Department of State Hospitals

2022-23

May Revision
Proposals and Estimates

Submitted to:
California Department of Finance
May 13, 2022

Department of State Hospitals
2022-23 May Revision
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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

POPULATION BY HOSPITAL	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
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**
HOSPITAL 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	-40	237
SINGLE COUNTY JBCT	138	142	93	0	-115	120
SMALL COUNTY MODEL JBCT[3]	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
NORTHERN CA ACUTE FACILITY	0	0	0	0	60	60
CENTRAL VALLEY MHRC	0	0	0	0	0	0
TOTAL - CONTRACTED PROGRAMS	**850**	**834**	**307**	**0**	**-95**	**1,046**
CONREP PROGRAMS						
CONREP SVP		16	0	1	5	22
CONREP PROVIDERS		668	-15	0	0	653
CONREP FACT REGIONAL PROGRAM		0	0	100	0	100
NORTHERN CA IMD		10	0	10	0	20
NORTHERN CA ARF		0	0	30	0	30
STRP		35	0	0	0	35
SOUTHERN CA IMD (76 BED)		0	0	76	-70	6
SOUTHERN CA IMD (24-BED)		24	0	0	0	24
TOTAL - CONREP PROGRAMS	**815**	**753**	**-15**	**217**	**-65**	**890**
CY POPULATION AND CONTRACTED TOTAL	**7,402**	**7,164**	**305**	**217**	**-160**	**7,526**

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

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

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

[3] 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

POPULATION BY HOSPITAL	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
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**
HOSPITAL 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 - PC 2962	558	417	3	0	0	420
OMD - 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	237	0	3	46	286
SINGLE COUNTY JBCT	260	120	5	54	55	234
SMALL COUNTY MODEL JBCT[3]	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
NORTHERN CA ACUTE FACILITY	0	60	0	0	57	117
CENTRAL VALLEY MHRC	0	0	0	0	40	40
TOTAL - CONTRACTED PROGRAMS	**1,176**	**1,046**	**203**	**57**	**198**	**1,504**
CONREP PROGRAMS						
CONREP SVP		22	0	1	4	27
CONREP PROVIDERS		653	0	0	0	653
CONREP FACT REGIONAL PROGRAM		100	0	80	0	180
NORTHERN CA IMD		20	0	0	0	20
NORTHERN CA ARF		30	0	0	0	30
STRP		35	0	0	0	35
SOUTHERN CA IMD (76 BED)		6	0	0	70	76
SOUTHERN CA IMD (24-BED)		24	0	0	0	24
TOTAL - CONREP PROGRAMS	**830**	**890**	**0**	**81**	**74**	**1,045**
BY POPULATION AND CONTRACTED TOTAL	**7,919**	**7,526**	**353**	**138**	**272**	**8,289**

Projected census will be adjusted as contracts are entered into as a result of the IST Solutions program implementation.

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

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

[3] 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

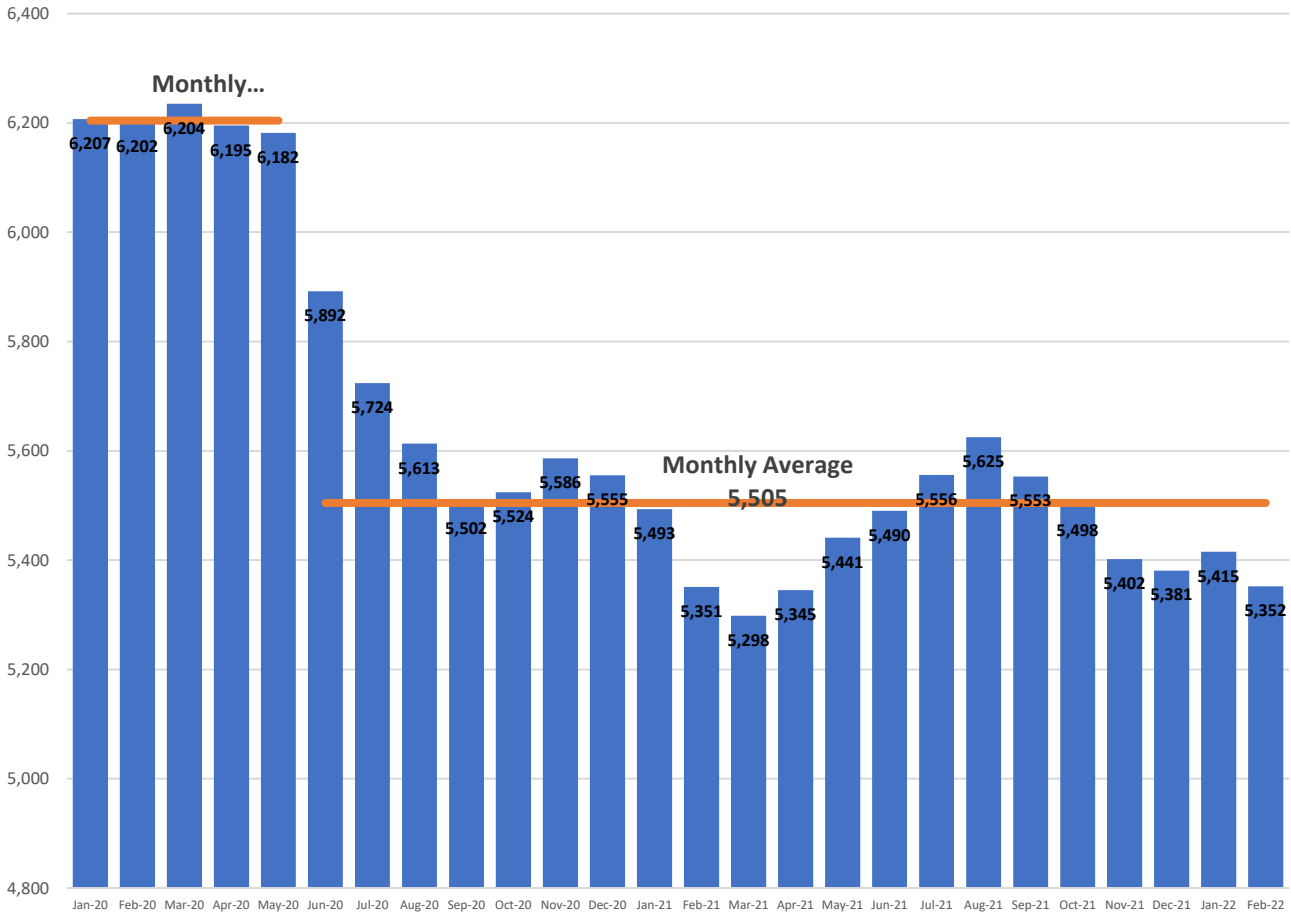
Temporary Census Reduction due to COVID-19

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

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

As a result of the COVID-19 pandemic including the creating of AOUs and isolation units, DSH's census reduced by approximately 14 percent from 6,235 on March 1, 2020 to 5,352 on February 1, 2022. 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.

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



Staffing Needs

While the DSH census has temporarily decreased as a result of COVID-19, staffing needs and responsibilities at all hospitals have increased. Maintaining appropriate staffing levels in a hospital is essential to preserving safe patient care and providing a safe work environment for health care personnel. 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 need to perform as a result of COVID-19. Hospitals have implemented 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 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 the 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 Departments
- Coordinate and manage all off-unit patient movement to avoid cross-contamination between units by requiring staff to escort patients
- Coordinate return to work functions for staff returning from COVID-19 related leave
- Provide all meals on unit for high-risk populations and quarantined units, impacting both nutrition services and staff on unit
- Suspend all in-person patient visits and switch to a virtual visitation experience

With the additional protocols and procedures being implemented at the hospitals staff assumes the following additional responsibilities:

- Increased tracking and documentation requirements related to COVID-19
- Admit patients in cohorts, which involves bringing in larger groups of patients over a short period of time, increasing the treatment team workload as documentation requirements are needing to be completed quicker for a larger group of patients
- Perform screening protocols for patients and staff arriving at the hospital
- Provide continuous education to patients and other staff regarding safety protocols, droplet/contact precautions, and medical isolation process and expectations to mitigate COVID-19 risk and exposure
- Continuously clean and disinfect units, equipment, and high touch surface areas in both patient and staff occupied areas
- Perform high-risk procedures such as administering COVID-19 tests on patients, made more complex by DSH's patient population

- Follow specific testing protocols for quarantined units including baseline testing for all patients and staff and subsequent testing until two sequential rounds of testing show negative results for all employees and patients
- Perform surveillance testing for Skilled Nursing Facility (SNF) patients and health care personnel.
- Perform assessments of patients displaying symptoms of COVID-19
- Continuously assess vital signs and respiratory status for patients in quarantined units, isolation units and PUI rooms
- Coordinate all on unit meal services for high-risk populations and quarantined units
- Provide all treatment, including religious service options and group treatment, on unit, creating the need to rewrite/restructure treatment plans and groups to accommodate the new delivery formats
- Coordinate virtual visits for patients

Referral and Census Trends

Since the inception of COVID-19 and the implementation of the SIP order, followed by the implementation of a safe admission process into AOUs, the Incompetent to Stand Trial (IST) waitlist has increased by 125 percent to 1,951 as of February 28, 2022. 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. The following table displays the difference between the waitlists and average weekly referrals for the forementioned commitment types before and after the California Statewide SIP order effective March 19, 2020:

Table 1: Pre and Post SIP Order Waitlist and Weekly Referral Averages[1]							
	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: 2/28//2022	1951	303	25	13	12	<11	<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
Percentage Change (Referrals):	*-56%*	*-23%*	*23%*	*-57%*	*-43%*	*-51%*	*-77%*
Current Average Weekly Referrals[2]	84.3	<11	<11	<11	<11	<11	<11

[1] Referral data excludes JBCT Transfers, State Hospital Transfers, Court Returns and includes CBR referrals/off-ramps.
[2] Current average weekly referrals reflect most recent referral data from January 2022 through February 2022.
Note: 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.

Prior to COVID-19, 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 (+7.6% increase from prior year). In the current year (CY) IST referrals are trending at an all-time high with averages reaching almost 404 ISTs per month, a 28 percent increase as compared to FY 2020-21. The following table displays the average monthly referrals by fiscal year from FY 2018-19 through FY 2021-22:

Table 2: Average Monthly Referrals by Fiscal Year							
	FY 2018-19	**FY 2019-20**		**FY 2019-20**	**FY 2020-21**	**FY 2021-22** (through February 2022)	**% Change** FY 2020-21 to FY 2021-22
		(Pre-COVID-19)[1]	(Post-COVID-19)[2]				
IST *(with JBCT/AES)*	372.0	368.0	224.0	320.0	315.3	403.6	28.0%
LPS	15.8	<11	<11	<11	***	<11	-39.0%
OMD 2962	46.4	40.6	46.5	42.6	25.8	27.1	5.1%
OMD 2972	<11	<11	<11	<11	<11	<11	-25.0%
NGI	11.3	11.8	<11	<11	<11	<11	-16.1%
SVP	<11	<11	<11	<11	<11	<11	-23.5%
CDCR	35.3	56.1	26.3	46.2	15.8	18.8	18.7%
Total	**487.7**	**490.3**	**310.8**	**430.3**	**384.6**	**469.3**	**22.0%**

[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.
Note: 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.
Note: 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.

The following table displays the patient censuses for different DSH commitment types:

Table 3: Patient Census					
	6/30/2019	**2/29/2020** (Pre-COVID-19)	**6/30/2021**	**2/28/2022**	**% Change** (6/30/2021 to 2/28/2022)
IST *(with JBCT/AES)*	1,811	1,894	1,603	1,395	-13.0%
LPS	736	747	789	740	-6.2%
OMD 2962	559	508	415	408	-1.7%
OMD 2972	778	760	716	698	-2.5%
NGI	1,416	1,415	1,338	1,278	-4.5%
SVP	962	943	939	928	-1.2%
CDCR	185	296	169	178	5.3%
	6,447	**6,563**	**5,969**	**5,625**	**-5.8%**

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

POPULATION PROJECTIONS

Census and Pending Placement List Projections

DSH utilizes the actual census as the baseline census for both 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 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 May Revision 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 March 2021 through December 2021 for the IST, NGI, LPS, and SVP populations. OMD variables

continue to be based on the most recent 12-month period ending February 28, 2022 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.

Table 4: Census and Pending Placement List Projections			
CURRENT YEAR			
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	1,614	1,921
LPS	801	801	314
OMD 2962	414	417	23
OMD 2972	729	732	13
NGI	1,340	1,343	12
SVP	931	931	11
Subtotal	5,827	5,838	2,294
Coleman[2]	169	169	
Total	**5,996**	**6,007**	**2,294**
BUDGET YEAR			
Legal Class	**July 1, 2022 Projected Census**	**June 30, 2023 Projected Census**	**June 30, 2023 Projected Pending Placement List**
IST[1] *(with JBCT/AES)*	1,614	1,951	867
LPS	801	801	349
OMD 2962	417	420	14
OMD 2972	732	735	12
NGI	1,343	1,343	11
SVP	931	931	3
Subtotal	5,838	6,181	1,255
Coleman[2]	169	169	
Total	**6,007**	**6,350**	**1,255**

[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.

STATE HOSPITALS AND PSYCHIATRIC PROGRAMS
COMMITMENT CODES

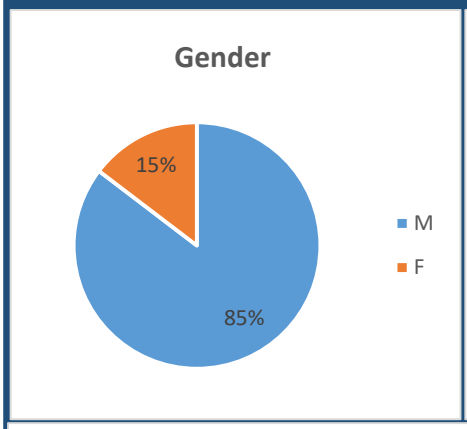
Legal Category	Legal Class Text	Code Section	Description
NGI	NGI PC1026	PC 1026	Not Guilty by Reason of Insanity
Other NGI*	RONGI, RO1026	PC 1610	Temporary Admission while waiting for Court Revocation of a PC 1026 (NGI)
Other NGI	MNGI	WIC 702.3	Minor Not Guilty by Reason of Insanity
IST	IST PC1370	PC 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 BPT 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
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	MURCON	WIC 5008(h)(1)(B)	Murphy's Conservatorship
LPS	DMR	WIC 6500, 6509	Dangerous Mentally Retarded Committed by Court
LPS	CAMR	WIC 4825, 6000(a)	Voluntary Adult Mentally Retarded 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)

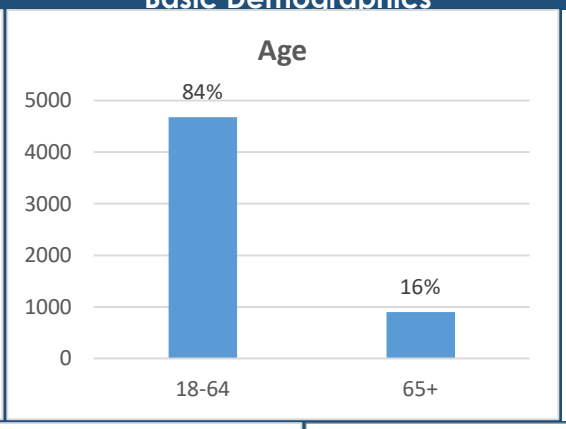
***** Items marked with an asterisk were previously captured in the "Other PC" category

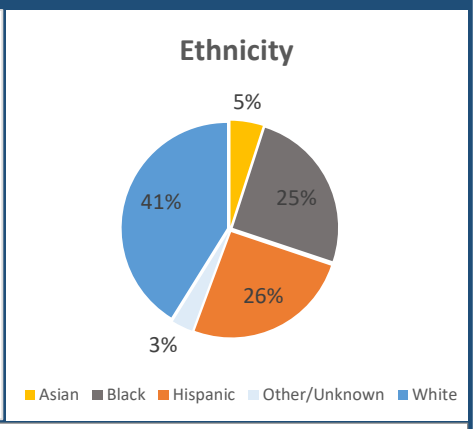
Demographic Snapshot: All Commitment Types

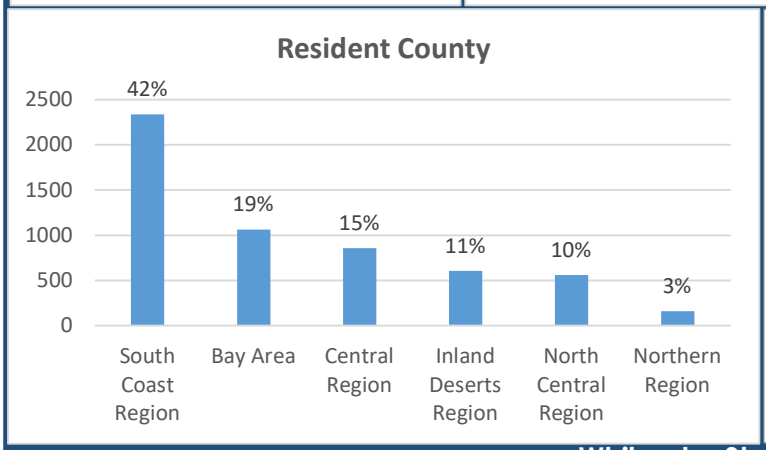
July 1, 2021; Census: 5,580

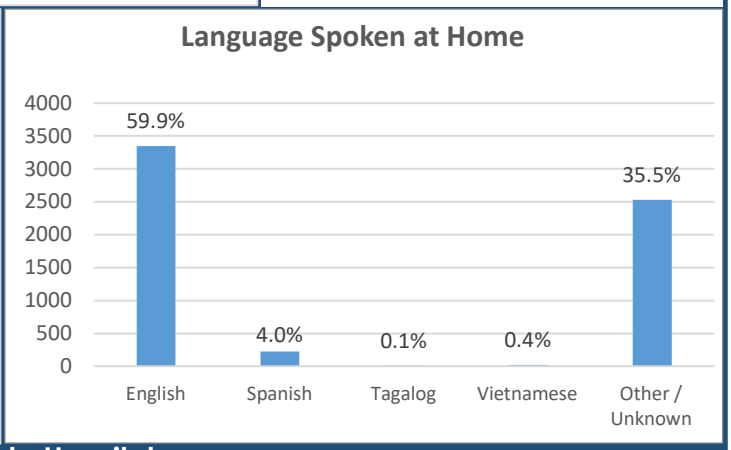
Basic Demographics



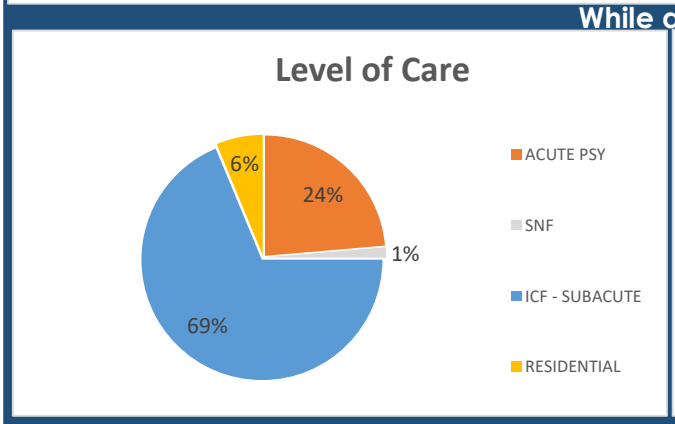


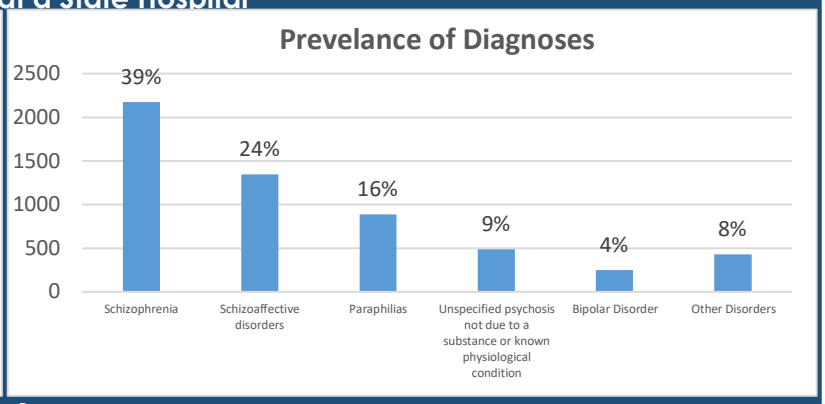






While at a State Hospital





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".

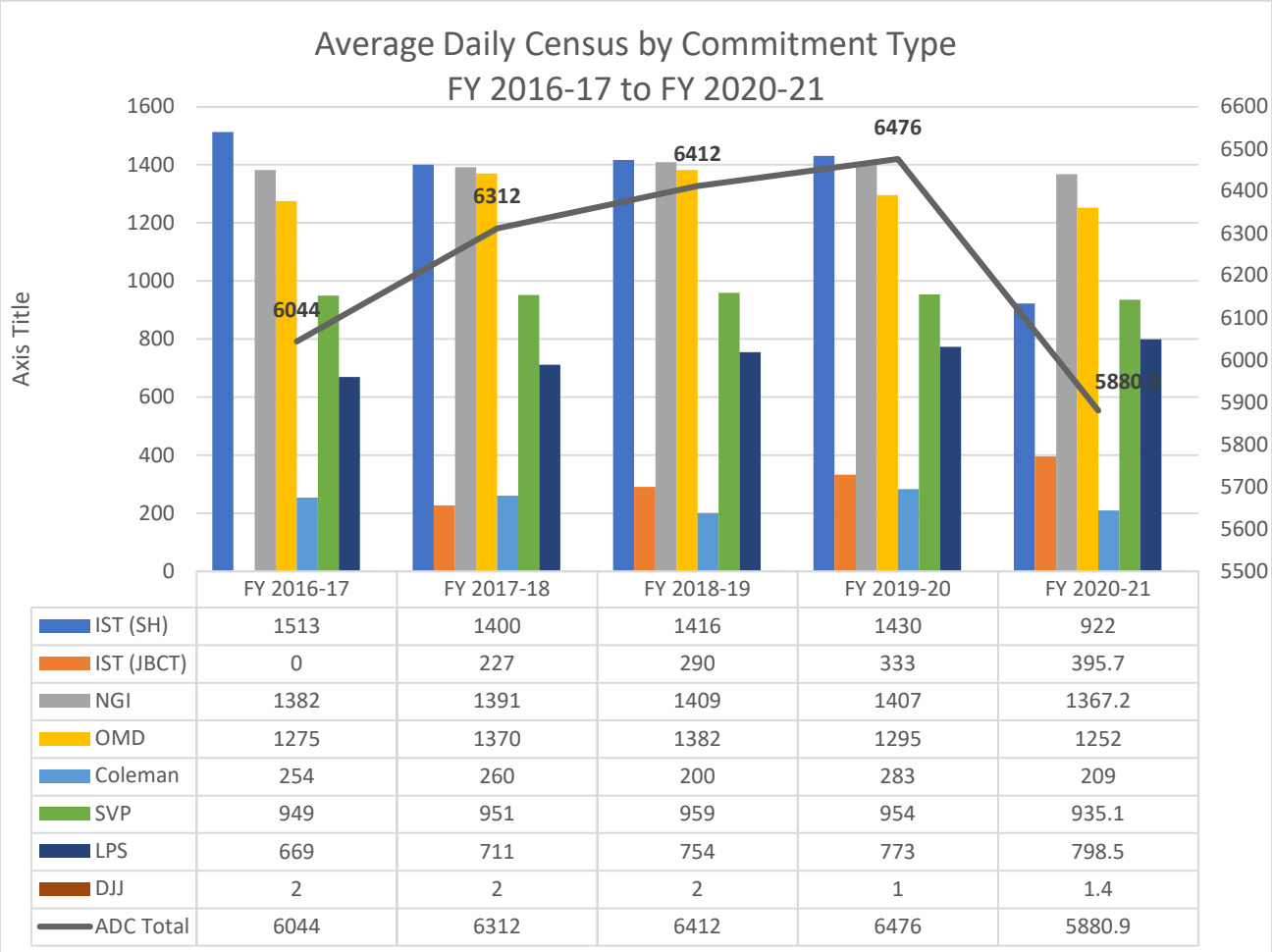
[3]Taken from U.S. Census Bureau 2020 American Community Survey (ACS). Does not include 4.1% labeled "two or more races".

[4]Includes MDSO.

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

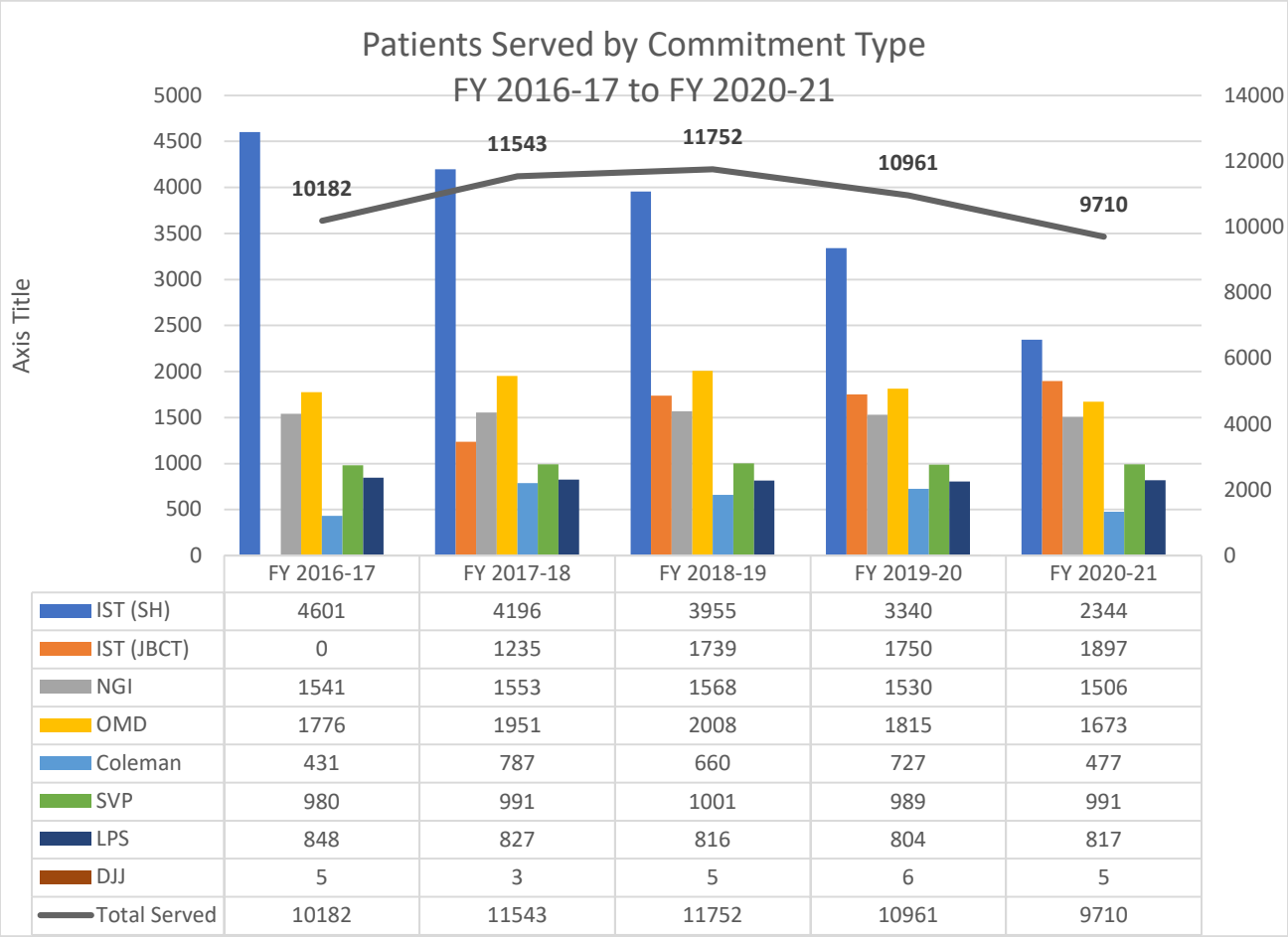
Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data.

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.



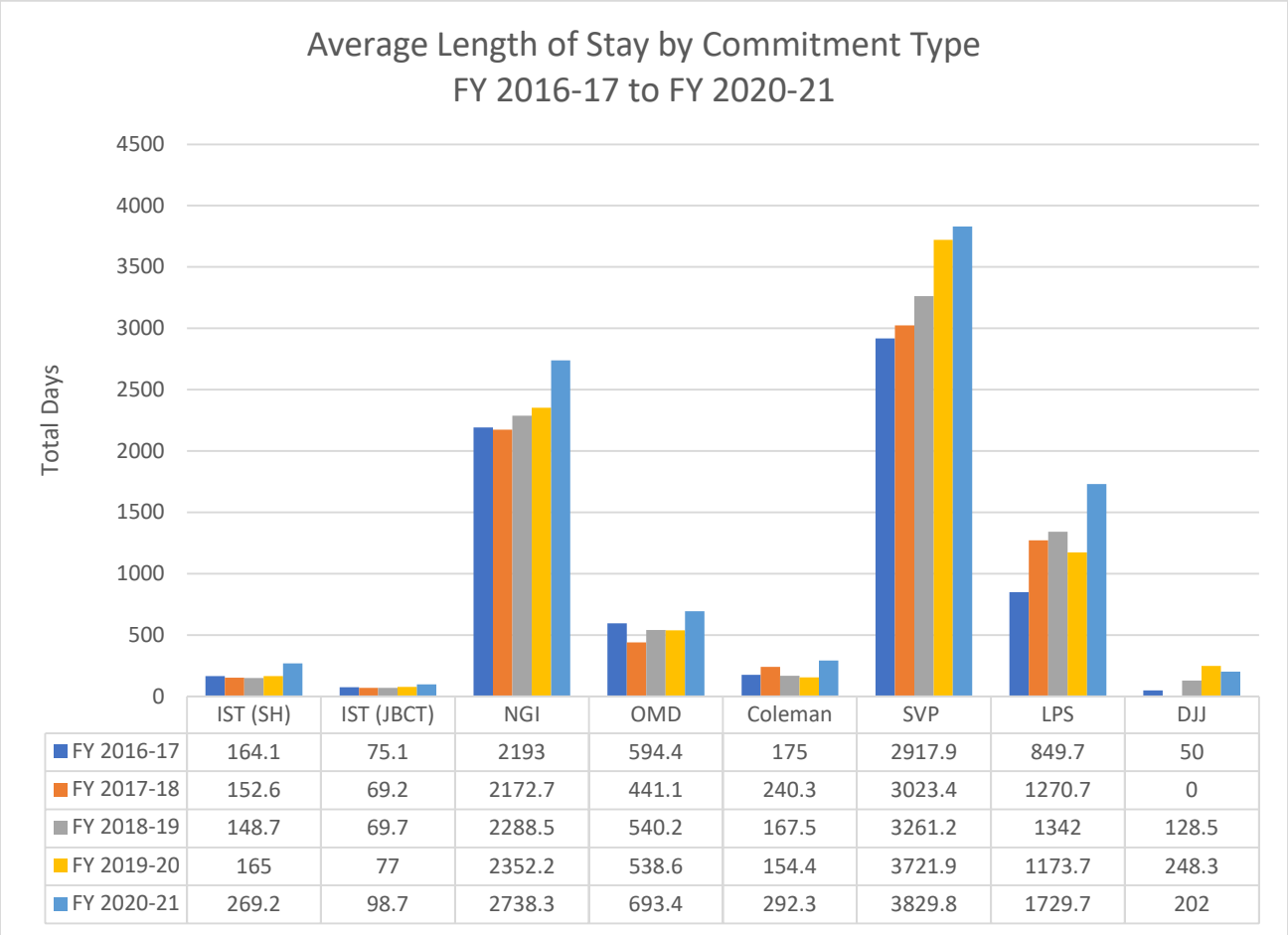
	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
IST (SH)	1513	1400	1416	1430	922
IST (JBCT)	0	227	290	333	395.7
NGI	1382	1391	1409	1407	1367.2
OMD	1275	1370	1382	1295	1252
Coleman	254	260	200	283	209
SVP	949	951	959	954	935.1
LPS	669	711	754	773	798.5
DJJ	2	2	2	1	1.4
ADC Total	6044	6312	6412	6476	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**
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*
May Revision	**0.0**	**0.0**	**0.0**	**$0**	**$9,160**	**$9,160**
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*	*$9,160*	*$9,160*
Total	**0.0**	**0.0**	**0.0**	**$0**	**$9,160**	**$9,160**
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*	*$9,160*	*$9,160*

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 Non-Restorable/Maximum-Term 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) § 5000 et seq.). WIC § 5358 specifies DSH as one treatment option, however, there are multiple treatment options for the LPS population including a medical, psychiatric, nursing, other state-licensed facility, a county hospital, hospital operated by the Regents of the University of California, a United States government hospital, other nonmedical facility approved by the Department of Health Care Services (DHCS), or an agency accredited by DHCS. 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 § 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.

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

Pursuant to penal code (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. Assembly Bill (AB) 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 ISTs, 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 is consistent with current rates for patients committed to DSH pursuant to the LPS Act. Per AB 133, Chapter 143, billing will occur if the County Sheriff does not pick-up the relevant IST defendant from a DSH facility and return them to county custody within 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 § 17601 to allow DSH to collect reimbursement from counties.

DESCRIPTION OF CHANGE

LPS Population

DSH requests an increase to DSH's reimbursement authority to reflect updated daily bed rates as a result of ongoing bed rate negotiations have been finalized with the California Mental Health Services Authority (CalMHSA) and the increases take effect July 1, 2022. These rate increases are a result of negotiations with counties and CalMHSA focusing on a proposed increase in the daily bed rate based on DSH's actual costs. The current bed rates charged to the counties, per the current LPS Memorandum of Understanding (MOU), have not been updated since fiscal year (FY) 2012-13. DSH currently charges a daily bed rate of $775 for Skilled Nursing Facility (SNF) and $626 as a blended rate for an Acute or Intermediate Care Facility (ICF) bed type (blended rate went into effect FY 2014-15 based on the per diem bed rates that were already in place).

The new bed rates are listed below and will govern the next three fiscal years. The rates are based on actual costs from 2018-19 by level of acuity and average daily census to arrive at a daily bed rate by level of care. As compared to the current per day bed rates, the ICF rate represents a $102 increase in 2022-23 and $110 increase in 2023-24 and 2024-25. The Acute rate represents a $127 increase in 2022-23 and $134 increase in 2023-24 and 2024-25. Last, the SNF rate represents an increase of $31 in 2022-23 and $39 in 2023-24 and 2024-25.

Fiscal Year	Date	ICF Rate	Acute Rate	SNF Rate
2022-23	July 1, 2022 - June 30, 2023	$728	$753	$806
2023-24	July 1, 2023 - June 30, 2024	$736	$760	$814
2024-25	July 1, 2024 - June 30, 2025	$736	$760	$814

As of the 2022-23 May Revision, DSH has a current year (CY) and budget year (BY) projected LPS census of 801. DSH will be adjusting the reimbursement authority annually based on the rate schedule and updated days billed for LPS patients. The methodology used is based on actual LPS charges that have been converted to days billed. Based on the LPS days billed, there is not an adjustment needed for CY. For BY and ongoing, DSH used the current year projected bed days and multiplied by the new bed rates. Based on this calculation, DSH requests an additional $8.9 million in reimbursement authority in BY and ongoing.

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

As of the 2022-23 May Revision, the IST and Non-Restorable collection efforts are ongoing. From October 2021 through February 2022 the average total monthly

collection is $20,658. The overall reimbursement collection trends show a decrease in the number of IST patients that meet the criteria to bill. This suggests patients are being picked-up within the 10-day grace period as defined by statute. Additionally, due to statewide health and safety protocols, counties are not billed when an IST patient is quarantined due to COVD-19 or is offsite due to outside medical treatment and cannot be timely returned to the county. Based on the actual data, DSH will use existing reimbursement authority to collect in 2021-22 and requests reimbursement authority of $299,000 in 2022-23 and ongoing. 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 § 17601.

BCP Fiscal Detail Sheet

BCP Title: County Bed Billing Reimbursement Authority **BR Name: 4440-086-ECP-2022-MR**

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	9,160	9,160	9,160	9,160	9,160
Total Operating Expenses and Equipment	**$0**	**$9,160**	**$9,160**	**$9,160**	**$9,160**	**$9,160**
Total Budget Request	**$0**	**$9,160**	**$9,160**	**$9,160**	**$9,160**	**$9,160**

Fund Summary

Fund Source - State Operations						
0995 - Reimbursements	0	9,160	9,160	9,160	9,160	9,160
Total State Operations Expenditures	**$0**	**$9,160**	**$9,160**	**$9,160**	**$9,160**	**$9,160**
Total All Funds	**$0**	**$9,160**	**$9,160**	**$9,160**	**$9,160**	**$9,160**

Program Summary

Program Funding						
4410010 - Atascadero	0	357	357	357	357	357
4410020 - Coalinga	0	14	14	14	14	14
4410030 - Metropolitan	0	4,814	4,814	4,814	4,814	4,814
4410040 - Napa	0	1,516	1,516	1,516	1,516	1,516
4410050 - Patton	0	2,459	2,459	2,459	2,459	2,459
Total All Programs	**$0**	**$9,160**	**$9,160**	**$9,160**	**$9,160**	**$9,160**

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*
May Revision	**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*
Total	**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 triggered 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).

In the 2022-23 Governor's Budget, DSH reported a delay in the activation of the remaining three units with a planned July 2022 date for resuming work. These delays resulted in a one-time savings in fiscal year (FY) 2021-22 of $21.8 million associated with personal services savings.

DESCRIPTION OF CHANGE

As of 2022-23 May Revision there are no additional savings projected as DSH is still projecting a completion date of July 2022 consistent with the Governor's Budget timeline for the remaining three units to serve patients deemed IST. Below is an update for each of the three remaining units:

1. Unit 3 is being used for COVID-19 Isolation through July 2022. However, this may be extended if the need for COVID-19 isolation space is needed for a longer time period.
2. Units 4 and 5 were being used for COVID-19 Admission Observation Units (AOUs), however the two units at the Norwalk Alternate Care Site (ACS) were activated and the COVID-19 AOUs moved to that facility. At that time these two units were then used for the swing space needed for the remaining units affected by the Continuing Treatment East (CTE) Fire Alarm Project. As of March 2022, two units are awaiting final State Fire Marshall approval, following approval, construction will commence. At this time, DSH is projecting to complete the CTE Fire Alarm Projection in July 2022. Once complete, these two 46 bed units will be back online for IST patients.

Request Summary

As DSH is showing no change in activation from what was reported in the 2022-23 Governor's Budget, no additional savings are reported. DSH will provide another update in the 2023-24 Governor's Budget.

Activation Timeline Adjustment

Unit	# of Beds	Scheduled Activation as of 2022-23 Governor's Budget	Scheduled Activation as of 2022-23 May Revision	Change from 2022-23 Governor's Budget
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	July 2022	July 2022	No change from Governor's Budget
Unit 4	46	July 2022	July 2022	No change from Governor's Budget
Unit 5	46	July 2022	July 2022	No change from Governor's Budget

Funding and Position Summary

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

DSH-Metropolitan ISBC Position Breakdown						
Timeframe	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**2021-22**	**2022-23**
FY 2017-18 Governor's Budget	0.0	0.0	0.0	0.0	0.0	0.0
FY 2017-18 May Revision	22.2	35.5	35.5	35.5	35.5	35.5
FY 2018-19 Governor's Budget	0.0	346.1	473.4	473.4	473.4	473.4
FY 2018-19 May Revision	(10.1)	(183.3)	(131.2)	(1.2)	0.0	0.0
FY 2019-20 Governor's Budget	0.0	0.0	119.3	130.0	130.0	130.0
FY 2019-20 May Revision	0.0	0.0	(20.1)	(128.5)	(128.5)	(128.5)
FY 2020-21 Governor's Budget	0.0	0.0	(51.1)	2.0	2.0	2.0
FY 2020-21 May Revision	0.0	0.0	(171.3)	(43.7)	0.0	0.0
FY 2021-22 Governor's Budget	0.0	0.0	0.0	(120.6)	0.0	0.0
FY 2021-22 May Revision	0.0	0.0	0.0	0.0	(1.2)	(1.2)
FY 2022-23 Governor's Budget	0.0	0.0	0.0	0.0	(127.3)	0.0
FY 2022-23 May Revision	0.0	0.0	0.0	0.0	0.0	0.0
Total Authority Ongoing	**12.1**	**198.3**	**254.5**	**346.9**	**383.9**	**511.2**

DSH-Metropolitan ICSB Cost Breakdown						
(Dollars in Thousands)						
Timeframe	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**2021-22**	**2022-23**
FY 2017-18 Governor's Budget	$0	$0	$0	$0	$0	$0
FY 2017-18 May Revision	$7,827	$12,370	$5,276	$5,276	$5,276	$5,276
Total as of 2017 Budget Act	**$7,827**	**$12,370**	**$5,276**	**$5,276**	**$5,276**	**$5,276**
FY 2018-19 Governor's Budget	$0	$53,085	$68,953	$68,953	$68,953	$69,003
FY 2018-19 May Revision	($1,049)	($28,304)	($18,374)	$17	$0	$0
Total as of 2018 Budget Act	**$6,778**	**$37,151**	**$55,855**	**$74,246**	**$74,229**	**$74,279**
FY 2019-20 Governor's Budget	$0	$0	$18,589	$20,117	$20,117	$20,117
FY 2019-20 May Revision	$0	$0	($3,055)	($19,850)	($19,850)	($19,850)
Total as of 2019 Budget Act	**$6,778**	**$37,151**	**$71,389**	**$74,513**	**$74,496**	**$74,546**
FY 2020-21 Governor's Budget	$0	$0	($7,928)	$294	$294	$294
FY 2020-21 May Revision	$0	$0	($26,455)	($6,758)	$0	$0
Total as of 2020 Budget Act	**$6,778**	**$37,151**	**$37,006**	**$68,049**	**$74,790**	**$74,840**
FY 2021-22 Governor's Budget	$0	$0	$0	($18,617)	$0	$0
FY 2021-22 May Revision	$0	$0	$0	$0	$17	$17
Total as of 2021 Budget Act:	**$6,778**	**$37,151**	**$37,006**	**$49,432**	**$74,807**	**$74,857**
FY 2022-23 Governor's Budget	$0	$0	$0	$0	($21,830)	$0
FY 2022-23 May Revision	$0	$0	$0	$0	$0	$0
Total as of 2022 Budget Act	**$6,778**	**$37,151**	**$37,006**	**$49,432**	**$52,977**	**$74,857**

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*
May Revision	**0.0**	**0.0**	**0.0**	**$388**	**$253**	**$0**
One-time	*0.0*	*0.0*	*0.0*	*$388*	*$253*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Total	**0.0**	**-56.5**	**-56.5**	**-$9,225**	**-$8,649**	**-$8,902**
One-time	*0.0*	*0.0*	*0.0*	*-$3,192*	*$253*	*$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, that increases safety in the facility and protects 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.

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 to 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 who 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 attributed to existing site conditions, code issues, unforeseen conditions such as unknown regular and low voltage electrical conduits, materials damage, unexpected ductwork, and uncertainties connected to COVID-19.

In the 2022-23 Governor's Budget, DSH reported a 3-month delay in the U-06 activation at DSH-Patton as well as a postponement of Units 33 and 34 at DSH-Atascadero due to significant bed capacity pressures. As a result, DSH anticipated a one-time savings of $9.6 million in FY 2021-22 and ongoing savings of $8.9 million and 56.5 positions in the FY 2022-23 and ongoing.

DESCRIPTION OF CHANGE

As of the 2022-23 May Revision, DSH continues to recommend postponing construction of units 33 and 34 at DSH-Atascadero given that significant bed capacity pressures remain. For the DSH-Patton U-Building, an unforeseen fire sprinkler installation design change, the need to survey for potential asbestos-containing materials, and the discovery of gaps in the existing smoke barrier have further extended the anticipated length of the project. DSH anticipates ETP Construction to be complete in March 2023 (5-month delay).

<u>DGS Suspension Fees</u>

With the recommended postponement of units 33 and 34 at DSH-Atascadero, DSH has incurred project suspension fees. In the Governor's Budget, there was an

error in calculating the suspension fees. Along with correcting the error, DSH will incur suspension fees for the remaining three months of the current year. DSH will incur $294,000 in fees, that is a decrease of $12,000 needed from current year one-time savings as compared to the reported fees at Governor's Budget.

DSH-Patton Renovations

In FY 2019-20 May Revision, DSH received approval to redirect $139,000 ETP savings for one-time funding to support additional items that needed to be addressed for the ETP to run successfully. These items were not included in the ETP construction project. These items included courtyard improvements and fence security upgrade, and conversion of U06 South Wing rooms to staff offices and clinical treatment space. With the onset of the COVID-19 pandemic, these projects were not completed. Due to the amount of time that has passed and the impact of COVID-19 on the supply chain and construction industry, increased costs for building materials, construction and labor exceeds the amount previously provided. In addition, the extent of courtyard renovation required to ensure a safe and secure outdoor space for the ETP patients was greater than originally estimated. DSH requests to redirect $400,000 in current year savings to complete these projects.

Equipment

Funding in the 2018 Budget Act provided one-time Operating, Expense and Equipment (OE&E) funding to DSH-Atascadero and DSH-Patton. This funding was intended for furniture and equipment to furnish the treatment areas of each of the four ETP units. Items such as tables and chairs for the patients and staff, as well as medical carts used to distribute medication to patients. Some furniture was purchased out of the initial funding, as detailed below, however no equipment. Now that one unit has activated and another is set to activate next fiscal year, DSH would like to request to redirect a minimal amount of funding to procure equipment needed on these units.

DSH-Atascadero was provided initial funding for all three units and Norix furniture was purchased and placed in storage. This furniture is currently being used in the DSH-Atascadero Unit 29 ETP. DSH-Atascadero has a need for equipment and supplies for facility modifications that were unforeseen when funding was first requested. Equipment needs are for portable medical machines that can be brought to the unit versus having to take an ETP patient off campus. Because patients treated in an ETP are those with the highest risk of violence, DSH has found these methods to be safer for patients and staff. Machines that are successful being portable and on unit are EKG, X-ray and MRI equipment. Facility modifications include soundproofing walls, soundproofing paint, perforated

metal plate inserts for the food port slide door to communicate with the patient in a non-contact room and window coverings. DSH is requesting to redirect $100,000 of budget year savings to fund the equipment and facility modification needs.

DSH-Patton was provided initial funding, however due to the delays in activation, no equipment was purchased. The funding was repurposed to provide ETP training to staff and to fund travel for DSH-Patton staff who assisted with ETP Academy training at DSH-Atascadero. Now that activation is approaching, DSH-Patton is learning from the current open ETP unit at DSH-Atascadero what items are needed for a successful ETP operation. DSH-Patton has a need to purchase equipment and supplies for the unit. Equipment DSH-Patton is requesting are portable machines, similar to DSH-Atascadero, as well as a medical cart, technology services for patient sensory tools and an overhead projection machine. Supply needs for this unit include those for patient grooming, exercise equipment, art supplies, games, books, DVDs, music equipment and spiritual items. Items of similar nature were shared between this unit and another before being converted to be specific for ETP. Because the ETP will be a locked unit and operated separately from the other unit in the building, these items can no longer be shared and need to be available for this individual unit. DSH is requesting $153,000 in FY 2022-23 to purchase equipment and supplies.

ETP Activation Timeline

Units/Hospital	Construction Scheduled Initiation	Construction Scheduled Completion	Delay from 2022- 23 Governor's Budget
DSH-Atascadero Unit 29	September 24, 2018 (Actual)	July 2021 (Actual)	N/A
DSH-Atascadero Unit 33	Suspended	Suspended	Unknown
DSH-Atascadero Unit 34	Suspended	Suspended	Unknown
DSH-Patton Unit U-06	September 2022	March 2023	5-month delay

Funding and Position Summary

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

ETP Position Breakdown						
DSH-Atascadero Units 29 & 33						
Timeframe	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**2021-22**	**2022-23**
FY 2017-18 Governor's Budget	44.7	115.1	115.1	115.1	115.1	115.1
FY 2017-18 May Revision	0.0	0.0	0.0	0.0	0.0	0.0
FY 2018-19 Governor's Budget	(35.8)	0.0	0.0	0.0	0.0	0.0
FY 2018-19 May Revision	0.0	(57.9)	0.0	0.0	0.0	0.0
FY 2019-20 Governor's Budget	0.0	0.0	0.0	0.0	0.0	0.0
FY 2019-20 May Revision	0.0	(7.1)	(3.4)	0.0	0.0	0.0
FY 2020-21 Governor's Budget	0.0	0.0	(26.7)	0.0	0.0	0.0
FY 2020-21 May Revision	0.0	0.0	(21.1)	(6.0)	0.0	0.0
FY 2021-22 Governor's Budget	0.0	0.0	0.0	(21.1)	(5.0)	0.0
FY 2021-22 May Revision	0.0	0.0	0.0	(23.0)	(2.4)	0.0
FY 2022-23 Governor's Budget	0.0	0.0	0.0	0.0	(6.6)	(22.3)
FY 2022-23 May Revision	0.0	0.0	0.0	0.0	0.0	0.0
Total Authority Ongoing	**8.9**	**50.1**	**63.9**	**65.0**	**101.1**	**92.8**

DSH-Atascadero Unit 34 & DSH- Patton Unit U-06						
Timeframe	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**2021-22**	**2022-23**
FY 2017-18 Governor's Budget	0.0	0.0	0.0	0.0	0.0	0.0
FY 2017-18 May Revision	0.0	0.0	0.0	0.0	0.0	0.0
FY 2018-19 Governor's Budget	0.0	23.2	65.7	65.7	65.7	65.7
FY 2018-19 May Revision	0.0	(22.2)	(5.4)	0.0	0.0	0.0
FY 2019-20 Governor's Budget	0.0	0.0	(12.7)	0.0	0.0	0.0
FY 2019-20 May Revision	0.0	0.0	5.7	0.0	0.0	0.0
FY 2020-21 Governor's Budget	0.0	0.0	(5.6)	(1.5)	0.0	0.0
FY 2020-21 May Revision	0.0	0.0	0.0	(2.4)	0.0	0.0
FY 2021-22 Governor's Budget	0.0	0.0	0.0	(9.0)	(6.6)	0.0
FY 2021-22 May Revision	0.0	0.0	0.0	0.0	(5.8)	0.0
FY 2022-23 Governor's Budget	0.0	0.0	0.0	0.0	(54.3)	(34.2)
FY 2022-23 May Revision	0.0	0.0	0.0	0.0	0.0	0.0
Total Authority Ongoing	**0.0**	**1.0**	**47.7**	**52.8**	**(1.0)**	**31.5**

ETP Cost Breakdown						
(Dollars in Thousands)						
Timeframe	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**2021-22**	**2022-23**
2017-18 Governor's Budget	$7,868	$14,704	$14,704	$14,704	$14,704	$14,704
2017-18 May Revision	$122	$524	$545	$545	$545	$545
Total as of 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)	($1,379)	$0	$0
Total as of 2020 Budget Act	***$3,107***	***$8,041***	***$12,653***	***$23,037***	***$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***	***$14,611***	***$22,584***	***$25,046***
2022-23 Governor's Budget	$0	$0	$0	$0	($9,613)	($8,902)
2022-23 May Revision	$0	$0	$0	$0	$388	$253
Total as of 2022 Budget Act	***$3,107***	***$8,041***	***$12,653***	***$14,611***	***$13,359***	***$16,397***

BCP Fiscal Detail Sheet

BCP Title: Enhanced Treatment Program (ETP) Staffing **BR Name: 4440-085-ECP-2022-MR**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5301 - General Expense	0	65	0	0	0	0
5324 - Facilities Operation	400	0	0	0	0	0
5340 - Consulting and Professional Services - External	-12	0	0	0	0	0
539X - Other	0	188	0	0	0	0
Total Operating Expenses and Equipment	**$388**	**$253**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$388**	**$253**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	388	253	0	0	0	0
Total State Operations Expenditures	**$388**	**$253**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$388**	**$253**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4410010 - Atascadero	-12	100	0	0	0	0
4410050 - Patton	400	153	0	0	0	0
Total All Programs	**$388**	**$253**	**$0**	**$0**	**$0**	**$0**

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*
May Revision	**0.0**	**0.0**	**0.0**	**-$203**	**$0**	**$0**
One-time	*0.0*	*0.0*	*0.0*	*-$203*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Total	**0.0**	**0.0**	**0.0**	**-$482**	**$0**	**$0**
One-time	*0.0*	*0.0*	*0.0*	*-$482*	*$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 that provides a range of vocational skills and therapeutic interventions. DSH clinicians work closely with DSH Vocational Rehabilitation Program managers to incorporate a treatment plan to assist patients in developing social, occupational, life, and career skills, and confidence. Vocational Rehabilitation assists patients by preparing for discharge and/or transition to next level of care, successful community integration when released, obtaining future employment and reducing criminal recidivism.

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:

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

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.

In the 2021 Budget Act, 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 of increased public health infection control measures, the Vocational Services Program experienced a decline in capacity.

In the 2022-23 Governor's Budget, DSH reported a current year one-time savings of $279,000 due to a decrease in patient workers as a result of COVID-19 safety precautions on patient movement around the hospital. DSH reported to not resume pre-pandemic patient work on units until July 2022.

DESCRIPTION OF CHANGE

As of the FY 2022-23 May Revision, the Vocational Services Program is still impacted due to the restrictions from COVID-19. 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.

The table below reflects current year (CY) actual data through January 2022. This data includes average hours worked, the average number of patient workers and expenditures.

FY 2021-22 Actual Data as of January 2022

FY 2021-22 Actuals			
State Hospitals	**Avg Hours Worked Per Patient**	**Avg Number of Patient Workers**	**Expenditures**
Atascadero	31	119	$322,865
Coalinga	21	487	$893,117
Metropolitan	10	93	$78,815
Napa	12	60	$61,691
Patton	8	46	$30,236
Total	**82**	**805**	**$1,386,724**

CY Projections

Due to COVID-19 and the availability of more current data at May Revision, DSH has adjusted its projection methodology. The below projections were calculated by utilizing FY 2021-22 actuals through January 2022 and using a straight-line methodology for the remaining months.

FY 2021-22 Projection			
State Hospitals	**Avg Hours Worked Per Patient**	**Avg Number of Patient Workers**	**Expenditures**
Atascadero	53	119	$553,000
Coalinga	36	487	$1,531,000
Metropolitan	17	93	$135,000
Napa	20	60	$106,000
Patton	13	46	$52,000
Total	**139**	**805**	**$2,377,000**

CY Allocation Adjustment

Comparing the base allocation for FY 2021-22 to the updated current year projections above, DSH is showing an overall one-time savings of $482,000. This is an additional savings of $203,000 over the $279,000 savings reported at Governor's Budget. The table below displays the savings. DSH is anticipating that as the program resumes standard operations, the program will return to capacity similar to FY 2019-20. An update will be provided in FY 2023-24 Governor's Budget.

FY 2021-22 Vocational Services Program Projections					
State Hospitals	**FY 2021-22 Allocation**	**FY 2021-22 Projected Expenditures**	**Net Difference**	**Less GB Adjustment**	**Total MR Adjustment**
Atascadero	$624,000	$ 553,000	-$71,000	-$63,000	-$8,000
Coalinga	$1,607,000	$1,531,000	-$76,000	-$114,000	$38,000
Metropolitan	$133,000	$135,000	$2,000	-$8,000	$10,000
Napa	$167,000	$106,000	-$61,000	-$41,000	-$20,000
Patton	$328,000	$52,000	-$276,000	-$53,000	-$223,000
Total	**$2,859,000**	**$2,377,000**	**-$482,000**	**-$279,000**	**-$203,000**

BCP Fiscal Detail Sheet

BCP Title: Vocational Services and Patient Minimum Wage Caseload **BR Name: 4440-077-ECP-2022-MR**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	-203	0	0	0	0	0
Total Operating Expenses and Equipment	**$-203**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-203**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-203	0	0	0	0	0
Total State Operations Expenditures	**$-203**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-203**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4410010 - Atascadero	-8	0	0	0	0	0
4410020 - Coalinga	38	0	0	0	0	0
4410030 - Metropolitan	10	0	0	0	0	0
4410040 - Napa	-20	0	0	0	0	0
4410050 - Patton	-223	0	0	0	0	0
Total All Programs	**$-203**	**$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*
May Revision	***0.0***	***-27.1***	***-29.5***	***-$19,087***	***-$8,155***	***-$9,420***
One-time	*0.0*	*0.0*	*0.0*	*-$18,411*	*$179*	*$0*
Ongoing	*0.0*	*-27.1*	*-29.5*	*-$676*	*-$8,334*	*-$9,420*
Total	***0.0***	***13.9***	***11.5***	***-$36,335***	***-$3,945***	***-$5,496***
One-time	*0.0*	*0.0*	*0.0*	*-$36,931*	*$465*	*$0*
Ongoing	*0.0*	*13.9*	*11.5*	*$596*	*-$4,410*	*-$5,496*

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 been temporarily impacted due to COVID-19. 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 regular review and analysis of current staffing models.

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

support the current populations served, assessed relief factor coverage needs and reviewed current staffing levels within core clinical and safety functions.

Court Evaluations and Reports

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

Direct Care Nursing

The staffing standard was developed through research conducted within DSH's Clinical Staffing Study and in collaboration with the DOF Research and Analysis Unit through a Mission-Based Review. The proposal examined nurse-to-patient ratios for providing 24-hour nursing care and the components available to achieve these ratios including internal registries, overtime, 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 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. As a solution, DSH developed and implemented a Psychiatric Residency Program and expanded resources for

Nursing Recruitment to meet the mission of providing mental health services to patients and reduce vacancy rates for mental health providers.

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 of the clinical staffing study 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*
May Revision	**0.0**	**0.0**	**0.0**	**$2,273**	**$0**	**$0**
One-time	*0.0*	*0.0*	*0.0*	*$2,273*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Total	**0.0**	**0.0**	**0.0**	**$751**	**$0**	**$0**
One-time	*0.0*	*0.0*	*0.0*	*$751*	*$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.

In the 2022-23 Governor's Budget, DSH reported one-time savings in current year (CY) of $1,522,000 due to delays in hiring.

DESCRIPTION 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 February 28, 2022, all 53.1 positions have been established and 41.0 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 an additional one-time CY savings of $1,355,000.

Evaluations, Court Reports and Testimony	Total	Filled
Senior Psychiatrist Supervisor	2.0	0.0
Senior Psychiatrist Specialist	5.1	3.0
Staff Psychiatrist	-0.5	-0.5
Senior Psychologist Supervisor	5.9	4.0
Senior Psychologist Specialist	45.2	39.0
Psychologist - Clinical	-10.5	-10.5
Consulting Psychologist	4.9	5.0
Research Data Specialist II	1.0	1.0
TOTAL	**53.1**	**41.0**

Outcomes

Due to impacts of COVID-19, reporting of outcomes will be delayed as DSH continues to focus 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 February 28, 2021, all 16.3 positions have been established and 10.1 positions have been filled. DSH is actively recruiting to fill these positions, however not all positions have been filled. DSH over projected savings in the 2022-23 Governor's Budget for this section and is actually projecting to utilize one-time CY savings previously reported of $166,000.

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	14.8
Correctional Case Records Analyst	-14.5	-14.5
Staff Services Analyst	17.7	15.8
TOTAL	**16.3**	**10.1**

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 February 28, 2022, all 25.2 positions have been established and 20.5 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 an additional one-time CY savings of $38,000.

Neuropsychological Services	**Total**	**Filled**
Neuropsychological Assessments and Treatment		
Senior Psychologist Supervisor	3.5	3.0
Senior Psychologist Specialist	7.7	3.5
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 has decreased the wait time for completion of referrals and increased the number of patients seen monthly.

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

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 31 patients enrolled from July 2021 to December 2021, 17 achieved competency and nine were deemed NSL (No Substantial Likelihood that the patient will be able to stand trial). An additional 26 patients are currently enrolled as of February 28, 2022. The RISE program currently has 24 patients enrolled. There are currently 6 RISE groups that provide treatment to eight different treatment units.

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.

Renovation of DSH-Patton General Services Building

DSH proposes to redirect $3.5 million in current year savings across all Mission-Based Review proposals to fund the renovation of the General Services building at DSH-Patton. Upon completion, this renovation will consolidate all of the current Forensic Department staff into one location. DSH has estimated $3 million for the facility modernization expenses plus information technology (IT) costs of $500,000. By renovating this space, a multitude of other moves will follow and assist with other space issues. The two spaces vacated by the Forensics staff will allow Pharmacy staff to occupy one of the spaces. Currently, they are overwhelmed in a building with various machines and only have limited space between each area and too many staff occupied per office, these issues have previously been cited by licensing. This will allow Pharmacists and Pharmacy Techs the ability to work safely social distanced. The second vacated space will allow the Equal Employment Office, External Affairs, Trauma Informed Care and Clinical Operations Advisory Council hoteling space to occupy. This space will allow unions to utilize the conference room for meetings with their members as the

space previously used was recently condemned. Movement of this space will free up space in another location where public health is located, the vacated space will allow public health to expand and allow space for the employee clinic. Moving the employee clinic will free up space for the expanding Human Resources department staff. Renovating one building will provide relief for eight areas in grave need of space and are not eligible for telework options. Capital Outlay or Department of General Services will not need to be involved with the renovations as these are minor public works contracts and renovations that will be done with DSH-Patton Plant Operations Staff.

BCP Fiscal Detail Sheet

BCP Title: Mission Based Review: Court Evaluations and Reports **BR Name: 4440-072-ECP-2022-MR**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Salaries and Wages						
Earnings - Permanent	-794	0	0	0	0	0
Total Salaries and Wages	**$-794**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-371	0	0	0	0	0
Total Personal Services	**$-1,165**	**$0**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-34	0	0	0	0	0
5304 - Communications	-4	0	0	0	0	0
5320 - Travel: In-State	-4	0	0	0	0	0
5324 - Facilities Operation	-21	0	0	0	0	0
5346 - Information Technology	501	0	0	0	0	0
539X - Other	3,000	0	0	0	0	0
Total Operating Expenses and Equipment	**$3,438**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$2,273**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	2,273	0	0	0	0	0
Total State Operations Expenditures	**$2,273**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$2,273**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4400020 - Hospital Administration	501	0	0	0	0	0
4410010 - Atascadero	-463	0	0	0	0	0
4410020 - Coalinga	149	0	0	0	0	0
4410030 - Metropolitan	-614	0	0	0	0	0
4410040 - Napa	-300	0	0	0	0	0
4410050 - Patton	3,000	0	0	0	0	0
Total All Programs	**$2,273**	**$0**	**$0**	**$0**	**$0**	**$0**

BCP Title: Mission Based Review: Court Evaluations and Reports **BR Name: 4440-072-ECP-2022-MR**

Personal Services Details

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
5157 - Staff Svcs Analyst (Gen)	38	0	0	0	0	0
5393 - Assoc Govtl Program Analyst	51	0	0	0	0	0
7609 - Sr Psychiatrist (Supvr)	-279	0	0	0	0	0
7616 - Sr Psychiatrist (Spec)	-61	0	0	0	0	0
9831 - Sr Psychologist (Hlth Facility) (Supvr)	-158	0	0	0	0	0
9839 - Sr Psychologist (Hlth Facility) (Spec)	-385	0	0	0	0	0
Total Salaries and Wages	**$-794**	**$0**	**$0**	**$0**	**$0**	**$0**
Staff Benefits						
5150200 - Disability Leave - Industrial	-10	0	0	0	0	0
5150210 - Disability Leave - Nonindustrial	-3	0	0	0	0	0
5150350 - Health Insurance	-37	0	0	0	0	0
5150450 - Medicare Taxation	-11	0	0	0	0	0
5150500 - OASDI	6	0	0	0	0	0
5150600 - Retirement - General	-146	0	0	0	0	0
5150800 - Workers' Compensation	-37	0	0	0	0	0
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	-22	0	0	0	0	0
5150900 - Staff Benefits - Other	-111	0	0	0	0	0
Total Staff Benefits	**$-371**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$-1,165**	**$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*
May Revision	**0.0**	**0.0**	**0.0**	**-$4,569**	**$0**	**$0**
One-time	*0.0*	*0.0*	*0.0*	*-$4,569*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Total	**0.0**	**32.0**	**32.0**	**-$9,141**	**$735**	**$735**
One-time	*0.0*	*0.0*	*0.0*	*-$9,141*	*$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.

In the 2022-23 Governor's Budget, DSH reported one-time savings in current year (CY) of $4,572,000 due to vacant positions, requested position authority only for 32.0 off-unit positions to allow current staff to go back on-unit beginning in FY 2022-23, and requested $735,000 to fill the phase-in gap for positions coming on in 2022-23.

DESCRIPTION OF CHANGE:

<u>Medication Pass Psychiatric Technicians</u>

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 February 28, 2022, a total of 220.5 positions have been established and 145.0 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 an additional one-time savings in CY of $4,459,000.

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 within the dedicated Medication Pass rooms. If hospitals have been unsuccessful in their recruiting efforts with the PT classification, LVNs may be able to be recruited for to assist in getting vacancies filled. DSH will provide a report on in the 2021-22 May Revision on the status of filling these positions with either classification.

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, more staff time is dedicated to medication administration and contributes to a lower number of medication errors. Quality Improvement reviews of Medication Room operations at a few DSH locations where the resources were implemented 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 February 28, 2022, a total of 44.5 positions have been established and 34.3 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 an additional one-time savings in CY of $110,000.

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	25.3
TOTAL	**44.5**	**34.3**

Outcomes

Due to impacts of COVID-19, reporting of quantitative outcomes continues to be in progress, but DSH has made significant progress in filling these positions. 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.

Bargaining Unit 18 Pay Differential Request to CalHR

DSH has experienced significant challenges in recruiting and retaining Bargaining Unit (BU) 18 employees (BU 18 employees are Psychiatric Technicians). To attract and retain BU 18 employees, DSH has requested a Recruitment and Retention Pay Differential for all BU 18 employees and managerial/supervisory staff that oversee them.

BCP Fiscal Detail Sheet

BCP Title: Mission Based Review: Direct Care Nursing **BR Name: 4440-073-ECP-2022-MR**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Salaries and Wages						
Earnings - Permanent	-2,689	0	0	0	0	0
Total Salaries and Wages	**$-2,689**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-1,291	0	0	0	0	0
Total Personal Services	**$-3,980**	**$0**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-295	0	0	0	0	0
5304 - Communications	-37	0	0	0	0	0
5320 - Travel: In-State	-37	0	0	0	0	0
5324 - Facilities Operation	-184	0	0	0	0	0
5346 - Information Technology	-36	0	0	0	0	0
Total Operating Expenses and Equipment	**$-589**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-4,569**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-4,569	0	0	0	0	0
Total State Operations Expenditures	**$-4,569**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-4,569**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4400020 - Hospital Administration	-36	0	0	0	0	0
4410010 - Atascadero	-3,291	0	0	0	0	0
4410020 - Coalinga	-665	0	0	0	0	0
4410030 - Metropolitan	-121	0	0	0	0	0
4410040 - Napa	36	0	0	0	0	0
4410050 - Patton	-492	0	0	0	0	0
Total All Programs	**$-4,569**	**$0**	**$0**	**$0**	**$0**	**$0**

BCP Title: Mission Based Review: Direct Care Nursing **BR Name: 4440-073-ECP-2022-MR**

Personal Services Details

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
8094 - Registered Nurse (Safety)	-67	0	0	0	0	0
8253 - Psych Techn (Safety)	-2,622	0	0	0	0	0
Total Salaries and Wages	**$-2,689**	**$0**	**$0**	**$0**	**$0**	**$0**
Staff Benefits						
5150200 - Disability Leave - Industrial	-36	0	0	0	0	0
5150210 - Disability Leave - Nonindustrial	-10	0	0	0	0	0
5150350 - Health Insurance	-124	0	0	0	0	0
5150450 - Medicare Taxation	-40	0	0	0	0	0
5150600 - Retirement - General	-523	0	0	0	0	0
5150700 - Unemployment Insurance	-3	0	0	0	0	0
5150800 - Workers' Compensation	-124	0	0	0	0	0
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	-76	0	0	0	0	0
5150900 - Staff Benefits - Other	-355	0	0	0	0	0
Total Staff Benefits	**$-1,291**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$-3,980**	**$0**	**$0**	**$0**	**$0**	**$0**

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*
May Revision	**0.0**	**0.0**	**0.0**	**$60**	**$179**	**$0**
One-time	*0.0*	*0.0*	*0.0*	*$60*	*$179*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Total	**0.0**	**0.0**	**0.0**	**-$355**	**$179**	**$0**
One-time	*0.0*	*0.0*	*0.0*	*-$355*	*$179*	*$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 2022-23 Governor's Budget, DSH reported one-time current year (CY) savings of $415,000 due to the over shift by one year of the residency program. DSH also stated that more information on the status of the proposed Residency Program expansion at DSH-Napa would be provided in the May Revision.

DESCRIPTION OF CHANGE:

Residency Program Update

The Residency Program at St. Joseph Medical Center (SJMC) received temporary accreditation from the Accreditation Council for Graduate Medical Education (ACGME) in February 2021. Both DSH positions, an Associate Program Director and Hospital Administration Resident II were filled. The Residency Program hired its first cohort of seven residents who began their training in July 2021. Five of the seven rotated through DSH-Napa and two will be there in May 2022. DSH-Napa has also entered the recruitment phase for the next cohort. In the process, DSH-Napa reviewed over 700 applications, interviewed 147 candidates, and submitted its

rank order list to the residency match program. DSH-Napa has been matched with another seven candidates. 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 was provided by SJMC, it was higher than what DSH had projected in the original request (seven residents versus four residents per program year). However, due to the yearlong delay in implementation because of COVID-19, sufficient funding remains from the original BCP until fiscal year (FY) 2024-25 to fund the additional residents. There are no additional savings to report at this time.

DSH reported in the 2022-23 Governor's Budget that, due to the success of the Residency Program thus far, DSH would investigate an expansion of the program to include more residents. DSH has since learned that an expansion at DSH-Napa will not be allowable until the program is fully accredited and has graduated its first class of residents, which will not occur until FY 2024-25. However, DSH requests to redirect CY savings of $60,000 and $179,000 in BY to fund 1.0 Staff Services Manager II Specialist to be hired on a limited term basis using existing position authority to lead research efforts to build future partnerships to expand the psychiatry residency programs to other DSH state hospitals.

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.

Cohorts from 2019 started with 90 students, graduated 73 and DSH-Atascadero hired 58. Cohorts from 2020 started with 55 students (due to COVID-19, one class was not registered), graduated 60 and DSH-Atascadero hired 32. Cohorts for 2021 started with 60 students, graduated 53 and DSH-Atascadero hired eight. The January 2022 cohort has 26 students, and the May 2022 cohort will have 26 students.

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 first cohort from 2020 started with 30 students, three of which graduated in May 2021. Two graduates obtained employment at DSH-Napa in August 2021. The second cohort from 2020 started with 30 students graduated 15 students in December 2021. Of these 15, 11 have been hired by DSH-Napa. The first cohort from 2022 has started with 26 students and 15 will be graduating in May 2022.

BCP Fiscal Detail Sheet

BCP Title: Mission Based Review: Workforce Development **BR Name: 4440-074-ECP-2022-MR**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Salaries and Wages						
Earnings - Permanent	33	58	-42	-42	-42	-42
Total Salaries and Wages	**$33**	**$58**	**$-42**	**$-42**	**$-42**	**$-42**
Total Staff Benefits	22	56	-8	-8	-8	-8
Total Personal Services	**$55**	**$114**	**$-50**	**$-50**	**$-50**	**$-50**
Operating Expenses and Equipment						
5301 - General Expense	3	8	0	0	0	0
5304 - Communications	0	1	0	0	0	0
5320 - Travel: In-State	0	1	0	0	0	0
5324 - Facilities Operation	2	5	0	0	0	0
5340 - Consulting and Professional Services - External	0	50	50	50	50	50
Total Operating Expenses and Equipment	**$5**	**$65**	**$50**	**$50**	**$50**	**$50**
Total Budget Request	**$60**	**$179**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	60	179	0	0	0	0
Total State Operations Expenditures	**$60**	**$179**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$60**	**$179**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4400010 - Headquarters Administration	60	229	50	50	50	50
4410040 - Napa	0	-50	-50	-50	-50	-50
Total All Programs	**$60**	**$179**	**$0**	**$0**	**$0**	**$0**

Personal Services Details

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
4969 - Staff Svcs Mgr II (Mgrial)	33	100	0	0	0	0
5393 - Assoc Govtl Program Analyst	0	73	73	73	73	73
8154 - Nurse Instructor	0	-115	-115	-115	-115	-115
Total Salaries and Wages	**$33**	**$58**	**$-42**	**$-42**	**$-42**	**$-42**
Staff Benefits						
5150200 - Disability Leave - Industrial	0	0	-1	-1	-1	-1
5150350 - Health Insurance	2	3	-2	-2	-2	-2
5150450 - Medicare Taxation	0	0	-1	-1	-1	-1
5150500 - OASDI	2	11	5	5	5	5
5150600 - Retirement - General	11	29	-1	-1	-1	-1
5150800 - Workers' Compensation	2	3	-2	-2	-2	-2
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	1	2	-1	-1	-1	-1
5150900 - Staff Benefits - Other	4	8	-5	-5	-5	-5
Total Staff Benefits	**$22**	**$56**	**$-8**	**$-8**	**$-8**	**$-8**
Total Personal Services	**$55**	**$114**	**$-50**	**$-50**	**$-50**	**$-50**

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*
May Revision	**0.0**	**0.0**	**0.0**	**-$4,807**	**$0**	**$0**
One-time	*0.0*	*0.0*	*0.0*	*-$4,131*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*-$676*	*$0*	*$0*
Total	**0.0**	**10.0**	**10.0**	**-$6,396**	**$2,298**	**$2,012**
One-time	*0.0*	*0.0*	*0.0*	*-$6,396*	*$286*	*$0*
Ongoing	*0.0*	*10.0*	*10.0*	*$0*	*$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.

In the 2022-23 Governor's Budget, DSH reported one-time savings in current year (CY) of $2.0 million due to hiring delays. Of that savings, DSH requested $676,000 be used to Administratively hire and fund 10.0 Hospital Police Officer positions to staff the DSH-Coalinga Main Courtyard Expansion. DSH also requested to shift $286,000 in overtime funding to conduct field training from CY to budget year (BY) due to delays in hiring. In FY 2022-23 and ongoing, DSH requested position authority and funding of $1.3 million for the 10.0 Hospital Police Officers to staff the DSH-Coalinga Main Courtyard and funding of $660,000 to fill the phase-in gap for positions coming on in FY 2022-23.

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

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 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 February 28, 2022, a total of 52.8 positions have been established and 6.0 have been filled. To fill the remaining positions, DSH has converted the exams to online, multiple choice with Hospital Police Officer exams offered monthly and the sergeant and lieutenant exams offered every six months. DSH has also contracted with CPS HR to market the vacancies and will be centralizing the five hospitals' separate job postings into one posting in early April 2022. The next DSH Academy cohort will run from May 2, 2022, through August 10, 2022. This cohort currently has 13 cadets assigned and 30 applicants pending pre-employment screenings. DSH is projecting an additional savings in CY of $3,529,000.

Classification	Total as of 2/28/22	Filled as of 2/28/22
Hospital Police Lieutenant	3.0	0.0
Hospital Sergeant	4.3	0.0
Hospital Police Officer	45.5	6.0
TOTAL	**52.8**	**6.0**

DSH-Coalinga's Main Courtyard Expansion

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. 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. In the 2022-23 Governor's Budget proposal, DSH requested to redirect $676,000 in savings and administratively establish 10.0 HPOs effective January 1, 2022, for current year. However, because of a delay in construction, the DSH-Coalinga Main Courtyard Expansion project will not be completed this fiscal year and DSH will no longer require the 10.0 HPOs in the current year. DSH maintains its request for $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 February 28, 2022, 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 the 5.0 Chief of Police positions have been advertised; four of the five Chief positions are expected to be filled soon. DSH awaits CalHR approval for the Assistant Chief of Law Enforcement position. As a result, DSH is projecting an additional savings in CY of $602,000.

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**

BCP Fiscal Detail Sheet

BCP Title: Mission Based Review: Protective Services **BR Name: 4440-075-ECP-2022-MR**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Salaries and Wages						
Earnings - Permanent	-2,626	0	0	0	0	0
Total Salaries and Wages	**$-2,626**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-1,635	0	0	0	0	0
Total Personal Services	**$-4,261**	**$0**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-268	0	0	0	0	0
5304 - Communications	-36	0	0	0	0	0
5320 - Travel: In-State	-36	0	0	0	0	0
5324 - Facilities Operation	-172	0	0	0	0	0
5346 - Information Technology	-34	0	0	0	0	0
Total Operating Expenses and Equipment	**$-546**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-4,807**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-4,807	0	0	0	0	0
Total State Operations Expenditures	**$-4,807**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-4,807**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4400010 - Headquarters Administration	-3	0	0	0	0	0
4400020 - Hospital Administration	-130	0	0	0	0	0
4410010 - Atascadero	-100	0	0	0	0	0
4410020 - Coalinga	-771	0	0	0	0	0
4410030 - Metropolitan	-811	0	0	0	0	0
4410040 - Napa	-2,892	0	0	0	0	0
4410050 - Patton	-100	0	0	0	0	0
Total All Programs	**$-4,807**	**$0**	**$0**	**$0**	**$0**	**$0**

Personal Services Details

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
1935 - Hosp Police Lieut	-195	0	0	0	0	0
1936 - Hosp Police Sgt	-251	0	0	0	0	0
1937 - Hosp Police Officer	-1,838	0	0	0	0	0
7500 - - C.E.A. - A	-342	0	0	0	0	0
Total Salaries and Wages	**$-2,626**	**$0**	**$0**	**$0**	**$0**	**$0**
Staff Benefits						
5150200 - Disability Leave - Industrial	-36	0	0	0	0	0
5150210 - Disability Leave - Nonindustrial	-9	0	0	0	0	0
5150350 - Health Insurance	-123	0	0	0	0	0
5150450 - Medicare Taxation	-40	0	0	0	0	0
5150600 - Retirement - General	-849	0	0	0	0	0
5150700 - Unemployment Insurance	-2	0	0	0	0	0
5150800 - Workers' Compensation	-123	0	0	0	0	0
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	-104	0	0	0	0	0
5150900 - Staff Benefits - Other	-349	0	0	0	0	0
Total Staff Benefits	**$-1,635**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$-4,261**	**$0**	**$0**	**$0**	**$0**	**$0**

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*
May Revision	**0.0**	**-27.1**	**-29.5**	**-$12,044**	**-$8,334**	**-$9,420**
One-time	*0.0*	*0.0*	*0.0*	*-$12,044*	*$0*	*$0*
Ongoing	*0.0*	*-27.1*	*-29.5*	*$0*	*-$8,334*	*-$9,420*
Total	**0.0**	**-28.1**	**-30.5**	**-$21,194**	**-$7,175**	**-$8,243**
One-time	*0.0*	*0.0*	*0.0*	*-$21,790*	*$0*	*$0*
Ongoing	*0.0*	*-28.1*	*-30.5*	*$596*	*-$7,175*	*-$8,243*

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.

In the 2022-23 Governor's Budget, DSH reported one-time current year (CY) savings of $9,150,000 due to delays in hiring, permanently abolished 1.0 position and funding that was established in error, requested ongoing funding needed to fund the Clinical Executives' salaries which were under-funded in the original proposal, and requested ongoing funding to fill the phase-in gap for positions coming on in 2022-23.

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:

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 February 28, 2022, a total of 26.2 positions have been established and 4.0 have been filled. DSH is actively recruiting to fill these positions, however not all positions have been filled. As a result, DSH is projecting an additional savings in CY of $4,505,000. Due to the delays and challenges in hiring, DSH is requesting to shift a number of positions back to allow time to recruit for positions already authorized. By pushing these positions back, this will allow DSH to get caught up in current recruitment and be better positioned for future hires. This shift will not adjust the length of the phase-in. DSH is proposing to shift 29.5 positions that are

scheduled to be authorized in 2022-23 to January 1, 2026 (FY 2025-26). This shift will result in a budget reduction of $8.3 million in 2022-23, $9.4 million in 2023-24 and 2024-25, and $4.7 million in 2025-26 when the positions are phased-in mid-year.

Interdisciplinary Treatment Team	Total	Filled
Psychiatrist	11.0	0.0
Psychologist	10.0	0.0
Clinical Social Worker	0.2	1.0
Rehabilitation Therapist	5.0	3.0
TOTAL	**26.2**	**4.0**

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 February 28, 2022, a total of 19.6 positions have been established and 2.2 positions have been filled. As a result, DSH recognizes an additional one-time savings in CY of $3,743,000.

Primary Medical Care	Total	Filled
Chief Physician & Surgeon	5.0	0.0
Physician & Surgeon	14.6	2.2
TOTAL	**19.6**	**2.2**

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 February 28, 2022, a total of 6.0 positions have been established and all 6.0 positions have been filled. DSH received an entire year of funding for these positions, but they were only filled for half the year. There are no additional savings to report at this time.

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

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

Clinical Executive Structure

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

Administrative Support Positions

A total of 6.0 positions were allocated to support Administrative Services to be fully phased in beginning of FY 2021-22. 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 positions at each of the five hospitals and DSH-Sacramento. These positions are 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. These support positions can be either an Associate Personnel Analyst (APA) or a Staff Services Analyst (SSA)/Associate Governmental Program Analyst (AGPA) interchangeable position.

As of February 28, 2022, a total of 6.0 positions have been established and 4.0 have been filled. DSH is actively recruiting to fill the two remaining positions. As a result, DSH is projecting an additional one-time savings in CY of $135,000.

Administrative Support	Total	Filled
Associate Personnel Analyst	6.0	4.0
TOTAL	**6.0**	**4.0**

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 the positions.

As of February 28, 2022, a total of 12.0 positions have been established and none have been filled. DSH currently has recruits for three of the 12.0 positions pending final approval by control agencies. The Medical Director and Assistant Medical Director positions are still awaiting Safety Retirement approval. The remaining seven positions are currently being recruited and interviews are scheduled. As a result of the processes delay in hiring, DSH is projecting an additional one-time savings in CY 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 February 28, 2022, a total of 6.0 positions have been established and 1.0 has been filled. DSH has developed the duty statements for these new positions, and they have been advertised. As a result, DSH is projecting an additional one-time savings in CY of $363,000.

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

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 February 28, 2022, 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 expending all of the $12,193,000 allocated for this project and requests to reappropriate the remaining balance and extend the encumbrance and expenditure period until June 30, 2024. Provisional language is provided below:

4440-490—Reappropriation, State Department of State Hospitals. The balances of the appropriations provided in the following citations are reappropriated for the purposes provided for those appropriations and shall be available for encumbrance or expenditure as specified below:

0001—General Fund

(3) Item 4440-011-0001, Budget Act of 2021, Program 4400-Administration and 4410-State Hospitals to support the Mission Based Review – Treatment Team for Information Technology Infrastructure, Facilities and Minor Equipment shall be available for encumbrance or expenditure until June 30, 2024.

BCP Fiscal Detail Sheet

BCP Title: Mission Based Review: Treatment Team **BR Name: 4440-076-ECP-2022-MR**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	0.0	-27.1	-29.5	-29.5	-14.8	0.0
Total Positions	**0.0**	**-27.1**	**-29.5**	**-29.5**	**-14.8**	**0.0**
Salaries and Wages						
Earnings - Permanent	-7,777	-5,321	-6,024	-6,024	-3,013	0
Total Salaries and Wages	**$-7,777**	**$-5,321**	**$-6,024**	**$-6,024**	**$-3,013**	**$0**
Total Staff Benefits	-3,733	-2,579	-2,921	-2,921	-1,464	0
Total Personal Services	**$-11,510**	**$-7,900**	**$-8,945**	**$-8,945**	**$-4,477**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-259	-216	-236	-236	-118	0
5304 - Communications	-37	-28	-30	-30	-15	0
5320 - Travel: In-State	-37	-28	-30	-30	-15	0
5324 - Facilities Operation	-168	-136	-148	-148	-74	0
5346 - Information Technology	-33	-26	-31	-31	-13	0
Total Operating Expenses and Equipment	**$-534**	**$-434**	**$-475**	**$-475**	**$-235**	**$0**
Total Budget Request	**$-12,044**	**$-8,334**	**$-9,420**	**$-9,420**	**$-4,712**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-12,044	-8,334	-9,420	-9,420	-4,712	0
Total State Operations Expenditures	**$-12,044**	**$-8,334**	**$-9,420**	**$-9,420**	**$-4,712**	**$0**
Total All Funds	**$-12,044**	**$-8,334**	**$-9,420**	**$-9,420**	**$-4,712**	**$0**

Program Summary

Program Funding						
4400010 - Headquarters Administration	-629	0	0	0	0	0
4400020 - Hospital Administration	-33	-26	-31	-31	-13	0
4410010 - Atascadero	-2,126	-1,406	-1,515	-1,515	-758	0
4410020 - Coalinga	-2,890	-1,469	-2,138	-2,138	-1,070	0
4410030 - Metropolitan	-2,367	-1,935	-2,044	-2,044	-1,024	0
4410040 - Napa	-1,962	-2,166	-2,359	-2,359	-1,180	0
4410050 - Patton	-2,037	-1,332	-1,333	-1,333	-667	0

Total All Programs	**$-12,044**	**$-8,334**	**$-9,420**	**$-9,420**	**$-4,712**	**$0**

BCP Title: Mission Based Review: Treatment Team **BR Name: 4440-076-ECP-2022-MR**

Personal Services Details

Positions			Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
5142	-	Assoc Pers Analyst				0.0	0.0	0.0	0.0	0.0	0.0
7552	-	Physician & Surgeon (Safety)				0.0	0.0	0.0	0.0	0.0	0.0
7561	-	Chief Physician & Surgeon				0.0	0.0	0.0	0.0	0.0	0.0
7619	-	Staff Psychiatrist (Safety)				0.0	-13.1	-15.5	-15.5	-7.8	0.0
8324	-	Rehab Therapist (Recr-Safety)				0.0	0.0	0.0	0.0	0.0	0.0
9872	-	Clinical Soc Worker (Hlth/CF)-Safety				0.0	0.0	0.0	0.0	0.0	0.0
9873	-	Psychologist (Hlth Facility-Clinical-Safety)				0.0	-14.0	-14.0	-14.0	-7.0	0.0
VR00	-	Various				0.0	0.0	0.0	0.0	0.0	0.0
Total Positions						**0.0**	**-27.1**	**-29.5**	**-29.5**	**-14.8**	**0.0**

Salaries and Wages			CY	BY	BY+1	BY+2	BY+3	BY+4
5142	-	Assoc Pers Analyst	-73	0	0	0	0	0
7552	-	Physician & Surgeon (Safety)	-1,615	0	0	0	0	0
7561	-	Chief Physician & Surgeon	-814	0	0	0	0	0
7619	-	Staff Psychiatrist (Safety)	-2,324	-3,799	-4,502	-4,502	-2,252	0
8324	-	Rehab Therapist (Recr-Safety)	-8	0	0	0	0	0
9872	-	Clinical Soc Worker (Hlth/CF)-Safety	-345	0	0	0	0	0
9873	-	Psychologist (Hlth Facility-Clinical-Safety)	-435	-1,522	-1,522	-1,522	-761	0
VR00	-	Various	-2,163	0	0	0	0	0
Total Salaries and Wages			**$-7,777**	**$-5,321**	**$-6,024**	**$-6,024**	**$-3,013**	**$0**
Staff Benefits								
5150200	-	Disability Leave - Industrial	-105	-69	-79	-79	-39	0
5150210	-	Disability Leave - Nonindustrial	-28	-22	-24	-24	-13	0
5150350	-	Health Insurance	-359	-245	-276	-276	-140	0
5150450	-	Medicare Taxation	-118	-81	-92	-92	-44	0
5150500	-	OASDI	-4	0	0	0	0	0
5150600	-	Retirement - General	-1,509	-1,060	-1,205	-1,205	-603	0
5150700	-	Unemployment Insurance	-6	-5	-6	-6	-3	0
5150800	-	Workers' Compensation	-359	-245	-276	-276	-140	0

5150820	-	Other Post-Employment Benefits (OPEB) Employer Contributions	-217	-149	-169	-169	-84	0
5150900	-	Staff Benefits - Other	-1,028	-703	-794	-794	-398	0
Total Staff Benefits			**$-3,733**	**$-2,579**	**$-2,921**	**$-2,921**	**$-1,464**	**$0**
Total Personal Services			**$-11,510**	**$-7,900**	**$-8,945**	**$-8,945**	**$-4,477**	**$0**

STATE HOSPITALS
PATIENT-DRIVEN OPERATING EXPENSES & EQUIPMENT
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*
May Revision	**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*
Total	**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. While DSH received funding for positions and associated staff operating expenses and equipment (OE&E) for the bed activations, the department did not receive funding for patient related OE&E items such as outside medical care, pharmaceuticals, patient clothing, food stuffs, etc. The Budget Act of 2019 adopted a standardized cost estimate methodology to provide funding for such patient purchases based on updated census estimates for budget year (BY) and an estimated cost per patient, derived from past year actual expenditures.

In the Budget Act of 2020 and 2021 this proposal was converted to an informational only proposal due to difficulties with projecting future patient driven costs and patient census during the COVID-19 pandemic. DSH continued to monitor and manage these expenditures closely through each budget year, and has determined 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.

In the 2022-23 Governor's Budget, DSH requested $1.9 million in FY 2022-23 and ongoing to support patient related operating and expense (OE&E) needs for DSH's adjusted population and FY 2018-19 average cost per patient actual expenditures.

DESCRIPTION OF CHANGE

In the 2022-23 May Revision, DSH continues to request $1.9 million in FY 2022-23 to support the Operating Expense and Equipment needs for the projected FY 2022-23 patient census of 5,740 in the state hospitals.

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*
May Revision	**0.0**	**0.0**	**0.0**	**$0**	**$18,524**	**$0**
One-time	*0.0*	*0.0*	*0.0*	*$0*	*$18,524*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Total	**0.0**	**0.0**	**0.0**	**$0**	**$83,124**	**$0**
One-time	*0.0*	*0.0*	*0.0*	*$0*	*$83,124*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*

BACKGROUND

Since late May 2020, DSH has experienced a significant number of positive cases of COVID-19 among its patients, its employees and other workers assigned to DSH facilities. The hospitals are performing widespread testing for both patients and employees to minimize the spread of COVID-19 within the high-risk congregate living setting. DSH is also performing ongoing surveillance testing for employees working in its skilled nursing facilities, gero-psychiatric units, and medically fragile units within its hospitals.

The Department has activated a number of patient isolation units at each hospital where patients who have tested positive for COVID-19 are isolated from other patients. Units where potential exposures may have occurred were placed on quarantine with increased infection prevention measures while serial testing of patients and employees is conducted. DSH has also implemented Admission Observation Units for patients returning from outside medical facilities or who are newly admitting to a state hospital. Patients admitted to these units will be observed for signs and symptoms of COVID-19 for a specified period of time and receive serial testing for COVID-19. After the observation period, if they are negative for COVID-19, the patient will be moved to their regularly assigned treatment unit. The Department has also implemented an on-site employee testing program.

DSH remains committed to preventing the spread of COVID-19 within DSH hospitals and working with local Public Health officials to protect patients and employees. The COVID-19 pandemic continues to rapidly evolve. The

Department continues to plan, assess and progress its preparedness and response to the rapidly changing circumstances and Public Health guidance. Highlights of the Department's preparation activities since the pandemic started including:

- In mid-March 2020, DSH-Sacramento activated the department's Emergency Operation Center, and hospitals have activated their incident command centers and developed incident action plans to better communicate and coordinate our department's response efforts.
- Hospitals have updated their plans for infection control, respiratory protection, and pandemic response.
- Video-visiting is available at all hospitals for patients and their family members.
- All hospital employees are being screened for symptoms of COVID-19, including having their temperature taken, as they arrive for work. Employees who do not pass the screening are sent home.
- Hospital employees are required to wear a mask when they are in patient care areas. In addition, they must wear a mask in other areas when working in close proximity to others, or as mandated by local orders.
- New or readmitting patients are tested for COVID-19 either prior to or upon admission to our hospitals. Current patients are tested for COVID-19 when clinically indicated or when there has been a potential exposure to COVID-19.
- Employees are being tested for COVID-19 when there has been a potential exposure. Surveillance testing is ongoing for employees working in DSH's skilled nursing, medically fragile, and geriatric units.
- All patients are being provided a mask and encouraged to wear it.
- Isolation spaces for treatment of patients who have tested positive for COVID-19 were identified and prepared.
- Patient social distancing measures have been implemented and regular patient activities have been modified.
- Telework is available for positions that are eligible, to the extent that the department can still fulfill its critical essential services.
- Admissions of certain categories of patients were temporarily suspended due to high in-facility COVID-19 rates from mid-March through late May 2020, again in mid-January through mid-February2021 and again in early January through early March 2022.
- Admissions Observation Units were established to observe and test patients who are admitting to our hospitals for COVID-19 before they are moved to their treatment unit.
- In November 2020, DSH activated the Southern Youth Correctional Center, Norwalk, to treat patients if more bed space is needed at a state hospital to respond to a COVID-19 outbreak.

- In December 2020, DSH began daily COVID-19 antigen testing of hospital staff who have contact with patients or work in patient care areas. All other hospital staff who do not have patient contact are required to participate in weekly PCR testing.
- In December, DSH began offering COVID-19 vaccinations to patients and staff.
- Patients and employees have received, and continue to receive, information about how to protect themselves from COVID-19, including activities involving personal hygiene and social distancing.
- DSH programs including the statewide Conditional Release Program, the Los Angeles Community Based Restoration Program and Jail-Based Competency Programs have implemented modified programming to ensure continued delivery of effective treatment while adhering to social distancing guidelines.
- Members of the Executive Team serve as members of regional and national workgroups and associations with members from other state hospitals across the country. They are monitoring trends and best practices of our state hospitals and other healthcare systems who are planning, preparing and responding to COVID-19.

As of the 2022-23 May Revision DSH has the following updates:

- Vaccination Update – As of March 18, 2022, DSH has achieved a staff vaccination rate of 82% and staff booster rate of 70% of staff eligible for booster doses. For patients, DSH has achieved a vaccination rate of 81% and patient booster rate of 86% of patients eligible for booster doses. Some staff and patients may have qualified for a medical or religious exemption from the mandatory COVID-19 vaccination. Below are the details on the State Public Health Orders as they were issued.
    - 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.
    - In December 2021, an updated State Public Health Order on vaccines was issued and requires eligible workers in health care and high-risk congregate settings, including those who work at DSH hospitals, to receive their COVID-19 booster by February 1, 2022. The State Public Health Order lays out the eligibility and recommended timeframes for booster doses.
    - In January 2022, the deadline for the required booster shots was extended from February 1, 2022, to March 1, 2022.

- COVID-19 Cases and Hospital Updates – As of March 17, 2022, DSH performed 150,222 PCR tests on 10,117 patients across all five hospitals, with 3,317 patients testing positive. DSH also performed 254,678 PCR staff tests statewide, 1,600,613 antigen tests statewide and with a total of 5,802 testing positive.

In the 2022-23 Governor's Budget, DSH requested $64.6 million one-time General Fund (GF) in fiscal year (FY) 2022-23 related to estimated direct response expenditure costs to continue responding to and mitigating the impacts of the COVID-19 Pandemic.

DESCRIPTION OF CHANGE

As of the 2023-23 May Revision, DSH requests an additional $18.5 million one-time GF in FY 2022-23 due to increased direct response expenditure costs to continue responding to and mitigating the impacts of the COVID-19 Pandemic. Increased costs due to DSH having more actual data to use as a base methodology and due to the extension of DSH being able to use the Norwalk Alternate Care Site (ACS) for an additional six months. Funding for the ACS includes staffing and operating costs.

Proposed funding will be used for three main areas of response: personnel services, operating equipment and expenses (OE&E) and testing. Personnel services increased by $14.1 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. OE&E costs were not captured in the Governor's Budget request, however, are necessary and total to $11.7 million. OE&E captures costs operating expenses that are both tangible and intangible. Tangible items are generally consumable in nature, requiring continuous replenishment such as PPE, sanitation supplies and food supplies that are above and beyond normal expenditures. Intangible items are non-consumables in nature. This includes equipment, heating/air, filters, IT solutions, outside medical and service contracts are used to provide services DSH does not offer. Testing funding has decreased by $7.2 million as the lab costs originally included are now captured under CDPH for the Valencia Lab. Costs remaining are for contracted staff to conduct COVID-19 tests on staff.

Below is a summary of all requested costs for FY 2022-23 by category for the Governor's Budget and May Revision.

Category	Governor's Budget	May Revision	Total
Personnel Services	$50,600,000	$14,061,000	$64,661,000
OE&E	$0	$11,697,000	$11,697,000
Testing	$14,000,000	-$7,234,000	$6,766,000
TOTAL	**$64,600,000**	**$18,524,000**	**$83,124,000**

BCP Fiscal Detail Sheet

BCP Title: COVID-19 Allocation **BR Name: 4440-078-ECP-2022-MR**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Salaries and Wages						
Earnings - Permanent	0	10,332	0	0	0	0
Overtime/Other	0	3,729	0	0	0	0
Total Salaries and Wages	**$0**	**$14,061**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$0**	**$14,061**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	0	5,552	0	0	0	0
5340 - Consulting and Professional Services - External	0	-2,992	0	0	0	0
539X - Other	0	1,903	0	0	0	0
Total Operating Expenses and Equipment	**$0**	**$4,463**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$0**	**$18,524**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	0	-64,600	0	0	0	0
3398 - California Emergency Relief Fund	0	83,124	0	0	0	0
Total State Operations Expenditures	**$0**	**$18,524**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$0**	**$18,524**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4400020 - Hospital Administration	0	-36	0	0	0	0
4410010 - Atascadero	0	-1,525	0	0	0	0
4410020 - Coalinga	0	4,547	0	0	0	0
4410030 - Metropolitan	0	10,915	0	0	0	0
4410040 - Napa	0	3,350	0	0	0	0
4410050 - Patton	0	1,191	0	0	0	0
4410060 - State Hospital Police Academy	0	82	0	0	0	0
Total All Programs	**$0**	**$18,524**	**$0**	**$0**	**$0**	**$0**

BCP Title: COVID-19 Allocation **BR Name: 4440-078-ECP-2022-MR**

Personal Services Details

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
VR00 - Various	0	14,061	0	0	0	0
Total Salaries and Wages	**$0**	**$14,061**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$0**	**$14,061**	**$0**	**$0**	**$0**	**$0**

STATE HOSPITALS
COST OF CARE AND TREATMENT
Program Update

BACKGROUND

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 completed fiscal years (FY) from Medicare, private payors, and supplemental Medicare insurance. In addition, in FY 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 patient 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	**$160,645,062**	**$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 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.

As part of the 2021 Budget Act, DSH is required to submit a 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.

In the 2022-23 Governor's Budget, DSH recommended updating and/or removing outdated statutory language no longer applicable to DSH's current system of care and providing patient financial relief that DSH does not anticipate would jeopardize DSH's ability to collect Medicare. DSH proposed trailer bill language to develop a statutory and policy framework for implementing a Financial Assistance/Discounted Care Program.

DESCRIPTION OF CHANGE

As of the FY 2022-23 May Revision, DSH continues to work with stakeholders on the proposed TBL that was put forward at 2022-23 Governor's Budget. There are no additional changes at this time.

STATE HOSPITALS
DSH-COALINGA INTERMEDIATE CARE FACILITY CONVERSION
New Premise

	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*
May Revision	**0.0**	**27.3**	**27.3**	**$0**	**$4,490**	**$4,490**
One-time	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Ongoing	*0.0*	*27.3*	*27.3*	*$0*	*$4,490*	*$4,490*
Total	**0.0**	**27.3**	**27.3**	**$0**	**$4,490**	**$4,490**
One-time	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Ongoing	*0.0*	*27.3*	*27.3*	*$0*	*$4,490*	*$4,490*

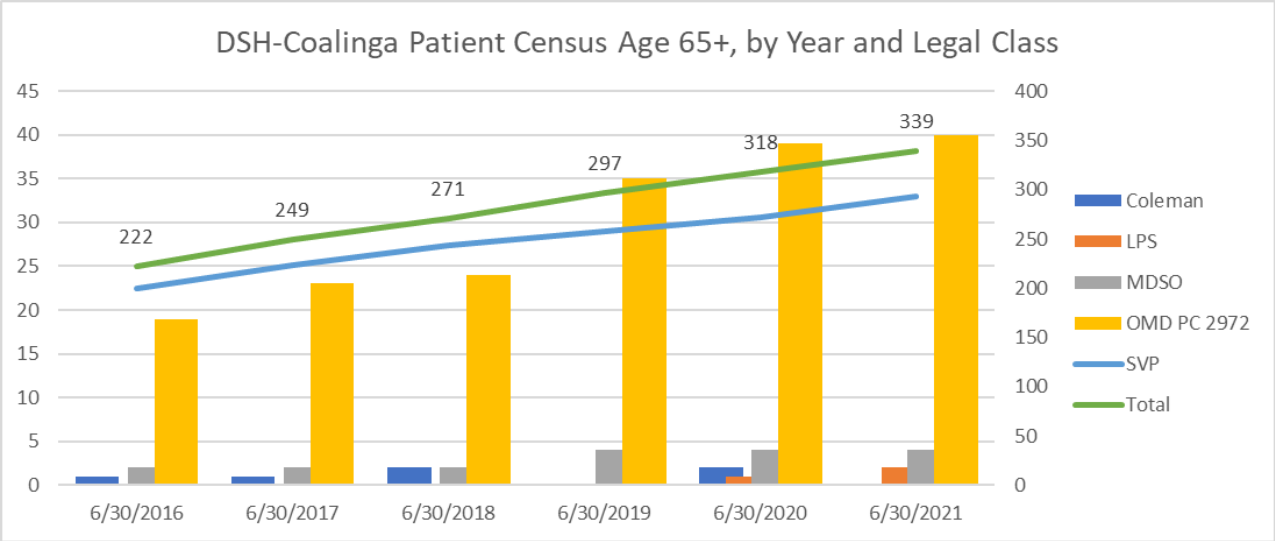
BACKGROUND

Opened in 2005, Department of State Hospitals (DSH)-Coalinga operates a total of 30 residential units. Of these 30 units, 23 are licensed as Intermediate Care Facilities (ICFs) by the California Department of Public Health (CDPH) under California Code of Regulations Title 22, Intermediate Care Facility (ICF). DSH-Coalinga has seven units currently exempted from CDPH licensure which are classified as Residential Recovery Units (RRU). Within these seven RRUs, DSH-Coalinga houses and treats up to 350 forensic patients.

Many patients committed to DSH either due to the nature of their mental illness or the crimes that they commit have longer 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 DSH-Coalinga at the end of FY 2020-21.

Commitment Type	Average Patient Days
Coleman	86.8
LPS	3,507.5
MDSO	2,150.2
NGI	1,901.0
OMD PC 2972	2,159.8
SVP	3,726.0

DSH has an aging population in need of higher levels of medical care. The number of patients age 65 and older has increased by 53 percent since June 30, 2016, as illustrated in the graph below.



While all DSH hospitals experience aging of its patient population, DSH-Coalinga is unique given it's the only hospitals that serve SVP patients which is one of the commitment types with the longest average length of stay. As they age, this increasingly geriatric population requires enhanced medical treatments in addition to their ongoing psychiatric treatment. As of June 30, 2021, the average age of an SVP patient housed at DSH-Coalinga was just over 58 years old.

Residential Recovery Units (RRUs) vs. Intermediate Care Facilities (ICFs)

DSH historically has converted existing RRUs to ICFs to better serve the medical needs of this aging population. RRUs are unlicensed units specific to DSH-Coalinga that operate pursuant to WIC section 6606, subdivision (d) to house SVP patients who can be higher functioning than other patient commitments served by DSH. RRUs provide care to patients who are required to reside at a state hospital but have a lesser need for constant observation. RRUs mostly house patients who can ambulate and function independently. These patients tend to require minimal medical and/or psychiatric treatment care, minimal prompting for activities of daily living (ADLs) and are compliant with their treatment plan and medications.

In contrast, an ICF is a unit that provides care to ambulatory or non-ambulatory patients who have recurring need for nursing supervision and supportive care, but who do not require the level of medical care of a continuous skilled nursing home. Patients on an ICF unit have minimal serious chronic medical conditions and require increased levels of observation, seclusion, restraint or higher levels of care,

making them unsuitable for housing in an RRU. This includes patients who are aging and beginning to experience more significant health challenges, but also individuals on court order for medications, those at risk for suicide, self-harm and aggression, and patients needing behavioral plan interventions.

DSH-Coalinga currently has seven (7) RRUs and 23 ICF units. As DSH-Coalinga serves a patient population that is increasingly geriatric, DSH is required to provide higher levels of care to its forensically committed patients and an ICF conversion allows DSH to accomplish this goal.

DESCRIPTION OF CHANGE

DSH requests 27.3 positions and $4.5 million dollars in fiscal year 2022-23 and ongoing for staffing costs related to the conversion of one existing RRU at DSH-Coalinga to an ICF unit.

In order to convert an RRU to an ICF, DSH must secure the Title 22 licensure which requires higher staffing levels to maintain compliance. The current staffing ratios of an RRU at DSH-Coalinga do not meet Title 22 requirements or the needs of Welfare Institutions Code (WIC) 6602/6604 psychiatric patients and their aging population. According to Title 22 and the staffing standards adopted in the Department of Finance (DOF), Mission Based Review (MBR), higher ratios are required due to the acuity of the patients being treated. Under that adopted proposal, the nursing staff to patient ratios for SVP patients on ICF units is 1:6 on AM shift, 1:6.5 on PM shift and 1:13.5 on NOC shift. For comparison, RRUs are approved to operate at 1:13 on AM shift, 1:17 on PM shift and 1:32.5 on NOC shift. The ICF treatment team, which is considered "moderate workload", is composed of a caseload ratio of 1:30, in contrast to a caseload ratio of 1:50 for an RRU. Increasing the levels of nursing and treatment team staff will allow DSH to secure the CDPH licensing required for ICF units. Below is a table that displays the total position need for this unit conversion, the offset for current resources and the total position request.

Treatment Team & Primary Care	Total Position Need	Current Resources	Position Request
Staff Psychiatrist (7619)	1.7	0.0	1.7
Nurse Practitioner (Psychiatric)	0.0	1.0	-1.0
Psychologist (9873)	1.7	1.0	0.7
Rehabilitation Therapist (8324)	1.7	1.0	0.7
Clinical Social Worker (9872)	1.7	1.0	0.7
Physician and Surgeon (7552)	1.0	0.0	1.0
Nurse Practitioner (Family)	0.0	1.0	-1.0
Total	**7.8**	**5.0**	**2.8**
Nursing Staffing	**Total Position Need**	**Current Resources**	**Position Request**
Unit Supervisor (8104)	1.0	1.0	0.0
Senior Psych Tech - Shift Lead (8252)	5.3	5.3	0.0
Registered Nurse (8094)	10.3	4.4	5.9
Psych Tech (8253)	18.9	4.7	14.2
Psych Tech - Medication Room (8253)	2.6	0.0	2.6
Afterhours Supervising RN (8096)	0.3	0.0	0.3
Total	**38.4**	**15.4**	**23.0**
Additional Staffing	**Total Position Need**	**Current Resources**	**Position Request**
Custodian (2011)	2.0	0.5	1.5
Total	**2.0**	**0.5**	**1.5**
Grand Total	**48.2**	**20.9**	**27.3**

BCP Fiscal Detail Sheet

BCP Title: DSH-Coalinga Intermediate Care Facility Conversion **BR Name: 4440-079-ECP-2022-MR**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	0.0	27.3	27.3	27.3	27.3	27.3
Total Positions	**0.0**	**27.3**	**27.3**	**27.3**	**27.3**	**27.3**
Salaries and Wages						
Earnings - Permanent	0	2,923	2,923	2,923	2,923	2,923
Total Salaries and Wages	**$0**	**$2,923**	**$2,923**	**$2,923**	**$2,923**	**$2,923**
Total Staff Benefits	0	1,131	1,131	1,131	1,131	1,131
Total Personal Services	**$0**	**$4,054**	**$4,054**	**$4,054**	**$4,054**	**$4,054**
Operating Expenses and Equipment						
5301 - General Expense	0	218	218	218	218	218
5304 - Communications	0	27	27	27	27	27
5320 - Travel: In-State	0	27	27	27	27	27
5324 - Facilities Operation	0	137	137	137	137	137
5346 - Information Technology	0	27	27	27	27	27
Total Operating Expenses and Equipment	**$0**	**$436**	**$436**	**$436**	**$436**	**$436**
Total Budget Request	**$0**	**$4,490**	**$4,490**	**$4,490**	**$4,490**	**$4,490**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	0	4,490	4,490	4,490	4,490	4,490
Total State Operations Expenditures	**$0**	**$4,490**	**$4,490**	**$4,490**	**$4,490**	**$4,490**
Total All Funds	**$0**	**$4,490**	**$4,490**	**$4,490**	**$4,490**	**$4,490**

Program Summary

Program Funding						
4400020 - Hospital Administration	0	27	27	27	27	27
4410020 - Coalinga	0	4,463	4,463	4,463	4,463	4,463
Total All Programs	**$0**	**$4,490**	**$4,490**	**$4,490**	**$4,490**	**$4,490**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
2011 - Custodian I				0.0	1.5	1.5	1.5	1.5	1.5
7552 - Physician & Surgeon (Safety)				0.0	1.0	1.0	1.0	1.0	1.0
7619 - Staff Psychiatrist (Safety)				0.0	1.7	1.7	1.7	1.7	1.7
8094 - Registered Nurse (Safety)				0.0	5.9	5.9	5.9	5.9	5.9
8096 - Supvng Registered Nurse (Safety)				0.0	0.3	0.3	0.3	0.3	0.3
8253 - Psych Techn (Safety)				0.0	16.8	16.8	16.8	16.8	16.8
8324 - Rehab Therapist (Recr-Safety)				0.0	0.7	0.7	0.7	0.7	0.7
9700 - Nurse Practitioner (Safety)				0.0	-2.0	-2.0	-2.0	-2.0	-2.0
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	0.7	0.7	0.7	0.7	0.7
Total Positions				**0.0**	**27.3**	**27.3**	**27.3**	**27.3**	**27.3**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
2011 - Custodian I	0	58	58	58	58	58
7552 - Physician & Surgeon (Safety)	0	377	37	37	37	37
7619 - Staff Psychiatrist (Safety)	0	650	650	650	650	650
8094 - Registered Nurse (Safety)	0	659	659	659	659	659
8096 - Supvng Registered Nurse (Safety)	0	38	38	38	38	38
8253 - Psych Techn (Safety)	0	1,217	1,217	1,217	1,217	1,217
8324 - Rehab Therapist (Recr-Safety)	0	57	57	57	57	57
9700 - Nurse Practitioner (Safety)	0	-270	-270	-270	-270	-270
9872 - Clinical Soc Worker (Hlth/CF)-Safety	0	61	61	61	61	61
9873 - Psychologist (Hlth Facility-Clinical-Safety)	0	76	76	76	76	76
Total Salaries and Wages	**$0**	**$2,923**	**$2,583**	**$2,583**	**$2,583**	**$2,583**

Staff Benefits						
5150200 - Disability Leave - Industrial	0	34	34	34	34	34
5150210 - Disability Leave - Nonindustrial	0	11	11	11	11	11
5150350 - Health Insurance	0	122	122	122	122	122
5150450 - Medicare Taxation	0	40	40	40	40	40

5150600	-	Retirement - General	0	515	515	515	515	515
5150700	-	Unemployment Insurance	0	3	3	3	3	3
5150800	-	Workers' Compensation	0	122	122	122	122	122
5150820	-	Other Post-Employment Benefits (OPEB) Employer Contributions	0	74	74	74	74	74
5150900	-	Staff Benefits - Other	0	210	210	210	210	210
Total Staff Benefits			**$0**	**$1,131**	**$1,131**	**$1,131**	**$1,131**	**$1,131**
Total Personal Services			**$0**	**$4,054**	**$3,714**	**$3,714**	**$3,714**	**$3,714**

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*
May Revision	**0.0**	**2.5**	**2.5**	**$7,425**	**$3,670**	**$4,154**
One-time	*0.0*	*0.0*	*0.0*	*$7,425*	*$0*	*$0*
Ongoing	*0.0*	*2.5*	*2.5*	*$0*	*$3,670*	*$4,154*
Total	**0.0**	**2.5**	**2.5**	**$0**	**$8,223**	**$8,717**
One-time	*0.0*	*0.0*	*0.0*	*-$452*	*$0*	*$0*
Ongoing	*0.0*	*2.5*	*2.5*	*$452*	*$8,223*	*$8,717*

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 typically 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; however, the average length of stay may be longer due to medical necessity. 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.

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

The CONREP FACT Regional Program (CFRP) 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 at least 180 dedicated beds and staff resources for this new treatment option in CONREP across three regions of the state: 60 beds in Northern CA, 60 beds in the Bay Area, and 60 beds in Southern CA to start. In addition to increasing the placement options available for NGI and OMD patients transitioning from the state hospitals, the FACT model of care can be used to treat 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 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 patient income offsets, such as Supplemental Security Income (SSI) which support housing and personal incidentals (also known as supplemental service costs).

The 2021 Budget Act included 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.

In the 2022-23 Governor's Budget, DSH reported a one-time current year (CY) savings of $7.9 million due to activation and implementation delays in the 78-bed Southern California (CA) Institute for Mental Disease (IMD) and 20-bed Northern CA IMD facilities. Additionally, DSH proposed to discontinue the 5-bed Northern CA Mental Health Rehabilitation Center (MHRC), reflecting an ongoing savings of $913,000 in FY 2021-22. The full savings from MHRC was redirected permanently to the 30-bed Northern CA Adult Residential Facility (ARF) while the remaining CY need of $452,000 was funded through the IMD savings. An ongoing request of $4.6 million was included to support the ARF. In total, DSH reflected a one-time savings of $7.4 million in FY 2021-22 and requested $4.6 million in FY 2022-23 and ongoing.

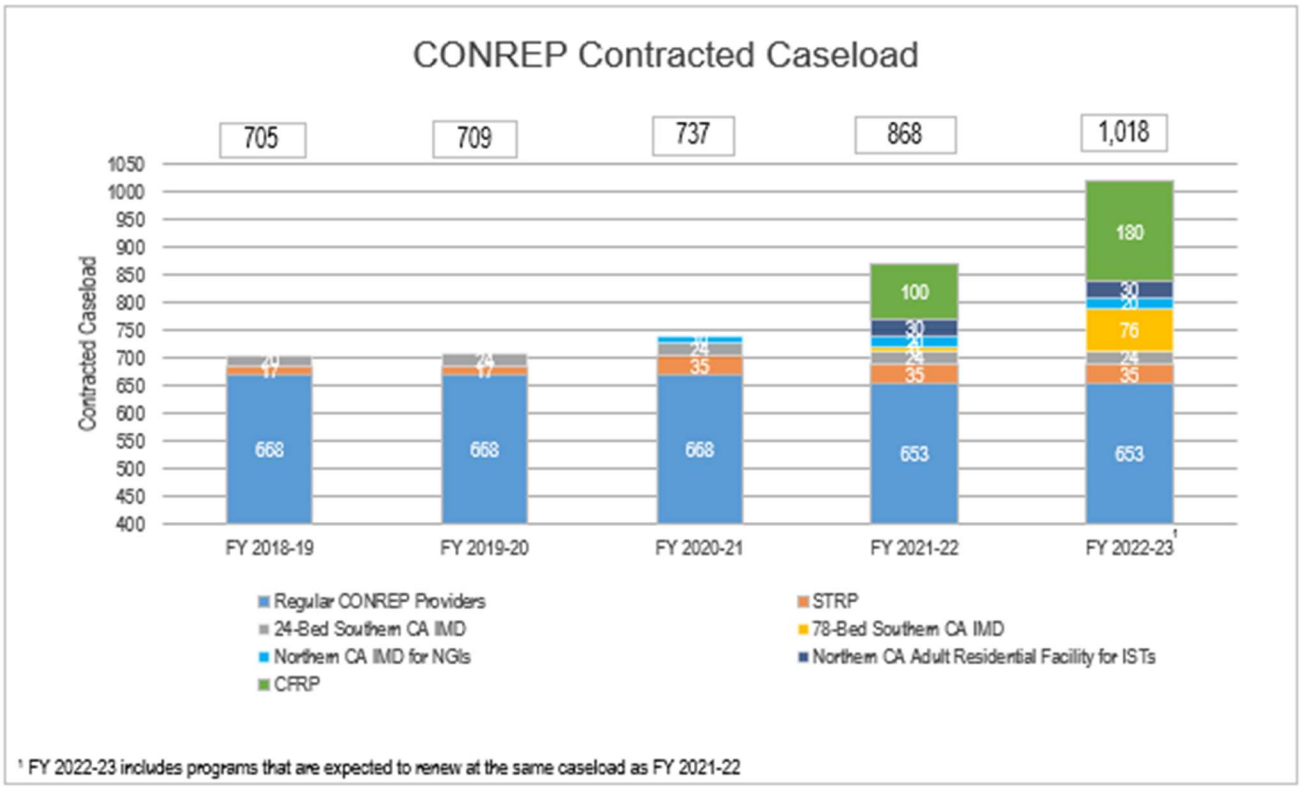
Caseload Update

DSH anticipates a total contracted caseload of 868 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 CFRP beds
    - 100 in FY 2021-22
    - Additional 80 in FY 2022-23
- 150 Institution for Mental Diseases (IMD)/Adult Residential Facility (ARF) beds
    - 78-bed Southern CA IMD
        - 26 in FY 2021-22
        - Additional 50 in FY 2022-23
    - 24-bed Southern CA IMD in FY 2021-22

- 20-bed Northern CA IMD in FY 2021-22
- 30-bed Northern CA ARF in FY 2021-22

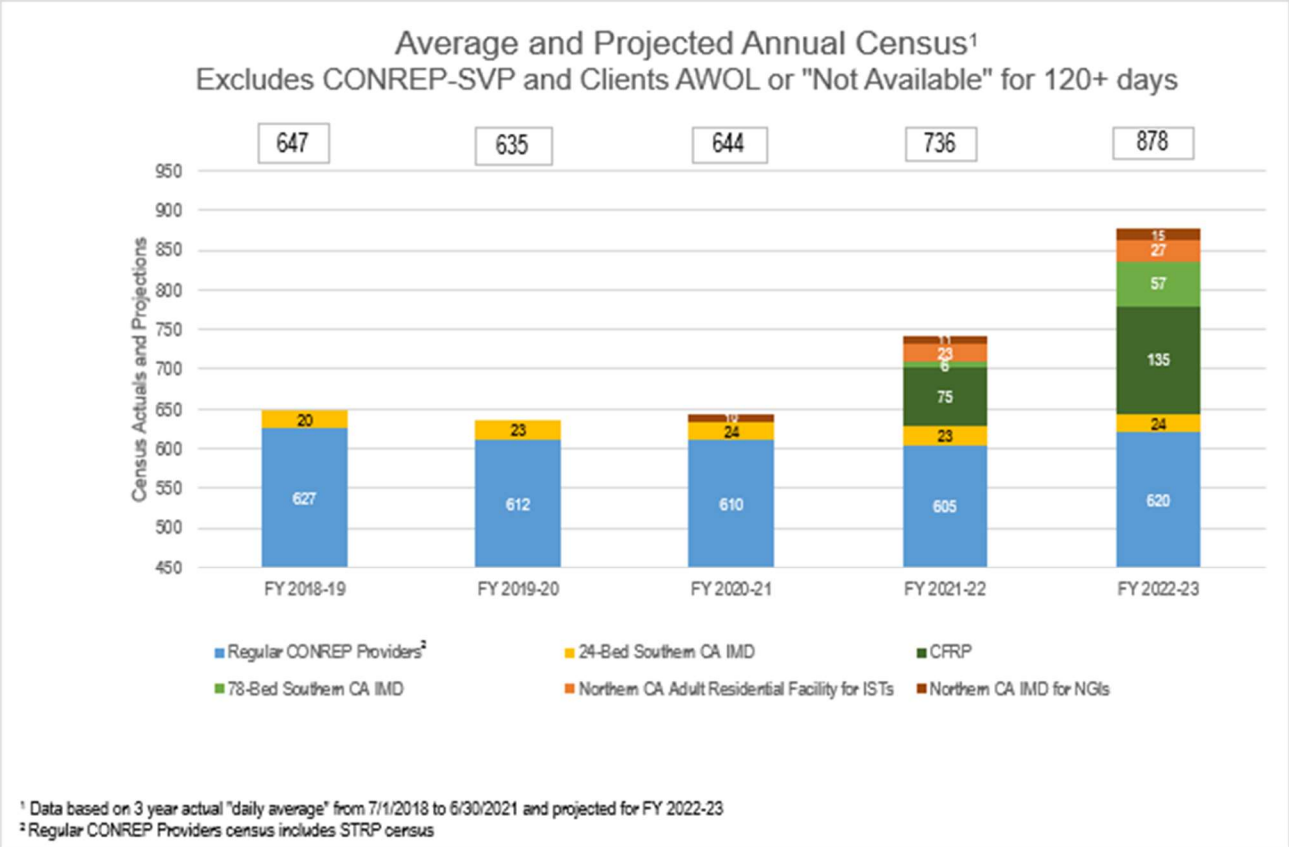
The following chart illustrates DSH's previous, current, and projected CONREP contracted caseload for FY 2018-19 through FY 2022-23.



This contracted caseload reflects the total number of clients and beds available by the end of FY 2021-22 and FY 2022-23. The actual caseload may vary from these projections based on activation of the specialized beds.

While DSH anticipates the activation of new beds dedicated to CONREP in FY 2022-23, patients will be phased into this program, and the actual number of patients served at a given time will vary over the course of two years. Reflecting the projected patient phase-in, DSH estimates an average census of 736 in FY 2021-22 and 878 in FY 2022-23.

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



As of February 2022, there are approximately 52 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.

DESCRIPTION OF CHANGE

As a result of the increase in DSH's CONREP population and associated workload, key program areas have been identified which would require additional staffing and contract funds to support an enhanced continuum of care. In the 2022-23 Governor's Budget, DSH reported a net one-time CY savings of $7.4 million due to activations delays. As of the 2022-23 May Revision, DSH proposes to repurpose all one-time CY savings for additional implementation and construction costs for the 78-Bed Southern CA IMD Facility. DSH also requests 2.5 position authority in 2022-23 and ongoing, along with funding of $3.7 million in budget year (BY) and $4.2 million ongoing to support program activations, caseload increases, and staffing.

The following sections will provide specific updates on program activations and caseload, as well as new resource requests for CONREP non-SVP programs.

Step-Down Transitional Programs

78-Bed Southern CA IMD Facility (Golden Legacy) ($7.3 million in 2021-22)

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. This program has not yet been activated due to pending external approvals and construction delays.

A surveyor for Centers for Medicare & Medicaid Services (CMS) raised an issued around serving a justice-involved population and the patients' rights related to freedom of movement. To mitigate this concern the entire facility was decertified as of December 7, 2021. The CMS certification in no longer an issue and construction activities began in January 2022.

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

Due to supply chain and labor shortages related to the COVID-19 pandemic, in addition to certification requirements, program activation will be delayed until August 2022. DSH had originally anticipated program activation to occur in March 2022.

In the 2022-23 Governor's Budget, DSH anticipated a one-time savings of $7.3 million. However, unanticipated operating equipment and expense (OE&E), implementation and construction costs have increased for the program and are estimated to be approximately $11.0 million. As of the 2022-23 May Revision, DSH now proposes to redirect the full one-time savings in CY to support the estimated costs for implementation and construction.

As prospective state hospital patients are selected for the new IMD program, DSH's provider has identified six beds available in their adjacent Sylmar Health and

Rehabilitation IMD facility in which to place OMD patients during this transition period. The utilization of these beds is temporary; once the 78-bed program has been activated, patients placed at Sylmar will be transferred to the new facility. As of March 2022, three of the six beds are filled, and the provider anticipates filling the final three beds in May 2022.

20-bed Northern CA IMD Facility (Canyon Manor) ($118,000 in 2021-22)

DSH established a 20-bed Northern CA IMD facility for NGI patients ready for step-down into a CONREP program in 18 to 24 months. Delays in expanding the program were due to building reconfigurations and limited staffing bandwidth as a result of COVID-19 related court reporting backlogs. The current census is at 12 and the provider is currently reviewing referral packets and up to three additional beds are expected to be filled by the end of the fiscal year at a rate of one patient placement per month. DSH expects to fill one additional bed per month through the end of the fiscal year. At this time, DSH reports an additional one-time savings of $484,000 in CY for a total of $1,054,000 in savings. DSH requests to redirect the savings to fund the remaining need for the Northern CA ARF and additional construction costs for the 78-bed Southern CA IMD.

30-bed Northern CA Adult Residential Facility (A&A Health Services) (No adjustment at this time)

In the 2022-23 Governor's Budget, DSH requested to establish a 30-bed Northern CA Adult Residential Facility (ARF) to serve NGI and OMD patients ready for CONREP in 6 to 12 months. This facility will expand CONREP capacity and patient placement would allow DSH to backfill vacant state hospital beds with IST patients from the waitlist. Additionally, DSH has been in discussions with this provider to dedicate a portion of their beds to serve ISTs that are suitable for community-based restoration. This program's 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 programming, nursing care, life skills coaching, and in-county transportation to all necessary appointments. Activation of the 30-bed Northern CA ARF occurred on March 1, 2022, slightly ahead of what was anticipated as of the 2022-23 Governor's Budget. As such, DSH does not anticipate any adjustments to funding.

Program Support ($81,000 and 0.5 FTE in 2022-23 and ongoing)

The 2021 Budget Act included authority for a half-time (0.5) Staff Services Manager I position to act in a specialist capacity as a project manager to oversee program implementation activities, along with future expansion efforts. To support these program expansions, DSH requests an additional 0.5 position authority and additional

funding of $81,000 to build out the position to full-time. DSH underestimated the workload and dedicated personnel resources needed for program implementation activities, contract development for new programs, and to pursue potential new programs to partner and build out the community continuum of care. DSH requests position authority and funding in BY and ongoing to fill the position at full-time aligning with the necessary workload to implement the various programs.

CONREP FACT Regional Program (CFRP)

Caseload and Activation Update (No adjustment at this time)

DSH identified a single service provider for the new FACT level of care and executed a contract in November 2021. CFRP activation began on February 1, 2022 and is consistent with the timeline originally anticipated. Currently, the contracted provider has secured housing required for both CFRP programs in Sacramento and San Diego counties. The provider will begin housing procurement for Alameda County in early fall for program activation in October 2022. These counties are the current locations that will support regional FACT programs for CONREP clients. In accordance with the schedule below, the program activation timeline is a phased in approach to scaling up beds across all the three regions:

- Northern CA (CFRP-Sacramento) – activated February 2022
- Southern CA (CFRP-San Diego) – activated February 2022
- Bay Area (CFRP-Alameda) – activation planned for October 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. As of March 2022, CFRP-Sacramento is expecting to fill 19 of 20 activated beds and CFRP-San Diego is expected to fill 10 of 10 activated beds. DSH continues to work the provider to review referrals and fill the newly activated beds each month.

DSH has developed admission and discharge protocols for the program and the provider has hired the necessary staff for both CFRP-Sacramento and CFRP-San Diego with plans to begin hiring for Alameda in Summer 2022. Additionally, DSH is continually working with state hospital discharge planning staff and CONREP CPDs to assess which patients are best suited for placement within CFRP. This will allow DSH to mitigate potential delays in filling beds with activated programs.

Program Support Staffing (1.0 FTE and $224,000 in 2022-23 and ongoing)

Upon activation of CFRP-Sacramento and CFRP-San Diego, DSH determined that additional support was needed for the remaining activations and the associated clinical workload. As such, DSH requests 1.0 Consulting Psychologist given the need to train CFRP staff, provide a thorough quality review and assurance of the work product, and provide guidance and expertise in the field of clinical and forensic risk assessment. This position requires experience in psychological assessment, experience with forensic mental health populations, experience with community-based treatment and high-level case management and program coordination. This position will be required to perform the following duties:

- Collaborate with the referring CONREP program's CPD and the patient's primary therapist and hospital liaison to establish potential referrals for the CFRP
- Provide training and consultation regarding risk assessment of client cases and cases continuing to meet legal criteria for legal commitments
- Mediate and consult between CFRP and CONREP Programs regarding patient readiness for discharge to CONREP program and meeting clinical markers
- Provide consultation, oversight, and quality review of CFRP, including review of reports and monitoring of contract compliance and performance measures

In the 2022-23 May Revision, DSH requests 1.0 position and $224,000 in BY and ongoing to support the increased CFRP workload and new program implementation.

California Forensic Assessment Project (CFAP) Staffing Resources *(1.0 FTE and $224,000 in 2022-23 and ongoing)*

The California Forensic Assessment Project (CFAP) is a panel of evaluators who provide specialized psychological testing and consultations for individuals clinically referred by CONREP providers who feel that additional assessment and clinical care may be necessary. These evaluators are contracted with DSH and accept referrals statewide from all CONREP providers. Currently, DSH monitors the panel for quality control through supervision and reviews by the CONREP CFAP liaison. This is necessary to ensure that standardized, consistent quality of testing is administered for all forensic assessment services.

With the increase of new CONREP programs presented in the CONREP FACT Regional Program, as well as the new and expanding step-down transitional programs, DSH inadvertently overlooked the need to expand the existing CFAP contracts to serve the increasing caseload. DSH requests 1.0 Consulting Psychologist to support the need to train evaluators, provide a thorough quality review of the work product, and remain up-to-date with the field of clinical and forensic risk assessment. This position

requires expertise in psychological assessment, with specialty in forensic risk assessment and some experience/exposure to specialized assessment, including neuropsychology and sexual violence risk assessment. This position will be required to perform the following job functions:

- Provide psychological testing and assessment, as well as the psychological reports, to CONREP patients pursuant to the CFAP
- Collaborate with the referring CONREP program's CPD and the patient's primary therapist to establish and define the focus of the assessment, understand the patient's current clinical issues, and develop referral questions for each assessment
- Coordinate with the CONREP program provider to ensure that initial testing materials have been administered or, otherwise, administers at the time of the interview
- Obtain all necessary records and documents needed for the CFAP assessment
- Conduct upwards of four evaluations per month, including writing comprehensive and integrated psychological reports addressing referral questions and issues
- Provide consultation or court testimony on risk assessment or other psycho-legal issues to courts, attorneys, and other legal stakeholders regarding evaluations/reports produced from CFAP referrals

In the 2022-23 May Revision, DSH requests 1.0 position and $224,000 in BY and ongoing to support the increased CFAP caseload commensurate with the increase in CONREP census.

Substance Abuse Screening Contract *($753,000 in 2022-23 and ongoing)*

In conjunction with the court-approved treatment plan, CONREP providers coordinate and provide a wide array of services needed to support community reintegration. One service required for CONREP patients is regular and/or random substance abuse screenings to assess potential substance abuse behavior.

In December 2021, the vendor providing substance abuse screening services for DSH CONREP for the past 10 years unexpectedly closed their business. The vendor was the sole CONREP non-SVP testing laboratory providing services to all 58 counties. DSH received no advance notice when the vendor closed, which required CONREP providers to implement amended screening protocols until a new contract was established, resulting in a backlog of screenings. DSH has identified an alternative vendor to perform these services and is currently in negotiations to execute a new contract.

Screening technology has advanced in recent years, with an increased substance detection panel available for over 50 different substances. The vendor provides testing via analysis of urine drug tests (UDT), or as a secondary option, analysis of oral fluid drug tests (OFT) in circumstances when the UDT oversight is not feasible. The added benefit of screening using an OFT addresses a common issue created by the previous UDT methodology, which was the need to ensure that CONREP programs had both male and female staff members available to conduct the testing, something that isn't always feasible.

While the new vendor is able to provide improved testing services, there is a cost increase associated with the new contract. Both vendors provide up to 20,000 tests annually, but whereas the screenings performed by the previous vendor cost between $9.50-$10.50 per test, screenings performed by the new vendor are charged at a flat rate of $47 per test. While this is a significant increase in cost, the alternate testing method now made available provides better screening accuracy and an expanded substance panel and will allow CONREP to better serve individuals within the program as required for treatment. In the 2022-23 May Revision, DSH requests $753,000 in BY and ongoing for the difference in funding between the previous and new contract.

Funding Adjustments

Provider Personnel Funding ($1.2 million in BY and $1.5 million in BY+1 and ongoing)

Due to a significant lag in compensation package development over the past ten years, one of DSH's contracted CONREP providers is unable to recruit and retain staff and remain competitive in the industry. Recent salary comparisons indicate current contracted clinical staff salaries rates are 15 percent below the base rates of competitors. Program workload also requires staff to work in person, so providers are unable to compete with potential telework options. As a result, current providers are unable to maintain existing staff or hire new staff to fill vacancies, resulting in the need to reduce census in order to maintain operations and provide the minimum clinical and programmatic coverage.

While the programs actively work to hire additional staff to fill vacancies, there will still be a gap between training new employees and having fully trained and functioning staff. It is estimated that approximately a year and a half minimum is needed to fully train staff, based on the complexity of working with forensic patients and learning CONREP programmatic requirements, policies, and procedures.

Providers are working to find additional incentives to bring in new staff as they are actively recruiting. Program enhancements are added when possible, through contract amendments, with the most recent occurring in November 2021. Bilingual

staff, as an example, have been provided a pay differential, which allowed the contractor to save on interpreter expenses when utilizing these services at the programs. While these efforts incentivize applicants to apply, it does not fully cover the difference in cost. As such, DSH requests additional funding equivalent to the 15 percent in BY to allow for better staff retention and more competitive recruitment efforts, with an additional 5 percent rate increase starting in BY+1 and ongoing. In the 2022-23 May Revision, DSH requests $1.2 million in BY and $1.5 million in BY+1 ongoing to bridge the program personnel gap for this contracted provider.

Life Support Funding ($1.2 million in BY and $1.4 million in BY+1 and ongoing)

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. Additionally, many of the current CONREP population located in the area are aging with complex health issues, which require an increased level of oversight or possible housing at a Skilled Nursing Facility (SNF).

In recent years, housing costs have dramatically increased affecting CONREP programs' ability to provide service to clients throughout CA and the availability of housing has diminished drastically. Providers contract with SNFs, board and cares, room and boards, sober living environments, and even some private landlords, but these beds are not necessarily reserved or dedicated as programs are unable to fund the cost to hold and backfill beds, as clients step down to a lower acuity, due to increasing rents. In FY 2021-22, one CONREP program is currently averaging $87,000 per month in housing costs, an increase of $33,000 per month when compared to prior year data. Patients may also require specialized housing for specific treatment and services, which costs $6,000 per month. Across programs, DSH has seen an overall increase of 32 percent in housing costs, with two particular programs seeing an increase of 62 percent and 45 percent, respectively.

CONREP providers are also actively trying to secure new beds to expand the number of patients who can be treated, but this can be difficult due to the low housing inventory. They are actively competing with other private, county or state providers and may not be the only program to try to reserve beds for patients who need them. The surrounding counties that providers serve also may or may not have the

necessary types of beds or SNFs available; if they do not, the program may need to have the patient transported to an available facility once a bed becomes available or find alternate housing. Additional funding will allow CONREP providers to be more competitive in the restricted housing market and expand to housing options they may not have been able to consider previously.

In the 2022-23 May Revision, DSH requests $1.2 million in BY and $1.4 million in BY+1 and ongoing to support these increased housing and SNF costs for client and community safety. The following table shows a breakdown of all CONREP Non-SVP requests put forward in the 2022-23 May Revision.

May Revision Funding Requested						
	2021-22 Positions	2022-23 Positions	2023-24 Positions	2021-22 Funding	2022-23 Funding	2023-24 Funding
Golden Legacy[1]	0.0	0.0	0.0	$7,307,000	$0	$0
Canyon Manor[1]	0.0	0.0	0.0	$118,000	$0	$0
A&A	0.0	0.0	0.0	$0	$0	$0
CONREP Staffing Resources	0.0	2.5	2.5	$0	$529,000	$529,000
Substance Abuse Screening Contract	0.0	0.0	0.0	$0	$753,000	$753,000
Program Personnel Funding[2]	0.0	0.0	0.0	$0	$1,152,000	$1,490,000
Life Support Funding[2]	0.0	0.0	0.0	$0	$1,236,000	$1,382,000
TOTAL	**0.0**	**2.5**	**2.5**	**$7,425,000**	**$3,670,000**	**$4,154,000**

[1] The requested funds are redirected CY savings reported in the 2022-23 Governor's Budget. This is not a new funding enhancement.

[2] Includes a 5% rate increase starting in BY+1 ongoing.

BCP Fiscal Detail Sheet

BCP Title: Conditional Release Program (CONREP) Non-Sexually Violent Predator (SVP) **BR Name: 4440-084-ECP-2022-MR**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	0.0	2.5	2.5	2.5	2.5	2.5
Total Positions	**0.0**	**2.5**	**2.5**	**2.5**	**2.5**	**2.5**
Salaries and Wages						
Earnings - Permanent	0	298	298	298	298	298
Total Salaries and Wages	**$0**	**$298**	**$298**	**$298**	**$298**	**$298**
Total Staff Benefits	0	189	189	189	189	189
Total Personal Services	**$0**	**$487**	**$487**	**$487**	**$487**	**$487**
Operating Expenses and Equipment						
5301 - General Expense	0	20	20	20	20	20
5304 - Communications	0	3	3	3	3	3
5320 - Travel: In-State	0	3	3	3	3	3
5324 - Facilities Operation	0	13	13	13	13	13
5340 - Consulting and Professional Services - External	7,425	3,141	3,625	3,625	3,625	3,625
5346 - Information Technology	0	3	3	3	3	3
Total Operating Expenses and Equipment	**$7,425**	**$3,183**	**$3,667**	**$3,667**	**$3,667**	**$3,667**
Total Budget Request	**$7,425**	**$3,670**	**$4,154**	**$4,154**	**$4,154**	**$4,154**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	7,425	3,670	4,154	4,154	4,154	4,154
Total State Operations Expenditures	**$7,425**	**$3,670**	**$4,154**	**$4,154**	**$4,154**	**$4,154**
Total All Funds	**$7,425**	**$3,670**	**$4,154**	**$4,154**	**$4,154**	**$4,154**

Program Summary

Program Funding						
4400010 - Headquarters Administration	0	14	14	14	14	14
4400020 - Hospital Administration	0	3	3	3	3	3
4420010 - Conditional Release Program	7,425	3,653	4,137	4,137	4,137	4,137
Total All Programs	**$7,425**	**$3,670**	**$4,154**	**$4,154**	**$4,154**	**$4,154**

BCP Title: Conditional Release Program (CONREP) Non-Sexually Violent Predator (SVP) **BR Name: 4440-084-ECP-2022-MR**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
4800 - Staff Svcs Mgr I				0.0	0.5	0.5	0.5	0.5	0.5
7620 - Consulting Psychologist				0.0	2.0	2.0	2.0	2.0	2.0
Total Positions				**0.0**	**2.5**	**2.5**	**2.5**	**2.5**	**2.5**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
4800 - Staff Svcs Mgr I	0	43	43	43	43	43
7620 - Consulting Psychologist	0	255	255	255	255	255
Total Salaries and Wages	**$0**	**$298**	**$298**	**$298**	**$298**	**$298**
Staff Benefits						
5150200 - Disability Leave - Industrial	0	4	4	4	4	4
5150210 - Disability Leave - Nonindustrial	0	1	1	1	1	1
5150350 - Health Insurance	0	14	14	14	14	14
5150450 - Medicare Taxation	0	4	4	4	4	4
5150500 - OASDI	0	18	18	18	18	18
5150600 - Retirement - General	0	87	87	87	87	87
5150800 - Workers' Compensation	0	14	14	14	14	14
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	0	8	8	8	8	8
5150900 - Staff Benefits - Other	0	39	39	39	39	39
Total Staff Benefits	**$0**	**$189**	**$189**	**$189**	**$189**	**$189**
Total Personal Services	**$0**	**$487**	**$487**	**$487**	**$487**	**$487**

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*
May Revision	**0.0**	**2.0**	**2.0**	**-$1,032**	**$2,593**	**$3,139**
One-time	*0.0*	*0.0*	*0.0*	*-$1,032*	*$0*	*$0*
Ongoing	*0.0*	*2.0*	*2.0*	*$0*	*$2,593*	*$3,139*
Total	**0.0**	**3.0**	**3.0**	**-$1,032**	**$2,838**	**$3,384**
One-time	*0.0*	*0.0*	*0.0*	*-$1,032*	*$0*	*$0*
Ongoing	*0.0*	*3.0*	*3.0*	*$0*	*$2,838*	*$3,384*

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 SVPs within CONREP typically reside in: a house, a recreational vehicle (RV), or a 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 individualized, 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.

The 2021 Budget Act included funding to update the budgeting methodology used to establish CONREP-SVP services and support the anticipated costs for a projected average of 25 CONREP-SVP clients. Under this new methodology, the contracted provider works with DSH to establish monthly client rates based upon prior year actual expenditures.

In the 2022-23 Governor's Budget, DSH reported a total caseload of 25 SVPs could be conditionally released into the community by June 30, 2022. Additionally, DSH's Legal Division has experienced an increased trend of county courts requesting DSH attorney presence at CONREP-SVP client placement hearings. As a result, DSH requested $245,000 and 1.0 Attorney III in 2022-23 and ongoing.

DESCRIPTION OF CHANGE

In recent years, the CONREP-SVP program has experienced increased media coverage, community protests, and political attention. This scrutiny impacts client safety, requiring enhanced security and provider supervision, housing fortifications, and limits the availability of potential housing. This had led to a decreased average caseload in current year. Despite this decline in clients placed, the increased scrutiny has also resulted in increased workload for both the program contractor as well as DSH.

As of the 2022-23 May Revision, DSH anticipates a one-time CY savings of $1.0 million due to the reduced average caseload, requests 2.0 position authority in 2022-23 and ongoing, along with associated funding of $2.7 million in budget year (BY) and $3.2

million ongoing to support the projected increased caseload, program costs, and staffing.

Caseload Update

In the 2022-23 Governor's Budget, DSH assumed that a CONREP-SVP caseload of 25 clients would be placed by June 30, 2022. As of the 2022-23 May Revision, DSH projects that an average of 22 clients will be placed by June 30, 2022, resulting in a one-time cost savings. The reduced placements are due to various factors such as delays in the courts, community protests resulting in property owners withdrawing their property for SVP placements, appeals to block an ordered placement, county agencies' lack of assistance in housing searches as ordered, and court required housing enhancements before placement. DSH is actively addressing these issues to better inform county officials and the community on SVP placements, with a goal of increased placements.

While DSH is anticipating a reduction in SVP community placements in CY, many of the delayed client placements are expected to occur in the near future. As a result, DSH projects an increased average caseload of 27 clients in BY. The following table provides a summary of the current and projected placement caseload.

CONREP-SVP Caseload Update and Projection for FY 2022-23					
		Governor's Budget		**May Revision**	
Status	Projected Caseload as of 2021-22 May Revise	Projected Placements FY 2021-22[1]	Projected Placements FY 2022-23[1]	Projected Placements FY 2021-22[1]	Projected Placements FY 2022-23[1]
Individuals currently in CONREP	16	17	18	22	27
Individuals approved for CONREP	11	13	13	13	13
TOTAL	**27**	**30**	**31**	**35**	**40**
Average Caseload[1]	**25**	**25**	**25**	**22**	**27**

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

While the number of placements made over the fiscal year appears to be static, admissions and discharges occur throughout the year and should be considered when reviewing projected placements. In the 2022-23 May Revision, DSH anticipates a one-time CY savings of $1.0 million due to the projected decrease in average caseload from 25 to 22 SVP clients.

Funding Adjustment

The projected client census and resulting program operations impacts has led to an increase in provider costs. Caseload costs, which include program personnel and operating costs, are projected to increase due to increasing staff coverage and resources needed for necessary client treatment. Additionally, the attention drawn to CONREP-SVP has resulted in a need for court ordered security details for an increasing number of clients.

In addition, CONREP-SVP continues to provide all necessary pre-placement services for clients whose petitions are approved by the courts. This can include attending multiple hearings, resourcing potential housing properties, and performing special residence enhancements as directed by the court. To address this workload, the provider is forming a team to prioritize housing activities such as conducting searches and coordinating special housing enhancements ordered by the court. Due to increased media attention and community involvement, as well as the competitive California housing market, landlords are requiring increased rental amounts. Finally, there has been an increase in the number of court-ordered residential enhancements and housing holds, requiring monthly payments until an order is made on the potential property.

The following table displays the projected increase in the projected annual cost for the CONREP-SVP Program to support an average caseload of 27 SVP clients. In addition, an annual cost increase of five percent (5%) has been assessed starting July 2023 to account for the increasing costs of housing and labor.

Proposed CONREP-SVP Annual Program Costs		
	FY 2022-23	FY 2023-24 (+5% Rate Inc)
Caseload Costs	$7,496,000	$7,871,000
Pre-Placement Costs	$406,000	$426,000
Enhanced Supervision Costs	$403,000	$423,000
Life Support Costs[1]	$1,620,000	$1,701,000
Outside Security Costs	$1,000,000	$1,050,000
TOTAL	$10,925,000	$11,471,000
Program Costs for 2021-22[2]	$8,686,000	$8,686,000

Additional Funding Needed	**$2,239,000**	**$2,785,000**

[1]Life support costs include client housing expenses, medication and medical services, and other personal incidentals.
[2]Based on the 2021-22 authorized budget to support the program as displayed in the 2021-22 May Revise caseload estimate. This does not reflect any one-time CY savings reported in the 2022-23 May Revision.

In the 2022-23 May Revision, DSH requests $2.2 million in BY and $2.8 million in BY+1 and ongoing to support the increased caseload and program costs.

Staffing for Increased Workload

DSH requests 1.0 Senior Psychologist (Specialist), associated funding of $194,000, and 1.0 Health Program Specialist II, and associated funding of $159,000 in BY and ongoing to support the increased workload and enhanced programmatic oversight of the CONREP-SVP program.

The volume of workload associated with the CONREP-SVP program exceeds DSH's current capacity to provide dedicated clinical and programmatic oversight. DSH proposes 1.0 Senior Psychologist (Specialist) to ensure clinical oversight for the increasingly complex community placement process, as well as the program and policy compliance needed to safeguard the program against the increased public scrutiny. DSH also proposes 1.0 Health Program Specialist II to act as a subject matter expert to provide highly technical program oversight and as a result of the increasing number of public and media information requests.

The requested positions and their associated job duties are detailed below:

1.0 Senior Psychologist (Specialist) – Program Support and Oversight ($194,000 in BY and ongoing)

- Lead the monitoring of clinical and administrative performance of the CONREP-SVP program
- Lead and oversee efforts to support streamlining and process improvement within CONREP-SVP
- Gather and use data to support findings of program deficiencies. Monitor CONREP-SVP program's plan to resolve deficiencies and maintain compliance
- Provide consultation in the development of corrective action plans
- Identify trends and areas for continuous quality improvement
- Provide consultation, training, and technical assistance related to the operation of the CONREP-SVP program
- Identify and provide consultation in preventing barriers to the timely placement of SVPs into the CONREP-SVP program

1.0 Health Program Specialist II – Program Support and Oversight ($159,000 in BY and ongoing)

- Serve as the CONREP-SVP subject matter expert and provide highly technical program oversight and consultation to leadership to support to the CONREP-SVP program
- Analyze administrative problems related to the program and recommend effective action, including recommending development of new or amending current policies and procedures
- Conduct administrative review of the program to ensure for fiscal and contractual compliance
- Responsible for analyzing, writing, and coordinating approvals for Public Records Act and media inquiry responses for CONREP-SVP
- Develop and maintain system queries and reports for tracking public records requests and media inquiries
- Lead the development and maintenance of policies, procedures, standards, and/or monitoring tools. Respond to related inquiries
- Work closely with the Senior Psychologist Specialist to monitor patient census trends
- Perform independent analysis of fiscal and programmatic data in support of the CONREP-SVP budget
- Develop caseload estimates and budget change proposals for the CONREP-SVP program which includes, but is not limited to, forecasting population trends, researching, and analyzing program and policy impacts, developing cost estimates and written narratives to convey findings, recommendations, and proposed budget changes

DSH is requesting $354,000 and 2.0 position authority BY and ongoing to support this increased workload.

BCP Fiscal Detail Sheet

BCP Title: Conditional Release Program (CONREP) Sexually Violent Predator (SVP) **BR Name: 4440-080-ECP-2022-MR**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	0.0	2.0	2.0	2.0	2.0	2.0
Total Positions	**0.0**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**
Salaries and Wages						
Earnings - Permanent	0	208	208	208	208	208
Total Salaries and Wages	**$0**	**$208**	**$208**	**$208**	**$208**	**$208**
Total Staff Benefits	0	114	114	114	114	114
Total Personal Services	**$0**	**$322**	**$322**	**$322**	**$322**	**$322**
Operating Expenses and Equipment						
5301 - General Expense	0	16	16	16	16	16
5304 - Communications	0	2	2	2	2	2
5320 - Travel: In-State	0	2	2	2	2	2
5324 - Facilities Operation	0	10	10	10	10	10
5340 - Consulting and Professional Services - External	-1,032	2,239	2,785	2,785	2,785	2,785
5346 - Information Technology	0	2	2	2	2	2
Total Operating Expenses and Equipment	**$-1,032**	**$2,271**	**$2,817**	**$2,817**	**$2,817**	**$2,817**
Total Budget Request	**$-1,032**	**$2,593**	**$3,139**	**$3,139**	**$3,139**	**$3,139**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-1,032	2,593	3,139	3,139	3,139	3,139
Total State Operations Expenditures	**$-1,032**	**$2,593**	**$3,139**	**$3,139**	**$3,139**	**$3,139**
Total All Funds	**$-1,032**	**$2,593**	**$3,139**	**$3,139**	**$3,139**	**$3,139**

Program Summary

Program Funding						
4400010 - Headquarters Administration	0	10	10	10	10	10
4400020 - Hospital Administration	0	2	2	2	2	2
4420020 - Conditional Release Program - Sexually Violent Predators	-1,032	2,581	3,127	3,127	3,127	3,127
Total All Programs	**$-1,032**	**$2,593**	**$3,139**	**$3,139**	**$3,139**	**$3,139**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
8336 - Hlth Program Spec II				0.0	1.0	1.0	1.0	1.0	1.0
9839 - Sr Psychologist (Hlth Facility) (Spec)				0.0	1.0	1.0	1.0	1.0	1.0
Total Positions				**0.0**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
8336 - Hlth Program Spec II	0	88	88	88	88	88
9839 - Sr Psychologist (Hlth Facility) (Spec)	0	120	120	120	120	120
Total Salaries and Wages	**$0**	**$208**	**$208**	**$208**	**$208**	**$208**
Staff Benefits						
5150200 - Disability Leave - Industrial	0	3	3	3	3	3
5150210 - Disability Leave - Nonindustrial	0	1	1	1	1	1
5150350 - Health Insurance	0	10	10	10	10	10
5150450 - Medicare Taxation	0	3	3	3	3	3
5150500 - OASDI	0	5	5	5	5	5
5150600 - Retirement - General	0	49	49	49	49	49
5150800 - Workers' Compensation	0	10	10	10	10	10
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	0	6	6	6	6	6
5150900 - Staff Benefits - Other	0	27	27	27	27	27
Total Staff Benefits	**$0**	**$114**	**$114**	**$114**	**$114**	**$114**
Total Personal Services	**$0**	**$322**	**$322**	**$322**	**$322**	**$322**

CONTRACTED PATIENT SERVICES

CONTRACTED PATIENT SERVICES
INCOMPETENT TO STAND TRIAL SOLUTIONS PROPOSAL
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**12.0**	**41.0**	**55.0**	**$93,000**	**$571,521**	**$571,521**
One-time	*0.0*	*0.0*	*0.0*	*$42,000*	*$234,949*	*$0*
Ongoing	*12.0*	*41.0*	*55.0*	*$51,000*	*$336,572*	*$571,521*
May Revision	**0.0**	***35.0***	***38.5***	**$0**	***-$36,070***	**-$89,298**
One-time	*0.0*	*0.0*	*0.0*	*$0*	*$93,801*	*$160,000*
Ongoing	*0.0*	*35.0*	*38.5*	*$0*	*-$129,871*	*-$249,298*
Total	**12.0**	**76.0**	**93.5**	**$93,000**	**$535,451**	**$482,223**
One-time	*0.0*	*0.0*	*0.0*	*$42,000*	*$328,750*	*$160,000*
Ongoing	*12.0*	*76.0*	*93.5*	*$51,000*	*$206,701*	*$322,223*

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 despite recent efforts including increased bed capacity, decreased average length of stay, and implementation of county-based treatment programs, leading to a large waitlist and long wait times for IST defendants pending DSH placement. Furthermore, the impacts of the COVID-19 pandemic and infection control measures required at DSH facilities, necessitate slower admissions and result in reduced capacity for the treatment of felony ISTs at DSH.

In 2015, the American Civil Liberties Union sued DSH (*Stiavetti v. Clendenin*) alleging the amount of time IST defendants were waiting for admission into a DSH treatment program violated individuals' constitutional right to due process. The Alameda Superior Court ultimately ruled in 2021 that DSH must commence substantive treatment services within 28 days from receipt of commitment for felony IST patients, with a specified timeline for meeting that standard over the next three years. By February 27, 2024, DSH must provide substantive treatment services within 28 days.

In 2021, the Legislature enacted Welfare & Institutions Code (WIC) section 4147 through the passage of Assembly Bill 133 (Chapter 143, Statutes of 2021) and the Budget Act of 2021 (Chapter 69, Statutes of 2021), which charged the California Health & Human Services Agency (CalHHS) and DSH to convene an IST Solutions Workgroup (Workgroup) to identify actionable solutions that address the increasing number of individuals with serious mental illness who become justice-involved and

deemed IST on felony charges. The IST Workgroup convened between August 2021 and November 2021 with various representatives and stakeholders. Per the statute, the Workgroup identified short-, medium-, and long-term solutions to advance alternatives to placement in DSH competency restoration programs.

DSH IST Solutions Proposal Summary

In the 2022-23 Governor's Budget, DSH proposed a total of $571 million in fiscal year (FY) 2022-23 and ongoing, utilizing 2021 Budget Act set-aside funding for IST programs of $75 million in FY 2021-22 and $175 million ongoing. The components of the proposal provide early stabilization, care coordination, expand community-based treatment and diversion options for felony ISTs that help end the cycle of criminalization and increase community transitions for state hospital patients. Collectively, these proposals will also assist the state in meeting treatment timelines ordered by the Superior Court in *Stiavetti v. Clendenin*.

Early Stabilization and Community Care Coordination

The goal of Early Stabilization and Community Care Coordination is to provide timely treatment access and promote stabilization of IST defendants to increase community-based treatment placements. DSH plans to leverage existing Jail-Based Competency Treatment (JBCT) programs to provide services at the earliest point possible upon IST commitment when individuals are arrested and booked into jail. The goal is to facilitate the stabilization and medication compliance of IST patients, both of which will promote increased eligibility and placement in a Diversion or other community-based treatment program.

Care Coordination & Waitlist Management

The Patient Management Unit (PMU) was established in June 2017 in the Welfare and Institutions Code 7234 through Chapter 17, Statutes of 2017 to provide centralized management, oversight, and coordination of the referral and patient pre-admission processes to ensure placement of patients in the most appropriate setting based on clinical and safety needs. Prior to the establishment of the PMU, the court system was able to order commitments to any DSH hospital of its choosing, creating admission backlogs and inefficiencies. Now, PMU receives all court commitments to the department and utilizes DSH's Patient Reservation Tracking System (PaRTS) to manage the admissions of all DSH patients.

Counties are required to provide specified information and documents to PMU to facilitate admission. Under *Stiavetti v. Clendenin*, DSH is required to begin substantive treatment for patients within 28 days from receipt of the commitment. In Fiscal Year 2021-22, DSH has received approximately 400 new referrals of patients deemed IST

per month. The length of time it takes for the court or county to send all statutorily-required documents varied greatly (between 1-77 days) with a median time of 13 days. The variance to submitting all statutorily required documents by a single county also remains high, with several counties exceeding 60 days. Receiving documentation, such as medical records, to appropriately place and treat the patient in a timely manner, and in the most appropriate setting, is imperative and requires continued dedicated case management resources to address and innovate. The length of time it takes counties to submit this information can make it difficult to meet the 28-day requirement set forth in *Stiavetti v. Clendenin*.

As DSH continues to add community-based programs to the menu of patient placement options to mitigate the IST waitlist, PMU's role as the hub of patient information and coordination grows more complex. PMU will require additional resources to manage the waitlist and coordinating patient placement.

Expanding Felony IST Community Programing via Community Based Restoration and Diversion

The goal of expanding Community Based Restoration (CBR) and Felony Mental Health Diversion (Diversion) programs is to provide care in the most appropriate community-based setting as an alternative to a placement in a DSH bed. In the 2022-23 Governor's Budget, DSH estimated that 60-70% of IST commitments would be eligible for services each year in a community-based program, for a total of approximately 3,000 felony ISTs based on current IST referral trends. Counties can utilize this funding to provide housing to Diversion clients in the most appropriate level-of-care. These resources are designed as a short-term solution to increase the number of felony ISTs served in county Diversion programs until DSH is able to partner with counties to establish long-term residential housing infrastructure. Additionally, the funds can be used to develop residential housing settings to support felony IST individuals who are participating in either CBR or Diversion programs. This residential housing program will complement the IMD, and Sub-Acute infrastructure program funded in the 2021 Budget Act.

In combination with current budget authority to support existing CBR and Diversion programs, DSH proposes to invest funding to create or expand permanent community-based treatment programs for felony IST patients at a funding rate of $125,000 per felony IST client. However, DSH acknowledges that County costs for establishing and maintaining this programming goes beyond the direct costs of care for the clients. Funding to assist counties with the additional costs incurred by the county implementers and stakeholders involved in planning and running these programs is also included. Funds will be allocated based on the county's baseline number of actual IST referrals. DSH also proposes to work with counties to explore opportunities for transitional placement services to support client housing needs if an

IST is restored in jail and released back to the community. The goal is to facilitate a smooth community transition and allow time for the county's coordination of benefits and qualified services. Additional funding is included for robust county technical assistance, an external program evaluation, and resources to provide administrative and clinical support to the community programs.

IST Re-Evaluation Services

In the 2021 Budget Act, DSH received resources to implement the Re-Evaluation Services for Felony ISTs program to help reduce the demand for beds, by identifying individuals who have restored to competency before they are transferred to a DSH facility or community treatment bed. DSH established this program for a 4-year term beginning July 1, 2021 (FY 2021-22) to June 30, 2025 (FY 2024-25).

Increased Placements to CONREP

DSH proposes to pilot a new independent placement determination panel to increase the number of individuals found not guilty by reason of insanity and offenders with mental health disorders served in the community via Conditional Release Program (CONREP). The overall increased utilization of CONREP will free beds in the state hospitals to serve patients from the waitlist. While CONREP Community Program Directors will continue to be responsible for placement determinations of ISTs prior to DSH commitment, future consideration will be made to revise this responsibility and pilot an independent evaluation model for IST placement determinations.

Felony IST Referral Growth and Penalties

These investments support the goal of providing care in the least restrictive, community-based settings while maintaining public safety. To ensure the expansion of DSH funded community-based care does not result in additional IST referrals, DSH proposes to set each county's referral cap at the total number of felony ISTs committed to DSH in FY 2021-22. If counties exceed their baseline referral rate, they will be assessed a penalty payment for IST patients referred above their baseline. The total penalty payment will be based on the published per individual rate set forth by DSH and will apply to all counties, regardless of whether they contract with the department for community-based programming. Counties will be charged penalty payments as follows: 50 percent of the rate for the first five to seven felony ISTs over the baseline, 75 percent of the rate for the eighth and ninth felony ISTs over the baseline and one hundred percent of the rate for the tenth and all subsequent felony ISTs over the set baseline. For any excess IST determinations made in FY 2025-26 and fiscal years thereafter, counties will be assessed a penalty payment equivalent to one hundred and fifty percent of the rate. Collected penalty payment funds will be

reallocated back to the penalized counties and used to invest in upstream community interventions to prevent the arrest of individuals with serious mental illness.

DESCRIPTION OF CHANGE

In the 2022-23 Governor's Budget, due to the timing of the IST solutions workgroup's recommendation, the IST Solutions proposal was not yet reflected in DSH's budget. Over the past few months, DSH has met with various county partners and stakeholders. The following sections provide an update on funding and resources needed for the IST Solutions proposal based on both program implementation activities and stakeholder meetings. As of the 2022-23 May Revision, the overall request to support IST Solutions is $535.5 million in BY, $328.8M is one-time funding, $482.2 million in BY+1, $160 million is one-time funding, $517.9 million in BY+2, $5 million is one-time funding and $638 million ongoing. While this represents an overall reduction in funding in the first three years of implementation, this is primarily due to updating the infrastructure schedule for CBR and Diversion from three years to four years. The ongoing funding beginning in fiscal year 2025-26 represents an increase of $66.5 million due to additional funding needs identified through discussions with stakeholders and implementation planning, as well as additional solutions added for discharge planning.

Early Access and Stabilization

In the 2022-23 Governor's Budget, DSH requested $24.9 million in current year (CY) from the $75 million CY set-aside as identified in provision 18 of Chapter 69, Statutes 2021, and $66.8 million in BY and ongoing to provide access to treatment at the earliest point possible upon IST commitment for individuals on DSH's IST waitlist. Treatment will be initiated in partnership with county jail mental health providers and will include administration of psychiatric medications, increased clinical engagement, and competency education. The use of long-acting injectable (LAI) medications in county jails for felony ISTs are used to facilitate IST patient stabilization and medication compliance in preparation for transfer into one of DSH's community-based treatment programs. Additionally, 10.0 positions were requested to be phased in over two years to support program implementation and ongoing operations.

Also, in the 2022-23 Governor's Budget via the JBCT estimate item, DSH requested $2.6 million in BY and ongoing to support implementation of the Early Access and Stabilization (EAS) program. This would expand the services provided by the JBCT programs to initiate early access to treatment services for IST defendants pending placement to a state hospital or JBCT program and waiting in or near a jail which hosts a JBCT program. DSH proposes to realign the $2.6 million jail in-reach services funding from the JBCT budget to the EAS funding in order to streamline the program, consolidate the number of contracts, and maximize programmatic oversight and

efficacy. Please see Jail-Based Competency Treatment Programs and Admission, Evaluation, and Stabilization Center Existing Programs and Activation Updates section (C13) – for additional details.

DSH has identified two prospective providers to provide EAS services in the jails. Both vendors currently provide JBCT services and are therefore a known entity to the county sheriffs' departments and jail staff. Program development and planning discussions with both prospective providers are ongoing and DSH estimates both contracts will be executed in May 2022. A phased implementation of EAS is anticipated to begin before the end of the current fiscal year. Full activation is not anticipated until later next fiscal year and will be contingent upon recruitment of necessary staffing, the most crucial being prescribers, such as psychiatrists and psychiatric nurse practitioners. DSH is working with one county to implement an EAS program through their county behavioral health and correctional healthcare services department and estimates activation to begin in FY 2022-23 to accommodate staff recruitment, training, and ramp up activities. Through these combined efforts, DSH has the ability to activate EAS programs in all 58 counties.

Through program development and stakeholder engagement, DSH has discovered the resource assumptions presented in the 2022-23 Governor's Budget did not include sufficient funding to reimburse counties for deputy costs related to medication pass and clinical escorting, such as to groups and individual therapy as well as for observation. These are critical components to support providing early access to services. As of the 2022-23 May Revision, DSH requests an additional $37.2 million in contracted provider funding to support the EAS program efforts.

Care Coordination & Waitlist Management

Care Coordination Teams

In the 2022-23 Governor's Budget, DSH requested $1.3 million in CY from the $75 million CY set-aside, $4 million in BY and $5 million ongoing to support the Care Coordination effort associated with implementation of the IST Solutions proposal. Additionally, a phase in of 22.0 positions were requested beginning with 5.5 in CY, an additional 12.5 in BY and the remaining 4.0 in BY+1 and ongoing. After meeting with various stakeholders, it is clear that a model which employs close collaboration, such as a vertical case management model, is needed. This model will take individual county resources, needs, and processes into account when placing patients, to increase successful outcomes. In addition to supporting the appropriate model of case management services, additional funding is needed to support the statewide transportation contract. A network of 7-8 transportation providers will be needed to cover transportation to and from community programs and the state hospitals, rather than one vendor as was originally anticipated in the fall. In the 2022-23 May Revision,

DSH requests an additional $2 million in BY and ongoing for additional transportation contract dollars.

A vertical case management model recognizes the innate complexity of healthcare systems, and instead of addressing a singular element of a patient's needs, aims to integrate care across providers and settings for a holistic, patient-centered approach. Utilizing this model along with an advanced pre-screening component, DSH will work with community partners to facilitate placement for waitlisted patients. Using small teams dedicated to specific regions of the state will foster the growth of professional relationships with regional stakeholders and allow PMU to process and admit patients to the most appropriate level of care with the higher efficiently.

Each vertical care coordination team is comprised of psychologists, nurse practitioners, and support analysts and varies in size based on caseload and number of community programs in the region. Below are the functions performed by Care Coordination team members:

- *Clinical Support* – Each team includes 1.0 psychologist responsible for screening patients for eligibility for community programs and providing clinical consult to community programs as needed. Each psychologist will support a caseload ratio of approximately 1:50 for the region, or approximately 400 monthly referrals.
- *Medical Support* – Also included on each Care Coordination Team is 1.0 Nurse Practitioner, Psychiatry. Under the guidance of the Assistant Medical Director of Clinical Operations, these positions will provide consultation to their team members and community partners regarding the medical needs and appropriate placement of incoming patients. These individuals participate in and facilitate medication consults, including those with the Psychopharmacology Resource Network team, to assist with the medication stabilization of patients moving through the care continuum.
- *Patient Navigators* – Under the guidance and support of the psychologists on the Care Team, Patient Navigators (Health Program Specialists) facilitate weekly meetings with county partners, navigate program options and ensure efficient utilization of resources and timely admission to the most appropriate bed available. Patient Navigators work with community and internal partners to coordinate services including transfers, transport, and other associated logistics with the goal of mitigating barriers to admission. These positions also provide administrative and analytic support to the care teams. Analysts work with the care teams as well as the Research, Evaluation, and Data (RED) branch to develop, maintain, and report on appropriate outcomes unique to the patients and community programs that they support. Analysts assist the care team with logistics management and provide administrative support for case management conferences.

- *Referral Coordinators* – These staff (Staff Services Analysts) prepare the patient files for care team review. They are responsible for assembling and tracking all pre-admission records, conducting data entry in all related applications, and consulting with the care team on priority items. These positions participate in the case conferences to provide administrative support and coordinate packet processing issues that arise.

This model retains the preadmission functions of PMU and adds a Care Coordination and Clinical Screening team, who will assume responsibility for patient placement once preadmission initial processing is completed. Staffed at a ratio of 1 team for every 50 referrals (for a total of 8 teams), adding these specialized teams will allow PMU to leverage entry-level staff to complete basic packet processing, leaving the more complex work of coordinating patient care and placement to more experienced specialists and clinicians.

Initial admission packet processing will also be enhanced to include screening of non-clinical criteria for eligibility to IST programs, including factors such as diagnosis, charges/criminal history, and referring county. Once initial processing is completed, packets will be forwarded to the Care Coordination and Clinical Screening team, who will then complete a file review utilizing clinical criteria to determine eligibility for community-based programs.[1] Simultaneously, nurse practitioners will complete a medical review of patient files, when clinically indicated, to determine eligibility based on a patient's medical care needs.

After the clinical team has opined, care coordinators will work with community and internal program partners to admit the individual to the most appropriate program based on availability and the individual's position on the waitlist, which is according to commitment date order. Patient Navigators (Health Program Specialists) will hold case conferences with county and internal program partners to coordinate placement and maximize bed days. These conferences will be held bi-weekly for counties referring fewer than two individuals per month and weekly for counties referring more individuals. The clinical screening teams will be available for these conferences and for clinical-to-clinical consults to place patients in the lowest level of care available based on date of earliest commitment. Nurse Practitioners can also provide psychopharmacology consultations for community and jail-based treatment provides to help facilitate successful patient treatment.

[1] If clinically indicated to refer to the Re-Evaluation Service, an in-depth forensic psychological evaluation would be completed to determine whether a patient meets competency criteria as defined in Penal Code 1372, and therefore should be returned to the court to face charges, or whether they would be likely to restore in a lower level of care such as CONREP, Diversion, or other available program based on the pre-screen and case management screening.

Due to the necessity of transitioning to a vertical case management model more expediently, a revised timeline for recruitment is proposed in addition to an increase in positions requested. In the 2022-23 May Revision, DSH requests an additional $287,000 and 1.0 positions in BY+1 for a Sr. Psychologist Supervisor as a second supervisor is needed based on the number of clinicians needed.

Analytical Support: Outcomes, Data Collection, and Reporting

Tracking outcomes and data reporting will be critical to demonstrating success of the new vertical integration model, in addition to providing accountability for community partners and DSH. This will include identifying data collection and reporting objectives and key performance indicators (KPIs), establishing robust data collection processes with automated business solutions and data management activities, conducting extensive data analysis and developing scorecards to demonstrate performance across all efforts, assessing benchmarks, evaluating outcomes, and identifying areas of improvement on a regular basis. Furthermore, extensive, highly complex reporting will be required by the *Stiavetti* court as the enforcement phase of the litigation moves forward and will necessitate the development of standardized metrics and methodologies along with a strong data quality and accuracy process.

In the 2022-23 Governor's Budget, DSH requested $306,000 and 2.0 position authority in BY and $612,000 and an additional 2.0 position authority in BY+1 and ongoing to support developing and maintaining outcome measures, in addition to providing analytical support to team clinicians. The focus of the Research Data Specialists will be developing and implementing outcomes research and reporting, conducting research into state and county-based datasets, conducting qualitative and quantitative analysis using descriptive and inferential statistical methods, and developing regular statistical reports and automated dashboards to ensure frequent assessment of KPIs. There is no adjustment to this section in the 2022-23 May Revision,

Technological Support

In the 2022-23 Governor's Budget, DSH requested $430,000 in CY from the $75 million CY set-aside and $657,000 in BY and ongoing for technological support for the Care Coordination effort associated with implementation of the IST Solutions proposal. Additionally, 3.0 positions were requested to be phased in over two years, beginning with 1.5 in CY and the remaining 1.5 in BY and ongoing.

Enhancing the level of service provided by PMU will require improving existing technology solutions. Leveraging technology so routine tasks are automated will bring efficiencies, allowing PMU staff the flexibility to allocate more time to complex tasks. Additionally, more sophisticated technology applications connected to

enterprise data systems will ensure PMU can quickly and effectively respond to variables which impact program outcomes, such as operational constraints, which drive placement decisions, ensuring patients are provided substantive treatment in a timely manner. In the 2022-23 May Revision, DSH requests $44,000 in BY and a savings of $6,000 in BY+1 and ongoing due to finalizing the information technology equipment and software licenses needed.

Expanding Felony IST Community Programing via Community Based Restoration and Diversion

County Program and Services Funding

In the 2022-23 Governor's Budget, DSH requested $66.4 million in CY, $490.1 million in BY, $483.9 million in BY+1 and $478.5 million in BY+2 and ongoing for the statewide expansion of the Diversion and CBR programming and to establish 5,000 residential beds dedicated to serving the Felony IST population. CY one-time funding is to support interim housing investment for felony IST clients participating in the Diversion program as well as supporting the beginning phases of the infrastructure for residential housing.

Of the BY funding, $235 million is one-time infrastructure funding to develop residential housing settings to support felony IST individuals who are participating in either community-based restoration or diversion programs. The ongoing funding is for the creation or expansion of permanent community-based treatment programs. In the 2022-23 May Revision, DSH estimates the annual rate of felony IST referrals to the department will be 4,764 per year as opposed to the projected referrals of 5,460 made during 2022-23 Governor's Budget based on fiscal year 2021-22 referral trends through March 2022. DSH experienced its highest rate of IST commitments in the first quarter of FY 2021-22; second quarter referral rates are slightly lower and reduced the department's projected referrals through the end of the fiscal year. Using the same assumption that 60-70% of ISTs will be eligible for community treatment, DSH still estimates that approximately 3,000 ISTs will be treated in community programs annually.

DSH still proposes to fund counties at $125,000 per felony IST patient admitted into a community treatment program assuming an average length of stay (ALOS) of 18-20 months. This ALOS is based on the current experience with the Los Angeles County CBR program. Based on this information, DSH continues to estimate needing a total of 5,000 residential treatment beds to accommodate approximately 3,000 new felony IST admissions per year. In the Budget Act of 2021, DSH received funding to establish 252 new CBR beds; DSH's request to fund 5,000 new beds accounts for those previously funded CBR beds. DSH proposes to update the funding available per community housing unit to an average of $750,000 per unit (assuming eight beds per

unit) increased from $350,000 as proposed at Governor's Budget. This funding is estimated to cover the initial down payment to purchase a property, refurbishment costs and furniture. This update considers current costs driven by the housing market, supply chain issues and inflation. DSH will require that the property be used to serve DSH identified populations for a minimum of 30 years. Any remaining mortgage debt owed to support the full cost of a property's purchase, as well as ongoing future maintenance would be covered through the $125,000 per client wrap-around funding provided to counties.

In 2022-23 May Revision, DSH proposes to add a 15% administrative overhead budget for county administrative costs consistent with the overhead rates allowed by Medi-Cal (see WIC §14711), as well as funding for court liaison positions. The court liaisons will be responsible for recommending the appropriate treatment program in the community to the courts when community treatment for a felony IST defendant is ordered. Adding these two services totals to an additional ask of $10.7 million in BY and totaling $67.3 million in BY+3 and ongoing. Additionally, DSH is proposing to restructure the phase in of the funding from three years to four to better align with the estimated time to stand up the housing infrastructure and activate county treatment programs. This change results in a savings of $91.9 million in BY, savings of $142.7 million in BY+1, savings of $97.9 million in BY+2 and an ask of $29 million in BY+3 and ongoing. DSH is also requesting to add provisional language to extend the encumbrance and expenditure period of the one-time funding in BY. The proposed language is listed below:

> *Proposed Provisional Language:*
>
> XX. Of the funds appropriated in schedule (4), $318,750,000 is for support of the Incompetent to Stand Trial Solutions Workgroup and shall be available for encumbrance or expenditures until June 30, 2027.

Technical Assistance and Evaluation Funding

In the 2022-23 Governor's Budget, DSH requested $8.3 million in BY, $11.6 million in BY+1 and $15 million in BY+2 and ongoing to provide support statewide technical assistance for counties to establish and manage community-based treatment programs for felony IST patients as well as for statewide program evaluations. DSH anticipates contracting with local and national experts to provide group and individual training and assistance to every county participating in the Diversion and CBR programs. In addition, DSH plans to contract with a national expert to conduct a full program outcomes evaluation of Diversion and CBR, including the development of program fidelity measures and interventions for struggling counties. DSH has recalculated the funding needed to provide the above support and reports a savings beginning in BY and ongoing. DSH also requests two-year limited term

resources to support additional research into the root causes of the ongoing IST crisis. In the 2022-23 May Revision, DSH requests $4.3 million in BY, $1 million in BY+1 and a savings of $7.3 million in BY+2 and ongoing based on a recalculation of funding needed to provide county and research support.

Program Operational Resources

In the 2022-23 Governor's Budget, DSH requested $1 million in BY, $1.7 million in BY+1 and $3.7 million in BY+2 and ongoing to provide programmatic, accounting, and contracting work associated with county and private provider invoicing and tracking payments into and out of the special fund for growth cap penalty payments. Additionally, 19.0 positions were requested to be phased in over four years, beginning with 5.0 in BY, 4.0 in BY+1, 7.5 in BY+2 and 2.5 in BY+3 and ongoing. For every five counties or regional county programs, DSH estimates required resources will be comprised of 1.0 full-time equivalent (FTE) Consulting Psychologist, 0.5 FTE Health Program Specialist, and a 0.5 Associate Governmental Program Analysts (AGPA)[2]. This staffing will be allocated to the Diversion and CBR Programs team.

As of the 2022-23 May Revision, DSH requests an additional $640,000 in BY, $1,329,000 in BY+1, $502,000 in BY+2 and $1,167,000 in BY+3 and ongoing to provide the increased program operational support needed to meet the methodology above, as well as positions for the Administrative Services Division to support the additional accounting and contracts workload related to this program. Additional position authority is requested to be phased in over three years, beginning with 4.0 in BY, 6.5 in BY+1 and 4.0 in BY+2 and ongoing.

IST Re-Evaluation Services

As a part of the IST Solutions Proposal, DSH proposes to update and refine program requirements for the Re-Evaluation for Felony IST Program based on actual experience in implementing this new program authorized in the 2021 Budget Act. Information on the implementation status can be found in the Re-Evaluation Services narrative (C19). Additional requirements for this program arise from two elements – staffing to support the original program concept and staffing to support 90-day IST reviews and restoration evaluations for patients in Sub-Acute/IMD and related programs.

Administrative Support

The original proposal for the Re-Evaluation for Felony IST program was based on the results of a small pilot program. When the program was implemented at scale, DSH

[2] In the 2022-23 Governor's Budget DSH estimated needing 0.4 AGPA positions for every five counties or regional programs

found the program implementation was more complex than originally predicted. While original projected existing resources could complete 309 re-evaluation reports per month, when the program was implemented at scale, DSH found actual productivity for the approved staffing to be approximately 150 evaluations per month, well short of the original goal of 309 per month. The complexity of the reports and level of training required to have all reports meet necessary standards were unanticipated. Consequently, onboarding and training have taken longer, and new staff were slower to take on caseloads than originally projected. To address the reduced productivity, more evaluators were brought on to achieve the reporting goals included in the original proposal. This in turn led to too many evaluators for one supervisor to monitor and train in a sustainable way.

Additional required quality control measures, including detailed review by legal and the medical director or designee, have added more tasks and duties for each re-evaluation performed. Also impacting productivity is the varying capabilities and needs of the 58 county jails with IST patients. Working with these community partners has required extensive coordination and a more complex level of program management than originally foreseen.

Through the lessons learned from program implementation, DSH has found additional resources are required to support supervision, training, and quality assurance to support the original goals of the Re-Evaluation for Felony IST program. In addition, DSH has discovered some evaluations require additional extensive clinical review and medical consultation. These additional factors require DSH to reimburse psychiatrists on the contract panel at a higher rate for select evaluations.
The implementation of Sub-Acute/IMD and related programs, which emerged from the IST Solutions Workgroup, has also led to an additional workload for the contracted psychiatry staff in the Re-Evaluation program. The review performed for these reports differs from the original IST Re-Evaluation reports in their components, their purpose of evaluation and level of review required, and more closely resemble the standard update and restoration reports completed by hospital and JBCT teams. While the additional workload relies upon the existing processes and basic infrastructure of the original program, the volume of work requires additional support.

As of the 2022-23 May Revision, DSH requests $1.3 million and 6.0 position authority in BY through BY+2 to supplement existing staffing and resources for the duration of the IST Re-Evaluations Services pilot.

County Support

DSH proposes to increase per IST evaluation reimbursement paid to county sheriffs based on feedback from the counties. The initial rate of $500 per IST evaluation was intended to support deputy escorting and supervision costs and clerical staff for the

pulling of medical records. Since program implementation, feedback from counties shows that these costs are closer to $1,000 per IST evaluation to support the deputy coverage occurring through overtime or in the evenings or on weekends, and therefore paid at a premium rate. Additionally, the number of hours initially assumed was lower than what is actually incurred by county staff. As of the 2022-23 May Revision, DSH requests $1.1 million in BY through BY+2 to support this increase.

Increased Placements to CONREP

In the 2022-23 Governor's Budget, DSH requested $443,000 in BY and $1.2 million BY+1 and ongoing to support the recruitment and training process to pilot a new independent placement determination panel, designed to increase utilization of CONREP, increase the number of individuals served in the community, and decrease institutionalization. This included position authority to be phased in over two years, beginning with 3.0 in BY, with the remaining 4.0 in BY+1 and ongoing. As of the 2022-23 May Revision, DSH requests 1.0 Senior Psychologist Supervisor to supervise the resources and oversee the clinical, operational, and administrative workload of this panel.

Implementation of the independent placement panel is planned in phases with full implementation anticipated by January 1, 2024. The independent placement panel will:

- Review placement orders, including violence risk assessment, updated psychiatric progress notes and specialty assessments
- Conduct placement evaluations
- Determine suitable housing based on a variety of factors including, but not limited to, acuity, medical necessity, compliance (i.e., PC 290 considerations), appropriateness, regional availability
- Monitor patient progress
- Review revocation requests, including considerations for rehospitalization
- Review orders for discharge from CONREP

This panel will help to reduce current barriers preventing patient placement into CONREP, support continuous improvement of discharge processes across all DSH patient commitments, and ensure timely release of discharge-ready patients from DSH to increase overall efficiency of state hospital beds. While CONREP CPDs will continue to be responsible for placement determinations of ISTs prior to DSH commitment, future consideration will be made to revise this responsibility and pilot an independent evaluation model for IST placement determinations once community investments in Felony IST infrastructure and expanded programming become available.

Felony IST Referral Growth and Penalties

As of May Revision, DSH proposes updates to the IST Referral Growth methodology to be used to assess whether a county has had growth in the number of IST determinations over their baseline which becomes the basis for calculating any penalties to be assessed. Specifically, DSH proposes for counties that had zero IST referrals in the baseline year (2021-2022) to set their baseline number of IST determinations at one. Additionally, DSH proposes to change the year that the penalty rate increases to 150% from 2025-26 to 2026-27, to reflect the change in the full implementation timeline for IST housing infrastructure and services over four years. DSH also proposes for counties who have a contract to operate diversion or community-based restoration to cap the rate to be applied at 100%. DSH also proposes to provide periodic notification each year to counties on their number of IST determinations compared to baseline.

Discharge Planning and Coordination with Counties

A primary goal of DSH is to ultimately transition individuals committed for treatment to the least restrictive level of care feasible to maintain public safety, honor patient rights, and minimize recidivism. Discharge from DSH facilities may include return to the community with or without supervision, transfer to other DSH facilities, or return to court, prison, or jail. DSH endeavors to commence the process of preparing individuals for discharge at the point of admission and to continuously address it throughout patient hospitalization. Comprehensive discharge planning encompasses many components, including but not limited to: development of treatment goals and objectives in collaboration with interdisciplinary treatment teams and patients; coordination with available community resources; liaison and consult with family and social supports; and partner with stakeholders and agencies such as but not limited to CONREP, county behavioral health, skilled nursing facilities (SNF), board and care facilities, California Department of Corrections and Rehabilitation (CDCR), county jails, Office of the Public Guardian, private conservators and others. Currently, dedicated discharge staffing and support resources that exist outside of the limited functions performed by the treatment team social worker are inadequate to increase coordination among county behavioral health partners and others necessary to successfully plan for individuals discharging. The resources requested support feedback provided by county stakeholders and during the IST Solutions Workgroup that there is a necessity to facilitate and increase coordination related to IST documentation and transition planning to successfully support a discharge back to the county. Increased flow of information from DSH supports county behavioral health in their preparation for an individual deemed IST returning to court where their charges may be dropped or reduced to misdemeanors and then released back to the community.

As of the 2022-23 May Revision, DSH requests $4 million and 24.0 in position authority in BY and ongoing to improve discharge planning and coordination with the county behavioral health for ISTs and other commitments discharging from the state hospitals or the jails to the community to facilitate the coordination of county services and support upon discharge and to support the increased transitions of hospital patients into the expanded continuum of care. Position authority requested is 2.0 Clinical Social Workers (CSW) per hospital and 1.0 AGPA, 1.0 Staff Services Analyst (SSA), and 1.0 Office Technician (OT) for DSH-Atascadero, DSH-Metropolitan, DSH-Napa, and DSH-Patton; as well as 1.0 SSA and 1.0 OT for DSH-Coalinga.

Alienist Training

DSH proposes to partner with the Judicial Council, via interagency agreement, to develop training to improve the quality of evaluations that are utilized by the courts to make determinations regarding a defendant's competency status. DSH would serve as a consultant partner with the Judicial Council in the development of the training. As of the 2022-23 May Revision, DSH requests $5 million annually beginning in 2022-23 through 2024-25 to support this IAA to provide funding to the Judicial Council for an alienist training program.

IST Solutions Total Request

As of the 2022-23 May Revision, DSH reports a decrease of $36.1 million in BY, a decrease of $89.3 million in BY+1, a decrease of $53.7 million in BY+2 and requests an increase of $66.5 million in BY+3 and ongoing. For position authority, DSH requests 35.0 in BY, 38.5 in BY+1, 36.0 position in BY+2 and 30.0 in BY+3 and ongoing. Funding and positions are to support the various components of the IST Solutions programs.

IST Solutions (Dollars in thousands)	CY 2021-22		BY 2022-23		BY+1 2023-24		BY +2 2024-25		BY +3 2025-26+	
	Positions	Funding	Positions	Funding	Positions	Funding	Positions	Funding	Positions	Funding
Early Access & Stabilization	**5.0**	**$24,900**	**10.0**	**$103,985**	**10.0**	**$103,985**	**10.0**	**$103,985**	**10.0**	**$103,985**
Governor's Budget	5.0	$24,900	10.0	$66,800	10.0	$66,800	10.0	$66,800	10.0	$66,800
May Revision	0.0	$0	0.0	$37,185	0.0	$37,185	0.0	$37,185	0.0	$37,185
Care Coordination & Waitlist Management	**7.0**	**$1,700**	**23.0**	**$6,999**	**30.0**	**$8,599**	**30.0**	**$8,599**	**30.0**	**$8,599**
Governor's Budget	7.0	$1,700	23.0	$4,906	29.0	$6,312	29.0	$6,312	29.0	$6,312
May Revision	0.0	$0	0.0	$2,093	1.0	$2,287	1.0	$2,287	1.0	$2,287
Expanding IST	**0.0**	**$66,400**	**9.0**	**$412,468**	**15.5**	**$356,873**	**20.5**	**$392,504**	**23.0**	**$520,052**
Governor's Budget	0.0	$66,400	5.0	$499,382	9.0	$497,209	16.5	$497,209	19.0	$497,209
May Revision	0.0	$0	4.0	-$86,914	6.5	-$140,336	4.0	-$104,705	4.0	$22,843
Re-Evaluation Services	**0.0**	**$0**	**6.0**	**$2,354**	**6.0**	**$2,354**	**6.0**	**$2,354**	**0.0**	**$0**
Governor's Budget	0.0	$0	0.0	$0	0.0	$0	0.0	$0	0.0	$0
May Revision	0.0	$0	6.0	$2,354	6.0	$2,354	6.0	$2,354	0.0	$0
CONREP	**0.0**	**$0**	**4.0**	**$645**	**8.0**	**$1,412**	**8.0**	**$1,412**	**8.0**	**$1,412**
Governor's Budget	0.0	$0	3.0	$433	7.0	$1,200	7.0	$1,200	7.0	$1,200
May Revision	0.0	$0	1.0	$212	1.0	$212	1.0	$212	1.0	$212
Discharge Planning	**0.0**	**$0**	**24.0**	**$4,000**	**24.0**	**$4,000**	**24.0**	**$4,000**	**24.0**	**$4,000**
Governor's Budget	0.0	$0	0.0	$0	0.0	$0	0.0	$0	0.0	$0
May Revision	0.0	$0	24.0	$4,000	24.0	$4,000	24.0	$4,000	24.0	$4,000
Alienist Training	**0.0**	**$0**	**0.0**	**$5,000**	**0.0**	**$5,000**	**0.0**	**$5,000**	**0.0**	**$0**
Governor's Budget	0.0	$0	0.0	$0	0.0	$0	0.0	$0	0.0	$0
May Revision	0.0	$0	0.0	$5,000	0.0	$5,000	0.0	$5,000	0.0	$0
TOTAL IST Request	**12.0**	**$93,000**	**76.0**	**$535,451**	**93.5**	**$482,223**	**98.5**	**$517,854**	**95.0**	**$638,048**
Governor's Budget	12.0	$93,000	41.0	$571,521	55.0	$571,521	62.5	$571,521	65.0	$571,521
May Revision	0.0	$0	35.0	-$36,070	38.5	-$89,298	36.0	-$53,667	30.0	$66,527

Of the $75 million CY set aside funding, DSH requests to reappropriate the remaining as follows:

4440-490—Reappropriation, State Department of State Hospitals. The balances of the appropriations in the following citations are reappropriated for the purposes provided for those appropriations and shall be available for encumbrance or expenditure as specified below:

0001—General Fund

(4) Item 4440-011-0001, Budget Act of 2021, 4400020-Hospital Administration, 4430020-Jail Based Competency Treatment and Program 4430030-Other Contract Services to support the Incompetent to Stand Trial Solutions shall be available for encumbrance or expenditure until June 30, 2024.

BCP Fiscal Detail Sheet

BCP Title: IST Solutions **BR Name: 4440-103-ECP-2022-MR**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	0.0	69.0	86.5	91.5	88.0	88.0
Total Positions	**0.0**	**69.0**	**86.5**	**91.5**	**88.0**	**88.0**
Salaries and Wages						
Earnings - Permanent	0	6,238	8,119	8,624	8,301	8,301
Total Salaries and Wages	**$0**	**$6,238**	**$8,119**	**$8,624**	**$8,301**	**$8,301**
Total Staff Benefits	0	3,550	4,548	4,833	4,633	4,633
Total Personal Services	**$0**	**$9,788**	**$12,667**	**$13,457**	**$12,934**	**$12,934**
Operating Expenses and Equipment						
5301 - General Expense	0	549	687	729	701	701
5304 - Communications	0	69	87	92	88	88
5320 - Travel: In-State	0	69	87	92	88	88
5324 - Facilities Operation	0	345	433	458	440	440
5340 - Consulting and Professional Services - External	0	303,447	247,060	281,819	402,594	402,594
5346 - Information Technology	0	69	87	92	88	88
Total Operating Expenses and Equipment	**$0**	**$304,548**	**$248,441**	**$283,282**	**$403,999**	**$403,999**
Total Budget Request	**$0**	**$314,336**	**$261,108**	**$296,739**	**$416,933**	**$416,933**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	0	314,336	261,108	296,739	416,933	416,933
Total State Operations Expenditures	**$0**	**$314,336**	**$261,108**	**$296,739**	**$416,933**	**$416,933**
Total All Funds	**$0**	**$314,336**	**$261,108**	**$296,739**	**$416,933**	**$416,933**

Program Summary

Program Funding						
4400010 - Headquarters Administration	0	1,045	1,344	1,392	1,359	1,359
4400020 - Hospital Administration	0	6,357	7,897	7,902	7,898	7,898
4410010 - Atascadero	0	641	641	641	641	641
4410020 - Coalinga	0	508	508	508	508	508
4410030 - Metropolitan	0	641	641	641	641	641

4410040	-	Napa	0	641	641	641	641	641
4410050	-	Patton	0	641	641	641	641	641
4420010	-	Conditional Release Program	0	2,771	3,492	3,492	2,229	2,229
4430050	-	Jail Based Treatment Programs	0	65,431	65,431	65,431	65,431	65,431
4430060	-	Community Based IST Programs	0	229,635	173,847	209,425	336,944	336,944
4450020	-	Incompetent to Stand Trial Re-Evaluation Services	0	6,025	6,025	6,025	0	0
Total All Programs			**$0**	**$314,336**	**$261,108**	**$296,739**	**$416,933**	**$416,933**

BCP Title: IST Solutions **BR Name: 4440-103-ECP-2022-MR**

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	7.0	7.0	7.0	7.0	7.0
1401	-	Info Tech Assoc				0.0	1.0	1.0	1.0	1.0	1.0
1402	-	Info Tech Spec I				0.0	1.0	1.0	1.0	1.0	1.0
1414	-	Info Tech Spec II				0.0	1.0	1.0	1.0	1.0	1.0
4563	-	Accounting Officer (Supvr)				0.0	1.0	1.0	1.0	1.0	1.0
4800	-	Staff Svcs Mgr I				0.0	0.5	1.0	1.0	1.0	1.0
4802	-	Staff Svcs Mgr III				0.0	1.0	1.0	1.0	0.0	0.0
5157	-	Staff Svcs Analyst (Gen)				0.0	4.0	4.0	4.0	4.0	4.0
5237	-	Legal Analyst				0.0	1.0	1.0	1.0	1.0	1.0
5393	-	Assoc Govtl Program Analyst				0.0	11.0	13.0	14.0	12.0	12.0
5742	-	Research Data Spec I				0.0	1.0	2.0	2.0	2.0	2.0
5758	-	Research Data Spec II				0.0	1.0	2.0	2.0	2.0	2.0
5795	-	Atty III				0.0	-1.0	-1.0	-1.0	-1.0	-1.0
7620	-	Consulting Psychologist				0.0	8.0	12.0	13.5	14.0	14.0
8336	-	Hlth Program Spec II				0.0	0.5	0.5	0.0	0.0	0.0
8338	-	Hlth Program Spec I				0.0	4.5	5.5	6.0	6.0	6.0
8427	-	Hlth Program Mgr I				0.0	2.5	3.0	4.0	4.0	4.0
8428	-	Hlth Program Mgr II				0.0	0.0	1.0	2.0	2.0	2.0
9700	-	Nurse Practitioner (Safety)				0.0	6.0	8.0	8.0	8.0	8.0
9831	-	Sr Psychologist (Hlth Facility) (Supvr)				0.0	3.0	4.5	5.0	4.0	4.0
9839	-	Sr Psychologist (Hlth Facility) (Spec)				0.0	5.0	7.0	7.0	7.0	7.0
9872	-	Clinical Soc Worker (Hlth/CF)-Safety				0.0	10.0	11.0	11.0	11.0	11.0
Total Positions						**0.0**	**69.0**	**86.5**	**91.5**	**88.0**	**88.0**

Salaries and Wages			CY	BY	BY+1	BY+2	BY+3	BY+4
1139	-	Office Techn (Typing)	0	316	316	316	316	316
1401	-	Info Tech Assoc	0	75	75	75	75	75
1402	-	Info Tech Spec I	0	93	93	93	93	93
1414	-	Info Tech Spec II	0	110	110	110	110	110
4563	-	Accounting Officer (Supvr)	0	65	65	65	65	65
4800	-	Staff Svcs Mgr I	0	43	86	86	86	86
4802	-	Staff Svcs Mgr III	0	109	109	109	0	0

5157 -	Staff Svcs Analyst (Gen)	0	218	218	218	218	218
5237 -	Legal Analyst	0	64	64	64	64	64
5393 -	Assoc Govtl Program Analyst	0	800	946	1,018	873	873
5742 -	Research Data Spec I	0	80	160	160	160	160
5758 -	Research Data Spec II	0	86	176	176	176	176
5795 -	Atty III	0	-136	-136	-136	-136	-136
7620 -	Consulting Psychologist	0	1,021	1,530	1,722	1,785	1,785
8336 -	Hlth Program Spec II	0	44	44	0	0	0
8338 -	Hlth Program Spec I	0	360	440	480	480	480
8427 -	Hlth Program Mgr I	0	215	258	344	344	344
8428 -	Hlth Program Mgr II	0	0	95	189	189	189
9700 -	Nurse Practitioner (Safety)	0	810	1,080	1,079	1,079	1,079
9831 -	Sr Psychologist (Hlth Facility) (Supvr)	0	396	593	659	527	527
9839 -	Sr Psychologist (Hlth Facility) (Spec)	0	602	843	843	843	843
9872 -	Clinical Soc Worker (Hlth/CF)-Safety	0	867	954	954	954	954
Total Salaries and Wages		**$0**	**$6,238**	**$8,119**	**$8,624**	**$8,301**	**$8,301**
Staff Benefits							
5150200 -	Disability Leave - Industrial	0	79	104	110	106	106
5150210 -	Disability Leave - Nonindustrial	0	25	32	34	32	32
5150350 -	Health Insurance	0	286	372	396	380	380
5150450 -	Medicare Taxation	0	95	122	130	124	124
5150500 -	OASDI	0	208	244	259	243	243
5150600 -	Retirement - General	0	1,569	2,000	2,125	2,037	2,037
5150700 -	Unemployment Insurance	0	5	7	8	7	7
5150800 -	Workers' Compensation	0	289	374	397	382	382
5150820 -	Other Post-Employment Benefits (OPEB) Employer Contributions	0	169	221	235	226	226
5150900 -	Staff Benefits - Other	0	825	1,072	1,139	1,096	1,096
Total Staff Benefits		**$0**	**$3,550**	**$4,548**	**$4,833**	**$4,633**	**$4,633**
Total Personal Services		**$0**	**$9,788**	**$12,667**	**$13,457**	**$12,934**	**$12,934**

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

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	***-$6,989***	***$11,620***	***$11,839***
One-time	*0.0*	*0.0*	*0.0*	*-$4,716*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*-$2,273*	*$11,620*	*$11,839*
May Revision	**0.0**	**0.0**	**0.0**	***-$5,425***	***$3,880***	***$5,029***
One-time	*0.0*	*0.0*	*0.0*	*-$5,491*	*-$1,094*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$66*	*$4,974*	*$5,029*
Total	**0.0**	**0.0**	**0.0**	***-$12,414***	***$15,500***	***$16,868***
One-time	*0.0*	*0.0*	*0.0*	*-$10,207*	*-$1,094*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*-$2,207*	*$16,594*	*$16,868*

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. This increased over prior years is 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 oversees four JBCT program models that either serve IST patients with an established number of dedicated beds or on an individual basis:

1. Single county model – One specific county
2. Regional model – Several surrounding counties
3. Statewide model - Multiples counties statewide
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 established, 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.

Additionally, DSH continues to identify ways to reduce wait times and access to treatment services. These services provide early access to psychotropic medication including long-acting injectable (LAI) 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. In addition, 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.

The 2022-23 Governor's Budget included a current year (CY) savings due to contract negotiation and program activation delays amid the COVID-19 pandemic and funding to support existing and new JBCT programs. Additionally, DSH requested funding for Jail In-Reach/Early Access to provide early access to treatment for ISTs awaiting admissions to a JBCT program.

DESCRIPTION OF CHANGE

As of the 2022-23 May Revision, DSH reflects an additional one-time CY savings of $5.4 million due to continued contract negotiation delays amid the COVID-19 pandemic. In addition, DSH requests $3.9 million in FY 2022-23 and $5.0 million in FY 2023-24 and ongoing to support the expansion of existing JBCT programs, the addition of new JBCT programs, and associated program support funding for patients' rights advocacy services. The following sections will provide additional

information and funding adjustments anticipated at this time for all existing JBCT program activations and refer to Attachment A for an itemized list of adjustments.

Existing AES and JBCT Cost Increase and Expansion Updates

DSH reflects a one-time savings of $5.4 million in FY 2021-22 and requests $3.7 million in FY 2022-23 and $4.8 million ongoing to support the existing JBCT programs. Specifically, the requested adjustments to currently funded and existing programs include:

- Five currently funded county programs pending activation are experiencing recruitment challenges and contract negotiation delays
- Seven existing JBCT programs experienced increasing level of IST referrals and can support a bed capacity expansion: Butte, Calaveras, San Luis Obispo, Santa Barbara, Shasta, Solano, Ventura
- A rate increase is anticipated for: Calaveras, Sacramento, Santa Barbara, Solano, Central CA County C, Northern CA County H

Additionally, DSH was informed by the San Bernardino JBCT of the need to reduce their program bed capacity and convert from a statewide program to a single county model program. This is resulting from the custody staffing concerns, the need to repurpose a portion of the JBCT designated space into COVID-19 quarantine space and, subsequently, to centralize the county's inmates with serious mental illness. The San Bernardino JBCT program's current capacity of 146 beds will be reduced to 60-65 beds through patient attrition after all ISTs from the county that are pending placement have been admitted into the program. Analysis of the county's typical rate of IST referrals to DSH and the program's average length of stay and competency restoration rate will determine the final number of beds needed to sustain the JBCT program. A reduction in the number of clinical staff commensurate with the reduction in beds will be offset by the county's request to increase their custody staffing in order to safely continue administering the JBCT program. DSH continues to work closely with San Bernardino County to calculate the final bed rate and budget. DSH will provide an update in the 2023-24 Governor's Budget.

Service Expansion to Provide Early Access to IST Treatment

In the 2022-23 Governor's Budget, DSH proposed to utilize CY savings to expand JBCT services and perform early access to treatment services for IST defendants that are pending placement to a DSH program and housed in or near a county jail with a JBCT program. The funding will support the expansion of current jail medical and behavioral health provider contracts by providing additional

medication prescribers (psychiatrists or psychiatric nurse practitioners), mental health clinicians to deliver one to one clinical engagement and initiate competency restoration services, and nursing staff to administer and monitor medications.

DSH estimated an ongoing cost of $2.6 million at the 2022-23 Governor's Budget to support this need. However, as of the May Revision, DSH now anticipates additional funding will be needed based on discussions with prospective providers and a revised analysis utilizing the most recent IST referral data. This analysis included a reassessment of the necessary staffing in each county jail, and a refined estimate for the utilization of LAIs. To streamline this treatment option, consolidate the number of contracts, and maximize programmatic oversight and monitoring of efficacy, DSH will redirect the proposed funding from the JBCT caseload to the Early Access and Stabilization component of the IST Solutions budget proposal. Please see the IST Solutions Update narrative (C12) for additional details of this request and a status update on program implementation.

New JBCT Programs with Dedicated JBCT Beds/Treatment Milieu

As of the 2022-23 May Revision, DSH has updated its assumptions commensurate with the timing of contract execution and program activation for the new programs proposed in the 2022-23 Governor's Budget. As a result, DSH requests $204,000 in FY 2022-23 and ongoing to reflect cost increases. Refer to Attachment A for an itemized list of costs by proposed JBCT location.

New JBCT Cost Increases and Activation Updates ($184,000 in FY 2022-23 and ongoing)

DSH requests $184,000 in FY 2022-23 and ongoing for JBCT to support cost increases to new JBCT programs statewide.

Patients Right's Advocacy Funding: Increase Request ($20,000 in FY 2022-23 and Ongoing)

In the 2022-23 Governor's Budget, DSH requested $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. However, as of the 2022-23 May Revision, DSH requests an additional $20,000 in BY and ongoing to support the proposed expansions of the JBCT program.

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 2022-23 May Revision 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.

Change from Governor's Budget Total JBCT Capacity and Projected Funding										
Existing JBCT Capacity and Projected Funded										
Program	**FY 21-22 Bed Capacity**	**FY 22-23 Bed Capacity**	**FY 22-23 GB Activation**	**FY 22-23 MR Activation**	**Existing Per Diem Rate**	**GB Proposed Per Diem Rate**	**MR Proposed Per Diem Rate**	**FY 21-22[2]**	**FY 22-23[2]**	**FY 23-24[2]**
Butte	10	10	N/A	N/A	$420	$441	$441	$66	$805	$805
Calaveras	10	14	N/A	N/A	$420	$420	$441	-	$721	$721
Humboldt	6	8	N/A	N/A	$419	$441	$441	-	-	-
Kern AES	60	90	N/A	N/A	$480	$480	$480	-	-	-
Kings	5	8	N/A	N/A	$420	$441	$441	-$189	$16	$16
Mariposa	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-	-	-
Mendocino	6	6	N/A	N/A	$420	$420	$420	-	-	-
Monterey	10	11	N/A	N/A	$441	$441	$441	-	-	-
Placer	15	15	N/A	N/A	$374	$420	$420	-	-	-
Riverside	25	25	N/A	N/A	$402	$402	$402	-	-	-
Sacramento	44	44	N/A	N/A	$474	$499	$520	-	$337	$337
San Bernardino	146	146[1]	N/A	N/A	$472	$472	$472[1]	-	-	-
San Diego	30	40	N/A	N/A	$391	$391	$391	-$630	-	-
San Joaquin	12	12	N/A	N/A	$403	$403	$403	-	-	-

San Luis Obispo	5	8	N/A	N/A	$424	$446	$446	-	$488	$488
Santa Barbara	10	15	N/A	N/A	$418	$418	$441	-	$881	$881
Shasta	6	8	N/A	N/A	$374	$441	$441	-	$322	$322
Solano	12	16	N/A	N/A	$418	$418	$441	-	$736	$736
Sonoma	14	14	N/A	N/A	$431	$462	$462	-$52	-	-
Stanislaus	18	18	N/A	N/A	$375	$441	$441	-	-	-
Ventura	8	10	N/A	N/A	$415	$441	$441	-	$267	$322
Central CA County B	10	10	May 2022	July 2022	$420	$420	$420	-$256	-	-
Central CA County C	15	15	April 2022	June 2022	$420	$420	$441	-$375	$115	$115
Northern CA Small County D	N/A	N/A	Dec 2022	Dec 2022	N/A	N/A	N/A	-	-	-
Northern CA County E	N/A	5	Dec 2022	Dec 2022	$420	$420	$420	-	-	-
Northern CA County F	5	5	Dec 2022	Dec 2022	$420	$420	$420	-	-	-
Northern CA County G	7	7	Jan 2022	Mar 2022	$420	$420	$452	-$146	$82	$82
Northern CA County H	40	40	Feb 2022	Sept 2022	$441	$441	$441	-$2,646	-$1,094	-
Northern CA County I	15	15	March 2023	Mar 2023	$420	$420	$420	-	-	-
Northern CA County J	15	15	Mar 2023	Mar 2023	$420	$420	$420	-	-	-

Central CA County K	4	7	Mar 2023	Mar 2023	$420	$420	$420	-	-	-
Northern CA County N	19	19	Feb 2022	July 2022	$420	$420	$420	-$1,197	-	-
Jail In-Reach Services	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-	-	-
Existing Subtotal	**582**	**656**						**-$5,425**	**$3,676**	**$4,825**
New JBCT Capacity and Projected Funding										
Program	**FY 21-22 Bed Capacity**	**FY 22-23 Bed Capacity**	**FY 22-23 GB Activation**	**FY 22-23 MR Activation**	**Existing Per Diem Rate**	**GB Proposed Per Diem Rate**	**MR Proposed Per Diem Rate**	**FY 21-22[2]**	**FY 22-23[2]**	**FY 23-24[2]**
Central CA County L	0	12	July 2022	July 2022	N/A	$420	$462	-	$184	$184
Southern CA County M	0	23	Mar 2023	Mar 2023	N/A	$420	$420	-	-	-
Patients' Rights Advocacy	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-	$20	$20
PRA Travel	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-	-	-
New Subtotal	**0**	**35**						**$0**	**$204**	**$204**
TOTAL	**582**	**691**	**$0**	**$0**	**$0**	**$0**	**$0**	**-$5,425**	**$3,880**	**$5,029**

[1] The number of beds and associated per diem rate will be adjusted upon execution of an amended contract with the county.
[2] Dollars in Thousands.

BCP Fiscal Detail Sheet

BCP Title: Jail Based Competency Treatment - Existing Programs **BR Name: 4440-082-ECP-2022-MR**

Budget Request Summary

	FY22					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	-5,425	3,676	4,825	4,825	4,825	4,825
Total Operating Expenses and Equipment	**$-5,425**	**$3,676**	**$4,825**	**$4,825**	**$4,825**	**$4,825**
Total Budget Request	**$-5,425**	**$3,676**	**$4,825**	**$4,825**	**$4,825**	**$4,825**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-5,425	3,676	4,825	4,825	4,825	4,825
Total State Operations Expenditures	**$-5,425**	**$3,676**	**$4,825**	**$4,825**	**$4,825**	**$4,825**
Total All Funds	**$-5,425**	**$3,676**	**$4,825**	**$4,825**	**$4,825**	**$4,825**

Program Summary

Program Funding						
4430020 - Jail Based Competency Treatment	-5,425	0	0	0	0	0
4430050 - Jail Based Treatment Programs	0	3,676	4,825	4,825	4,825	4,825
Total All Programs	**$-5,425**	**$3,676**	**$4,825**	**$4,825**	**$4,825**	**$4,825**

BCP Fiscal Detail Sheet

BCP Title: Jail Based Competency Treatment - New Programs **BR Name: 4440-083-ECP-2022-MR**

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	204	204	204	204	204
Total Operating Expenses and Equipment	**$0**	**$204**	**$204**	**$204**	**$204**	**$204**
Total Budget Request	**$0**	**$204**	**$204**	**$204**	**$204**	**$204**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	0	204	204	204	204	204
Total State Operations Expenditures	**$0**	**$204**	**$204**	**$204**	**$204**	**$204**
Total All Funds	**$0**	**$204**	**$204**	**$204**	**$204**	**$204**

Program Summary

Program Funding						
4430050 - Jail Based Treatment Programs	0	204	204	204	204	204
Total All Programs	**$0**	**$204**	**$204**	**$204**	**$204**	**$204**

CONTRACTED PATIENT SERVICES
FELONY MENTAL HEALTH DIVERSION PROGRAM
Program Update

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.

The 2021 Budget Act included a 12-month extension to expend the remaining FY 2018-19 funding and an additional allocation 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. As of February 2022, all program positions were filled.

In the 2022-23 Governor's Budget, DSH reported the diversion of 458 eligible individuals to a county run program by June 30, 2021. Additionally, as of September 30, 2021, DSH reported the activation of 24 Diversion programs which anticipate diverting 820 felony ISTs. In fall 2021, DSH received Letters of Intent from sixteen existing counties looking to expand their Diversion programs and six new counties interested in establishing Diversion programs.

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 September 30, 2021, $93.1million 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 2021-22. Although 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.

Expanding Existing County Programs

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. Eight counties have submitted program plans and contract amendments which are being routed through DSH for approvals. Five counties are reviewing draft contract language and DSH is awaiting response to move forward approvals and execution. As of September 30, 2021, $16.3 million of the $17.4 million has been earmarked for expansion contracts with county partners.

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, DSH provided intensive technical assistance to aid counties in developing their programs, resulting in six new counties submitting LOIs to establish new Diversion programs. As of March 2021, DSH has received program plans from five of these counties. Of the $29.0 million for new county contracts, $7.8 million has been earmarked for the following counties:

- Madera
- Nevada
- San Joaquin
- Tulare
- Tuolumne

Please see the IST Solutions Update narrative (C12) for requested changes to this program.

County Program Implementation Status

As of September 30, 2021, DSH has executed contracts with 24 counties, and all 24 have activated their Diversion programs. Of these, 16 counties have elected to expand their programs and their contracts are being amended. And after significant effort by DSH in the fall of 2021, five new counties have submitted plans for new programs. These programs aim to divert a total of 990 felony ISTs over the course of their program, including the new expansion efforts. The chart below displays the current 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**	
County Program Status - FY 2021-22 Funding			
Expansion Programs			
County	**Funding**	**Population**	**Program Start Date**
Alameda	$568,000.00	4	Summer 2022
Contra Costa	$568,000.00	4	Summer 2022
Humboldt	$710,000.00	5	Summer 2022
Kern	$1,562,000.00	11	March 2022
Los Angeles	$5,680,000.00	40	February 2022
Marin	$284,000.00	2	April 2022
Riverside	$1,420,000.00	10	Summer 2022
Sacramento	$852,000.00	6	Summer 2022
San Diego	$852,000.00	6	Summer 2022
San Francisco	$852,000.00	6	Summer 2022
San Mateo	$284,000.00	2	Summer 2022
Santa Barbara	$568,000.00	4	Summer 2022
Santa Clara	$568,000.00	4	Summer 2022
Solano	$710,000.00	5	Summer 2022

Ventura	$568,000.00	4	Summer 2022
Yolo	$284,000.00	2	Summer 2022
Subtotal	**$16,330,000.00**	**115**	
County Program Status - FY 2021-22 Funding			
New Programs			
County	**Funding**	**Population**	**Program Start Date**
Madera	$568,000	4	TBD
Nevada	$284,000	2	TBD
San Joaquin	$3,692,000	26	TBD
Tulare	$2,698,000	19	TBD
Tuolumne	$568,000	4	TBD
Subtotal	**$7,810,000**	**55**	
Grand Total	**$117,216,269**	**990**	

Additional Program Funding – IST Solutions

In FY 2021-22, the Legislature set aside $75 million to fund current year IST Solutions identified by DSH and approved by the Joint Legislative Budget Committee (JLBC). In the 2022-23 Governor's Budget, DSH requested to use $48.4 million of the set aside funds to augment the funding available to counties to apply towards increased housing and placement costs for the felony IST population. Counties can only access these funds for clients who are felony IST; clients who are likely to be IST are not eligible. DSH submitted its 30-day notification to the JLBC in February 2022 and sent notification to the counties in March 2022. As of April 2022, 17 counties submitted Letters of Interest in the additional housing funding and DSH anticipates completing all associated contract amendments before the end of the fiscal year.

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 September 30, 2021, 558 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 9/30/2021	558	100%

Total ISTs Diverted Prior to Referral to DSH I[1]	236	42.2%
Total Eligible for Diversion[2]	533	95.5%
Total Found Likely to Be IST Prior to Diversion	322	57.7%
Total ISTs Diverted Directly from DSH Waitlist	58	10.4%
Diagnosis	**Total Number**	**Percentage**
Schizophrenia	228	41.2%
Schizoaffective Disorder	197	35.6%
Bipolar Disorder	125	22.6%
Nonqualifying Disorder[3]	<11[4]	***%
Ethnicity	**Total Number**	**Percentage**
Black	212	36.5%
Hispanic	167	28.7%
White	158	27.2%
Other	44	7.6%
Gender	**Total Number**	**Percentage**
Male	368	65.9%
Female	186	33.3%
Other	<11[4]	***%
Living Situation at Arrest	**Total Number**	**Percentage**
Homeless	438	78.6%
Not Homeless	119	21.4%
Felony Charges	**Total Number**	**Percentage**
Arson	41	7.1%
Assault/ Battery	190	32.8%
Criminal Threats	49	8.4%
Kidnapping	17	2.9%
Obstruction of Justice	15	2.6%

[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.

Other	84	14.5%
Robbery	83	14.3%
Theft	101	17.4%

As of September 30, 2021, 190 participants in the program have either successfully completed or been revoked from Diversion. Of those participants, 65% of those who were found IST prior to diversion completed the program successfully while 61.8% of the participants diverted as likely-to-be IST were revoked from the program. While these are preliminary findings, they indicate that participants who were found IST are more successful in this program than those who are diverted as likely-to-be IST.

Diversion Outcome			
Only Eligible Participants			
IST by Judge			
Outcome	**IST**	**At risk of IST**	**Total**
	N (%)	N (%)	N (%)
Successful Completion	52 (65.0)	42 (38.2)	94 (49.5)
Negative Outcome	28 (35.0)	68 (61.8)	96 (50.5)
Total	**80 (42.1)**	**110 (57.9)**	**190**

Abdul Lateef Jameel Poverty Action Lab North America Grant

In September 2019, DSH was awarded an incubation grant 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. After exploring options for designing a RCT it was determined that it would not be feasible to conduct this type of evaluation with the ongoing COVID-19 pandemic and current waitlist pressures. DSH is withdrawing from the awarded grant. No funds were exchanged in the process.

In winter of 2021, DSH began contract negotiations with a national expert to build a full-scale program evaluation model that will look at outcomes, program fidelity, and data collection for all community-based IST treatment programs including Diversion. This study will not be a RCT and will look at the full scope of community IST solutions being implemented by the department.

Program Administration Update

DSH works closely with the Council of State Governments Justice Center (CSG) and the Council on Criminal Justice and Behavioral Health (CCJBH) to implement the

Diversion program. Both DSH and CCJBH have contracts with CSG to develop technical assistance trainings, learning materials, and program templates for county use. As of March 1, 2022, DSH has provided counties with 160 hours of in-person and web-based training. 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 FY 2021-22, DSH is focusing county technical assistance into two tracks. The first track is designated for all new counties contracting with DSH to implement a new Diversion program. Leveraging prior experience with existing Diversion programs, DSH released a five-session Diversion Academy for new counties which contains 20 hours of targeted assistance in developing new Diversion programs. DSH developed the Academy with the goal of helping new counties stand up programs more quickly and efficiently.

The second track is targeted at existing county programs and focuses 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. This approach is designed to optimize current programs and provide better patient outcomes.

Reappropriation of FY 2018-19 Funding

As previously reported, the majority of DSH Diversion programs experienced delays in program activation due to the onset of the COVID-19 pandemic in spring of 2020.

In the 2021 Budget Act, DSH requested to reappropriate the balance of the funding appropriated in FY 2018-19 for an additional 12 months. In order for counties whose contracts were already encumbered, an additional 12 months is needed in order to give the counties full three-year pilots and fully expend the funding. This will align the original funding with new funding received in the 2021 Budget Act. DSH requests to reappropriate the balance of all FY 2018-19 funding as follows:

4440-490—Reappropriation, State Department of State Hospitals. The balances of the following citations are reappropriated for the purposes provided for those appropriations and shall be available for encumbrance or expenditure as specified below:

0001—General Fund

(5) Item 4440-011-0001, Budget Act of 2018, 4430030 Other Contract Services to support the Incompetent to Stand Trial Diversion Program shall be available for encumbrance or expenditure until June 30, 2024.

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*
May Revision	**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*
Total	**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 Department of State Hospitals' (DSH) established the Community Based Restoration (CBR) program in partnership with Los Angeles (LA) County to treat felony Incompetent to Stand Trial (IST) patients, as authorized in the 2018 Budget Act. The LA county CBR program provides mental health treatment in community settings to LA county felony ISTs who would otherwise be treated in a state hospital or Jail Based Competency Treatment (JBCT) program.

The 2021 Budget Act authorized the expansion of the LA CBR program and established 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.

In the 2022-23 Governor's Budget, DSH reported a calculation error that undercounted the total number of beds funded in FY 2022-23 and ongoing by one acute bed and 33 unlocked residential beds. As a result, DSH requested $2.3 million in FY 2022-23 and ongoing to correct this error. Additionally, DSH requested an adjustment of $675,000 in FY 2022-23 and $900,000 in FY 2023-24 and ongoing to update the daily-bed rates for the original 150 beds of the LA CBR program. In total, DSH requested $3.0 million in FY 2022-23 and $3.2 million in FY 2023-24 and ongoing for the CBR program.

DESCRIPTION OF CHANGE

DSH is in the process of implementing the CBR expansion authorized in the 2021 Budget Act. The information below provides an update to DSH's expansion efforts. DSH does not request any additional resources to support the CBR program via this estimate. However, DSH is planning to utilize resources from the IST Solutions proposal to support the CBR program and mitigate the IST crisis holistically. Please see the IST Solutions Update narrative (C12) for requested changes to this program.

Los Angeles (LA) County CBR Expansion Update

The 2021 Budget act included an expansion of the LA County CBR program by 300 beds. In November 2021, the LA County CBR program activated the remaining 100 beds approved for this fiscal year. The LA CBR program now operates a total of 515 CBR beds. Between July 1, 2018 and March 14, 2022, the LA CBR program has treated 958 IST patients.

New County CBR Expansion Update

In the summer of 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 is in ongoing conversations with counties in the Bay Area, Central Valley, and Southern California that are actively exploring implementation of a CBR program in their communities. DSH is still in the early stages of discussion and will provide more details in the 2023-24 Governor's Budget.

Program Administration Update

In summer 2021, DSH reached out to multiple vendors and Subject Matter Experts (SMEs) to contract with DSH and provide technical assistance and training to counties and providers who elect to participate in the CBR program. DSH has contracted with a former lead of the LA Office of Diversion and Reentry's CBR program and an expert in community-based housing to provide direct support to counties planning and implementing CBR programs. These SMEs have already provided direct assistance to counties exploring how to design and implement CBR programming in their communities.

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 resources to establish the IMD and Sub-Acute Bed Capacity funding program which will serve one or more DSH commitment types. Specifically, DSH received 15.5 positions to 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

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.

In the 2022-23 Governor's Budget, DSH reported on engagement meetings with multiple private providers to develop potential programs across the State. Through these discussions, DSH identified the need to support acute level of care beds as a complement to IMD and sub-acute levels. Acute beds will promote stabilization for a portion of the felony IST population who may require involuntary medications. Additionally, DSH has been discussing this funding opportunity with targeted counties and strategizing the use of these funds to support recommendations resulting from the IST Solutions Workgroup.

DESCRIPTION OF CHANGE

117-Bed Sacramento Behavioral Healthcare Hospital - Acute Psychiatric Facility ($52.3 million in FY 2022-23 and ongoing)

DSH proposes to utilize funding authority for the IMD and Sub-Acute Bed Capacity program to lease beds at an acute psychiatric hospital in Sacramento County. This facility will serve felony IST patients from select counties and facilitate psychiatric stabilization, primarily through administration of medications, to support restoration of competency or a pathway to participation in a Diversion or other outpatient treatment program. DSH is working with county Diversion programs to create a pathway to Diversion and Community-Based Restoration programs. DSH patient admissions to Sacramento Behavioral Healthcare Hospital began on April 20, 2022.

36 – 40-Bed Central Valley Mental Health Rehabilitation Center (MHRC)

DSH is in negotiations with a private provider to activate a Mental Health Rehabilitation Center (MHRC) in the Central Valley. A location for this program has

been identified and the provider anticipates program activation and admissions within 14 months of securing the property lease. DSH anticipated activation to occur in spring 2023.

198-Bed Southern California Mental Health Rehabilitation Center (MHRC)

DSH is in negotiations with a private provider to build a new 198-bed Mental Health Rehabilitation Center (MHRC) in Southern California that will provide a mix of acute and sub-acute beds. A location for this program has been identified and DSH anticipates program activation to occur in 2024.

Future Expansions

DSH is in negotiations with three other prospective providers. While no specific locations have been identified at this point, one of the providers has a presence in several counties and is a behavioral health provider in county and other private programs. The other two providers have the ability to partner with developers to construct or refurbish facilities to suit the needs of DSH. An update will be provided in the 2023-24 Governor's Budget.

The table below provides a display of all the contract negotiations and program activity DSH is currently tracking for this program.

IMD/Sub-Acute Facility Bed Capacity and Cost Updates						
Program	**Patient Beds**		**Level of Care**	**Activation Date**	**FY 22-23 One-time Costs**	**FY 23-24 Ongoing Costs**
	Count	**Type**				
Sacramento Behavioral Healthcare Hospital	117	Acute	Acute Psychiatric Hospital	April 2022	$52,365,303	$40,267,120
Central Valley MHRC	36-40	Sub-Acute	MHRC	Spring 2023	TBD	TBD
Southern California MHRC	198	Acute, Sub-Acute	MHRC	2024	TBD	TBD
TOTAL	**355**	**N/A**	**N/A**	**N/A**	**$52,365,303**	**$40,267,120**

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:

- Conduct Psychological evaluations
- Develop forensic evaluation reports
- Provide expert witness court testimony and consultation related to these evaluation services
- Maintain up-to-date training associated with these programs

SOCP and OMD evaluation 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. Prior to the COVID-19 pandemic, forensic evaluators typically traveled 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 and court testimony.

Travel continues to be minimal amid the COVID-19 pandemic as DSH continues to utilize remote video interviews for conducting forensic evaluations. DSH continues to monitor COVID protocols to determine if travel will increase to pre-pandemic levels.

The forensic evaluator staffing described above reflects the level of support required to facilitate interviews, conduct evaluations, develop forensic reports, and provide expert witness and court testimony services needed for the potential SVP and OMD commitments who originate as CDCR referrals for 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

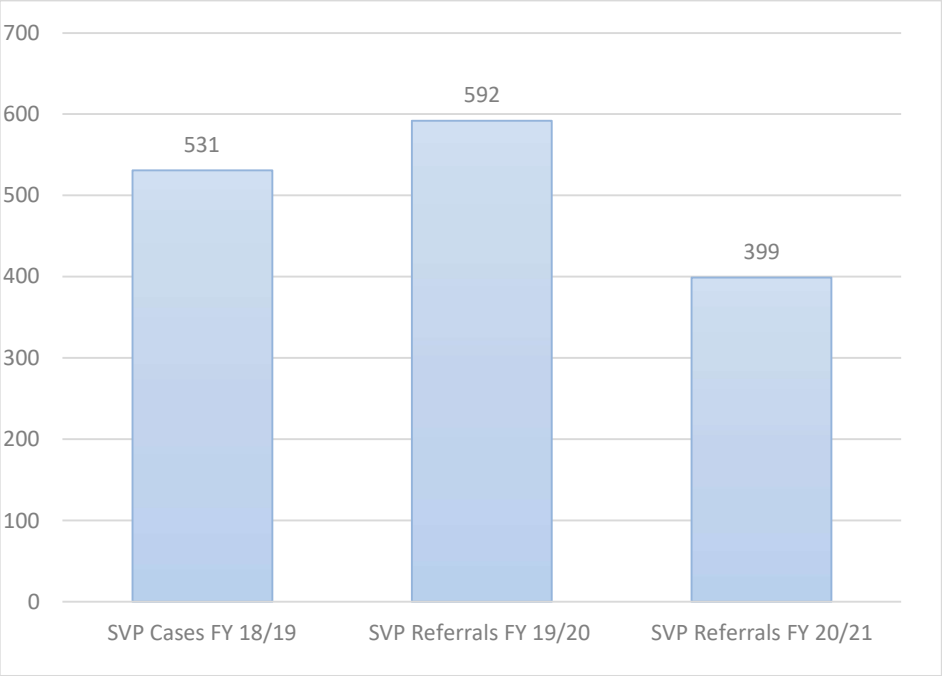
Failure to perform these forensic services accurately and timely could result in the inappropriate release of an OMD or SVP into the community, compromising public safety.

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.

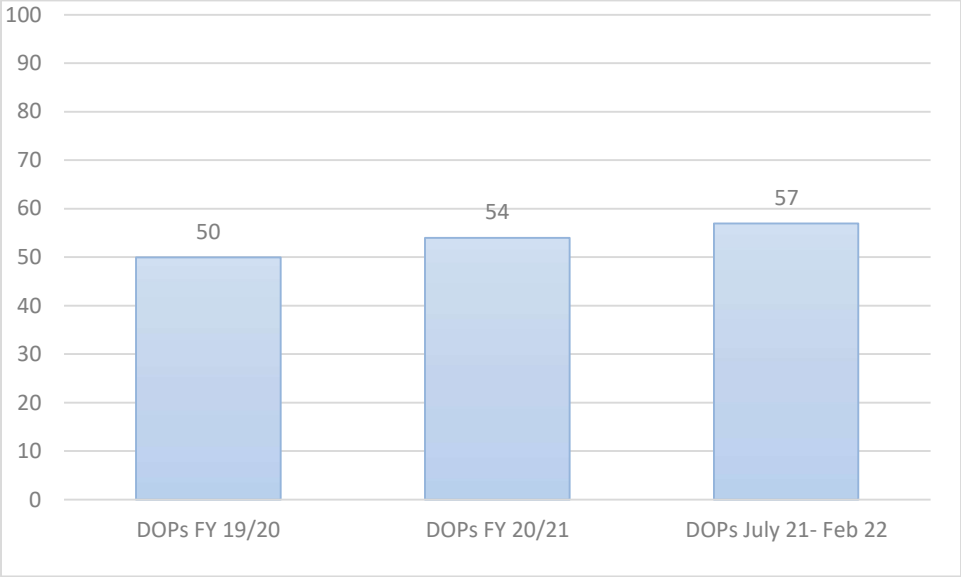
Per WIC 6601(b), CDCR and BPH are responsible for performing a two-part screening process of CDCR inmates. This consists of identifying whether the individual committed qualifying offenses for commitment as an SVP. If so, BPH must conduct a clinical review of the individual's qualifying offense(s) and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

For the period between July 2020 and June 2021, approximately 399 referrals were referred to DSH for full evaluations, which was only three more than the 396 projected at the 2021-22 May Revision. The chart below illustrates the trends observed over the past three years:



For each referral from CDCR, DSH is required to complete two forensic psychological evaluations to determine if the individual meets the statutory criteria for civil commitment as an SVP. When there is a difference of opinion (DOP) by the two forensic evaluators initially assigned by DSH to perform full evaluations, DSH is statutorily required to assign 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. From July 1, 2021 to February 28, 2022, approximately 57 DOPs were completed by DSH. As shown below, FY 2019-20 received a total of 50 referrals for the entirety of the fiscal year, which increased by 8% in FY 2020-21, bringing the total to 54. Only eight months into the current fiscal year, DSH has already received 57 such CDCR referrals. DSH has noted this increasing trend and will continue to monitor it.

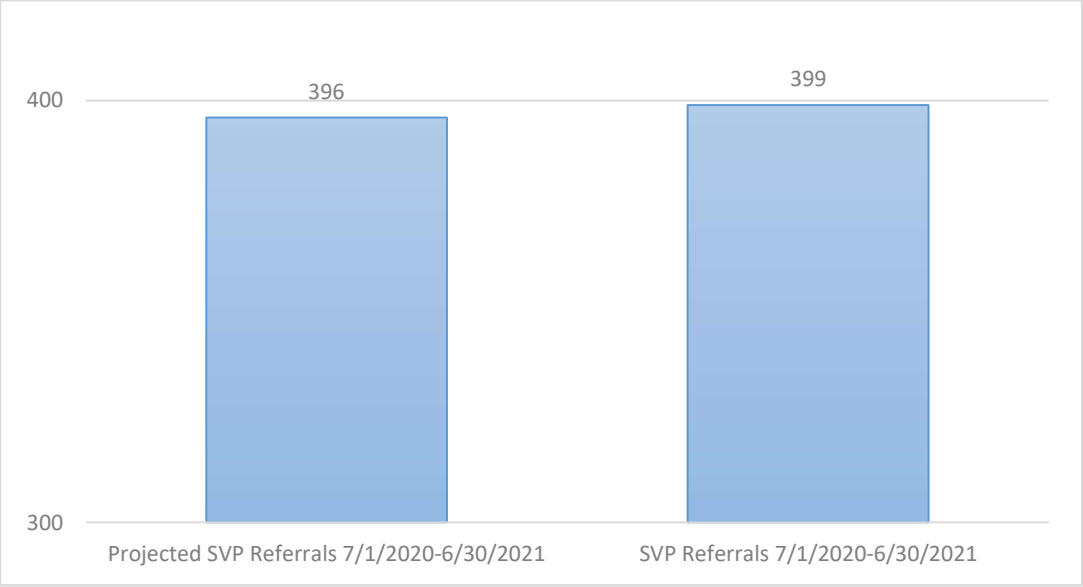


Contracted Evaluators

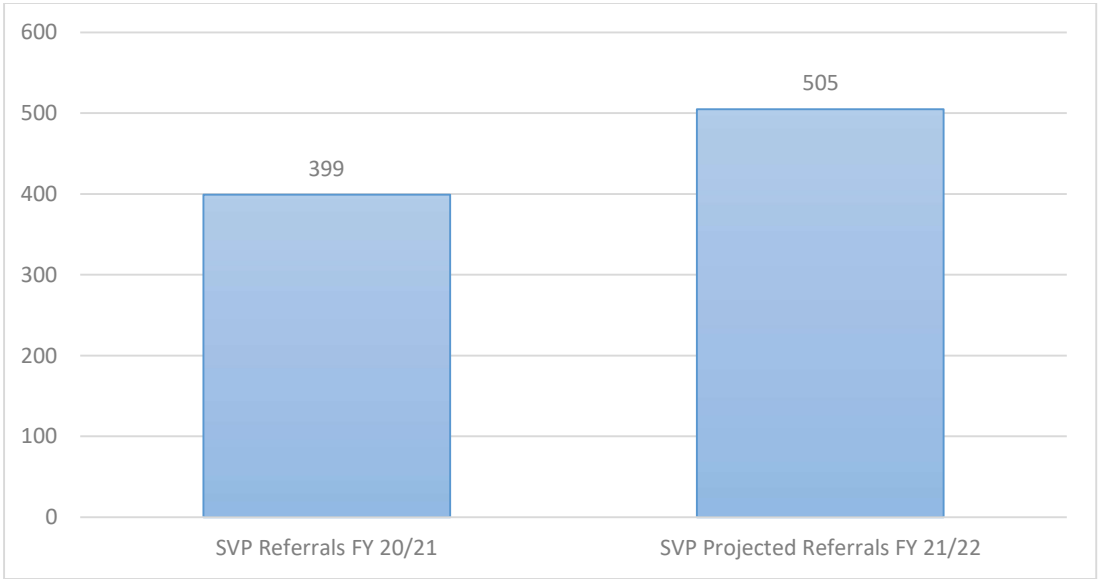
Per WIC 6600 statute, initial evaluations should be performed by civil servants. However, in the event state staff are unavailable to perform an evaluation and the individual referred has an impending release date, DSH will engage contracted staff to perform the evaluation. In the past three years DSH has significantly reduced its reliance upon contracted evaluators for initial SVP evaluations, and rush referrals in which a contracted evaluator may be required continue to make up a small portion of total referrals.

Projecting SOCP Program Referrals

To calculate SVP referral projections, DSH annualizes the previous 6 months of referral activity. Using this methodology, DSH projected as of the 2021-22 May Revision 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 actual SVP referrals received for FY 2020-21.



In the 2022-23 Governor's Budget, it was estimated that 570 SVP referrals were projected for FY 2021-22. Based on the number of referrals received between July 2021 and February 2022, DSH has adjusted this projection to 505, or 65 fewer referrals than initially projected for FY 2021-22. And while this is a reduction from the originally projected amount of 570, the updated projection of 505 SVP referrals is still a substantial 27% increase from the previous fiscal year. This 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 compares the number of SVP referrals received by DSH in FY 2020-21 to the updated projection for SVP referrals for FY 2021-22.



DSH does not currently seek resources for this projected additional workload in SOCP but will continue to coordinate with CDCR/BPH to monitor potential workload impacts.

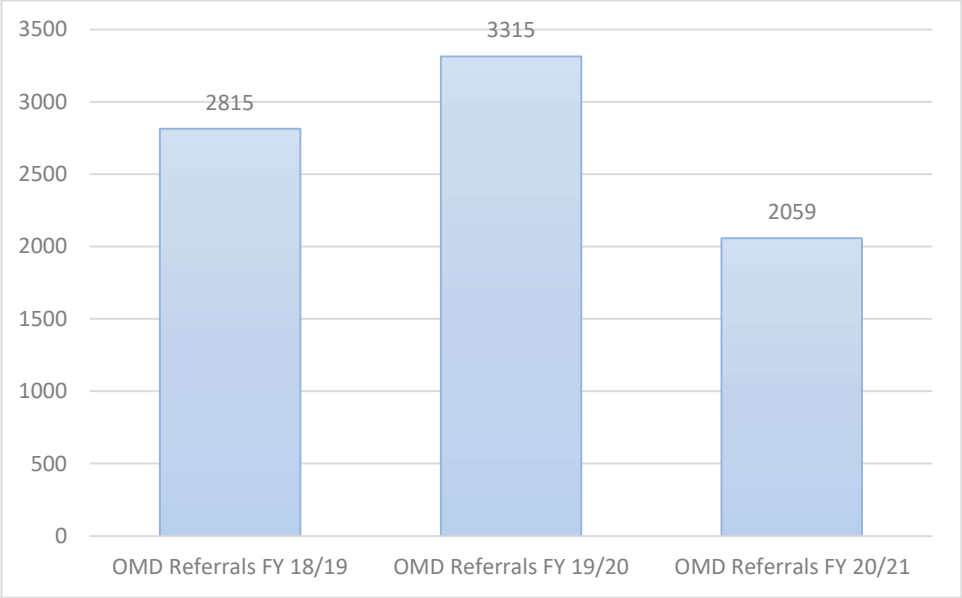
Offender with a Mental Health Disorder (OMD) Program

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

The first phase 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.

The second phase of the OMD process 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.

In FY 2020-21, DSH received 2,059 referrals from CDCR to perform an OMD evaluations for potential commitments to a state hospital, each requiring an evaluation and designation of positive or negative. A positive evaluation means it was determined the individual does meet the OMD criteria necessary for a potential commitment to a state hospital. If the CDCR and DSH evaluators determine 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 fiscal years 2018-19 through 2020-21.



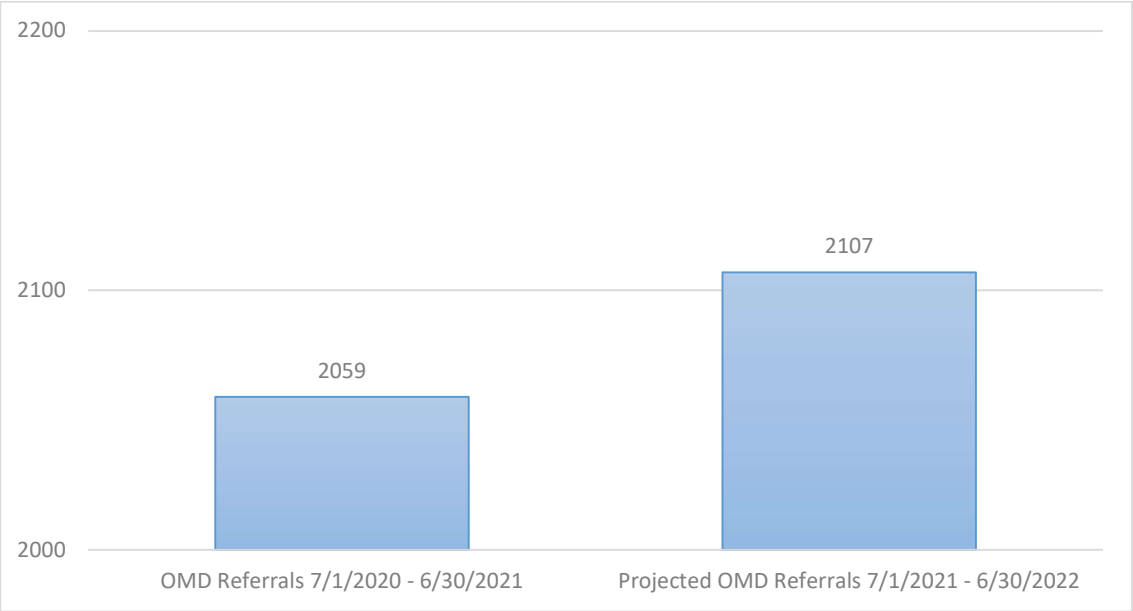
Projecting OMD Program Referrals

Beginning in June 2020, DSH experienced a spike 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 referred displayed a lower acuity (meaning the individual may not meet all OMD criteria). This surge in referrals, coupled with shorter timeframes until the earliest possible release dates, required DSH to perform parallel evaluations without waiting for the BPH assessment, deviating 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.

In the 2021-22 May Revision, DSH had projected to receive 2,093 OMD referrals in FY 2020-21. The actual number of referrals received was 2,059. This difference between the projected number of OMD referrals against the actual number received, was a variance of only 2%. Of the 2,059 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.

In the 2022-23 Governor's Budget, DSH reported that CDCR and BPH anticipated a temporary increase of OMD referrals with expedited release dates but were expected to resume pre-pandemic rates by Spring 2022. DSH estimated 2,019 OMD

referrals would be received in FY 2021-22. Between July 2021 and February 2022, DSH has received 1,405 OMD referrals. Based on this data, DSH now projects to receive 2,107 OMD referrals for 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.



Despite the increase in OMD referrals, it is not anticipated that referrals will reach pre-pandemic levels at this time. 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. DSH is not currently seeking any new funding or requesting position authority for the OMD Program.

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 committed to DSH and waiting in jail for 60 days or more pending transfer to a DSH facility or a DSH jail-based competency treatment program. The goal of this program is to assist in reducing the DSH IST waitlist by identifying individuals who have already been restored to competency and no longer need to be transferred to a DSH treatment program or to help identify individuals who may be candidates for involuntary medication orders, 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 and coordinate 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.
    b. The payment to the County Sheriffs covers the jail staff time to provide support and escort the patient for the evaluation.

IST forensic evaluators perform the following duties:

1. Assess if the individual has been restored while in jail, is malingering, , could benefit from an involuntary medication order, or has no substantial likelihood of being restored to competency. .
2. Prepare a report for the court on the status of the patient (effectively acting as the 90-day report); and if restored, file the Penal Code (PC) 1372 report.
3. Assess whether the individual is a potential candidate for Diversion or other outpatient treatment program, and through the report, inform the District Attorney, Public Defender, and the IST Diversion or community-based restoration program, if one is available in the county.
4. If within the scope of their license and as specified by the DSH Medical Director, offer expert medication consultation and technical assistance to local sheriffs to support effective use of psychotropic medications and stabilization of IST defendants awaiting placement to a department facility.

Assembly Bill (AB) 133, enacted July 1, 2021, authorized DSH to perform these re-evaluations, primarily through telehealth interviews, on IST defendants in jail pending placement as 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 included resources to implement the Re-Evaluation Services for Felony ISTs program. DSH established this program for a 4-year term, beginning July 1, 2021 (fiscal year (FY) 2021-22) to June 30, 2025 (FY 2024-25). DSH projected that the program could complete 309 evaluations per month based on the experience of a small pilot program. In addition, the 2021 Budget Act included a permanent redirection of funding from the Statewide Incompetent to Stand Trial Off-Ramp (SISTOR) program.

In the 2022-23 Governor's Budget, DSH reported that the implementation of this program is in the final stages. DSH reported that it was finalizing the evaluator panel contract, and developing implementation contracts with new evaluators, and reimbursement contracts with county sheriffs. Additionally, DSH had been reviewing the potential need for budget bill language which would grant the authority to reimburse county jail partners without requiring an executed contract to expedite reimbursement to county sheriffs.

DESCRIPTION OF CHANGE

As of the 2022-23 May Revision, DSH proposes to reappropriate the remaining balances from the existing appropriations to assist with ramp up efforts. The information below provides an update to DSH's implementation efforts and no additional resources are requested to support the Re-Evaluation Services program via this estimate item. However, resources to support this effort are reflected in the IST Solutions proposal update. Please see the IST Solutions Update narrative (C12) for requested changes to this program.

Program Implementation Updates

As of mid-March 2022, 20 IST evaluators were onboarded to conduct IST re-evaluations and DSH continues seek and accept applications for evaluator contracts. To increase caseload capacity, DSH submitted a request to the California Department of Human Resources (CalHR) for approval of 25 additional limited term appointments for Consulting Psychologists (Bargaining Unit 19) which was approved on November 4, 2021. As a result, 23 candidates have been hired and began accepting IST cases. It is anticipated the final two additional position appointments will be made by the end of April and mid-May 2022.

From July 2021 to mid-March 2022, 315 reports were completed by a combination of DSH civil service employees, contractors, and additional second position evaluators. Of these, 100 (approximately 38%) have been determined to be already competent. DSH anticipates completing onboarding of all recently hired evaluators by April 2022 and conducting approximately 120 re-evaluation cases on a monthly basis.

DSH also increased their community partnership outreach and held individual meetings with approximately 50 counties to establish central points of contact, address additional questions, and provide a draft reimbursement contract for review. DSH continues to work with counties and schedule additional meetings as needed.

DSH is no longer pursuing the need for additional budget bill language which would facilitate reimbursement payments to county sheriffs in the absence of an executed contract. Individual contracts with county jails appear to be the best mechanism to outline roles and responsibilities for both the state and counties and serve as the mechanism for payment. As of March 2022, five county sheriff reimbursement contracts have been fully executed. Additionally, DSH is currently collaborating with approximately 46 county jails to facilitate IST re-evaluations while simultaneously pursuing a reimbursement contract with each county jail.

Based on re-evaluations conducted from July 2021 to mid-March 2022, nearly 40 percent of IST defendants on the waitlist were determined to be competent and did not require admission to a DSH facility, highlighting the importance of this program to IST waitlist management.

Re-Evaluation Ramp Up

The duration of the COVID-19 pandemic and the associated safety measures adopted at various stages led to decreased admissions for DSH and a resulting increased waitlist. Through a ramp-up of current operations, DSH plans to temporarily increase the number of IST re-evaluations performed per month from 120-150 reports to 240-300 re-evaluations in an effort to address this.

Recent admissions and discharge modeling, assuming activation of other DSH IST programs and continued stabilization of the COVID-19 pandemic, suggests the number of ISTs currently on the waitlist and eligible for re-evaluation will taper to current levels by late 2022. Therefore, DSH requests additional support via a reappropriation noted below as an interim measure to immediately reduce the current waitlist backlogs created by COVID-19 admission and transfer restrictions considering the impending *Stiavetti* court deadlines. It is anticipated this increased capacity measure will operate for eight months between May/June 2022 to January/February 2023. Leveraging the existing processes and basic infrastructure

of the program, the Re-Evaluation Ramp Up is an efficient and cost-effective way to reduce the existing waitlist backlog.

Reappropriation of Funding

DSH requests the unused funds allocated for the Re-Evaluation Services program for FY 2021-22 be re-appropriated to fund the Re-Evaluation Ramp Up to conduct training, case management and tracking, clinical review, data entry, and technology troubleshooting. While the Re-Evaluation Program has recognized successes, program establishment measures such as contract execution, and establishing procedures and protocols, in addition to delays in hiring, have resulted in current year (CY) savings. The following provides the authorized funding for contract evaluators, county jail reimbursement, projected encumbrances for FY 2021-22 and projected savings.

Funding Source	**FY 2021-22**
Authorized Evaluator Funding	$6,018,000
Authorized Jail Reimbursement Funding	$1,961,000
Total Funding	**$7,979,000**
Encumbered Contractor Funding Projection (Contract evaluators onboarded December 2021)	$2,160,000
Encumbered Jail Funding Projection	$1,500,000
Additional position evaluators (25 @ .25-time base – onboarded starting January 2022) Projection	$419,000
Projected Savings	**$4,079,000**

DSH requests to reappropriate the balance of all FY 2021-22 funding as follows:

4440-490—Reappropriation, State Department of State Hospitals. The balances of the appropriations in the following citations are reappropriated for the purposes provided for those appropriations and shall be available for encumbrance or expenditure as specified below:

0001—General Fund

(6) Item 4440-011-0001, Budget Act of 2021, Program 4440 Evaluation and Forensic Services to support the Re-Evaluation Services for Felony Incompetent to Stand Trial shall be available for encumbrance or expenditure until June 30, 2024.

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.

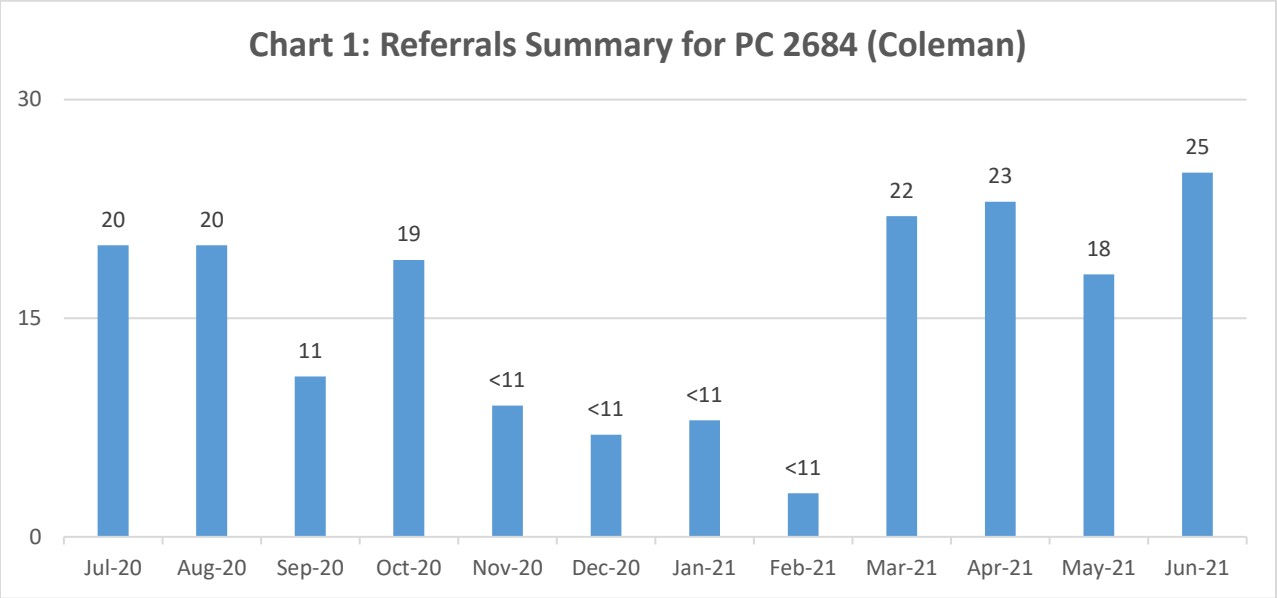
TREATMENT

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

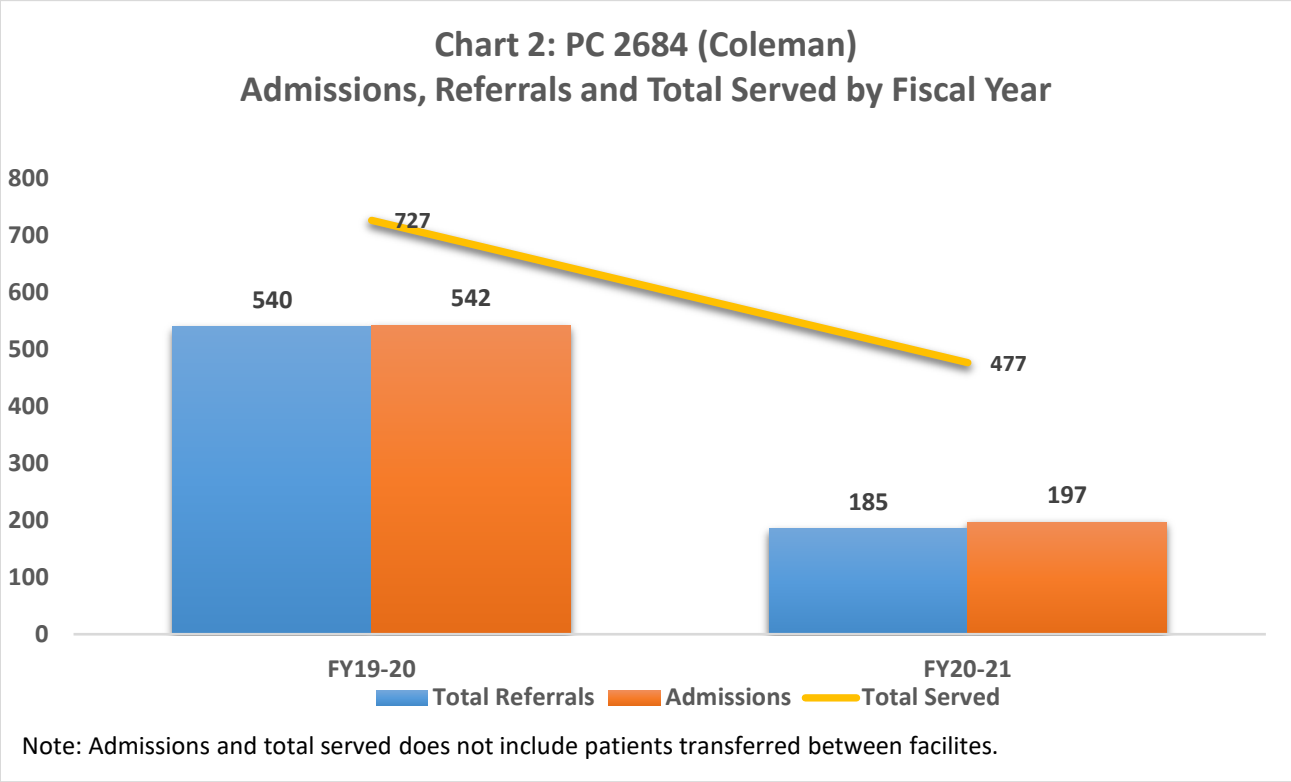
their mental illness symptoms and reintegrate back into a prison environment when discharged from the state hospital.

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.

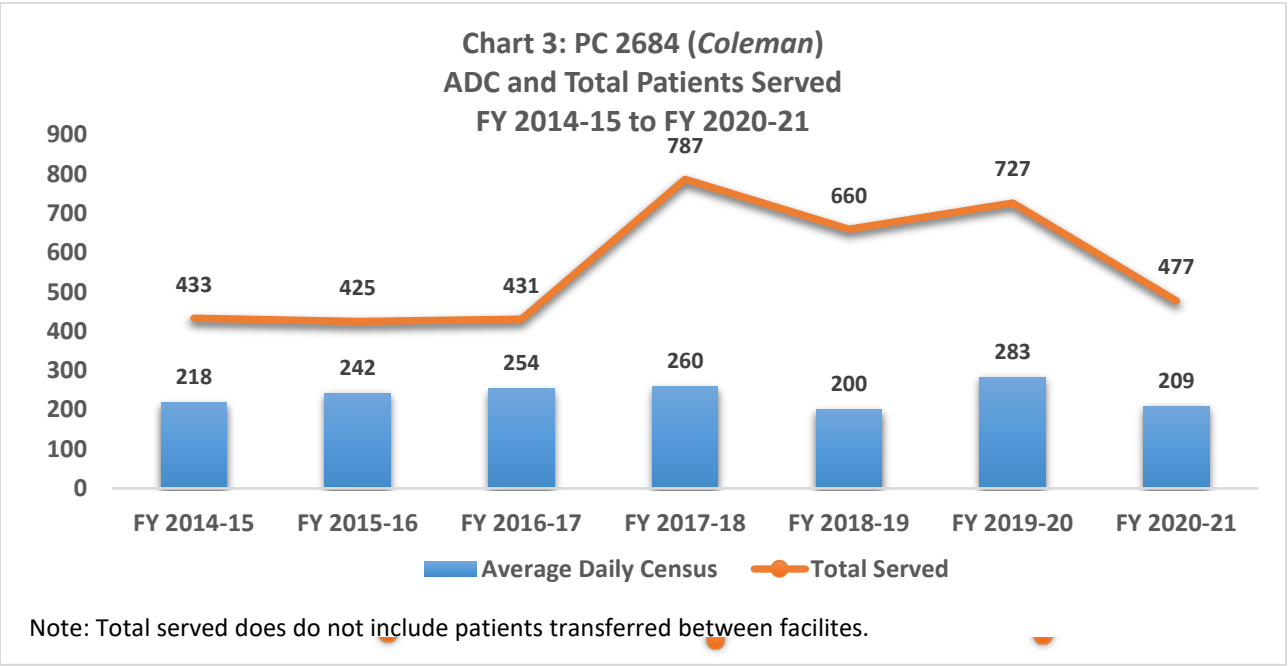


Over the course of FY 2020-21, 197 *Coleman* patients were admitted into a state hospital. Chart 2 displays the admission, referrals, and total patients served systemwide for the *Coleman* population in FY 2019-20 and FY 2020-21. The number of admissions decreased by 64 percent.



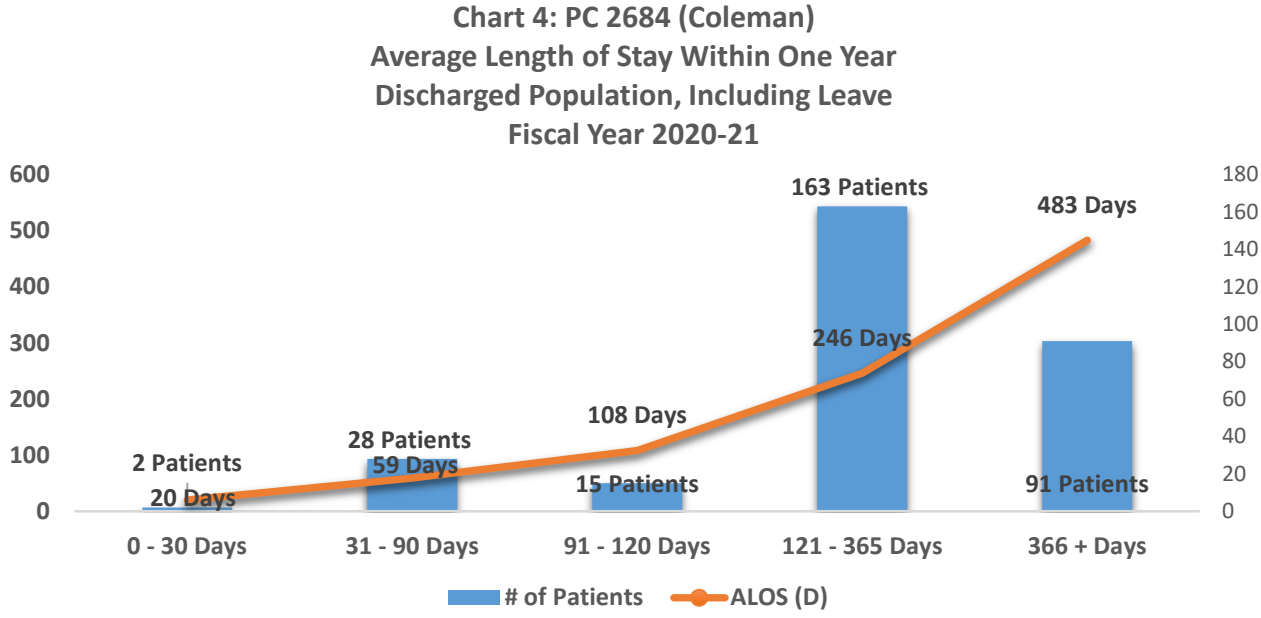
Note: Admissions and total served does not include patients transferred between facilites.

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

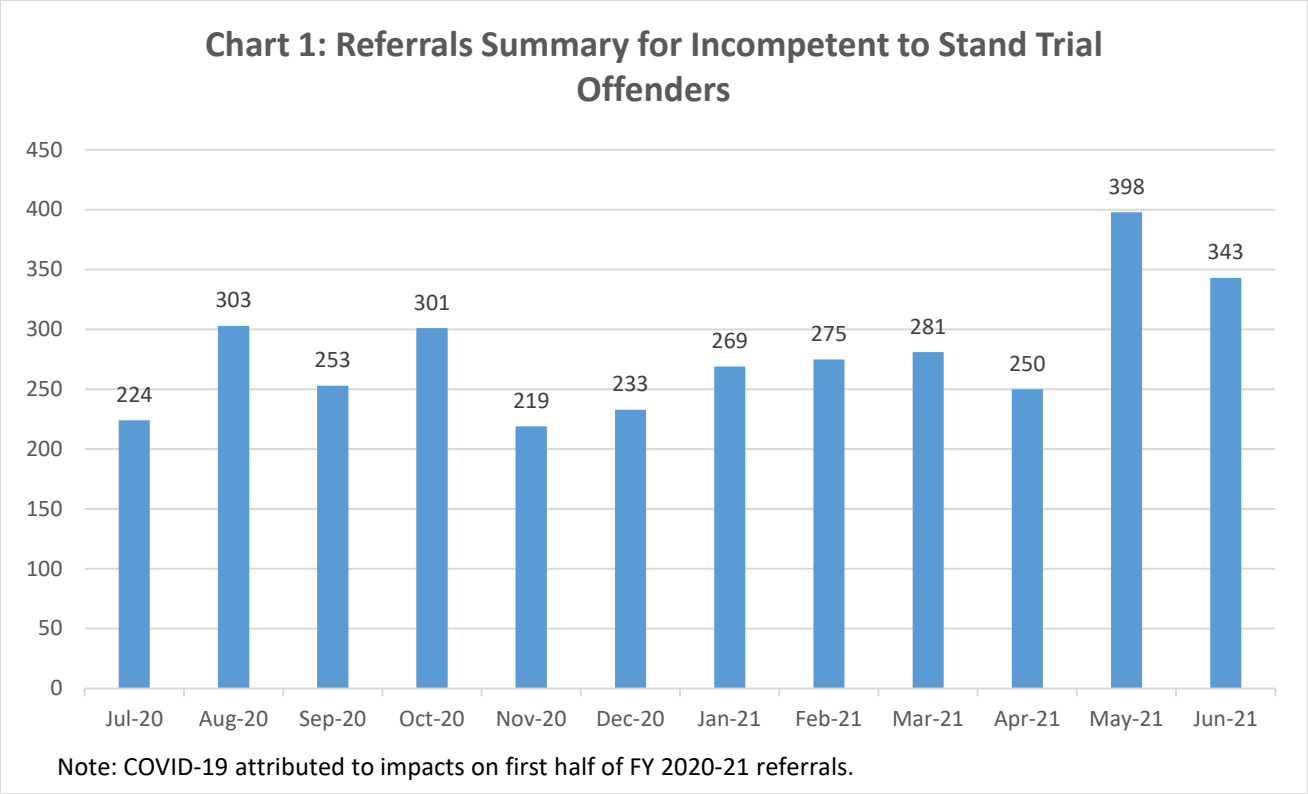
The focus of treatment for the IST population is on restoration of trial competency in the most expeditious manner. To this end, IST patients are treated in one treatment program so the training of criminal procedures can be constantly present in the treatment milieu. Once specific mental health issues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

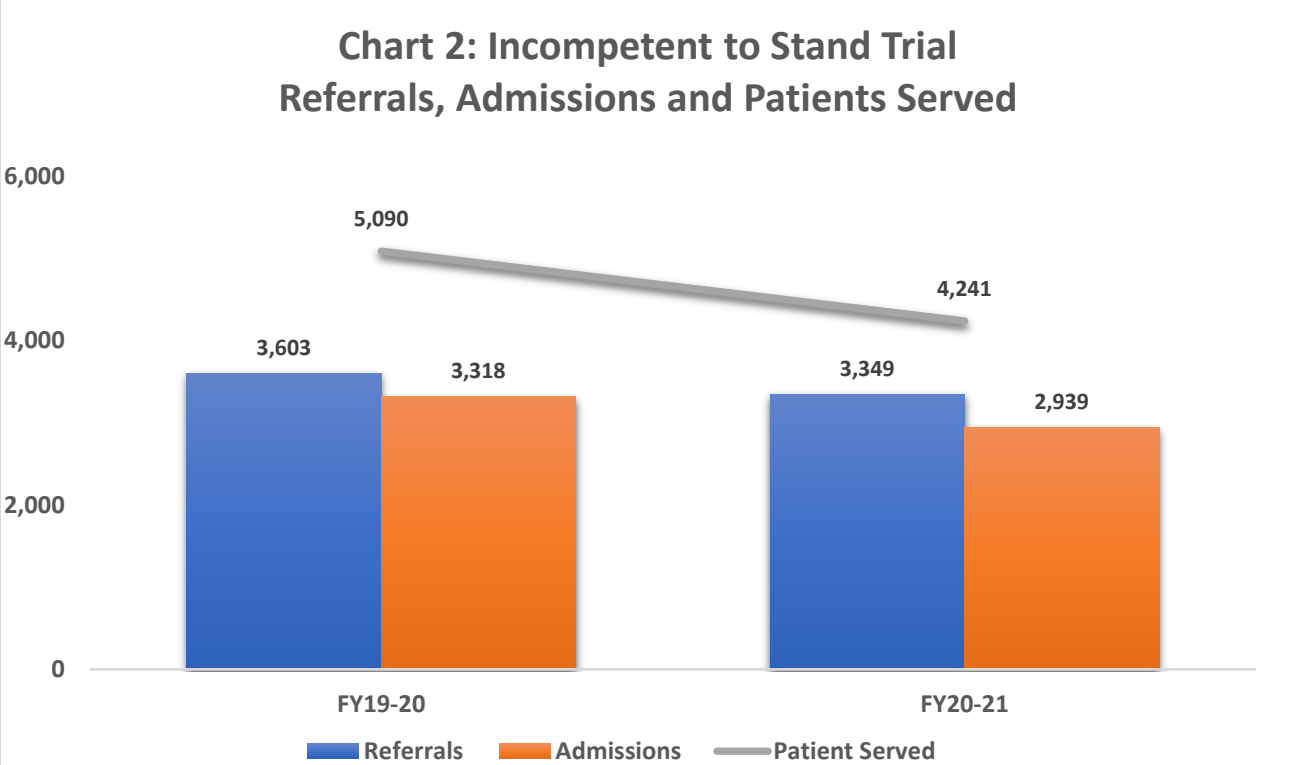
In FY 2020-21 3,349 IST patients were committed[2] to DSH, a 7 percent decrease from FY 2019-20. The COVID-19 pandemic directly impacted IST referral rates. As county courts began resuming court proceedings, IST referral rates have been steadily increasing, specifically in the second half of FY 2020-21 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.



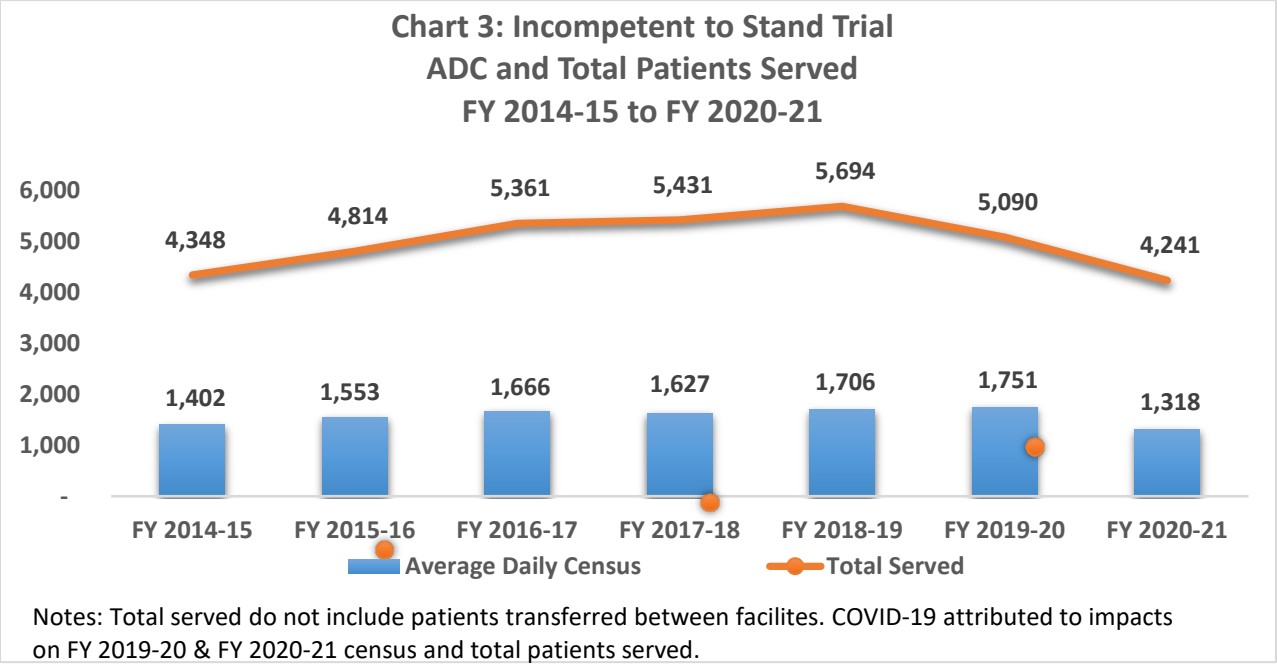
Incompetent to Stand Trial Data

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.



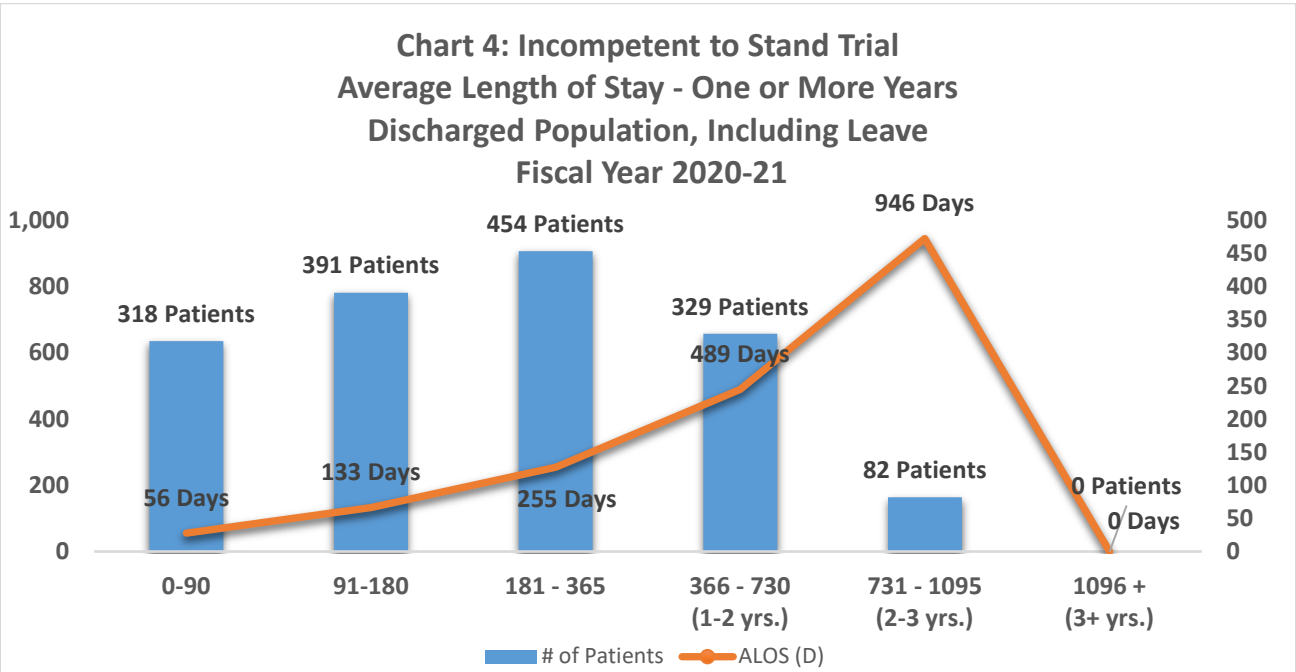
Notes: Total admissions and total served does not include patients transfers from DSH or JBCT facilities. COVID-19 attributed to impacts on first half FY 2020-21 referrals, admissions and total patients served.

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.

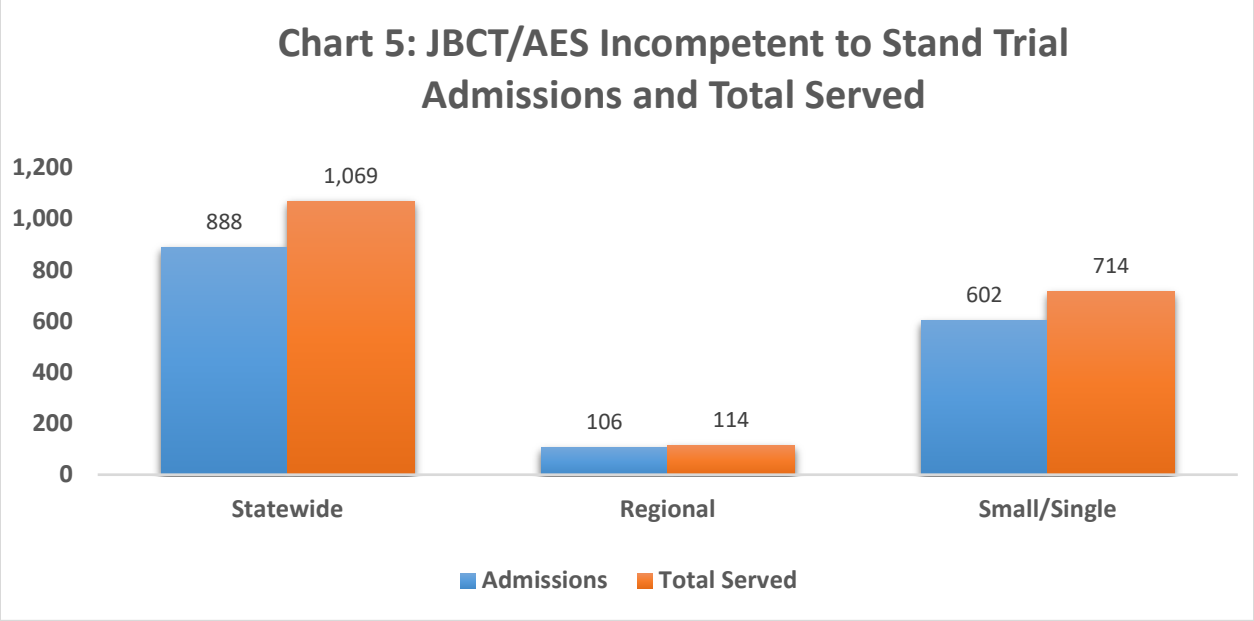
In FY 2020-21, 1,574 IST patients were discharged from state hospitals with an average length of stay of 269 days, 0.7 years. The State Hospital length of stay increased by 63 percent (or approximately 104 days) as compared to the prior year. This increase in the length of stay can be attributed to COVID-19 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.



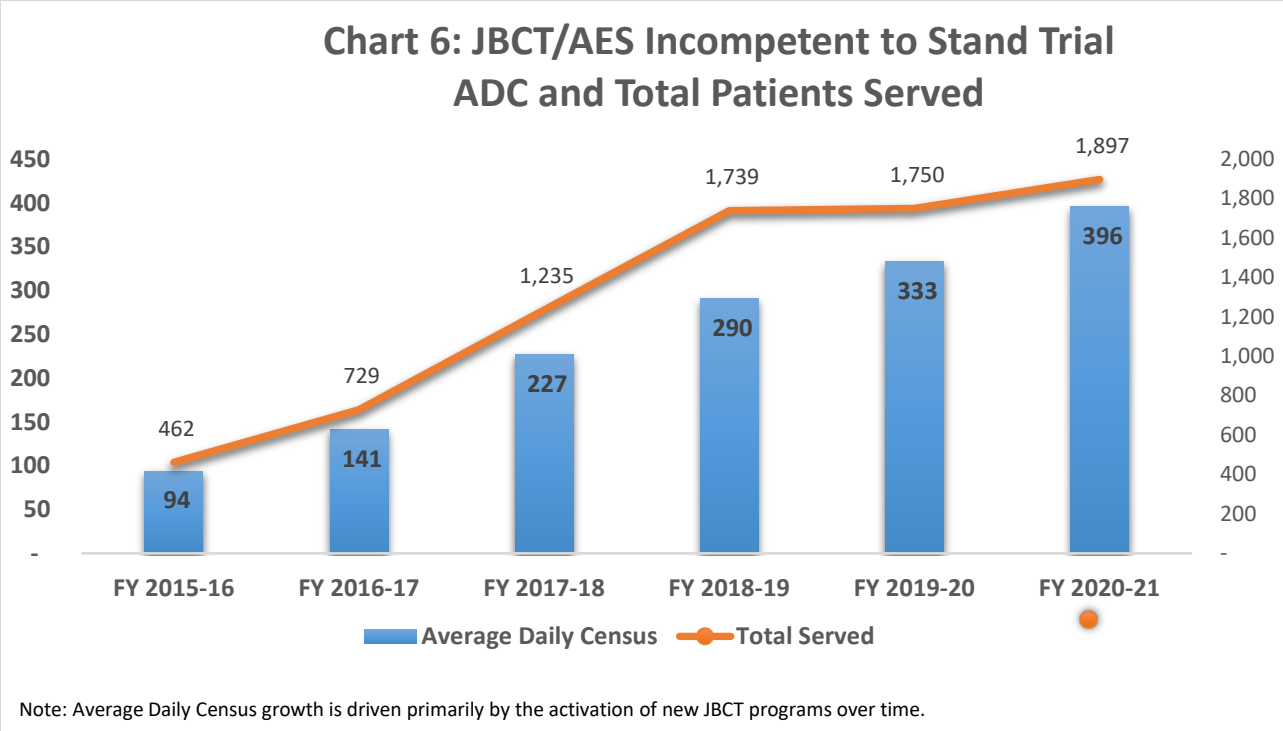
Notes: During FY2020-21, 3 EISTs were excluded from ALOS patient count. COVID-19 attributed to impacts on FY 2020-21 average length of stay.

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.

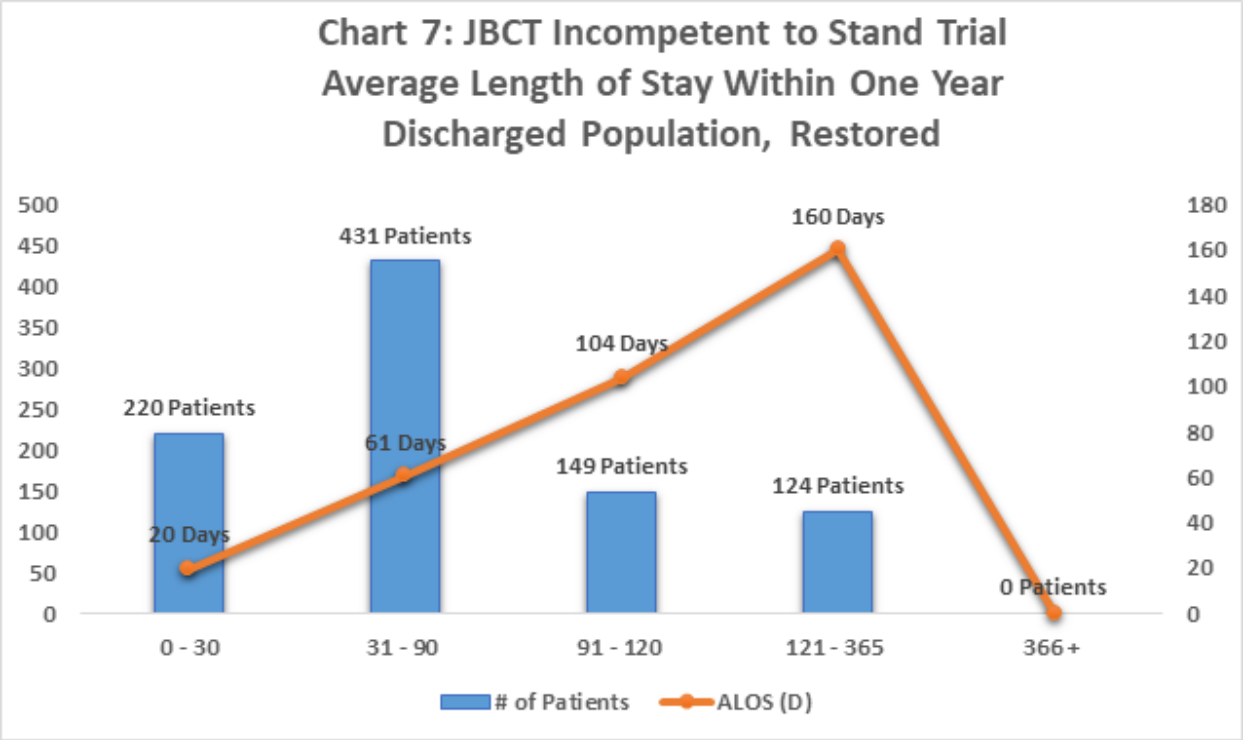


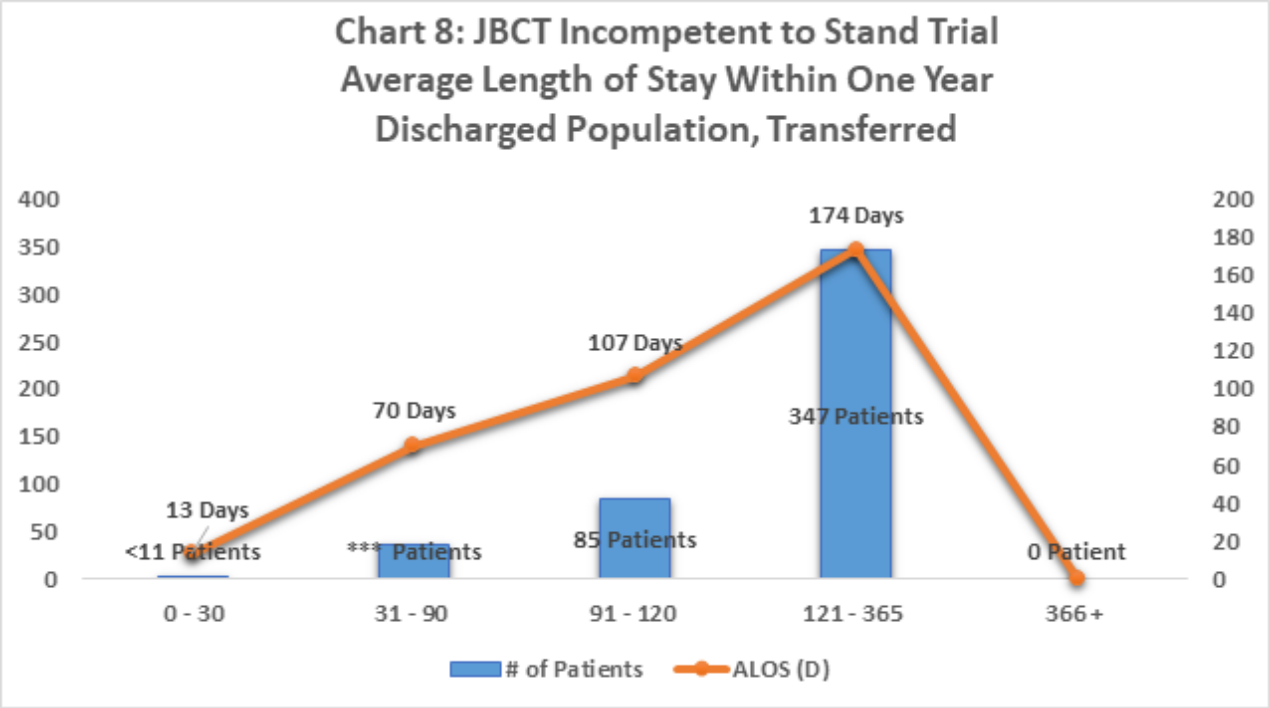
On average, 396 IST patients are treated daily in the AES/JBCTs, a 19 percent increase from FY 2019-20. Chart 6 displays the ADC and total number of patients served year over year in the AES/JBCTs for the IST population. As of June 30, 2021, the AES/JBCT system-wide IST census is 421 patients.



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.

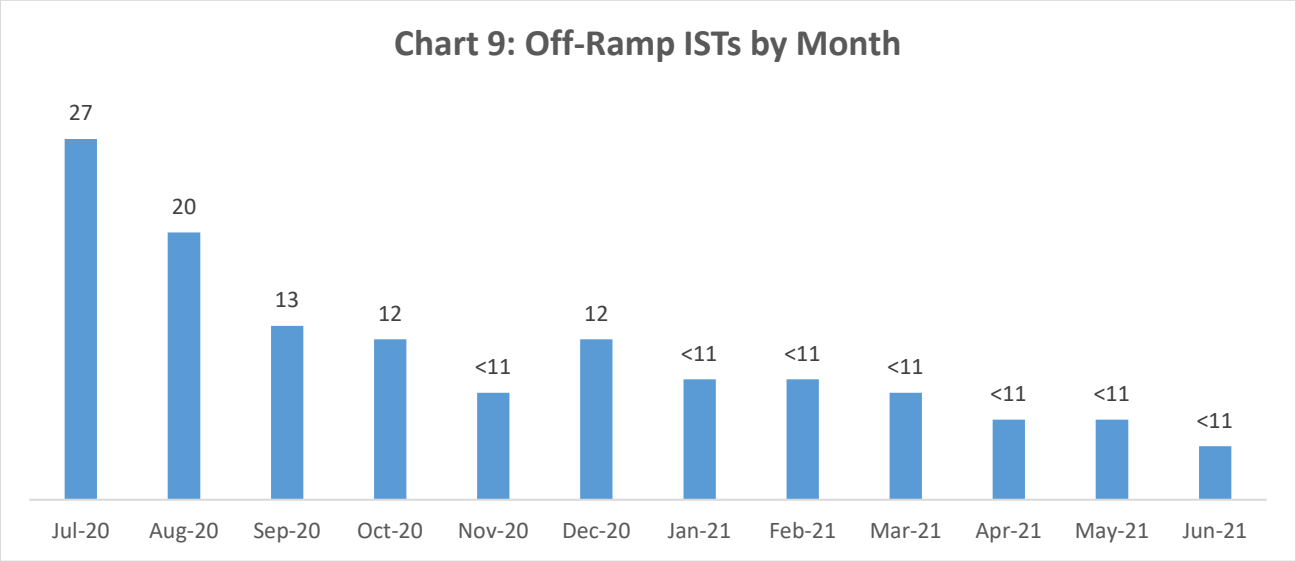


Chart 9. Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines.

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.

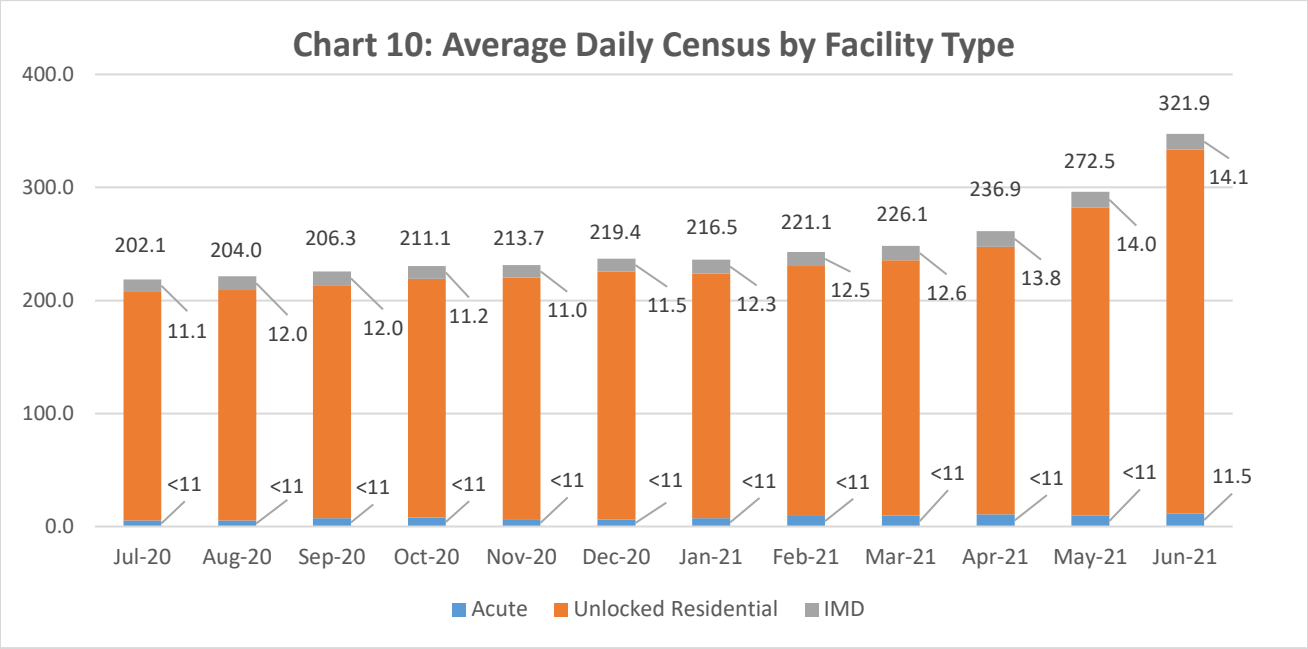


Chart 10. Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines.

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

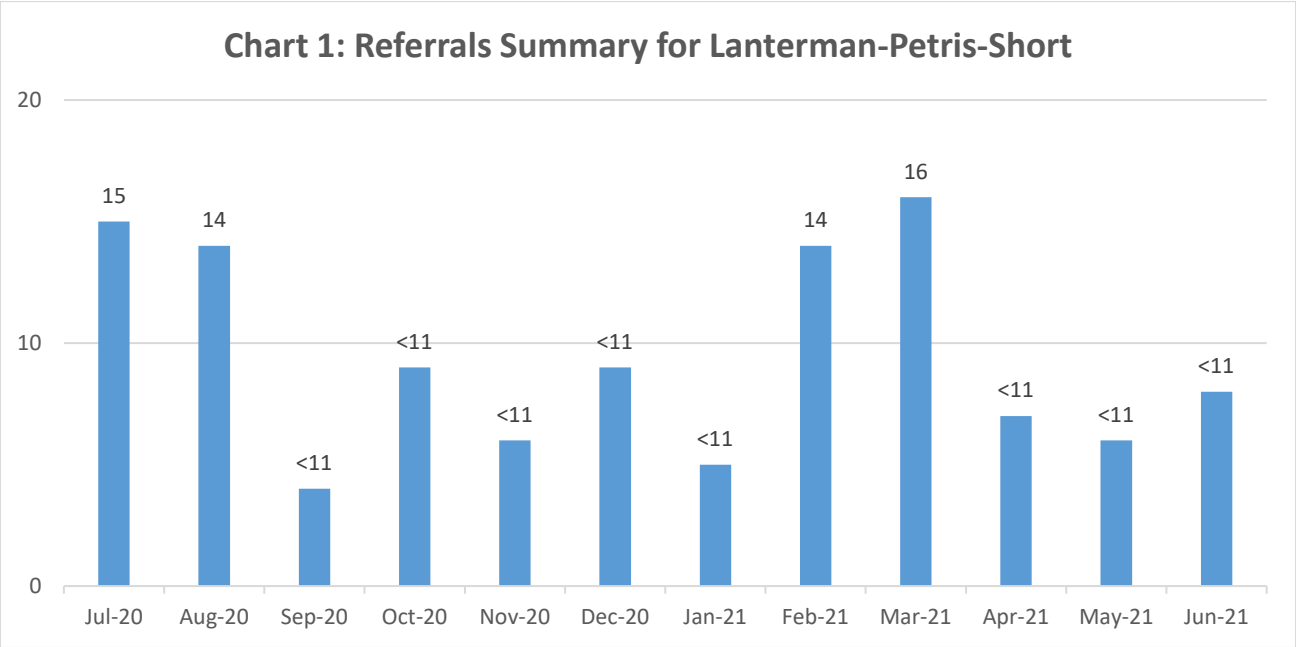
Under WIC 5150, an individual, on probable cause, can be taken into custody for mental health treatment for 72 hours. The individual can then be evaluated for an additional 14-day period of treatment pursuant to WIC 5250. After further evaluation and judicial review, the individual can then be placed 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.

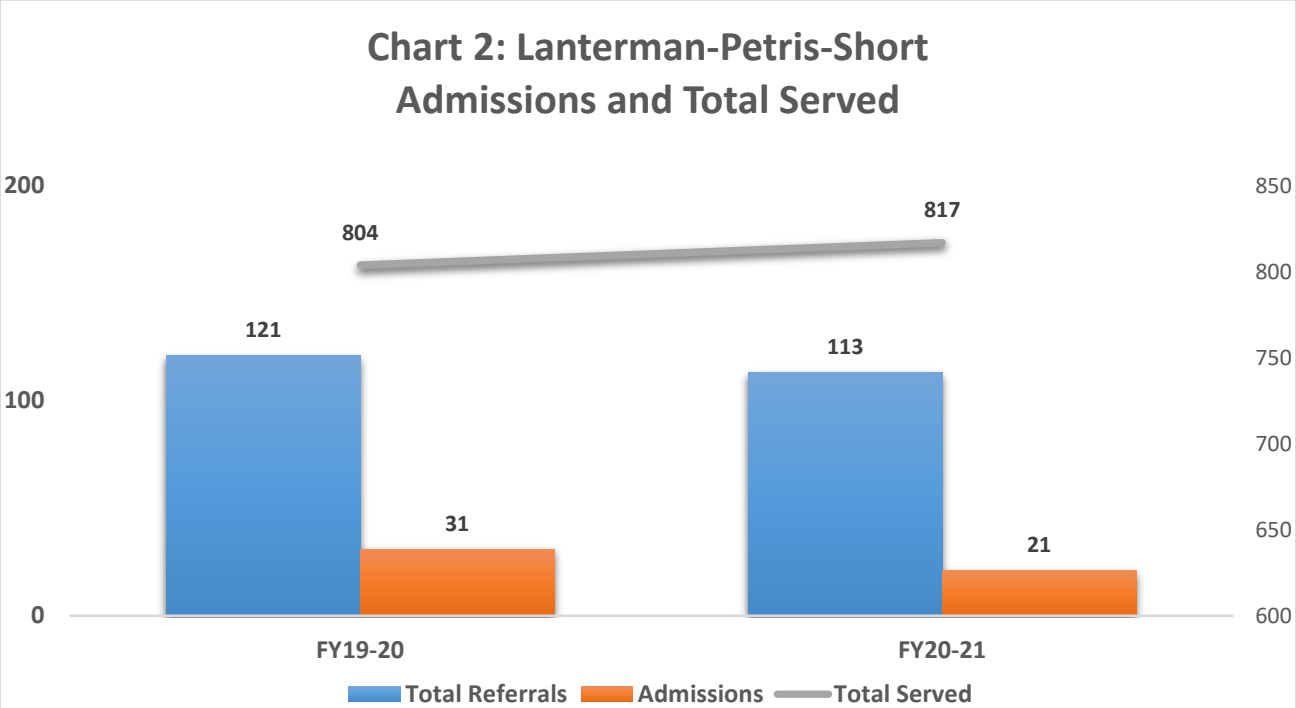
POPULATION DATA

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.



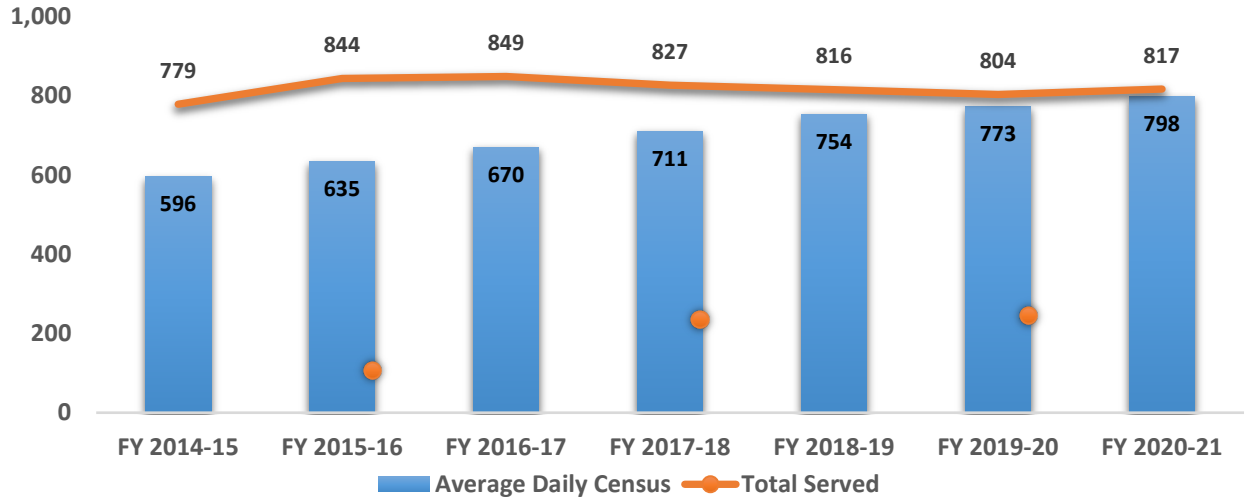
Over the course of FY 2020-21, 21 LPS patients were admitted into a state hospital. Chart 2 displays the referrals, admissions, and total patients served for the LPS population in FY 2019-20 and FY 2020-21.



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.

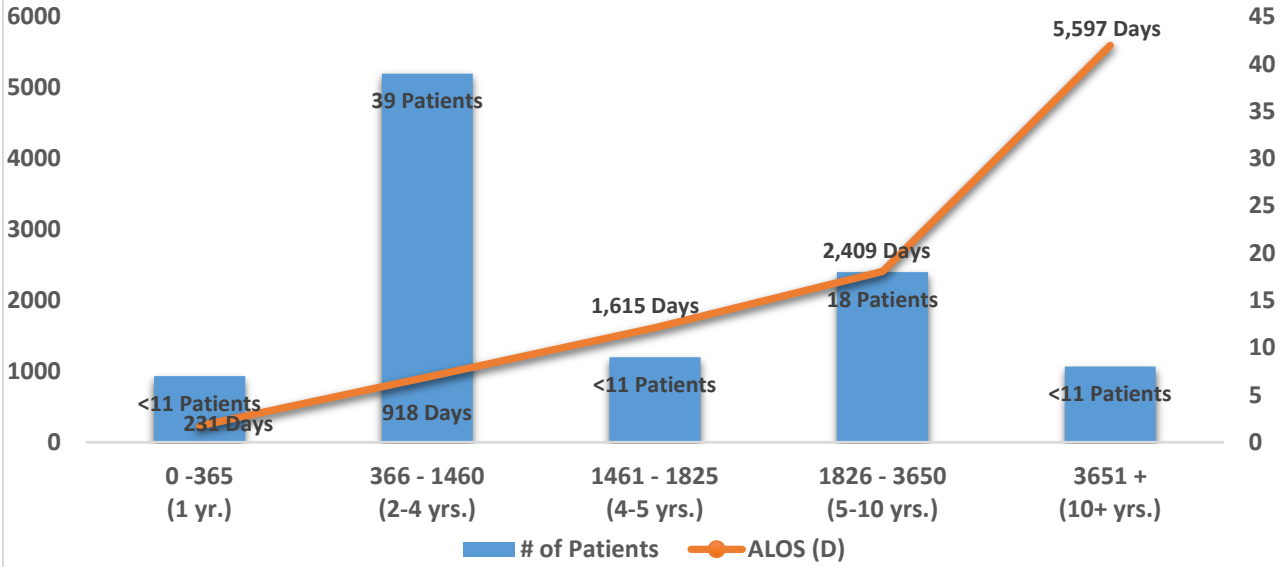
Chart 3: Lanterman-Petris-Short
ADC and Total Patients Served
FY 2014-15 to FY 2020-21



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

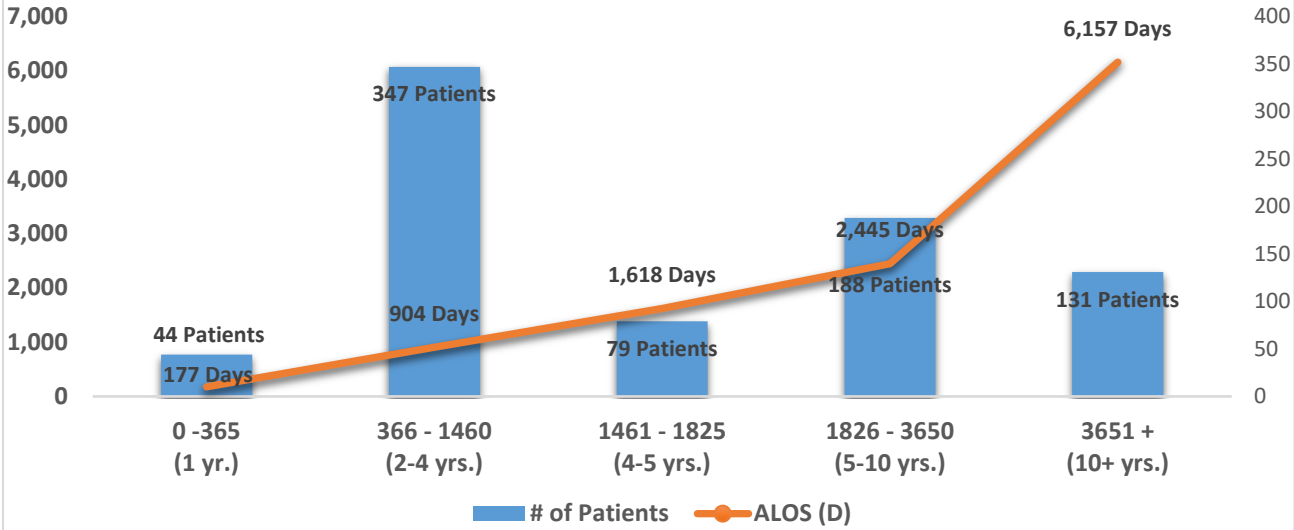
In FY 2020-21, 81 LPS patients were discharged with an average length of stay of 4.7 years. Chart 4 displays the distribution of lengths of stay for all discharged LPS patients, and Chart 5 displays the distribution of patient days for those LPS patients who remain residents on unit as of June 30, 2021.

Chart 4: Lanterman-Petris-Short Average Length of Stay



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

Chart 5: Lanterman-Petris-Short Current Patient Days

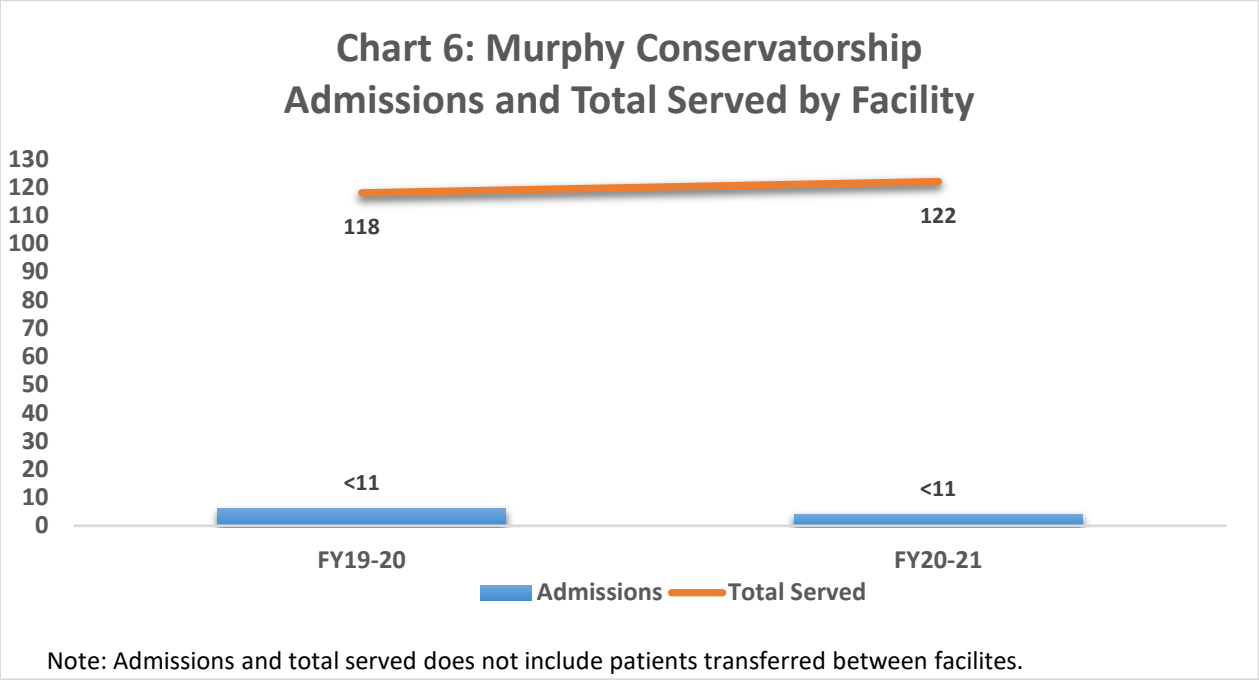


Note: Current patient days is, as of a particular point in time, the number of days residents-on-unit have spent in a state hospital, including leave.

Murphy Conservatorships

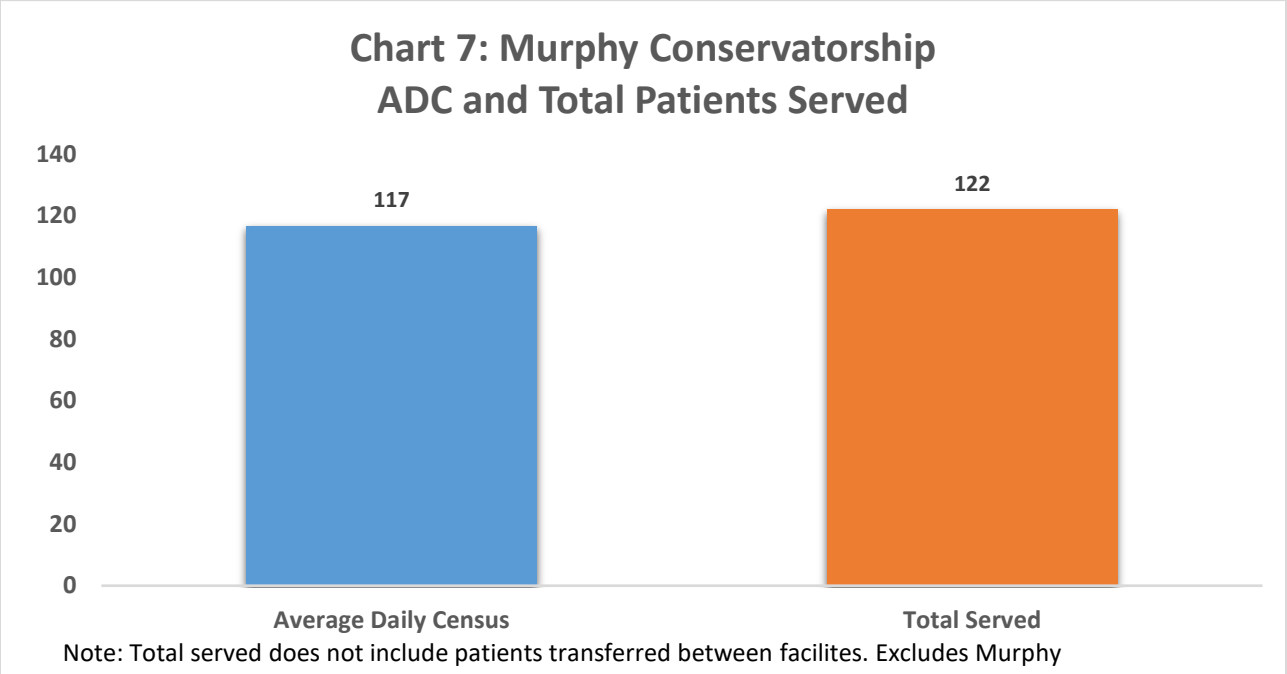
Murphy conservatorships (MURCON) are patients that have been previously found to be IST, and at the end of the IST commitment period the patient has been retained for further treatment if all of the following exist: (1) the patient is subject to a pending indictment or information charging the individual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

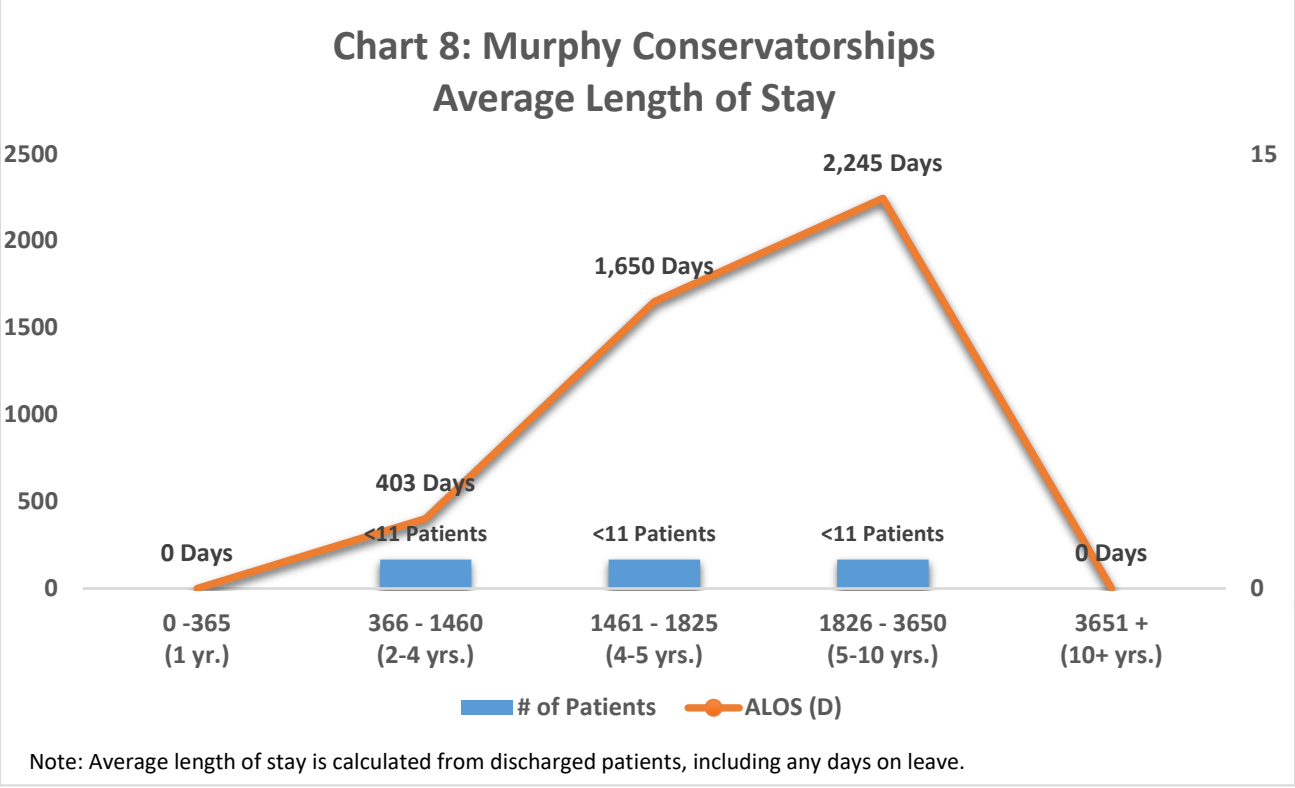


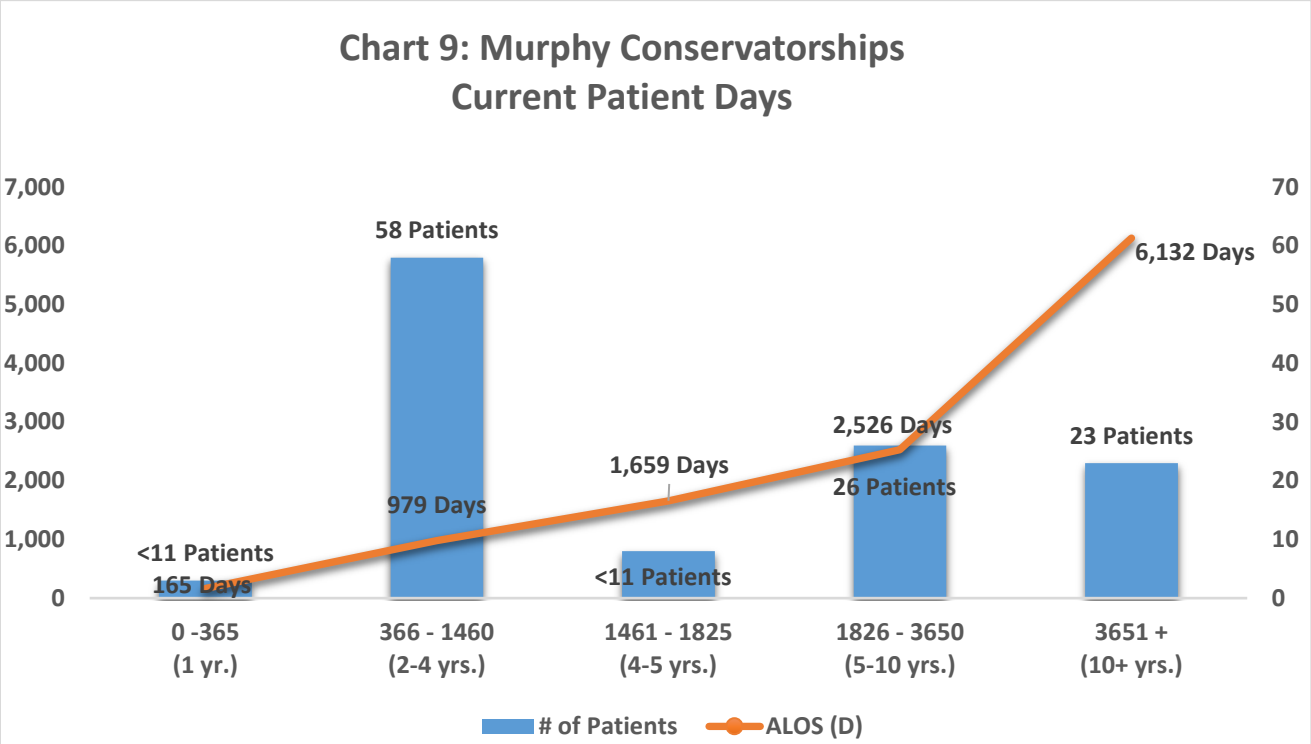
Note: Admissions and total served does not include patients transferred between facilites.

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

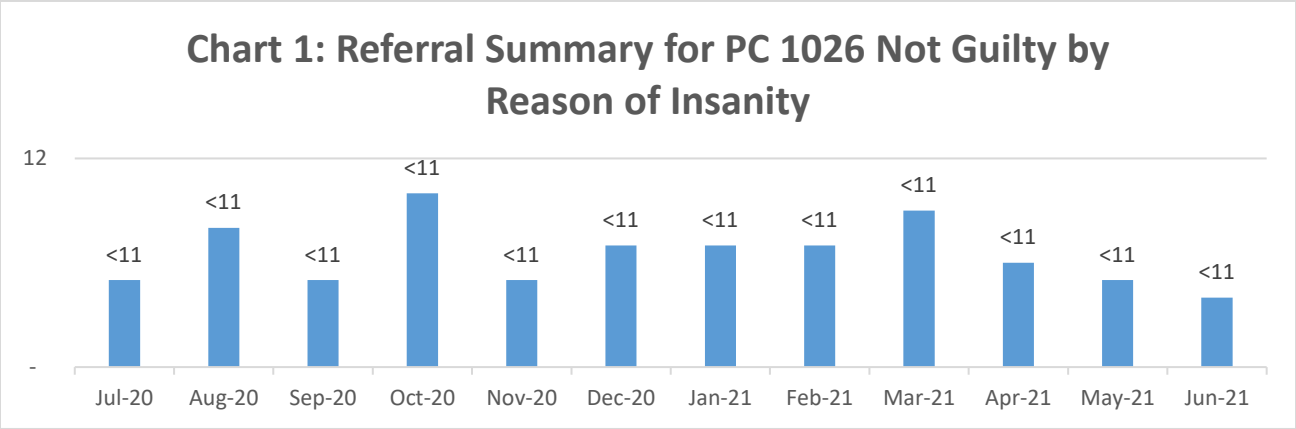
Because NGI patients tend to be severely mentally ill and their crimes involve severe violence, treatment requires substantial time resources. The treatment team must demonstrate to the court that the NGI patient has achieved long-term stabilization and no longer poses a danger due to their mental illness. 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.

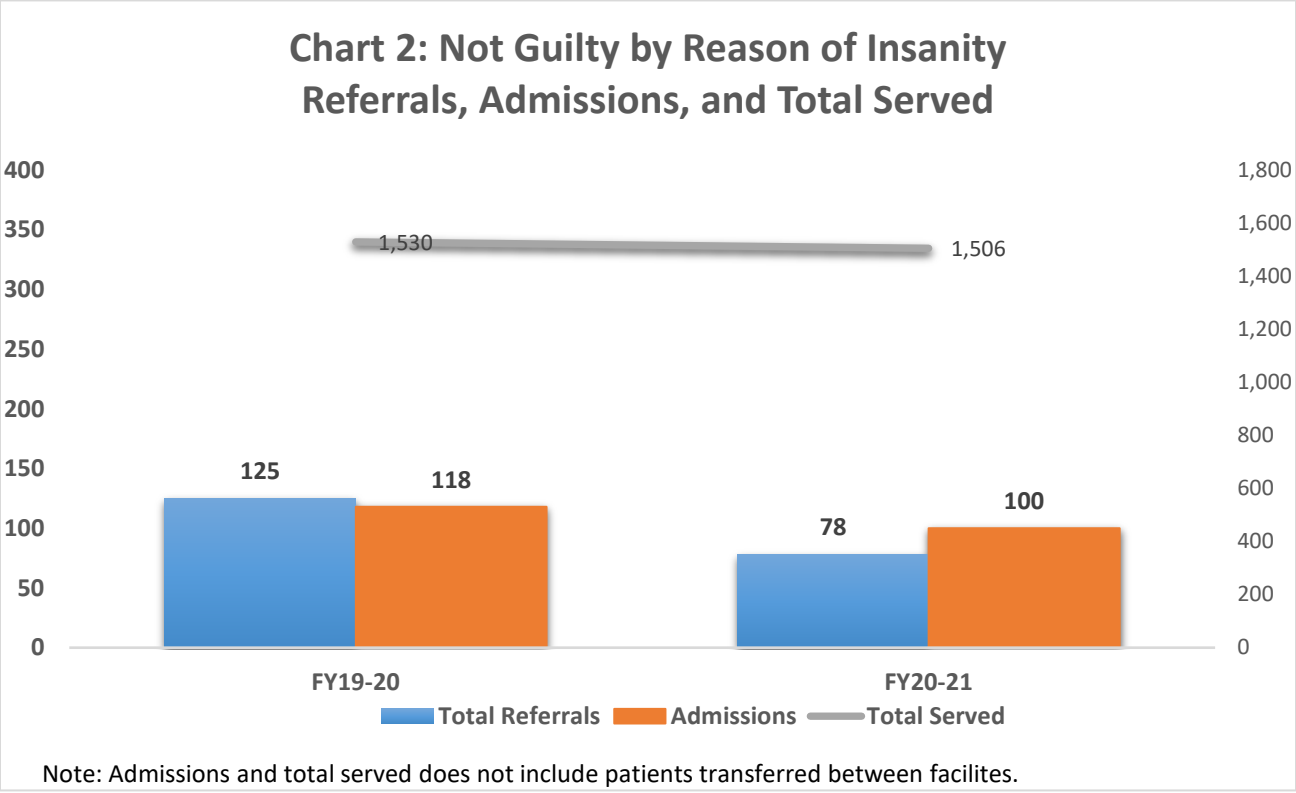
Although NGI patients are admitted to DSH because of severe mental illness and dangerousness, NGI patients have the right to refuse treatment unless that right is removed by case law or regulation, as guided by the *Greenshields* involuntary medication order process. This can effectively lengthen the 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.

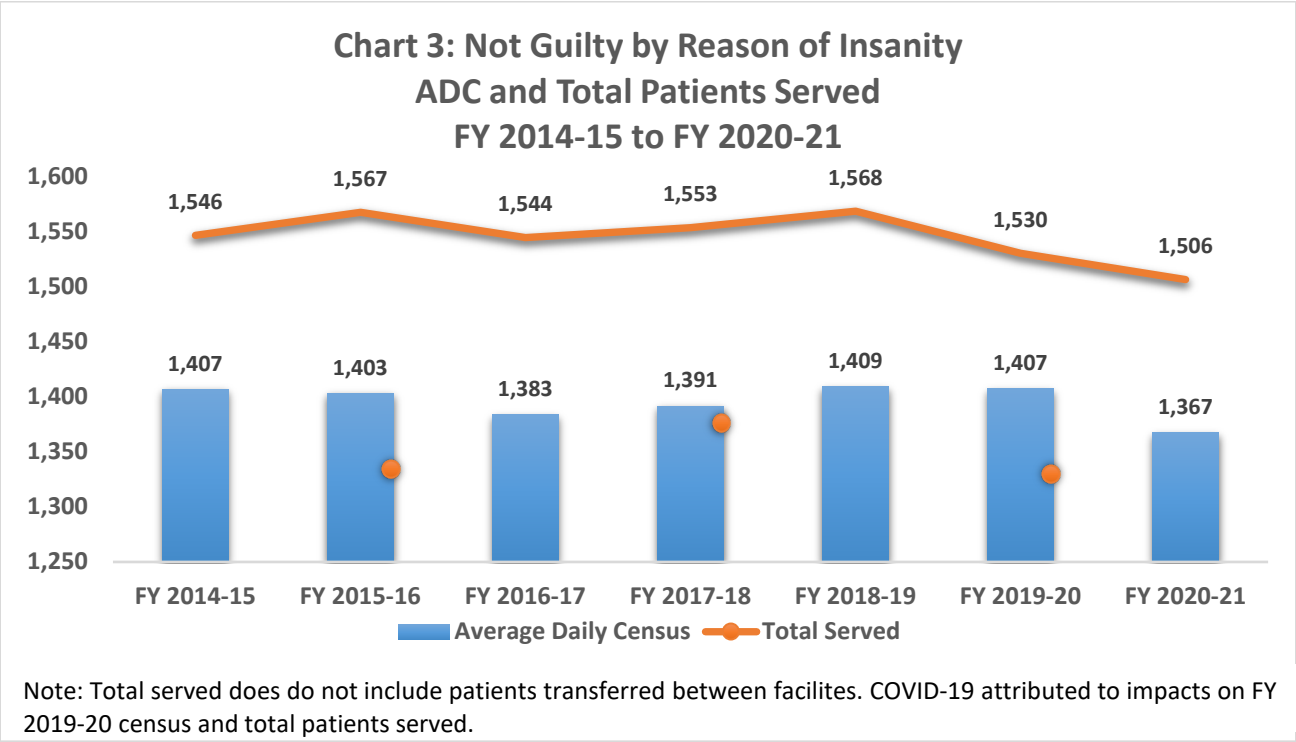


Over the course of FY 2020-21, 100 NGI patients were admitted into a state hospital which is a decrease of 15 percent from the prior year. Chart 2 displays the referrals, admissions and total patients served for the NGI population for FY 2019-20 and FY 2020-21.



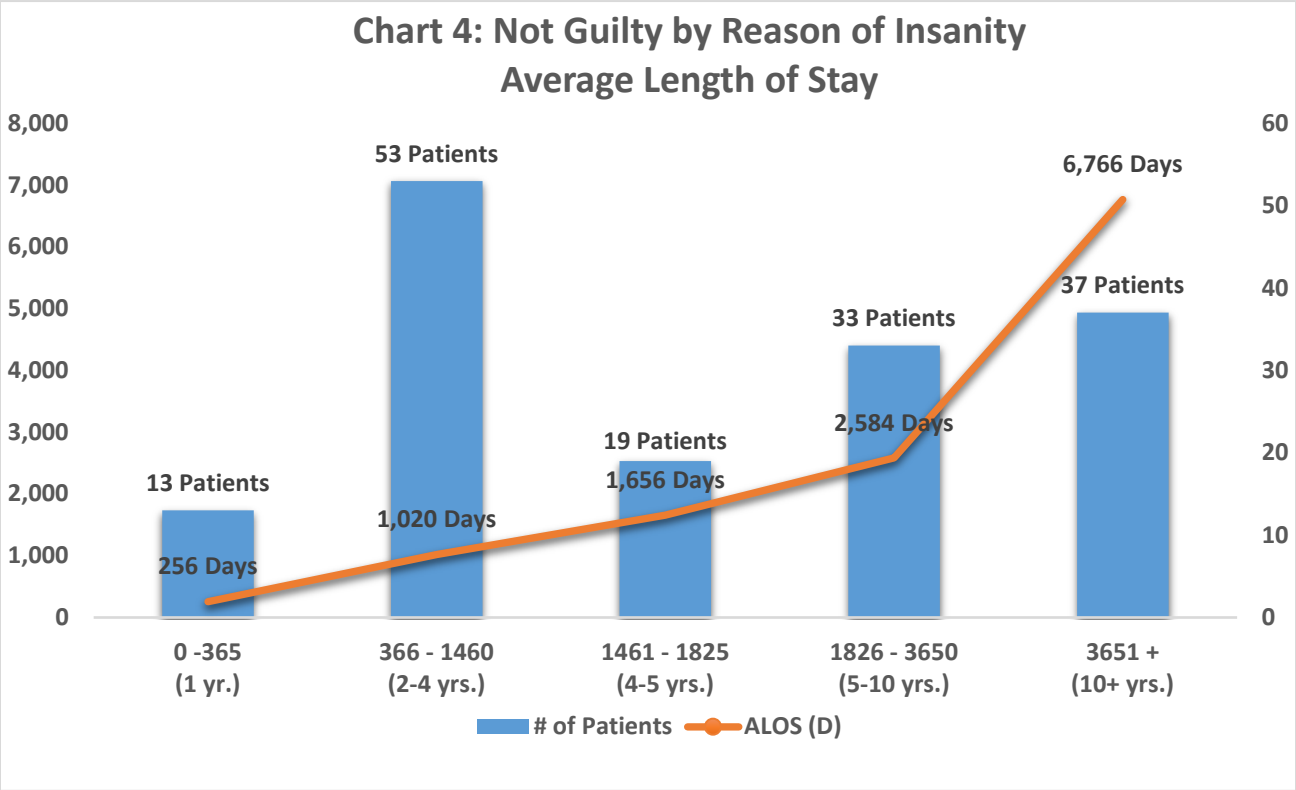
Note: Admissions and total served does not include patients transferred between facilites.

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.

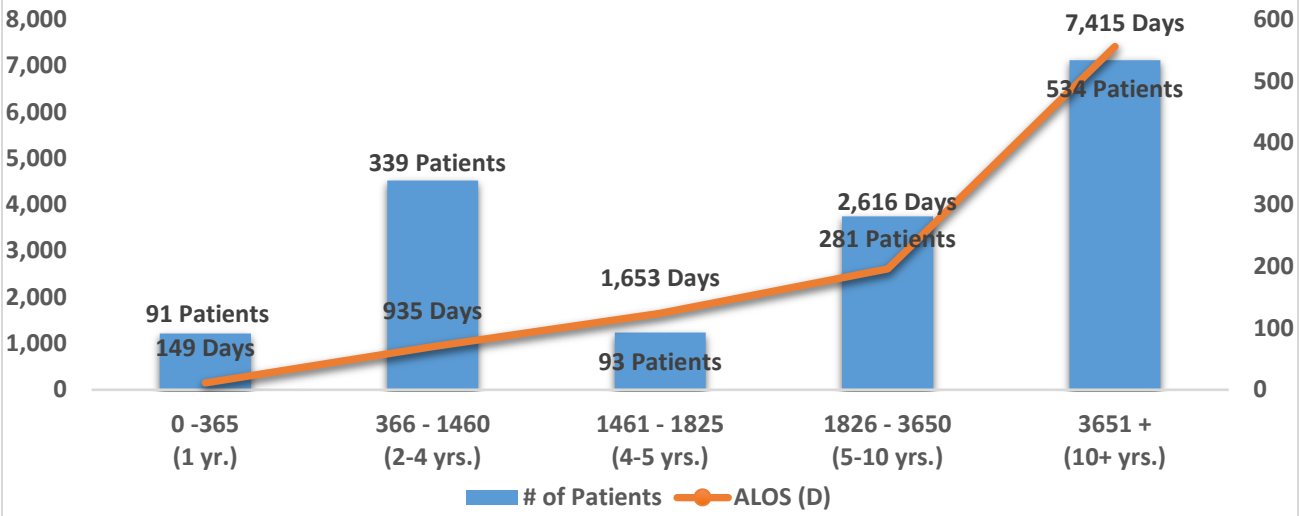
In FY 2020-21, 155 NGI patients were discharged with an average length of stay of 7.5 years. Chart 4 displays the distribution of lengths of stay for all discharged NGI patients.



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

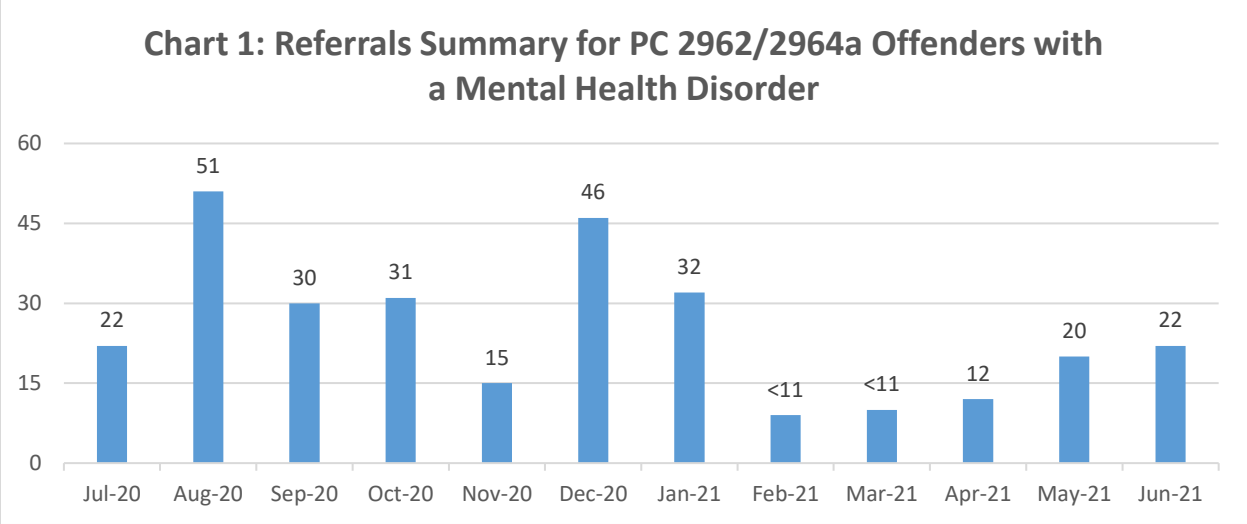
OMD patients have unique needs and challenges. Because their crimes involve violence, many have spent years in prison and need specialized psychosocial treatments to aid in their reintegration back into society. Due to the seriousness and long-term nature of their mental illness, as well as a history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

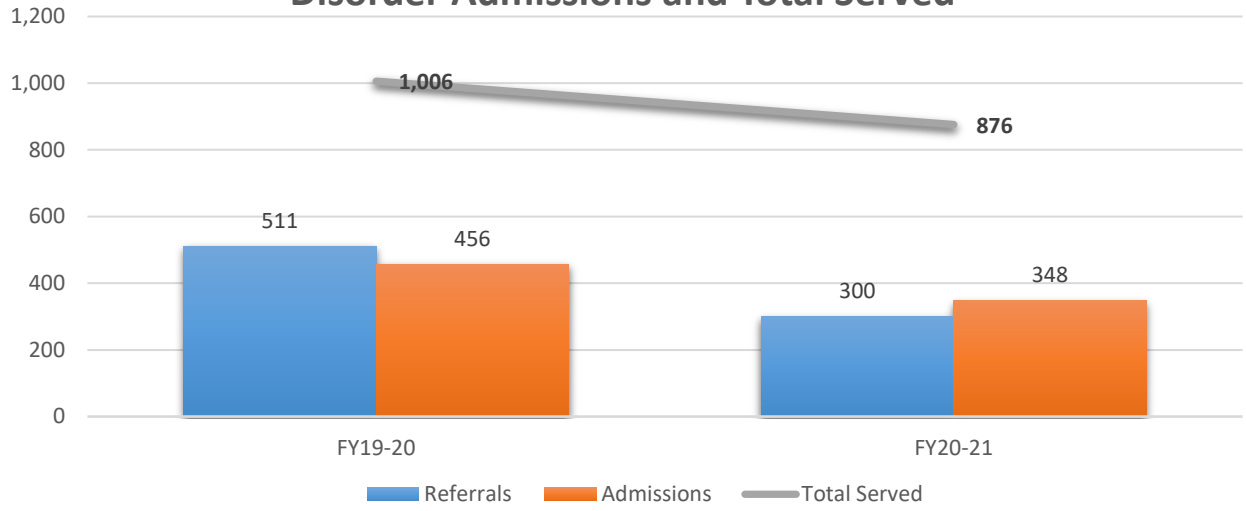
POPULATION DATA

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.

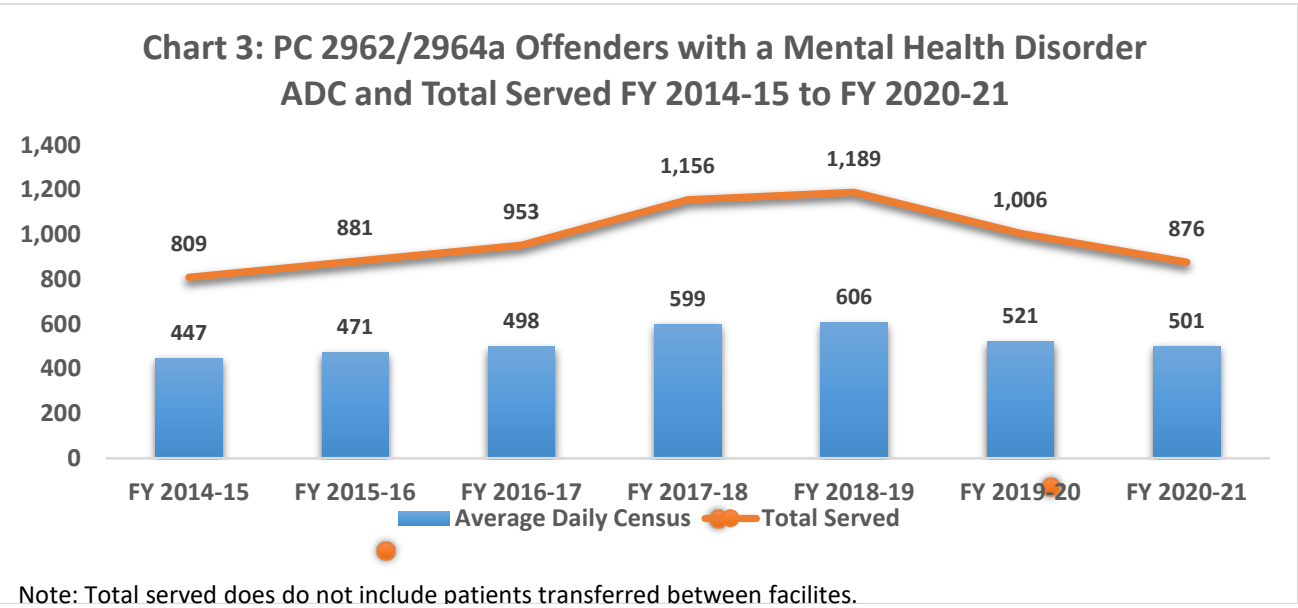


Over the course of FY 2020-21, 348 PC 2962/2964a OMD patients were admitted into a state hospital. Chart 2 displays the referrals, admissions and total patients served for the PC 2962/2964a OMD population in FY 2020-21.



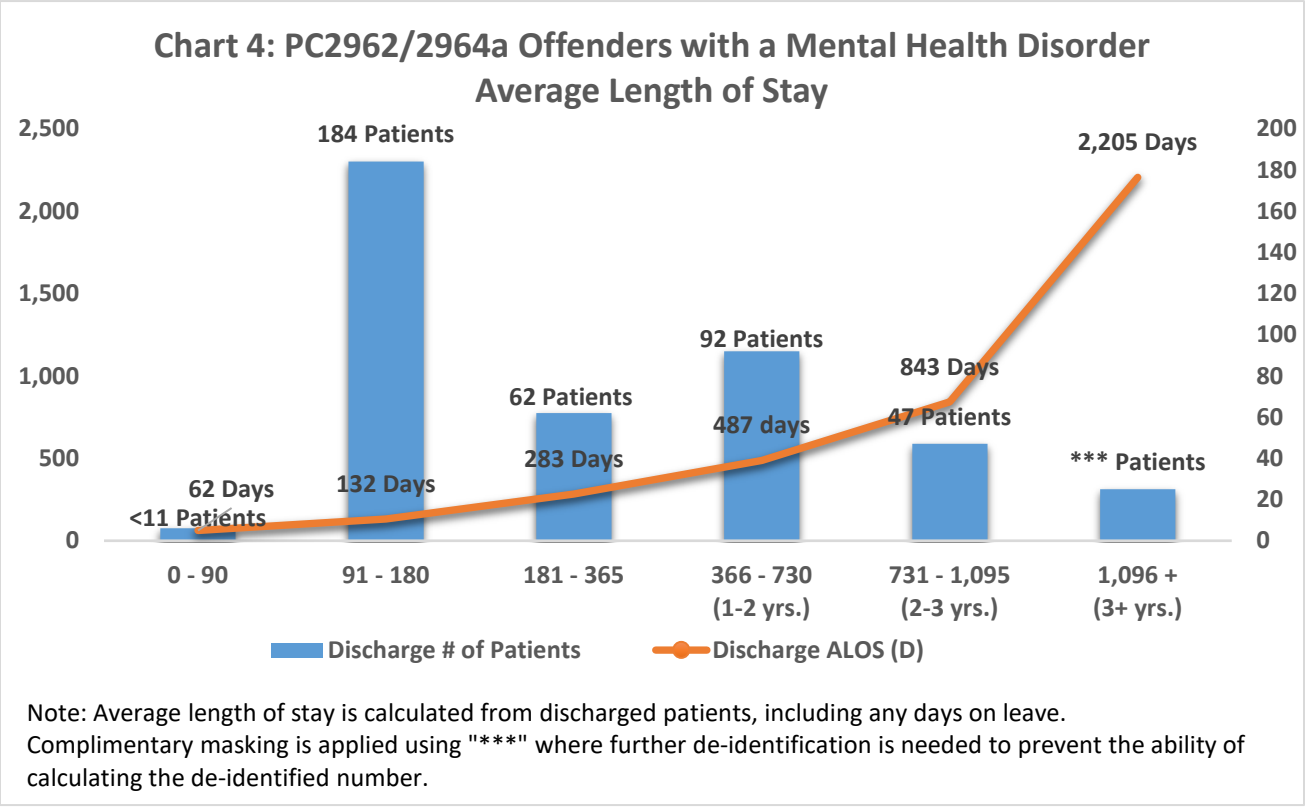
Note: Admissions and total served does not include patients transferred between facilites.

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.

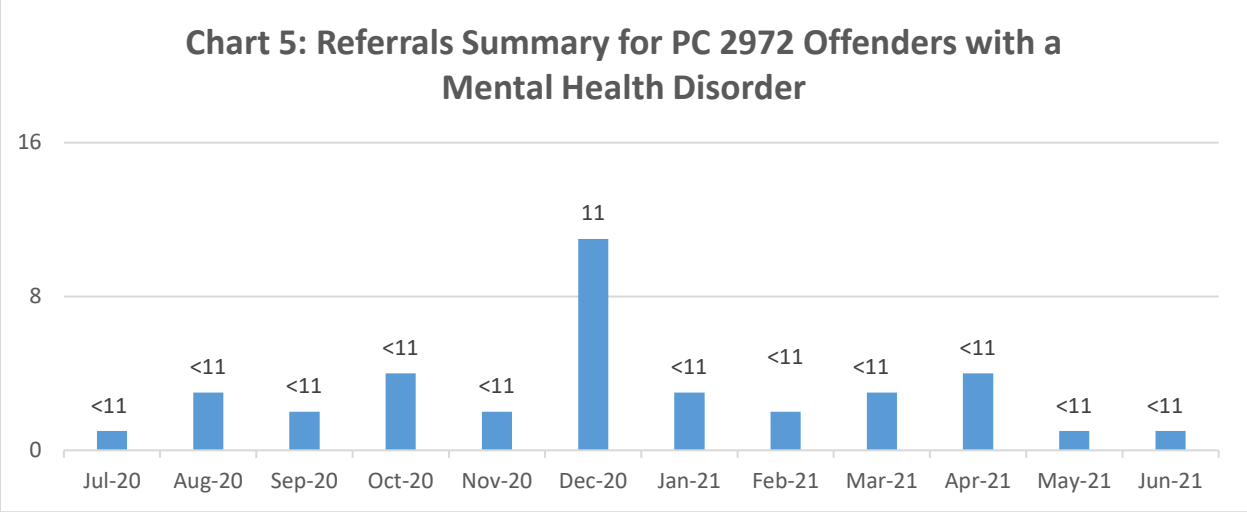
Chart 4 displays the distribution of lengths of stay for all discharged PC 2962/2964a OMD patients. In FY 2020-21, 416 PC 2962/2964a OMD patients were discharged with an average length of stay of 437 days, a little more than 1 year.



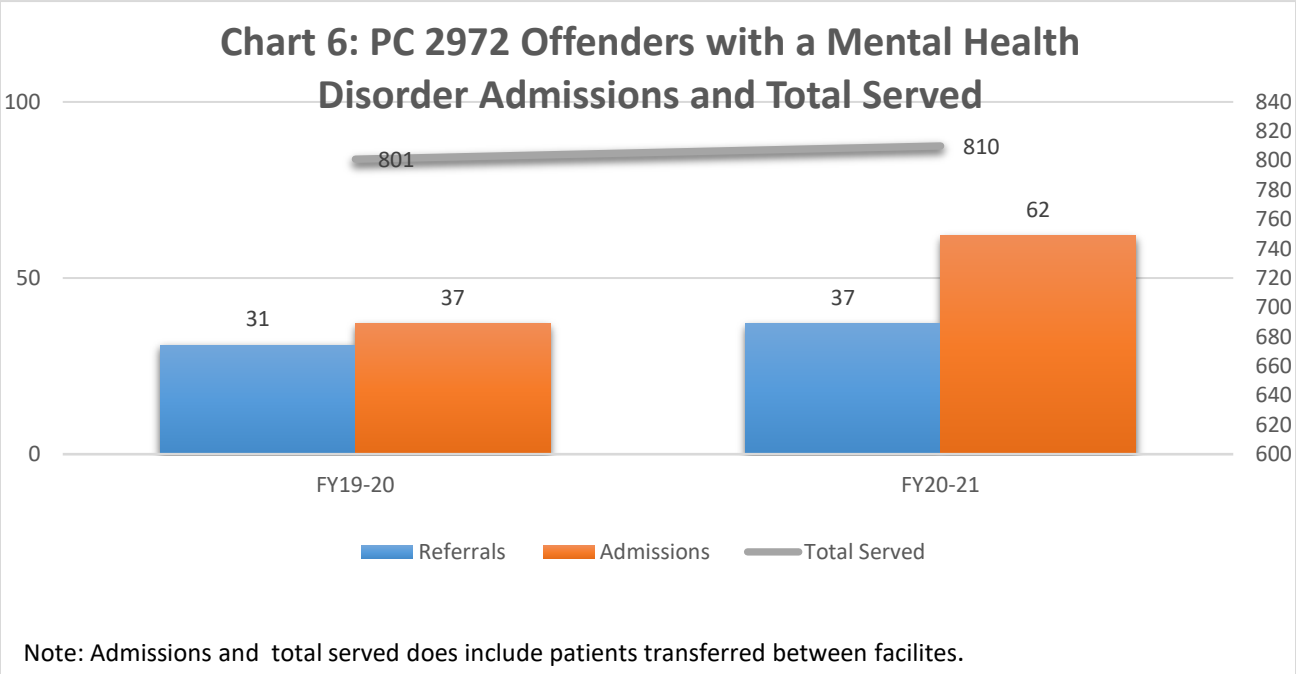
Note: Average length of stay is calculated from discharged patients, including any days on leave. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

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.



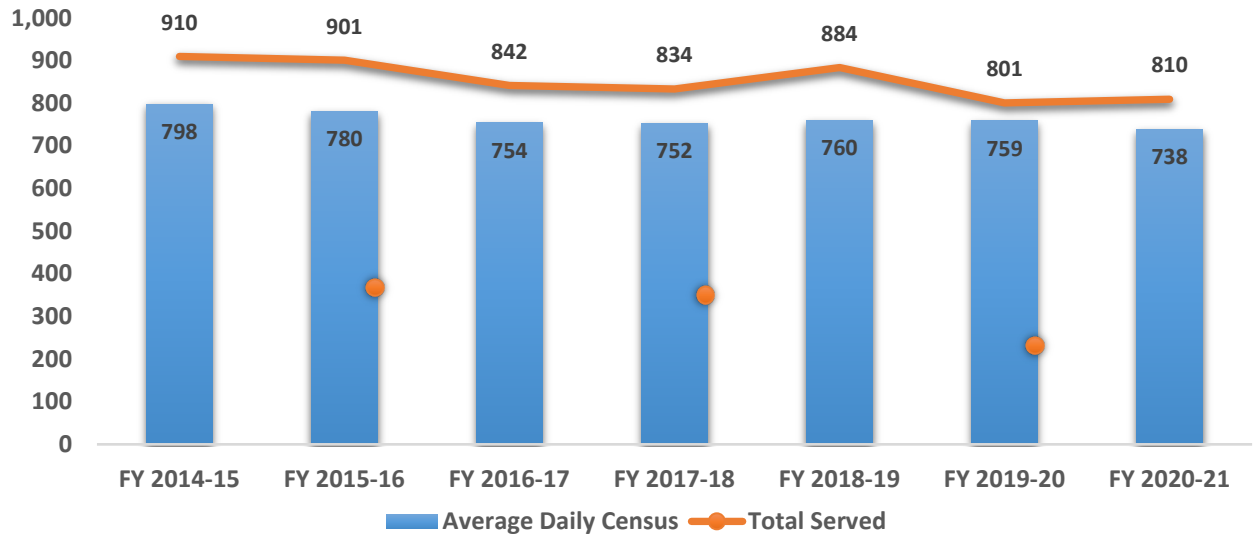
Over the course of FY 2020-21, 62 PC 2972 OMD patients were admitted (including transfer admissions) to a state hospital. Chart 6 displays the referrals, admissions and total patient served for the PC 2972 OMD population in FY 2020-21.



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

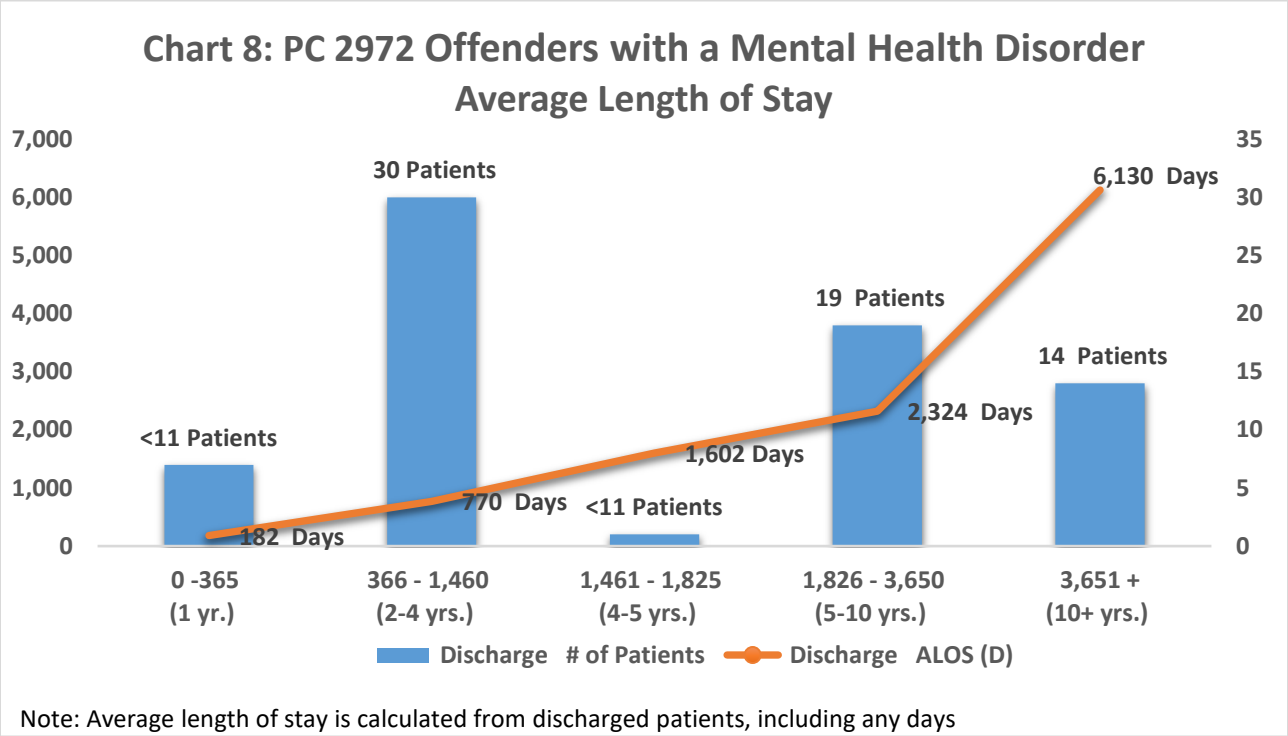
Chart 7 displays the average daily census (ADC) and total number of patients served for the PC 2972 OMD population during FY 2014-15 to FY 2020-21. On average, 738 PC 2972 OMD patients are treated daily in the state hospitals, representing 13 percent of the overall patient population. As of June 30, 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.

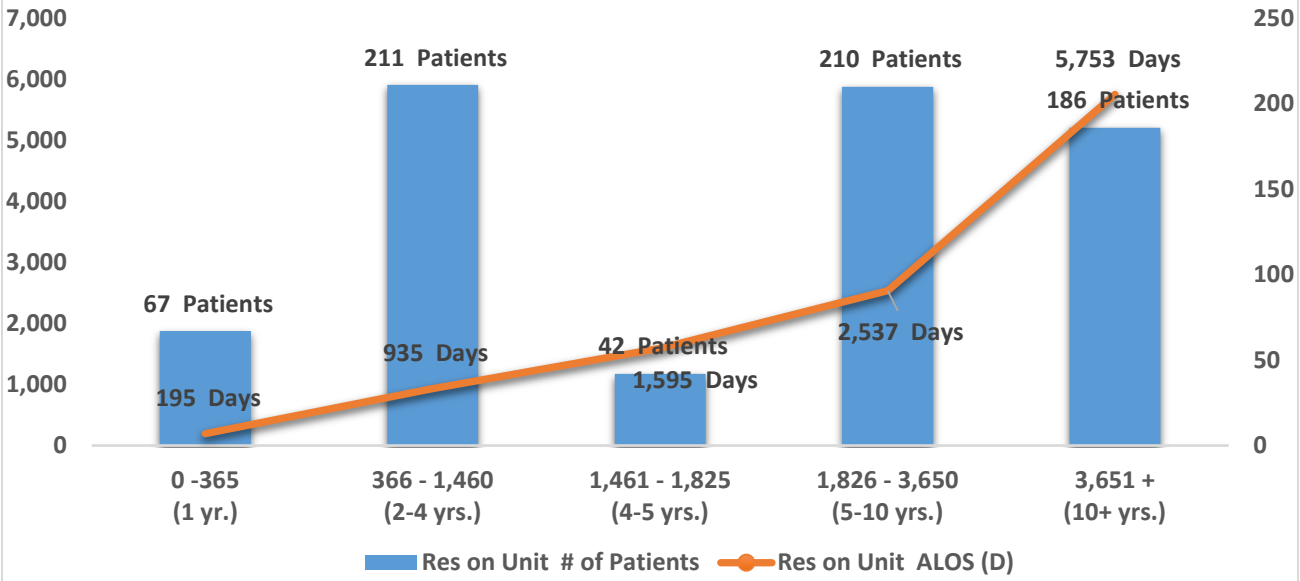
In FY 2020-21, 71 PC 2972 OMD patients were discharged with an average length of stay of 6 years. Chart 8 displays the distribution of lengths of stay for all discharged PC 2972 OMD patients.



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



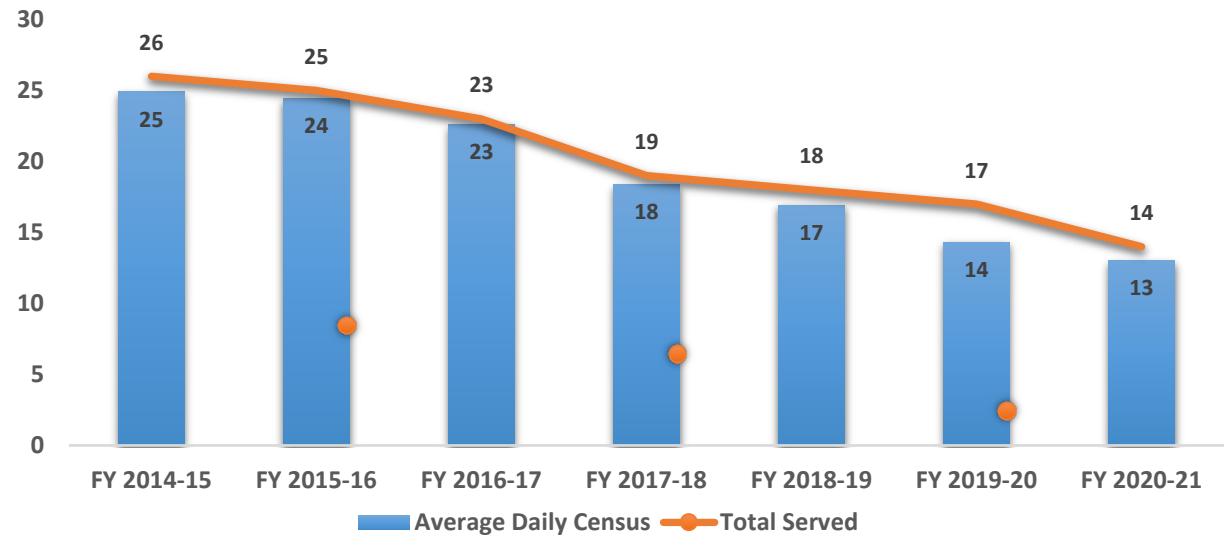
Note: Current patient days is, as of a particular point in time, the number of days residents-on-unit have spent in the state hospital, including leave.

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

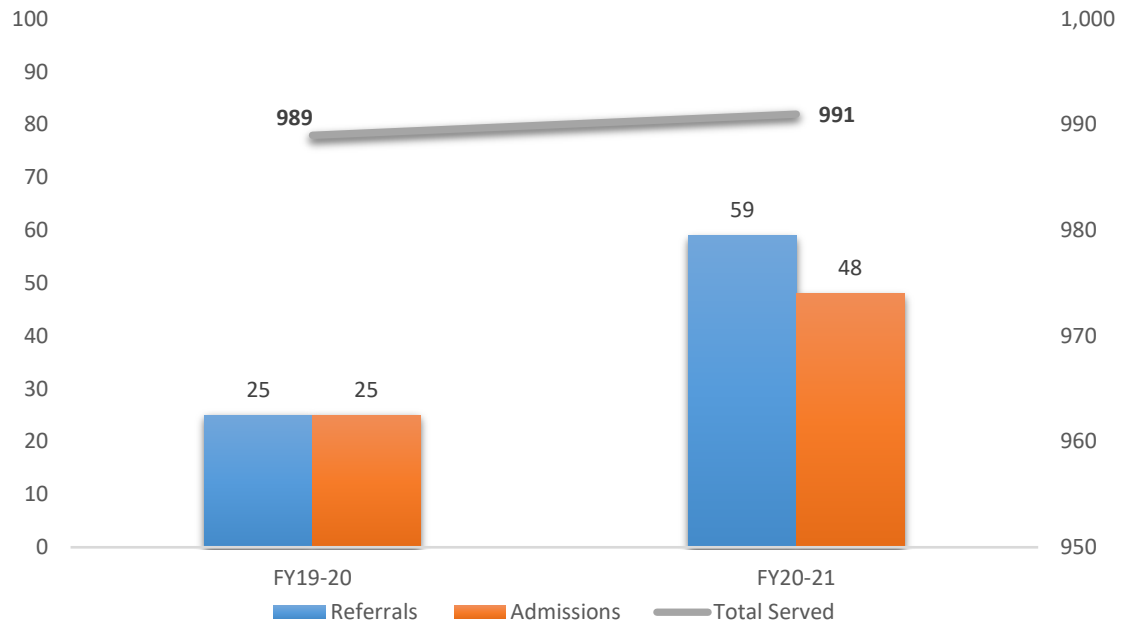
demonstrate that they would take preventive actions to avoid or mitigate any factors that would increase their sexual violence risk.

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

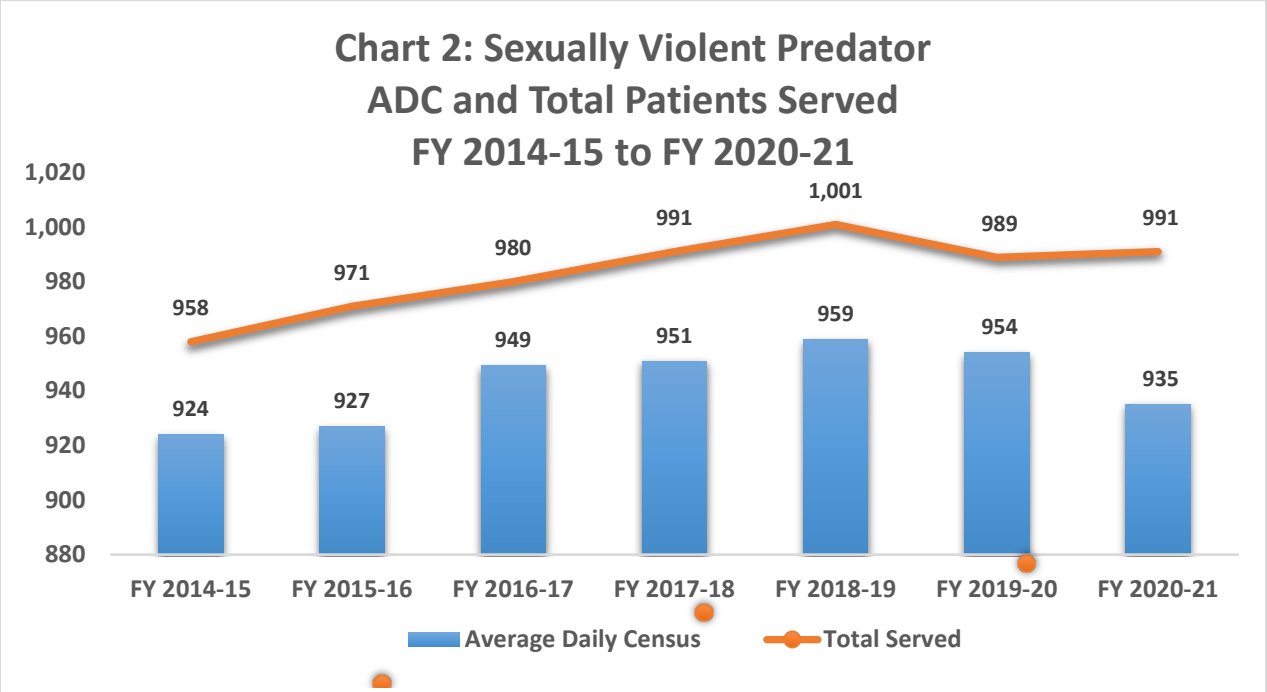
In Fiscal Year (FY) 2020-21, 59 SVP patients were committed, of which 48 SVP patients were admitted into a state hospital. Chart 1 displays the referrals, admissions, and total patients served for the SVP population in FY 2019-20 and FY 2020-21.

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



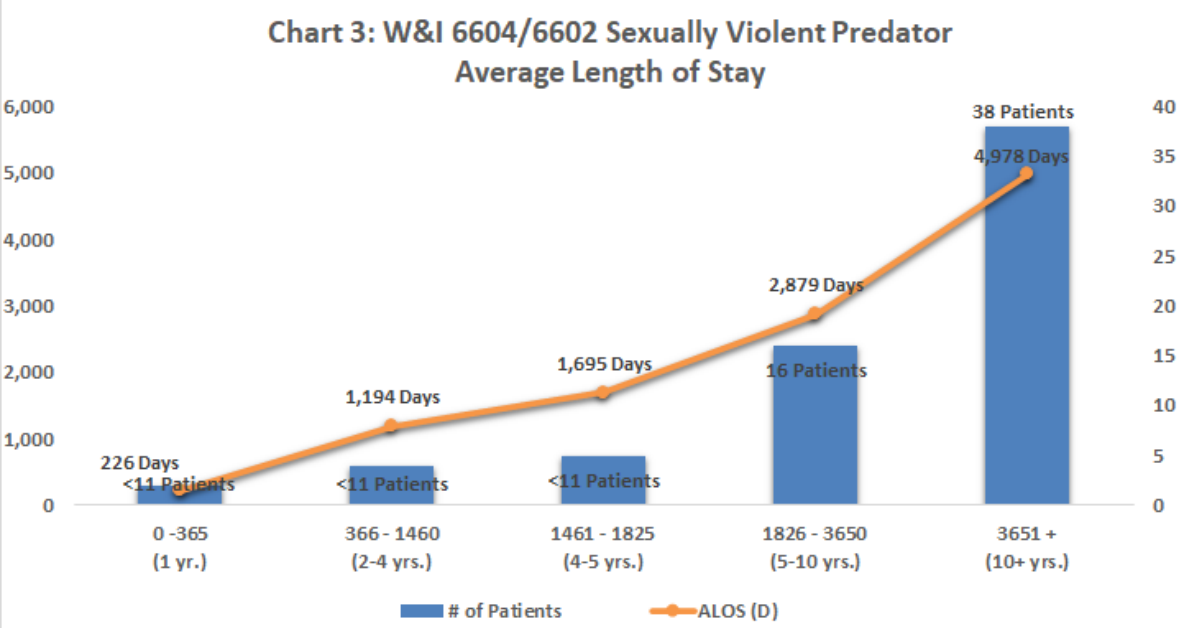
Note: Admissions and total served does not include patients transferred between facilites.

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.



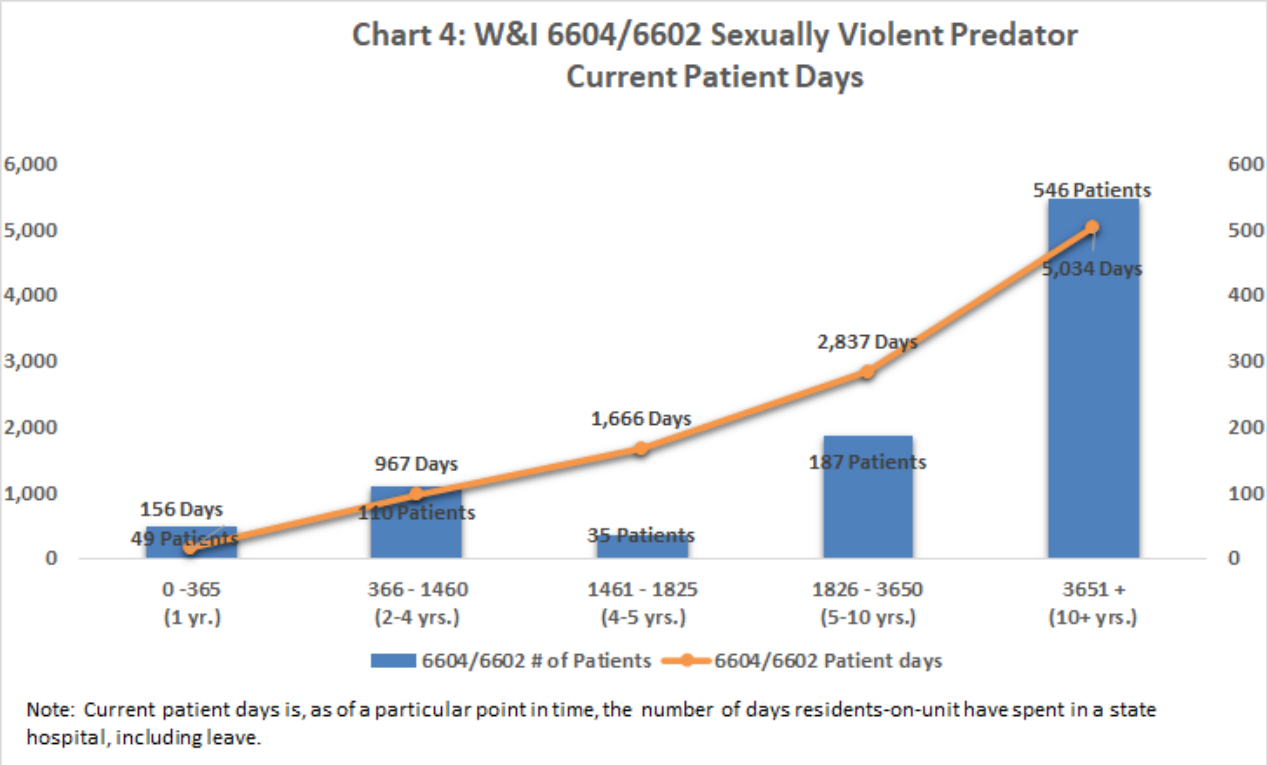
Note: Total served does do not include patients transferred between facilites.

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

May 13, 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 April 1, 2022.

State Hospital	Authorized Positions[1/2]	Vacant as of 4/1/22	Percent Vacant
Atascadero	2,248.1	429.6	19.59%
Coalinga	2,425.7	368.3	15.23%
Metropolitan	2,300.2	523.5	23.73%
Napa	2,607.1	409.2	16.05%
Patton	2,558.4	291.7	11.86%
Totals	**12,139.5**	**2,022.3**	**17.10%**

[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 April 1, 2022, DSH's vacancy rate is 17.1 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	41.2	33.2	39.6	24.6	70.3	41.3	55.4	13.7	66.5	35.0
Psychologist	9873	45.7	10.7	36.9	14.9	44.0	9.0	52.4	3.9	61.3	23.4
Senior Psychiatric Technicia	8252	104.2	23.2	88.0	8.0	83.7	29.7	83.0	15.0	81.0	0.0
Rehabilitation Therapist	Various	55.0	11.0	45.3	4.3	56.0	10.3	62.1	3.1	70.3	7.3
Registered Nurse	8094	244.8	43.8	232.0	13.8	294.1	78.1	461.2	57.0	362.1	24.1
Clinical Social Worker	9872	46.2	7.2	44.3	5.3	58.3	13.3	56.2	6.7	70.0	5.5
Psychiatric Technician	8253	641.7	129.7	722.7	135.7	493.5	131.5	464.0	86.6	724.6	52.6
Physician/Surgeon	7552	17.5	4.5	17.0	7.0	26.4	3.4	24.7	0.2	29.0	3.0

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 April 1, 2022. The Department is continuing to evaluate the use of internal registry positions to determine the appropriate temporary help position authority.

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

STATE HOSPITAL ALLOCATIONS AND EXPENDITURES

Exhibit I (attached) provides detail on the budget and expenditures for all five state hospitals and each facility individually, listed by FI$Cal account code for FY 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	$372,465,000	$342,356,000	$370,803,510	$338,932,440
4410020-Coalinga	$353,984,000	$368,462,000	$353,032,020	$364,777,380
4410030-Metro	$197,913,000	$224,964,000	$198,138,600	$222,714,360
4410040-Napa	$355,455,000	$360,965,000	$354,457,620	$357,355,350
4410050-Patton	$396,899,000	$387,896,000	$395,520,840	$384,017,040
Grand Total	**$1,676,716,000**	**$1,684,643,000**	**$1,671,952,590**	**$1,667,796,570**

[8]Budget and expenditure do not include reimbursements.

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

BACKGROUND

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 that contributed to a reduced number of cadets in the academy.

DESCRIPTION OF CHANGE

Hospital Police Officer Positions

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

March 1, 2022, HPO Authorized Positions[1]

Hospitals	Filled	Vacant	FTE[2]	Vacancy Rate
Atascadero	119.0	12.1	131.1	9.2%
Coalinga	186.0	25.5	211.5	12.1%
Metropolitan[3]	98.0	46.0	144.0	31.9%
Napa	95.0	27.9	122.9	22.7%
Patton	59.0	0.0	59.0	0.0%
Total	**557.0**	**111.5**	**668.5**	**16.7%**

Hospital Police Office Attrition Rate

The table below displays As of March 1, 2022, the projected attrition rate based on actual attrition rates and trends for fiscal years (FYs) 2017-2018, 2018-19, 2019-20, 2020-21, and 2021-22:

March 1, 2022, HPO Attrition Rates

Hospitals	FY 2021-22 FTE[4]	FY 2021-22 Attrition Rate[5]	Avg Estimated Monthly Pos.	FY 2022-23 Attrition Rate[6]	Avg Estimated Monthly Pos.
Atascadero	131.1	1.40%	1.8	1.00%	1.3
Coalinga	211.5	4.17%	8.8	1.54%	3.3
Metropolitan	144.0	1.13%	1.6	1.44%	2.1
Napa	122.9	0.60%	0.7	0.59%	0.7
Patton	59.0	0.45%	0.3	0.90%	0.5
Total	**668.5**	**1.55%**	**13.3**	**1.09%**	**7.9**

[1] Only Includes classification 1937- Hospital Police Officer
[2] Authorized Positions as of DSH Budget Management Branch (BMB) Hospital Position Report FY 2021-22 January, Rev A
[3] Metropolitan FTEs include 23 positions for the Metro Increase Secure Bed Capacity project delayed until 7/1/2022 due to COVID-19
[4] Authorized Positions as of DSH Budget Management Branch (BMB) Hospital Position Report FY 2021-22 August, Rev A
[5] Projected attrition rate based on FY 2017-18, 2018-19, 2019-20, 2020-21, and 2021-22 data
[6] Projected attrition rate based on FY 2018-19, 2019-20, 2020-21, and 2021-22 data

Cadet Graduation Rates

The table below displays the actual graduation rates from cohorts conducted from FY 2018-19 through the present.

Cadet Graduation Rates

Academy	Academy Dates	Number of Cadets Attended	Number of Cadets Graduated	Graduation Rate
Academy 27	(02/12/18 – 05/18/18)	50	44	88.0%
Academy 28	(08/13/18 – 11/16/18)	49	42	85.7%
Academy 29	(10/01/18 – 01/10/19)	38	32	84.2%
Academy 30	(02/11/19 – 05/31/19)	33	31	93.9%
Academy 31	(08/12/19 – 11/22/19)	43	34	79.1%
Academy 32	(12/02/19 – 03/20/20)	19	17	89.5%
Academy 33	(02/10/20 – 05/22/20)	20	16	80.0%
Academy 34	(08/24/20 – 12/10/20)	25	21	84.0%
Academy 35	(12/28/20 – 04/22/21)	19	10	52.6%
Academy 36[7]	(05/03/21 – 08/12/21)	16	9	56.3%
Academy 37	(08/23/21 – 12/09/21)	10	4	40.0%
Academy 38[8]	(12/28/21 – 04/17/22)	15	11	73.3%
TOTAL:		**337**	**271**	**80.4%**

HPO Recruitment Efforts

COVID-19 has continued to impact the recruitment and hiring of cadets for Academy cohorts. The pandemic has impacted hiring as the rest of the country continues to experience workforce shortages. In response, OPS established a vendor contract in December 2021 to assist with recruitment efforts and increase the number of applications received. Working with this vendor, DSH has adopted new job advertising approaches including ads on social media platforms, Google banner advertisements, and participation in virtual career fairs. Although these changes have only recently been applied, DSH is already observing promising results. The number of potential cadets registered for the entry examination averages at 78 applicants per month. However, following the change in advertising approach, the numbers have increased as displayed below.

[7] Academy 36 graduation was conducted virtually to reduce the number of individuals gathering and reduce any potential COVID-19 exposures.
[8] Number of Cadets Graduated for Academy 37 are projected as of March 2022

Month of Entry Examination	# of Cadets Registered
January 2022	52
February 2022	67
March 2022	61
April 2022	200
May 2022	209
June 2022	75
July 2022	38

DSH will continue to work on HPO recruitment efforts and will provide an update in the 2023-24 Governor's Budget.