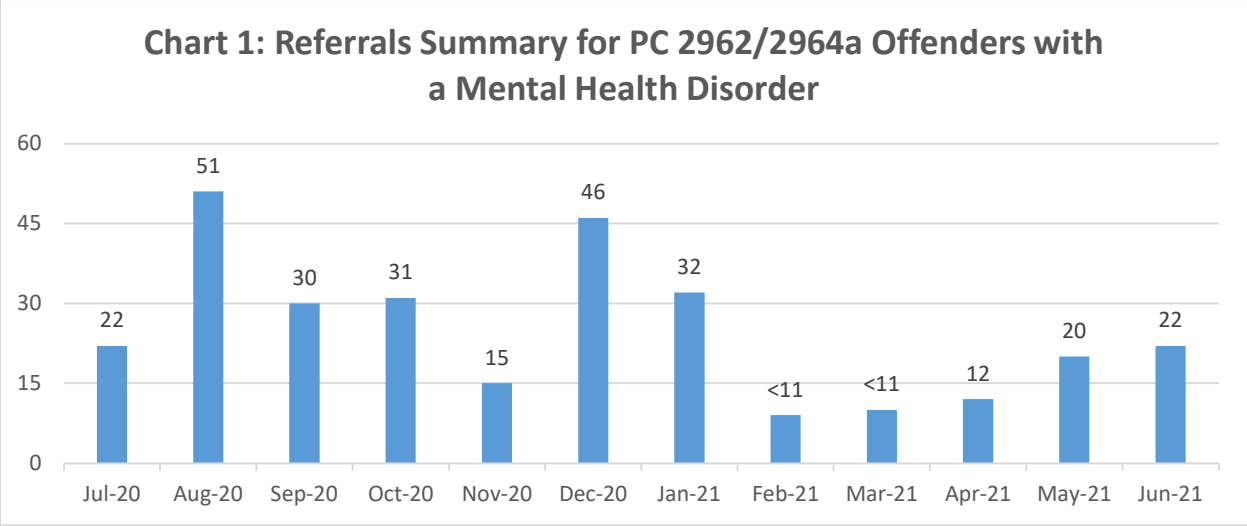
OMD patients have unique needs and challenges. Because their crimes involve violence, many have spent years in prison and need specialized psychosocial treatments to aid in their reintegration back into society. Due to the seriousness and long-term nature of their mental illness, as well as a history 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 CONREP. Another area of focus is substance abuse treatment since a history of substance abuse is prevalent in most OMD patients. Other goals are to motivate patients for treatment, develop greater self-autonomy and independence, and the mastery of self-discipline and Activities of Daily Living (ADL) skills. Examples of ADL skills include practicing good hygiene, grooming, and feeding.

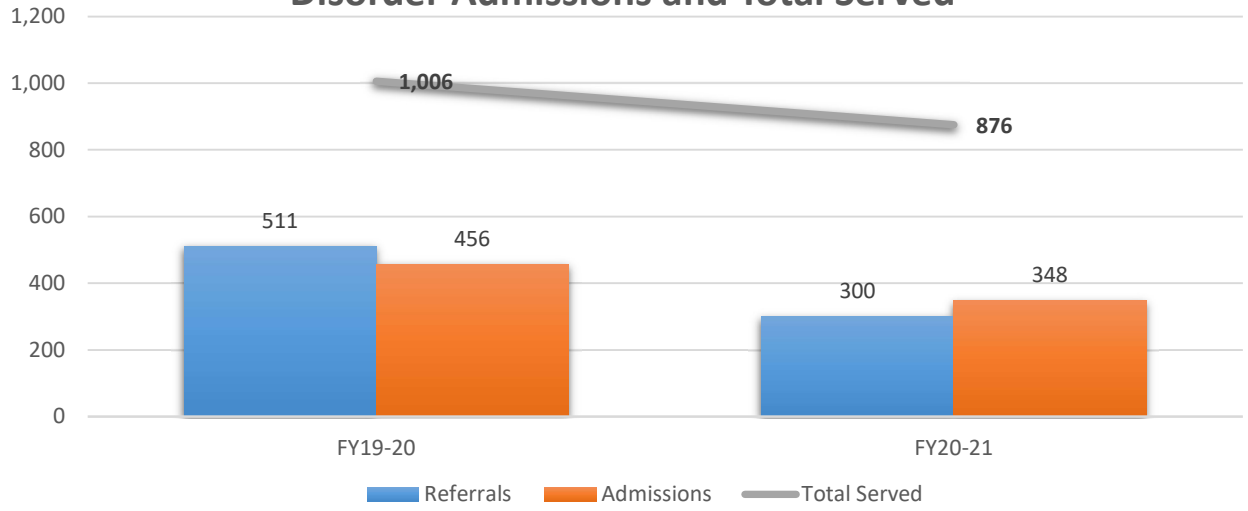
POPULATION DATA

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

In Fiscal Year (FY) 2020-21, 300 PC 2962/2964a OMD patients were committed to the state hospitals, a 41 percent decrease from FY 2019-20.

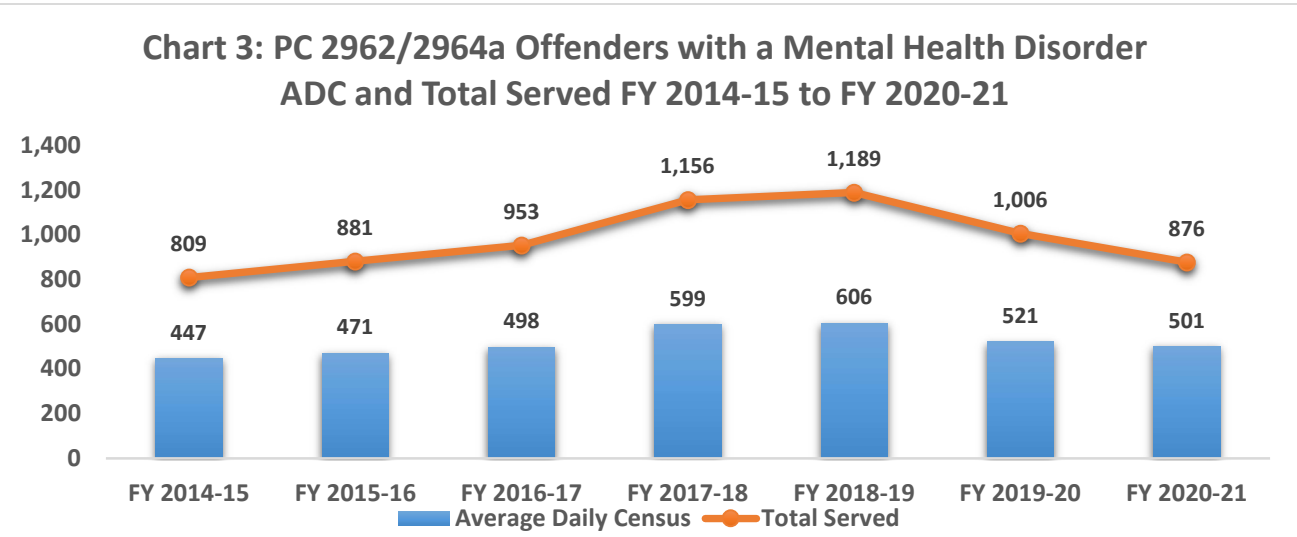


Over the course of FY 2020-21, 348 PC 2962/2964a OMD patients were admitted into a state hospital. Chart 2 displays the referrals, admissions and total patients served for the PC 2962/2964a OMD population in FY 2020-21.



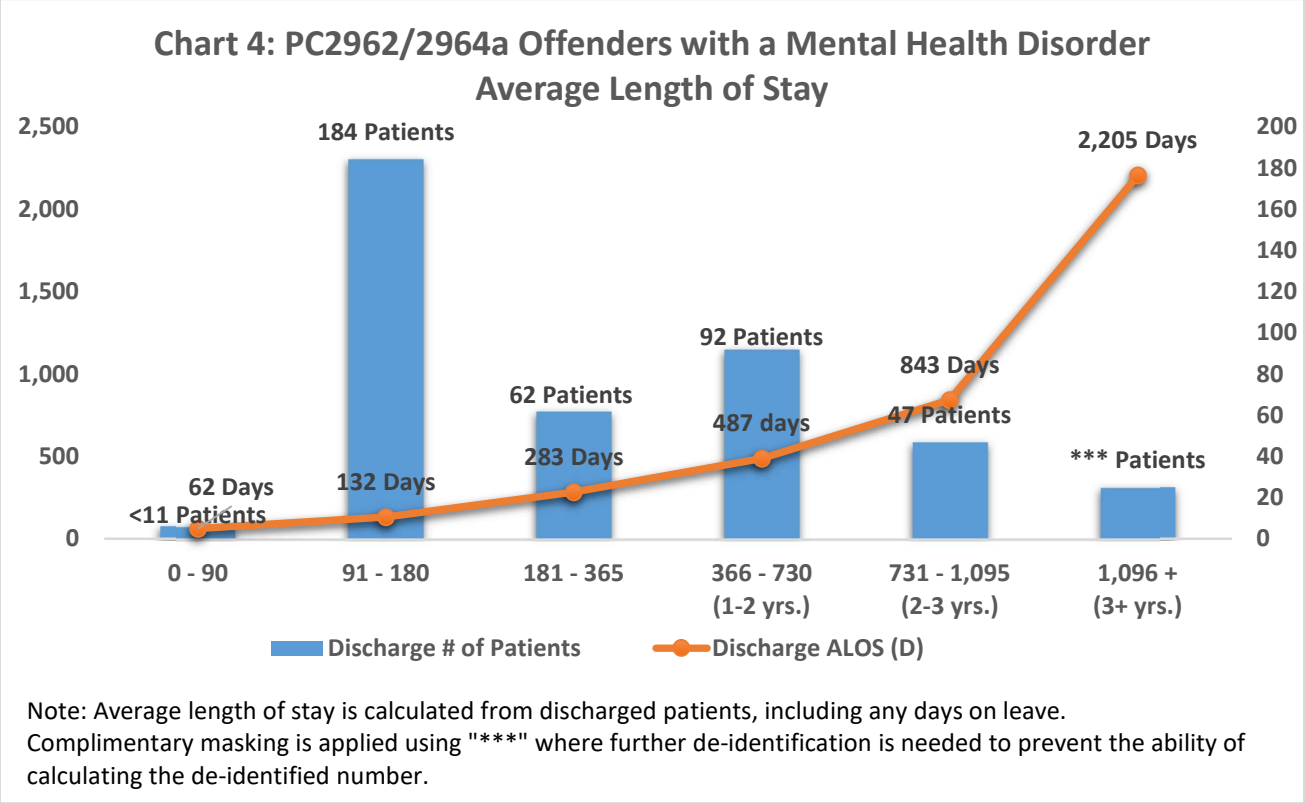
Note: Admissions and total served does not include patients transferred between facilites.

Chart 3 displays the average daily census (ADC) and total number of patients served for the PC 2962/2964a OMD population during FY 2014-15 to FY 2020-21. On average, 501 PC 2962/2964a OMD patients are treated daily in the state hospitals, representing 9 percent of the overall patient population. As of June 30, 2021, the system-wide PC 2962/2964a OMD census was 413 patients.



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

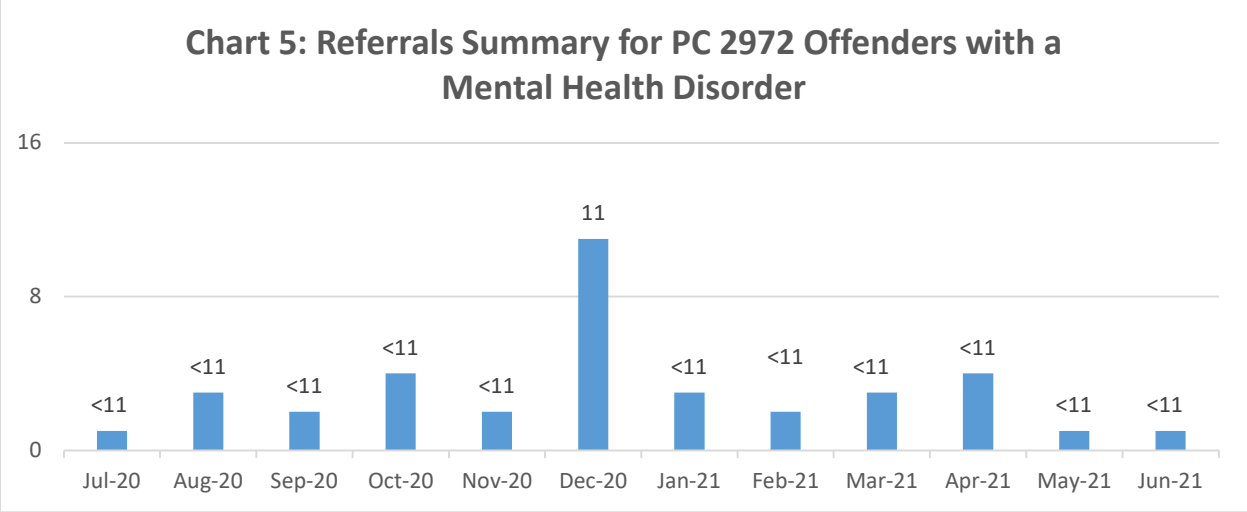
Chart 4 displays the distribution of lengths of stay for all discharged PC 2962/2964a OMD patients. In FY 2020-21, 416 PC 2962/2964a OMD patients were discharged with an average length of stay of 437 days, a little more than 1 year.



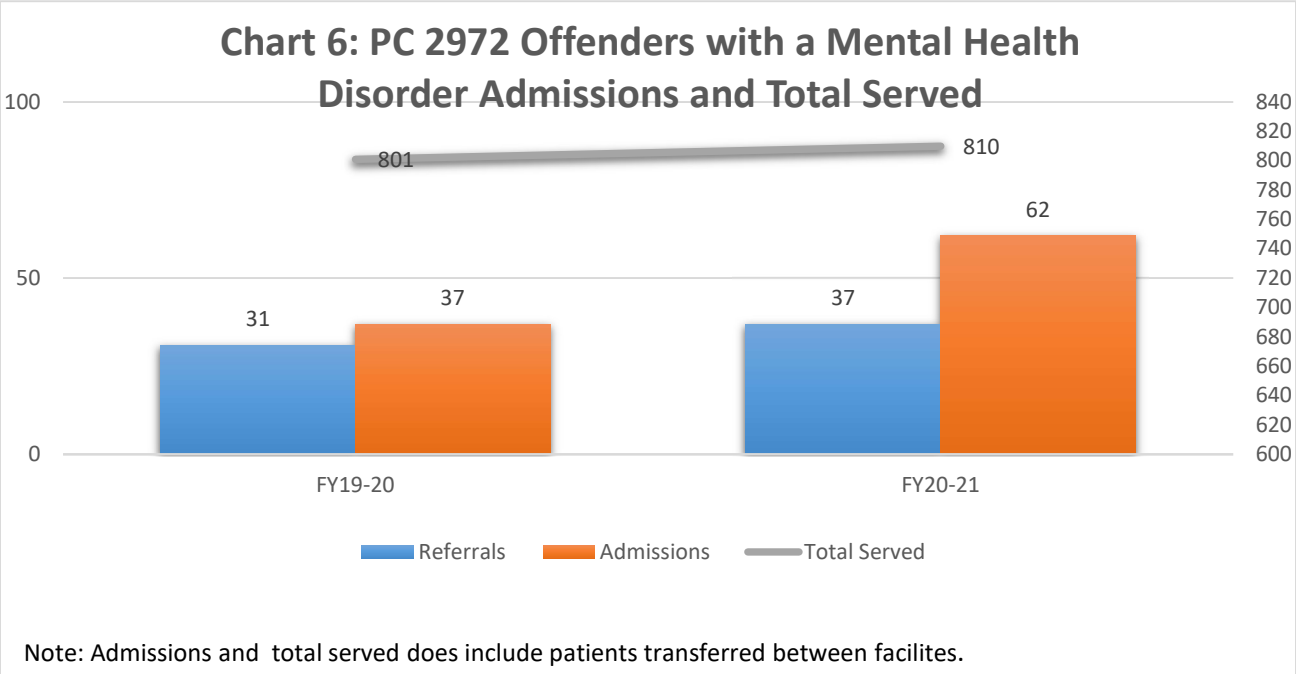
Note: Average length of stay is calculated from discharged patients, including any days on leave. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

PC 2972 Offenders with a Mental Health Disorder (OMD)

In Fiscal Year (FY) 2020-21, 37 PC 2972 OMD patients were committed to the state hospital, a 19 percent increase from FY 2019-20.



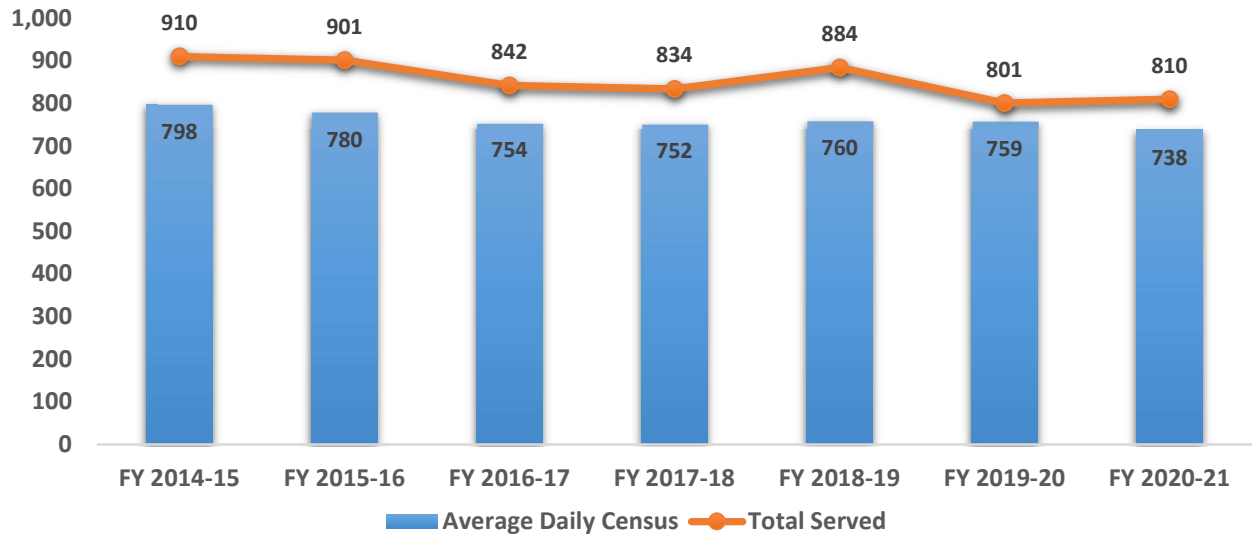
Over the course of FY 2020-21, 62 PC 2972 OMD patients were admitted (including transfer admissions) to a state hospital. Chart 6 displays the referrals, admissions and total patient served for the PC 2972 OMD population in FY 2020-21.



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

Chart 7 displays the average daily census (ADC) and total number of patients served for the PC 2972 OMD population during FY 2014-15 to FY 2020-21. On average, 738 PC 2972 OMD patients are treated daily in the state hospitals, representing 13 percent of the overall patient population. As of June 30, 2021, the system-wide PC 2972 OMD census was 717 patients.

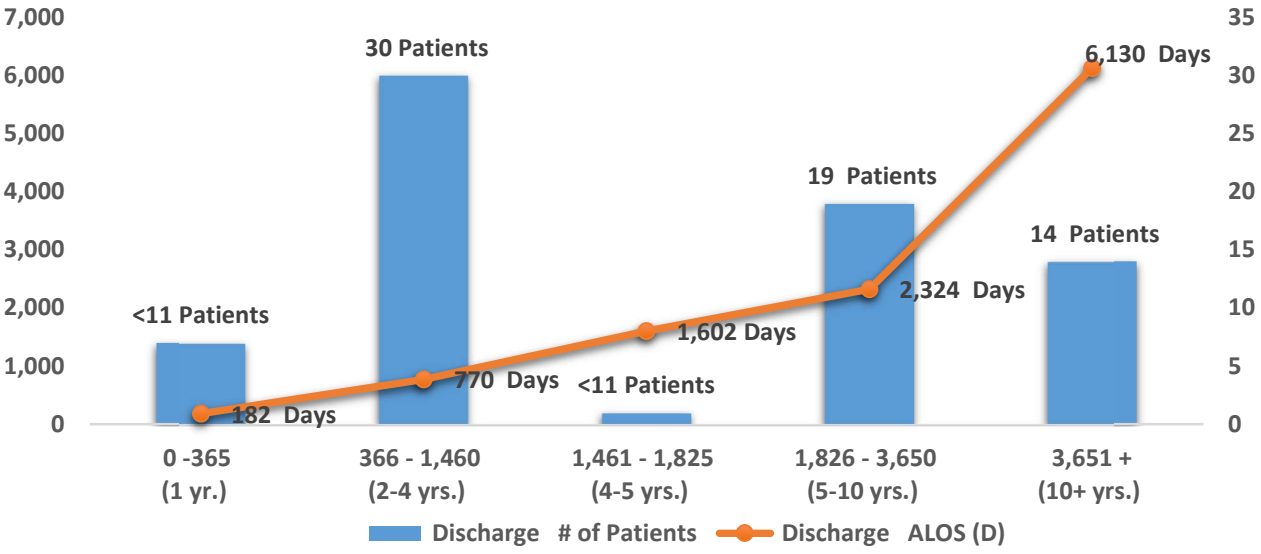
Chart 7: PC 2972 Offenders with a Mental Health Disorder
ADC and Total Served FY 2014-15 to FY 2020-21



Note: Total served does include patients transferred between facilites.

In FY 2020-21, 71 PC 2972 OMD patients were discharged with an average length of stay of 6 years. Chart 8 displays the distribution of lengths of stay for all discharged PC 2972 OMD patients.

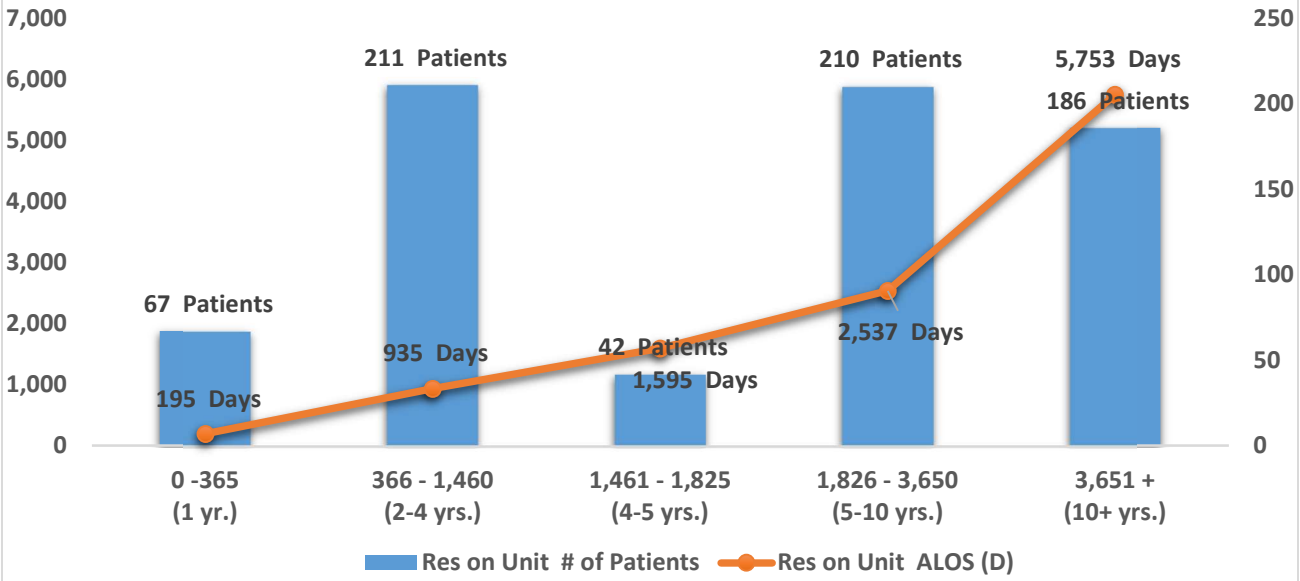
Chart 8: PC 2972 Offenders with a Mental Health Disorder
Average Length of Stay



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

Chart 9 displays the distribution of patient days for all PC 2972 OMD residents on unit as of June 30, 2021. On average, the 716 PC 2972 OMD patients who continue to reside at DSH as of June 30, 2021 have been there for 2,626 days or a little over 7 years; these days will continue to accrue until the individual PC 2972 OMD patients have been discharged.

Chart 9: PC 2972 Offenders with a Mental Health Disorder
Current Patient Days



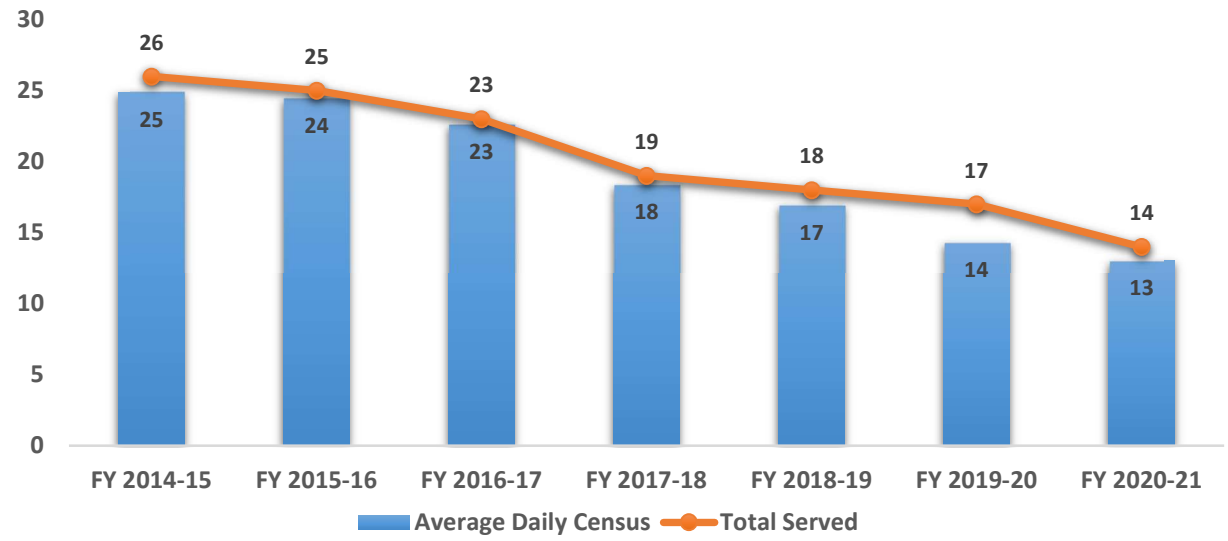
Note: Current patient days is, as of a particular point in time, the number of days residents-on-unit have spent in the state hospital, including leave.

WIC 6316 Mentally Disordered Sex Offender (MDSO) Patients

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

Chart 10 displays the average daily census (ADC) and total number of patients served for the WIC 6316 MDSO population during FY 2014-15 to FY 2020-21. On average, 13 WIC 6316 MDSO patients are treated daily in the state hospitals, representing 0.2 percent of the overall patient population. As of June 30, 2021, the system-wide WIC 6316 MDSO census was 12 patients.

Chart 10: WIC 6316 Offenders with a Mental Health Disorder ADC and Total Served FY 2014-15 to FY 2020-21



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

In FY 2020-21, WIC 6316 MDSO patients that discharged had an average length of stay of over sixteen years. For the 12 WIC 6316 MDSO patients who continue to reside at DSH, they have been there for 2,737 days, or 7.5 years. These days will continue to accrue until the individual WIC 6316 MDSO patients have been discharged.

POPULATION PROFILE
Sexually Violent Predator Patients

DESCRIPTION OF LEGAL CLASS

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

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

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

WIC 6602	An individual who has been identified as likely to engage in sexually violent predatory criminal behavior upon release and will remain in custody until the completion of the probable cause hearing 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) 2020-21, 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, relapse prevention/wellness, and recovery action planning are emphasized and reinforced across all clinical disciplines and treatment modalities.

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

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

Before being recommended for release, the SVP patient must demonstrate long-term stability and adherence to treatments, as well as demonstrate an understanding of their sexual violence risk factors and patterns of thinking that relates to their criminal activity patterns. Furthermore, the SVP patient must be able to

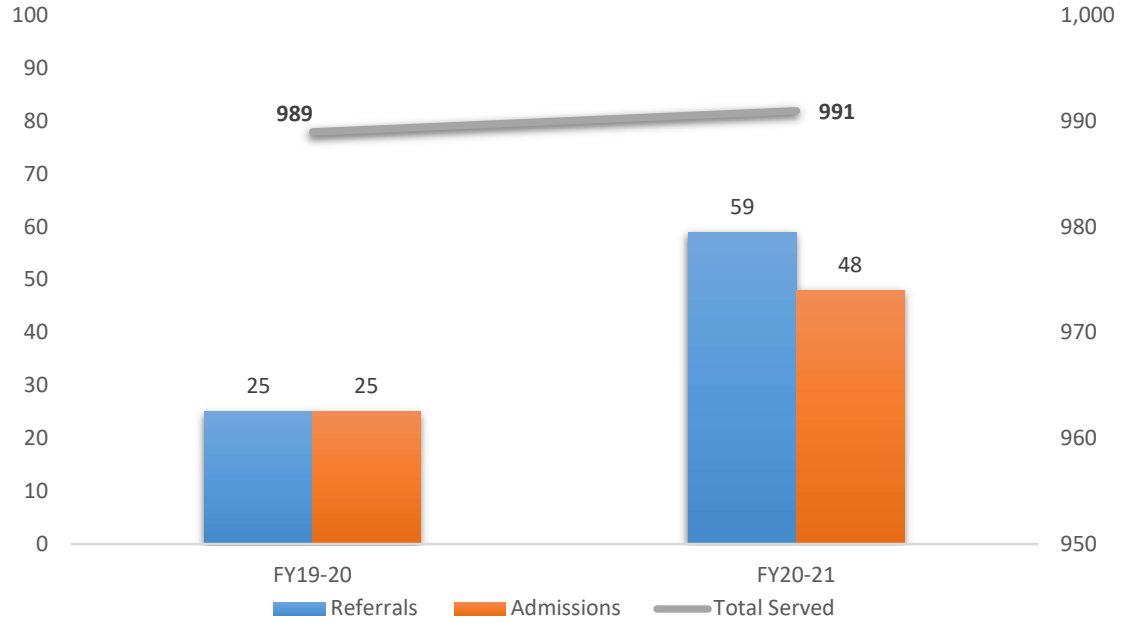
demonstrate that they would take preventive actions to avoid or mitigate any factors that would increase their sexual violence risk.

Although SVP patients are admitted to DSH because of severe mental illness and dangerousness, all patients (including SVPs) have the right to refuse treatment, unless individually directed by a court to comply. This can effectively lengthen the patient stay at the state hospital if a patient chooses not to actively engage or fully participate in the treatments recommended by their treatment team.

POPULATION DATA

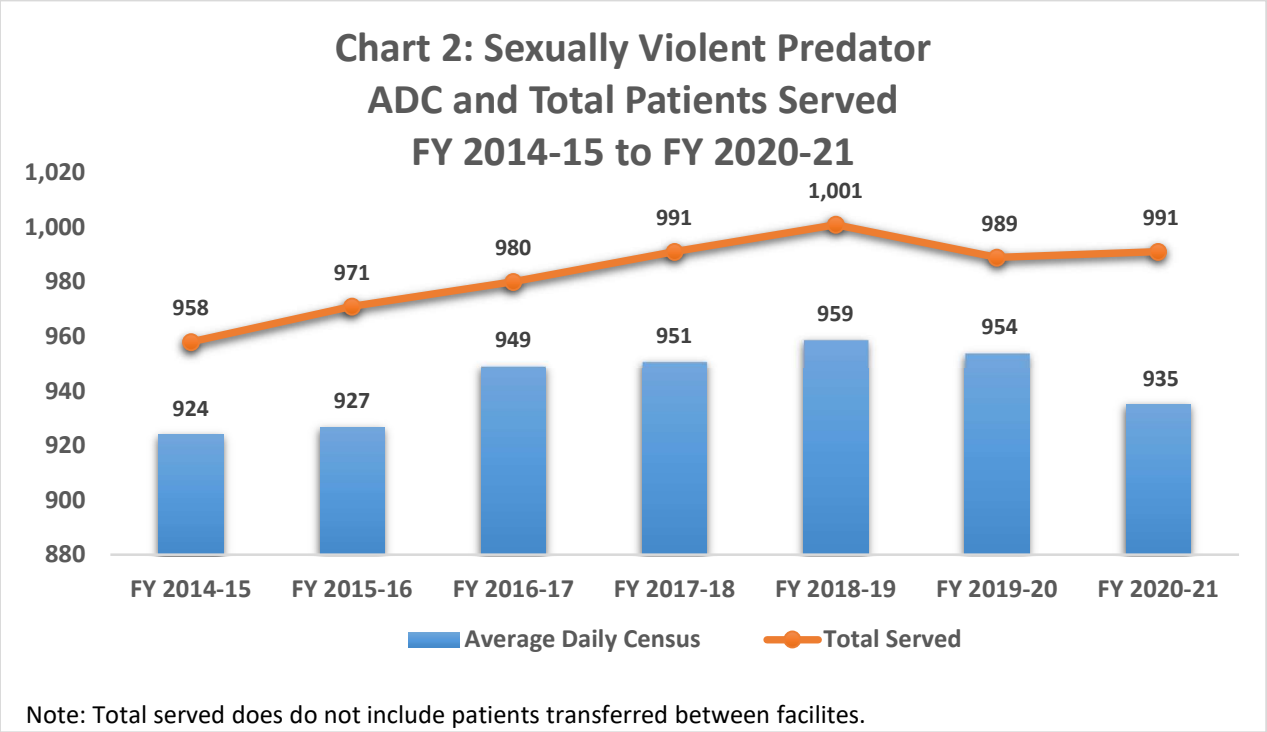
In Fiscal Year (FY) 2020-21, 59 SVP patients were committed, of which 48 SVP patients were admitted into a state hospital. Chart 1 displays the referrals, admissions, and total patients served for the SVP population in FY 2019-20 and FY 2020-21.

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



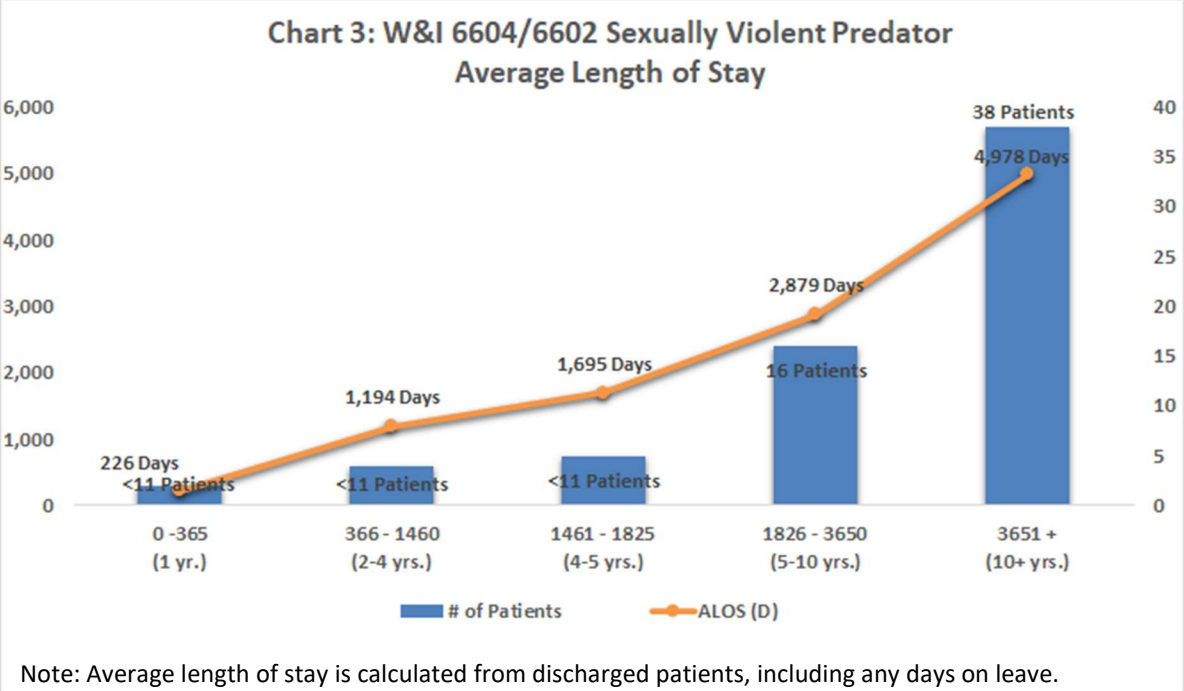
Note: Admissions and total served does not include patients transferred between facilites.

Chart 2 displays the average daily census (ADC) and total number of patients served for the SVP population during FY 2014-15 to FY 2020-21. On average, 935 SVP patients are treated daily in the state hospitals, representing 16 percent of the overall patient population. As of June 30, 2021, the system-wide SVP census was 926 patients.



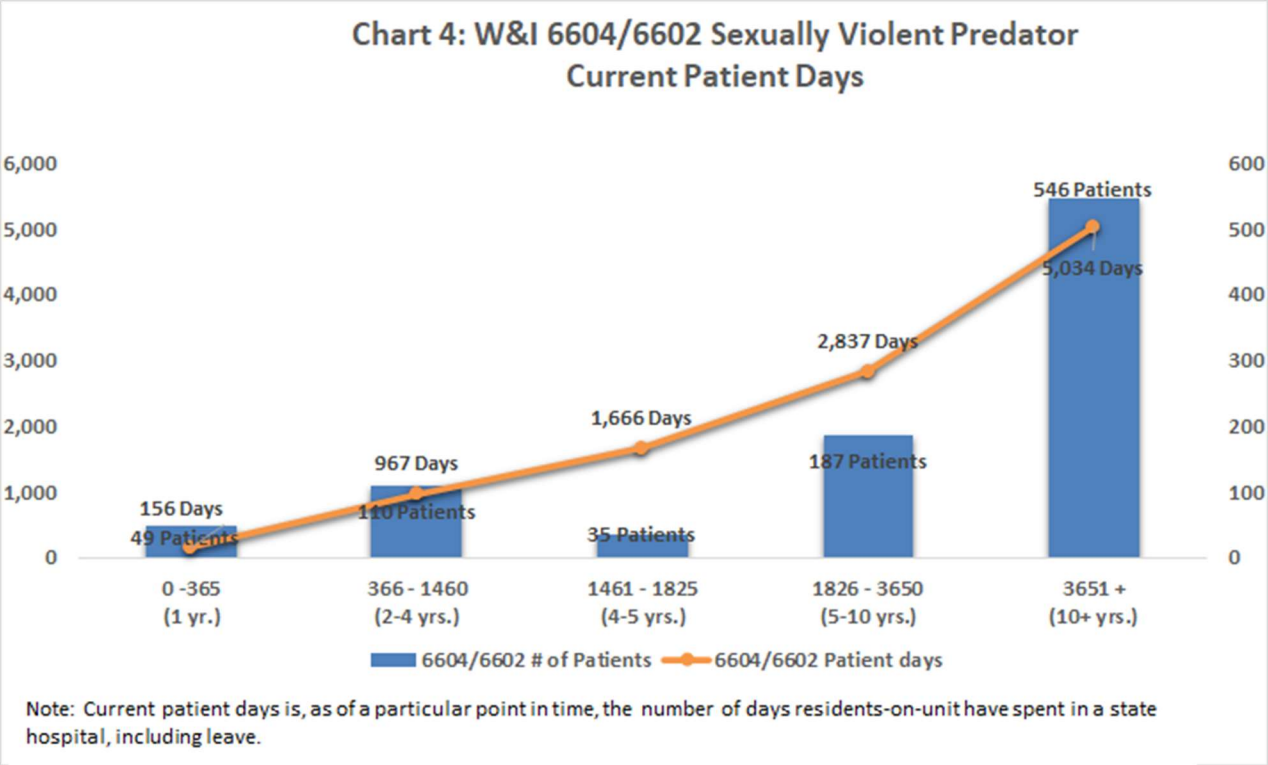
Note: Total served does do not include patients transferred between facilites.

In FY 2020-21, 65 SVP patients were discharged with an average length of stay of 10.5 years. Chart 3 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.

Chart 4 displays the patient days for all SVP patients that remained on census as of June 30, 2021. On average, the 927 SVP patients who continue to reside at DSH as of June 30, 2021 have been there for an average of 3,723 days, or 10 years.



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

Department of State Hospitals – Atascadero

HISTORY

The Department of State Hospitals-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) 2020-21, DSH-Atascadero served 1,750 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 2,248 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 delivery of group psychotherapy, psychoeducational and rehabilitation treatment specific to the patients' needs.

When indicated, individual patient psychotherapy, vocational training, and educational training are also provided.

Treatment Plan

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

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

accepted professional standards of care. Such plans are developed and reviewed on a regular basis in collaboration with the patient.

Treatment Team

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

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

Provision of Treatment, Rehabilitation, and Supplemental Activities

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

Recovery and Mall Services (RMS)

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

The RMS department offers Interfaith Services, Volunteer Services, Library Services— through the Logan Library – Patient and Professional Libraries, Aztec Adult School, Graphic Arts Services, Barbershop Services, and Substance Use Recovery Services. In addition, RMS also offers Vocational Training Programs that include Printing/Graphic Arts and Landscape Gardening. Furthermore, RMS

offers scheduled hospital wide supplemental activities, events and meetings including but not limited to: Phoenix Club, Incentive Bingo and Community Center, Evening Open Gym, Monthly Birthday Party and the Hospital Advisory Council meetings.

Central Medical Services (CMS)

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

Enhanced Treatment Program (ETP)

The Enhanced Treatment Program (ETP) is a 4-year pilot within the California Department of State Hospitals (DSH). The ETP is designed to provide enhanced treatment in a secure setting for patients at the highest risk of most dangerous behavior. The ETP is intended to provide increased therapy opportunities within a structured, least restrictive environment. The ETP is to be utilized when safe treatment is not possible in a standard treatment environment. The pilot is driven by Assembly Bill 1340. Unit 29 opened in September 2021.

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

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 whether or not certain conditions or reporting requirements should be implemented to maintain accreditation status. TJC standards deal with subject matter such as organization quality, patient safety, provision of care, treatment and services, as well as the environment in which care is provided.

DSH-Atascadero is licensed by the California Department of Public Health. 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 below 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 located at the edge of the Coastal Mountain Range on the western side of Fresno County. Coalinga is halfway between Los Angeles and San Francisco and 60 miles southwest of Fresno.

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

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,500 beds. In Fiscal Year (FY) 2020-21, DSH-Coalinga served 1,462 patients. The commitment categories of patients treated at DSH-Coalinga are as follows:

Patient Commitments	Penal Code
Lanterman-Petris Short	5358 (WIC)
Offender with a Mental Health Disorder	2972
Coleman/CDCR	2684
Not Guilty by Reason of Insanity	1026
Sexually Violent Predators	6602/6604

HOSPITAL STAFF

Approximately 2,425 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 patient to acquire pro-social skills and to prevent recurrence of sexual offending. The program combines components of the Self-Regulation/Better Life models with the principles of Risk-Need-Responsivity (RNR). This combined approach strengthens the patient's self-regulation skills to prepare for a life free of sexual offending. The three principals of the RNR model are explained here in more detail.

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

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

The responsivity principle states that services should be delivered in a manner that is engaging and consistent with the learning style of the individual. Examples include fostering strengths; establishing meaningful relationships; and attending to relevant characteristics such as age, cognitive skills, cultural factors, and

emotional regulation issues. It also states that the primary treatment components should use social learning and cognitive-behavioral approaches.

Empirical studies indicate that adhering to RNR principles can maximize treatment effects and reduce recidivism.

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

LICENSURE

DSH-Coalinga is licensed by the California Department of Public Health. DSH-Coalinga has two units designated as acute psychiatric. An acute psychiatric facility means having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary services. In addition, DSH-Coalinga 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 unlicensed 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 below for a brief description of DSH-Coalinga's training programs.

DSH-Coalinga Training Programs

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

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

[2] **Psychiatric Technicians:** 1. Psychiatric Technician Trainees are currently enrolled in a Psychiatric Technician School and work part time inside DSH hospitals (up to 20 hours/week). 2. Pre-Licensed Psychiatric Technicians are graduates from Psychiatric Technician School but have not yet passed the state licensing exam. They are limited to 9 months in that role (test must be passed within the 9 months) and work full time with some limitations on their job responsibilities. 3. 20/20

Psychiatric Technician training programs are open to current employees that have been accepted into a Psychiatric Technician School. The modified work hours shall be a maximum of twelve (12) months in length and the amount of the 20/20 time utilized by each selected employee will depend on the type of education/training programs available.

[3] **Recreational Therapy Internship:** Recreational Therapy Internship Candidates are in their final semester of their degree and are required to complete a minimum of a 14-week 560-hour internship. Partners can be made with any accredited school in the country with a Recreational Therapy or Therapeutic Recreation program. The specific DSH-C Recreation Therapy Internship Program lasts for a minimum of 17-weeks due to New Employee Orientation. Once completed, students are eligible for national certification with National Council for Therapeutic Recreation Certification (NCTRC). To ensure the safety and well-being of students, patients, and staff, the internship is designed to follow the guidelines outlined in the American Therapeutic Recreation Association (ATRA) Code of Ethics. DSH-C is able to provide current opportunities for skill growth and professional development in accordance with American Music Therapy Association (AMATA) guidelines.

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

Department of State Hospitals – Metropolitan

HISTORY

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

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,106 beds. In Fiscal Year (FY) 2020-21, DSH-Metropolitan served 1,265 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 2,300 employees work at DSH-Metropolitan providing around-the-clock care, including psychiatrists, psychologists, social workers, rehabilitation therapists,–registered nurses, psychiatric technicians, and other clinical staff. In addition, there are various non-level of care staff at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, teachers and other administrative staff.

TREATMENT AND PROGRAMS

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

Research indicates DBT to be effective in reducing:

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

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

Each patient in the DBT Program participates in the following activities:

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

Other treatment programs include:

Trial Competency Program

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

Offender with a Mental Health Disorder (OMD) Program

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

Lanterman-Petris Short (LPS) Program

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

Skilled Nursing Facility (SNF)

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

ACCREDITATION AND LICENSURE

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

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

TRAINING AND PARTNERSHIPS

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

DSH-Metropolitan Training Programs

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

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

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

[3] **Psychiatric Technicians:** DSH-M offers 20/20 Psychiatric Technician training program for only Psychiatric Technician Assistants to become a Psychiatric Technician. The modified work hours shall be a maximum of twelve (12) months in length and the amount of the 20/20 time utilized by each selected employee will depend on the type of education/training programs available.

Department of State Hospitals – Napa

HISTORY

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

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,418 beds, but current maximum capacity is 1,374 beds. In Fiscal Year (FY) 2020-21, DSH-Napa served 1,591 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	2972
Not Guilty by Reason of Insanity	1026
Recommitment After Expiration of Prison Term (Must have concurrent W&I commitment)	2974
Department of Juvenile Justice	-

HOSPITAL STAFF

Approximately 2,607 employees work at DSH-Napa, providing round-the-clock care, including psychologists, psychiatrists, physicians, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, and other clinical staff. In addition, there are various non-level of care job classifications at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, and other administrative staff.

TREATMENT PROGRAMS

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

In addition to the living units there are other service sites. For instance, Mall Services provides a variety of off unit services for patients. Mall Services is a centralized approach to delivering services where the patients and staff from throughout the hospital come together to participate in services. Mall Services represents more of a centralized system of programming rather than a reference

to a specific building or certain location. The services are provided, as much as possible, in the context of real-life functioning and in the rhythm of life of the patient. Thus, Mall Services extends beyond the context of a "building or place," and its services are based on the needs of the patient, not the needs of the program, the staff members, or the institution. Vocational Services provides opportunities for patients to develop job skills and habits, as well as earn funds. Educational Services enables patients to continue their education, high school or college, and provide skills groups for anger management and development of interpersonal skills. Rehabilitation Therapy Services, facilitated by music, dance, art, occupational and recreation therapists, provide treatment groups to engage the patient in wellness and improved quality of life. Department of Medicine and Ancillary Services provides clinics that deliver various 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 issued, 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 below for a brief description of DSH-Napa's training programs.

DSH-Napa Training Programs

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

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

of Pharmacy, University of Montana, University of the Pacific (UOP), Western University of Health Science, Chapman University.

[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) 2020-21, DSH-Patton served 1,745 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 2,558 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 Offenders with a Mental Disorder (OMD) and Not Guilty by Reason of Insanity (NGI) population emphasizes the potential for each patient to learn new skills and adaptive coping mechanisms to 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 127 years.

Patton accepted its first patients on August 1, 1893. The museum, only the second of its kind west of the Mississippi River, features more than 140 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 below for a brief description of DSH-Patton's training programs.

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 12 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, and Marshal B Ketchum College of Pharmacy.

CALIFORNIA DEPARTMENT OF STATE HOSPITALS

REPORT ON STATE HOSPITAL FINANCIAL ACTIVITY

California Department of State Hospitals

FISCAL YEAR 2021-22

January 10, 2022






DIRECTOR
Stephanie Clendenin

EXECUTIVE SUMMARY

Pursuant to the Budget Act of 2021, 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 2021 Budget Act which requires DSH to provide a year-end summary and an operating budget for each state hospital with the fiscal year (FY) 2022-23 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 2020-21 year-end budget and expenditures by line-item detail for each institution
- The budgeted allocations for each institution for current and budget year
- The projected expenditures for current and budget years

DEPARTMENT OF STATE HOSPITALS OVERVIEW

DSH manages the nation's largest inpatient forensic mental health hospital system. Its mission is to provide evaluation and treatment in a safe and responsible manner, seeking innovation and excellence in state hospital operations, across a continuum of care and settings. DSH is responsible for the daily care and provision of mental health treatment of its patients. DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton) and employs nearly 13,000 staff. In addition to state hospital treatment, DSH provides services in contracted jail-based competency treatment (JBCT), community-based restoration (CBR), pre-trial felony mental health diversion programs and the conditional release program (CONREP). DSH is responsible for the daily care to over 7,000 patients, in FY 2020-21, DSH served 7,813 across the state hospitals, 2,403 in JBCT and CBR programs and 841 in CONREP programs. In addition, as of December 31, 2020, a total of 276 individuals were diverted into county programs funded by DSH.

SUMMARY OF AUTHORIZED AND VACANT POSITIONS

The following table provides a summary of the authorized and vacant positions for the state hospital system as of November 1, 2021.

State Hospital	Authorized Positions[1/2]	Vacant as of 11/1/21	Percent Vacant
Atascadero	2,248.1	389.0	17.3%
Coalinga	2,425.7	330.0	13.6%
Metropolitan	2,300.2	510.7	22.2%
Napa	2,607.1	346.2	13.3%
Patton	2,558.4	289.7	11.3%
Totals	**12,139.5**	**1,865.6**	**15.4%**

[1]Includes authorized Temporary Help per the Schedule 7A.
[2]Includes positions approved for Estimate Items Enhanced Treatment Program (28.0 in Atascadero and 2.1 in Patton) and Metropolitan State Hospital Increased Secure Bed Capacity (120.6 in Metropolitan) that will not be filled due to COVID-19 impacts to these as described in the 2022-23 Governor's Budget Estimate.

AUTHORIZED VERSUS VACANT POSITIONS BY CLASSIFICATION

As of November 1, 2021, DSH's vacancy rate is 15.4 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	44.2	35.2	36.6	19.6	70.3	44.3	55.4	11.7	66.5	33.0
Psychologist	9873	44.7	10.7	36.9	11.9	44.0	9.0	51.4	4.9	61.2	15.9
Senior Psychiatric Technician	8252	104.2	26.2	88.0	15.0	82.7	28.7	83.0	17.0	81.0	0.0
Rehabilitation Therapist	Various	56.0	8.0	45.3	4.3	56.0	11.3	62.1	5.1	71.3	7.3
Registered Nurse	8094	244.8	45.8	232.0	13.0	294.1	75.1	461.2	52.0	362.1	37.1
Clinical Social Worker	9872	46.1	4.1	44.3	5.3	58.3	13.3	56.2	3.7	70.0	6.0
Psychiatric Technician	8253	632.7	104.7	715.7	107.5	486.5	125.5	464.0	67.8	714.6	54.6
Physician/Surgeon	7552	16.0	3.0	17.0	7.0	26.4	4.4	24.7	0.2	29.0	4.0

TEMPORARY HELP BLANKET POSITIONS

Temporary help blanket positions are utilized to offset vacancies and overtime. The following table provides a summary of authorized temporary help blanket positions for the state hospitals as of November 1, 2021. The Department is continuing to evaluate the use of internal registry positions to determine the appropriate temporary help position authority.

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

STATE HOSPITAL ALLOCATIONS AND EXPENDITURES

Exhibit I (attached) provides detail on the budget and expenditures for all five state hospitals and each facility individually, listed by FI$Cal account code for FY 2020-21. For FY 2021-22 and FY 2022-23, Exhibit II (attached) displays the projected budget and expenditures for all five hospitals and each facility individually. Any anticipated savings due to delayed projects or unit activations have been reflected in these allocations and projected expenditures.

Exhibit I—All Hospitals[1]

		2020-21 Budget	2020-21 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$654,364,000	$654,562,000
	5100150-Earnings - Temporary Civil Service Employees	$31,863,000	$31,873,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$112,409,000	$112,443,000
Salaries and Wages Total		**$798,636,000**	**$798,878,000**
Staff Benefits	5150150-Dental Insurance	$1,141,000	$1,059,000
	5150200-Disability Leave - Industrial	$13,014,000	$12,072,000
	5150210-Disability Leave - Nonindustrial	$4,034,000	$3,742,000
	5150350-Health Insurance	$21,947,000	$20,358,000
	5150400-Life Insurance	$64,000	$59,000
	5150450-Medicare Taxation	$12,983,000	$12,043,000
	5150500-OASDI	$8,407,000	$7,798,000
	5150600-Retirement - General	$167,689,000	$155,549,000
	5150700-Unemployment Insurance	$755,000	$700,000
	5150750-Vision Care	$217,000	$201,000
	5150800-Workers' Compensation	$42,383,000	$39,315,000
	5150900-Staff Benefits - Other	$183,611,000	$170,318,000
Staff Benefits Total		**$456,245,000**	**$423,214,000**
Operating Expenses and Equipment	5301400-Goods - Other	$5,536,000	$5,643,000
	5302900-Printing - Other	$638,000	$650,000
	5304800-Communications - Other	$1,716,000	$1,749,000
	5306700-Postage - Other	$164,000	$167,000
	5308900-Insurance - Other	$603,000	$614,000
	5320490-Travel - In State - Other	$831,000	$847,000
	5320890-Travel - Out of State - Other	$3,000	$3,000
	5322400-Training - Tuition and Registration	$738,000	$752,000
	5324350-Rents and Leases	$19,971,000	$20,352,000
	5326900-Utilities - Other	$17,297,000	$17,627,000
	5340330-Consulting and Professional Services - Interdepartmental - Other	$4,294,000	$4,376,000
	5340580-Consulting and Professional Services - External - Other	$117,895,000	$120,145,000
	5344000-Consolidated Data Centers	$46,000	$47,000
	5346900-Information Technology - Other	$63,000	$64,000
	5368115-Office Equipment	$9,140,000	$9,314,000
	5390900-Other Items of Expense - Miscellaneous	$71,775,000	$73,145,000
	5415000-Claims Against the State	$15,000	$15,000
	5490000-Other Special Items of Expense	$3,216,000	$3,277,000
Operating Expenses and Equipment Total		**$253,941,000**	**$258,787,000**
Grand Total		**$1,508,822,000**	**$1,480,879,000**

[1]Budget and expenditure do not include reimbursements.

Exhibit I—Atascadero State Hospital[2/3]

		2020-21 Budget	2020-21 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$123,661,000	$129,089,000
	5100150-Earnings - Temporary Civil Service Employees	$7,081,000	$7,391,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$15,456,000	$16,134,000
Salaries and Wages Total		**$146,198,000**	**$152,614,000**
Staff Benefits	5150150-Dental Insurance	$176,000	$169,000
	5150200-Disability Leave - Industrial	$2,202,000	$2,106,000
	5150210-Disability Leave - Nonindustrial	$1,363,000	$1,303,000
	5150350-Health Insurance	$3,988,000	$3,814,000
	5150400-Life Insurance	$13,000	$12,000
	5150450-Medicare Taxation	$2,361,000	$2,258,000
	5150500-OASDI	$1,686,000	$1,612,000
	5150600-Retirement - General	$31,962,000	$30,565,000
	5150700-Unemployment Insurance	$119,000	$114,000
	5150750-Vision Care	$41,000	$39,000
	5150800-Workers' Compensation	$11,461,000	$10,960,000
	5150900-Staff Benefits - Other	$29,800,000	$28,498,000
Staff Benefits Total		**$85,172,000**	**$81,450,000**
Operating Expenses and Equipment	5301400-Goods - Other	$527,000	$534,000
	5302900-Printing - Other	$47,000	$48,000
	5304800-Communications - Other	$510,000	$516,000
	5306700-Postage - Other	$37,000	$37,000
	5308900-Insurance - Other	$8,000	$8,000
	5320490-Travel - In State - Other	$273,000	$276,000
	5322400-Training - Tuition and Registration	$153,000	$155,000
	5324350-Rents and Leases	$3,148,000	$3,185,000
	5326900-Utilities - Other	$2,812,000	$2,845,000
	5340330-Consulting and Professional Services - Interdepartmental - Other	$1,284,000	$1,299,000
	5340580-Consulting and Professional Services - External - Other	$26,651,000	$26,963,000
	5344000-Consolidated Data Centers	$13,000	$13,000
	5346900-Information Technology - Other	$25,000	$25,000
	5368115-Office Equipment	$616,000	$623,000
	5390900-Other Items of Expense - Miscellaneous	$10,356,000	$10,477,000
	5415000-Claims Against the State	$1,000	$1,000
	5490000-Other Special Items of Expense	$367,000	$371,000
Operating Expenses and Equipment Total		**$46,828,000**	**$47,376,000**
Grand Total		**$278,198,000**	**$281,440,000**

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

Exhibit I—Coalinga State Hospital[4]

		2020-21 Budget	2020-21 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$134,855,000	$145,442,000
	5100150-Earnings - Temporary Civil Service Employees	$593,000	$640,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$23,535,000	$25,383,000
Salaries and Wages Total		**$158,983,000**	**$171,465,000**
Staff Benefits	5150150-Dental Insurance	$212,000	$223,000
	5150200-Disability Leave - Industrial	$2,869,000	$3,027,000
	5150210-Disability Leave - Nonindustrial	$1,025,000	$1,081,000
	5150350-Health Insurance	$4,052,000	$4,275,000
	5150400-Life Insurance	$13,000	$14,000
	5150450-Medicare Taxation	$2,402,000	$2,534,000
	5150500-OASDI	$1,680,000	$1,772,000
	5150600-Retirement - General	$33,561,000	$35,406,000
	5150700-Unemployment Insurance	$201,000	$212,000
	5150750-Vision Care	$40,000	$42,000
	5150800-Workers' Compensation	$5,874,000	$6,197,000
	5150900-Staff Benefits - Other	$33,257,000	$35,085,000
Staff Benefits Total		**$85,186,000**	**$89,868,000**
Operating Expenses and Equipment	5301400-Goods - Other	$1,571,000	$1,526,000
	5302900-Printing - Other	$144,000	$140,000
	5304800-Communications - Other	$632,000	$614,000
	5306700-Postage - Other	$46,000	$45,000
	5308900-Insurance - Other	$241,000	$234,000
	5320490-Travel - In State - Other	$439,000	$426,000
	5320890-Travel - Out of State - Other	$3,000	$3,000
	5322400-Training - Tuition and Registration	$95,000	$92,000
	5324350-Rents and Leases	$3,005,000	$2,918,000
	5326900-Utilities - Other	$4,830,000	$4,690,000
	5340330-Consulting and Professional Services - Interdepartmental - Other	$303,000	$294,000
	5340580-Consulting and Professional Services - External - Other	$35,955,000	$34,916,000
	5344000-Consolidated Data Centers	$2,000	$2,000
	5346900-Information Technology - Other	$26,000	$25,000
	5368115-Office Equipment	$2,429,000	$2,359,000
	5390900-Other Items of Expense - Miscellaneous	$18,643,000	$18,104,000
	5415000-Claims Against the State	$1,000	$1,000
	5490000-Other Special Items of Expense	$408,000	$396,000
Operating Expenses and Equipment Total		**$68,773,000**	**$66,785,000**
Grand Total		**$312,942,000**	**$328,118,000**

[4]Budget and expenditure do not include reimbursements.

Exhibit I—Metropolitan State Hospital[5]

		2020-21 Budget	2020-21 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$120,743,000	$88,313,000
	5100150-Earnings - Temporary Civil Service Employees	$5,492,000	$4,017,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$16,005,000	$11,706,000
Salaries and Wages Total		**$142,240,000**	**$104,036,000**
Staff Benefits	5150150-Dental Insurance	$246,000	$181,000
	5150200-Disability Leave - Industrial	$1,725,000	$1,272,000
	5150210-Disability Leave - Nonindustrial	$212,000	$156,000
	5150350-Health Insurance	$4,230,000	$3,119,000
	5150400-Life Insurance	$12,000	$9,000
	5150450-Medicare Taxation	$2,226,000	$1,641,000
	5150500-OASDI	$1,538,000	$1,134,000
	5150600-Retirement - General	$28,757,000	$21,202,000
	5150700-Unemployment Insurance	$141,000	$104,000
	5150750-Vision Care	$39,000	$29,000
	5150800-Workers' Compensation	$6,154,000	$4,537,000
	5150900-Staff Benefits - Other	$38,099,000	$28,089,000
Staff Benefits Total		**$83,379,000**	**$61,473,000**
Operating Expenses and Equipment	5301400-Goods - Other	$407,000	$392,000
	5302900-Printing - Other	$136,000	$131,000
	5304800-Communications - Other	$60,000	$58,000
	5306700-Postage - Other	$13,000	$13,000
	5308900-Insurance - Other	$135,000	$130,000
	5320490-Travel - In State - Other	$17,000	$16,000
	5322400-Training - Tuition and Registration	$114,000	$110,000
	5324350-Rents and Leases	$3,014,000	$2,905,000
	5326900-Utilities - Other	$2,378,000	$2,292,000
	5340330-Consulting and Professional Services - Interdepartmental - Other	$508,000	$490,000
	5340580-Consulting and Professional Services - External - Other	$12,697,000	$12,239,000
	5344000-Consolidated Data Centers	$9,000	$9,000
	5346900-Information Technology - Other	$1,000	$1,000
	5368115-Office Equipment	$957,000	$922,000
	5390900-Other Items of Expense - Miscellaneous	$9,099,000	$8,771,000
	5415000-Claims Against the State	$4,000	$4,000
	5490000-Other Special Items of Expense	$361,000	$348,000
Operating Expenses and Equipment Total		**$29,910,000**	**$28,831,000**
Grand Total		**$255,529,000**	**$194,340,000**

[5]Budget and expenditure do not include reimbursements.

Exhibit I—Napa State Hospital[6]

		2020-21 Budget	2020-21 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$134,086,000	$147,389,000
	5100150-Earnings - Temporary Civil Service Employees	$5,675,000	$6,238,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$25,353,000	$27,868,000
Salaries and Wages Total		**$165,114,000**	**$181,495,000**
Staff Benefits	5150150-Dental Insurance	$271,000	$271,000
	5150200-Disability Leave - Industrial	$2,968,000	$2,972,000
	5150210-Disability Leave - Nonindustrial	$481,000	$482,000
	5150350-Health Insurance	$4,988,000	$4,994,000
	5150400-Life Insurance	$12,000	$12,000
	5150450-Medicare Taxation	$2,760,000	$2,763,000
	5150500-OASDI	$1,647,000	$1,649,000
	5150600-Retirement - General	$34,229,000	$34,270,000
	5150700-Unemployment Insurance	$106,000	$106,000
	5150750-Vision Care	$46,000	$46,000
	5150800-Workers' Compensation	$8,031,000	$8,041,000
	5150900-Staff Benefits - Other	$39,557,000	$39,605,000
Staff Benefits Total		**$95,096,000**	**$95,211,000**
Operating Expenses and Equipment	5301400-Goods - Other	$590,000	$913,000
	5302900-Printing - Other	$82,000	$127,000
	5304800-Communications - Other	$31,000	$48,000
	5306700-Postage - Other	$28,000	$43,000
	5308900-Insurance - Other	$134,000	$207,000
	5320490-Travel - In State - Other	$49,000	$75,000
	5322400-Training - Tuition and Registration	$153,000	$236,000
	5324350-Rents and Leases	$3,385,000	$5,224,000
	5326900-Utilities - Other	$3,098,000	$4,781,000
	5340330-Consulting and Professional Services - Interdepartmental - Other	$1,011,000	$1,561,000
	5340580-Consulting and Professional Services - External - Other	$13,342,000	$20,593,000
	5346900-Information Technology - Other	$3,000	$4,000
	5368115-Office Equipment	$1,936,000	$2,988,000
	5390900-Other Items of Expense - Miscellaneous	$11,402,000	$17,599,000
	5415000-Claims Against the State	$1,000	$1,000
	5490000-Other Special Items of Expense	$298,000	$460,000
Operating Expenses and Equipment Total		**$35,543,000**	**$54,860,000**
Grand Total		**$295,753,000**	**$331,566,000**

[6]Budget and expenditure do not include reimbursements.

Exhibit I—Patton State Hospital[7]

		2020-21 Budget	2020-21 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$141,914,000	$144,329,000
	5100150-Earnings - Temporary Civil Service Employees	$13,360,000	$13,587,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$30,827,000	$31,352,000
Salaries and Wages Total		**$186,101,000**	**$189,268,000**
Staff Benefits	5150150-Dental Insurance	$241,000	$215,000
	5150200-Disability Leave - Industrial	$3,040,000	$2,695,000
	5150210-Disability Leave - Nonindustrial	$812,000	$720,000
	5150350-Health Insurance	$4,689,000	$4,156,000
	5150400-Life Insurance	$14,000	$12,000
	5150450-Medicare Taxation	$3,212,000	$2,847,000
	5150500-OASDI	$1,840,000	$1,631,000
	5150600-Retirement - General	$38,476,000	$34,106,000
	5150700-Unemployment Insurance	$185,000	$164,000
	5150750-Vision Care	$51,000	$45,000
	5150800-Workers' Compensation	$10,808,000	$9,580,000
	5150900-Staff Benefits - Other	$44,044,000	$39,041,000
Staff Benefits Total		**$107,412,000**	**$95,212,000**
Operating Expenses and Equipment	5301400-Goods - Other	$2,722,000	$2,278,000
	5302900-Printing - Other	$244,000	$204,000
	5304800-Communications - Other	$614,000	$513,000
	5306700-Postage - Other	$35,000	$29,000
	5308900-Insurance - Other	$42,000	$35,000
	5320490-Travel - In State - Other	$65,000	$54,000
	5322400-Training - Tuition and Registration	$190,000	$159,000
	5324350-Rents and Leases	$7,320,000	$6,120,000
	5326900-Utilities - Other	$3,611,000	$3,019,000
	5340330-Consulting and Professional Services - Interdepartmental - Other	$876,000	$732,000
	5340580-Consulting and Professional Services - External - Other	$30,423,000	$25,434,000
	5344000-Consolidated Data Centers	$28,000	$23,000
	5346900-Information Technology - Other	$11,000	$9,000
	5368115-Office Equipment	$2,897,000	$2,422,000
	5390900-Other Items of Expense - Miscellaneous	$21,763,000	$18,194,000
	5415000-Claims Against the State	$10,000	$8,000
	5490000-Other Special Items of Expense	$2,036,000	$1,702,000
Operating Expenses and Equipment Total		**$72,887,000**	**$60,935,000**
Grand Total		**$366,400,000**	**$345,415,000**

[7]Budget and expenditure do not include reimbursements.

Exhibit II—All Hospitals[8]

	2021-22 Budget	2022-23 Budget	2021-22 Projected Expenditure	2022-23 Projected Expenditure
4410010-Atascadero	$380,544,000	$350,063,000	$376,738,560	$346,562,370
4410020-Coalinga	$360,729,000	$368,581,000	$357,121,710	$364,895,190
4410030-Metropolitan	$204,034,000	$252,826,000	$201,993,660	$250,297,740
4410040-Napa	$363,174,000	$367,544,000	$359,542,260	$363,868,560
4410050-Patton	$398,958,000	$398,638,000	$394,968,420	$394,651,620
Grand Total	**$1,707,439,000**	**$1,737,652,000**	**$1,690,364,610**	**$1,720,275,480**

[8]Budget and expenditure do not include reimbursements.