Department of State Hospitals

2025-26

May Revision
Proposals and Estimates

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Department of State Hospitals
2025-26 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 for individuals with complex behavioral health needs in a safe, equitable and responsible manner, by leading innovation and excellence across a continuum of care. Within the context of the broader mental health system of care, DSH primarily serves individuals who have been committed to the Department through the superior courts or Board of Parole Hearings. Additionally, DSH serves a contingent of conserved individuals referred by the counties and inmates from the California Department of Corrections and Rehabilitation (CDCR). DSH is responsible for the daily care and provision of mental health treatment of its patients. Upon discharge from a DSH commitment, individuals typically return to their community, and the county behavioral health system serves to provide additional services and linkages to treatment.

DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton). In addition to state hospital treatment, DSH provides services in contracted Jail-Based Competency Treatment (JBCT), Community-Inpatient Facilities (CIF), Conditional Release Program (CONREP), Community-Based Restoration (CBR), and pre-trial felony mental health Diversion programs. DSH is responsible for the daily care of over 7,400 patients. In fiscal year (FY) 2023-24, DSH served over 14,000 patients, with 9,510 served across the state hospitals, 1,881 in JBCT, 506 in CIF, 859 in CBR contracted programs, and 897 in CONREP programs. 11,897 individuals were treated within a DSH inpatient program and 2,117 were served through DSH's outpatient programs**.** Through Early Access Stabilization Services (EASS) and Re-Evaluation services, during FY 2023-24, DSH initiated services for 2,797 patients in EASS, and off ramped 198 through DSH's Re-Evaluation program. In addition, 249 individuals were diverted from jail into county Diversion programs funded by DSH.

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

DSH is funded through the General Fund and reimbursements from counties for the care of Lanterman-Petris-Short (LPS) patients. All DSH facilities are licensed through

the California Department of Public Health (CDPH) and four of the five facilities (Atascadero, Metropolitan, Napa, and Patton) are accredited by The Joint Commission, an independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States.

STATE HOSPITALS

DSH-Atascadero

Opened in 1954, DSH-Atascadero is located on the Central Coast of California in Atascadero (San Luis Obispo County). The hospital is a forensic mental health hospital and is a self-contained psychiatric hospital constructed within a security perimeter. The majority of the all-male patient population is remanded for treatment by county superior courts or by 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 primarily treats persons designated as 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 secure perimeter. Due to concerns raised by the community, DSH-Metropolitan maintains a formal agreement with the City of Norwalk and the Los Angeles County Sheriff not to accept patients charged with murder or a sex crime, or at high risk for escape. This agreement has limited the total number of patients that DSH-Metropolitan can treat below the licensed bed capacity. Until 2019, DSH-Metropolitan's operational bed capacity was restricted due to multiple units that were located outside of the hospital's secured treatment area (STA). The units outside of the STA were unable to house forensic patients. To provide additional capacity to serve forensic patients, a secured fence was constructed to surround the housing units located next to the existing secure

treatment area. To provide additional capacity to address an ongoing system-wide forensic waitlist at that time, the Budget Act of 2016 included the capital outlay construction funding for the Increased Secure Bed Capacity project, which was recently completed. 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 secure perimeter. Due to concerns from the community about the risk of a patient escape, CDCR correctional officers provide perimeter security and transportation at DSH-Patton. DSH-Patton primarily serves the following four patient commitment types: LPS, IST, OMD, and NGI.

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

Community-Based and Jail-Based Treatment

Since 1986, with the implementation of CONREP, community-based treatment has been part of the program options for forensically committed individuals. In 1996, SVPs were added to the CONREP population, thereby expanding the number of patients served in the community. In response to the *Stiavetti v Clendenin* ruling and significant growth in the IST waitlist, in 2021, DSH convened an IST Solutions Workgroup. Many of the suggestions developed by the IST Solutions Workgroup were included in the IST Solutions budget package in the Budget Act of 2022[1] with an emphasis on community-based treatment options including Felony Mental Health Diversion, CBR, and CIF programs. Furthermore, the IST Solutions Budget Package provided support to implement jail-based treatment through the EASS program, recognizing the need for treatment intervention at the earliest point possible to support stabilization and increase opportunities for eligibility and placement to Diversion and CBR programs. These new programs, together with foundational IST treatment programs available through the state hospitals and JBCT programs, establish a robust continuum of care for DSH patients. Lastly, the Budget Act of 2022 amended PC Section 1370 to

[1] See IST Solutions (Section C9) for more information

statutorily prioritize community outpatient treatment effective July 1, 2023, increasing consideration for placement of IST patients in Diversion, CBR, or other community IST facilities. DSH continues to focus efforts on the expansion of community-based treatment to encourage diversified treatment to reverse the cycle of criminalization for individuals with serious mental illness and increase community transitions for state hospital patients.

DEPARTMENT OF STATE HOSPITALS
FUNCTIONAL VACANCY DISPLAY
Informational Only

This item is updated annually.

Please see the 2025-26 Governor's Budget for the most recent version.

DEPARTMENT OF STATE HOSPITALS POPULATION

	CURRENT YEAR 2024-25					
	July 1, 2024 Actual Census	Previously Approved Adjustments CY 2024-25	2025-26 November Adjustment CY 2024-25	Census Adjustment	2025-26 May Revision Adjustment CY 2024-25	June 30, 2025 Projected Census
POPULATION BY HOSPITAL						
ATASCADERO	1,020	0	0	56	0	1,076
COALINGA	1,300	0	0	0	0	1,300
METROPOLITAN	847	86	0	0	0	933
NAPA	1,069	0	0	9	0	1,078
PATTON	1,314	10	0	0	0	1,324
TOTAL BY HOSPITAL	**5,550**	**96**	**0**	**65**	**0**	**5,711**
POPULATION BY COMMITMENT - SH						
Coleman - PC 2684[1]	159	0	0	56	0	215
IST - PC 1370	1,659	41	0	0	0	1,700
LPS & PC 2974	547	46	0	9	0	602
NGI - PC 1026	1,208	4	0	0	0	1,212
OMD - PC 2962	333	3	0	0	0	336
OMD - PC 2972	694	3	0	0	0	697
SVP - WIC 6602/6604	950	0	0	0	0	950
TOTAL BY COMMITMENT	**5,550**	**96**	**0**	**65**	**0**	**5,711**
CONTRACTED PROGRAMS						
JAIL BASED COMPETENCY TREATMENT	362	71	0	0	0	433
COMMUNITY BASED RESTORATION/ DIVERSION[2]	626	284	0	0	0	910
COMMUNITY INPATIENT FACILITIES	175	19	0	0	0	194
TOTAL - CONTRACTED PROGRAMS	**1,163**	**374**	**0**	**0**	**0**	**1,537**
CONREP PROGRAMS[3]						
CONREP SVP	19	12	0	0	0	31
CONREP NON-SVP	565	127	0	0	0	692
CONREP FACT PROGRAM	54	36	0	0	0	90
CONREP STEP DOWN FACILITIES	63	78	0	0	0	141
TOTAL - CONREP PROGRAMS	**701**	**253**	**0**	**0**	**0**	**954**
CY POPULATION AND CONTRACTED TOTAL	**7,414**	**723**	**0**	**65**	**0**	**8,202**

Total IST Population - State Hospitals, JBCT, CBR, and CIF (excludes CONREP)[4]

July 1, 2024 Actual: 2,822

June 30, 2025 Projected: 3,236

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

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

[2] Community Based Restoration/ Diversion totals exclude new Diversion programs. Projected census will be adjusted as programs are implemented with Counties.

[3] The projected census for CONREP is based on the contracted caseload. Actual census may vary based on activation delays.

[4] Totals are calculated using fractional data and are rounded for display purposes.

DEPARTMENT OF STATE HOSPITALS POPULATION

	BUDGET YEAR 2025-26					
	July 1, 2025 Projected Census	Previously Approved Adjustments BY 2025-26	2025-26 November Adjustment BY 2025-26	Census Adjustment	2025-26 May Revision Adjustment BY 2025-26	June 30, 2026 Projected Census
POPULATION BY HOSPITAL						
ATASCADERO	1,076	0	0	45	0	1,121
COALINGA	1,300	0	0	0	0	1,300
METROPOLITAN	933	0	0	0	16	949
NAPA	1,078	0	0	0	0	1,078
PATTON	1,324	0	0	0	0	1,324
TOTAL BY HOSPITAL	**5,711**	**0**	**0**	**45**	**16**	**5,772**
POPULATION BY COMMITMENT - SH						
Coleman - PC 2684[1]	215	0	0	45	0	260
IST - PC 1370	1,700	0	0	-23	4	1,681
LPS & PC 2974	602	0	0	23	0	625
NGI - PC 1026	1,212	0	0	0	6	1,218
OMD - PC 2962	336	0	0	0	6	342
OMD - PC 2972	697	0	0	0	0	697
SVP - WIC 6602/6604	950	0	0	0	0	950
TOTAL BY COMMITMENT	**5,711**	**0**	**0**	**45**	**16**	**5,772**
CONTRACTED PROGRAMS						
JAIL BASED COMPETENCY TREATMENT	433	0	0	0	0	433
COMMUNITY BASED RESTORATION/ DIVERSION[2]	910	123	0	0	0	1,033
COMMUNITY INPATIENT FACILITIES	194	34	0	0	0	228
TOTAL - CONTRACTED PROGRAMS	**1,537**	**157**	**0**	**0**	**0**	**1,694**
CONREP PROGRAMS[3]						
CONREP SVP	31	0	0	0	0	31
CONREP NON-SVP	692	0	0	0	-26	666
CONREP FACT PROGRAM	90	0	0	0	0	90
CONREP STEP DOWN FACILITIES	141	24	0	0	0	165
TOTAL - CONREP PROGRAMS	**954**	**24**	**0**	**0**	**-26**	**952**
BY POPULATION AND CONTRACTED TOTAL	**8,202**	**181**	**0**	**45**	**-10**	**8,418**

Total IST Population - State Hospitals, JBCT, CBR, and CIF (excludes CONREP)[4]

July 1, 2025 Projected: 3,236

June 30, 2026 Projected: 3,374

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

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

[2] Community Based Restoration/ Diversion totals exclude new Diversion programs. Projected census will be adjusted as programs are implemented with Counties.

[3] The projected census for CONREP is based on the contracted caseload. Actual census may vary based on activation delays.

[4] Totals are calculated using fractional data and are rounded for display purposes.

POPULATION DATA
STATE HOSPITALS
POPULATION AND PERSONAL SERVICES ADJUSTMENTS
Informational Only

BACKGROUND

A change in position and expenditure authority in fiscal year (FY) 2024-25 and FY 2025-26 is based on a broad range of factors and variables specific to the delivery of patient treatment. These variables may include treatment categories, patient legal classifications, capacity and facility adjustments impacting safety and security. Changes amongst these variables drive clinical and non-clinical staffing needs within state hospitals to meet staff-to-patient ratios, clinical caseloads, and other staffing methodologies adopted in the Budget Acts of 2019 and 2020.

To address treatment, population and facility changes, and the subsequent impact to hospital staffing, the Department of State Hospitals (DSH) conducts biannual assessments including census and population projections to identify significant fluctuations in hospital bed capacity and population growth as seen in the pending placement list, and adjustments within treatment categories, facilities, and treatment capacity.

POPULATION PROJECTIONS

Census and Pending Placement List Projections

DSH utilizes the July 1, 2024, actual census as the baseline census for both FY 2024-25 and FY 2025-26. For the 2025-26 Governor's Budget and May Revision, the methodologies to project future census figures are applied as described below.

Methodology[1]

In the 2016-17 Governor's Budget, DSH implemented a methodology to project the pending placement list, which has since been enhanced and expanded to include additional commitments through collaborative efforts with the University of California, Irvine's (UCI) Department of Criminology, Law, and Society research team. DSH continues to use this as the standard forecasting tool to project the pending placement list for the Incompetent to Stand Trial (IST), Lanterman–Petris–Short (LPS), Offender with a Mental Health Disorder (OMD), Not Guilty by Reason of Insanity (NGI), and Sexually Violent Predator (SVP) populations.

[1] This methodology does not project for the *Coleman* patients. The Department of Corrections and Rehabilitation (CDCR) determines the bed need and produces projections for the *Coleman* population.

This methodology utilizes four primary measures, as well as expected systemwide capacity expansions[2] 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 FY 2024-25 and FY 2025-26 is based on the modified pending placement list value calculated for June 30, 2025, and June 30, 2026. Variables are specific to patient legal class and are calculated based on trends observed in the 12-month period ending February 28, 2025.

Table 1 below provides the DSH pending placement list projections for the IST, LPS, NGI, OMD, and SVP populations. The table also presents the actual census for July 1, 2024, as well as the projected census for FY 2024-25 and FY 2025-26 for all DSH populations. The projected census for June 30, 2025 (for FY 2024-25) and June 30, 2026 (for FY 2025-26) reflects the actual census as well as the approved and proposed census adjustments.

[2] Systemwide capacity expansions include state hospitals, jail-based competency treatment programs, community inpatient facility programs, and community-based restoration programs.

Table 1: Census and Pending Placement List Projections

CURRENT YEAR			
Legal Class	**July 1, 2024 Actual Census**	**June 30, 2025 Projected Census**	**June 30, 2025 Projected Pending Placement List**
IST[3]	2,822	3,236	293
LPS	547	602	230
NGI	1,208	1,212	7
OMD2962	333	336	41
OMD2972	694	697	2
SVP	950	950	7
Coleman[4]	159	215	N/A
Subtotal	*6,713*	*7,248*	*580*
CONREP[5]	701	954	N/A
Total	**7,414**	**8,202**	**580**
BUDGET YEAR			
Legal Class	**July 1, 2025 Projected Census**	**June 30, 2026 Projected Census**	**June 30, 2026 Projected Pending Placement List**
IST[3]	3,236	3,374	261
LPS	602	625	97
NGI	1,212	1,218	3
OMD2962	336	342	44
OMD2972	697	697	1
SVP	950	950	8
Coleman[4]	215	260	N/A
Subtotal	*7,248*	*7,466*	*414*
CONREP[5]	954	952	N/A
Total	**8,202**	**8,418**	**414**

[3] The IST projected census excludes new Diversion programs. These programs will be added to projected census as they are implemented with our county partners.
[4] The projected pending place list is not calculated for the Coleman population within the DSH forecasting model. Projections for the Coleman population is developed by CDCR.
[5] The projected census for CONREP is based on the contracted caseload. Actual census may vary based on activation delays.

Referral[6] and Census Trends

Over the span of the last seven years, DSH has seen an increase of 45% in IST referrals when comparing annual referral rates from FY 2017-18 (339 per month) through FY 2023-24 (490 per month). Notably, during FY 2019-20 and FY 2020-21, DSH observed declines in IST referrals, which were attributed to the COVID-19 pandemic and disruption of court proceedings. However, county courts have since resumed their activities, subsequently leading to surges in IST referral rates that show a consistent year over year increase. In FY 2023-24, DSH experienced a continued growth in referrals, with an increase of 0.4% in IST referrals as compared to the preceding year. In the current fiscal year DSH is experiencing a decrease of four percent in IST referrals rates as compared to the prior year. The data displayed in Table 2 below highlights a significant and sustained trend in IST referral growth, with a four percent decrease in the current year.

Table 2: Average Monthly Referrals[6,7]

Fiscal Year	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25 (YTD)[8]	% Change[9]
IST	343	346	415	488	490	469	-4%
LPS	<11	***	<11	***	***	***	6%
NGI	<11	<11	<11	<11	<11	<11	-34%
OMD 2962	43	26	27	30	30	33	11%
OMD 2972	<11	<11	<11	<11	<11	<11	-5%
SVP	<11	<11	<11	<11	<11	<11	32%
Coleman	46	16	16	17	51	60	17%
Total	**456**	**416**	**483**	**559**	**603**	**593**	**-2%**

Following the onset of COVID-19, DSH experienced a reduction in its patient census due to necessary infection control protocols such as the creation of isolation units, admission observation units, and at times, pausing admissions to protect the health and safety of its patients and staff. As DSH began its post-pandemic recovery, there was a substantial increase in admissions, leading to an increase in state hospital census. Along with increased hospital admission rates, DSH has been rapidly implementing an array of innovative IST solutions to address the increasing IST referrals and pending placement list. These include expansion of community-based

[6] Referrals include all ISTs initially committed to DSH or a DSH-funded program. Excludes any administrative errors, duplicate records, program transfers, and court returns.
[7] Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or "less than 11" within the narrative. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.
[8] FY 2024-25 referral data is a year-to-date average from July 1, 2024, through February 28, 2025.
[9] Percentage of change from FY 2023-24 to FY 2024-25 is based on raw data, which has been rounded to whole numbers for display purposes.

treatment and diversion options for felony ISTs, activation of community inpatient facility programs, expansion of existing Jail Based Community Treatment (JBCT) programs, and the addition of new JBCT programs to serve the IST population. All these efforts have resulted in an overall increase in IST census. DSH did experience a slight dip in census in June 2024 due to an increase of COVID-19 positives. As the system recovered from the temporary COVID-19 surge, IST census continued to increase reaching to almost 2,900 by the end of February 2025.

Table 3: Patient Census

	6/30/2021	6/30/2022	6/30/2023	6/30/2024	2/28/2025	% Change[10]
IST[11]	1,951	2,096	2,843	2,824	2,884	2%
LPS[12]	789	707	584	550	551	0%
NGI	1,338	1,244	1,225	1,208	1,192	-1%
OMD 2962	415	383	334	333	336	1%
OMD 2972	716	685	710	696	689	-1%
SVP	939	956	954	951	951	0%
Coleman[13]	169	114	112	160	190	19%
Subtotal	*6,317*	*6,185*	*6,762*	*6,722*	*6,793*	*1%*
CONREP	647	714	733	697	685	-2%
Total	**6,964**	**6,899**	**7,495**	**7,419**	**7,478**	**1%**

Post COVID-19 Impact

Throughout the pandemic, DSH followed the guidance issued by the Centers for Disease Control and Prevention (CDC), California Department of Public Health (CDPH), epidemiologists and medical Subject Matter Experts (SMEs), and the local county public health director for each DSH facility. As COVID-19 guidance changed, and requirements for health care entities from earlier phases of the pandemic eased, the impacts to DSH operations and census lessened. While DSH continues to take the necessary steps to mitigate the spread of infection, such as exposure testing and isolation of COVID-19 positive patients, some interventions such as Admission Observation Units, utilized for patients entering into a state hospital, are no longer

[10] Percentage of change from FY 2023-24 to FY 2024-25 is based on raw data, which has been rounded to whole numbers for display purposes.
[11] IST census includes the following facilities and programs: state hospitals, community-based restoration program, IST diversion, jail-based competency treatment program, and community inpatient facilities.
[12] LPS census reductions reflect outcomes of statutory changes pertaining to non-restorable IST and IST individuals who have reached maximum commitment and may undergo a conservatorship investigation as well as efforts to align the LPS census to the number of beds contracted by the counties.
[13] Coleman census was impacted by COVID-19 related infection control measures and transfer protocols between DSH and CDCR.

required. As a result, DSH has been able to increase admissions, leading to an increase of census and a decrease in the pending placement list.

DSH reached a high of 1,953 IST patients on the pending placement list as of January 2022 and is now down to 278 as of 2025-26 May Revision. This significant reduction is due to the rapid implementation of the IST solutions authorized in the budget, the easing of CDC and CDPH requirements on healthcare facilities in response to the pandemic, no longer having to cohort admissions, and shorter quarantine timelines associated with exposures. Due to the average monthly referrals, it is unlikely this current pending placement list trend will change significantly moving forward. In FY 2023-24, DSH received an average of 490 IST referrals per month. The current waitlist reflects real-time monthly referrals, and the number of patients pending admission to a treatment bed is fewer than the number of referrals received per month.

STAFFING ANNUAL ASSESSMENT

In 2013, DSH initiated a comprehensive effort to evaluate staffing practices amongst the five state hospitals. This study, identified as DSH's Clinical Staffing Study, was assembled to perform a thorough analysis of past practices and staffing methodologies, and ensure they continue to be adequate and appropriate for the department's growing and evolving populations across all DSH facilities. The standardized staffing methodologies, supported through the Department of Finance (DOF) Mission-Based Review (MBR) and adopted in the Budget Acts of 2019 and 2020, provide data driven and data informed methods to calculate hospital staffing across the following areas:

- Hospital Forensic Departments
- 24-Hour Care Nursing Services
- Treatment Planning and Delivery
- Protective Services

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, delivery of psychiatric and medical treatment, and safety and security to patients and staff.

Staffing Adjustments

Using the methodologies and unit categorization system established in the staffing studies, DSH will examine fluctuations to treatment categories, population and facilities and identify necessary staffing adjustments that impact position and expenditure authority.

FY 2024-25

DSH is not currently requesting a change in position and expenditure authority in accordance with the standard staffing and funding methodology outlined above.

FY 2025-26

DSH-Coalinga

DSH must regularly assess the level of care needs for its patient population, specifically as it relates to DSH-Coalinga's aging patient population. In FY 2022-23, DSH Coalinga converted an SVP Residential Recovery Unit (RRU) to an SVP intermediate care facility (ICF) level of care unit to begin addressing this need. The 2025-26 Governor's Budget Estimate item, DSH-Coalinga Intermediate Care Facility Conversion, addresses this continued need to support its aging patient population.

DSH-Metropolitan

Changes to DSH-Metropolitan's population and treatment categories may necessitate a staffing assessment based on DSH's staffing standards. This assessment will apply described staffing methodologies across DSH-Metropolitan's population and treatment units to determine if these changes impact position authority and expenditure resources. The primary factors requiring this assessment include the following changes at DSH-Metropolitan:

- Increase in total capacity unaccounted for in the Hospital Forensic Services Department staffing standard implementation due to the timing of implementation and the subsequent increase in capacity associated with expansion of the secure treatment area.
- The high workload associated with the increased capacity anticipated to treat IST designated patients.
- Changes in treatment categories, including:
    - Conversion of moderate workload longer-term forensic legal classifications (NGI and OMD) units to higher workload legal classifications (IST) units.
    - Shift in legal classifications, reflecting an increased treatment focus for IST patients and decreased capacity across other legal classifications, such as NGI and OMD.

DSH-Atascadero

Changes to DSH-Atascadero's population and treatment categories may necessitate a staffing assessment based on DSH's staffing standards. This assessment will apply described staffing methodologies across DSH-Atascadero's population and treatment units to determine if these changes impact position authority and expenditure resources. The primary factors requiring this assessment include the following changes at DSH-Atascadero:

- Changes in treatment categories, including shift in legal classifications, reflecting an increased treatment focus for IST patients and decreased capacity across other legal classifications, such as OMD PC2962.
- Changes in workload associated with the changes in legal classifications unaccounted for in the staffing study staffing standards due to timing.

Findings from this assessment impacting position and expenditure authority may be presented in the 2026-27 Governor's Budget.

DSH Staffing Standards
Unit-Based Nursing, Treatment Team, and Primary Care Staffing

Treatment Category & Unit Type Sub-Category	Nursing			Treatment Team		Primary Care	
	AM Shift Ratios	PM Shift Ratios	NOC Shift Ratios	Workload Designation	Caseload Ratios	Workload Designation	Caseload Ratios
Admissions							
PC Standard Admissions	1: 4.5	1: 5	1: 8	High	1:15	Standard	1:45
Hybrid Admissions	1: 5.5	1: 5.5	1: 9.5	High	1:15	Standard	1:45
Medical Treatment							
Medical Unit	1: 2	1: 2	1: 2.5	Moderate	1:30	High	1:15
Skilled Nursing Facility	1: 2.5	1: 2.5	1: 4	Moderate	1:30	High	1:15
Medically Fragile/Gero psych	1: 4.5	1: 5	1: 7.5	Moderate	1:30	Moderate	1:30
Specialized Services Treatment							
High Aggression/Enhanced Treatment Unit (ETU)	1: 1.5	1: 1.5	1: 3	High	1:15	Standard	1:45
Enhanced Treatment Program (ETP)	1: 1.5	1: 1.5	1: 3	High	1:13*	Standard	1:45
PC Specialized Services: Intermediate Care High Behavior Acuity	1: 4.5	1: 4.5	1: 7.5	High	1:15	Standard	1:45
PC Specialized Services: Polydipsia	1: 5.5	1: 5.5	1: 9	High	1:15	Standard	1:45
PC Specialized Services: DBT	1: 5.5	1: 5.5	1: 9	High	1:15	Standard	1:45
LPS Specialized Services: Polydipsia	1: 3	1: 3	1: 4.5	High	1:15	Standard	1:45
LPS Specialized Services: DBT	1: 3	1: 3	1: 4.5	High	1:15	Standard	1:45
LPS Specialized Services: Acute Psychiatric/Pre-DBT	1: 3	1: 3	1: 4.5	High	1:15	Standard	1:45
Specialized Services: Deaf, Hard of Hearing	1: 3	1: 3	1: 6	High	1:15	Standard	1:45
PC Specialized Services: Substance Abuse	1: 5.5	1: 5.5	1: 9	Moderate	1:30	Standard	1:45
PC Specialized Services: Psychologically Fragile	1: 5.5	1: 5.5	1: 9	Moderate	1:30	Standard	1:45
Specialized Services: Sex Offender Treatment	1: 7.5	1: 7.5	1: 14	Moderate	1:30	Standard	1:45
Specialized Services: Monolingual	1: 5	1: 5.5	1: 8	Moderate	1:30	Standard	1:45

Incompetent to Stand Trial (IST) Treatment							
IST Admission to Discharge	1:5.5	1:5.5	1:9.5	High	1:15	Standard	1:45
IST Permanent Housing-Single Rooms	1:5.5	1:6.5	1:9.5	Moderate	1:30	Standard	1:45
IST Permanent Housing-Dorm, Mixed Rooms	1:6.5	1:6.5	1:12	Moderate	1:30	Standard	1:45
Offender with a Mental Disorder (OMD) Treatment							
OMD Permanent Housing-Single, Mixed Rooms	1:5	1:5	1:10	Moderate	1:30	Standard	1:45
Multi-Commitment Treatment							
OMD, NGI, LPS Permanent Housing-Dorm, Mixed Rooms	1:6.5	1:6.5	1:12	Moderate	1:30	Standard	1:45
OMD, NGI Permanent Housing-Single Rooms	1:5.5	1:6.5	1:11	Moderate	1:30	Standard	1:45
CDCR/OMD Permanent Housing	1:7.5	1:8	1:13	Moderate	1:30	Standard	1:45
CDCR (Coleman) Treatment							
CDCR Permanent Housing	1:5.5	1:6	1:12	Moderate	1:30	Standard	1:45
Sexually Violent Predator (SVP) Treatment							
SVP Permanent Housing	1:6	1:6.5	1:14	Moderate	1:30	Standard	1:45
SVP Residential Recovery Unit	1:13	1:17	1:33	Low	1:50	Standard	1:45
Lanterman-Petris Short (LPS) Treatment							
LPS Permanent Housing	1:5	1:5	1:9	High	1:15	Standard	1:45
Discharge Preparation Units							
Discharge Ready	1:7	1:7.5	1:13	Low	1:35	Standard	1:45

DEPARTMENT OF STATE HOSPITALS
COMMITMENT CODES

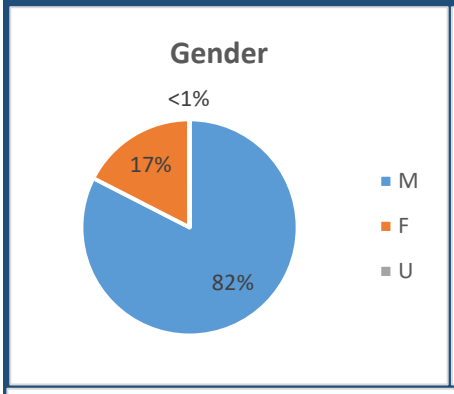
Legal Category	Legal Class Text	Code Section	Description
NGI	NGI PC1026	PC 1026	Not Guilty by Reason of Insanity
Other NGI	RONGI, RO1026	PC 1610	Temporary Admission while waiting for Court Revocation of PC1026 (NGI)
Other NGI	MNGI	WIC 702.3	Minor Not Guilty by Reason of Insanity
Other NGI	TANGI	PC 1610	Rehospitalization, temporary admission not guilty by reason of insanity
IST	IST PC1370	PC 1370.1	Incompetent to Stand Trial
Other IST	EIST	PC 1372(e)	Restored (IST) on Court Hold
Other IST	ROIST, RO1370, TAIST	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	Supervised Persons Referred from the Department of Corrections and Rehabilitation (CDCR)
OMD	PC2964a	PC 2964(a)	Supervised Persons Rehospitalized from Conrep after DSH hearing
OMD	PC2972	PC 2972	Former Supervised Person 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
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	Person Designated as a Sexually Violent Predator BPH Hold
Other SVP	ROSVP	PC 1610	Pending Revocation of a Person Designated as a Sexually Violent Predator
SVP	SVP	WIC 6604	Person Designated as a Sexually Violent Predator
SVP	SVPP	WIC 6602	Person Designated as a Sexually Violent Predator Probable Cause
PC 2684	PC2684	PC 2684	Incarcerated Person from CDCR
LPS	T.Cons	WIC 5353	Temporary Conservatorship
LPS	CONS	WIC 5358	Conservatorship
LPS	VOL	WIC 6000	Voluntary
LPS	MURCON	WIC 5008(h)(1)(B)	Murphy's Conservatorship
LPS*	PC 2974	PC 2974	Recommitment after expiration of prison term (must have concurrent W&I commitment)

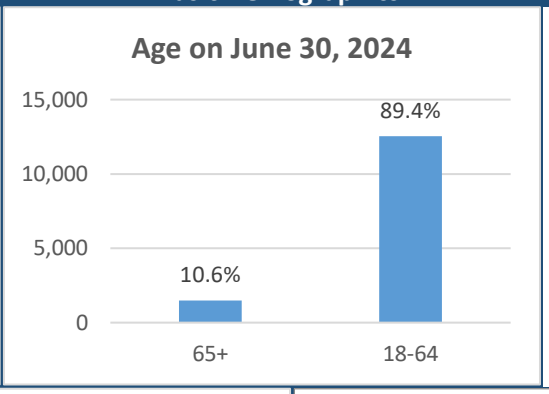
*Historical legal codes that are no longer admitted into DSH are excluded from this table.

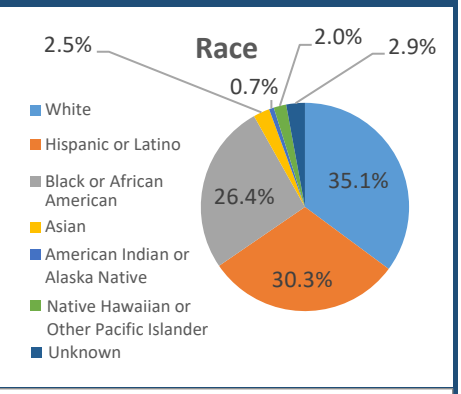
Demographic Snapshot: All Commitment Types

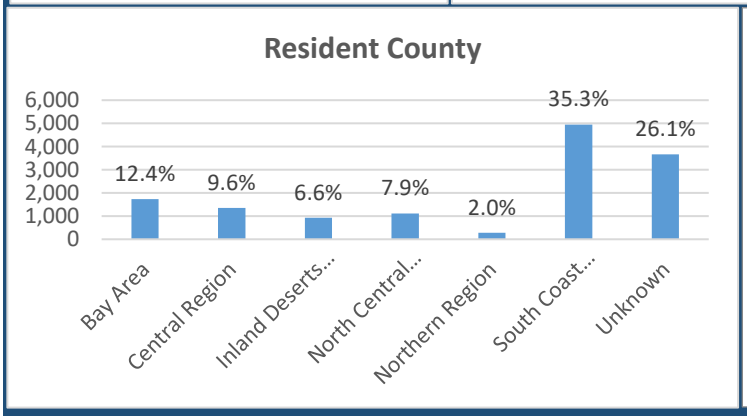
Patients Served from July 1, 2023 to June 30, 2024 is 14,014

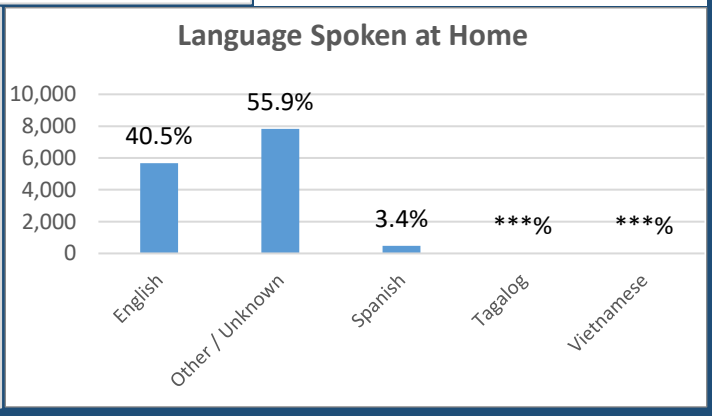
Basic Demographics

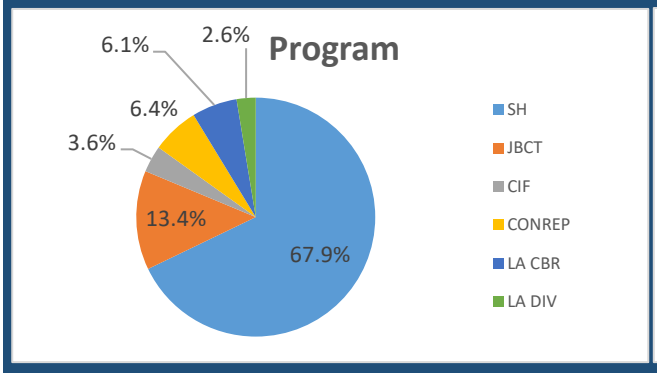


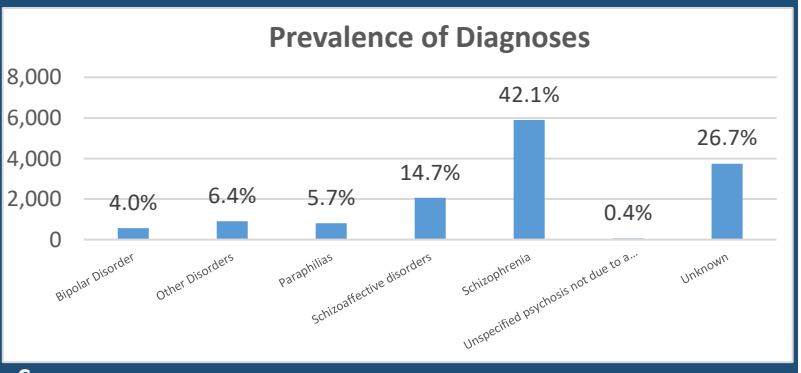












Summary

The data shown above is a combination of State Hospital (SH), Jail-Based Competency Treatment (JBCT), Conditional Release Program (CONREP), Community Inpatient Facility (CIF), LA Community Based Resoration (LA CBR), and LA Diversion (LA DIV) information. The DSH population is composed of approximately 82% males and 17% females; a majority of this population is between the ages of 18 and 64. The age of all patients is calculated as of June 30, 2024. Approximately 35% identify as White, 26% Black, and 30% Hispanic with mostly English spoken at home. The majority of the DSH population are residents of South Coast and Bay Area counties. During this time period, approximately 68% of DSH patients were treated at a State Hospital (excluding transfers from other Programs) and 13% at a JBCT facility. Schizophrenia, Schizoaffective, and Bipolar-type disorders are the three most common diagnoses for the DSH population, accounting for approximately 83% of the population with known diagnoses.

Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

RESEARCH, EVALUATION AND DATA INSIGHTS
DATA MONITORING AND STATISTICS

Patients Served by Race

Fiscal Year 2023-2024

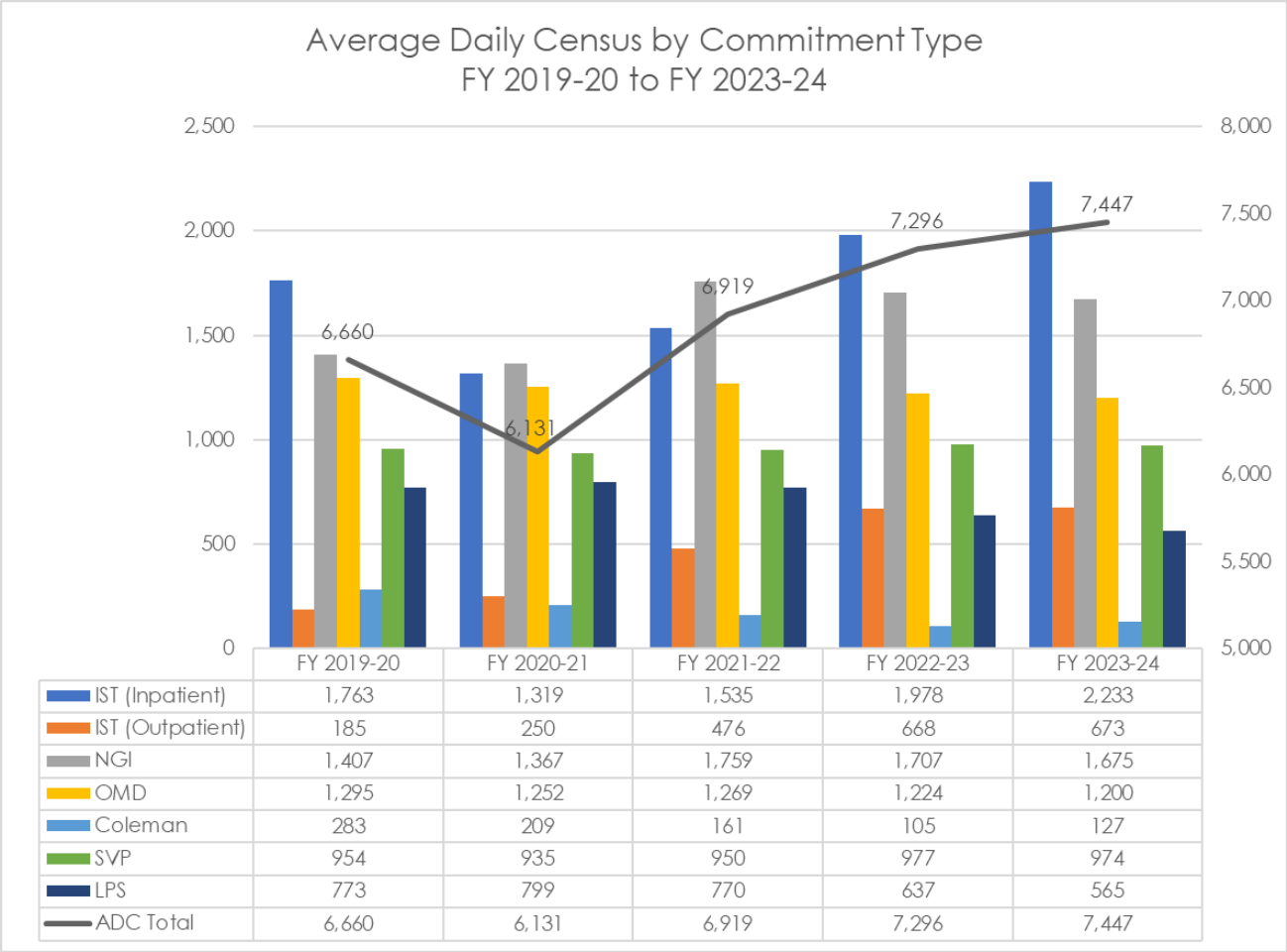
		CDCR	IST	LPS	NGI	OMD[4]	SVP	Grand Total
DSH Inpatient and Outpatient Program's Patients Served by Count[1]	*White*	134	2,584	234	825	557	590	4,924
	Hispanic or Latino	138	2,888	201	418	446	156	4,247
	Black or African American	116	2,400	154	359	444	230	3,703
	Asian	<11	224	***	64	25	<11	356
	Unknown	***	270	18	50	37	***	406
	Native Hawaiian or Other Pacific Islander	<11	143	***	81	25	<11	274
	American Indian or Alaska Native	<11	61	<11	11	16	***	104
	TOTAL	419	8,570	652	1,808	1,550	1,015	**14,014**

		CDCR	IST	LPS	NGI	OMD[4]	SVP	Grand Total	2022 State of California[2]	2023 State of California[3]
DSH Inpatient and Outpatient Program's Patients Served by Percentage[1]	*White*	32.0%	30.2%	35.9%	45.6%	35.9%	58.1%	35.1%	35.2%	33.3%
	Hispanic or Latino	32.9%	33.7%	30.8%	23.1%	28.8%	15.4%	30.3%	39.7%	40.4%
	Black or African American	27.7%	28.0%	23.6%	19.9%	28.6%	22.7%	26.4%	5.3%	5.1%
	Asian	***%	2.6%	***%	3.5%	1.6%	***%	2.5%	14.9%	15.5%
	Unknown	***%	3.2%	2.8%	2.8%	2.4%	***%	2.9%	0.4%	0.7%
	Native Hawaiian or Other Pacific Islander	***%	1.7%	***%	4.5%	1.6%	***%	2.0%	0.3%	0.3%
	American Indian or Alaska Native	***%	0.7%	***%	0.6%	1.0%	***%	0.7%	0.3%	0.3%
	TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	**100.0%**		

[1] Total counts of Patients Served do not include patient transfers from other facilities.
[2]Taken from U.S. Census Bureau 2022 American Community Survey (ACS 5-Year Estimates). Does not include 3.8% labeled "two or more races".
[3]Taken from U.S. Census Bureau 2023 American Community Survey (ACS 1-Year Estimates). Does not include 4.4% labeled "two or more races".
[4]Includes MDSO.

*Headers represent the following commitments: California Department of Correction and Rehabilitation (CDCR), Incompetent to Stand Trial (IST), Lanterman-Petris Short (LPS), Not Guilty by Reason of Insanity (NGI), Offenders with a Mental Health Disorder (OMD), and Sexually Violent Predator (SVP).

Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. Counts between 1-10 are masked with "<11". Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.



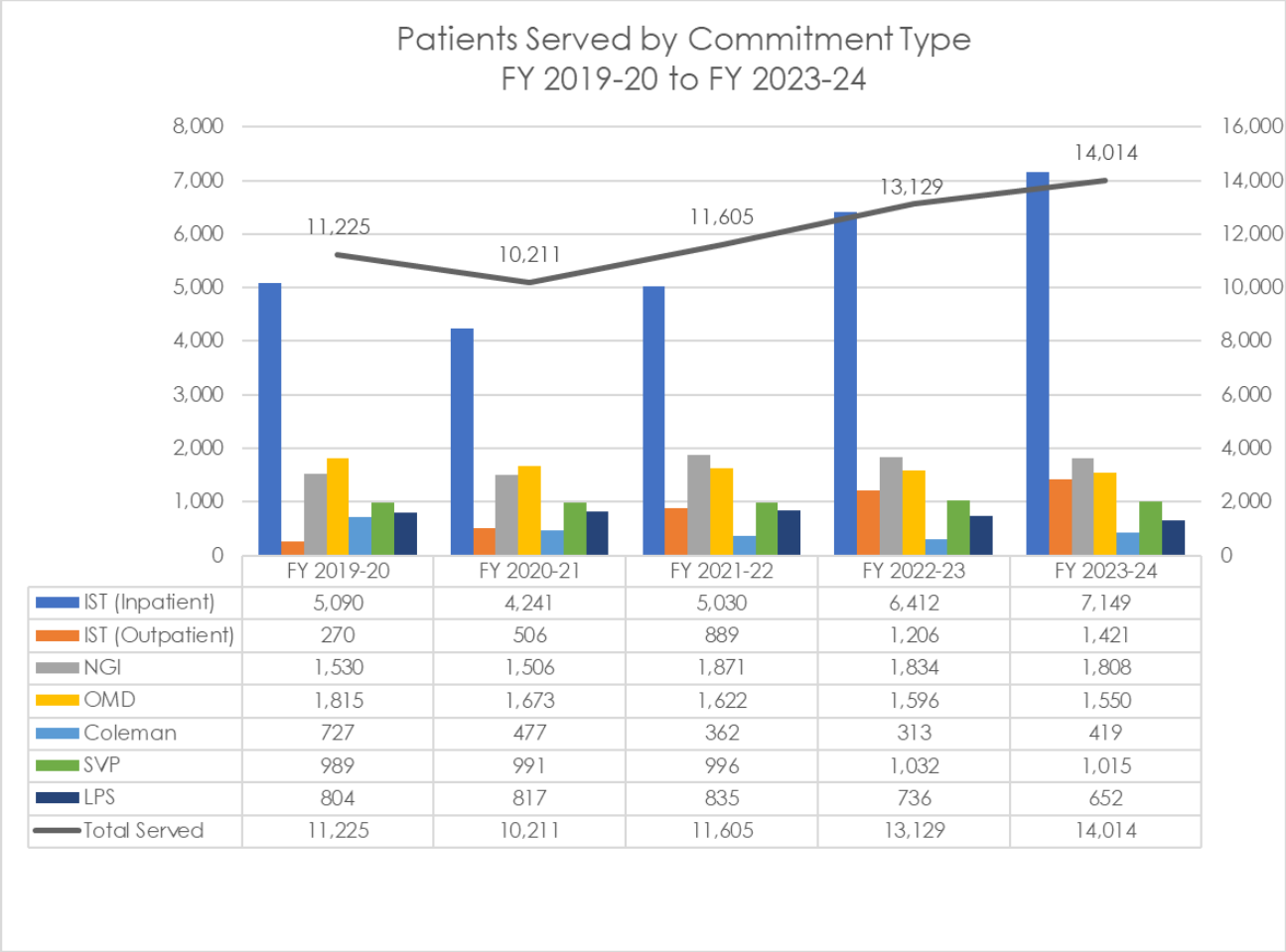
	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
IST (Inpatient)	1,763	1,319	1,535	1,978	2,233
IST (Outpatient)	185	250	476	668	673
NGI	1,407	1,367	1,759	1,707	1,675
OMD	1,295	1,252	1,269	1,224	1,200
Coleman	283	209	161	105	127
SVP	954	935	950	977	974
LPS	773	799	770	637	565
ADC Total	6,660	6,131	6,919	7,296	7,447

Data includes State Hospitals data in all years and for all commitments. IST (Inpatient) also includes Community Inpatient Facilities (CIF) and Jail-Based Competency Treatment Programs (JBCT) Community. IST Outpatient includes Community Based Restoration for all years. LA Diversion beginning in FY 2022-23. Conditional Release Program (CONREP), CONREP-Sexually Violent Predators (SVP) and CONREP- Forensic Assertive Community Treatment (FACT) Program are included within IST (Outpatient), NGI, OMD, and SVP beginning FY 2021-22. Data excludes less than 11 Division of Juvenile Justice (DJJ) Patients in FY 2019-20 through FY 2022-23.

During fiscal year (FY) 2023-24, following the cessation of various COVID-19 pandemic protocols and a return to normal admissions, the Department of State Hospitals (DSH) had an average daily census of 7,447 patients; a 2% growth in average daily census over FY 2022-23.

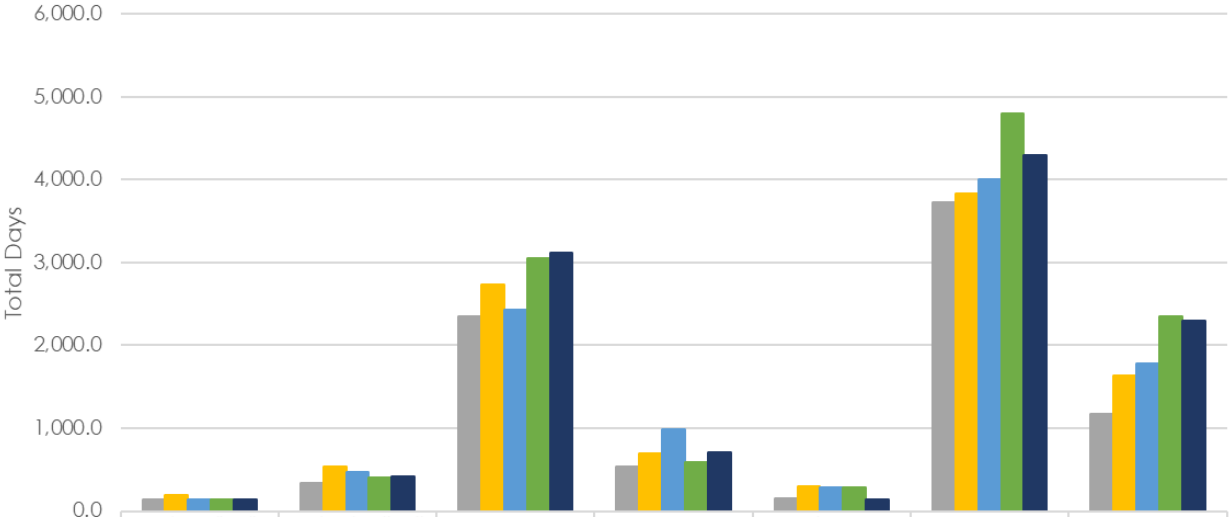
In FYs 2020-21 and 2021-22, COVID-19 impacted both admission rates and inpatient census. Admission rates decreased due to the implementaiton of a 10-day isolation period prior to transfer to a treatment unit, as well as continuous COVID-19 outbreaks requiring quarintines. Inpatient census was further impacted by the need to create Admission Observation Units (AOUs) and other spaces dedicated to isolating patients. The 2% growth from FY 2022-23 to FY 2023-24 reflects DSH's continuum of care and expansion of inpatient and outpatient programs, and a focus of growing

census while balancing continued health and safety measures associated with COVID-19.



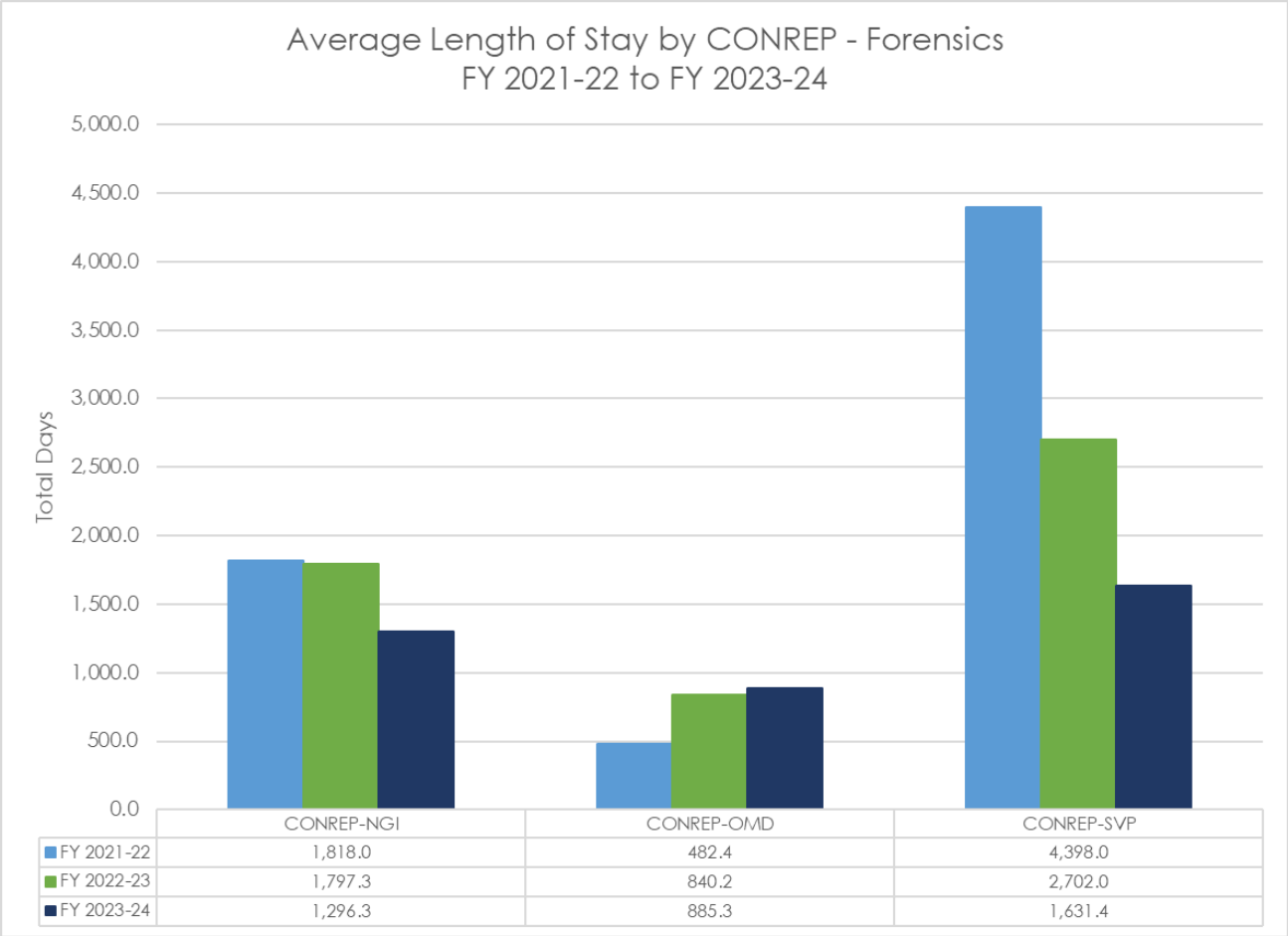
	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
IST (Inpatient)	5,090	4,241	5,030	6,412	7,149
IST (Outpatient)	270	506	889	1,206	1,421
NGI	1,530	1,506	1,871	1,834	1,808
OMD	1,815	1,673	1,622	1,596	1,550
Coleman	727	477	362	313	419
SVP	989	991	996	1,032	1,015
LPS	804	817	835	736	652
Total Served	11,225	10,211	11,605	13,129	14,014

Data includes State Hospitals data in all years and for all commitments. IST (Inpatient) also includes Community Inpatient Facilities (CIF) and Jail-Based Competency Treatment Programs (JBCT) Community. IST Outpatient includes Community Based Restoration. LA Diversion beginning in FY 2022-23. Conditional Release Program (CONREP), CONREP-Sexually Violent Predators (SVP) and CONREP-Forensic Assertive Community Treatment (FACT) Program are included within IST (Outpatient), NGI, OMD, and SVP beginning FY 2021-22. Data excludes less than 11 Division of Juvenile Justice (DJJ) Patients in FY 2019-20 through FY 2022-23.



	IST (Inpatient)	IST (Outpatient)	NGI	OMD	Coleman	SVP	LPS
FY 2019-20	135.0	343.8	2,352.2	538.6	154.4	3,721.9	1,173.7
FY 2020-21	187.4	530.1	2,730.7	693.4	292.3	3,829.8	1,638.3
FY 2021-22	133.6	474.9	2,433.9	986.1	289.0	4,006.8	1,779.2
FY 2022-23	134.0	409.7	3,045.1	591.7	283.8	4,802.4	2,353.4
FY 2023-24	141.5	416.7	3,110.5	711.4	141.0	4,298.4	2,296.2

Data includes State Hospitals data in all years. Data includes State Hospitals data in all years and for all commitments. IST (Inpatient) also includes Community Inpatient Facilities (CIF) and Jail-Based Competency Treatment Programs (JBCT). IST Outpatient includes Community Based Restoration all years. LA Diversion beginning FY 2022-23. Conditional Release Program (CONREP), CONREP-Sexually Violent Predators (SVP) and CONREP-Forensic Assertive Community Treatment (FACT) Program are included within IST (Outpatient), NGI, OMD, and SVP beginning FY 2021-22. Data excludes less than 11 Division of Juvenile Justice (DJJ) Patients in FY 2019-20 through FY 2022-23.



	CONREP-NGI	CONREP-OMD	CONREP-SVP
FY 2021-22	1,818.0	482.4	4,398.0
FY 2022-23	1,797.3	840.2	2,702.0
FY 2023-24	1,296.3	885.3	1,631.4

IST patients treated in CONREP are reflected in the IST (Outpatient) graph above.

STATE HOSPITALS
BUDGET CHANGE PROPOSALS

Please see the Department of Finance (DOF) website for all Budget Change Proposals (BCPs).

STATE HOSPITALS
COUNTY BED BILLING REIMBURSEMENT AUTHORITY
Program Update

SUMMARY

As of the 2025-26 May Revision, the Department of State Hospitals (DSH) agreed to updated county bed billing daily bed rates with the California Mental Health Services Authority (CalMHSA) based on actual costs. DSH projects no change for fiscal year (FY) 2024-25 and requests an increase in reimbursement authority of $13.4 million in FY 2025-26 and $21 million in FY 2026-27 and ongoing due to a projected increase in Lanterman-Petris-Short (LPS) patient census and negotiated increases to the daily bed rates.

BACKGROUND

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

LPS Population

The LPS population includes civilly committed patients who have been admitted to DSH under the LPS Act (Welfare and Institutions Code (WIC) § 5000 et seq.). The LPS population is referred to DSH by county behavioral health agencies through involuntary civil commitment procedures pursuant to the LPS Act. Individuals conserved under the LPS Act are to be treated in the least restrictive setting to meet their treatment needs. DSH is identified in the LPS Act as one treatment setting for LPS conserved individuals along with other community treatment settings and is the more restrictive placement option under the LPS Act. WIC § 4330 requires counties to reimburse DSH for their use of hospital beds and services provided pursuant to the LPS Act.

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

Pursuant to penal code (PC) §1370, when a state hospital issues a progress report for an IST individual stating there is no substantial likelihood the defendant will recover mental competence, the defendant shall be returned to the committing court, and custody of the defendant shall be transferred without delay to the committing county and shall remain with the county until further order of the court. Pursuant to PC §1370 (b)(1) and §1370 (c)(1), if a county does not take custody of a defendant committed to DSH within 10 calendar days following notification, DSH is authorized

to charge counties the daily rate for a state hospital bed. Assembly Bill 133 (Chapter 143, Statutes of 2021) authorizes DSH to charge a county the daily bed rate for each day that a defendant is not transported back to the county and remains in DSH custody.

The Budget Act of 2024 reported no adjustments to DSH reimbursement authority. In the 2025-26 Governor's Budget, DSH reported no adjustment to its County Bed Billing Reimbursement Authority, with LPS and IST NR/MT daily bed rates under negotiation with the counties.

JUSTIFICATION

As of the 2025-26 May Revision, DSH concluded negotiations with CalMHSA pursuant to WIC 4330 regarding increases to LPS daily bed rates. The individual Memorandum of Understanding (MOU) for each county are in progress of being updated with the new daily bed rates. DSH assumes no adjustments to its current reimbursement authority for FY 2024-25, however, DSH projects an increase in reimbursement collections of $13.4 million in FY 2025-26 and $21 million in FY 2026-27 and ongoing based on monthly projected billing derived from FY 2024-25 actuals (July 2024 through January 2025), projected increases to LPS patient census, and negotiated phased-in increases to the daily bed rates governing the next two FYs.

DSH provides care to LPS and IST NR/MT patients based on the level of acuity that meets the patient's needs. There are three levels of care: Acute, Intermediate Care Facility (ICF), and Skilled Nursing Facility (SNF). Each level of care has its own billable rate. DSH negotiations with CalMHSA on the daily bed rates for LPS patients resulted in phased-in increases across all three levels of acuity of 4% in FY 2025-26 and an additional 3.5% in FY 2026-27 and ongoing.

The table below displays the negotiated daily bed rates starting July 1, 2025.

Changes to Daily Bed Rates			
	FY 2024-25	**FY 2025-26** *(initial 4% increase)*	**FY 2026-27** *(additional 3.5% increase)*
Acute	$760	$790	$818
ICF	$736	$765	$792
SNF	$814	$847	$876

DSH also plans to expand the use of DSH beds by 69 at DSH-Metropolitan (DSH-M) for LPS patients. In March 2025, DSH converted an IST unit at DSH-M to LPS unit. After consolidating LPS patients from other DSH hospitals, this unit is expected to net approximately 23 additional LPS beds. Additionally, DSH plans to activate an additional 46 bed unit to treat LPS[1]. This increase in bed capacity will increase

[1] Please see DSH-Metropolitan Increased Secure Bed Capacity (Section C2) for more information.

reimbursement collections, help address the LPS pending placement list and help relieve challenges counties are experiencing as a result of the December 19, 2024, *In re Lerke* decision by the 4th *District Court of Appeal*. In this decision the appellate court ruled that a jail is not a statutorily authorized placement location for individuals who have a Murphy's conservatorship when a bed is not available at a DSH state hospital. The appellate court maintained that the court and conservatorship had to find an alternate placement, or the individual had to be released from jail.

In addition, DSH is actively collaborating with CalMHSA on strategies, including implementing a bed allocation methodology, to support counties in more effectively utilizing the LPS beds. As of the 2025-26 May Revision, 103[2] DSH LPS patients were ready to transition to a lower level of care and the county had not yet discharged them and an additional 249[3] LPS patients were referred to DSH for admission. In addition to adding additional capacity, improving bed utilization will help DSH admit additional individuals who have been referred.

FY 2025-26

DSH projections for LPS and IST NR/MT reimbursement collections are derived from monthly billing actuals. DSH utilizes the most recent fiscal year billing data to project average monthly billing for a full fiscal year. For the 2025-26 May Revision, DSH used FY 2024-25 (July 2024 through January 2025) monthly actuals to calculate average monthly billing and project reimbursement collections for FY 2025-26. DSH included the increase in LPS bed capacity to the projected monthly billing.

The table below displays the projected average monthly billing for LPS and IST NR/MT patients by level of acuity, the negotiated daily bed rates effective as of July 1, 2025, and the projected total reimbursement collections in FY 2025-26.

FY 2025-26 Reimbursement Collections Projections[4]				
Average Projected Monthly Billing[5]		**Daily Bed Rate**	**Total Amount Billed Per Month**	**Total Collections Projected for FY 2025-26**
Acute	366	$790	$8,385,060	**$177,629,805**
ICF	248	$765	$5,332,526	
SNF	48	$847	$1,193,720	

[2] Data as of December 31, 2024
[3] Data as of April 7, 2025
[4] Numbers are rounded for display purposes. Projection calculations use raw billing data and fractional averages.
[5] Beds billed does not reflect the actual number of beds available for LPS and IST NR/MT patients. LPS patients may transition from different levels of acuity within a month, so a single bed may be used for multiple patients within a month period, effectively being counted more than once for the purposes of reimbursement collections.

FY 2026-27

Similar to FY 2025-26 reimbursement collections projections, DSH used FY 2024-25 (July 2024 through January 2025) monthly billing actuals to calculate average monthly billing and project reimbursement collections in FY 2026-27.

The table below displays the average projected monthly billing for LPS and IST NR/MT patients by level of acuity, the negotiated daily bed rates effective as of July 1, 2026, and the projected total reimbursement collections in FY 2026-27.

FY 2026-27 Reimbursement Collections Projections[1]				
Average Projected Monthly Billing[2]		**Daily Bed Rate**	**Total Amount Billed Per Month**	**Total Collections Projected for FY 2025-26**
Acute	366	$818	$8,682,252	**$185,250,915**
ICF	248	$792	$5,520,733	
SNF	48	$876	$1,234,591	

Conclusion

The table below displays the adjustment to reimbursement authority requested in FYs 2025-26 and 2026-27 taking the projected reimbursement collections and reducing the current reimbursement authority.

Reimbursement Authority Adjustment			
Fiscal Year	**Projected Reimbursement Collections**	**Current Reimbursement Authority**	**Reimbursement Authority Adjustment**
FY 2025-26	$177,629,805	$164,228,000	$13,401,805
FY 2026-27	$185,250,915	$164,228,000	$21,022,915

As of the 2025-26 May Revision, DSH reports no adjustment to its reimbursement authority in FY 2024-25, however, DSH requests an increase in reimbursement authority of $13.4 million in FY 2025-26 and $21 million in FY 2026-27 based on LPS and IST NR/MT projected monthly average billing, increased LPS bed capacity, and the negotiated increases to the daily bed rates based on level of acuity.

DSH will provide an update to county bed billing reimbursement authority in the 2026-27 Governor's Budget.

Resource Table

Description	**CY**	**BY**	**BY+**

Current Service Level	$164,228	$164,228	$164,228
Governor's Budget Request	$0	$0	$0
May Revision Request	$0	$13,402	$21,023
TOTAL	**$164,228**	**$177,630**	**$185,251**

*Dollars in thousands

STATE HOSPITAL
DSH – METROPOLITAN INCREASED SECURE BED CAPACITY
Program Update

SUMMARY

As of the 2025-26 May Revision, the Department of State Hospitals (DSH)-Metropolitan Increased Secure Bed Capacity (ISBC) project continues to experience delays in the activation of Units 4 and 5. DSH anticipates the Skilled Nursing Facility (SNF) building restoration will be completed in May 2025; a three-month delay from the 2025-26 Governor's Budget. This results in an additional one-time savings of $5.9 million in fiscal year (FY) 2024-25. Total one-time savings in FY 2024-25 of $10.3 million. Additionally, DSH projects it will activate the first of the two units for Lanterman Petris Short (LPS) patients rather than IST patients as originally planned.

BACKGROUND

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

Construction of all five ISBC units is complete; however, as of the Budget Act of 2022, DSH had activated two of the five units for the treatment of IST patients. The remaining three units were utilized to accommodate various operational needs related to DSH's COVID-19 response, the Chronic Treatment East (CTE) Fire Alarm Project, and to provide temporary housing to DSH-Metropolitan SNF patients while their building remains under construction/repairs.

As of the Budget Act of 2023, Unit 3, previously utilized for COVID-19 isolation space, was activated for treatment of IST patients. Units 4 and 5 continued to be utilized as temporary housing for SNF patients. In the Budget Act of 2024, DSH reported a one-time savings of $3.9 million in FY 2023-24 due to continued construction delays.

In the 2025-26 Governor's Budget, DSH and the Department of General Services (DGS) reported continued construction delays in the SNF building restoration and repairs. Due to these delays, DSH-Metropolitan continued to utilize Units 4 and 5 for SNF patients, resulting in a one-time savings of $4.4 million in FY 2024-25.

JUSTIFICATION

While roof replacement of the SNF building is complete, construction and repairs continue on the interior portion of the SNF building, which began November 2023 following extensive water intrusion. Electrical repairs to reestablish damaged electrical systems such as Personal Duress Alarm Systems (PDAS), fire alarms and sprinkler system, and a new nursing call system remain in progress, and DSH/DGS Projection Management continue to work on obtaining final regulatory approval in order to reactivate the SNF building.

As of the 2025-26 May Revision, DSH and DGS anticipate internal restorations of the SNF building will be completed in May 2025; a three-month delay from the 2025-26 Governor's Budget. Following the completion of the SNF building restoration, SNF patients will be relocated back to the SNF building. This will allow DSH-Metropolitan to proceed with activation of Units 4 and 5. Due to the continued delays in the interior restoration on the SNF building, DSH reports an additional one-time savings of $5.9 million in FY 2024-25.

Based upon current increased demand for beds for LPS patients, DSH plans to activate the first of the two units for LPS rather than for IST's as originally planned[1]. Based on current IST referrals and time to treatment trends, utilizing these beds for LPS patients rather than IST's is not expected to impact DSH's ability to provide substantive treatment within 28 days as required by *Stiavetti v. Clendenin.*

Completion Timeline Adjustment

Unit	# of Beds	Scheduled Completion as of 2025-26 Governor's Budget	Scheduled Completion as of 2025-26 May Revision	Change
Unit 1	46	September 23, 2019	September 23, 2019	No change - Activated
Unit 2	46	January 29, 2020	January 29, 2020	No change - Activated
Unit 3	46	November 1, 2022	November 1, 2022	No change - Activated
Unit 4	48	Early 2025	May 2025	Delayed
Unit 5	48	Early 2025	May 2025	Delayed

[1] Please see County Bed Billing Reimbursement Authority (Section C1) for more information.

Resource Table

Description	CY	BY	BY+
Current Service Level	$74,857	$74,857	$74,857
Governor's Budget Request	($4,372)	$0	$0
May Revision Request	($5,880)	$0	$0
TOTAL	**$64,605**	**$74,857**	**$74,857**

*Dollars in thousands

STATE HOSPITALS
ENHANCED TREATMENT PROGRAM (ETP) STAFFING
Program Update

SUMMARY

As of the 2025-26 May Revision, the Department of State Hospitals (DSH) anticipates construction of the Enhanced Treatment Program (ETP) unit at DSH-Patton (Unit 06) to be completed in May 2025, with no change to its activation date of June 2025.

BACKGROUND

The ETP was developed to accept patients who are at the highest risk of violence and cannot be safely treated in a standard treatment environment. The Budget Act of 2018 authorized DSH to construct four ETP units; three 13-bed units at DSH-Atascadero and one 10-bed unit at DSH-Patton. ETP Unit 29 at DSH-Atascadero was activated in September 2021, while construction for Units 33 and 34 were postponed due to bed capacity pressures associated with Incompetent to Stand Trial (IST) referrals.

The Budget Act of 2024 reflected a one-time savings of $281,000 in FY 2023-24 due to continued challenges with the fire sprinkler redesign and regulatory approvals. Unit construction completion was anticipated in July 2024, with unit activation in September 2024.

In the 2025-26 Governor's Budget, DSH reported a one-time savings of $571,000 due to continued delays in construction.

JUSTIFICATION

On July 30, 2024, the State Fire Marshal approved the fire sprinkler system redesign for DSH-Patton Unit 06. Construction on the sprinkler system began shortly after in the ancillary corridor of the U building and the U5 building. DSH anticipates completion of DSH-Patton Unit 06 in May 2025, with no change to the activation date of June 2025.

Please see the table below for the completion timeline.

ETP Activation Timeline			
Units/Hospital	**Scheduled Initiation**	**Scheduled Completion**	**Delay from 2025-26 Governor's Budget**
DSH-Atascadero Unit 29	September 24, 2018 (Actual)	July 2021 (Actual)	N/A

DSH-Patton Unit U-06	December 2023	May 2025	1-month delay

Resource Table[1]

Description	**CY**	**BY**	**BY+**
Current Service Level	$16,144	$16,144	$16,144
Governor's Budget Request	($571)	$0	$0
May Revision Request	$0	$0	$0
TOTAL	**$15,573**	**$16,144**	**$16,144**

*Dollars in thousands

[1] In the Budget Act of 2021, DSH received $1,015,000 in FY 2022-23 and ongoing to account for underfunded phased-in positions. The Resource Table has been corrected to include this funding amount, which was previously erroneously excluded.

STATE HOSPITALS
PATIENT-DRIVEN OPERATING EXPENSES & EQUIPMENT
Program Update

SUMMARY

Due to changes in projected patient census, the Department of State Hospitals (DSH) reports an adjustment to the 2025-26 Governor's Budget of a reduction of $1.5 million in fiscal year (FY) 2024-25 and a request for an additional $290,000 in FY 2025-26 and ongoing for Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization as part of support for patient-driven operating expenses and equipment (OE&E).

BACKGROUND

DSH provides 24 hour, 7 days a week care and treatment to its patients. In order to ensure DSH received the appropriate amount of funding to care for its patients, and under the recommendation of the Legislative Analyst Office (LAO), the Budget Act of 2019 adopted a standardized methodology to provide funding for patient-related OE&E, based on an updated projected census for each fiscal year and a cost per patient derived from past year actual expenditures. As part of the approved methodology, DSH identified key components of care required to provide adequate care and treat DSH patients. Below is a table displaying those categories:

Budget Categories	Sub-Categories
Utilities	Electricity, Natural Gas, Water, and Sewer
Outside Hospitalization	Includes but is not limited to, Oncology, Dialysis, Surgery, Radiology, Hospice, and Geriatric Specialties
Clothing/Personal Supplies	Clothing, Hygiene products, Footwear
Recreation & Religion	Vocational Services Supplies, Religious materials
Foodstuffs	Food products (recognizing dietary restrictions/needs), Utensils, Kitchen Supplies
Quartering & Housekeeping	Towels, Bedding, Housekeeping Supplies
Laundry	Prison Industry Authority (PIA) contracted services, etc.
Miscellaneous Client Services	Patient Transportation (i.e. ambulance services), Indigent Aid, Discharge Gate Allowance, etc.
Chemicals, Drugs and Lab Supplies	Prosthetics, Eye Services, Dentures
Pharmaceuticals	Medications, Prescriptions
Educational Supplies	Academic and Vocational Education Program Materials and Supplies

Utilizing a per patient cost of $17,076 for Utilities, Foodstuffs, and Pharmaceuticals only, in the Budget Act of 2024, DSH received $9.2 million for FY 2023-24 and $10.2 million in FY 2024-25 and ongoing to support an increase in patient census and rising costs.

In the 2025-26 Governor's Budget, DSH requested $21.7 million in FY 2024-25 and ongoing due to increases in per patient costs for Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization only.

JUSTIFICATION

Following an abridged version of the methodology adopted in the Budget Act of 2019, the patient-driven OE&E costs are based on updated hospital census projections and per patient costs derived from FY 2023-24 actual expenditures for Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization only.

Per Patient Cost

Inflation[1] and rising costs in 2024 remain the driving factors to the reported increase in per patient cost for patient-driven OE&E. For Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization, per patient expenditures from FY 2022-23 to FY 2023-24 increased by $3,936.70 per patient, or 16%, to $29,039.70. The chart below displays the increase in cost per patient for these categories.

Figure 1: All State Hospitals

Budget Categories	2022-23 Avg. Cost Per Patient	2023-24 Avg. Cost Per Patient	Percentage Change
State Hospital Census	*5,689*	*5,550*	*-2%*
Utilities	$4,987	$5,132	3%
Outside Hospitalization	$8,027	$11,009	37%
Foodstuffs	$4,469	$4,705	5%
Pharmaceuticals	$7,620	$8,195	8%
Total	**$25,103**	**$29,040**	16%

As of the 2025-26 May Revision, the per patient cost remains unchanged.

[1] Please see Department of Finance Budget Letter (BL) 24-26, 2025-26 Price Letter, reflecting the impact of inflation on rising costs.

Allotment Adjustment for FY 2024-25

In the 2025-26 Governor's Budget, the projected patient census was 5,762 for FY 2024-25. As of the 2025-26 May Revision, the projected patient census is 5,711. This is a decrease of 51 patients. To calculate the additional funding need, the abridged methodology follows a two-step process:

- Step One: Since there is no change to per patient cost, there is no adjustment from step one.

- Step Two: The second step is calculating the funding adjustment resulting from the decrease in projected patient census. The per patient cost for Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization only ($29,039.70) is multiplied by the difference in patient census (-51), resulting in -$1,481,025.

The adjustment from the 2025-26 Governor's Budget for Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization in FY 2024-25 is determined by adding steps one and two above, resulting in -$1,481,025.

Allotment Adjustment for FY 2025-26

In the 2025-26 Governor's Budget, the projected patient census was 5,762 for FY 2025-26. As of the 2025-26 May Revision, the projected patient census is 5,772. This is an increase of 10 patients. To calculate the additional funding need, the abridged methodology follows a two-step process:

- Step One: Since there is no change to per patient cost, there is no adjustment from step one.

- Step Two: The second step is calculating the funding adjustment resulting from the increase in projected patient census. The per patient cost for Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization only ($29,039.70) is multiplied by the difference in patient census (10), resulting in $290,397.

The adjustment from the 2025-26 Governor's Budget for Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization in FY 2025-26 and ongoing is determined by adding steps one and two above, resulting in $290,397.

As of the 2025-26 May Revision, DSH requests a reduction of $1.5 million in FY 2024-25 from the 2025-26 Governor's Budget and an increase of $290,000 in FY 2025-26 and ongoing for Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization, due to changes in patient census projections.

DSH will continue to monitor costs and patient census and provide an update in the 2026-27 Governor's Budget.

Resource Table

Description	CY	BY	BY+
Current Service Level	$146,043	$146,043	$146,043
Governor's Budget Request	$21,679	$21,679	$21,679
May Revision Request	($1,481)	$290	$290
TOTAL	**$166,241**	**$168,012**	**$168,012**

*Dollars in thousands

STATE HOSPITALS
***COLEMAN* INCREASED REFERRALS**
New Item

SUMMARY

The Department of State Hospitals (DSH), in conjunction with the California Department of Corrections and Rehabilitation (CDCR), developed new methodologies to increase *Coleman* referrals from CDCR to DSH to increase DSH's *Coleman* census. As of the 2025-26 May Revision, DSH reports no change to its request from the 2025-26 Governor's Budget.

BACKGROUND

Pursuant to Penal Code (PC) 2684: Treatment of Prisoners, DSH *Coleman*[1] patients are CDCR incarcerated individuals who have transferred from CDCR to DSH for inpatient mental health care, with the expectation they will return to CDCR[2] when they have reached maximum benefit from treatment. The *Coleman* Program Guide, agreed to by the court, establishes criteria by which incarcerated individuals are referred to DSH, which includes complicated presentations, (such as complex medical diagnoses), cognitive issues, or developmental disabilities along with mental illness.

In compliance with *Coleman* court order, DSH has designated beds at three hospitals for individuals referred via PC 2684:

- DSH-Atascadero -256 *Coleman* beds
- DSH-Coalinga - 50 *Coleman* beds
- DSH-Patton - 30 *Coleman* beds (female institutions only)

Treatment focus for the *Coleman* population is psychiatric stabilization. In addition to psychiatric and medical services, psychosocial treatments are provided, with a focus on helping patients manage the symptoms of their mental illness and reintegrate back into a prison environment when discharged from the state hospital.

Prior to 2023, referrals to DSH only occurred if 1) the patient's custodial Least Restrictive Housing (LRH) designation, as determined by California Correctional Health Care Services (CCHCS) was unlocked dorms, and 2) if CDCR's Inpatient Referral Unit (IRU) clinically recommend unlocked dorms. Referrals with a different LRH and/or different IRU clinical recommendations would be referred to a CDCR psychiatric inpatient program. Due to the number of inmate-patients meeting these

[1] For more information on the *Coleman* patient population, please see Section F1.
[2] Pursuant to PC 2685

eligibility limitations, the *Coleman* census at DSH has remained lower than anticipated by the *Coleman* court since the COVID-19 pandemic.

California Welfare and Institutions Code (WIC) Section 7234 established the Patient Management Unit (PMU) as a centralized hub for processing referrals received by DSH, including those committed via PC 1370 (Incompetent to Stand Trial), PC 1026 (Not Guilty by Reason of Insanity), and PC 2684 (*Coleman)*. Referrals for both PC 1370 and *Coleman* patients have court mandated timelines for processing and admitting patients.

Prior to December 2020, PMU processed *Coleman* referrals utilizing 1.0 Associate Governmental Program Analyst (AGPA) and 1.0 Nurse Consultant. Due to the lack of a clinical review process, most Coleman referrals were admitted to DSH with mixed results. A significant number of the patients admitted were not clinically appropriate for a DSH hospital setting due to violent or disruptive behaviors not suitable for housing in DSH's unlocked dorm settings which put other patients and DSH team members at risk.

During the COVID-19 pandemic, the *Coleman* court and Special Master's Office increased oversight of CDCR's referrals to DSH, requiring DSH to dedicate clinical resources to liaise and manage a new, in-depth clinical referral review process. PMU hired 1.0 Senior Psychologist Specialist who provided in-depth reviews of every CDCR referral to help determine the patient's appropriateness for admission, key areas of concern that could impact treatment, and other salient clinical matters. In addition to providing initial reviews, the Senior Psychologist Specialist was also responsible for coordinating acute discharges from the state hospital, communication with multiple CDCR and DSH entities, and touring different hospitals with the Special Master expert team, as needed. The increase in clinical review led to fewer state hospital admissions when *Coleman* referrals were found not appropriate for admission.

On October 9, 2023, as part of discussions between CDCR, DSH, and the Special Master, a "trial process" was initiated that led to a significant increase in CDCR referrals and reviews. Previously, an endorsement to DSH required the patient to have a LRH of unlocked dorms and IRU clinical recommendation for unlocked dorm. The "trial process" eliminated the requirement for an IRU clinical recommendation and sent all referrals with a LRH of unlocked dorms to DSH, regardless of the clinical housing recommendation. This led to an increase in CDCR referrals from 26 per month to 51; an increase of 96%.

Prior to the "trial process" DSH received approximately 22.2% of all Intermediate Care Facility (ICF) referrals made by CDCR, but since the "trial process" implementation DSH has now received approximately 47.3% of all ICF referrals made by CDCR.

Beforehand, DSH reviewed less than a quarter of the ICF referrals and currently DSH reviews close to half of all ICF referrals, with a trend this will increase in the near term.

The "trial process" also implemented a procedure for DSH and CDCR to review CDCR patients who are housed in a CDCR inpatient psychiatric program and have not been referred to DSH. Under this process, the CDCR IRU in collaboration with DSH, every 30-45 days identifies and reviews a selection of patients who are being treated in CDCR's psychiatric inpatient programs and have the Least Restrictive Housing designation of Unlocked Dorms to determine if it may be clinically appropriate to step the individual down to an unlocked dorm setting based on the patient's current clinical presentation. This utilization review expands the number of patients that may be admitted to DSH and requires additional staff time to complete the reviews. Since implementation of this "trial process" DSH has reviewed approximately 442[3] patients not referred to DSH and housed within a CDCR inpatient psychiatric program.

In June 2024, in response to concerns from the court regarding the low census of the *Coleman* population within DSH, the DSH and CDCR collaborated to develop three proposals to increase potential utilization of *Coleman* beds:

Long-Term Intermediate Program

The Long-Term Intermediate Program was designed to house patients who have previously been referred to DSH, and who have demonstrated difficulty in reintegrating into CDCR's outpatient level of care due to the severity of their mental illness. This will result in longer lengths of stay than typical for *Coleman* patients. Given the nature of this program, a DSH Consulting Psychologist is required to perform a deeper clinical review to determine whether patients meet criteria and require continued care in such a program. In addition, the Consulting Psychologist will have to regularly coordinate with the treatment team, leadership, and, upon an eventual discharge, will also organize a case conference to ensure the patient is transferred back to CDCR without any significant issues.

Admissions Unit

Traditionally, *Coleman* patients had been admitted directly to their home unit without first being admitted to an Admissions Unit for patient stabilization. This proposal would admit sub-acute individuals referred from CDCR to an Admissions Unit first. Admission Units are single, unlocked rooms, which provide a higher level of support for individuals transitioning from the custodial environment at CDCR, to DSH's standard intermediate care facility (ICF) unlocked dorms. This change will increase both the number of admissions to DSH and the overall *Coleman* census, resulting in an increased workload for PMU.

[3] Data as of April 1, 2025

Review of Close Custody, Single Cell, and Life Without Parole (LWOP)

The final proposal addressed CDCR patient referrals with a Close Custody, Single Cell designation, or LWOP term. Historically, inmate-patients with these custody classifications have been ineligible for placement at DSH. However, it was proposed that DSH clinically review referrals with these custody classifications to make a clinical determination if the patient is clinically indicated for the state hospital setting. In the event the inmate-patient is recommended for admission, CDCR custody leadership will review and determine if the custody classifications can be removed or modified to allow for admission to the state hospital. Based on 2023 data provided by CDCR, this would increase the number of referrals reviewed by 27 per month.

In addition to DSH reviewing referrals for Close Custody, Single Cell and LWOP, to identify if they are clinically indicated for DSH's setting, DSH and CDCR IRU will also periodically review individuals who were not clinically indicated for treatment in an unlocked dorm at the time of initial referral and were ultimately admitted into a CDCR PIP. This utilization review creates additional review workload but will help identify individuals who after treatment at the CDCR PIP may have become clinically appropriate for step down to DSH unlocked dorms.

All three proposals went into effect September 16, 2024.

In the 2025-26 Governor's Budget, DSH requested 3.0 positions (authority only) in fiscal year (FY) 2025-26 and ongoing to address increased workload related to referral intake for Coleman patients.

JUSTIFICATION

Prior to December 2020, PMU was allocated 2.0 positions (1.0 AGPA and 1.0 Nurse Consultant) to review referrals from Coleman. However, since FY 2020-21, *Coleman* referrals received by DSH and *Coleman* admissions have steadily continued to increase, resulting in an increased workload for PMU.

In order to more accurately reflect the increased workload for PMU associated with *Coleman*, DSH has updated the table below to reflect all Coleman patient reviews. Please see the table below displaying the number of *Coleman* reviews by DSH and admissions by fiscal year from FY 2020-21 to projections for FY 2024-25:

Fiscal Year	*Coleman* Patients Reviewed	Monthly Average Reviews	Admissions to State Hospitals	Monthly Average (Admissions)
2020-2021	265	22	195	16
2021-2022	305	25	193	16
2022-2023	308	26	198	17

2023-2024	824	69	307	26
2024-2025 (Projected)	1056	88	415	35

Since FY 2022-23, reviews of CDCR patients by DSH have increased by 168% and admissions have increased by 55%. With the addition of the three DSH proposals (Long-Term Intermediate Program, Admissions Unit, and Review of Close Custody, Single Cell, and LWOP), there is a projected increase of 243% for referrals and 110% for admissions, when compared to FY 2022-23 (prior to the trial process implementation).

As a result of the trial process and three DSH proposals, the census of *Coleman* patients at DSH has increased by 88% from October 2023 (102) to March 2025 (194). It is anticipated the increase in the *Coleman* census will continue to where most of the available beds for the *Coleman* population will be fully utilized.

In addition, prior to October 2023, DSH only received less than a quarter of all ICF referrals made by CDCR, but now with the "trial process" implementation, DSH has received close to half of all of CDCR's ICF referrals made which makes for a 114% increase. This demonstrates DSH reviews a significant portion of the ICF referrals generated within CDCR that will increase in the near future. Additionally, DSH is currently developing a presentation and planned tours within CDCR to help CDCR institutions and treatment teams better understand the DSH setting and encourage more referrals to DSH.

Current population projections for CDCR suggest a population increase with the passage of Proposition 36[4]. When CDCR overall population increases, the CDCR mental health population increases, leading to an increase in ICF referrals.

Staffing Resources – 2.0 Associate Governmental Program Analysts

DSH reports no change to its request for 2.0 additional AGPAs in order to address the increased ongoing workload. Please see Attachment A for the Workload Analysis.

Staffing Resources – 1.0 Chief Psychologist

DSH reports no change to its request for 1.0 Chief Psychologist to provide oversight and supervision to PMU's clinical team. Please see Attachment B for the Workload Analysis.

As of the 2025-26 May Revision, DSH reports no change to its request for 3.0 positions (authority only) in FY 2025-26 and ongoing.

[4] California may take a big step backwards towards more incarceration with Proposition 36 | Prison Policy Initiative by Sarah Staudt, published October 17, 2024.

Resource Table

Description	CY	BY	BY+
Current Service Level	$1,020	$1,020	$1,020
Governor's Budget Request	$0	$0	$0
May Revision Request	$0	$0	$0
TOTAL	**$1,020**	**$1,020**	**$1,020**

*Dollars in thousands

Attachment A - Associate Governmental Program Analyst Workload Analysis

	PROJECTED ONGOING WORKLOAD	
ACTIVITY TASK	**Hours per Month**	**Number of Hours Annually**
Specific Task		
Works closely with assigned counties, programs, and facilities to ensure patients are assigned to the most appropriate facility within required timeframes that best suits their treatment needs.	60.0	720.0
Serves in a lead capacity, working independently, and closely with other Care Coordination Teams, to ensure PMU is in receipt of required patient documentation and identify any missing information prior to assigning placement of the patient to a facility.	15.0	180.0
Independently conducts research and performs outreach as necessary to external county partners to request any pertinent documentation or information related to patient treatment.	15.0	180.0
Verifies documents to validate any exclusionary criteria that would preclude a patient from placement at specific facilities within the DSH continuum of care.	5.0	60.0
Monitors patient placement to ensure admission occurs within timelines.	10.0	120.0
Submits patient documentation to appropriate facility once it is determined where the patient should receive treatment.	10.0	120.0
Manages, monitors, and analyzes waitlists for adherence to timelines and other legal and regulatory expectations.	10.0	120.0
Collaborates with county partners, DSH staff across facilities and programs, contractors, and external stakeholders.	15.0	180.0
Independently provides policy, technical support, and program guidance as directed by management.	15.0	180.0
Independently prepares oral or written recommendations on various issues to	15.0	180.0

management, stakeholders, as well as internal and external partners.		
Facilitates and coordinates stakeholder conferences and other meetings as needed to address any questions, concerns, or issues that arise.	15.0	180.0
Provides superior customer service and transparent communication with internal and external entities.	10.0	120.0
Identifies any barriers related to patient admission or treatment and works with assigned programs to develop solutions.	20.0	240.0
Responds to all inquiries in a timely manner and elevates any significant issues or barriers to leadership.	10.0	120.0
Develops PMU related policies and operating procedures, as well as relevant departmental Regulations, Memoranda of Understanding, and collaborates closely with affected divisions and units in DSH.	5.0	60.0
Facilitates and participates in meetings and workgroups related to DSH preadmission as requested; prepares recommendations to management.	5.0	60.0
Leads trainings and demonstrations as requested by management.	5.0	60.0
Independently prepares written, analytical, and/or visual interpretation and impact of legislative proposals, bill analyses, budget change proposals, and other special projects as required.	35.0	420.0
Independently develops and prepares internal reports and analyses as requested by management.	15.0	180.0
Serves as a lead regarding PMU practices and procedures to workgroups and innovation projects as assigned.	5.0	60.0
Provides coverage for patient referral processing and placement, including data entry, as assigned.	15.0	180.0
Participates in Division, Branch, and Unit training program including formal training, on the job training, mentoring, and coaching.	5.0	60.0

Participates in cross-training on other assignments and provides coverage as assigned.	2.0	24.0
Independently develops literacy with DSH datasets, specifically the application of data to court reporting, admissions and discharge data, and IST solutions programs outcomes.	5.0	180.0
TOTAL HOURS PROJECTED ANNUALLY	**322**	**3,984**
Total New AGPAs Needed		**2.2**

Attachment B - Chief Psychologist Workload Analysis

	PROJECTED ONGOING WORKLOAD	
ACTIVITY TASK	**Hours per Month**	**Number of Hours Annually**
Specific Task		
Provides mental health guidance, leadership, and consultation on all post-trial commitments being admitted, treated, and discharged to and from DSH state hospital or contracted agency	60.00	720.00
Communicate regularly with DSH executive leadership, hospital leadership, other agencies, the court, and as indicated interested parties (i.e. Special Master)	15.00	180.00
Subject matter expert on matters involving post-trial commitments, namely commitments consistent with PC 2684, PC 2685, PC 1026, WIC 7301, PC 2974, and LPS	15.00	180.00
Collaborate with DSH personnel to ensure timely access to care	5.00	60.00
Collaborate with DSH personnel on emergent cases (i.e. acute discharges) from the hospital	3.00	36.00
Maintain all policies, procedures, and court orders are being followed	7.00	84.00
Attend all court hearings, court ordered tours of the hospitals, and all other tours of the hospitals from other agencies	8.00	96.00
Develop and/or modify policies and procedures as needed	20.00	240.00
Provide training to DSH personnel on policies, procedures, and court orders	5.00	60.00
Manages a team of consulting psychologists and one supervising psychiatric social worker, along with providing guidance to analysts as indicated	35.00	420.00
Participates in case conferences, appeals, and utilization management meetings	8.00	96.00
TOTAL HOURS PROJECTED ANNUALLY	**181.00**	**2,172.00**
Total New Chief Psychologist Needed		**1.04**

STATE HOSPITALS
DSH-COALINGA TELEPSYCHOLOGY PILOT
New Item

SUMMARY

The Department of State Hospitals (DSH) requests to pilot telepsychology services at DSH-Coalinga, modeled off its successful telepsychiatry program, for three fiscal years starting fiscal year (FY) 2025-26. DSH proposes to redirect 4.0 existing, vacant Psychologist positions at DSH-Coalinga to provide telepsychology services for a three-year pilot program, and requests $286,000 in FY 2025-26 through FY 2027-28 for 2.0 limited-term (LT) coordinators to provide administrative and technical support onsite at the hospital to the telepsychologists. DSH also requests $188,000 in FY 2025-26 and $56,000 through FY 2027-28 for the associated information technology (IT) equipment required to support telepsychology services.

BACKGROUND

In recognition of the need to expand remote mental health services and treatment for DSH patients, the Budget Act of 2019 authorized DSH to expand telepsychiatry services by redirecting 18.0 existing, vacant Staff Psychiatrist positions as telepsychiatrists, and providing funding for coordinator positions and the equipment required to support telepsychiatry services. Although physically in another location, the remote telepsychiatrist maintains the same responsibilities as a psychiatrist that is physically located on the unit at the treating hospital.

Since its implementation, the telepsychiatry program has increased recruitment and retention of Staff Psychiatrists at DSH-Coalinga and DSH-Napa allowing for the provision of quality care. The use of remote psychiatry services at DSH has also increased access to treatment for DSH patients, especially at locations where it has been historically difficult to recruit psychiatrists, such as DSH-Coalinga.

Recruitment and retention have been historically challenging for DSH due to multiple compounding factors. DSH's patient population present some of the most difficult to treat behavioral challenges, including significant violence risk level. This, in addition to the geographic locations of DSH hospitals, and the national shortage in the healthcare workforce, result in higher vacancy rates for certain clinical classifications at DSH, such as Psychologists. One of the hospitals with the greatest impact in this area is DSH-Coalinga.

In order to overcome these challenges, DSH has taken a multi-faceted approach. DSH has expanded its outreach efforts and streamlined its hiring process, including

hosting an onsite career fair at DSH-Coalinga. DSH has also invested in expanding training programs, and providing flexible working conditions for DSH employees, such as alternate work schedules, and more recently, opportunities to work remotely on a limited basis. Remote mental health services and treatment, such as telepsychiatry and telepsychology, use electronic communications and information technologies to expand access to services for patients and increase recruitment and retention of mental health services providers.

JUSTIFICATION

DSH requests a three-year pilot, from FY 2025-26 through FY 2027-28, for telepsychology services at DSH-Coalinga, similar to the telepsychiatry program, to maintain and expand access to treatment for DSH patients, especially at locations where it has been historically difficult to recruit psychologists, such as DSH-Coalinga. Utilizing 4.0 existing, vacant Psychologist positions at DSH-Coalinga would increase recruitment and retention and expand access to psychology services for DSH patients.

Staffing Resources – Coordinators

In order to provide administrative and technical support for telepsychology services, DSH requests 2.0 LT Staff Services Analyst (SSA)/ Associate Governmental Program Analyst (AGPA) to serve as coordinators at a 1:2 ratio with telepsychologists. Coordinators will be onsite at the hospital and provide support to the telepsychologists by administrating daily telepsychology visits, scheduling appointments, setting up and troubleshooting equipment, maintaining, storing, and providing electronic records to the designated telepsychologist, maintaining communication with unit staff and shift leads, and ensuring sessions proceed smoothly.

DSH requests $286,000 in FY 2025-26 through FY 2027-28 for 2.0 LT SSA/AGPA positions in order to provide administrative support for telepsychology services.

Information Technology Equipment

Telepsychology services are provided through a video conferencing system which allows the psychologist to see their patient remotely. To utilize and effectively operate a video conferencing system, DSH requires additional hardware and software, including centralized meeting scheduling, initiation and management features for the program, managed telecommunications room kit packages including 65" screens, video and sound bar hardware with anti-ligature enclosures and all necessary cabling and power configurations planned, permitted and installed for the patient service side locations. The remote

psychologists will be outfitted with enabling technology including dual monitors with conferencing features, wireless headsets, laptops and docking stations to enable remote interactions scheduled and managed by the centralized meeting management platform. This approach will allow the program to effectively remotely support the meeting instances at scale as required by the program, while integrating into standard DSH technology tools and avoid duplicative software licensing costs.

DSH requests $188,000 in FY 2025-26 and $56,000 through FY 2027-28 for the IT equipment required to support telepsychology services.

Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$0	$0	$0
Governor's Budget Request	$0	$0	$0
May Revision Request	$0	$474	$342
TOTAL	**$0**	**$474**	**$342**

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

Program Update

SUMMARY

As of the 2025-26 May Revision, DSH anticipates an updated total contracted caseload of 923 CONREP clients in fiscal year (FY) 2024-25 and 921 in FY 2025-26. DSH reports an additional one-time savings of $3.3 million in FY 2024-25 as a result of a reduced census and program closures, for a total one-time savings in FY 2024-25 of $6.9 million.

BACKGROUND

CONREP is DSH's statewide system of community-based services for specified court-ordered forensic individuals. CONREP aims to promote greater public protection in California's communities via an effective and standardized community outpatient treatment system. The CONREP Non-SVP population includes individuals deemed Not Guilty by Reason of Insanity (NGI), Offender with a Mental Health Disorder (OMD), and Incompetent to Stand Trial (IST)[1] for those who have been court-approved for outpatient placement in lieu of state hospital placement. Individuals suitable[2] for CONREP may be recommended to the courts by the state hospital Medical Director.

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

- Life skills training
- Residential placement
- Collateral contacts (e.g., other individuals/agencies)
- Home visits
- Substance abuse screenings
- Psychiatric services
- Case management
- Court reports
- Psychological assessments

[1] The Budget Act of 2022 amended PC Section 1370 to statutorily prioritize community outpatient treatment effective July 1, 2023, increasing consideration for placement of IST patients in community IST facilities.

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

When a DSH patient is discharged to CONREP, the goal is to provide an independent living environment in the least restrictive setting. Historically, CONREP's model of care is a centralized outpatient clinic where most treatment services are delivered. In this treatment model, clients must seek transportation or walk to access these services, requiring them to live close to the outpatient clinic or along a major bus route to access timely treatment regularly. As it is impractical to place individuals in areas which require a client to navigate multiple bus routes or obtain a costly taxi ride, the current type of service model limits the inventory of housing secured for the placement of CONREP clients. In order to address these service model limitations, CONREP has expanded its continuum of care to include Step-Down Transitional Programs and Forensic Assertive Community Treatment (FACT) Programs. Both programs allow for care in an enhanced supportive setting with services delivered on-site where the CONREP clients reside.

Step-Down Transitional Program

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

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

CFRP is a 24/7 mobile treatment team providing onsite individual and group treatment to clients at their residence. In addition to providing treatment, the CFRP's mobility allows them to respond quickly to provide de-escalation and crisis intervention practices, reducing the likelihood of rehospitalization. DSH contracts with providers for up to 90 dedicated beds, including staff resources, across three regions of the state: Northern California, Bay Area, and Southern California.

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

Independent Placement Panel (IPP) & Placement Presumption

The Budget Act of 2022 included resources to pilot a new Independent Placement-Determination Panel (IPP), which sought to increase participation in CONREP by patients found NGI or OMD, thereby increasing state hospital bed capacity for those on the IST waitlist.

In November 2022, DSH initiated a stakeholder workgroup to develop the IPP, consisting of several county CONREP Community Program Directors (CPDs), DSH CONREP clinical staff, and state hospital discharge-planning teams. This group was tasked with establishing an implementation plan, with specific focus on determining assessment and referral protocols, justice partner engagement, CONREP program training, technical assistance, and streamlining of the referral process and patient records database.

The IPP policies and procedures manual was completed and finalized in June 2023 and implementation of the IPP began on July 1, 2023. Following completion of the IPP, the Budget Act of 2022 amended PC Section 1370 to statutorily prioritize community outpatient treatment effective July 1, 2023[3], increasing consideration for placement of IST patients in Diversion, CBR, or other community IST facilities.

Budget Act of 2024

In the Budget Act of 2024, DSH reported a one-time savings of $3.2 million in FY 2023-24 due to delays in admissions at the Northern CA STRP facility and ongoing challenges with hiring clinical staff for programs.

In the 2025-26 Governor's Budget, DSH reported one-time savings of $3.6 million in 2024-25 as a result of reduced census: $450,000 for Northern CA IMD facility, $832,000 for Northern CA STRP facility, and $2.3 million for FACT regional program.

JUSTIFICATION

As of the 2025-26 May Revision, DSH anticipates a total contracted caseload of 923 CONREP clients in FY 2024-25 and 921 in FY 2025-26. This contracted caseload includes 692 regular CONREP clients in FY 2024-25 and 666 in FY 2025-26 who are currently placed in settings which do not offer dedicated beds to the program. In addition, CONREP's contracted caseload includes the following current and planned specialized beds dedicated to the program:

- 55 STRP beds in FY 2023-24, 35 STRP beds in FY 2024-25 and ongoing

[3] Unless a court, based on the recommendation of the Community Program Director or designee, finds the clinical needs or community safety risk warrants placement in a more secure setting, such as a state hospital or JBCT program.

    - 35-bed activated Southern CA STRP
    - 20-bed activated Northern CA STRP, closed in December 2024.
- 90 FACT beds in FY 2024-25, 90 FACT beds in FY 2025-26
    - 30 activated beds in Northern CA Region - (Sacramento County), anticipated to close June 30, 2025
    - 30 activated beds in Southern CA Region - (San Diego County)
    - 30 beds anticipated to activate in Northern CA Region - (Solano County) in May 2025
    - 30 beds anticipated to activate in Central CA Region - (TBD) in January 2026
- 106 Institute for Mental Disorder (IMD) beds in FY 2024-25 and ongoing
    - 76-bed activated Southern CA IMD
    - 30-bed activated Northern CA IMD
- 24 Mental Health Rehabilitation Center (MHRC) beds in FY 2025-26 and ongoing[4]
    - 24 beds anticipated to activate in a Northern CA MHRC in July 2025

This contracted caseload reflects the total number of clients and beds available by the end of FY 2024-25 and FY 2025-26, which may vary based on activation timelines. Reflecting the projected client phase-in, DSH estimates an average census of 690 in FY 2024-25 and 743[4] in FY 2025-26.

CONREP community program providers have continued to experience challenges in hiring and retention for clinical and administrative staff. This barrier is consistent across all programs and impacts census and contract costs.

30-Bed Northern CA IMD Facility (Canyon Manor)

In the 2025-26 Governor's Budget, DSH reported a one-time savings of $450,000 in FY 2024-25 resulting from unfilled beds. As of March 2025, 19 of the 30 contracted beds are currently filled and an additional 7 referrals are being reviewed. Recruitment of clinical staff needed to maintain appropriate staffing ratios continues to be a challenge. DSH is working with the provider to determine the appropriate bed capacity moving forward given the recruitment and retention difficulties. As of the 2025-26 May Revision, DSH reports an additional one-time savings of $591,000 in FY 2024-25 due to unfilled beds.

20-Bed Northern CA STRP Facility (A&A Health Services)

[4] Northern CA MHRC program previously reported as 60-beds in 2025-26 Governor's Budget. DSH has reassessed bed capacity needs and is moving forward with a proposed bed capacity of 24 beds. The estimated average census has been adjusted to reflect the projected caseload from this capacity adjustment.

The 20-bed Northern CA STRP facility officially closed in December 2024 as a result of the provider's difficulty maintaining adequate staffing as well as concerns around the development and refinement of the program. DSH is currently exploring alternate program opportunities for expansion and is in negotiations for the development of new CFRPs statewide. In an effort to support these alternate programs, DSH proposes to redirect the savings from the 20-bed facility closure in FY 2025-26 and ongoing to support pursuit of another facility. In the 2025-26 May Revision, DSH reports an additional one-time savings of $2.7 million in FY 2024-25.

CONREP FACT Regional Program (CFRP)

DSH continues to fine-tune its programming options within the CONREP continuum of care, including working with providers in support of the CFRP. DSH is currently in the process of engaging a new contract provider to operate a 30-bed CFRP in Northern California. The new provider is currently undergoing implementation activities, recruitment efforts, and housing procurement. These activities are planned to occur between March and May 2025, with initial client placements beginning in May 2025. Additionally, negotiations for a 30-bed CFRP in Central CA are currently underway, with program activation tentatively planned for January 2026.

Over the last year, DSH has experienced concerns related to the viability and success of the CFRP-Sacramento program, specifically around the program development and the provider's ability to meet DSH's clinical requirements. DSH clinical and operational staff evaluated the program's operations, providing close on-site supervision, outcomes monitoring, training, and technical assistance. After reviewing outcomes from these efforts, DSH has decided to discontinue the CFRP-Sacramento program, effective July 2025. DSH will instead refocus on the successful CFRP-San Diego program, as well as the activation of the new Northern CA and Central CA programs through contract with a new provider. Of the total 60 CFRP beds currently operating as of March 2025, CFRP-San Diego's census is at 27 and CFRP-Sacramento's is at 21.

In the 2025-26 May Revision, no further savings are being reported. DSH proposes to re-utilize the reported savings from the Northern CA STRP Facility closure to support the increased program costs and new program activations, beginning in FY 2025-26 and ongoing. DSH will continue to monitor program activations and provide an update in the 2026-27 Governor's Budget.

Independent Placement Panel (IPP)

The IPP policies and procedures manual was completed and finalized in June 2023 and implementation of the IPP began on July 1, 2023. In the 2025-26 Governor's Budget, it was reported that the pilot expanded to include two additional CONREP

programs on November 1, 2024. On January 1, 2025, the IPP expanded to include an additional CONREP program. These expansions provide coverage to nine CONREP programs statewide and five additional counties, resulting in 42 counties participating in the IPP efforts. As of March 2025, IPP has received a total of 110 referrals, 96 of which had completed evaluations submitted to the courts. Approximately 81% of conventional evaluations resulted in a recommendation from IPP for community outpatient treatment or stepdown into a lower setting within CONREP. Additionally, IPP has a 98% agreement rate with the Courts statewide for these discharge recommendations.

Future Fiscal Impact of Healthcare Minimum Wage Implementation

DSH is monitoring the implementation of Senate Bill (SB) 525 (Durazo, Chapter 890, Statutes of 2023)[5], which incrementally increases the minimum wage for healthcare workers in certain healthcare settings. DSH's contracted providers have raised to DSH that the healthcare minimum wage will impact their cost of operating the CONREP programs and continuum of care. While DSH is not requesting resources in the 2025-26 May Revision, the potential increased program costs resulting from SB 525 are being tracked as a potential future fiscal pressure. DSH continues to monitor impacts to contract costs and will provide updates in the future.

Future Fiscal Impact of Increasing Provider Costs

In recent years, DSH has monitored increasing cost pressures for CONREP providers statewide. The shortage of licensed clinical staff, competitive job market, and increasing cost of living expense has significantly increased contracted personnel cost. Additionally, projected program operating costs supporting client care, including housing and medical services, have also risen beyond what was projected and based on historical contracts. DSH is completing a cost analysis for current programs to identify fiscal needs to maintain the required client caseload. While resources are not being requested in the 2025-26 May Revision, the increased program costs are being tracked as a future fiscal pressure and DSH will provide an update in the 2026-27 Governor's Budget.

[5] SB 525 (Durazo, Chapter 890, Statutes of 2023)

Resource Table[1]

Description	CY	BY	BY+
Current Service Level	$48,508	$48,508	$48,508
Governor's Budget Request[2]	($3,558)	$0	$0
May Revision Request	($3,335)	$0	$0
TOTAL	**$41,615**	**$48,508**	**$48,508**

[1]Dollars in thousands

[2] The savings amounts for the programs above are rounded to the tenth, resulting in slight differences in the amounts presented in the resource table.

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

SUMMARY

As of the 2025-26 May Revision, the Department of State Hospitals (DSH) projects a caseload of 31 persons designated as a Sexually Violent Predator (SVP) to be conditionally released into the community as of June 30, 2026.

BACKGROUND

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

When an SVP client is conditionally released into the community by court order, existing law requires they be released to their county of domicile, and that sufficient funding be available to provide treatment and supervision services. Clients in CONREP SVP are provided the same array of mental health services as general non-SVP program clients. Additional required services for SVP clients in CONREP include regularly scheduled sex offender risk assessments, objective measures of sexual interests, polygraph testing, a Community Safety Team (CST), and Global Positioning System (GPS) data and surveillance.

DSH has experienced significant community opposition in securing housing for SVP clients to be released into CONREP. Since the SVP law was enacted, the average timeframe is slightly less than 12 months from approved petition to placement in the community. However, in recent years, this average time to placement has been increasing.

Effective January 1, 2023, implementation of SB 1034[1] required DSH to convene a committee of specified county representatives to obtain assistance and consultation regarding securing suitable housing for each client approved for conditional release. These new requirements resulted in the creation of county-specific Housing Committee Meetings (HCMs), which are open to the public pursuant to the Bagley-Keene Open Meeting Act. Each committee remains in effect from the date of the initial order approving placement into CONREP, to the date of actual transition from the state hospital to the community CONREP program. This change resulted in an increased number of court hearings, task and criteria tracking, reporting

[1] SB 1034 (Atkins, Chapter 880, Statutes of 2022)

requirements, housing status reports to the court, and inter-agency coordination across multiple counties throughout the state.

Additionally, 6608.5 (f) dictates placement shall not occur "within one-quarter mile of *any public or private school providing instruction in kindergarten or any of grades 1 to 12*". In January 2023, the Court of Appeals found that the definition of a "private school" is inclusive of homeschools, regardless of when the home school is established. As a result, every homeschool within the state creates a new area where an individual designated as an SVP cannot be housed. Furthermore, this finding applies to any homeschools identified following property vetting and submission to the court, potentially rendering the property as ineligible for community placement.

As a result of these new requirements, the current average wait time for individuals who are approved for CONREP, but pending a court-approved placement location, is 22 months. As these new processes evolve, DSH will continue to monitor for potential impacts to the average placement waiting period, including those resulting from implementation of the HCMs.

In the 2024 Budget Act, DSH assumed conditional release of a total caseload of 31 persons designated as Sexually Violent Predators (SVPs) into the community by June 30, 2025. The 2024 Budget Act reflected no position authority or funding changes for the CONREP SVP program. In the 2025-26 Governor's Budget, DSH reported no adjustment to the total caseload.

JUSTIFICATION

As of the 2025-26 May Revision, 23 court-ordered clients are participating in CONREP SVP, however, a small number of these individuals have been re-hospitalized and are pending potential re-release to the community in the current year. Additionally, 21 individuals with court-approved petitions are awaiting placement into the community and 11 more have filed petitions and are proceeding through the court process. With the dynamic nature of court processes and timelines, challenges surrounding housing availability, as well as other factors, DSH projects a caseload of 31 clients conditionally released in CONREP by the end of fiscal year (FY) 2025-26. Please refer to the table below which displays the total projected caseload for FY 2024-25 and FY 2025-26.

CONREP-SVP Projected Caseload for 2025-26 May Revision[2]		
Description	Projected Caseload as of FY 2024-25	Projected Caseload as of FY 2025-26
Individuals currently in CONREP	23	27
Adjusted Caseload	8	4
Total	**31**	**31**

DSH calculates the estimated projected caseload by reviewing the current status of the clients in the community, those with a court-approved petition to CONREP awaiting placement, and those who have filed a petition for CONREP awaiting trial on the petition. Consideration is given to various factors such as revocations, unconditional release from CONREP, and upcoming delays to court proceedings and/or community placement progress.

The SVP program provider has realized increased costs related to the HCMs requirements and standard operating practices. Significant areas of increase are in enhanced monitoring services, additional personnel for the housing search process due to the increase in approved petitions and the obstacles in securing suitable housing, and increases in the general operating costs related to salary and benefits, liability and malpractice insurance, and other standard operating expenses. While DSH is not requesting resources in the 2025-26 May Revision, the projected impact is being tracked as a future fiscal issue. An update will be provided in the 2026-27 Governor's Budget.

Resource Table

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

*Dollars in thousands

[2] Table includes point-in-time caseload data.

CONTRACTED PATIENT SERVICES
INCOMPETENT TO STAND TRIAL SOLUTIONS
Program Update

SUMMARY

The Department of State Hospitals (DSH) continues its efforts that support timely access to treatment for individuals who are found Incompetent to Stand Trial (IST) on a felony charge. As of the 2025-26 May Revision, DSH reports a one-time savings within the Early Access and Stabilization Services (EASS) program of $10.2 million in FY 2024-25 and $27.0 million beginning in FY 2025-26 and ongoing due to changes of program implementation. Additionally, for the 2025-26 May Revision, DSH reports the following savings within the Jail Based Competency Treatment (JBCT) program: $628,000 in FY 2024-25, $10.8 million FY 2025-26, $12 million in FY 2026-27, and $24 million in FY 2027-28 and ongoing. The savings are due to discontinued program expansions, delayed new program activations, and canceled new program activations. Total savings for all IST related initiatives across Governor's Budget and May Revision is $248.4 million in FY 2024-25, $119.9 million in FY 2025-26, $117.9 million in FY 2026-27, and $50.3 million FY 2027-28 and ongoing.

IST WAITLIST

Background

For over a decade, the State of California observed significant growth in the number of individuals found IST on a felony charge and referred to DSH for competency restoration, with referrals outpacing the department's ability to create sufficient additional capacity. Prior efforts including increased inpatient bed capacity, systems efficiencies resulting in decreased average length of stays (ALOS), and implementation of community-based treatment programs, were insufficient to respond to the growing demand, resulting in a waitlist and extended wait times for IST defendants pending placement into a DSH treatment program. The COVID-19 pandemic and the adopted infection control measures required at DSH facilities contributed to significantly slower admissions and a reduction in the capacity to treat felony ISTs at DSH for the duration of the state of emergency, causing the IST waitlist and corresponding wait times to grow substantially.

In 2021, the Alameda Superior Court ruled in *Stiavetti v Clendenin*[1] that DSH must commence substantive treatment services to restore IST defendants to competency

[1]In 2015, the American Civil Liberties Union filed a lawsuit against DSH (*Stiavetti v. Clendenin*), alleging the time IST defendants were waiting for admission into a DSH treatment program violated the IST defendant's constitutional right to due process.

within 28 days from the transfer of responsibility to DSH[2]. The court provided a specified timeline to meet that standard over three years, setting February 27, 2024, as the target date for fully implementing the requirement. On October 6, 2023, the Alameda Superior Court modified the interim benchmarks and final deadline for compliance with the 28 days as follows:

- March 1, 2024 – provide substantive treatment services within 60 days
- July 1, 2024 – within 45 days
- November 1, 2024 – within 33 days
- March 1, 2025 – within 28 days

The Budget Act of 2022 (and subsequent adjustments authorized in the Budget Act of 2023) appropriated funding to implement many of the IST Solutions identified by the statewide IST Solutions Workgroup[3]. These included providing early stabilization to increase diversion opportunities and care coordination, expanding community-based treatment and diversion options for felony ISTs, improving IST discharge planning and coordination, implementing a pilot for Independent Placement Panels (IPP), and improving alienist training. These resources were combined with previously funded IST programs, including IST Re-evaluation services, JBCT, and Community Inpatient Facilities (CIF), to expand the DSH continuum of care for IST individuals. Additionally, statutory changes aimed at solving the IST demand for services have been implemented to streamline and improve IST processes, target growth in IST determinations (felony IST growth cap), and establish a comprehensive set of strategies and solutions, to ensure felony IST individuals have timely access to appropriate treatment and services. Collectively, these strategies and solutions assist the state in meeting the court-ordered treatment timelines outlined in *Stiavetti v. Clendenin* and expand community-based treatment and diversion options for felony ISTs that will help end the cycle of criminalization by connecting patients to comprehensive behavioral health treatment.

Prior to the COVID-19 declared State of Emergency, in February 2020, DSH had 850 individuals pending placement into a DSH IST treatment program. Throughout the pandemic, DSH observed seasonal fluctuations in the waitlist, with increases in winter and summer, and decreases in the spring and fall, as DSH recovered from COVID-19 surges. In January 2022, resulting from a COVID-19 surge, the IST waitlist reached a high of 1,953. In the 2024-25 May Revision, DSH reported the waitlist had declined to

[2]Date of service of the commitment packet to DSH for felony IST patients.
[3]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. Following a series of stakeholder meetings between August 2021 and November 2021, the Workgroup identified over 40 strategies and solutions to advance alternatives to placement in DSH competency restoration programs for those deemed felony IST.

397, inclusive of individuals receiving EEASS, which represented a reduction of 21% from the total waitlist of 501 reflected in the 2024-25 Governor's Budget.

Justification

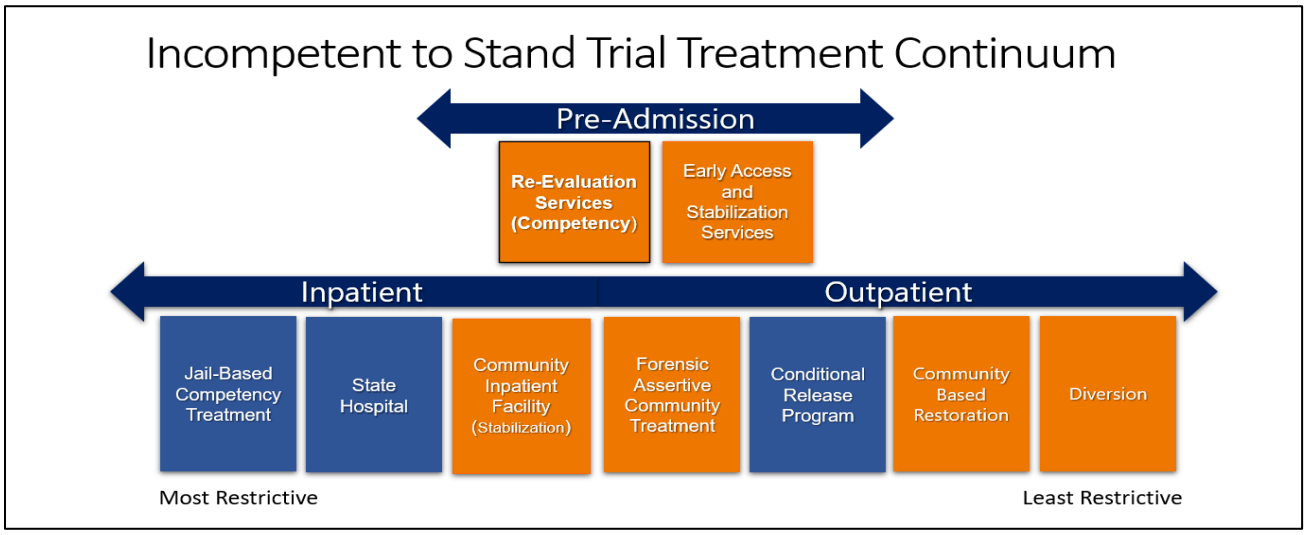
In the 2025-26 Governor's Budget, DSH reported the IST waitlist had declined to 359[4] due to the implementation and expansion of existing IST programs. As of the 2025-26 May Revision, there are 278[5] individuals on the waitlist. This change represents a reduction of 23% from the total waitlist reported in the 2025-26 Governor's Budget. Furthermore, of the 278 individuals on the waitlist pending admission to a treatment bed, 121 are receiving substantive treatment services through EASS or other treatment programs. There are 133 individuals on the waitlist who have not yet began receiving treatment services from a DSH program, of these individuals pending access to substantive services, 26 are out of custody and are in the community. Due to recent changes in PC 1370, if an individual is out of custody for 90 days from the date of commitment, DSH provides notification to the sheriff and presiding judge in the county that the individual will be removed if they are not made available for transport to DSH within another 90 days. As such, DSH will remove individuals from the waitlist six months after the date of commitment if they are out of custody and have not transported to DSH for admission. While significant progress has been made on reducing the number of individuals on the waitlist, DSH does not project any further significant downward trend. In FY 2024-25, DSH has received an average of 469 referrals per month. The current waitlist reflects real-time monthly referrals, as the number of patients pending admission to a treatment bed is significantly fewer than the number of referrals received per month.

Based on the modified timelines set by Alameda Superior Court in *Stiavetti v Clendenin,* DSH was required to provide substantive treatment services to IST patients within 28 days as of March 1, 2025. DSH filed a report to the court on March 28, 2025, which showed that DSH has provided access to substantive treatment services to 100% of IST defendants, who did not have extenuating circumstances outside of DSH's control, within 28 days since November 2024.

IST TREATMENT CONTINUUM

The following chart depicts the comprehensive continuum of IST services DSH has established and is continuing to build with the 2022 and 2023 Budget Act investments. Blue boxes indicate DSH legacy programs which have been part of DSH's continuum for a decade or more, while orange boxes represent newer service options which began implementation in recent years.

[4]Data as of January 1, 2025
[5] Data as of May 7, 2025



Historically, restoration treatment options for individuals deemed IST on felony charges were provided in state hospitals, and over the last decade, in JBCT programs. Beginning in 2018, DSH expanded its continuum to include the pilot Diversion program and partnered with Los Angeles (LA) County to establish the first felony IST Community Based Restoration (CBR) program. In 2021 and 2022, additional investments were made to expand the continuum of IST services with the implementation of pre-admission programs including IST re-evaluation services, early access and stabilization, and the establishment of additional levels of care and treatment settings to broaden the placement options available for all IST individuals. The information below describes the relevant programs within the IST treatment continuum addressed by this estimate.

COMMUNITY INPATIENT FACILITIES (CIF)

Background

Originally introduced under the title "Institute for Mental Disease (IMD) and Sub-Acute Bed Capacity program", the CIF program authorized DSH to contract with counties or private providers to develop new, or renovate existing, CIFs to provide alternative treatment options to state hospitals, including IMDs, Mental Health Rehabilitation Centers (MHRC), Skilled Nursing Facilities (SNF), and other types of facilities appropriate for felony IST patients. With the objective of supporting county-operated, community-based IST treatment programs where higher levels of care and/or security may be needed, individuals transitioning from jail are able to stabilize prior to stepping up, or down, into a treatment setting with different restrictions.

DSH activated its first 78-bed facility in Sacramento County in April 2022 at the Sacramento Behavioral Health Hospital (SBHH). As an acute psychiatric hospital, SBHH facilitates psychiatric stabilization of felony IST patients, primarily through

administering medications to support restoration of competency, or via pathways to participation in Diversion or other outpatient treatment programs. In the 2024-25 May Revision, DSH reported executing a new construction contract with Crestwood Behavioral Health, Inc. for the development of a 40-bed MHRC in Fresno County.

Justification

DSH continues to partner with five different CIF programs for a total of 197 beds throughout California, including:

- SBHH in Sacramento County
- Bakersfield Behavioral Healthcare Hospital (BBHH) in Kern County
- Anaheim Community Hospital (ACH) in Orange County
- Priorities, Inc. in Sutter County
- Sylmar Health and Rehabilitation Center, Inc. in LA County.

SBHH, BBHH, and ACH are acute inpatient psychiatric facilities while Priorities, Inc. and the Sylmar Health and Rehabilitation Center are intermediate care programs that provide full competency restoration services for IST patients.

The following table reflects DSH's activated CIF programs and total beds available in each program:

Activated Community Inpatient Facilities			
Facility Name	**Activation Date**	**Total Beds**	**Average Daily Census for FY 2024-25***
Sylmar	10/30/2023	24	22
BBHH	7/3/2023	29	27
ACH	7/3/2023	50	47
Priorities, Inc.	7/3/2023	16	15
SBHH	4/20/2022	78	70

*As of April 11, 2025

To further expand upon the above efforts, DSH has executed a construction contract with Crestwood Behavioral Health, Inc. to remodel an existing building for the development of a 40-bed licensed MHRC located in Fresno County. Construction for this project began in August 2024, with anticipated completion in June 2025, followed by program activation in Summer/Fall 2025.

DSH also executed a construction contract with NewGen Health, LLC for the development of a new building in San Bernardino County to establish a 198-bed licensed MHRC to serve IST patients. The Shandin Hills MHRC will be used to facilitate

stabilization, through the administration of medications and treatment, to support a pathway to participation in a mental health Diversion or other outpatient treatment program. This facility will also be utilized to serve those who cannot be diverted, by providing competency treatment services to continue legal proceedings. Construction is anticipated for completion in Summer 2026, with program activation in Fall 2026.

IST RE-EVALUATION SERVICES

Background

The IST Re-Evaluation Services Program was authorized in the Budget Act of 2021 as a 4-year limited-term solution to address the growing IST waitlist. Under this program, DSH psychologists re-evaluate individuals deemed IST pending transfer to a DSH treatment program. By performing these re-evaluations, DSH reduces the IST waitlist by identifying individuals who have already been restored to competency while receiving treatment in jail, or by identifying individuals who may be candidates for Diversion or other outpatient treatment programs. The re-evaluations also identify individuals who may be candidates for involuntary medication orders (IMOs), those who may warrant an acuity review, and those who may be unlikely to restore.

Since its inception, the IST Re-Evaluation Program has successfully implemented re-evaluation services in all eligible jails[6]. In addition to the re-evaluations, this team provides competency evaluations for newly emerging community IST treatment programs which currently do not or will not have forensic evaluator capacity available. DSH plans to deploy forensic evaluation resources flexibly and strategically to areas of IST forensic evaluation need as they become evident. In the 2024-25 May Revision, DSH reported a total of 6,250 evaluations completed since program inception, with 1,943 individuals found competent, returned to court, and removed from the IST waitlist due to Re-Evaluation Services. In the 2025-26 Governor's Budget, DSH reported a total of 7,999 completed evaluations.

In the 2025-26 Governor's Budget, DSH proposed to redirect savings from IST Solutions to support 22 positions (authority only) in FY 2025-26 and ongoing to support a modified version of the Re-Evaluation Services for Felony IST Program focused on community IST treatment programs on an ongoing basis.

Justification

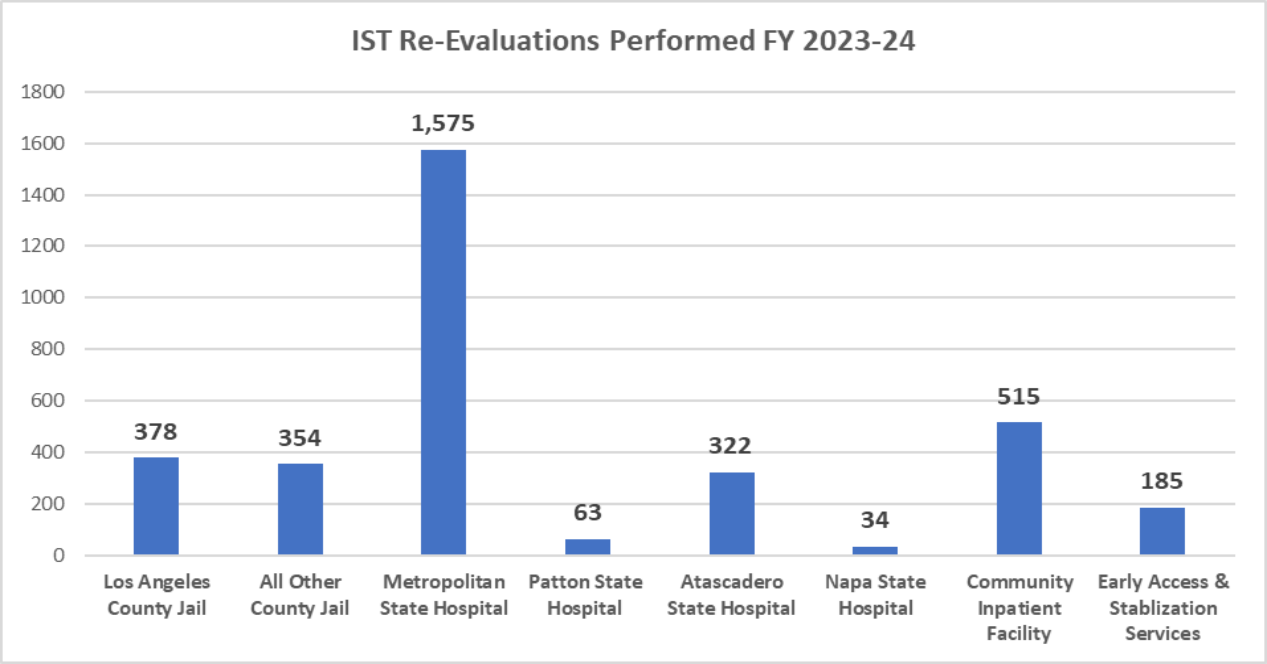
As of the 2025-26 May Revision, there is no change in the request to redirect savings from IST Solutions to support ongoing resources for the Re-Evaluation Services for Felony IST Program. DSH has completed a total of 9,163 evaluations, of which:

[6] Two counties (Alpine and Sierra) do not house IST patients.

- 6,105 (66.6%) were found not competent and continued competency restoration treatment
- 2,964(32.4%) were found restored to competency
- 94 (1.0%) were found unlikely to be restored to competency

For individuals found competent following re-evaluation services, DSH has submitted reports to the court regarding restored competency status, allowing those individuals to continue their court proceedings and be removed from the waitlist. Through earlier identification of individuals who are competent, court proceedings can resume, significantly reducing wait times for individuals still requiring treatment. Re-Evaluation reports also allow the courts to consider different treatment options. In FY 2023-24, approximately 15% of participants were identified as needing IMOs, and of those screened for Diversion, approximately 82% were referred.

With progress in meeting the *Stiavetti* treatment timelines and the expansion of EASS in county jails and community-based programs, the demand for in-jail re-evaluation has slowed. DSH has leveraged these IST Re-Evaluation resources to meet increasing demand for IST evaluations in an array of DSH programs. This utilization accelerates admissions and discharges, which reduces wait times and increases access to care. For example, of the 3,426 evaluations performed in FY 2023-24, 1,994 (58%), were performed at the hospitals. Due to significantly reduced wait times and other constraints, a substantial number of these evaluations were performed upon an individual's arrival to the treatment facility, rather than in-jail. The chart below shows the distribution of Re-Evaluation services across the state hospitals and community-based programs for FY 2023-24.



As DSH continues to deploy these forensic evaluation resources flexibly and strategically to meet IST forensic evaluation needs across its system, DSH proposes to extend and adapt the Re-Evaluation Services Pilot program, which is due to sunset on June 30, 2025.

DSH had an average daily census of 2,916 IST designated patients during FY 2023-24, with less than a 1% growth from 2,898 patients in July 2023, to 2,907 in June 2024. In addition, as compared to the prior fiscal year, the average daily census increased overall by 10% in FY 2023-24.

The Re-Evaluation Program also provides support to forensic evaluation services within the DSH-operated inpatient and outpatient CBR programs. Due to a shortage of forensic evaluators in the community, DSH was compelled to augment these programs in order to meet statutory and clinical requirements and maximize utilization of these beds. DSH expects the need for this augmentation to increase in the coming years due to planned expansions in these programs.

IST SOLUTIONS

The Budget Acts of 2022 and 2023 appropriated funding to implement many of the IST Solutions identified by the statewide IST Solutions Workgroup[7] which adjoined or enhanced existing DSH treatment options for those found to be Felony IST. These included providing early stabilization services, increasing diversion opportunities by expanding community-based treatment and diversion options for felony ISTs, improving patient care coordination, improving IST discharge planning and coordination with local counties, and improving alienist training.

Early Access and Stabilization Services (EASS)

Background

The EASS program was established in FY 2022-23 as part of IST Solutions to provide treatment and stabilization to individuals deemed IST on felony charges in jail, pending placement into a bed in the IST treatment continuum. EASS seeks to increase community-based treatment placements by facilitating IST patients' stabilization and medication compliance, increasing eligibility for placement into a Diversion or other outpatient treatment programs. In the 2024-25 May Revision, DSH

[7] 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. Following a series of stakeholder meetings between August 2021 and November 2021, the Workgroup identified over 40 strategies and solutions to advance alternatives to placement in DSH competency restoration programs for those deemed felony IST.

number of operating EASS programs to 49. In the 2025-26 Governor's Budget, DSH reported activation of an additional five county programs, bringing the total amount of EASS programs to 55.

Justification

As of April 8, 2025, DSH reports activation of a new county program, bringing the total number of EASS programs to 56. The following reflects updates as a result of EASS implementation:

- Total patients served: 6,874
- Total patients unenrolled[8]: 6,753
- Total restored while in EASS: 702 (10.4% of those who received services)

DSH continues to pursue standalone EASS county models for those counties preferring to use their county behavioral staff or currently contracted providers; however, operational costs for standalone EASS county models are higher than EASS programs operated by DSH's contracted clinical providers that deliver services across multiple counties. Standalone EASS county programs do not utilize DSH's current EASS contracted providers as was originally intended in a regional model, resulting in higher costs. As of the 2025-26 May Revision, DSH is in final contract and budget negotiations with one county to develop a standalone EASS program and estimates the program will activate in spring 2025. In the 2022 Governor's Budget, DSH received funding to establish EASS programs including a program in Los Angeles County. Due to the jail's inability to accommodate the program, DSH is not moving forward with this project at this time, resulting in savings of $10.2 million in FY 2024-25 and $27.0 million beginning in FY 2025-26 and ongoing.

Community-Based Restoration (CBR) and Felony Mental Health Diversion (Diversion)

Background

The Budget Act of 2022 provided one-time infrastructure funding in FY 2022-23 and FY 2023-24 to develop residential housing settings to support felony IST individuals participating in either CBR or Diversion programs. Expansions of the CBR and Diversion programs aim to provide care in the most appropriate community-based setting as an alternative to placement in a DSH inpatient bed, using an estimation that 60-70% of annual IST commitments would be eligible for services in a community-

[8] Unenrolled refers to patients no longer receiving EASS services due to competency reached or admission to another DSH program to continue IST treatment services. Patients who are not restored while receiving treatment in EASS maintain their place on the waitlist and are admitted to a DSH facility in accordance with their commitment date.

based program. In 2022-23, DSH began to develop community-based capacity for a total of approximately 3,000 annual felony IST admissions, expanding the number of available patient beds through a CBR or Diversion program over a four-year period[9].

In the 2024-25 May Revision, DSH reported four counties' proposals had been approved, and contract negotiations were underway to develop up to 350 beds to house felony IST defendants participating in Diversion or CBR programs. Additionally, 29 counties had expressed interest in submitting applications in the future. In the 2025-26 Governor's Budget, DSH reported nine counties' proposals had been approved for Diversion and CBR, providing 932 beds, and were in various stages of finalization.

In the 2025-26 Governor's Budget DSH requested 1.0 Research Data Specialists I (RDS I) position (authority only) in FY 2025-26 and ongoing to support the Diversion program. The RDS I will oversee data management, ensure data quality, develop analytic tools, and provide modeling and automation support across DSH's data infrastructure.

CBR and Diversion[10] Program Implementation

CBR and Diversion programs are community-based IST treatment options provided in the least restrictive, typically residential, settings. Access to locked acute and sub-acute settings may also be offered in response to the acuity needs of the individuals. Both programs offer intensive mental health treatment services with wraparound supports and housing.

The primary goal of CBR is restoration of competency and to that end, competency education is offered in addition to traditional mental health treatment and support. DSH can contract directly with counties or private providers to establish CBR programs statewide. The first CBR program for felony ISTs was implemented in 2018-19 in partnership with the LA County Office of Diversion and Re-entry.

The DSH Diversion program was designed to target a portion of the IST population most likely to succeed in an outpatient setting when provided the appropriate treatment, support, and housing. Established as a pilot in the Budget Act of 2018, and in partnership with 29 counties, the Diversion program serves individuals with serious mental illness (SMI) diagnosed with schizophrenia, schizoaffective disorder, or bipolar

[9] Dependent upon securing available housing.
[10] Permanent Diversion program updates will be included in this proposal as part of IST Solutions, while data gathered and analyzed from the pilot will continue to be reported under the Diversion pilot narrative (Section D4) until its conclusion in FY 2024-25, as DSH works to transition counties already participating in the Diversion pilot into new agreements following completion of their pilot program contracts.

disorder with the potential to be found IST or determined IST on felony charges. Individuals who successfully complete the Diversion program may have their charges dropped upon completion. The Budget Act of 2022 allocated ongoing funding to establish Diversion as a permanent program and has been modified to serve only those who are determined to be IST across an expanded list of qualifying diagnoses.

In the 2024-25 May Revision, DSH reported a Diversion Quarterly County meeting was held on November 9, 2023. During this webinar, counties were provided with fiscal details and were informed of new Diversion and CBR statutory and program requirements and recommendations. As of April 2025, 17counties have submitted Letters of Intent (LOI) to execute contracts with DSH in FY 2024-25 to establish permanent programs to serve up to 1,187 IST patients per year. DSH has received LOIs for an additional five counties to execute contracts in FY 2025-26 serving up to 238 patients per year.

County Stakeholder Workgroup Grants to Support IST Community Programs

In support of expanding IST community programming, DSH was allocated resources to aid behavioral health and criminal justice workgroups across the state, tasked with developing community interventions to reduce the overall number of residents with SMI who enter the criminal justice system, many of whom may be found IST on felony charges, with a focus on improving outcomes of those with a SMI who have fallen into cycles of incarceration and homelessness. Information about this opportunity was originally released to the counties on December 5, 2022, and in the 2023-24 May Revision, DSH reported 32 counties had submitted LOIs to contract with DSH for these annual resources.

As of the 2024-25 May Revision, all 32 counties had executed contracts with DSH.

Justification

Infrastructure Funding to Expand Residential Housing for the IST Population

DSH was allocated one-time infrastructure funding to expand the number of beds available to patients receiving services through a CBR or Diversion program, supporting the creation of statewide residential beds to house IST patients. In June 2023, DSH executed a contract with the Advocates for Human Potential (AHP) public consulting firm, and in March 2023, an application portal opened for counties to submit their requests for proposals for funding to develop residential housing. To accompany the portal, AHP developed a website which included responses to frequently asked questions, as well as contact information for further assistance.

In October 2022, January 2023, and June 2023, DSH and AHP hosted webinars to inform county stakeholders applications would be accepted on a rolling basis through June 30, 2024. The deadline for submitting applications was ultimately extended to December 31, 2024. AHP implemented a robust communication plan to reach all counties, respond to questions, remind counties of the funding opportunity, and encourage counties to apply. In March 2024, AHP began hosting bi-monthly "Office Hours" to provide technical assistance to counties and answer questions about housing opportunities.

Counties accepting funding from AHP for this project are required to contract with DSH for a Diversion and/or CBR program. Many counties have expressed concerns and informed DSH of barriers to applying, such as county staffing shortages, size, and rural location of the county, in addition to competing housing options, difficulty in locating housing sites, and challenges in securing a provider. Smaller and more rural counties have been encouraged to partner with neighboring counties to submit a joint application.

As of the 2025-26 May Revision, 15 applications have been submitted to AHP for Diversion and CBR infrastructure funding, providing 1,674 beds, and are in various stages of finalization. DSH will re-examine the remaining funds and propose a solution to gain additional county participation.

Los Angeles County CBR and Diversion Program

DSH and the Los Angeles County Office of Diversion and Re-entry (ODR) executed a contract in Summer 2023 to significantly expand the county's CBR and Diversion program. The new agreement with LA County expands the program from 515 beds previously designated for its CBR, up to a total of 1,274 beds, phased in over a five-year period. In the 2024-25 May Revision, DSH reported that ODR was contracted to activate a total of 1,344 beds by FY 2026-27. In the 2025-26 Governor's Budget, DSH reported that this total included bed capacity located through the CIF program and overstated the number of beds DSH is directly funding ODR to activate. This technical error impacts reported bed capacity only and not funding for the ODR programs. The following table displays the corrected total bed capacity from FY 2024-25 through FY 2026-27:

Fiscal Year	Original Bed Count	Corrected Bed Count
2024-25	1,025	1,005
2025-26	1,239	1,169
2026-27	1,344	1,274

ODR will establish beds at various locations throughout the county across a continuum of settings, including a locked acute psychiatric hospital, a locked IMD or MHRC, and residential facilities with onsite clinical and supportive services. At full activation of all beds, the program will admit up to 840 new (unique) felony IST patients per year in addition to patients residing in beds who may have been admitted in the prior year. The following table shows LA County CBR and Diversion program census from October 2022 and admissions from November 1, 2022, through March 31, 2025, to reflect the total patients served.

LA County Program	10/31/22 Census	Admissions (11/1/22 – 3/31/2025	Total Patients Served	3/31/2025 Census
CBR	450	1,048	1498	571
Diversion	159	405	564	118
Diversion (Non-DSH)[5]	0	104	104	79

As of the 2025-26 May Revision, 1,498 IST patients have been served in the CBR program and 668 in Diversion in LA County. In addition, 155 new beds for IST patients are scheduled to be activated in FY 2024-25 and 164 in 2025-26 bringing the total beds available in LA County to 1,169 by the end of the budget year.

Other Permanent Diversion and CBR Program Implementation

Beyond LA County, DSH assumed a number of counties would secure permanent ongoing contracts beginning in 2022-23 with a phase in of beds and services over a four-year period. As of the 2025-26 May Revise, many of the original 29 counties piloting DSH Diversion programs are still active and are either in the process of transitioning or planning to transition to permanent programs. As part of this planning process, DSH partnered with Capstone Solutions Consulting Group to advise DSH on the development of the permanent statewide program structure and assist DSH with better understanding the position of counties in the development of these programs. Capstone is also serving as a liaison between DSH, and counties interested in participating in the permanent program.

On November 9, 2023, DSH informed stakeholders of the permanent program requirements at a Diversion Quarterly County meeting. Counties were provided with fiscal details during this webinar, including information about funding for wraparound treatment services, county overhead costs, risk assessments, court liaison positions,

[5] Participants who are not committed to DSH but are eligible to participate in the DSH-funded diversion program. The court determined it is not in the interest of justice to restore them to competency and found them eligible for diversion pursuant to SB 1323, Menjivar, Statutes of 2024. These diversion participants are eligible to be funded by DSH Diversion program per statute.

justice partners, and other funding. Counties were also informed of new Diversion and CBR statutory and program requirements and recommendations, and the process and timelines for reporting data to DSH.

A variety of resources were shared with counties during the webinar, including information about the use of CIFs for ISTs, the DSH IST Re-Evaluation Team which may re-evaluate ISTs in CBR programs, the AHP grant opportunity and the application process for the permanent infrastructure funding which had a deadline of December 31, 2024. Counties were also informed of the Psychopharmacology Resource Network, and the DSH Diversion and CBR team of psychologists and program staff assigned to each county upon submission of an LOI and execution of a contract with the Department.

DSH is in the final negotiation process to execute permanent Diversion and/or CBR contracts in FY 2024-25 for 17 counties with a combined maximum admission of 1,187 clients per year. As of April 2025, ten counties have executed contracts with DSH for a permanent Diversion program:

- Kern
- Nevada
- Placer
- Sacramento
- San Bernardino
- San Joaquin
- San Mateo
- Sonoma
- Tuolumne
- Yolo

Information was re-released to counties by DSH on July 17, 2024, to provide additional opportunities for counties to submit a LOI for the permanent Diversion and CBR programs by September 20, 2024, to enter into a contract in FY 2025-26. Six counties submitted an LOI for FY 2025-26 and one county for 2026-27 with a combined maximum admission of 254 clients per year. Capstone Solutions and DSH continue to engage in technical assistance discussions and encourage counties that have not already applied to do so. Counties have an additional opportunity to submit an LOI for FY 2026-27 by June 30, 2025.

Update to Welfare and Institutions Code (WIC) 4361, DSH Diversion Program, via Senate Bill (SB)1323

Recently enacted legislation, SB 1323 effective January 1, 2025, modernizes the IST process by providing judges the authority to determine if restoration of competency is in the interest of justice and if not, to provide longer-term more comprehensive treatment options with an emphasis on mental health diversion.

When a court finds restoration is not in the interest of justice, the court must conduct an eligibility hearing within 30 days for placement into a diversion program. If the

individual is not eligible and granted diversion, the court may consider referral to the Public Guardian for conservatorship investigation, Assisted Outpatient Treatment (AOT), Community Assistance Recovery and Empowerment (CARE) Court, or to reinstate competency proceedings.

These changes may reduce the rate of felony IST referrals to DSH by diverting individuals to diversion or other community-based treatment options before an IST commitment is ultimately ordered and referred to DSH. Currently, the DSH Diversion Program authorized in WIC 4361 provides funding to counties to support diversion programs for those found IST on a felony charge *and* committed to DSH for restoration of competency. SB 1323 updates WIC 4361 by removing the requirement for a felony IST individual to be committed to DSH for restoration of competency, thereby allowing counties to fund diversion placements earlier in the process in accordance with the court's interest of justice ruling and order to diversion. To conform with the statutory changes to WIC 4361, DSH is in the process of updating program policies and presented a statewide webinar in February 2025 outlining those changes. DSH will monitor implementation of the changes outlined in SB 1323 and any impacts to DSH programs and IST referral rates and will provide an update in future caseload estimates.

Future Fiscal Issue: Permanent Diversion and CBR Program Implementation

DSH's original request for funding for the permanent Diversion and CBR programs in the Budget Act of 2022 did not include an annual growth factor to account for potential cost increases due to inflation, cost of living adjustments, and other cost pressures. Subsequently, funding for county programs can only be allocated at the FY 2022-23 level for multi-year service agreements. DSH will re-examine ongoing funding levels for the permanent Diversion and CBR programs to determine if they are sufficient to appropriately fund services and will consider a request for increased funding.

County Stakeholder Workgroup Grants

In December 2022, DSH released information to counties about supporting behavioral health and criminal justice workgroups by offering annual resources. As of September 2024, 39 counties have executed contracts with DSH:

- Amador
- Butte
- Contra Costa
- Del Norte
- Fresno
- Mariposa
- Mendocino
- Merced
- Modoc
- Mono
- San Bernardino
- San Diego
- San Joaquin
- San Luis Obispo
- San Mateo
- Solano
- Sonoma
- Stanislaus
- Sutter
- Tulare

- Humboldt
- Kern
- Kings
- Madera
- Marin
- Monterey
- Nevada
- Placer
- Riverside
- Sacramento
- Santa Barbara
- Santa Clara
- Santa Cruz
- Shasta
- Siskiyou
- Tuolumne
- Ventura
- Yolo
- Yuba

Information was re-released to counties by DSH on August 29, 2024, to provide another opportunity for counties to apply for funding. The deadline for counties to submit an LOI to enter into a contract effective January 1, 2025, was September 30, 2024. To enter into a contract effective July 1, 2025, counties must have submitted an LOI by December 31, 2024, however, DSH did not receive additional LOIs by the September and December 2024 deadlines.

Alienist Training

Background

Through a partnership formed with the Judicial Council in 2022, DSH has sought to develop statewide court-appointed IST evaluator training and workforce development programs, with the objective of improving the quality of IST evaluations performed by court-appointed evaluators. These forensic evaluations determine defendant competency status and serve as the basis for IST commitment to DSH.

In the 2024-25 May Revision, DSH reported the Judicial Council, in partnership with the Groundswell Group, developed statewide court-appointed IST evaluator training and workforce development programs, with the objective of improving the quality of IST evaluations performed by court-appointed evaluators. The first training was held in November 2023, with an advanced training held at the Forensic Mental Health Association of California in March 2024. The Groundswell Group also conducts quarterly meetings to facilitate communication between DSH and the courts.

Justification

As of the 2025-26 May Revision, the Judicial Council is developing a three-year extension of their existing interagency agreement to solidify training gains through continued in-person and hybrid trainings and development of web-based on-demand educational resources. This extension will be at a zero cost for DSH as the Judicial Council seeks to reappropriate unspent interagency agreement funds, including those from the current year. For additional information on future trainings and efforts, please refer to the Judicial Council.

Care Coordination and Waitlist Management (CCWM)

Background

The Patient Management Unit (PMU) centralized patient pre-admission processes in June 2017 to ensure the placement of patients in the most appropriate setting based on clinical and safety needs. Prior to this, courts could order commitments to any DSH hospital, creating admission backlogs and inefficiencies.

The Budget Act of 2022 implemented a vertical case management model for IST patient placement, using small teams comprised of clinical and analytical staff dedicated to specific counties, with the goal of building relationships with county stakeholders and using a patient-centered approach to place patients in the most appropriate level of care based on bed availability. Under this new model, PMU clinical staff complete patient intake upon receipt of commitment. Along with clinical and medical intakes[11], placement decisions are based on patient eligibility, charging, medical exclusions, and each individual's position on the waitlist, in addition to availability of DSH placement options in the hospitals and outpatient programs (i.e., EASS, Diversion, and CBR).

Justification

Care Coordination has been implemented to serve all 58 counties. In addition to implementing a patient-centered approach to patient placement, for counties with an active EASS program, PMU clinicians are actively liaising with EASS care providers to provide active case management. PMU convenes a bi-weekly workgroup with stakeholders in LA County to address specific county challenges. The LA Care Coordination team has centralized not only pre-admission processing, but transportation scheduling to better troubleshoot issues with county partners. This approach has significantly reduced missed admissions from LA County, lowering wait times and decreasing the number of individuals pending placement specifically from LA County.

Starting in 2025, PMU will begin piloting the processing of referrals for IST patients treated within Diversion or CBR needing to step-up for stabilization to CIFs and then back down to the community. DSH will continue to monitor the Care Coordination program activity and the pilot's impact on existing resources and provide an update in the 2026-27 Governor's Budget.

[11] Penal Code (PC) 1370 requires the courts and county sheriffs to remit health record information, commitment orders, and other relevant documents as specified for each IST committed to DSH to the PMU to facilitate admission.

Proposition 36 and IST Referrals

In November 2024, voters passed Proposition 36 that provides for specified drug and retail crimes, that previously were charged as misdemeanors, to be charged as treatment-mandated felonies or receive increased sentences. This increases the range of crimes that can be charged as felony and for which someone may be found incompetent to stand trial and referred to DSH programs for treatment. To the extent that Prop 36 increases the number of individuals arrested and charged with felony offenses, the number of individuals found incompetent to stand trial will likely increase. However, the number of individuals referred to DSH for treatment may be offset by the application of SB 1323, which is intended to divert eligible individuals into community-based treatment when appropriate rather than referring to DSH. DSH will monitor the trends and provide an update on the referral trends in the 2026-27 Governor's Budget.

Discharge Planning and County Care Coordination

Background

DSH undertakes comprehensive discharge planning to support continued patient success when releasing patients from a DSH facility, be it into the community with or without supervision, via transfer to other DSH facilities, or return to court, prison, or jail. Discharge efforts are myriad, including developing treatment goals and objectives with interdisciplinary treatment teams and patients, coordinating community resources (including family and social supports), and partnering with local stakeholders and agencies for further treatment options. Local treatment stakeholders coordinate with DSH to obtain IST patient information in preparation for return to their county, such as[12]:

- CONREP
- County Behavioral Health
- County jails
- Other inpatient or subacute facilities
- Board and Care facilities
- Office of the Public Guardian
- Private conservators
- California Department of Corrections and Rehabilitation (CDCR)

[12] Individuals may also be diverted from jail because of dropped or reduced charges and provided supervised release back to the community.

To establish a standardized packet of discharge documents and facilitate a warm handoff of IST patients to their transition location from a state hospital, DSH held a workgroup session in August 2022, with representatives from the County Behavioral Health Directors Association of California (CBHDA) and California State Association of Counties (CSAC). Taking feedback from the workgroup, DSH embarked in efforts to standardize discharge summaries and other documents necessary for continuity of care.

DSH also created a comprehensive four volume training series to enhance the CONREP Discharge Referral process. Discharge and Community Integration (DCI) Specialists provide discipline-specific discharge referral process trainings across all hospitals and serve as points of contact for questions and problem-solving for identified barriers to the successful implementation of the standardized CONREP referral process.

Justification

As of the 2025-26 May Revision, DSH continues to enhance the discharge process as patients transition from a state hospital to a community-based setting. Based on the feedback from CBHDA and CSAC, these efforts include standardizing electronic forms and uniform formats to facilitate and improve information exchange between DSH, County Behavioral Health, and county jails. In addition, DSH created a comprehensive four volume training series to enhance the CONREP Discharge Referral process. Discharge and Community Integration (DCI) Specialists provide discipline-specific discharge referral process trainings across all hospitals and serve as points of contact for questions and problem-solving for identified barriers to the successful implementation of the standardized CONREP referral process.

Felony IST Referral Growth Cap

Background

To address the growing IST waitlist, the Budget Act of 2022 enacted WIC section 4336 establishing a growth cap on the number of annual felony IST determinations per county and requiring a redirection of county funds to be assessed if annual caps are exceeded. Following discussions with a coalition of county associations representing key IST stakeholders, DSH made updates to the methodology and rate for the growth cap and implemented a dispute process for potential data discrepancies. DSH also released reconciled FY 2022-23 IST Growth Cap data to counties to review, compare to their FY 2021-22 baseline count of IST determinations, and submit any disputes to DSH. After the resolution/dispute process, DSH sent final invoices to counties in June 2024. In the Budget Act of 2024, DSH received position authority only for 2.0 RDS I's to

support the data collection, tracking and reporting needs for the Felony IST Growth Cap program. As of the 2025-26 Governor's Budget, 11 counties were invoiced for 2022-23 IST determinations exceeding their Growth Cap and remitted their payments in full. Additionally, seven county expenditure plans detailing the projected use of the Growth Cap funds were received.

Justification

Growth Cap expenditure plans are required from all counties assessed penalty fees prior to DSH disbursement of the funds back to the counties to be utilized on efforts aimed at reducing the number of new IST determinations in future years. Of the 7 plans received, DSH has processed payment of the funds back to 6 of the counties and is working with the remaining county to obtain clarity on the plan so that payment may be processed. Additionally, DSH is actively engaging counties who have not yet submitted their required expenditure plan to offer support and technical assistance in the preparation of their plan.

On October 31, 2024, the reconciled IST determination data for FY 2023-24 was released to all counties. The release of that information opened the dispute window for counties to submit potential corrections to DSH for consideration before the FY 2023-24 IST determination data is compared to their baseline IST cap and assessment of potential penalty fees. As of the 2025-26 May Revision four counties opted to participate in the dispute process for DSH consideration of adjusting final IST determination counts. DSH is currently reviewing the submissions and must respond by the end of April 2025. Final invoices to counties subject to Growth Cap fees are anticipated for release by the end of May 2025.

JAIL-BASED COMPETENCY TREATMENT (JBCT)

Background

DSH contracts with California county sheriffs' departments to provide restoration of competency treatment services to lower acuity patients committed as IST while they are housed in county jail facilities using one of the following four JBCT program models:

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

Providing lower acuity patients with restoration of competency services, generally within 90 days, JBCT programs provide local treatment to individuals deemed IST. IST patients unable to quickly restore to trial competency can be subsequently referred to a state hospital for longer-term IST treatment. As of the 2024-25 May Revision, DSH reported the operation of 424 JBCT beds across 24 counties, with plans for further expansions.

In the 2025-26 Governor's Budget, DSH reported the operation of 433 JBCT beds across 24 counties and reported anticipating one new county to activate and one existing county to expand in FY 2024-25, two new counties to activate and two existing counties to expand in FY 2025-26, and the remaining three new counties to activate in FY 2026-27.

Justification

DSH continues its efforts to expand the JBCT program and reports the operation of 433 JBCT beds across 24 counties. In the 2025-26 May Revision, DSH reflects the following savings in addition to savings reported in the 2025-26 Governor's Budget: $628,000 one-time in FY 2024-25; $2.5 million one-time and $8.3 million ongoing beginning FY 2025-26; $12 million ongoing beginning FY 2026-27; and $24 million ongoing beginning FY 2027-28. Savings are associated with existing program expansions for three counties (San Diego, Santa Barbara, and Tulare) that are no longer occurring due to capacity constraints within the jails; delayed new program activation for one county from December 2024 to Spring 2025; and new program activations no longer occurring for five counties that were originally planned for activation in FY 2025-26 and 2026-27.

IST GENERAL FUND SOLUTIONS SAVINGS

In addition to the savings being reported as a caseload adjustment at May Revision, DSH proposes further general fund solutions savings that can be reduced from the Department's IST Solutions budget: $4.5 million in FY 2024-25; $173.5 million in FY 2025-26; $251.1 million in 2026-27; and $169.6 million ongoing beginning in FY 2027-28. DSH also proposes to revert $232.5M from FY 2022-23, which had encumbrance availability until FY 2026-27. The additional savings resets the ongoing baseline budget for IST solutions to reflect current programs and obligations needed to support DSH's efforts to continue to provide substantive services to IST individuals within 28 days and to support continued community-based restoration and diversion. The additional savings achieved reflects adjustments to the programs summarized below:

levels. With the elimination of the backlog of patients pending placement and IST referral levels stabilizing, savings is realized due to reduced demand.

Community-Based Restoration (CBR) and Felony Mental Health Diversion (Diversion): Beginning in fiscal year 2022-23, DSH received funding to support the implementation of Diversion and CBR programs across all 58 counties. As of May 1, 2025, thirty counties have not contracted with DSH, nor are in current contract negotiation, to offer DSH-funded Diversion or CBR programs in their county. Additionally, the funding for this program assumed 60-70% of all IST referrals would be served in these programs and recognized that counties would need to ramp up programs over time to achieve maximum census levels. Specific to Los Angeles (LA) County, DSH assumed a phased in program with full activation by FY 2026-27 serving 70% of IST individuals referred to the program. As of the third year of the contract, LA county program enrollments are trending lower than anticipated and DSH proposes to maintain its contract with the county at current year funding levels. The adjusted baseline funding will continue to support the remaining counties who currently have or are in the process of contracting with DSH to operate a Diversion or CBR program.

County Stakeholder Workgroup Grants: In support of expanding IST community programming, DSH was allocated resources to aid behavioral health and criminal justice workgroups across. The funding supports $100,000 per county in annual ongoing resources. To date, 39 counties have contracted with DSH for these resources beginning in FY 2022-23 and 2023-24. DSH will maintain the existing county contracts but will not offer further opportunities for additional counties to participate in this grant program.

Alienist Training:
In support of providing training and technical assistance to court appointed evaluators to improve the quality of the alienist reports the court uses to inform its determination on whether a defendant is incompetent to stand trial, DSH was authorized funding FYs 2022-23, 2023-24 and 2024-25 to partner with Judicial Council to develop training for the court appointed evaluators. The Judicial Council contracted with an expert to develop and deliver the training; however all funds have not been utilized to date and will be returned to the General Fund.

IST Infrastructure Grant Program:
DSH was authorized funding in FY 2022-23 and FY 2023-24 to provide infrastructure grants to counties to develop up to 5,000 community beds to support IST individuals in community-based restoration or diversion. After multiple years of funding opportunities, there continues to be unused funding in this program and will be returned to the General Fund.

Resource Table[13]

Description	FY 2024-25	FY 2025-26	FY 2026-27	FY 2027-28 and Ongoing
Current Service Level Total	**$771,377**	**$933,295**	**$1,061,768**	**$932,295**
Community Inpatient Facilities	$145,526	$145,526	$274,999	$145,526
2025-26 Governor's Budget	($52,104)	$9,738	($39,936)	$59,537
2025-26 May Revision	$0	$0	$0	$0
Re-Evaluation	$10,176	$1,000	$1,000	$1,000
2025-26 Governor's Budget	($12,391)	$8,928	$10,800	$10,900
2025-26 May Revision	$0	$0	$0	$0
IST Solutions [14],[15]	$499,780	$659,774	$658,774	$658,774
2025-26 Governor's Budget	($131,361)	($62,798)	($49,238)	($69,238)
2025-26 May Revision	($10,238)	($27,000)	($27,000)	($27,000)
2025-26 May Revision GF Solutions[16]	($4,513)	($173,498)	($251,145)	($169,568)
JBCT	$115,895	$126,995	$126,995	$126,995
2025-26 Governor's Budget	($41,661)	($37,935)	($551)	($551)
2025-26 May Revision	($628)	($10,816)	($12,029)	($23,968)
TOTAL	**$518,481**	**$639,914**	**$692,669**	**$712,407**

[13] Dollars in thousands.
[14] Includes BCP redirections to CONREP SVP and Data Compliance in 2024-25 and ongoing. IST Re-Evaluation (In FY 2025-26, 2026-27, 2027-28 and ongoing) and Coleman in 2025-26 and ongoing.
[15] IST Solutions includes funding for Early Access and Stabilization Services (EASS), Care Coordination and Waitlist Management (CCWM), Community-Based Restoration (CBR) and Diversion, Alienist Training, Increased Conditional Release Program (CONREP) Placements, and Discharge Planning/County Care Coordination.
[16] May Revision GF Solutions also includes the reversion of $232.5 million in IST Infrastructure Grant funding from FY 2022-23 and $4.6 million related to Alienist Training from FY 2023-24 that is not displayed in Resource Table.

Attachment A

Early Access and Stabilization Services (EASS) Updates	
County	**Activation Date**
Santa Clara	03/19/25
Trinity	10/08/24
Orange	08/28/24
Mendocino	08/08/24
Kern	08/06/24
Contra Costa	08/05/24
Alameda	08/01/24
Placer	03/11/24
Marin	02/01/24
Siskiyou	12/13/23
Alpine	12/06/23
San Mateo	10/23/23
Yolo	10/18/23
Tehama	10/18/23
San Joaquin	10/16/23
Butte	09/27/23
Inyo	09/15/23
Sacramento	09/01/23
San Luis Obispo	08/23/23
San Diego	08/16/23
Modoc	06/01/23
Mono	04/19/23
Tulare	04/17/23
Colusa	04/12/23

Mariposa	04/01/23
Glenn	03/29/23
El Dorado	02/21/23
Solano	02/01/23
Plumas	01/12/23
Amador	12/19/22
Tuolumne	12/14/22
Lake	12/07/22
San Benito	12/07/22
Riverside	12/05/22
Sutter	12/01/22
Napa	11/16/22
Santa Cruz	11/09/22
Imperial	10/26/22
Del Norte	10/19/22
Humboldt	10/19/22
Lassen	10/17/22
Sonoma	10/17/22
Madera	10/06/22
San Bernadino	09/26/22
Merced	09/19/22
Santa Barbara	09/16/22
Shasta	09/12/22
Nevada	08/31/22
Sierra	08/31/22
Stanislaus	08/29/22

Yuba	08/29/22
Calaveras	08/25/22
Fresno	08/22/22
Ventura	08/03/22
Monterey	07/25/22
Kings	07/18/22

STATE HOSPITALS
WORKFORCE DEVELOPMENT
Informational Only

SUMMARY

As of the 2025-26 May Revision, the Department of State Hospitals (DSH) continues to implement various efforts to address workforce challenges and strategies funded in the Budget Act of 2023, to expand and develop psychiatric fellowship and residency rotations.

BACKGROUND

Historically, recruitment and retention have posed a challenge for DSH. This was further exacerbated by the COVID-19 pandemic, which resulted in nationwide shortages for the healthcare workforce. Additionally, multiple factors present unique challenges for DSH recruitment and retention. Individuals served by DSH have some of the most complex and difficult to treat behavioral health conditions, many with a significant violence risk level. This, coupled with the remote geographic locations of DSH facilities, makes recruitment and retention more challenging. As a result, DSH worked to implement a multi-faceted approach to recruit and retain healthcare workforce staff.

Psychiatric Technician (PT) Programs

The Budget Act of 2019 included ongoing resources to work in conjunction with the Mission-Based Review – Direct Care Nursing proposal to attract and retain a sufficient workforce of trained medical professionals, primarily focused on recruitment for registered nurses (RNs) and psychiatric technicians (PTs); the two most commonly utilized nursing classifications at DSH.

Long term, DSH's solution to fill vacancies for nursing level-of-care staff is to continue to expand partnerships with local community colleges to increase class sizes or cohort frequency, with the goal of producing more RN and PT candidates available to work at DSH hospitals. In March 2020, DSH-Atascadero, in collaboration with Cuesta College, increased the program class size from 30 to 45 students, with two cohorts per year. However, plans were significantly impacted during the COVID-19 pandemic, with class sizes reduced to accommodate spacing restrictions. DSH-Napa continues to contract with Napa Valley College which holds two cohorts per year, with an additional six students each, for a total size of 36 students per cohort.

DSH-Napa Psychiatric Residency Program - St. Joseph's Medical Center (SJMC)

The Psychiatric Residency Program at St. Joseph's Medical Center (SJMC) was approved for ongoing accreditation in February 2023, and the first cohort of seven residents began their training in July 2021. The program is now in its fourth year and has three cohorts, for a total of 20 residents participating annually. Based on data for Years 1 and 2 Residents, each resident in Year 1 provides two blocks of 160 hours each, totaling 320 hours of care, and each resident in Year 2 provides four blocks of 160 hours each, totaling 640 hours. Over the course of these two years, residents worked a total of 6,720 hours, equivalent to 3.8 full-time equivalent (FTE).

As of the 2024-25 May Revision, DSH had participated in the March 2024-25 match cycle and matched 10 additional residents into the program starting July 1, 2024. DSH was also discussing a possible expansion of the residency program with SJMC.

DSH-Patton Psychiatric Residency Program

DSH received resources in the Budget Act of 2023 to add a second residency program at DSH-Patton based on the successes of the DSH-Napa Psychiatric Residency Program by leveraging established DSH partnerships with community colleges for PT programs.

In the 2025-26 Governor's Budget, DSH reported DSH-Patton received a 4-year accreditation for the DSH-Patton residency program from the Accreditation Council for Graduate Medical Education (ACGME) through June 2028 after a successful onsite visit in March 2024.

Psychiatric Fellowships

The Budget Act of 2023 included resources to expand or develop psychiatric fellowship programs across all five State Hospitals, with the objective of providing new psychiatrists with specialized training focused on the unique needs of state hospital patients. These forensic fellowships will provide clinicians invaluable opportunities to gain experience and familiarity with forensic populations and provide the Department an opportunity for future recruitment. DSH partnered with University of California, Davis (UC Davis) to provide training to four forensic fellows a year at DSH-Napa.

Resources were also allocated to expand upon DSH's current forensic fellowships by establishing geriatric psychiatry fellowships, designed to provide the specialized training needed to serve the aging population of DSH patients. These fellowships were to establish training sites at DSH-Napa and eventually DSH-Metropolitan, both of which operate on-site skilled nursing facilities (SNF).

Finally, due to the prevalence of co-occurring substance use disorder within the patient population, the Budget Act of 2023 provided resources to develop an addiction psychiatry fellowship at DSH-Napa to establish a pipeline of psychiatrists prepared to treat dual diagnoses.

As of the 2025-26 Governor's Budget, DSH was working to implement fellowship expansions and fellowship rotation offerings with three universities:

- The Stanford Health Care Forensic Psychiatry Fellowship rotation contract is still in progress, with DSH-Atascadero as the primary location. Fellows continue to rotate at DSH-Atascadero as an elective.
- The University of California, Los Angeles (UCLA) Forensic Psychiatry Fellowship rotation agreement was successfully executed as of July 2024, with DSH-Metropolitan as the primary training rotation site
- The University of California, San Francisco (UCSF) Public Psychiatry Fellowship (PPF) rotation agreement was executed in June 2024, with DSH-Napa as the primary training location site.

DSH fellowship and resident rotations on existing contracts continue. DSH is actively working on developing a Forensic Psychiatry Fellowship Program at DSH-Coalinga with San Mateo County.

Resident Rotations

The Budget Act of 2023 included resources to increase the amount of rotation opportunities to post-graduate residents. Providing opportunities to gain exposure to the Department and DSH patient populations increases the possibility of attracting future physicians with knowledge of the state hospital system and affords experience applying that subspecialty knowledge in a large public sector health system.

As of the 2025-26 Governor's Budget, DSH executed an agreement with Kaiser Foundation Hospital and The Permanente Medical Group, Inc (KP) for resident rotations.

PROGRAM UPDATE

Psychiatric Technician (PT) Graduation Rates

DSH continues to partner with local community colleges to offer education and training programs to provide an adequate supply of PTs for the state hospitals. The below table displays actual graduation rates from cohorts conducted from calendar year 2020 through Spring 2025 at DSH-Atascadero and DSH-Napa.

DSH-Atascadero

PT Graduating Class	Number of Attendees	Number of Graduates	DSH Hires[1]
2020	60	44	32
2021	60	53	10
Spring 2022	26	17	10
Summer 2022	30	18	15
Fall 2022	33	17	11
Spring 2023	28	22	11
Summer 2023	32	22	22
Fall 2023	30	22	14
Spring 2024	26	16	4
Summer 2024	31	16	10
Fall 2024	26	20	11

[1] DSH Hires column is subject to change with PT licensure

DSH-Napa

Cohorts[1]	Number of Attendees	Number of Graduates	DSH Hires
Spring 2020	24	16	2
Fall 2020[2]	N/A	N/A	N/A
Spring 2021	30	19	11
Fall 2021	N/A	N/A	N/A
Spring 2022	26	17	4
Fall 2022	17	14	9
Spring 2023[3]	N/A	N/A	N/A
Fall 2023	12	3	TBD
Spring 2024	N/A	N/A	N/A
Fall 2024[4]	23	TBD	TBD
Spring 2025	N/A	N/A	N/A

[1] Cohorts with no new students are displayed as N/A
[2] No cohort held due to COVID-19 Restrictions
[3] In the 2024-25 Governor's Budget, number of attendees was erroneously reported as 12 due to a point in time issue
[4] Data expected for the 2027-28 Governor's Budget

DSH-Napa Residency Program

Effective July 1, 2024, the cohort size for the DSH-Napa Residency Program increased from seven to ten, with ten residents identified in the March 2024-25 match cycle starting in the program. This expansion of three additional residents per year, with three cohorts, yields a total of 30 residents participating annually. Based on data for

Years 1 and 2 Residents, each resident in Year 1 provides two blocks of 160 hours each, totaling 320 hours of care, and each resident in Year 2 provides four blocks of 160 hours each, totaling 640 hours. Over the course of these two years, residents have worked a total of 6,720 hours, equivalent to 3.8 FTE. In Year 3 of residency, there are zero residents rotating; however, DSH-Napa is responsible for training and educating all 4 years of cohorts. Year 4 of the residency program included a total of 20 blocks of 160 hours each and therefore, residents worked a total of 3,200 hours. In all 4 years, residents have worked a total of 9,920 hours caring for DSH-Napa patients, equivalent to 5.6 FTE.

DSH-Patton Residency Program

DSH-Patton received a 4-year accreditation for the DSH-Patton residency program from ACGME through June 2028.

As of the 2025-26 May Revision, DSH-Patton is in discussions with a prospective university partner to begin a Southern California residency program starting in July 2025 with the first year as a planning year, and residents starting rotations in July 2026. DSH is currently working with the university to develop a Scope of Work and a proposed budget, with contract finalization anticipated in Winter 2025.

The Residency Program Coordinator position was filled as of late February 2025.

Psychiatric Fellowships

DSH continues its work to implement and expand fellowship rotation offerings, both in forensic and public psychiatry.

Forensic Psychiatry Fellowship Rotations

- The UCLA Forensic Psychiatry Fellowship rotation agreement was successfully executed as of July 2024, with DSH-Metropolitan as the primary training rotation site.
- The UCSF Forensic Psychiatry Fellowship rotation agreement was successfully executed in July 2024 and provides virtual statewide services.
- The Stanford Health Care Forensic Psychiatry Fellowship rotation agreement, while reported in the 2024-25 May Revision as being effective through June 2026, is still in progress. However, fellows continue to rotate at DSH-Atascadero as an elective.
- The Riverside University Health System (RUHS) Forensic Psychiatry Fellowship rotation agreement was successfully executed as of December 2024, with DSH-Patton as the primary training rotation site.

Public Psychiatry Fellowship Rotations

- The UCSF Public Psychiatry Fellowship (PPF) rotation agreement was executed in June 2024, with DSH-Napa as the primary training location site. In addition, UCSF shall work in partnership with DSH leaders to select five DSH staff psychiatrists suitable for a remote public psychiatry administrative fellowship (PPAF).
- The Stanford Geriatric Psychiatry Fellowship rotation agreement was successfully executed March 2025, with DSH-Napa as the primary training rotation site.
- DSH is in preliminary discussions with a university partnership to offer a statewide PPF program sometime in FY 2025-26.

In addition to the current partnerships above, the DSH Office of Continuing Education and Medical Advancement (CEMA) is also exploring prospective partners to begin a fellowship program at DSH-Coalinga.

Resident Rotations

DSH has continued to seek additional opportunities for resident rotations. In May 2024, DSH executed an agreement with KP for resident rotations. The program has been well received by the rotating residents and DSH-Napa faculty, with interest being expressed to increase this rotation from once-a-week to two consecutive full-weeks.

In March 2025, DSH executed an agreement with Community Memorial Health System (CMHS) for resident rotations, with DSH-Atascadero as the primacy training rotation site.

As of the 2025-26 May Revision, contracts for psychiatry resident rotations through June 2028 are in development, with DSH-Patton as the primary location. Internal medicine resident rotation opportunities are also being explored.

Continuing Medical Education and Training Expansion

A primary objective of CEMA is to increase continuing medical education (CME) offerings as a retention tool for current DSH psychiatrists. Prior to the establishment of CEMA in the Budget Act of 2023, DSH had established a contract for continuing medical education with University of California, Irvine (UCI) in 2017. In the spring of 2024, CEMA expanded this agreement to now provide CME credits for professional events and conferences (i.e. Psychopharmacology Resource Network (PRN) providing an annual DSH Prescribers Summit), in addition to DSH's regularly scheduled series. This expansion of course offerings allow DSH providers and county partners the opportunity to refine their skills, and to stay current on the latest

developments in psychiatry, ultimately improving patient care. DSH will continue to coordinate with specialty experts to provide CME for DSH psychiatrists and county partners, including topics in psychopharmacology, perinatal care, and neurology.

As of the 2025-26 May Revision, CEMA is in early conversations to explore establishing forensic academy and psychopharmacology certification programs at DSH.

STATE HOSPITALS
SKILLED NURSING FACILITY (SNF) LEVEL OF CARE NEEDS
Informational Only

SUMMARY

The Department of State Hospitals (DSH) continues to evaluate options to meet the Skilled Nursing Facility (SNF) needs of DSH's aging and medically fragile patient population, as current SNF bed capacity remains insufficient to meet the needs of existing and future patients. Completion of the DSH-Metropolitan SNF internal restorations and repairs is expected in May 2025; a three-month delay from the 2025-26 Governor's Budget. Upon completion, two of the three units will be reopened to SNF patients, with the activation date for the third SNF unit yet to be determined.

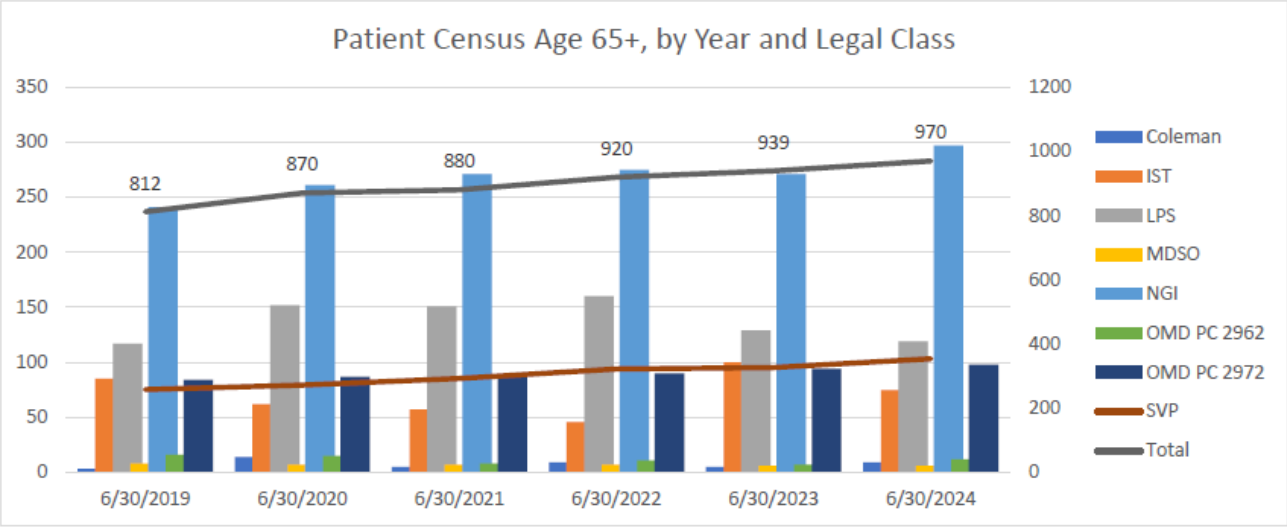
BACKGROUND

As the administrator of the nation's largest inpatient forensic mental health state hospital system, DSH is responsible for the daily care of over 7,000 patients; some of whom, due to either the severity of their mental illness or the crimes they have committed, have long lengths of stay. The following provides by commitment type, the average number of patient days for patients in census at the end of fiscal year (FY) 2023-24.

Commitment Type	Average Patient Days
Coleman/CDCR	138.4
Incompetent to Stand Trial (IST)	154.1
Lanterman-Petris Short (LPS)	2,514.0
Mentally Disordered Sex Offender (MDSO)	4,841.6
Not Guilty by Reason of Insanity (NGI)	3,896.1
Offender with Mental Health Disorder (OMD) PC 2962	295.4
OMD PC 2972	2656.2
Sexually Violent Predators (SVP)	4,107.7

Patients are provided mental, physical, and dental health care over the course of their stay at DSH. Depending on a patient's length of stay, their health care may include geriatric, end-of-life care, chronic illnesses, or recuperation from major illnesses or surgery requiring either interim or long-term skilled nursing care.

In recent years, the number of DSH patients aged 65 and over has continued to increase. As illustrated in the graph below, DSH has observed an increase of 19% over the last five years in the number of patients aged 65 and over.



Patients over the age of 65 are increasingly representative of DSH's population, composing 17% of FY 2023-24 DSH patients, up from 13% in FY 2019-20.

Age Range	Patient Census Age 65+ as of June 30											
	2019		2020		2021		2022		2023		2024	
	Count of Patients	% to Total Census	Count of Patients	% to Total Census	Count of Patients	% to Total Census	Count of Patients	% to Total Census	Count of Patients	% to Total Census	Count of Patients	% to Total Census
65-74	670	11%	715	13%	710	13%	736	14%	747	13%	760	14%
75-84	126	2%	142	2%	156	3%	172	3%	179	3%	192	3%
85-94	***	***%	***	***%	***	***%	***	***%	***	***%	***	***%
Systemwide	**6,129**	**100%**	**5,718**	**100%**	**5,557**	**100%**	**5,316**	**100%**	**5,688**	**100%**	**5,559**	**100%**

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

Older patients already experience a higher level of prevalence for multiple medical conditions, but current research reveals patients with schizophrenia experience accelerated aging and development of age-related illnesses 20 years earlier than expected and suffer from a dramatically decreased life expectancy. As of June 30, 2024, 50% of DSH's population had a diagnosis of schizophrenia. Moreover, mental illness, particularly psychotic spectrum disorders, bipolar disorders, and depressive disorders, are associated with increased prevalence of chronic diseases including asthma, arthritis, cardiovascular disease, cancer, diabetes, and obesity. As of June 30, 2024, 23% of DSH's population had a diagnosis of schizoaffective disorder and 4% had a diagnosis of bipolar disorder.

DSH currently operates three licensed[1] SNF units; two located at DSH-Metropolitan and one at DSH-Napa. As of June 30, 2024, there were 64 active SNF beds at DSH-

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

Metropolitan and 27 at DSH-Napa, for a combined total of 94 active SNF beds. This limited capacity must also accommodate SNF patients transferred from DSH-Atascadero and DSH-Patton. However, due to system limitations, DSH-Metropolitan and DSH-Napa are not able to serve SNF patients committed to DSH-Coalinga as Sexually Violent Predators (SVP).

For DSH-Coalinga, and any other facilities unable to place their SNF patients into one of the three existing DSH SNF units, DSH contracts out with community facilities when possible. However, community options pose challenges which often make placement difficult, including the limited availability of community beds. Additionally, even when an available bed is identified, many community options are unwilling to accept forensic commitments, particularly those with sexual offenses. DSH has taken steps to convert existing Residential Recovery Units (RRU) to meet the increased medical needs of patients with a higher level of acuity. The last RRU conversion was completed in May 2023, when DSH-Coalinga repurposed an existing RRU space into an Intermediate Care Facility (ICF) to accommodate the increasingly geriatric and high-acuity population.

In the 2024-25 May Revision, DSH projected the study detailing estimated costs of developing a SNF Unit at DSH-Coalinga would be completed by July 2024. As of the 2025-26 Governor's Budget, DSH reported completion of SNF building restorations in early 2025.

PROGRAM UPDATE

As of the 2025-26 May Revision, DSH anticipates internal restorations and repairs of the DSH-Metropolitan SNF building will be completed in May 2025; an additional three-month delay from the 2025-26 Governor's Budget. Following completion of the SNF building restorations, its units will be re-activated and the SNF patients will be relocated to these units.

DSH continues to explore options to meet the SNF needs of DSH's aging and high-acuity patient population, including a potential partnership to establish a community-based SNF unit. DSH can also report that the DGS study conducted at DSH-Coalinga to assess additional SNF capacity options was completed. DSH continues to evaluate options and next steps.

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

SUMMARY

The Department of State Hospitals (DSH) continues to support the 18 remaining active county pilot Diversion programs through the last year of the pilot program. As of September 30, 2024, 32 additional individuals have been diverted to county-run programs, bringing the total number of diverted participants to 1,835. DSH will continue to provide status updates on the Diversion pilot program through its completion on June 30, 2025[1].

BACKGROUND

The Budget Act of 2018 provided funding for DSH to develop pilot Diversion programs by contracting with various counties throughout California to serve individuals with serious mental illness diagnoses, such as schizophrenia, schizoaffective disorder, or bipolar disorder, who have been found or have the potential to be found Incompetent to Stand Trial (IST) on felony charges. In the following years, additional investments in the pilot program have been made to expand its footprint in the state and allow for additional treatment slots.

Funding for Existing County Programs[2]

Of the original funding provided in the Budget Act of 2018, 99.5% was allocated by November 15, 2022, securing 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

[1] The Department of State Hospitals (DSH) continues to provide status updates on the Diversion Pilot program, while providing permanent Diversion program updates in IST Solutions (see Section C9).
[2] Yolo DA contract ended in May 2023; Santa Cruz contract ended in October 2022, Del Norte, Kern, Los Angeles, Sacramento, San Francisco, San Luis Obispo, Santa Clara, and Sonoma contracts ended in June 2024; Marin ended in November 2024, and San Bernardino ended in January 2025.

Diversion Pilot Funding Reappropriation

In the 2023-24 May Revision, DSH requested to reappropriate any remaining contract funds provided in the Budget Act of 2018 to allow counties time to expend the remaining balances of their diversion program funding and meet their contracted number of individuals to be diverted under their contracts. This extension was needed due to activation delays of county diversion programs resulting from the COVID-19 pandemic.

Fiscal Year (FY) 2021-22 Pilot County Program Funding

The Budget Act of 2021 provided DSH additional resources to expand the Diversion pilot program to new, currently non-participating counties. In fall 2021, DSH provided intensive technical assistance to aid five new participating counties in developing their Diversion programs, resulting in programs in Madera, Nevada, San Joaquin, Tulare, and Tuolumne counties.

The five DSH Diversion programs (Madera, Nevada, San Joaquin, Tulare, and Tuolumne counties) were activated as of October 2022. As of September 30, 2024, Nevada County had enrolled a small number of contracted Diversion clients, while San Joaquin County had enrolled 24 of 26. Tulare County reported fewer than 11 of 13 enrolled Diversion clients, and Tuolumne County had fewer than 11 of 15 spots filled. Madera County had not yet enrolled any Diversion clients into its program, but DSH continues to provide support in working through barriers. All programs continue to work actively to identify eligible candidates for program participation.

Expanding Existing County Programs

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

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

There were 20 counties that elected to participate, accounting for 294 new Diversion slots.

Supplemental County Housing Funding

DSH received funds in the Budget Act of 2021 to expand Community Based Restoration (CBR) and Felony Mental Health Diversion (Diversion) programs. As part of the expansion, DSH provided counties with an opportunity to establish new or expand existing diversion programs by offering Supplemental County Housing funds for diverting and providing housing services to clients found IST per PC 1370, and on the DSH waitlist.

There are 17 counties participating in the program and as of February 2025 have billed DSH for a total of $16.1 million in Supplemental Housing funds.

Ongoing Technical Assistance and Support

In July 2023, DSH began holding monthly meetings with all pilot counties to discuss any local barriers to diversion, and to provide support and technical assistance. DSH continues to navigate barriers by educating judicial officials on the referral process for IST Diversion and providing state-wide virtual and in-person trainings. DSH also continues to provide technical assistance to the counties by coordinating monthly all-county meetings where counties can connect to collaborate on lessons learned and share resources.

DSH continues to work with all counties to improve the quality of reported data by analyzing the data submitted from all participating Diversion counties. Currently, DSH collects Diversion data quarterly. Counties that struggle to complete reports timely and accurately are provided with additional support to help with any barriers they may be facing.

The Budget Act of 2022 established Diversion as a permanent DSH program, and the Department is executing permanent program contracts, including a provision to provide data to DSH monthly rather than quarterly. This increase in frequency will allow DSH to resolve any data discrepancies with counties in a timely manner, to align the collection and reporting of Diversion data with other DSH program reporting, and to identify potential programmatic issues at the county level earlier than DSH was able to under the quarterly collection schedule.

PROGRAM UPDATE

Diversion Pilot Program Data Collection Efforts and Research

As of September 30, 2024, 1,835 eligible individuals have been diverted to a county-run program. DSH continues to work with all counties to ensure the quality of data

collected. The following table provides a high-level snapshot of Diversion program participants.

Diversion Program Participant Descriptive Data[3]		
Program Information	**Total Number**	**Percentage**
Total Enrolled as of 9/30/2024	1899	100 %
Total Ineligible	64	3.4 %
Total Eligible	1835	96.6 %
At Risk vs. IST	**Total Number**	**Percentage**
At risk of IST	696	37.9 %
IST	1139	62.1 %
Waitlist	**Total Number**	**Percentage**
Removed from DSH Waitlist	771	42.0 %
Diagnosis	**Total Number**	**Percentage**
Schizophrenia	732	39.9 %
Schizoaffective Disorder	599	32.6 %
Bipolar Disorder	367	20.0 %
Unspecified Schizophrenia Spectrum and Other Psychotic Disorder (OPD)	104	5.7 %
Other	33	1.8 %
Ethnicity	**Total Number**	**Percentage**
White	498	27.1 %
People of Color	1337	72.9 %
Gender	**Total Number**	**Percentage**
Male	1220	66.5 %
Female	601	32.7 %
Other	14	0.8 %
Living Situation at Arrest[4]	**Total Number**	**Percentage**
Homeless	1442	78.9 %
Not Homeless	385	21.1 %
Felony Charges	**Total Number**	**Percentage**
Assault/ Battery	595	32.4 %
Theft	324	17.7 %
Robbery	236	12.9 %
Miscellaneous (primarily Vandalism)	189	10.3 %
Criminal Threats	151	8.2 %
Arson	135	7.3 %
Other (primarily weapons, drugs, FTR)	118	6.4 %
Obstruction of Justice	56	3.1 %
Kidnapping	31	1.7%

[3] Two counties have not submitted FY 2023-24 Q4 and FY 2024-25 Q1 data to DSH.
[4] San Francisco and Santa Clara County did not provide data for all participants for this section in their quarterly reports.

Diversion Pilot Program Outcome & Predictive Data

Since the launch of the pilot in 2018, enrollment in Diversion has steadily increased. Using data collected throughout the pilot, DSH can now analyze and share participant predictor data outcomes and assess program impacts. Using data as of September 30, 2024, from all participating counties, DSH analyzed the outcomes of the 1,835 eligible Diversion participants. Of these participants, 59 were not included for analysis because they had met eligibility criteria and started their respective Diversion programs but were terminated for a variety of reasons including: client transfer to another program, judicial reasons unrelated to Diversion, or the occurrence of death prior to program completion. The following tables use the dataset described above to display predictors of status in the program:

Current Status		
	Total Number	**Percent**
Still In	478	26.9 %
Revoked/AWOL/Re-incarcerated	573	32.3 %
Successful Completion	725	40.8 %
Total	1776	100%
Length of Stay by Current Status		
	Average	**Standard Deviation**
Still In	517.63	304.6
Revoked/AWOL/Re-incarcerated	226.25	255.0
Successful Completion	612.08	141.9
Risk Assessment[5] Conducted		
	Total Number	**Percent**
Yes	657	69.0 %
No	295	31.0 %
Total	952	100%
Development of Treatment Plan[6]		
	Total Number	**Percent**
Intensive evaluation[7]	796	85.9 %
Formal RNR assessment[8]	107	11.5 %
Both	24	2.6 %
Total	927	100%

[5] Clinical assessment designed to evaluate an individual's risk of violence
[6] Individualized course of treatment and interventions based on specific patient needs
[7] The use of various disciplines, including psychiatry, to evaluate a patient's needs and the best course of treatment to meet those needs
[8] Structured assessment to determine what factors elevate a patient's risk of reoffending or responding poorly to treatment, how to minimize those risk factors for the patient through a treatment plan, and how to adjust the treatment plan over time as a patient's risk factors change

Diversion Program Participant Outcome Data[9]		
Incompetent to Stand Trial	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
IST	416 (54.8%)	343 (45.2 %)
At risk of IST	309 (57.3%)	230 (42.7 %)
Homeless	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
Yes	574 (54.5 %)	480 (45.5 %)
No	151 (62.4 %)	91 (37.6 %)
Abuse of Substances	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
Yes	595 (54.1 %)	504 (45.9 %)
No	114 (66.7 %)	57 (33.3 %)
Methamphetamine Use	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
Methamphetamine	332 (47.0 %)	375 (53.0 %)
No drug use/Other drugs	375 (66.8 %)	186 (33.2 %)

DSH's Diversion program participant outcome data is dynamic and unpredictable. Throughout the pilot, tracking indicators and data in various subgroups (e.g., 'IST' versus 'at risk of IST') have changed over time. Even modest changes within the dataset of smaller numbers can have a significant impact on results and determined conclusions. Additionally, data collected from the 18 participating counties, each from very disparate areas of the state with their own diverse populations, have expanded the characteristics of the sample data collected.

As counties continue to enroll participants in Diversion, the sample data from various subgroups may change proportionately to previous data. These observed fluctuations are likely to continue through the end of the pilot phase of the DSH Diversion program, resulting in dynamic changes in the outcomes when compared to previous quarters. DSH strives to improve upon the operational definitions of the data and refine data collection prior to the permanent program implementation to account for these dynamic fluctuations.

The Diversion pilot program will run through its completion on June 30, 2025. Pilot program closeout activities include continued technical assistance and support,

[9] Totals may not equal the Current Status Total as information regarding living situation and substance use are not required for eligibility, and when not provided, is not captured in the reported data.

collection and reconciliation of data, fiscal reports and billing, and other contract deliverables. In addition, DSH is working with counties that are participating in the permanent Diversion program to provide awareness of differences in treatment requirements, frequency of data collection, reporting, and invoicing processes.

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

SUMMARY

The Department of State Hospitals (DSH) continues to monitor the Sexually Violent Predator (SVP) and Offenders with a Mental Health Disorder (OMD) referral trends. In the 2025-26 Governor's Budget, DSH projected to receive 410 SVP and 1,924 OMD referrals in fiscal year (FY) 2024-25. As of the 2025-26 May Revision, DSH projects to receive 470 SVP and 2,122 OMD referrals in FY 2024-25.

BACKGROUND

Prior to an individual's release from California Department of Corrections and Rehabilitation (CDCR), statute requires DSH to provide forensic evaluation services[1] to determine if the individual needs treatment in a state hospital as an SVP or OMD upon release from prison. DSH administers these services through the Sex Offender Commitment Program (SOCP) and the OMD Program. DSH employs a team of Consulting Psychologists, SVP Evaluators, and contracted forensic psychologists to provide the forensic evaluations. The forensic evaluator staffing allows DSH to complete the volume of interviews, evaluations, forensic report development, and expert witness and court testimony services required. The number of CDCR referrals for potential SVP and OMD commitments to DSH is the primary driver of the workload. Additional workload may include, but is not limited to the following:

- Completing update and replacement evaluations and report addendums, as required by the court
- Completing recommitment evaluations in accordance with WIC 6604
- Completing independent evaluations to resolve differences of opinion (DOP) for SVP evaluations, as required by statute
- Developing and maintaining a robust quality assurance program, including data analytics, to target evaluators' training and/or support needs
- Developing and implementing standardized assessment protocols, policies, and regulations
- Preparing for, and participating in, expert witness and court testimony

[1] DSH continues to rely on the existing video conferencing infrastructure throughout the state. This has allowed DSH to conduct most forensic evaluations and provide much court testimony virtually, significantly reducing travel costs for SVP and OMD evaluations.

SOCP Program

In accordance with WIC 6601(b), CDCR and the Board of Parole Hearings (BPH) are responsible for screening CDCR incarcerated persons to determine if an individual is likely to be an SVP. If CDCR and BPH determine an individual is likely to be an SVP, BPH refers the individual to DSH for forensic psychological evaluation. For those referred, statue requires DSH to complete two forensic psychological evaluations to determine if the individual meets the statutory criteria for civil commitment as an SVP. In addition, the statute requires DSH to refer cases in which evaluations indicate an individual meets criterion to the county District Attorney's Office no less than 20 days prior to the individual's release from prison. In the 2024-25 May Revision, DSH reported that between July 2023 and February 2024, DSH had averaged 48 referrals per month, which is 65.5% higher than the average 29 referrals per month received between January and June 2023.

OMD Program

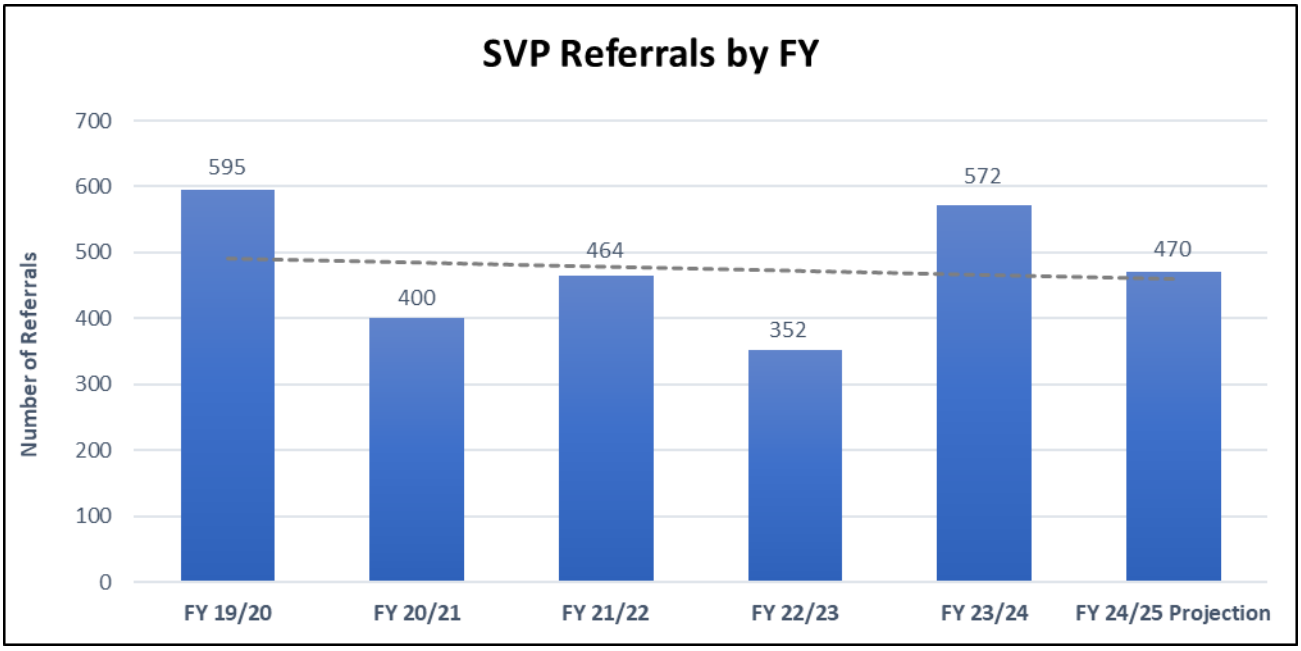
Pursuant to Penal Code (PC) 2960–2981, CDCR evaluators conduct a forensic evaluation of incarcerated persons who have a) been in CDCR mental health programs, and b) have a violent commitment offense, prior to the individual's release on parole. If the CDCR evaluator determines the inmate has a severe mental health disorder and could meet the criteria for OMD commitment, CDCR refers the inmate to DSH for an additional forensic evaluation. The CDCR Chief Psychiatrist then reviews the reports to determine if the inmate meets the criteria for commitment as an OMD. If the Chief Psychiatrist certifies the criteria are met, BPH transfers the inmate to a state hospital for treatment as a special condition of parole. In the 2025-26 Governor's Budget, DSH reported a 6% increase in OMD referrals in FY 2023-24 compared to prior FY 2022-23, and projected a total of 2,205 OMD referrals for FY 2024-25.

PROGRAM UPDATE

SOCP Program

As of the 2025-26 May Revision, DSH reports between July 2024 and February 2025, it has received an average of 36 referrals per month which is 23.4% lower than the average of 47 referrals per month received between January 2024 and June 2024. Based on the trends and using the most recent 12 months of actual referrals between April 2024 and March 2025, DSH now projects a total of 470 SVP referrals for FY 2024-25.

The chart below shows the total SVP referrals received by fiscal year from FY 2019-20 through the projection for FY 2024-25.

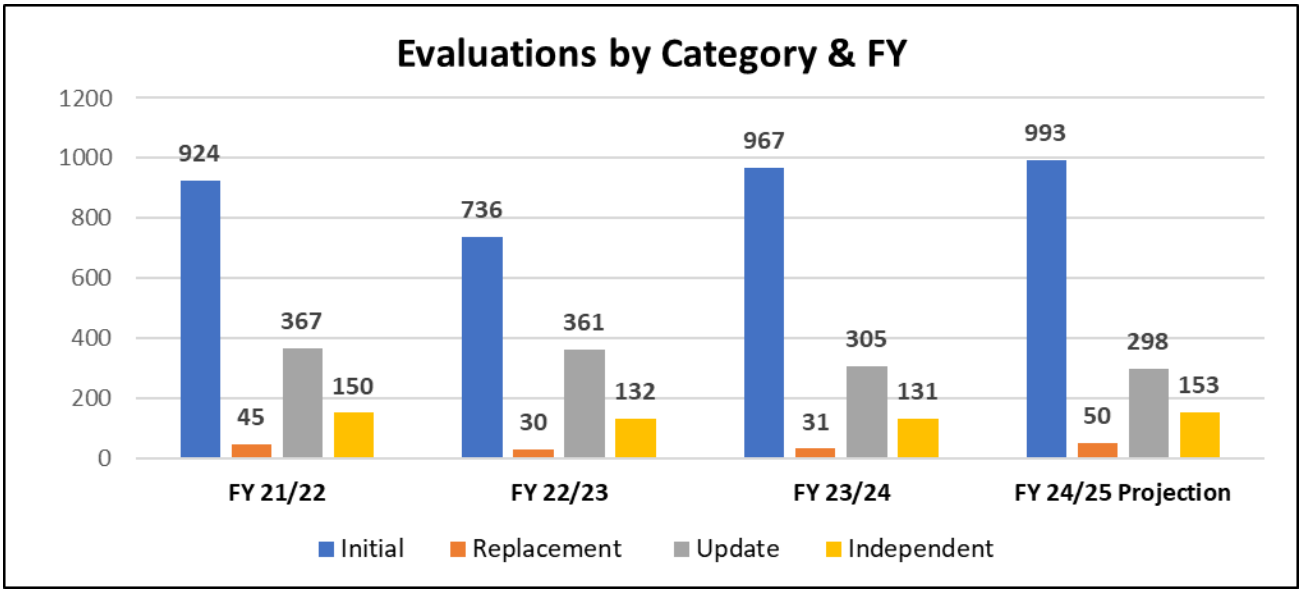


Note: The above actual referral totals are provided based on the FY the referral was received from CDCR/BPH.

The increase of SVP referrals recognized in FY 2023-24 was due to changes in California sentencing laws. These statute changes have resulted in the resentencing of eligible individuals serving prison terms, yielding earlier release dates to an increased number of incarcerated individuals who meet the criteria for evaluation under the SVP Act. However, in the current year, DSH is seeing a decrease in referrals compared to FY 2023-24 and the projected referrals in FY 2024-25 reflect this trend. DSH will continue to monitor SVP referral trends and provide an update in the 2026-27 Governor's Budget.

For each SVP referral received, DSH performs a minimum of two initial evaluations. When there is a difference of opinion (DOP) between the two forensic civil service evaluators initially assigned by DSH to perform SVP evaluations, DSH is statutorily required to assign two additional independent evaluators (who are not state government employees) to assess the individual. In addition, the Forensic Services Division (FSD) performs update evaluations (assigned when a court requests an update of an evaluation on an SVP patient pending trial) and replacement evaluations (assigned when an evaluator is not available to perform an update of an evaluation they performed earlier).

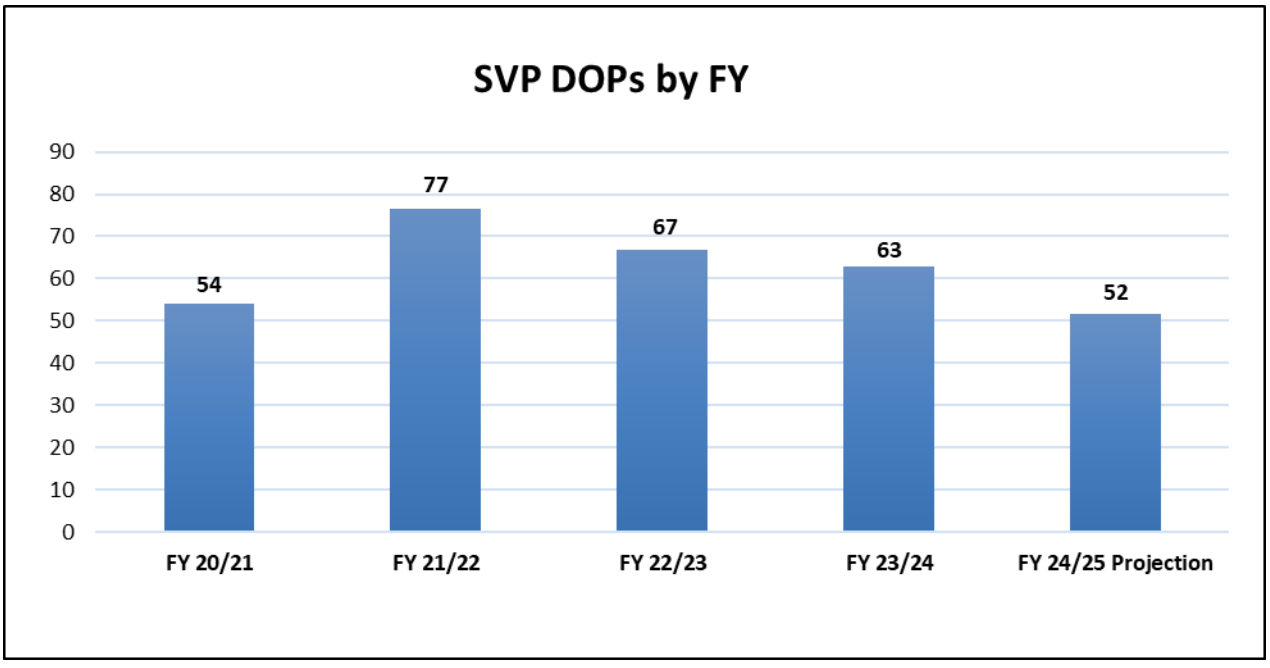
The chart below displays the total number of evaluations conducted by type of SVP evaluation, from FY 2021-22 to the projection for FY 2024-25 which is based on the most recent 12 months of actual referrals received between April 2024 and March 2025.



Note: The above actuals are determined by the number of evaluations completed by 6/30 of each FY.

FY 2022-23 experienced a decrease in initial evaluations due to the lower amount of SVP referrals received. In FY 2023-24, initial evaluation referral rates rebounded to those observed in FY 2021-22 and rates are projected to remain at this higher rate in FY 2024-25.

The chart below shows the number of SVP DOP referrals from FY 2021-22 to the projection for FY 2024-25.



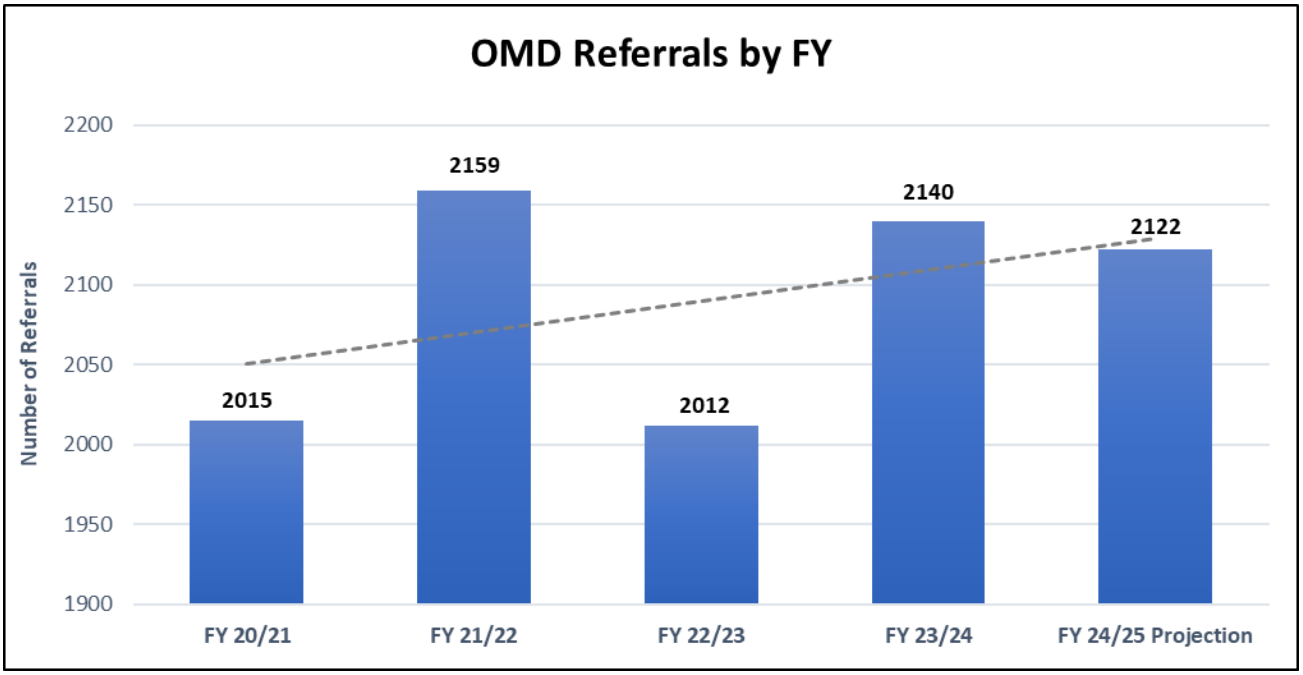
In FY 2023-24, DSH received a total of 63 DOP cases, equating to approximately 11% of the total SVP referrals received. Applying the same percentage to the projected 470 SVP referrals in FY 2024-25, DSH assumes a total of approximately 52 DOP cases in FY 2024-25.

Additionally, DSH evaluators testified in 206 SVP court cases during FY 2023-24. The workload involved in preparing and providing testimony for probable cause hearings and jury trials is significant, equal to approximately two SVP evaluations per evaluator. This translates to an approximate workload equivalent of 824 evaluations, as each court case includes at least two evaluators and requires four in the case of a difference of opinion. This approximation does not include independent court preparation and testimony.

OMD Program

In FY 2023-24, DSH received 2,140 OMD referrals for evaluation. This is approximately 6% higher than actual referral rates in FY 2022-23. Using the most recent 12 months of actual referrals received between April 2024 and March 2025, DSH projects 2,122 OMD referrals for FY 2024-25.

The following chart provides the total OMD referrals from FY 2020-21 to the projection for FY 2024-25.



In the 2025-26 Governor's Budget, DSH reported that OMD referrals trends were increasing, and projected a total of 2,205 for FY 2024-25. However, the recent trend of OMD referrals received has been lower resulting in the FY 2024-25 projection to be 1% lower than the prior FY.

DSH will continue to work closely with CDCR and BPH to determine potential workload impacts to the SOCP and OMD program and provide an update in the 2026-27 Governor's Budget.

STATE HOSPITALS
CAPITAL OUTLAY BUDGET CHANGE PROPOSALS

Please see the Department of Finance (DOF) website for all Capital Outlay Budget Change Proposals (COBCPs).

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: Treatment of Prisoners. 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 they will return to CDCR (pursuant to PC 2685) when they have reached maximum benefit from treatment. If the individuals are still mentally ill at the end of their prison term, they may receive further state hospital treatment as an Offender with a Mental Health Disorder (OMD) if they meet the criteria under PC 2962. Additionally, patients who do not meet the criteria pursuant to PC 2962 may be treated at DSH either as a parolee with a mental health disorder pursuant to PC 2974, or as a Lanterman-Petris-Short (LPS) civil commitment.

Legal Statutes and Commitments

- PC 2684 – Incarcerated Person from CDCR

Requirements 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 continuation of care has been arranged. A patient may be discharged directly into the community when they are institutionally released from CDCR.

DSH Treatment Continuum & Services

The focus of treatment for the *Coleman* population is psychiatric stabilization. A number of *Coleman* patients are sent to DSH due to complicated presentations, such as complex medical diagnoses, cognitive issues, or developmental disabilities in addition to mental illness. In addition to psychiatric and medical services, psychosocial treatments are provided with a focus on helping the patients manage their mental illness symptoms and reintegrate back into a prison environment when discharged from the state hospital.

Programs

DSH provides treatment to *Coleman* patients through inpatient care within the state hospitals at DSH-Atascadero, DSH-Coalinga, and DSH-Patton.

DSH Coleman Treatment Programs	
State Hospitals (SH)	DSH's inpatient mental health hospital system provides psychiatric, medical, and psychosocial treatment services to forensic and civil patients housed at Atascadero, Coalinga, Metropolitan, Napa, and Patton State Hospitals. Coleman patients are treated at Atascadero, Coalinga, and Patton State Hospitals.

Population Data

In fiscal year (FY) 2023-24, the *Coleman* patient population increased 40%, with an average census of 112 patients in July 2023, and ending with an average census of 156 in June 2024. Table 1 below summarizes key statistics across the *Coleman* population.

Table 1: *Coleman* Patient Data Summary

Coleman Patient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY[1]
Patients Referrals[2]	282	611	117%
Admissions[3]	199	307	54%
Patients Served[4]	313	419	34%
Average Daily Census	105	127	21%
Average Length of Stay	284	141	-50%
Discharges	189	251	33%

In FY 2023-24, 611 *Coleman* patients were referred to DSH for psychiatric stabilization treatment; an increase of 117% from FY 2022-23. Below, Chart 1 displays *Coleman* systemwide referrals and admissions for FY 2023-24. Chart 2 displays a five-year period of referrals and admissions with a trend line of patients served over the years.

[1] Totals are based on raw data, which have been rounded for display purposes.
[2] Patient referrals excludes other inpatient program transfers and court returns.
[3] Patient admissions include other inpatient program transfers.
[4] Patients served excludes other inpatient program transfers.

**Chart 1: *Coleman* Systemwide Referrals and Admissions
July 2023 through June 2024**

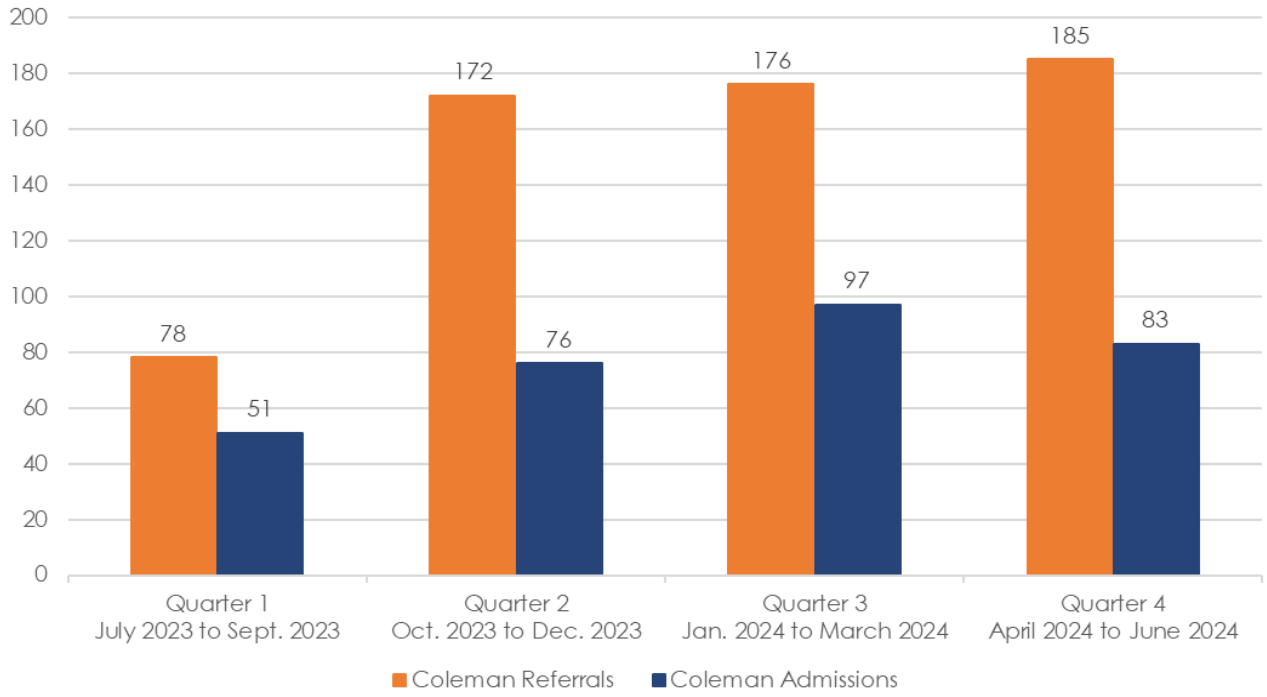
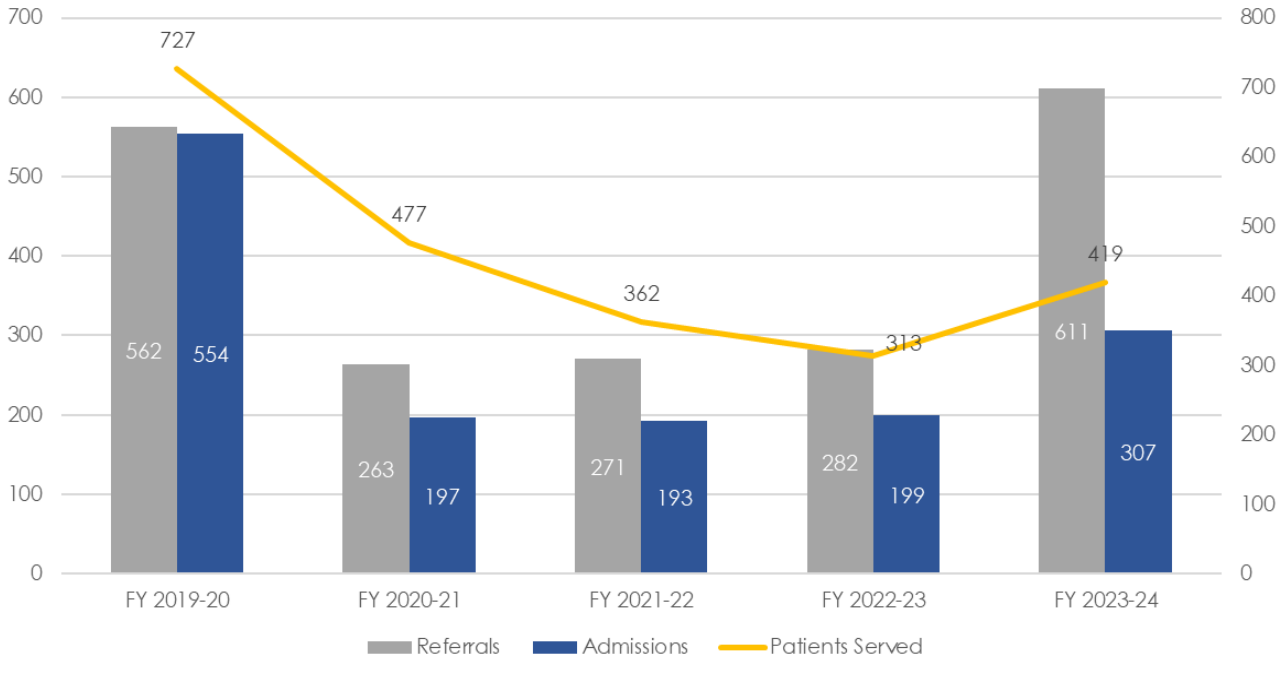


**Chart 2: *Coleman* Systemwide Patients Served, Referrals and Admissions
FY 2019-20 to FY 2023-24**



The chart above (Chart 2), displays 307 total admissions in FY 2023-24; a 54% growth in admissions from the prior FY. During this time, the Pending Placement List (PPL) has increased ***%[5] in the FY, with fewer than 11 in July 2023 and ending at 23 patients in June 2024. All patients referred for intermediate care treatment are subjected to court mandated timelines and must be admitted within 30 days, barring any medical holds.

As a result of the CDCR referrals accepted, DSH admitted 307 *Coleman* Patients in FY 2023-24 with an average of 26 admissions per month. Chart 3 displays *Coleman* admissions by quarter and the average monthly admissions rate.

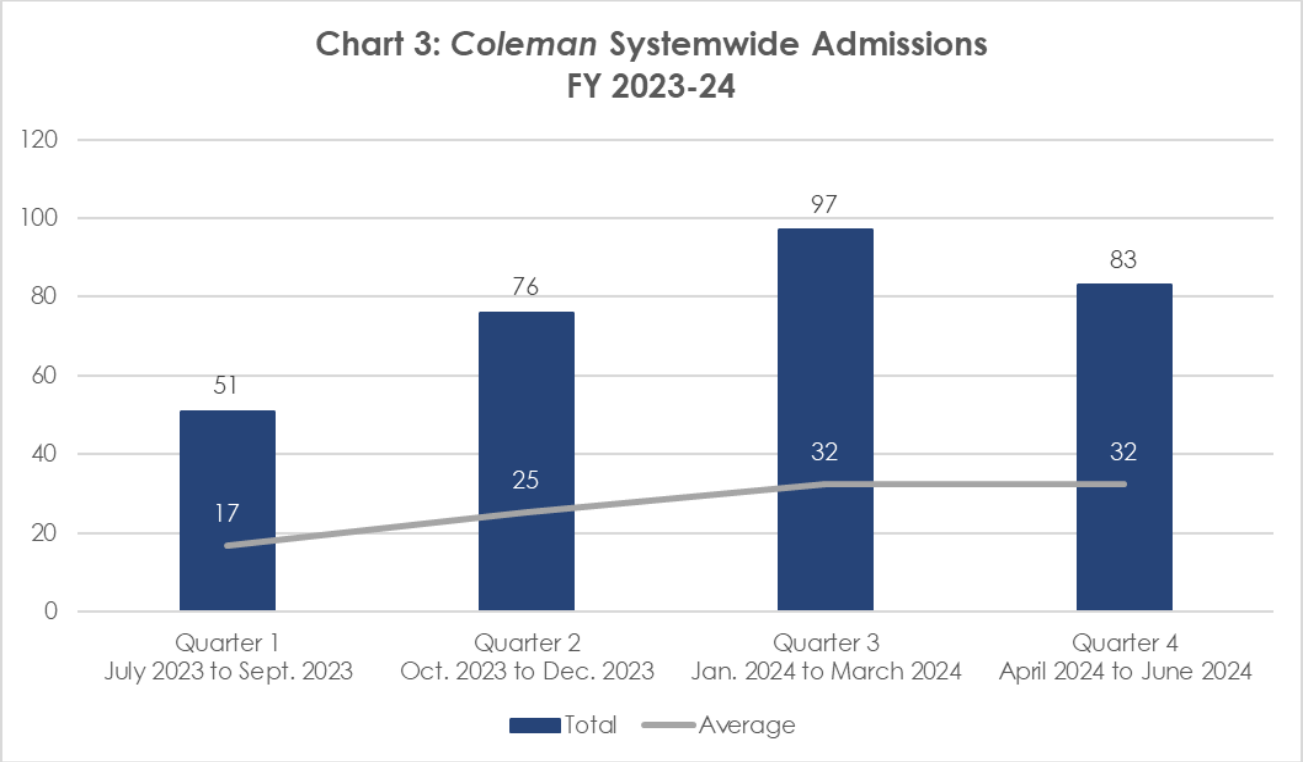


Table 2 below displays the number of patients treated across the year.

Table 2: *Coleman* Patients Served[6]

Patients Treated/ Served	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
	727	477	362	313	419

[5] Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or "less than 11" within the narrative. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.
[6] Patients served excludes other inpatient program transfers.

Discharge Data

In FY 2023-24, DSH discharged 251 *Coleman* patients with an average length of stay of 141 days and a median length of stay of 123 days. 40% of *Coleman* patients discharged within the first 90 days of their stay; 71% of the *Coleman* patients discharged within the first 180 days of their stay and 96% of the *Coleman* patients discharged within the first year of their stay. Table 3 displays length of stay by quarter.

Table 3: *Coleman* Patient Length of Stay by Quarter – FY 2023-24

Coleman **Length of Stay**	**Quarter 1** July 2023 to Sept. 2023	**Quarter 2** Oct. 2023 to Dec. 2023	**Quarter 3** Jan. 2024 to March 2024	**Quarter 4** April 2024 to June 2024	**Total**[7] FY 2023-24
Average Length of Stay	148.2	157.7	138.4	121.4	141.0
Median Length of Stay	144.5	146.0	106.0	97.0	123.0
Discharged Count	58	62	65	66	251

[7] Totals are based on raw data, which have been rounded for display purposes.

POPULATION PROFILE
Incompetent to Stand Trial Patients

Description of Legal Class

The Department of State Hospitals (DSH) admits individuals found Incompetent to Stand Trial (IST) under Penal Code (PC) 1370: Inquiry into the Competence of the Defendant Before Trial or After Conviction. Individuals found IST have been accused of felony crimes and are referred to DSH after a court has determined they are unable to understand the nature of the criminal proceedings or assist counsel in the conduct of a defense. The court commits these defendants to DSH for treatment specifically designed to enable the defendant to proceed with the trial. DSH provides treatment across a continuum of care, which includes inpatient and outpatient settings. Patients receive competency-based treatment and return to county custody 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.

Legal Statutes and Commitments

- PC 1370- Incompetent to Stand Trial
- PC 1370, subdivision (b)(1) – Unlikely to Regain Competency
- PC 1370, subdivision (c)(1) – Maximum Commitment
- PC 1372 – Certificate of Restoration
- PC 1372(e) – Continued Treatment Until Trial Commencement

Requirements 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]. An IST commitment ends when either: (1) the defendant obtains certification that they have regained competency, pursuant to PC section 1372; (2) the maximum time for confinement runs out, pursuant to PC 1370 (c)(1); or (3) DSH determines there is no substantial likelihood a patient will regain competency in the foreseeable future, pursuant to PC 1370 (b)(1). If a patient 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 must be returned to the committing county. Patients may return for further hospitalization under a civil commitment once civil proceedings pursuant to the Lanterman-Petris-Short (LPS) Act have concluded.

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

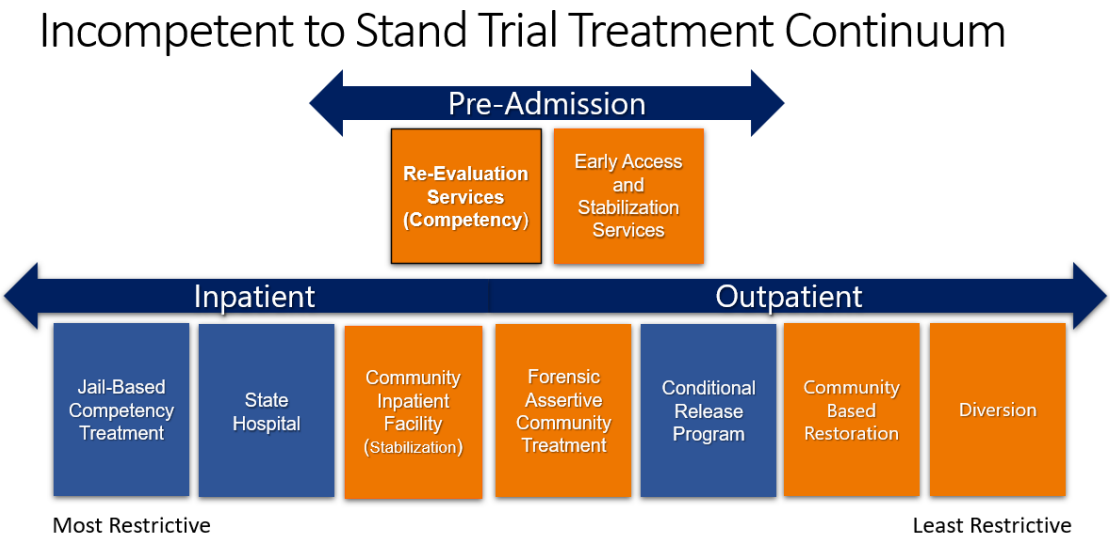
As defined in PC 1370(b)(1), a patient may be designated by their treatment team as unlikely to regain competency. Upon notification to the Sheriff of the county of commitment, the patient must be picked up within ten days and returned to county custody. Often, the county will pursue other means to ensure the patient receives treatment and care, including securing a conservatorship or 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 to pick up a patient who is within 90 days of expiration of their commitment term. The Sheriff must then pick up the patient within ten days of notice by DSH. Counties are billed for the continued costs of care for any patients remaining in a facility beyond the ten-day notice to the Sheriff.

DSH Treatment Continuum & Services

The diagram on the following page depicts the comprehensive continuum of IST services DSH has established and is continuing to build with the recent Budget Act investments. Blue boxes indicate DSH legacy programs which have been part of DSH's continuum for a decade or more, while orange boxes represent newer service options which began implementation in recent years.

Historically, restoration treatment options for individuals deemed IST on felony charges were primarily provided in state hospitals and Jail Based Competency Treatment (JBCT) programs. In 2018, DSH was authorized to partner with counties to pilot Felony Mental Health Diversion (Diversion) opportunities for individuals deemed IST on felony charges, or who were likely to be found IST on felony charges. Additionally, in 2018 DSH was authorized to partner with Los Angeles (LA) County to establish the first community-based restoration of competency program for individuals from LA County who were determined to be IST on felony charges. Utilizing the recent investments made in the Budget Acts of 2021 and 2022, DSH is building upon these initial community-based programs to expand the treatment continuum serving ISTs in the least restrictive community treatment options.



Programs

The following are DSH's IST programs and services, and their corresponding descriptions:

DSH IST Treatment Programs	
Jail Based Competency Program (JBCT)	DSH contracts with a number of California counties, through the local Sheriffs' Offices, to provide restoration of competency services to felony IST patients housed in county jail facilities. These services are provided by the county's chosen mental health provider. The JBCTs are responsible for assessment for competency and malingering, cognitive screenings, re-assessment of competency, and completion and submission of all court reports. Services provided to IST patients include daily clinical contact, group and individual therapy, competency education materials, and clinical support through interdisciplinary teams.
State Hospitals (SH)	DSH's inpatient mental health hospital system provides clinical, medical, and competency restoration treatment services to IST patients housed at Atascadero, Metropolitan, Napa, and Patton State Hospitals.
Community Inpatient Facility (CIF)	DSH's Community Inpatient Facility (CIF) program (formerly the Institutions for Mental Diseases (IMDs)/Sub-Acute program) contracts with community-based locked, inpatient facilities including Mental Health Rehabilitation

	Centers, Skilled Nursing Facilities and acute psychiatric hospitals where IST patients receive medication management, mental health therapy and support services, and when clinically indicated, competency education and evaluation services. Additionally, individuals deemed suitable for diversion receive mental health treatment and medication to facilitate psychiatric stabilization to support their participation in and transition to a DSH Diversion or CBR program in a lesser restrictive environment.
Forensic Assertive Community Treatment (FACT)	FACT Program services are available 24/7 through a mobile treatment team who provides onsite intensive wrap-around services, where the clients live, including psychiatry/medication management, individual and group treatment, as well as case management services and respond to clients as needed to reduce the likelihood of rehospitalization through de-escalation and crisis intervention practices.
Forensic Conditional Release Program (CONREP)	CONREP is DSH's statewide system of community-based services for specified court-ordered forensic individuals. DSH contracts with county and private providers to provide community-based treatment services for individuals committed to DSH under various commitment types, who have been approved by the court for outpatient treatment in lieu of state hospital placement, or for individuals approved by the courts to step down from state hospital treatment to the community. CONREP serves felony IST patients who have been court-approved for outpatient placement in lieu of state hospital placement.
Community Based Restoration (CBR)	DSH contracts with counties to operate Community Based Restoration programs where felony IST defendants from the contracted county can receive competency restoration services in a community treatment setting in lieu of a State Hospital or JBCT program.
Diversion	DSH Mental Health Diversion contracts with county-operated programs that allow felony IST defendants with certain serious mental illnesses to participate in intensive community-based mental health treatment. Services include housing, wrap-around support services, and medical evaluation and management with the goal of long-term mental health treatment, engagement, and connection to services. Criminal charges are dropped for

	individuals who successfully complete the program. Participating counties are required to connect individuals who successfully complete this program into ongoing community mental health care programs.
DSH IST Services	
DSH Re-Evaluation Services	DSH's Re-Evaluation Program (WIC 4335.2) utilizes expert forensic evaluators to re-evaluate an IST defendant's competency status after the individual has been ordered to DSH and is pending admission to a DSH IST program, to determine if the individual needs to continue into an IST treatment program or is competent or has no substantial likelihood to be restored and should be returned to court. If at the time of the evaluation the individual appears to be a candidate for Diversion or outpatient treatment, this program makes the recommendation for this consideration.
Early Access and Stabilization Services (EASS)	DSH contracts with county and private providers to provide substantive services including mental health services, psychiatric stabilization, and competency restoration services to felony IST defendants while the individual is in jail pending placement to a state hospital, Jail Based Competency Program, Diversion, or Community Based Program or facility.

The focus of treatment for the IST population is stabilization and restoration of competency.

- Stabilization: Stabilization focuses on medication evaluation and management, including a minimum of monthly visits with program psychiatrists, support with long-acting injectable medication, and daily contact with program staff.

- Restoration of Competency: Restoration treatment includes group psychoeducation, individual therapy, medication evaluation and management, and statutorily required competency to stand trial evaluations and court reports.

Throughout treatment, patients are regularly evaluated and, if there is concurrence a patient is competent, a forensic report (certificate of restoration) is sent to the court, identifying the patient as competent and ready to be discharged to the county of commitment where they can resume trial proceedings. Patients must be discharged and returned to the custody of the county of commitment within ten days of the certificate of restoration filing.

Population Data

System-wide Metrics

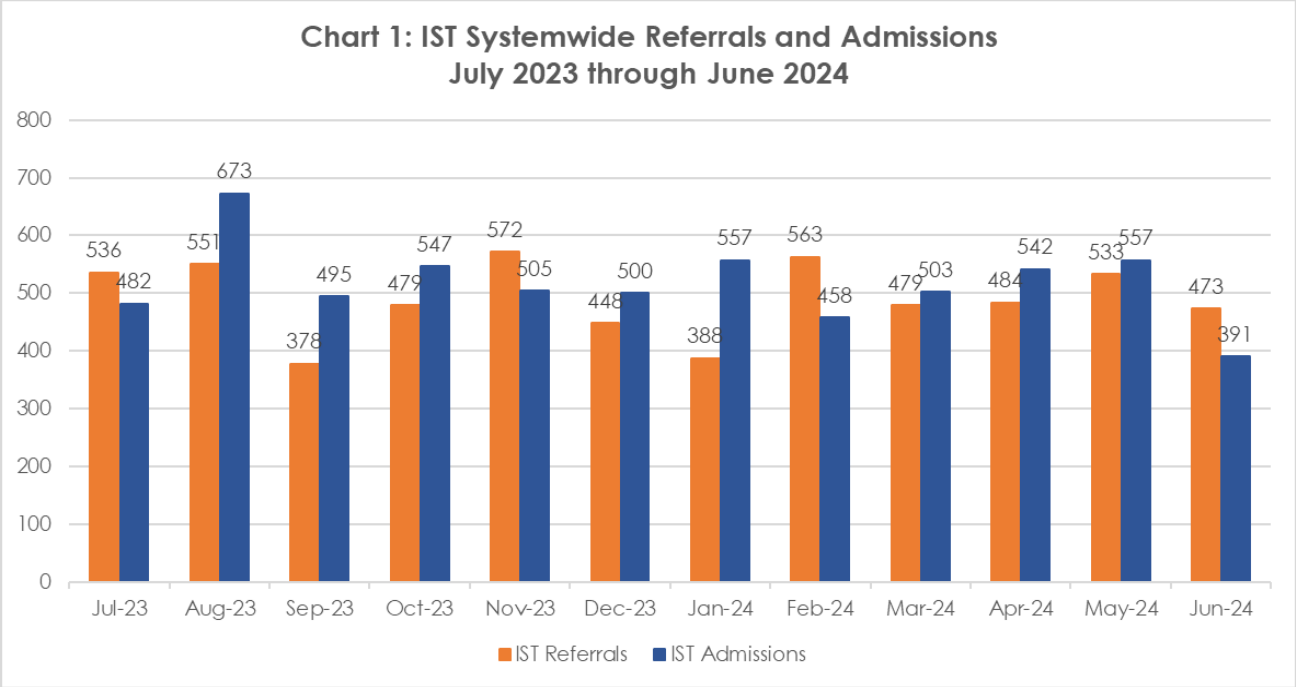
In FY 2023-24, DSH treated 8,570 patients designated as IST. This growth of 12% from prior year, reflects DSH's continuum of care expansion of inpatient and outpatient programs, and a focus of growing census while balancing continued health and safety measures associated with COVID-19. DSH had an average daily census of 2,906 IST designated patients during FY 2023-24, with a 1% growth from 2,881 patients in July 2023, to 2,908 in June 2024. In addition, as compared to the prior fiscal year, the average daily census increased overall by 10% in FY 2023-24. The table below summarizes key statistics across the IST population.

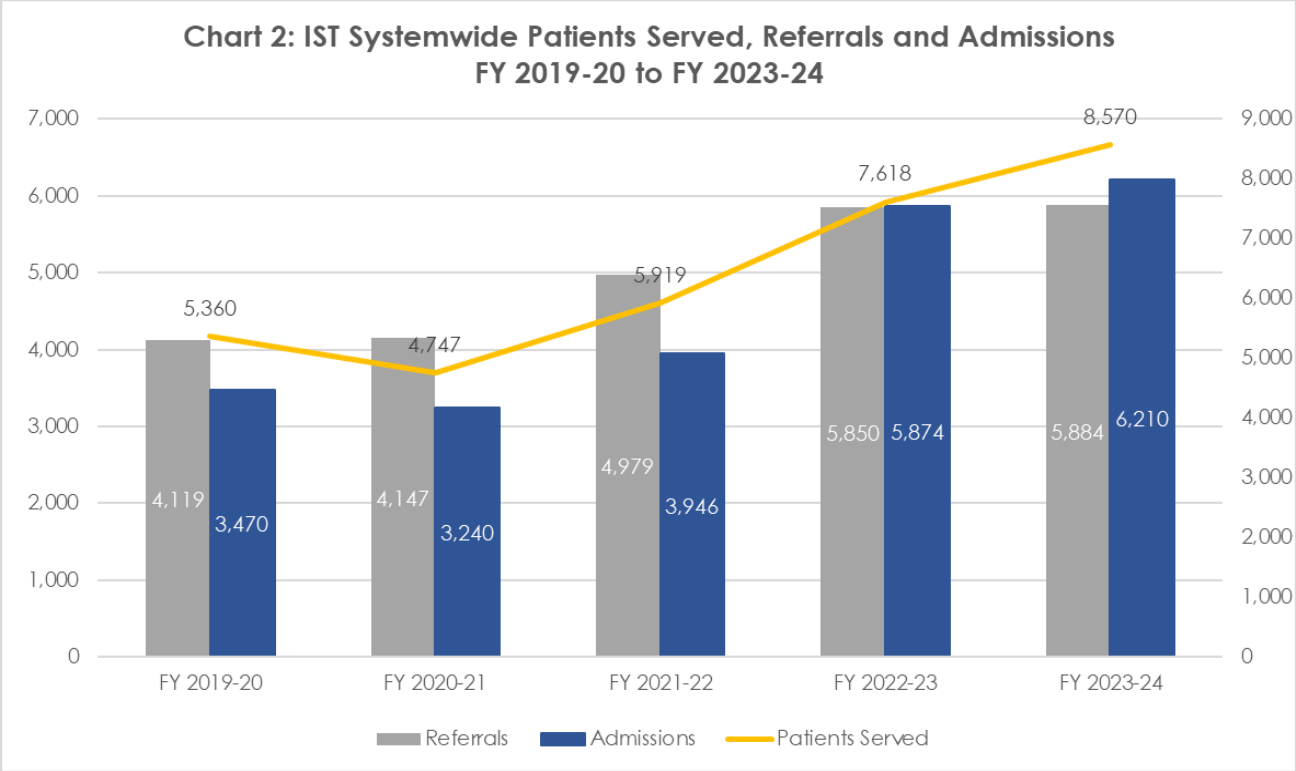
Table 1: System-wide IST Patient Data Summary

IST Patient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Referrals[2]	5,850	5,884	1%
Patient Admissions[3]	5,874	6,210	6%
Patients Served[4]	7,618	8,570	12%
Average Daily Census	2,647	2,906	10%

[2] Patient referrals excludes inpatient and outpatient program transfers and court returns.
[3] Patient admissions include inpatient and outpatient program transfers.
[4] Patients served excludes inpatient and outpatient program transfers.

In FY 2023-24, 5,884 IST designated patients were committed to DSH for competency treatment; an increase of 1% from FY 2022-23. Chart 1 below displays IST system-wide referrals and admissions for FY 2023-24. Chart 2 displays a five-year period of referrals and admissions, while also identifying DSH's increasing number of patients treated annually over the past few years.





In FY 2023-24, the IST Pending Placement List (PPL) decreased by 53% from 910 patients in July 2023 to 425 patients in June 2024. The PPL has continued to decrease with 384 patients pending placement as of September 30, 2024. Due to the average monthly referrals, it is unlikely this current pending placement list trend will change significantly moving forward. The primary drivers in reducing the IST PPL have included higher admission rates to inpatient and outpatient programs, and patients found competent prior to admission through a re-evaluation of competency while in county jail. The table below, Table 2, identifies the IST PPL as of June 30 of the corresponding year.

Table 2: IST System-wide Pending Placement List

IST Patients Pending Placement	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
	1,212	1,454	1,779	894	425

Inpatient Program Metrics

DSH inpatient treatment programs include State Hospitals, JBCT, and Community Inpatient Facilities (CIF). During FY 2023-24, DSH inpatient programs treated on average 2,233 IST designated patients daily. In July 2023, the average daily census was 2,176 with a 3% growth as compared to June 2024, with an average daily census of 2,233 patients. Table 3 (below) shows the IST Inpatient Data Summary for FY 2022-23 and FY 2023-24.

Table 3: IST Inpatient Data Summary

IST Inpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Admissions[5]	5,253	5,492	5%
Patients Served[6]	6,412	7,149	11%
Average Daily Census	1,978	2,233	13%

[5] Patient admissions include inpatient and outpatient program transfers.
[6] Patients served excludes inpatient and outpatient program transfers.

DSH inpatient programs admitted 5,492 IST designated patients in FY 2023-24 with an average of 458 admissions per month. Chart 3 displays inpatient program IST admissions by quarter and the average monthly admissions rate.

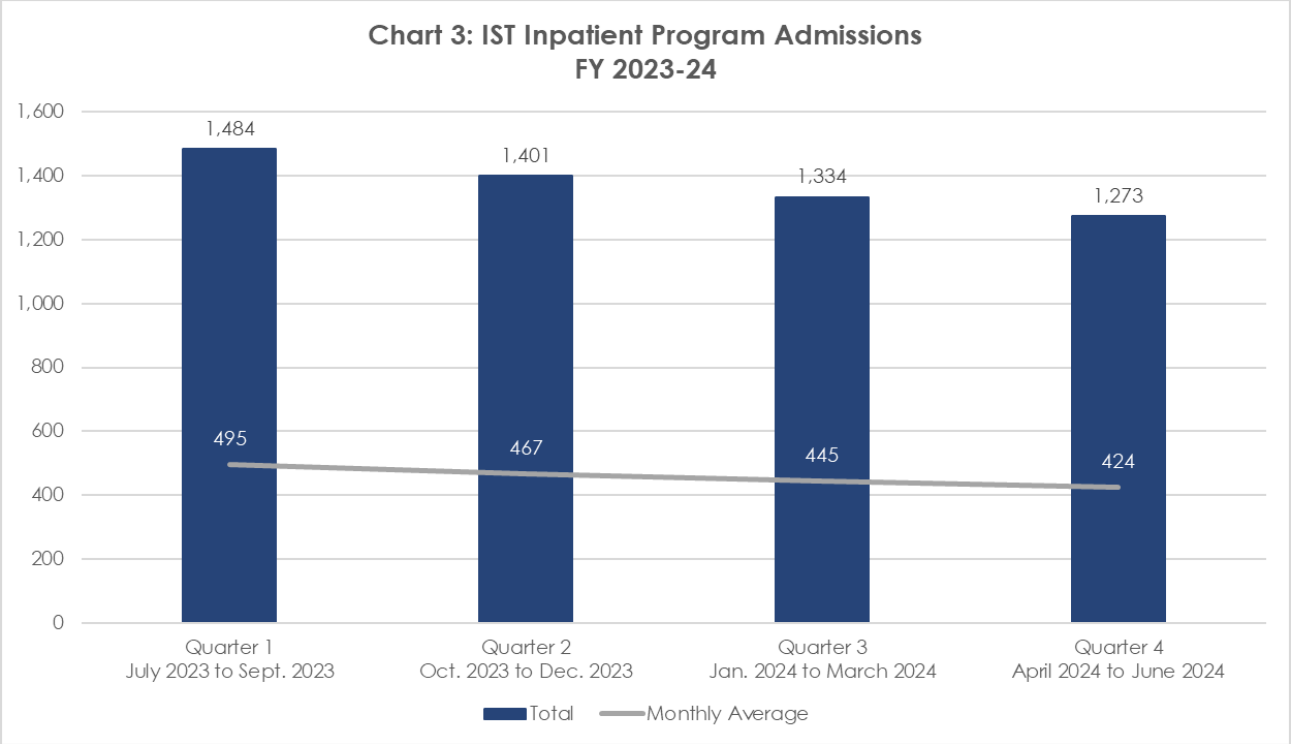


Table 4 below, displays the number of IST designated patients treated across the year in inpatient programs for the past five years.

Table 4: IST Patients Served – Inpatient Programs[7]

Patients Treated/ Served	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
	5,090	4,241	5,030	6,412	7,149

[7] Patients served excludes inpatient and outpatient program transfers.

Inpatient Discharge Data

DSH discharged 5,462 IST designated patients from inpatient programs with an average length of stay of 141 days and a median length of stay of 111 days across all programs. 42% of patients discharged within the first 90 days of their stay, 73% discharged within the first 180 days of their stay and 94% of patients discharged within the first year of their stay.

Table 5: IST Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 90 Days	42%
91 - 180 Days	32%
181 - 365 days	21%
366 - 730 days (1 - 2 years)	6%
731+ days (2+ years)	0%

For patients yet to discharge as of June 30, 2024, the average days in treatment is 132.7 days and the median days in treatment is 96 days. Table 6 displays Inpatient programs length of stay by quarter.

Table 6: IST Inpatient Length of Stay by Quarter – FY 2023-24

IST Inpatient Programs: Length of Stay	Quarter 1 July 2023 to Sept. 2023	Quarter 2 Oct. 2023 to Dec. 2023	Quarter 3 Jan. 2024 to March 2024	Quarter 4 April 2024 to June 2024	Total[8] FY 2023-24
Average Length of Stay	142.4	128.6	145.4	149.5	141.4
Median Length of Stay	114.0	103.0	111.0	113.0	111.0
Discharged Count	1,408	1,379	1,365	1,310	5,462

[8] Totals are based on raw data, which have been rounded for display purposes.

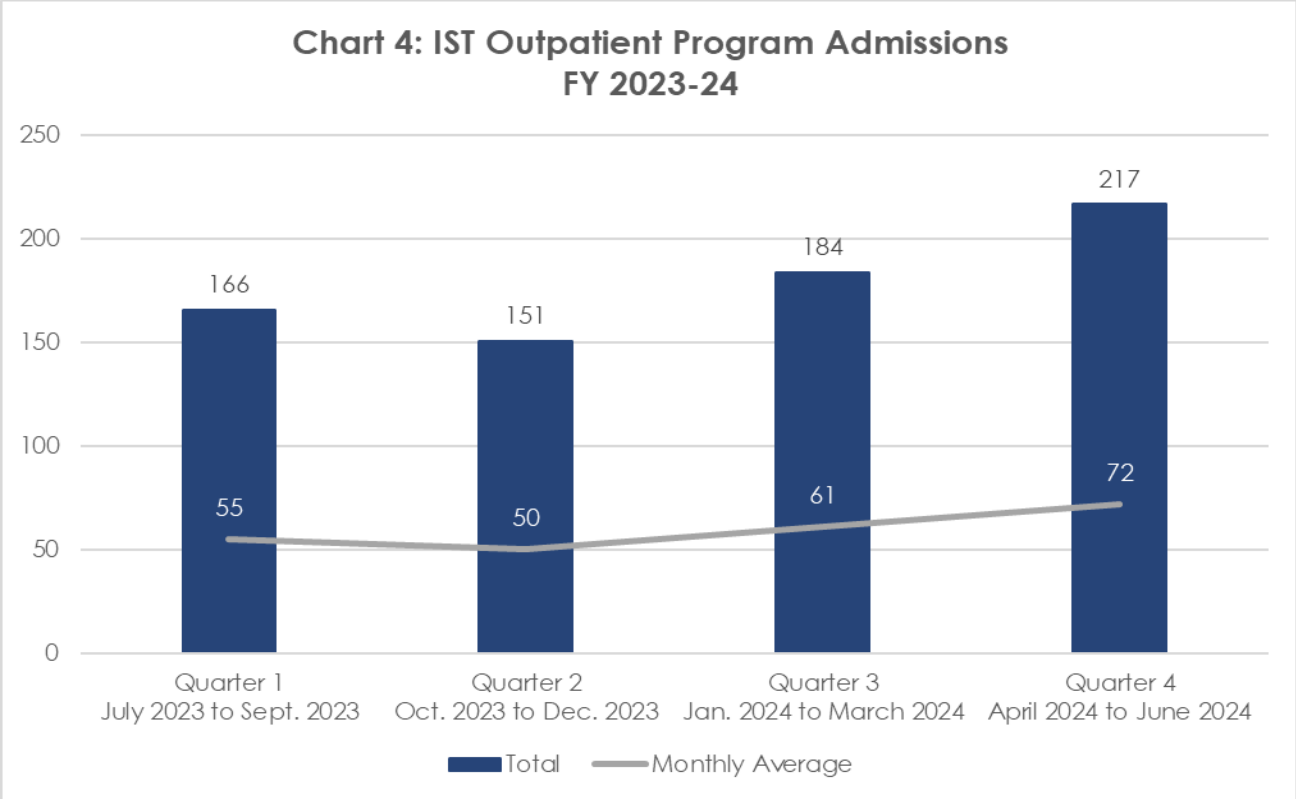
Outpatient Program Metrics

DSH outpatient treatment programs include CONREP, Community Based Restoration (CBR), and Diversion. During FY 2023-24 DSH outpatient programs treated on average 673 IST designated patients. In July 2023, the average census was 706 with a 4% decrease to 676 patients by the end of the FY in June 2024.

Table 7: IST Outpatient Data Summary

IST Outpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Admissions[9]	621	718	16%
Patients Served[10]	1,206	1,421	18%
Average Daily Census	668	673	1%

DSH outpatient programs admitted 718 IST designated patients in FY 2023-24, with an average of 60 admissions per month. Chart 4 displays IST outpatient program admissions by quarter.



[9] Patient admissions include inpatient and outpatient program transfers.
[10] Patients served excludes inpatient and outpatient program transfers.

Table 8, below, displays the number of patients treated in outpatient programs within each FY for the past five years.

Table 8: IST Patients Served – Outpatient Programs[11]

Patients Treated/Served	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
	270	506	889	1,206	1,421

Outpatient Discharge Data

DSH discharged 659 IST patients from outpatient programs, with an average length of stay of 418.5 days, and a median length of stay of 589 days, across all programs. 26% of patients discharged within the first 90 days of their stay, 34% discharged within the first 180 days of their stay, and 40% of patients discharged within the first year of their stay.

Table 9: IST Outpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 90 Days	26%
91 - 180 Days	8%
181 - 365 days	7%
366 - 730 days (1 - 2 years)	53%
731+ days (2+ years)	7%

Table 10 displays outpatient length of stay by quarter.

Table 10: IST Outpatient Length of Stay by Quarter – FY 2023-24

IST Outpatient Programs: Length of Stay	Quarter 1 July 2023 to Sept. 2023	Quarter 2 Oct. 2023 to Dec. 2023	Quarter 3 Jan. 2024 to March 2024	Quarter 4 April 2024 to June 2024	Total[12] FY 2023-24
Average Length of Stay	478.9	377.0	394.0	418.2	418.5
Median Length of Stay	620.0	535.0	577.0	598.0	589.0
Discharged Count	174	138	193	154	659

[11] Patients served excludes inpatient and outpatient program transfers.
[12] Totals are based on raw data, which have been rounded for display purposes.

IST Services Metrics

Early Access Stabilization Services

During FY 2023-24 DSH's Early Access Stabilization Services (EASS) Program provided IST services to 2,797 patients with 13 newly participating counties and a total of 49 counties actively participating in EASS during the FY.

Table 11: IST Early Access Stabilization Services Summary by Quarter

IST Early Access Stabilization Services	**Quarter 1** July 2023 to Sept. 2023	**Quarter 2** Oct. 2023 to Dec. 2023	**Quarter 3** Jan. 2024 to March 2024	**Quarter 4** April 2024 to June 2024	**Total** FY 2023-24
IST Services Initiated	569	736	748	744	2,797
Newly Participating Counties	5	6	2	0	13
Total Participating Counties	41	47	49	49	49

Re-Evaluation Services

IST Re-Evaluation Services completed 834 evaluations during FY 2023-24. Outcomes resulted in 24% IST patients found competent prior to admission, and 76% found retain and treat.

Table 12: IST Re-Evaluation Services Summary by Quarter[13]

IST Re-Evaluation Services	**Quarter 1** July 2023 to Sept. 2023	**Quarter 2** Oct. 2023 to Dec. 2023	**Quarter 3** Jan. 2024 to March 2024	**Quarter 4** April 2024 to June 2024	**Total** FY 2023-24
IST Evaluations Completed	**380**	**201**	**142**	**111**	**834**
IST Found Competent	23%	***%	23%	***%	24%
IST Retain and Treat	77%	70%	77%	82%	76%
IST Unlikely to Restore	0.0%	***%	0.0%	***%	***%

[13] Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or "less than 11" within the narrative. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

IST POPULATION DATA HIGHLIGHTS

Referral Growth

DSH has experienced a 28 percent growth in IST county referrals from FY 2018-19 through FY 2023-24.

Average Monthly Referrals	
FY 2018-19	383
FY 2019-20	343
FY 2020-21	346
FY 2021-22	415
FY 2022-23	488
FY 2023-24	490
6-Year ↑	**28% ↑**

KEY STATISTICS

2023-24 Patients Served
8,570
Inpatient
7,149
Outpatient
1,421
Increased by
12%
from FY 2022-23

2023-24 Admissions
6,210
Inpatient
5,492
Outpatient
718
Increased by
6%
from FY 2022-23

Expansion of and new IST Treatment and Services

- DSH increased IST treatment capacity by 1,231 beds since FY 2017-18 across State Hospitals, JBCT, CIF and CBR programs.
- DSH county funded Diversion program diverted 207 individuals.
- EASS and Re-evaluation Services provide increased access to competence evaluations and early access services. EASS has initiated services to 2,797 patients and Re-evaluation Services have conducted 834 re-evaluations finding 24% patients competent.

IST Waitlist & COVID-19 Impact

The DSH IST waitlist grew during the years of COVID-19 response, due to proactive public health measures aimed to protect the health and safety of patients and staff.

System Recovery & Decreased Waitlist

As the COVID-19 infection rate reduced, DSH has been able to increase admissions. Increased admissions, paired with new services and programs, has led to a significant reduction in the IST waitlist.

PPL Trends

February 2020: 848
PPL High: 1,953
September 2024 : 384
80% Decrease

IST Waitlist, Referrals and Admission Trends

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 a patient committed as Incompetent to Stand Trial (IST) 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.

Legal Statutes and Commitments[1]

- PC 2974 – Parolee from CDCR
- WIC 5353 – Temporary Conservatorship
- WIC 5358 – Conservatorship
- WIC 5008(h)(1)(B) – Murphy Conservatee
- WIC 5304(a) – 180-Day Post Certification
- WIC 6000 – Voluntary
- WIC 4825, 6000(a) – Admission to a state hospital of a developmentally disabled individual by their conservator
- WIC 6500, 6509 – A person with a developmental disability committed to a state hospital

Requirements for Discharge

LPS conservatees 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 hospitals 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

[1] Legal Statute and Commitments List only includes those applicable to patients treated by DSH in the past five years. Other LPS Act related legal statutes and commitments not typically treated by DSH include WIC 5304(b), WIC 5150, WIC 5250, WIC 5260, WIC 5270.15, WIC 5303, WIC 6506, and WIC 6552.

or with family, or 3) they have successfully petitioned the court to remove the conservatorship.

DSH Treatment Continuum & Services

Under Welfare and Institutions Code (WIC) section 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.

Over the past five years, 84% of all LPS patients treated in DSH were committed under WIC 5353 or 5358 as conservatees. Table 1 below displays the percent of LPS patients treated in DSH over the past five years by commitment type.

Table 1: LPS Patients Treated by Commitment Type[2]

Commitment Type	**Percent of LPS Patients Treated[3]** (Past 5 years)
WIC 5353 - Temporary Conservatorship WIC 5358 - Conservatorship	84%
WIC 5008(h)(1)(B) - Murphy Conservatorship	16%
Other LPS	***%

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 to 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, and the patient's county of residence pursues alternative placement options.

Programs

DSH provides inpatient treatment to LPS patients within the state hospitals.

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[3] Totals are based on raw data, which have been rounded for display purposes.

DSH LPS Treatment Programs	
State Hospitals (SH)	DSH's inpatient mental health hospital system provides psychiatric, medical, and psychosocial treatment services to forensic and civil patients housed at Atascadero, Coalinga, Metropolitan, Napa, and Patton state hospitals.

Population Data

System-wide Metrics

Although DSH is not statutorily required to admit LPS patients as is the case with other legal classifications, DSH continues to collaborate with the California Mental Health Services Authority (CalMHSA) to identify opportunities to improve county utilization of the 556 beds made available for treatment of the LPS population. In fiscal year (FY) 2023-24, DSH experienced a decrease in the total number of LPS patients treated and in the LPS average daily census, but an increase in LPS referrals and decrease in admissions as compared to the prior year. These statistics are summarized in Table 2 below.

Table 2: LPS Patient Data Summary

LPS Patient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Referrals[4]	135	202	50%
Patient Admissions[5]	94	77	-18%
Patients Served[6]	736	652	-11%
Average Daily Census	637	565	-11%
Average Length of Stay	2,353	2,296	-2%
Patient Discharges	245	140	-43%

The LPS patient referrals increased by 50% from FY 2022-23 to FY 2023-24. Even with the increase in referrals, the LPS patient admissions decreased by 18% and census decreased by 6% within FY 2023-24 from 589 patients in July 2023 to 554 patients in June 2024[7].

[4] Patient referrals excludes inpatient program transfers and court returns.
[5] Patient admissions include inpatient program transfers.
[6] Patients served excludes inpatient program transfers.
[7] DSH provides treatment to patients pursuant to the LPS Act through a Memorandum of Understanding (MOU) with California Counties via the California Mental Health Services Authority (CalMHSA), to provide a maximum of 556 treatment beds.

Chart 1 displays LPS system-wide referrals and admissions by quarter for FY 2023-24, and Chart 2 displays a five-year period of referrals and admissions for a broader historical view.

Chart 1: LPS Systemwide Referrals and Admissions FY 2023-24

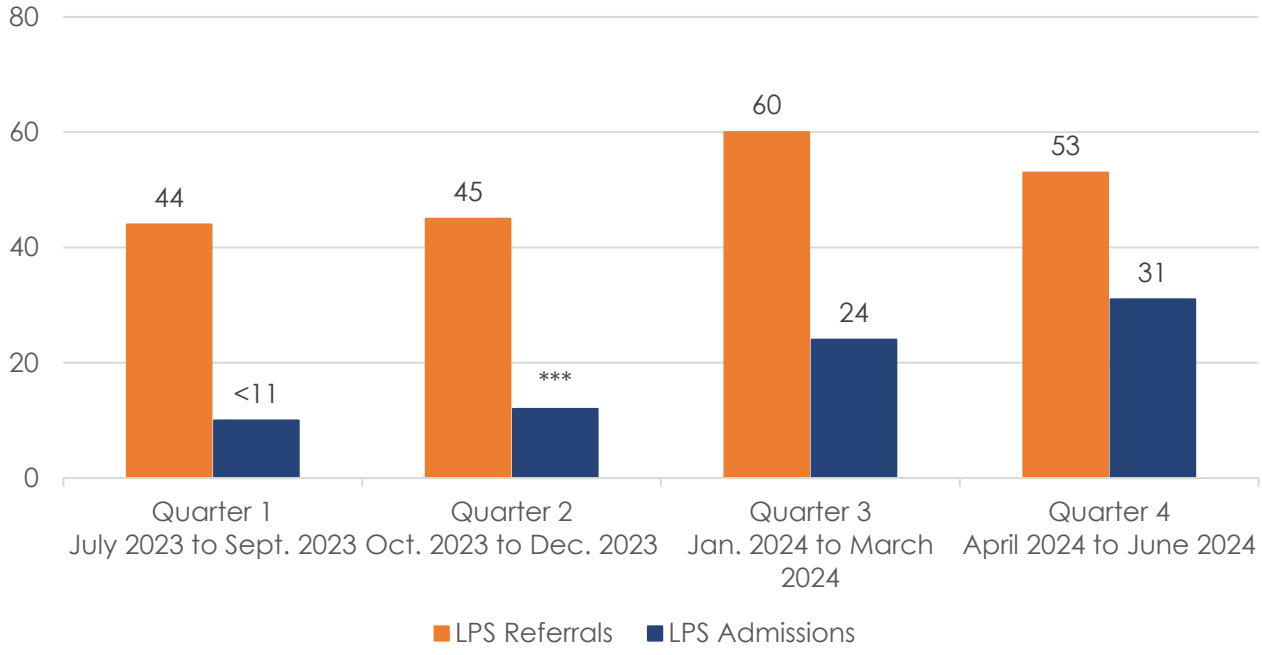
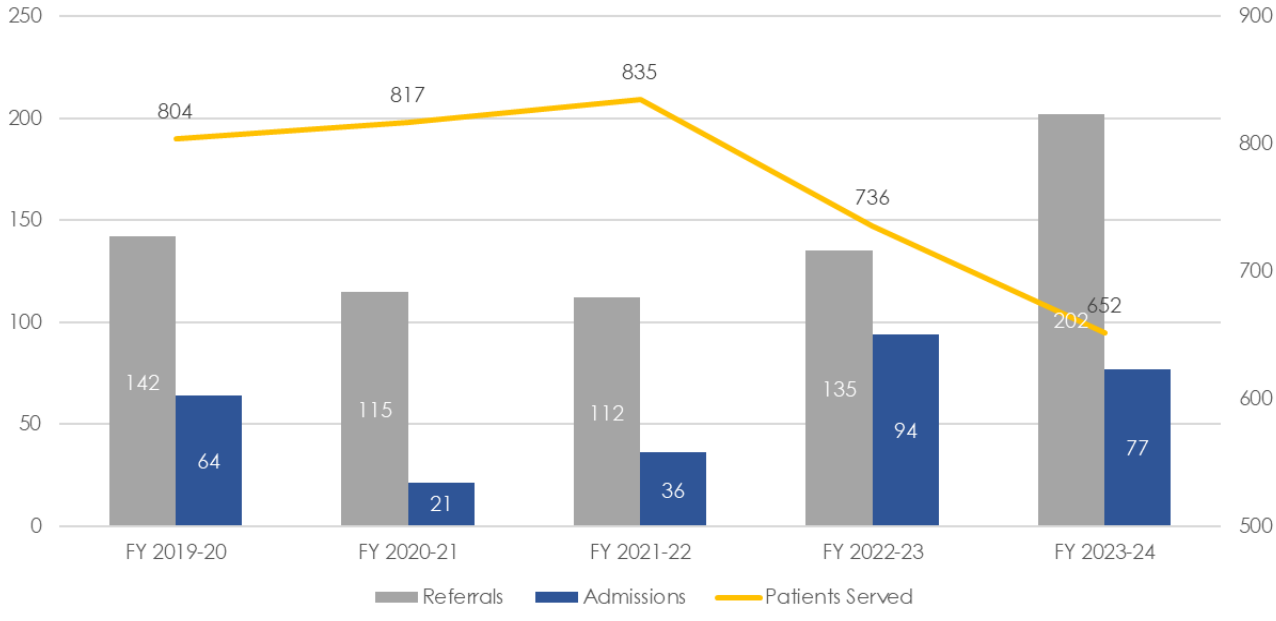


Chart 2: LPS Systemwide Patients Served, Referrals and Admissions FY 2019-20 to FY 2023-24



LPS patients referred and committed to DSH are added to the DSH System-wide LPS Pending Placement List until a bed becomes available or a DSH bed is no longer needed. Table 3 below identifies the number of LPS patients pending placement into a DSH bed as of June 30th of the corresponding year. The number of LPS patients pending placement decreased 22% from FY 2022-23 to FY 2023-24.

Table 3: LPS System-wide Pending Placement List

LPS Patients Pending Placement	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
	201	297	317	311	244

Discharge Data

DSH discharged 140 LPS patients in FY 2023-24 with an average length of stay of 2,296.2 days (6.3 years) and a median length of stay of 1,984 days (5.4 years). Only 14% of LPS patients discharged within one year, 50% discharged within five years, and 50% had a length of stay longer than five years. Table 4 below depicts the distribution of LPS patients discharged in FY 2023-24 by length of stay.

Table 4: LPS Patient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	14%
366 - 1,460 Days (2 - 4 years)	25%
1,461 - 1,825 days (4 - 5 years)	11%
1,826 - 3,650 days (5 - 10 years)	31%
3,651+ days (10+ years)	19%

For patients yet to discharge the average days in treatment is 2,514 days, approx. 7 years and median days in treatment is 1,984, 5.4 years.

Table 5 below displays length of stay by quarter for FY 2023-24.

Table 5: LPS Patient Length of Stay by Quarter – FY 2023-24

LPS Patient Length of Stay Days (Years)	Quarter 1 July 2023 to Sept. 2023	Quarter 2 Oct. 2023 to Dec. 2023	Quarter 3 Jan. 2024 to March 2024	Quarter 4 April 2024 to June 2024	Total[8] FY 2023-24
Average Length of Stay	2,207.7 (6.0 yrs.)	2,329.6 (6.34 yrs.)	2,083.0 (5.7 yrs.)	2,529.1 (6.9 yrs.)	2,296.2 (6.3 yrs.)
Median Length of Stay	1,561.0 (4.3 yrs.)	1,778.0 (4.9 yrs.)	1,695.5 (4.6 yrs.)	2,068.5 (5.7 yrs.)	1,984.0 (5.4 yrs.)

[8] Totals are based on raw data, which have been rounded for display purposes.

Discharged Count	31	33	36	40	140

LPS patients can be discharged to a variety of locations. For the 140 LPS patients discharged in FY 2023-24 those locations are displayed in the table below.

Table 6: LPS Patient Discharges by Location[9]

Discharge Location	**LPS** FY 2023-24	**MURCON** FY 2023-24	**Total FY 2023-24**	**Percent to Total**
Community Outpatient Treatment	<11	<11	***	***%
Deceased	13	0	**13**	9%
Discharged to Community	***	<11	**64**	46%
Locked Facility: CDCR, DJJ, Jail, Court, Other State Hospitals	***	<11	**21**	15%
Locked Medical Facility	25	0	**25**	18%
Other/Unknown	***	<11	***	***%
Total Discharges	**124**	**16**	**140**	**100%**

[9] Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or "less than 11" within the narrative. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

POPULATION PROFILE
Not Guilty by Reason of Insanity Patients

Description of Legal Class

The Department of State Hospitals (DSH) admits individuals found Not Guilty by Reason of Insanity (NGI) under Penal Code (PC) 1026: Pleadings and Proceedings before Trial-Plea. Once a court determines an individual (defendant) is found guilty but was insane at the time the crime was committed, the court commits the defendant 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.

Legal Statutes and Commitments

- PC 1026 – Not Guilty by Reason of Insanity
- PC 1026.5 – Not Guilty by Reason of Insanity, Extension of term
- PC 1610 – Temporary admission while waiting for court revocation of PC 1026, RONGI
- WIC 702.3 - Minor Not Guilty by Reason of Insanity, MNGI

Requirements for Discharge

Restoration of sanity is a two-step process in which evidence is presented and reviewed to determine whether a patient is a danger to the health and safety of others, due to their 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 their 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. 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.[1]

[1] Penal Code section 1606

DSH Treatment Continuum & Services

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 assessed by a forensic evaluator every six months, with progress reports submitted to the court. In the event the maximum term approaches and DSH 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 PC 1026.5. In fiscal year (FY) 2023-24, 367 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 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 designated patients are admitted to DSH due to severe mental illness and increased risk of violence, patients have the right to refuse treatment unless the Court finds the individual lacks capacity to make the decision; 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.

Programs

DSH provides treatment to NGI patients through inpatient care within the State Hospitals and on an outpatient basis through the Forensic Conditional Release Program (CONREP).

DSH NGI Treatment Programs	
State Hospitals (SH)	DSH's inpatient mental health hospital system provides psychiatric, medical, and psychosocial treatment services to forensic and civil patients housed at Atascadero, Coalinga, Metropolitan, Napa, and Patton state hospitals.

Forensic Conditional Release Program (CONREP)	CONREP is DSH's statewide system of community-based services for specified court-ordered forensic individuals. DSH contracts with county and private providers to provide community-based treatment services for individuals committed to DSH, under various commitment types, who have been approved by the court for outpatient treatment in lieu of state hospital placement or for individuals approved by the courts to step down from state hospital treatment to the community.

Population Data

System-wide Metrics

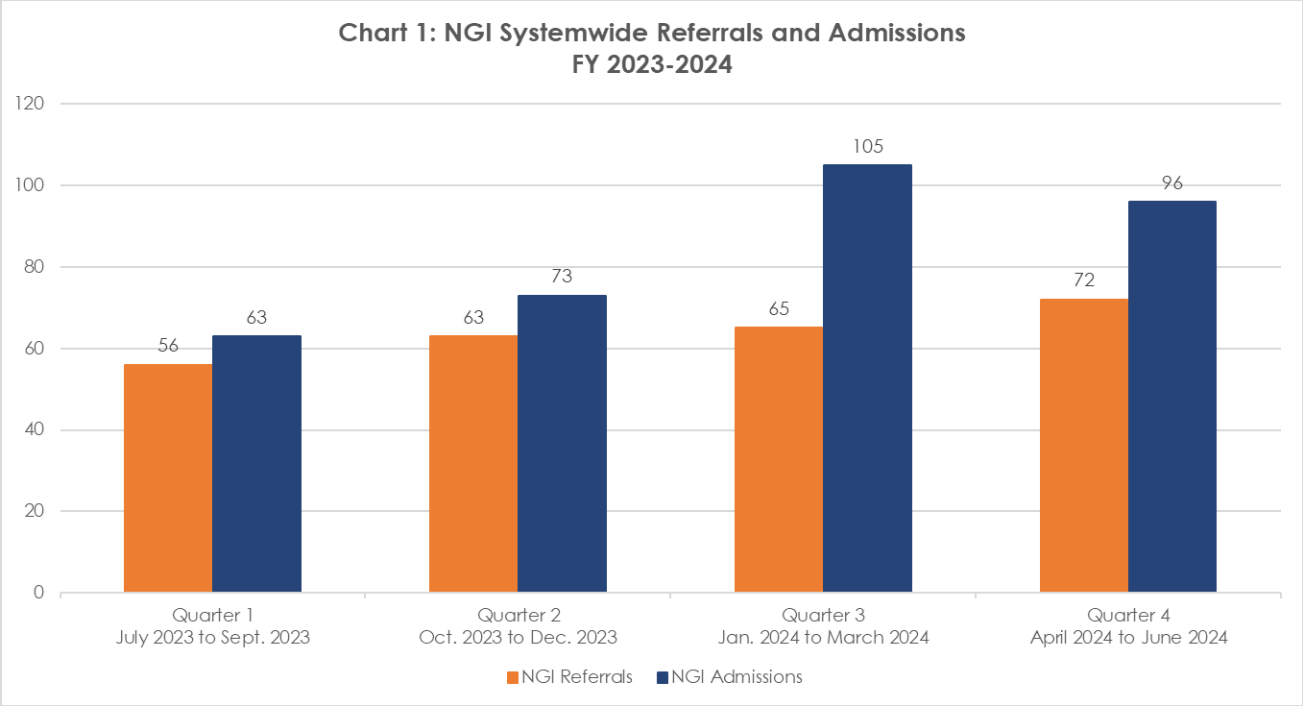
Across inpatient and outpatient programs, DSH treated 1,808 patients designated as NGI in FY 2023-24. The table below summarizes key statistics across the NGI population.

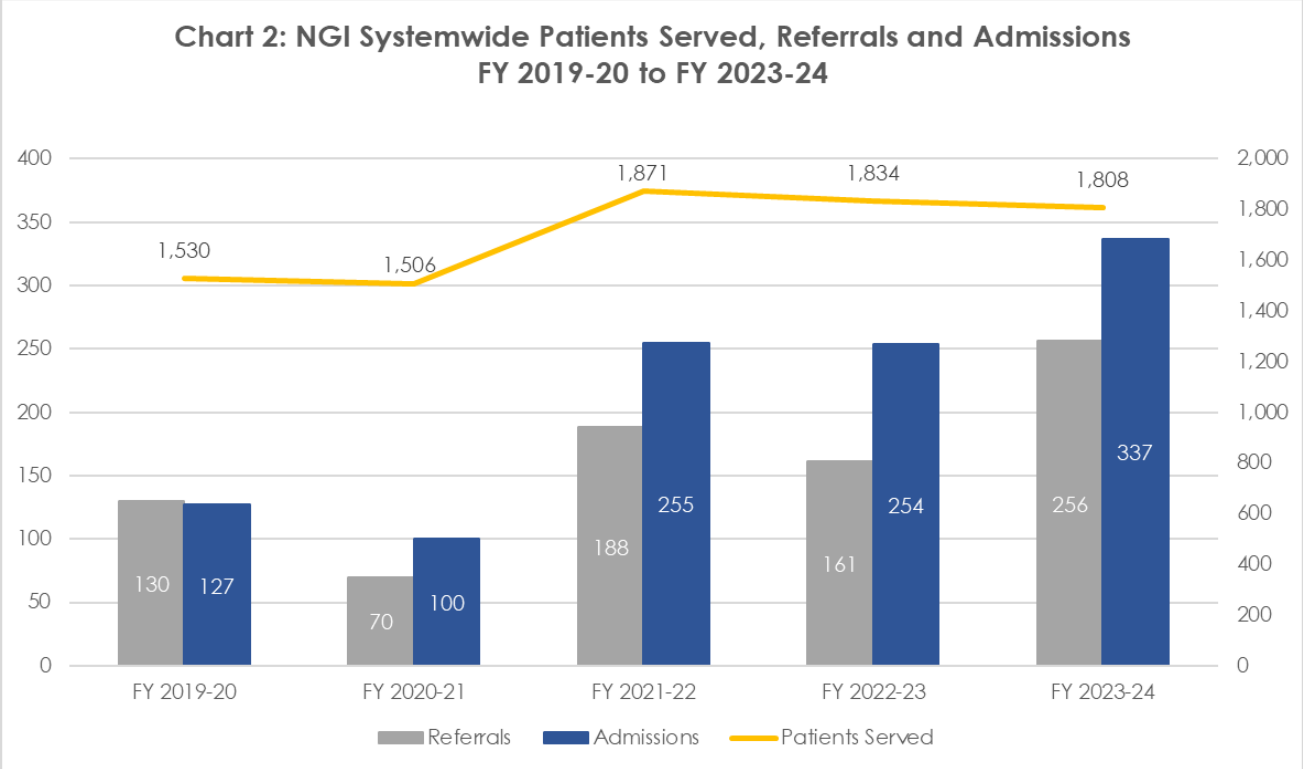
Table 1: System-wide NGI Patient Data Summary

NGI Patient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Referrals[2]	161	167	4%
Patient Admissions[3]	254	337	33%
Patients Served[4]	1,832	1,808	-1%
Average Daily Census	1,705	1,675	-2%

[2] Patient referrals excludes inpatient program transfers and court returns.
[3] Patient admissions include inpatient and outpatient program transfers.
[4] Patients served excludes inpatient and outpatient program transfers.

Chart 1 displays NGI system-wide referrals and admissions by quarter for FY 2023-24 and Chart 2 displays a five-year period of referrals and admissions for a broader historical view[5].





[5] Outpatient data is included beginning FY 2021-22 (Chart 2).

NGI patients are individuals committed to a state hospital for treatment by the courts and transfer directly from jail. The table below, Table 2, identifies the NGI pending placement list (PPL) as of June 30 of the corresponding year.

Table 2: NGI System-wide Pending Placement List[6,7]

NGI Patients Pending Placement	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
	34	14	44	11	<11

Inpatient Program Metrics

Patients committed to DSH as NGI receive inpatient treatment within four of DSH's state hospitals: DSH-Atascadero, DSH-Metropolitan, DSH-Napa and DSH-Patton. During FY 2023-24, DSH inpatient programs treated on average 1,209 NGI designated patients daily, with an average census of 1,229 in July 2023, including a slight decrease of 1% across the year, ending with an average census of 1,211 patients in June 2024.

Table 3: NGI Inpatient Data Summary

NGI Inpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Admissions[8]	149	202	36%
Patients Served[9]	1,348	1,297	-4%
Average Daily Census	1,228	1,209	-2%

[6] The pending placement list reflects patients pending inpatient treatment.
[7] Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or "less than 11" within the narrative. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.
[8] Patient admissions include other inpatient and outpatient program transfers.
[9] Patients served excludes other inpatient and outpatient program transfers.

DSH Inpatient programs admitted 202 patients in FY 2023-24 with an average of 17 admissions per month. Chart 3 displays Inpatient program NGI admissions by quarter and the average monthly admissions rate.

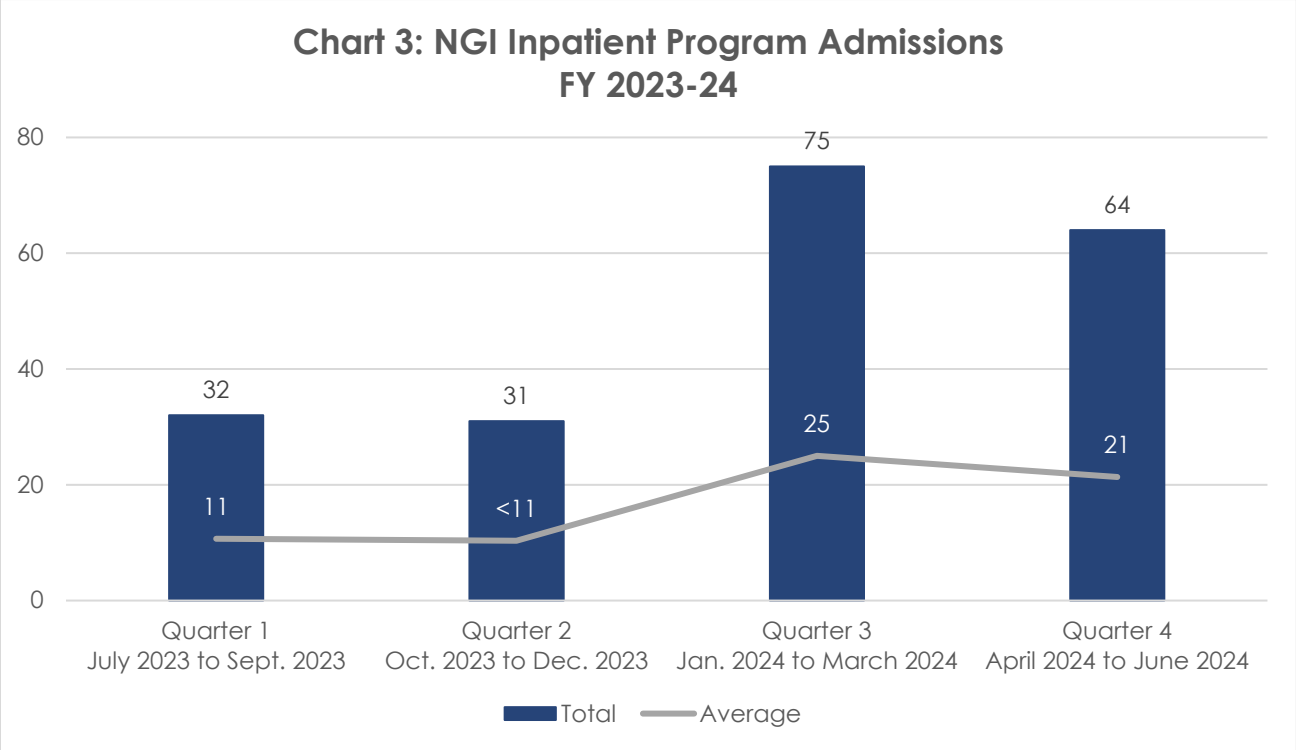


Table 4, below, displays the number of NGI patients treated in inpatient programs within each FY for the past five years.

Table 4: NGI Patients Served – Inpatient Programs[10]

Patients Treated/ Served	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
	1,530	1,506	1,406	1,348	1,297

Inpatient Discharge Data

DSH discharged 227 NGI designated patients from inpatient programs with an average length of stay of 3,110.5 days, 8.5 years, and a median length of stay of 2,120.0 days, over 5.5 years across all programs. Only 15% of the patients discharged within the first year of their stay, 43% discharged within the first five years of their stay, and 57% of the patients discharged with a length of stay of more than five years. Table 5 on the following page depicts the distribution of NGI patients discharged from inpatient programs in FY 2023-24 by length of stay.

[10] Patients served excludes other inpatient and outpatient program transfers.

Table 5: NGI Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	15%
366 - 1,460 Days (2 - 4 years)	22%
1,461 - 1,825 days (4 - 5 years)	6%
1,826 - 3,650 days (5 - 10 years)	26%
3,651+ days (10+ years)	31%

For patients yet to discharge the average days in treatment is 3,896.1 days, 10.7 years and median days in treatment is 2,421.0 days, 6.6 years.

Table 6 displays Inpatient programs length of stay by quarter.

Table 6: NGI Inpatient Length of Stay by Quarter – FY 2023-24

NGI Inpatient Length of Stay Days (Years)	Quarter 1 July 2023 to Sept. 2023	Quarter 2 Oct. 2023 to Dec. 2023	Quarter 3 Jan. 2024 to March 2024	Quarter 4 April 2024 to June 2024	Total[11] FY 2023-24
Average Length of Stay	3,001.1 (8.2 yrs.)	2,635.3 (7.2 yrs.)	3,859.2 (10.6 yrs.)	2,581.3 (7.1 yrs.)	3,110.5 (8.5 yrs.)
Median Length of Stay	2,319.0 (6.4 yrs.)	1,952.0 (5.3 yrs.)	2,931.0 (8.0 yrs.)	1,725.0 (4.7 yrs.)	2,120.0 (5.8 yrs.)
Discharged Count	46	45	77	59	227

NGI designated patients can be discharged to a variety of locations including outpatient treatment programs. The table below displays the discharge locations for the 227 patients discharged in FY 2023-24.

Table 7: NGI Inpatient Discharges by Location[12]

NGI Inpatient Discharge Location	NGI FY 2023-24	Percent to Total
Community Outpatient Treatment	67	30%
Locked Facility: CDCR, DJJ, Jail, Court, Other State Hospitals	97	43%
Discharged to Community	36	16%
Deceased	***	***%
Other/Unknown	<11	***%

[11] Totals are based on raw data, which have been rounded for display purposes.

[12] Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or "less than 11" within the narrative. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

Total Discharges	**227**	**100%**

Outpatient Program Metrics

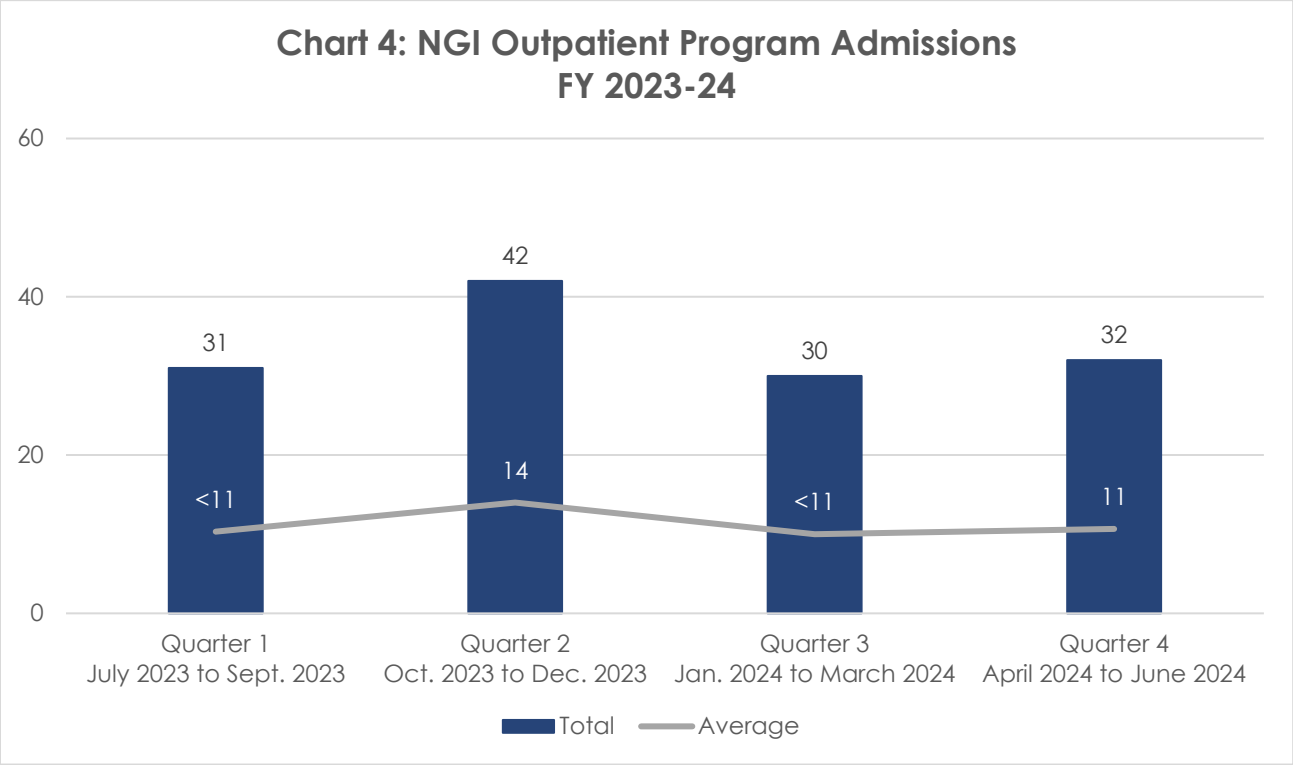
CONREP is the DSH outpatient treatment program for patients committed as NGI. During FY 2023-24, DSH CONREP treated on average 466 NGI designated patients daily, with an average census of 462 in July 2023, and an ending average census of 460 patients in June 2024.

Table 8: NGI Outpatient Data Summary

NGI Outpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY[13]
Patient Admissions[14]	105	135	29%
Patients Served[15]	484	511	6%
Average Daily Census	478	466	-2%

DSH outpatient programs admitted 135 NGI patients in FY 2023-24 with an average of 11 admissions per month. Chart 4 displays outpatient program NGI admissions by quarter.

[13] Percent change from prior fiscal year is based on raw data, which has been rounded to whole numbers for display purposes.
[14] Patient admissions include inpatient and outpatient program transfers.
[15] Patients served excludes inpatient and outpatient program transfers.



The table below displays the number of patients treated across the years in outpatient programs.

Table 9: NGI Patients Served – Outpatient Programs[16]

Patients Treated/Served	FY 2021-22	FY 2022-23	FY 2023-24
	465	486	511

Outpatient Discharge Data

DSH discharged 130 NGI patients from outpatient programs with an average length of stay of 1,296.3 days, approximately 4 years, and a median length of stay of 531.0 days, 1.5 years across all programs. 32% of NGI patients discharged within the first year of their stay, 82% of the NGI patients discharged within the first five years of their stay, and 18% of the NGI patients discharged with a length of stay of more than five years. Table 10 below depicts the distribution of NGI patients discharged from outpatient programs in FY 2023-24 by length of stay.

Table 10: NGI Outpatient Length of Stay Distribution

NGI Outpatient Length of Stay	% of Patients
0 - 365 Days (1 year)	32%
366 - 1,825 Days (2 - 5 years)	50%

[16] Patients served excludes inpatient and outpatient program transfers.

1,826 - 3,650 days (5 - 10 years)	9%
3,651+ days (10+ years)	9%

Table 11 displays outpatient length of stay by quarter for FY 2023-24.

Table 11: NGI Outpatient Length of Stay by Quarter – FY 2023-24

NGI Outpatient Length of Stay	**Quarter 1** July 2023 to Sept. 2023	**Quarter 2** Oct. 2023 to Dec. 2023	**Quarter 3** Jan. 2024 to March 2024	**Quarter 4** April 2024 to June 2024	**Total**[17] FY 2023-24
Average Length of Stay	1,335.6 (3.7 yrs.)	1,111.1 (3.0 yrs.)	1,161.7 (3.2 yrs.)	1,638.2 (4.5 yrs.)	1,296.3 (3.6 yrs.)
Median Length of Stay	938.0 (2.6 yrs.)	515.0 (1.4 yrs.)	387.0 (1.1 yrs.)	603.0 (1.7 yrs.)	531.0 (1.5 yrs.)
Discharged Count	27	39	33	31	130

[17] Totals are based on raw data, which have been rounded for display purposes.

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 Parole Hearings (BPH) can commit that individual to a state hospital as a condition of parole. The individual then receives treatment at DSH unless they can be certified for outpatient treatment or the individual challenges the commitment.

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

Legal Statutes and Commitments

- PC 2962 – Supervised Persons Referred from CDCR
- PC 2964(a) – Supervised Persons Rehospitalized from Conrep after DSH hearing
- PC 2972 – Former Supervised Person Referred from Superior Court
- PC 1610 – Temporary admission while waiting for court revocation of PC 2972
- PC 1610 – Temporary admission while waiting for court revocation of MDSO
- WIC 6316 – Person convicted of a sex offense ordered to treatment (former MDSO statute now repealed)

Requirements for Discharge

After one year, a parolee is entitled to an annual review hearing conducted by the BPH to determine if 1) the parolee still meets the six criteria for OMD classification and 2) whether the parolee can be treated on an outpatient basis. The length of a parole period is determined by statute and depends on the type of sentence imposed. Parole terms can extend beyond the maximum parole period due to revocation or escape attempts. A parole period can be waived at the discretion of BPH. Most parolees have a maximum parole period of two 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 supervised person) may be placed into outpatient treatment in the Forensic 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.[1]

DSH Treatment Continuum & Services

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 outpatient treatment in CONREP. Another area of focus is substance abuse treatment, as 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 such as practicing good hygiene, grooming, and feeding.

Programs

DSH provides treatment to OMD patients through inpatient care within state hospitals and on an outpatient basis in CONREP.

DSH OMD Treatment Programs	
State Hospitals (SH)	DSH's inpatient mental health hospital system provides psychiatric, medical, and psychosocial treatment services to forensic and civil patients housed at Atascadero, Coalinga, Metropolitan, Napa, and Patton state hospitals.

[1] Penal Code section 1606

Forensic Conditional Release Program (CONREP)	CONREP is DSH's statewide system of community-based services for specified court-ordered forensic individuals. DSH contracts with county and private providers to provide community-based treatment services for individuals committed to DSH, under various commitment types, who have been approved by the court for outpatient treatment in lieu of state hospital placement or for individuals approved by the courts to step down from state hospital treatment to the community.

Population Data

State-wide Metrics

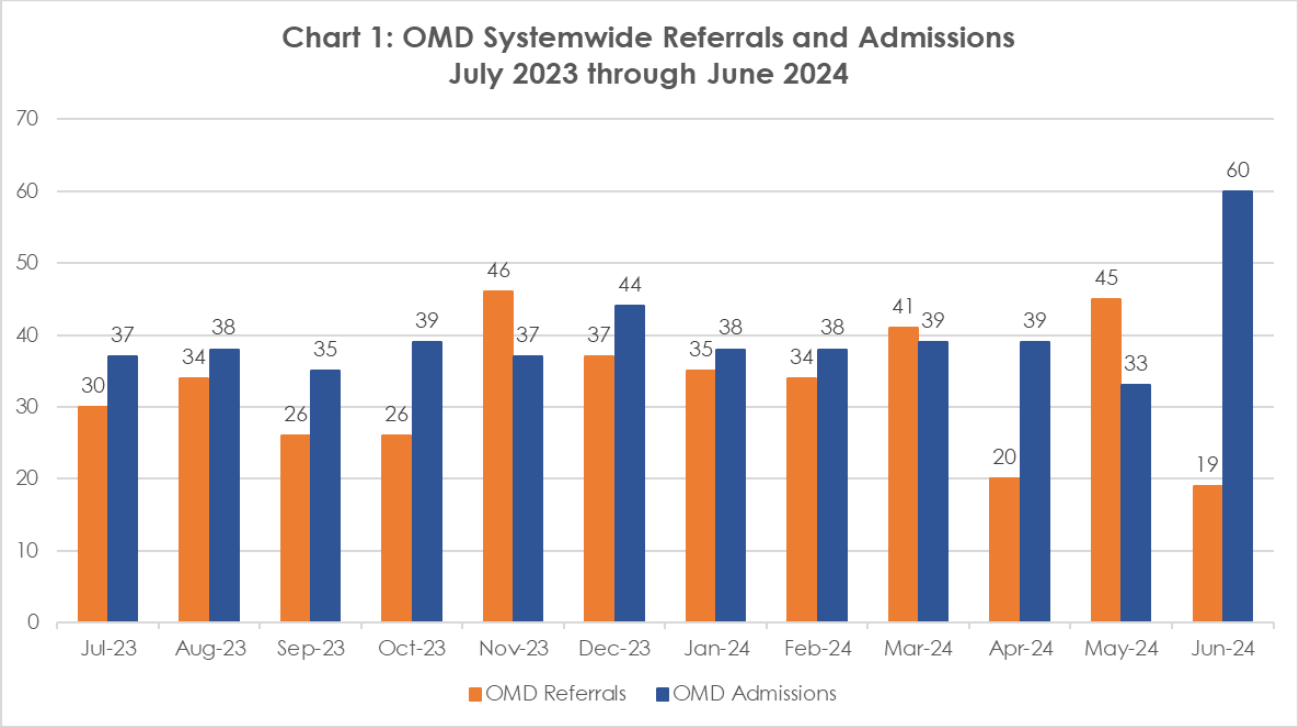
Across inpatient and outpatient programs, DSH treated 1,514 patients committed as OMD in fiscal year (FY) 2023-24. The table below summarizes key statistics across the OMD population.

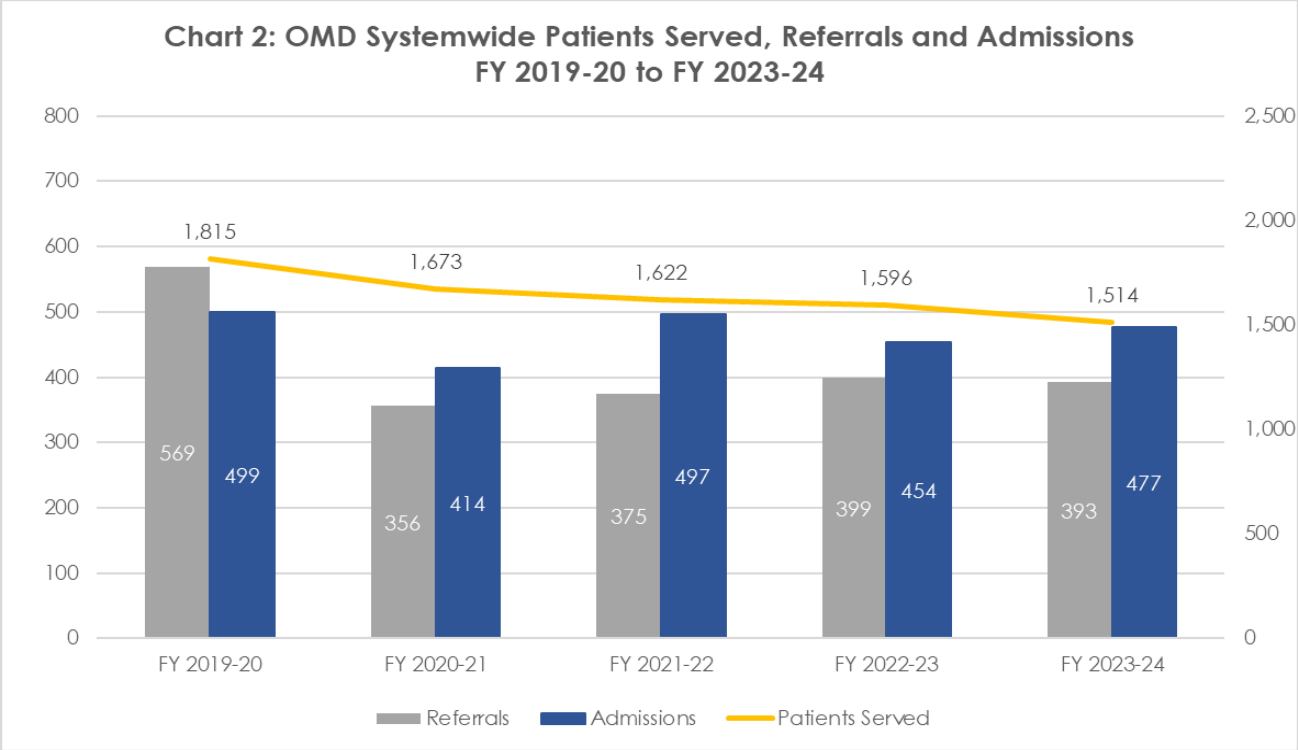
Table 1: System-wide OMD Patient Data Summary

OMD Patient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Referrals[2]	397	393	-1%
Patient Admissions[3]	454	477	5%
Patients Served[4]	1,596	1,514	-5%
Average Daily Census	1,224	1,272	4%

[2] Patient referrals excludes inpatient program transfers and court returns.
[3] Patient admissions include inpatient and outpatient program transfers.
[4] Patients served excludes inpatient and outpatient program transfers.

Chart 1 displays OMD system-wide referrals and admissions by month for FY 2023-24, and Chart 2 displays a five-year period of referrals and admissions for a broader historical view[5].





[5] Outpatient data is only included in FY 2021-22 and FY 2022-23 (Chart 2).

DSH is statutorily required to admit OMD patients upon completion of their prison sentence since these individuals are not able to safely serve their parole in the community until their severe mental health disorder is in remission and can be kept in remission. To ensure continuity of care and public safety, individuals are discharged from prison directly to a state hospital.

Inpatient Program Metrics

Patients committed to DSH as OMD can receive inpatient treatment within DSH's five state hospitals, with PC 2962 commitment treatment only at DSH-Atascadero (male patients) and DSH-Patton (female patients). Patients who are committed pursuant to PC 2972 may receive treatment across all five state hospitals. In FY 2023-24, the state hospitals treated an average of 1,112 OMD patients daily, with an average census of 1,138 in July 2023, and 1,076 in June 2024.

Table 2: OMD Inpatient Data Summary

OMD Inpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Admissions[6]	401	427	6%
Patients Served[7]	1,432	1,383	-3%
Average Daily Census	1,051	1,112	6%

DSH inpatient programs admitted 427 OMD patients in FY 2023-24 with an average of 36 admissions per month. Chart 3 displays Inpatient Program OMD admissions by quarter and the average monthly admissions rate.

[6] Patient admissions include inpatient and outpatient program transfers.
[7] Patients served excludes inpatient and outpatient program transfers.

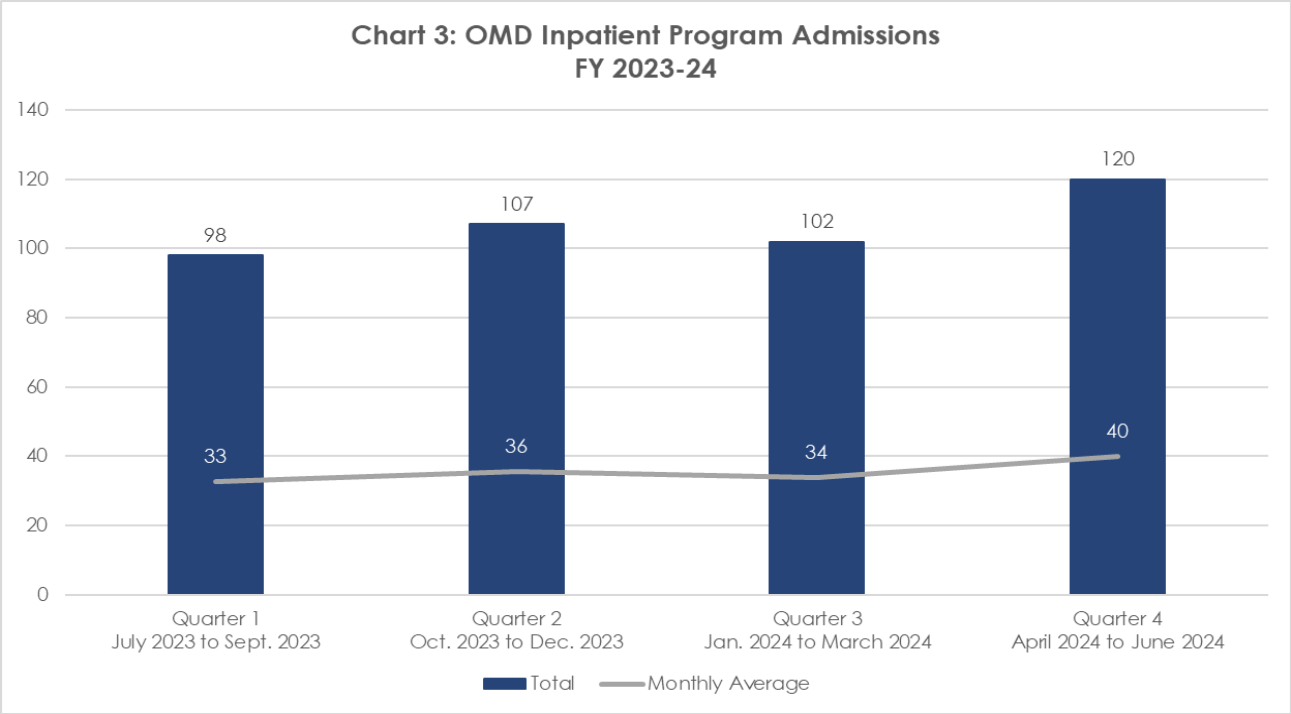


Table 3 displays the number of OMD patients treated in inpatient programs within each FY for the past five years.

Table 3: OMD Patients Served – Inpatient Programs[8]

Patients Treated/ Served	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
	1,815	1,673	1,478	1,430	1,383

PC 2962 Inpatient Data

Patients committed as PC 2962 make up 48% of the OMD patients treated within inpatient programs.

Table 4: PC 2962 Inpatient Data Summary

PC 2962 Inpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY[9]
Patient Admissions[10]	348	361	4%
Patients Served[11]	719	663	-8%
Average Daily Census	350	327	-6%

[8] Patients served excludes inpatient and outpatient program transfers.
[9] Percent change from prior fiscal year is based on raw data, which has been rounded to whole numbers for display purposes.
[10] Patient admissions include inpatient and outpatient program transfers.
[11] Patients served excludes inpatient and outpatient program transfers.

DSH discharged 318 PC 2962 patients from inpatient programs with an average length of stay of 276.1 days and a median length of stay of 144.5 days. 60% of PC 2962 patients discharged within the first 180 days of their stay, 72% of OMD patients discharged within the first year of their stay, 22% of the OMD patients discharged within the first two years of their stay, and only 7% had a length of stay longer than two years. The table below depicts the distribution of PC 2962 patients discharged from inpatient treatment in FY 2023-24 by length of stay.

Table 5: PC 2962 Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 180 Days	60%
181 - 365 Days	12%
366 - 730 (1-2 yrs.)	22%
731 + (2+ yrs.)	7%

Table 6 displays inpatient programs length of stay for PC 2962 patients by quarter for FY 2023-24.

Table 6: PC 2962 Inpatient Length of Stay by Quarter – FY 2023-24

PC 2962 Inpatient Programs: Length of Stay	Quarter 1 July 2023 to Sept. 2023	Quarter 2 Oct. 2023 to Dec. 2023	Quarter 3 Jan. 2024 to March 2024	Quarter 4 April 2024 to June 2024	Total[12] FY 2023-24
Average Length of Stay	264.3	343.9	262.1	240.6	276.1
Median Length of Stay	140.0	181.0	147.0	141.5	144.5
Discharged Count	83	76	69	90	318

For PC 2962 patients yet to discharge the average days in treatment is 295.4 and median days in treatment is 208.

[12] Totals are based on raw data, which have been rounded for display purposes.

PC 2962 patients can be discharged to a variety of locations including outpatient treatment programs. The table below displays the discharge locations for the 318 patients discharged in FY 2023-24.

Table 7: PC 2962 Inpatient Discharges by Location[13]

PC 2962 OMD Inpatient Discharge Location	Total FY 2023-24	Percent to Total
Community Outpatient Treatment	<11	***%
Discharged to Community	276	87%
Locked Facility: CDCR, DJJ, Jail, Court, Other State Hospitals	18	6%
Deceased	<11	***%
Other/Unknown	***	***%
Total Discharges	**318**	**100%**

PC 2972 Inpatient Data

Patients committed as PC 2972 make up 52% of the OMD patients treated within inpatient programs.

Table 8: PC 2972 Inpatient Data Summary

PC 2972 Inpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Admissions[14]	53	66	25%
Patients Served[15]	713	720	1%
Average Daily Census	701	712	2%

DSH discharged 119 PC 2972 patients from inpatient programs with an average length of stay of 1,879.6 days (5.1 years) and a median length of stay of 1,261 days (3.5 years). 19% of PC 2972 patients discharged within one year, 60% of PC 2972 patients discharged within five years, 88% had a length of stay longer within ten years, and 12% of PC 2972 patients discharged has a length of stay ten years or longer. The table below depicts the distribution of PC 2972 patients discharged from inpatient treatment in FY 2023-24 by length of stay.

[13] Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or "less than 11" within the narrative. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.
[14] Patient admissions include inpatient and outpatient program transfers.
[15] Patients served excludes inpatient and outpatient program transfers.

Table 9: PC 2972 Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	19%
366 - 1,825 Days (2 - 5 years)	40%
1,826 - 3,650 days (5 - 10 years)	29%
3,651+ days (10+ years)	12%

Table 10 displays inpatient programs length of stay by quarter for FY 2023-24.

Table 10: PC 2972 Inpatient Length of Stay by Quarter – FY 2023-24

PC 2972 Inpatient Programs: Length of Stay Days (Years)	**Quarter 1** July 2023 to Sept. 2023	**Quarter 2** Oct. 2023 to Dec. 2023	**Quarter 3** Jan. 2024 to March 2024	**Quarter 4** April 2024 to June 2024	**Total**[16] FY 2023-24
Average Length of Stay	1,174.9 (3.2 yrs.)	1,342.4 (3.7 yrs.)	2,496.5 (6.8 yrs.)	2,079.7 (5.7 yrs.)	1,879.6 (5.1 yrs.)
Median Length of Stay	419.0 (1.1 yrs.)	1,079.0 (3.0 yrs.)	1,587.5 (4.3 yrs.)	1,952.0 (5.3 yrs.)	1,261.0 (3.5 yrs.)
Discharged Count	17	25	24	53	119

For PC 2972 patients yet to discharge the average days in treatment is 2,681.3 (7.3 years) and median days in treatment is 2,049.0 (5.6 years).

PC 2972 patients can be discharged to a variety of locations including outpatient treatment programs. Table 11 displays the discharge locations for the 119 patients discharged in FY 2023-24.

Table 11: PC 2972 Inpatient Discharges by Location[17]

PC 2972 OMD Inpatient Discharge Location	**Total** FY 2023-24	**Percent to Total**
Community Outpatient Treatment	***	***%
Deceased	<11	***%
Discharged to Community	32	27%
Locked Facility: CDCR, DJJ, Jail, Court, Other State Hospitals	56	47%
Other/Unknown	<11	***%
Total Discharges	**119**	**100%**

[16] Totals are based on raw data, which have been rounded for display purposes.

[17] Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or "less than 11" within the narrative. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

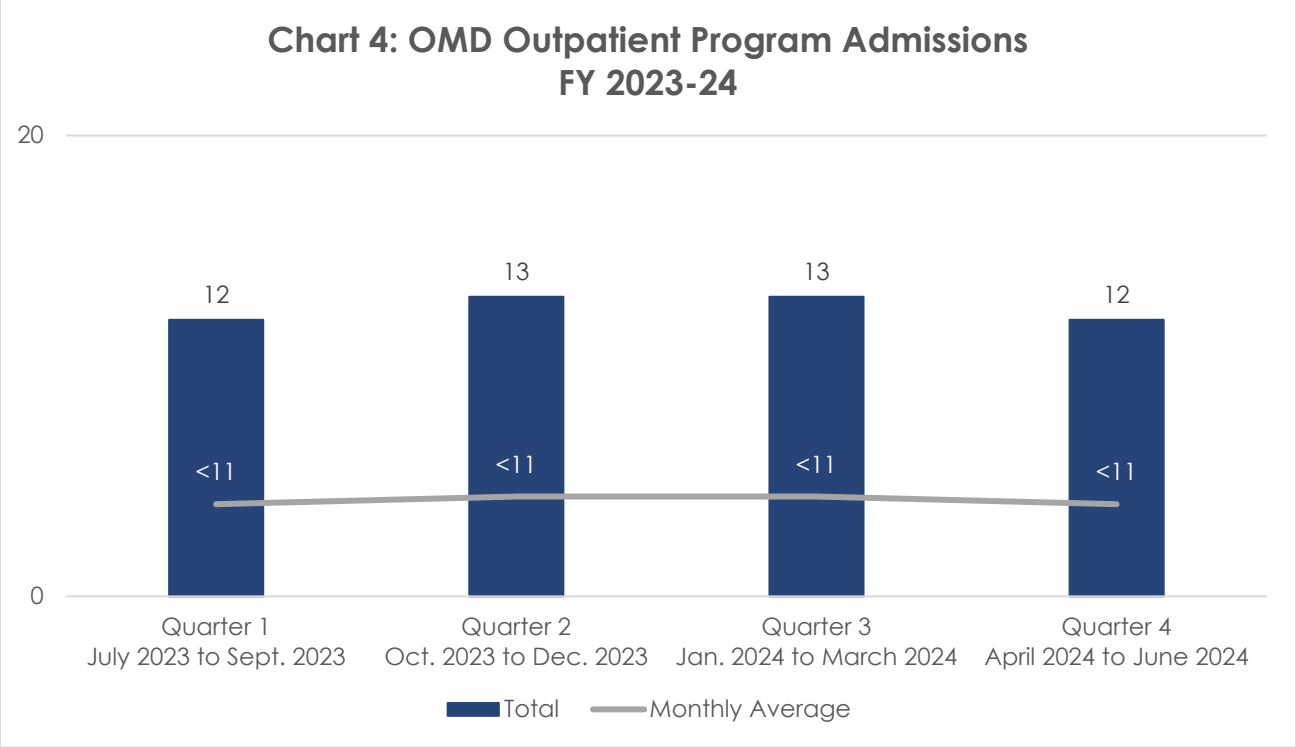
Outpatient Program Metrics

CONREP is the DSH outpatient treatment program for patients committed as OMD. Both PC 2962 and PC 2972 OMD patients can be committed to CONREP. During FY 2023-24, DSH CONREP treated on average 160 OMD patients daily, with an average census of 161 in July 2023 and an ending average census of 159 patients in June 2024.

Table 12: OMD Outpatient Data Summary

OMD Outpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY[18]
Patient Admissions[19]	53	50	-6%
Patients Served[20]	164	131	-20%
Average Daily Census	173	160	-7%

DSH outpatient programs admitted 50 OMD patients in FY 2023-24 with an average of fewer than 11 admissions per month. Chart 4 displays outpatient program OMD admissions by quarter.



[18] Percent change from prior fiscal year is based on raw data, which has been rounded to whole numbers for display purposes.
[19] Patient admissions include inpatient and outpatient program transfers.
[20] Patient admissions include inpatient and outpatient program transfers. Patients served excludes inpatient and outpatient program transfers.

Table 13, below, displays the number of OMD patients treated in outpatient programs within each FY for the past two years.

Table 13: OMD Patients Served – Outpatient Programs[21]

Patients Treated/Served	FY 2021-22	FY 2022-23	FY 2023-24
	144	164	131

DSH discharged 48 OMD patients from outpatient programs with an average length of stay of 885.3 days (2.4 years) and a median length of stay of 406.5 days (1.1 years) across all outpatient programs. 35% of OMD patients discharged within one year, 75% of OMD patients discharged within 2.5 years, and 25% had a length of stay longer than 2.5 years. The table below depicts the distribution of OMD patients discharged from outpatient treatment in FY 2023-24 by length of stay.

Table 14: OMD Outpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	35%
366 - 913 Days (1 – 2.5 years)	40%
914+ Days (2.5+ years)	25%

Table 15 displays outpatient length of stay by quarter for FY 2023-24.

Table 15: OMD Outpatient Length of Stay by Quarter – FY 2023-24[22]

OMD Outpatient Programs: Length of Stay Days (Years)	**Quarter 1** July 2023 to Sept. 2023	**Quarter 2** Oct. 2023 to Dec. 2023	**Quarter 3** Jan. 2024 to March 2024	**Quarter 4** April 2024 to June 2024	**Total[23]** FY 2023-24
Average Length of Stay	458.2 (1.3 yrs.)	1,066.2 (2.9 yrs.)	512.9 (1.4 yrs.)	1,631.7 (4.5 yrs.)	885.3 (2.4 yrs.)
Median Length of Stay	517.0 (1.4 yrs.)	479.0 (1.3 yrs.)	384.0 (1.1 yrs.)	1,131.0 (3.1 yrs.)	406.5 (1.1 yrs.)
Discharged Count	<11	15	***	<11	48

[21] Patients served excludes inpatient and outpatient program transfers.
[22] Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or "less than 11" within the narrative. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.
[23] Totals are based on raw data, which have been rounded for display purposes.

POPULATION PROFILE
Sexually Violent Predator Patients

Description of Legal Class

The Department of State Hospitals (DSH) admits persons designated as Sexually Violent Predator (SVP) 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/inmates are screened by the California Department of Corrections and Rehabilitation (CDCR) and Board of Parole Hearings (BPH) and referred to DSH for full evaluation to determine whether the individuals meet the criteria of an SVP before the completion of their prison term. DSH refers the SVP petition to the county of commitment 20 days prior to the prisoner's release date. If (or when) the District Attorney (DA) files an SVP petition, the patient/inmate is transferred to county jail pending the WIC section 6602 probable cause hearing. DSH admits patients committed as SVP once there is a WIC section 6602 finding of probable cause. After a WIC 6602 probably cause finding, a commitment trial is held and, if adjudged to be a SVP under WIC section 6604, the individual is committed to a state hospital for an indeterminate period of time. SVPs can petition for release; WIC 6604 SVP can be recommended for outpatient status by DSH or be found to no longer meet the SVP criteria by DSH.

Legal Statutes and Commitments

- WIC 6601.3 – Person designated as a Sexually Violent Predator BPH Hold
- WIC 6602 – Person designated as a Sexually Violent Predator Probable Cause
- WIC 6604 – Person designated as a Sexually Violent Predator
- PC 1610 – Pending revocation of a person designated as Sexually Violent Predator

Requirements for Discharge

Once a court determines a patient meets the criteria for an WIC 6604 SVP commitment, these patients undergo an annual review process where the patient's SVP status is evaluated. At that point, DSH may decide 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.

Unconditional releases occur when a court determines an individual no longer meets the legal criteria for SVP commitment. Conditional releases occur when a court determines the individual would not be a danger to the health and safety of others in that it is not likely that the person will engage in sexually violent criminal behavior due to the person's diagnosed mental disorder if under supervision and treatment in the community. If the patient is conditionally released, DSH's Forensic Conditional Release Program (CONREP) takes over the monitoring and supervision of the patient.

DSH Treatment Continuum & Services

Patients committed as SVP typically involve crimes with severe sexual violence and many have mental disorders not amenable to standard medication treatments, as such, treatment for SVP patients typically requires substantial time resources. Because of the risk to the community if an SVP patient is 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 of the SVP patient's mental condition to the court including 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 relate 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 might increase their sexual violence risk.

Programs

DSH provides treatment to SVP patients through inpatient care within state hospitals, at DSH-Coalinga (males) and DSH-Patton (females), and on an outpatient basis in CONREP.

DSH SVP Treatment Programs	
State Hospitals (SH)	DSH's inpatient mental health hospital system provides psychiatric, medical, and psychosocial treatment services to forensic and civil patients housed at Atascadero, Coalinga, Metropolitan, Napa, and Patton state hospitals. SVP patients are treated at Coalinga and Patton state hospitals.
Forensic Conditional Release Program (CONREP)	CONREP is DSH's statewide system of community-based services for specified court-ordered forensic individuals. DSH contracts with county and private providers to provide community-based treatment services for individuals committed to DSH, under various commitment types, who have been approved by the court for outpatient treatment in lieu of state hospital placement or for individuals approved by the courts to step down from state hospital treatment to the community.

Population Data

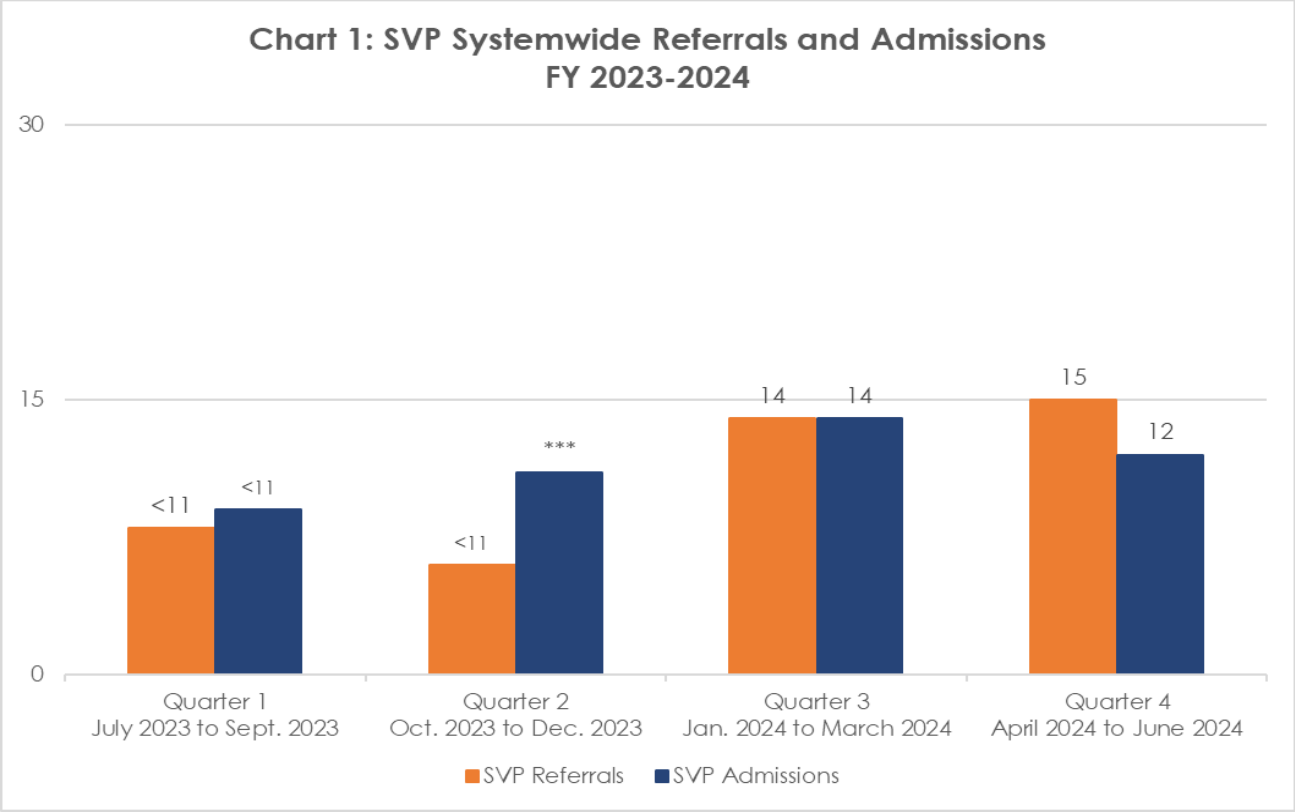
System-wide Metrics

In FY 2023-24, across inpatient and outpatient programs, DSH treated 1,015 patients designated as SVP; a decrease of 2% from prior year. DSH had an average daily census of 974 SVP patients during FY 2023-24 with no significant change from 976 SVP designated patients in July 2023, to 973 in June 2024. The table below summarizes key statistics across the SVP population.

Table 1: System-wide SVP Patient Data Summary[1]

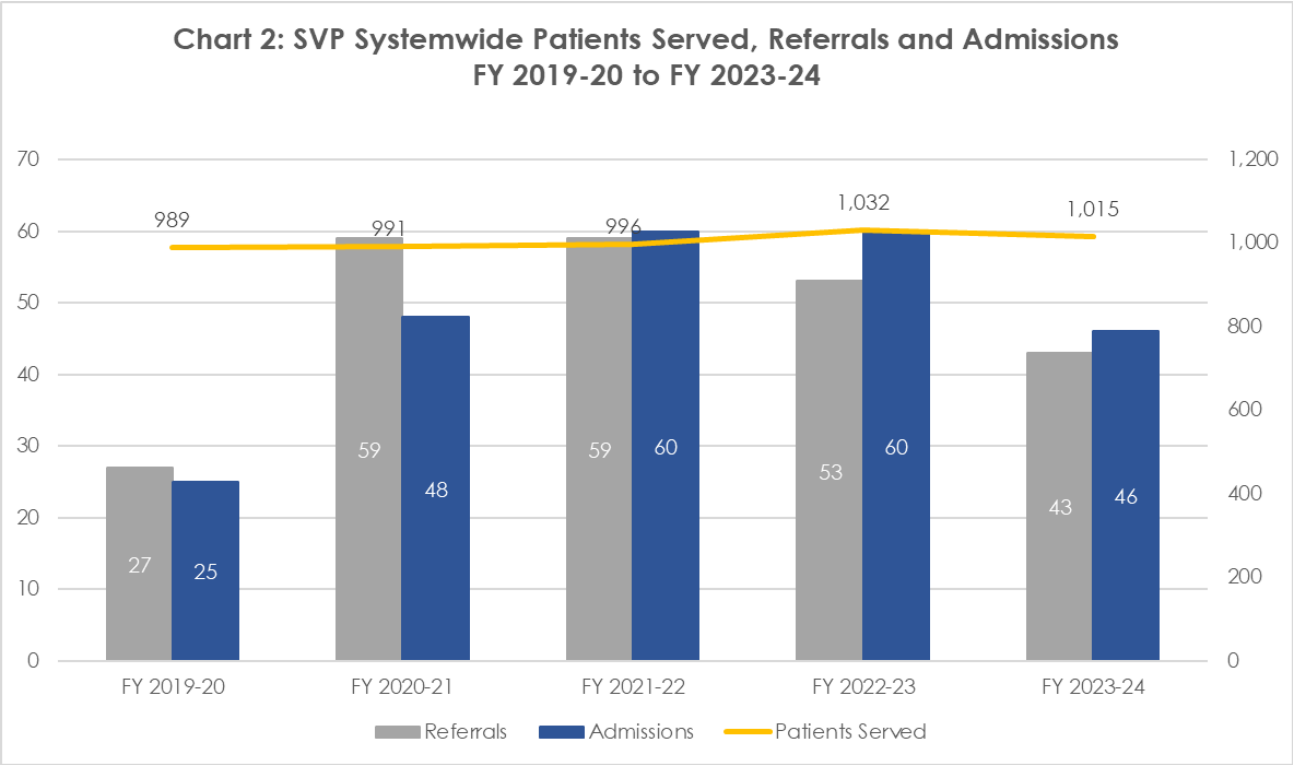
SVP Patient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Referrals[2]	53	40	-25%
Patient Admissions[3]	60	46	-23%
Patients Served[4]	1,032	1,015	-2%
Average Daily Census	977	974	0%

Chart 1[5] displays SVP system-wide referrals and admissions for FY 2023-24.



[1]Referral counts do not reflect referrals for SVP evaluation. Referrals reflect the number of patients committed as SVP once there is a WIC section 6602 finding of probable cause. Patients served excludes inpatient and outpatient program transfers.
[2] Patient referrals excludes inpatient program transfers and court returns.
[3] Patient admissions include inpatient and outpatient program transfers.
[4] Patients served excludes inpatient and outpatient program transfers.
[5] Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or "less than 11" within the narrative. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

Chart 2 displays a five-year period of referrals and admissions for a broader historic view[6].



The DSH system-wide SVP Pending Placement List (PPL) decreased 36% from the prior FY. FY 2023-24 began with fewer than 11 SVP patients pending placement in July 2023 and a slight increase to fewer than 11 patients pending placement in June 2024. The table below identifies the SVP PPL as of June 30th of the corresponding year.

Table 2: System-wide SVP Pending Placement List[7]

SVP Patients Pending Placement	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
	<11	11	20	11	<11

Inpatient Program Metrics

Patients committed to DSH as SVP receive inpatient treatment at DSH-Coalinga. During FY 2023-24 DSH-Coalinga treated on average 955 SVP patients daily, maintaining a stable census across the FY. In July 2023 the average census was 956, decreasing slightly to 953 SVP patients in June 2024.

[6] Outpatient data is only included in FY 2021-22 and FY 2022-23 (Chart 2).
[7] The pending placement list reflects patients pending inpatient treatment.

Table 3: SVP Inpatient Data Summary[8]

SVP Inpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Admissions	57	43	-25%
Patients Served	1,013	997	-2%
Average Daily Census	956	955	0%

DSH Inpatient programs admitted 43 SVP patients in FY 2023-24. Chart 3 displays inpatient program SVP admissions by quarter and the average monthly admissions rate.

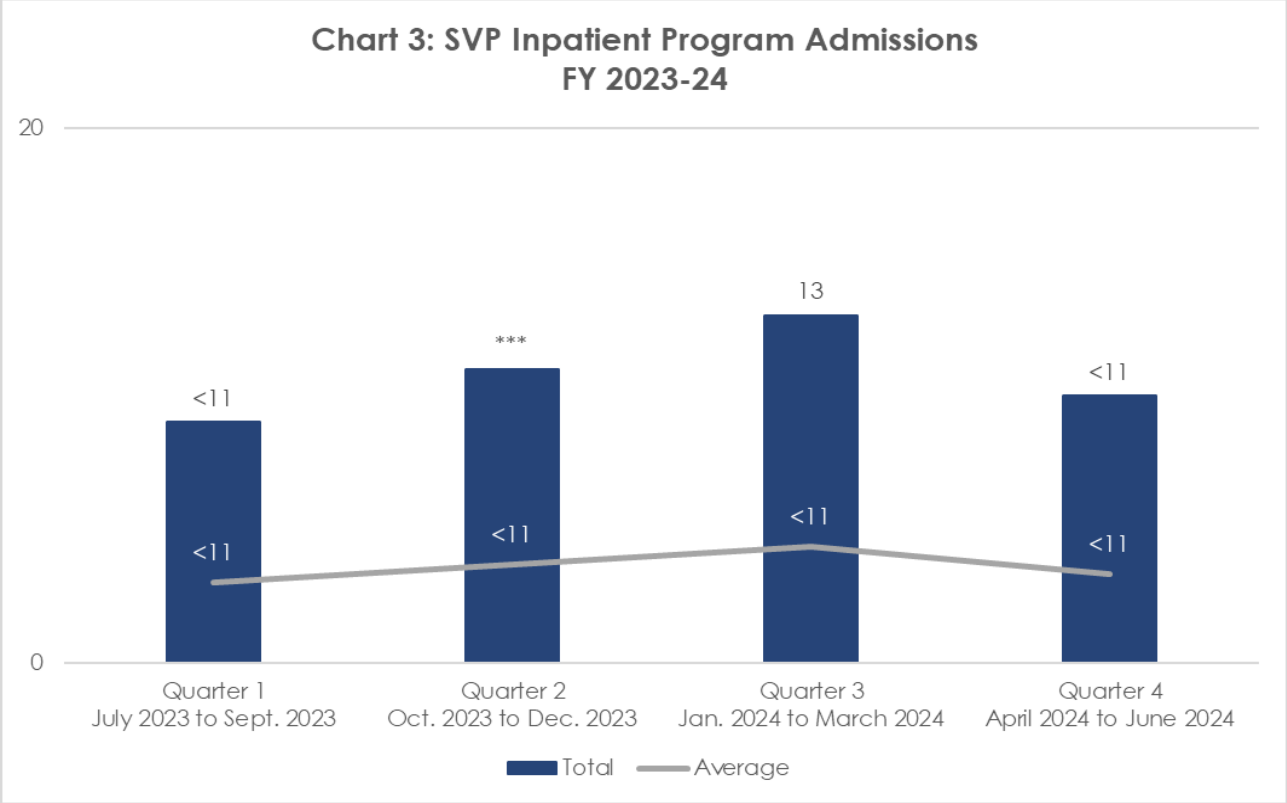


Table 4, below, displays the number of patients treated across the year.

Table 4: SVP Patients Served – Inpatient Programs[9]

Patients Treated/ Served	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
	989	991	981	1,013	997

[8] Patient admissions include inpatient and outpatient program transfers. Patients served excludes inpatient and outpatient program transfers.
[9] Patients served excludes inpatient and outpatient program transfers.

WIC 6602 Inpatient Data

Patients committed pursuant to WIC 6602 make up 42% of the SVP patients treated within inpatient programs.

Table 5: WIC 6602 Inpatient Data Summary

WIC 6602 Inpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Admissions[10]	39	31	-21%
Patients Served[11]	449	418	-7%
Average Daily Census	400	382	-5%

DSH discharged 25 WIC 6602 patients from inpatient programs with an average length of stay of 4,315 days, approximately 12 years, and a median length of stay of 4,298 days, 11.8 years. 44% of WIC 6602 patients discharged within the fifteen and half years of their stay, and 56% had a length of stay longer than 15.5 years. The table below depicts the distribution of WIC 6602 patients discharged from inpatient treatment in FY 2023-24 by length of stay.

Table 6: WIC 6602 Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 – 5,658 Days (0 – 15.5 years)	44%
5,659+ Days (15.5+ years)	56%

Table 7 displays inpatient programs length of stay for WIC 6602 patients by quarter for FY 2023-24.

Table 7: WIC 6602 Inpatient Length of Stay by Quarter – FY 2023-24

6602 Inpatient Programs: Length of Stay Days (Years)	**Quarter 1** July 2023 to Sept. 2023	**Quarter 2** Oct. 2023 to Dec. 2023	**Quarter 3** Jan. 2024 to March 2024	**Quarter 4** April 2024 to June 2024	**Total[12]** FY 2023-24
Average Length of Stay	4,083.6 (11.2 yrs.)	4,134.4 (11.3 yrs.)	1,224.0 (3.4 yrs.)	4,902.4 (13.4 yrs.)	4,315.0 (11.8 yrs.)
Median Length of Stay	4,287.0 (14.3 yrs.)	4,239.0 (10.2 yrs.)	1,224.0 (13.6 yrs.)	5,302.0 (13.8 yrs.)	4,298.0 (13.0 yrs.)
Discharged Count	<11	<11	<11	<11	25

For WIC 6602 patients yet to discharge the average days in treatment is 2,906.7, 8 years and median days in treatment is 2,271.0, 6.2 years.

[10] Patient admissions include inpatient and outpatient program transfers.
[11] Patients served excludes inpatient and outpatient program transfers.
[12] Totals are based on raw data, which have been rounded for display purposes.

Table 8 displays the discharge locations for the 25 WIC 6602 patients discharged in FY 2022-23.

Table 8: WIC 6602 Inpatient Discharges by Location

6602 Inpatient Programs: Discharge Location	Total FY 2023-24	Percent to Total
Deceased	<11	***%
Discharged to Community[13]	15	60%
Other/Unknown	<11	***%
Total Discharges	**25**	**100%**

WIC 6604 Inpatient Data

Patients committed pursuant to WIC 6604 make up 58% of the SVP patients treated within inpatient programs.

Table 9: WIC 6604 Inpatient Data Summary

WIC 6604 Inpatient Data	FY 2022-23	FY 2023-24	Percent Change from Prior FY
Patient Admissions[14]	18	12	-33%
Patients Served[15]	564	579	3%
Average Daily Census	557	573	3%

DSH discharged 21 WIC 6604 patients from inpatient programs with an average length of stay of 4,278.7 days, approximately 12 years, and a median length of stay of 5,189 days, 14.5 years. 67% had a length of stay longer than 10 years. The table below depicts the distribution of WIC 6604 patients discharged from inpatient treatment in FY 2023-24 by length of stay.

Table 10: WIC 6604 Inpatient Length of Stay Distribution[16]

Length of Stay	% of Patients
0 - 365 Days (1 year)	***%
366 - 1,460 Days (2 - 4 years)	***%
1,461 - 1,825 days (4 - 5 years)	0%

[13] Fewer than 11 patients were conditionally discharged, and the remaining were unconditional discharges.
[14] Patient admissions include inpatient and outpatient program transfers.
[15] Patient admissions include inpatient and outpatient program transfers. Patients served excludes inpatient and outpatient program transfers.
[16] Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or "less than 11" within the narrative. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

1,826 - 3,650 days (5 - 10 years)	***%
3,651+ days (10+ years)	67%

The table below displays the FY 2023-24 length of stay by quarter for WIC 6604 commitments discharged from inpatient programs in FY 2023-24.

Table 11: WIC 6604 Inpatient Length of Stay by Quarter – FY 2023-24[17]

6604 Inpatient Programs: Length of Stay Days (Years)	**Quarter 1** July 2023 to Sept. 2023	**Quarter 2** Oct. 2023 to Dec. 2023	**Quarter 3** Jan. 2024 to March 2024	**Quarter 4** April 2024 to June 2024	**Total[18]** FY 2023-24
Average Length of Stay	3,464.0 (9.5 yrs.)	5,394.2 (14.8 yrs.)	3,303.5 (9.1 yrs.)	5,729.5 (15.7 yrs.)	4,278.7 (11.7 yrs.)
Median Length of Stay	3,464.0 (9.5 yrs.)	6,446.0 (17.7 yrs.)	4,147.5 (11.4 yrs.)	6,400.0 (17.5 yrs.)	5,289.0 (14.5 yrs.)
Discharged Count	<11	<11	<11	<11	21

For WIC 6604 patients yet to discharge the average days in treatment is 4,896.5 days, or 13.4 years and the median days in treatment is 5,583.0 days, or 15.3 years.

The table below displays the discharge locations for the 21 WIC 6604 patients discharged in FY 2023-24.

Table 12: WIC 6604 Inpatient Discharges by Location[17]

6604 Inpatient Programs: Discharge Location	**Total** FY 2023-24	**Percent to Total**
Community Outpatient Treatment	<11	***%
Discharged to Community[19]	<11	***%
Deceased	***	***%
Total Discharges	**21**	**100%**

Outpatient Program Metrics

DSH SVP outpatient treatment programs are provided by CONREP. During FY 2023-24, DSH outpatient programs treated on average 19 SVP patients. In July 2023, the SVP patient average census was 20 with no change in June 2024.

[17] Data has been de-identified in accordance with the Department of State Hospitals Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or "less than 11" within the narrative. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.
[18] Totals are based on raw data, which have been rounded for display purposes.
[19] Fewer than 11 patients were conditionally discharged to the community.

DSH outpatient programs admitted fewer than 11 SVP patients in FY 2023-24. Chart 4 displays outpatient program SVP admissions by quarter.

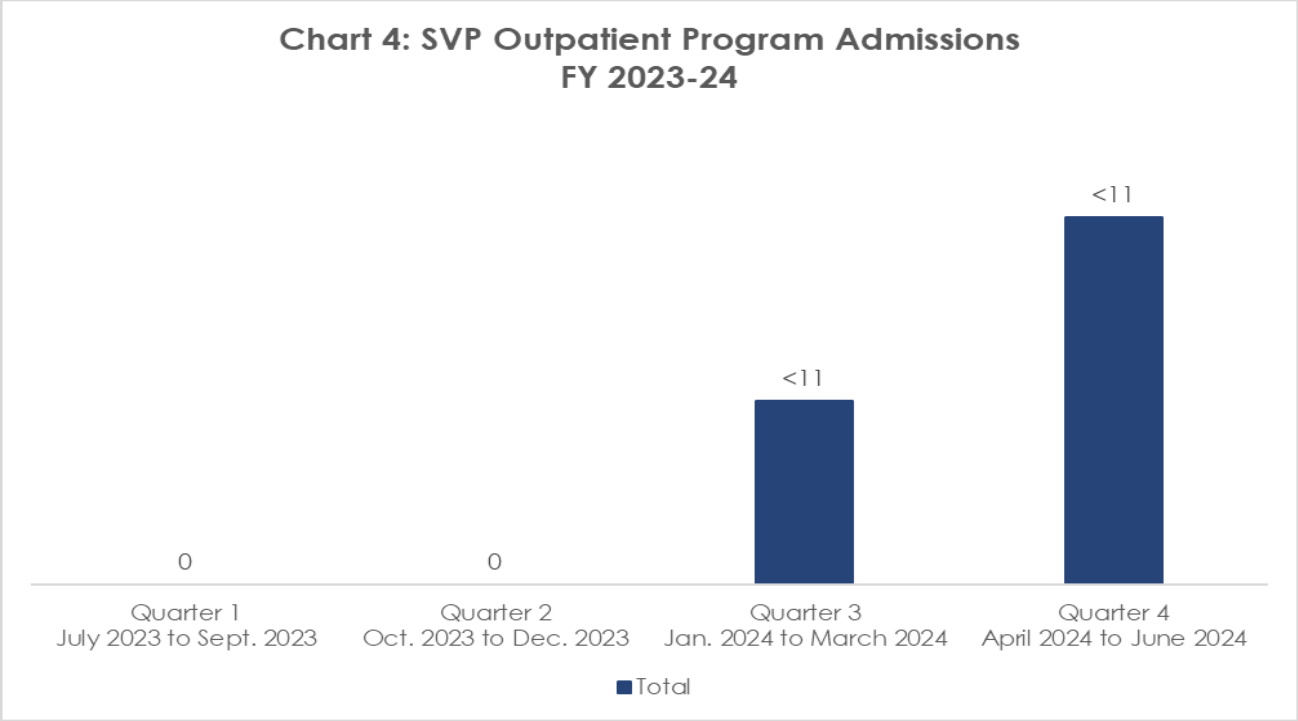


Table 13, below, displays the number of patients treated across the year in outpatient programs.

Table 13: SVP Patients Served – Outpatient Programs[20]

Patients Treated/Served	FY 2021-22	FY 2022-23	FY 2023-24
	15	19	18

DSH discharged fewer than 11 SVP patients from outpatient programs with an average length of stay of 1,631.4 days, 4.5 years and a median length of stay of 1,472 days, 4 years, across all programs. 100% of SVP patients discharged within the first five years of their stay. Table 14 displays outpatient length of stay by quarter.

Table 14: SVP Outpatient Length of Stay by Quarter – FY 2023-24

SVP Outpatient Programs: Length of Stay Days (Years)	**Quarter 1** July 2023 to Sept. 2023	**Quarter 2** Oct. 2023 to Dec. 2023	**Quarter 3** Jan. 2024 to March 2024	**Quarter 4** April 2024 to June 2024	**Total**[21] FY 2023-24
Average Length of Stay	0.0	1,266.0 (3.5 yrs.)	1,325.5 (3.6 yrs.)	2,120.0 (5.8 yrs.)	1,631.4 (4.5 yrs.)

[20] Patients served excludes inpatient and outpatient program transfers.
[21] Totals are based on raw data, which have been rounded for display purposes.

Median Length of Stay	0.0	1,266.0 (3.5 yrs.)	1,325.5 (3.6 yrs.)	2,120.0 (5.8 yrs.)	1,472.0 (4.0 yrs.)
Discharged Count	0	<11	<11	<11	<11

DEPARTMENT OF STATE HOSPITALS - ATASCADERO

HISTORY

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

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,275 beds. In fiscal year (FY) 2023-24, DSH-Atascadero served 1,876 patients. The commitment categories of patients treated at DSH-Atascadero are as follows:

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

HOSPITAL STAFF

Approximately 2,279 employees work at DSH-Atascadero providing 24/7 care, including psychologists, psychiatrists, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, and other clinical staff. In addition, there are various non-level of care staff at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, and other administrative staff.

TREATMENT AND PROGRAMS

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

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

Treatment Plan

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

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

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

Treatment Team

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

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

Provision of Treatment, Rehabilitation, and Supplemental Activities

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

Recovery and Mall Services (RMS)

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

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

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

Central Medical Services (CMS)

CMS provides medical care and evaluation to all patients 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 patients on referral from general physicians and psychiatrists who have primary responsibility for the care of patients on residential treatment units.

Enhanced Treatment Program (ETP)

The ETP is designed to provide enhanced treatment in a secure setting for patients at the highest risk of violence. The ETP is intended to provide increased therapy opportunities within a structured, least restrictive environment. The ETP is to be utilized when safe treatment is not possible in a standard treatment environment. The pilot is driven by Assembly Bill 1340.

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

ACCREDITATION AND LICENSURE

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

DSH-Atascadero is licensed by the California Department of Public Health and has eight units licensed as acute psychiatric. An acute psychiatric facility means

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

TRAINING AND INTERNSHIPS

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

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	•Paid MSW Internship (Graduate Student Assistant) •Social Work Intern (Student Assistant)

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

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

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

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

DEPARTMENT OF STATE HOSPITALS – COALINGA

HISTORY

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

DSH-Coalinga opened in 2005 and began treating forensically committed patients, most of which are persons designated as sexually violent predators (SVP). 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) 2023-24, DSH-Coalinga served 1,466 patients. The commitment categories of patients treated at DSH-Coalinga are as follows:

Patient Commitments	Code Section
Lanterman-Petris-Short	WIC 5000 Sec.
Offender with a Mental Health Disorder	2972
Coleman/CDCR	2684
Not Guilty by Reason of Insanity	1026
Mentally Disordered Sex Offenders	6316 (WIC)
Persons Designated as Sexually Violent Predators	6602/6604

HOSPITAL STAFF

Approximately 2,490 employees work at DSH-Coalinga providing 24/7 care, including psychologists, psychiatrists, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, and other clinical staff. In addition, there are various non-level of care job classifications at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, and other administrative staff.

TREATMENT AND PROGRAMS

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

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

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

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

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

LICENSURE

DSH-Coalinga is licensed by the California Department of Public Health. DSH-Coalinga has two units designated as acute psychiatric. An acute psychiatric facility means having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy and dietary services. In addition, DSH-Coalinga currently has 24 units licensed as an Intermediate Care Facility (ICF). An ICF is defined as 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. In May of 2023, DSH-Coalinga converted an additional Residential Recovery Units (RRU) to an ICF, bringing the total number of licensed units to 24. In addition, DSH-Coalinga has six unlicensed RRUs, 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 [1]	• Registered Nursing Programs Clinical Rotation • Nursing Students Preceptorship •20/20 Registered Nurse Training Program
Pharmacy [2]	•Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools.
Psychiatric Technicians [3]	•Psychiatric Technician Trainee •Pre-Licensed Psychiatric Technicians •20/20 Psychiatric Technician Training Program
Psychology	•American Psychological Association Approved Pre-Doctoral Internship
Rehabilitation Therapy [4]	•Recreation Therapy (Student Assistants) •Recreation Therapy Internship Program •Music Therapy (coming soon)
Social Work [5]	•Masters of Social Work Internships (Graduate Student Assistants)

[1] **Nursing:** Preceptorship for Bachelor of Science in Nursing (BSN) and Master of Science in Nursing (MSN) programs available on an individual basis. 20/20 Registered Nurse Training Program available on an individual basis.

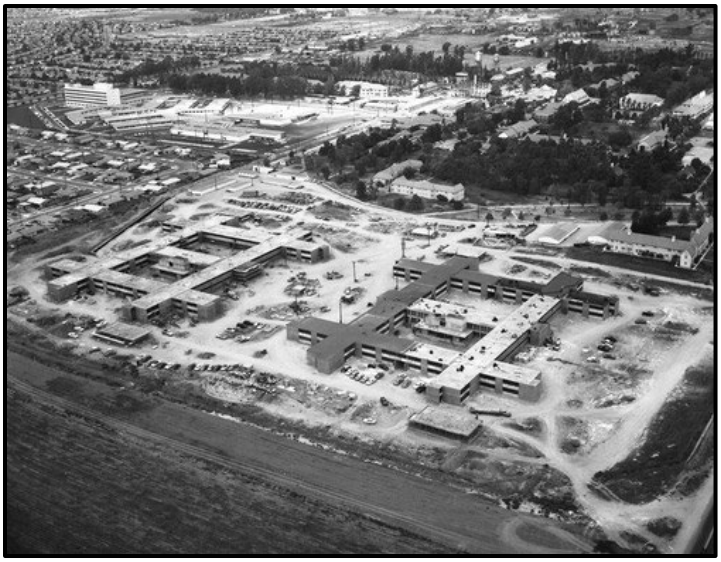
[2] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools. The preceptor at each of the hospitals will communicate with the schools to determine when to send students for their clinical rotations. The contracted schools are University of Southern California (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:** 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.

[4] **Recreational Therapy Internship:** Recreational Therapy Internship Candidates are in their final semester of their degree and are required to complete a minimum of a 14-week 560-hour internship. Partners can be made with any accredited school in the country with a Recreational Therapy or Therapeutic Recreation program. The specific DSH-C Recreation Therapy Internship Program lasts for a minimum of 17-weeks due to New Employee Orientation. Once completed, students are eligible for national certification with National Council for Therapeutic Recreation Certification (NCTRC). To ensure the safety and well-being of students, patients, and staff, the internship is designed to follow the guidelines outlined in the American Therapeutic Recreation Association (ATRA) Code of Ethics. DSH-Coalinga can provide current opportunities for skill growth and professional development in accordance with American Music Therapy Association (AMATA) guidelines.

[5] **Social Work:** The Master of Social Work Internship program accepts six 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), UMASS Global, and Simmons University.

DEPARTMENT OF STATE HOSPITALS – METROPOLITAN



HISTORY

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

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,106 beds. In fiscal year (FY) 2023-24, DSH-Metropolitan served 2,268 patients. The commitment categories of patients treated at DSH-Metropolitan are as follows:

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

HOSPITAL STAFF

Approximately 2,255 employees work at DSH-Metropolitan providing 24/7 care, including psychiatrists, psychologists, social workers, rehabilitation therapists, registered nurses, psychiatric technicians, and other clinical staff. In addition, there are various non-level of care staff at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, teachers, and other administrative staff.

TREATMENT AND PROGRAMS

DSH-Metropolitan is one of the state hospitals offering 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

At DSH-Metropolitan, DBT is used 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 influences their attachment styles, coping mechanisms, and interpersonal relationships. Each patient who received individualized DBT 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
- 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.

Offender with a Mental Health Disorder (OMD) Program

The OMD Program is for patients paroled to the hospital by authority of the Board of Parole Hearings under 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 forensic 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 is a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis.

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 •Psychiatric Fellowship Program for Child Psychiatry
Psychology	•Association of Psychology Postdoctoral and Internship Center – Affiliated Internship Program
Rehabilitation Therapy	•Art Therapy (Loyola Marymount University/ Practicum Students) •Music Therapy (American Music Therapy Association National Roster Internship Program/ Volunteer Positions) •Recreation Therapy (Volunteer Positions)
Social Work	•Masters of Social Work Internships (Volunteer Positions)

[1] **Nursing:** Preceptorship for Bachelor of Science in Nursing (BSN) and Master of Science in Nursing (MSN) programs available on an individual basis.
[2] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools. The preceptor at each of the hospitals will communicate with the schools to determine when to send students for their clinical rotations. The contracted schools are University of Southern California (USC), University of California-San Francisco (UCSF), Touro University California College of Pharmacy, California North State University, California Health Sciences University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (UOP), Western University of Health Science, Chapman University.
[3] **Psychiatric Technicians:** DSH-Metropolitan offers 20/20 Psychiatric Technician training program for only Psychiatric Technician Assistants to become a Psychiatric Technician. The modified work hours shall be a maximum of twelve (12) months in length and the amount of the 20/20 time utilized by each selected employee will depend on the type of education/training programs available.

DEPARTMENT OF STATE HOSPITALS – NAPA

HISTORY

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

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,418 beds, but current maximum capacity is 1,374 beds. In fiscal year (FY) 2023-24, DSH-Napa served 1,697 patients. The commitment categories of patients treated at DSH-Napa are as follows:

Patient Commitments	Code Section
Incompetent to Stand Trial	1370
Lanterman-Petris-Short	WIC 5000 Sec.
Offender with a Mental Health Disorder	2972
Not Guilty by Reason of Insanity	1026
Recommitment After Expiration of Prison Term (Must have concurrent W&I commitment)	2974

HOSPITAL STAFF

Approximately 2,663 employees work at DSH-Napa, providing 24/7 care, including psychologists, psychiatrists, physicians, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, and other clinical staff. In addition, there are various non-level of care job classifications at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, and other administrative staff.

TREATMENT PROGRAMS

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

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

various medical services, including, but not limited to primary care, dental, podiatry, neurology, cardiac, 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 are 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 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, such as:
    - Dialectic Behavior Therapy (DBT) which 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 treatment
- Discharge units focus on skills development for community living and on relapse prevention. Each patient prepares a personalized relapse prevention plan. The Treatment Teams work closely with CONREP towards returning patients to the community under CONREP supervision.

ACCREDITATION AND LICENSURE

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

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

DSH-Napa is licensed by the California Department of Public Health and has two units designated as acute psychiatric. An acute psychiatric facility means having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary services. DSH-Napa has one unit designated as a Skilled Nursing Facility (SNF). A SNF is a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. Additionally, DSH-Napa has 33 units designated as an Intermediate Care Facility (ICF). An ICF is 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 10 pharmacy schools.
Psychiatric Technicians [2]	•Psychiatric Technician Apprentice •Pre-Licensed Psychiatric Technicians •Psychiatric Technician Prorams Clinical Rotation
Psychiatry	•UC Davis, Psychiatry and Law •Touro University •Clinical Clerkships for Medical School Graduates •Residency Program with St. Joseph Medical Center
Psychology	•American Psychological Association Approved Pre-Doctoral Internship
Registered Dietitians	•Accredited Dietetic Internship
Rehabilitation Therapy	•Recreation Therapy Internship •Occupational Therapy •Music Therapy •Dance Movement Therapy •Art Therapy
Social Work	•Masters of Social Work Internships (Open to 2nd year MSW students)

[1] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with 10 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 (DSH)-Patton is a secure forensic psychiatric hospital located in San Bernardino County. DSH-Patton was established in 1890 and opened in 1893. DSH-Patton provides treatment to forensically and civilly committed patients within secure treatment areas (STA). 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) 2023-24, DSH-Patton served 2,203 patients. The commitment categories of patients treated at DSH-Patton are as follows:

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

HOSPITAL STAFF

Approximately 2,560 employees work at DSH-Patton providing 24/7 care, including psychiatrists, psychologists, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, registered dieticians, and other clinical staff. In addition, there are various non-level-of-care staff at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, information technology staff, facility operations staff, spiritual leaders, and other administrative staff.

TREATMENT AND PROGRAMS

The Trial Competency treatment along with the Court Preparation Project is for patients admitted to the hospital under Penal Code (PC) 1370 as Incompetent to Stand Trial (IST). These patients receive a specialized 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.

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

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

Enhanced Treatment Program (ETP)

The ETP is designed to provide enhanced treatment in a secure setting for patients at the highest risk of violence. 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 for those patients that pose the highest risk of aggression. The pilot program was authorized by Assembly Bill 1340, which has been incorporated into California Health & Safety Code 1265.9. DSH-Patton's 10-bed unit is estimated for construction completion in April 2025.

The ETP model allows for enhanced staffing which includes a complement of clinical, nursing and Hospital Police Officer (HPO) staff. Classifications utilized

include Staff Psychiatrist, Clinical Psychologist, Clinical Social Worker, Rehabilitation Therapist, Registered Nurse, and Psychiatric Technician.

DSH-PATTON MUSEUM

On April 17, 2015, the DSH-Patton Museum opened its doors for the first time to the public. The on-site museum examines the history of psychiatric treatment in California state-run facilities and offers a glimpse of the evolution of mental health treatment since Patton accepted its first patients on August 1, 1893.

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

The museum itself is located on the grounds of the hospital in a 1920s cottage home that once was inhabited by hospital staff and their families. Since the museum's opening, numerous Southern Californians have visited for tours and researchers from as far away as South Africa have experienced the museum. The DSH-Patton Museum remains a valuable resource for state employees and members of the public by providing insight and information about a local institution with a history that exemplifies the progression of mental health treatment in America. As understanding evolves with ongoing reflection on the past, staff will continue to develop the museum and its exhibits. Future plans include a monument to acknowledge individuals who were sterilized while at, or living in, state-run hospitals, homes, and institutions.

Since its inception in 2015, the museum has been visited by thousands of people such as authors, historians, students, community members and mental health professionals.

ACCREDITATION AND LICENSURE

DSH-Patton is awarded the *Gold Seal of Approval* for achieving accreditation under the Hospital Accreditation Program (HAP) by The Joint Commission (TJC) recognized as an independent, not-for-profit organization and the largest standards-setting and accrediting body in healthcare. The HAP accreditation program is achieved upon successful completion of an on-site triennial survey attained by meeting rigorous performance standards, delivering the best quality

care, and exhibiting a culture of excellence that inspires to continually improve performance. The hospital sustains accreditation with a mutual belief in patient and employee safety, effective care processes, patient outcomes using evidence-based practices, maintenance in environmental engineering controls, and, performance analysis studies, which are collectively woven into the fabric of our healthcare organization's operation. The hospital recognizes accreditation does not begin and end with an on-site survey, it is a continuous process of monitoring, communication, transparency, education, and evaluating sustainability.

DSH-Patton 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.

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 10 pharmacy schools.
Psychiatric Technicians [2]	•20/20 Psychiatric Technician Program
Psychiatry	•Loma Linda University Clerkship •Loma Linda University Forensic Psychiatry Residency •UC Riverside •Western University of Health Sciences •CA University of Science and Medicine
Psychology	•Practicum •American Psychological Association •Approved Pre-Doctoral Internship •Post-Doctoral Fellowship
Registered Dietitians	•Accredited Dietetic Internship
Rehabilitation Therapy	•Recreation Therapy (Student Assistants)
Social Work	•Master of Social Work Graduate Students (GSA Paid Internship) •Bachelor of Social Work Students (Volunteer Status)

[1] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with 10 pharmacy schools. The preceptor at each of the hospitals will communicate with the schools to determine when to send students for their clinical rotations. The contracted schools are University of Southern California (USC), University of California-San Francisco (UCSF), Touro University California College of Pharmacy, California North state University, California Health Sciences University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (Stockton), Western University of Health Science, Chapman University, American University of Health Sciences School of Pharmacy, and Marshal B Ketchum College of Pharmacy.

[2] **Psychiatric Technicians:** 1. 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.

CALIFORNIA DEPARTMENT OF STATE HOSPITALS

REPORT ON STATE HOSPITAL FINANCIAL ACTIVITY

California Department of State Hospitals

FISCAL YEAR 2024-25

May 14, 2025






DIRECTOR
Stephanie Clendenin

EXECUTIVE SUMMARY

Pursuant of the Budget Act of 2024, 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 Budget Act of 2024 which requires DSH to provide a year-end summary and an operating budget for each state hospital with the fiscal year (FY) 2025-26 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 2023-24 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. The mission of DSH is to provide evaluation and treatment for individuals with complex behavioral health needs in a safe, equitable and responsible manner, by leading innovation and excellence across a continuum of care. 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 employees. In addition to state hospital treatment, DSH provides services in contracted Jail-Based Competency Treatment (JBCT), Community-Inpatient Facilities (CIF), Conditional Release Program (CONREP), Community-Based Restoration (CBR), and pre-trial felony mental health Diversion programs. DSH is responsible for the daily care of over 7,400 patients. In FY 2023-24, DSH served over 14,000 patients, with 9,510 served across the state hospitals, 1,881 in JBCT, 506 in CIF, 859 in CBR contracted programs, and 897 in CONREP programs. 11,897 individuals were treated within a DSH inpatient program and 2,117 were served through DSH's outpatient programs. Through Early Access Stabilization Services (EASS) and Re-Evaluation services, during FY 2023-24, DSH initiated services for 2,797 patients in EASS, and off ramped 198 through DSH's Re-Evaluation program. In addition, 249 individuals were diverted from jail into county Diversion 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, 2025.

State Hospital	Authorized Positions[1]	Vacant as of 4/1/2025	Vacancy Percent[2]
Atascadero	2,285.90	549.60	24.0%
Coalinga	2,491.10	516.10	20.7%
Metropolitan	2,226.25	388.15	17.4%
Napa	2,595.30	604.55	23.3%
Patton	2,552.15	231.60	9.1%
Totals	**12,150.70**	**2,290.00**	**18.8%**

[1] Includes positions approved for Estimate Items Enhanced Treatment Program (21.0 in Patton) that will not be filled due to delays, which move the unit activation to June 2025. Metropolitan State Hospital Increased Secure Bed Capacity (51.1 in Metropolitan) that will not be filled due to SNF roof repairs as described in the 2025-26 Governor's Budget Estimate.
[2] This report addresses authorized and temporary help positions only. The department also utilizes contracted registry positions to support patient care, when needed. For details regarding the utilization of contracted registry, please refer to the Functional Vacancy Report in Section A2 of the DSH 2025-26 Governor's Budget Estimate.

AUTHORIZED VERSUS VACANT POSITIONS BY CLASSIFICATION

As of April 1, 2025, DSH's vacancy rate is 18.8 percent. Item 4440-011-0001, Provision 9 requires DSH to provide the number of authorized and vacant classifications, including psychiatric technicians, nurses, physicians, psychiatrists, social workers, and rehabilitation therapists. The following table provides a summary of the authorized and vacant positions for those classifications.

		Atascadero		Coalinga		Metropolitan[1]		Napa		Patton	
Class Title	Class Code	Authorized	Vacant	Authorized	Vacant	Authorized	Vacant	Authorized	Vacant	Authorized	Vacant
Staff Psychiatrist	7619	33.0	21.0	26.3	19.3	50.3	19.3	55.4	4.7	67.5	15.3
Psychologist	9873	45.5	15.5	35.7	19.7	41.0	6.0	51.4	13.0	61.3	15.7
Senior Psychiatric Technician	8252	105.4	17.4	95.0	4.0	82.3	24.3	82.0	20.0	88.0	0.0
Rehabilitation Therapist	Various	54.4	14.4	46.0	8.0	60.0	17.8	65.0	3.0	73.0	12.0
Registered Nurse	8094	246.4	44.4	236.0	22.4	299.7	28.7	458.4	46.5	363.1	17.1
Clinical Social Worker	9872	50.3	20.3	46.8	25.8	64.7	21.7	61.2	3.7	74.0	5.5
Psychiatric Technician	8253	683.0	228.0	712.5	224.9	487.0	117.0	449.2	171.7	752.3	40.3
Physician/Surgeon	7552	17.5	0.0	25.2	17.2	25.4	1.0	26.2	1.0	31.0	0.0

[1] Metropolitan State Hospital Increased Secure Bed Capacity (51.1 in Metropolitan) that will not be filled due to SNF roof repairs as described in the 2025-26 Governor's Budget Estimate.

TEMPORARY HELP BLANKET POSITIONS

Temporary help blanket positions are utilized to offset vacancies and overtime. The following table provides a summary of authorized temporary help blanket positions for the state hospitals as of April 1, 2025.

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 2023-24. For FY 2024-25 and FY 2025-26, 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]

		2023-24 Budget	2023-24 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$926,527,000	$906,658,000
	5100150-Earnings - Temporary Civil Service Employees	$35,497,000	$34,879,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$160,079,000	$157,198,000
Salaries and Wages Total		**$1,122,103,000**	**$1,098,735,000**
Staff Benefits	5150150-Dental Insurance	$1,127,000	$1,104,000
	5150200-Disability Leave – Industrial	$14,628,000	$14,341,000
	5150210-Disability Leave - Nonindustrial	$2,775,000	$2,694,000
	5150350-Health Insurance	$28,487,000	$27,851,000
	5150400-Life Insurance	$70,000	$70,000
	5150450-Medicare Taxation	$15,707,000	$15,376,000
	5150500-OASDI	$9,016,000	$8,808,000
	5150600-Retirement – General	$230,482,000	$225,284,000
	5150620-Retirement - Public Employees - Safety	$1,000	$1,000
	5150700-Unemployment Insurance	$506,000	$493,000
	5150750-Vision Care	$227,000	$222,000
	5150800-Workers' Compensation	$74,975,000	$73,285,000
	5150900-Staff Benefits – Other	$155,119,000	$151,759,000
Staff Benefits Total		**$533,120,000**	**$521,288,000**
Operating Expenses and Equipment	5301400-Goods – Other	$4,711,000	$4,608,000
	5302900-Printing – Other	$656,000	$644,000
	5304800-Communications – Other	$6,306,000	$6,216,000
	5306700-Postage – Other	$232,000	$227,000
	5308900-Insurance – Other	$1,112,000	$1,091,000
	5320490-Travel - In State – Other	$2,071,000	$2,028,000
	5320890-Travel - Out of State - Other	$3,000	$3,000
	5322400-Training - Tuition and Registration	$1,170,000	$1,148,000
	5324350-Rents and Leases	$34,939,000	$34,169,000
	5326900-Utilities – Other	$29,036,000	$28,472,000
	5340330-Consulting and Professional Services – Inter - Other	$4,769,000	$4,646,000
	5340580-Consulting and Professional Services - Ext - Other	$88,770,000	$85,923,000
	5344000-Consolidated Data Centers	$144,000	$136,000
	5346900-Information Technology - Other	$2,568,000	$2,541,000
	5368115-Office Equipment	$18,638,000	$18,339,000
	5390900-Other Items of Expense - Miscellaneous	$86,012,000	$83,958,000
	5415000-Claims Against the State	$142,000	$139,000
	5490000-Other Special Items of Expense	$3,089,000	$3,034,000
Operating Expenses and Equipment Total		**$284,368,000**	**$277,322,000**
Grand Total		**$1,939,591,000**	**$1,897,345,000**

[1]Budget and expenditure do not include reimbursements or reappropriations.

Exhibit I—Atascadero State Hospital[2&3]

		2023-24 Budget	2023-24 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$171,173,000	$159,640,000
	5100150-Earnings - Temporary Civil Service Employees	$5,128,000	$4,782,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$19,948,000	$18,604,000
Salaries and Wages Total		**$196,249,000**	**$183,026,000**
Staff Benefits	5150150-Dental Insurance	$180,000	$168,000
	5150200-Disability Leave - Industrial	$1,505,000	$1,404,000
	5150210-Disability Leave - Nonindustrial	$864,000	$806,000
	5150350-Health Insurance	$5,439,000	$5,073,000
	5150400-Life Insurance	$13,000	$13,000
	5150450-Medicare Taxation	$2,779,000	$2,591,000
	5150500-OASDI	$1,881,000	$1,754,000
	5150600-Retirement - General	$45,699,000	$42,620,000
	5150700-Unemployment Insurance	$102,000	$95,000
	5150750-Vision Care	$44,000	$41,000
	5150800-Workers' Compensation	$15,070,000	$14,054,000
	5150900-Staff Benefits - Other	$28,516,000	$26,594,000
Staff Benefits Total		**$102,092,000**	**$95,213,000**
Operating Expenses and Equipment	5301400-Goods - Other	$897,000	$836,000
	5302900-Printing - Other	$123,000	$115,000
	5304800-Communications - Other	$565,000	$527,000
	5306700-Postage - Other	$43,000	$40,000
	5308900-Insurance - Other	$120,000	$112,000
	5320490-Travel - In State - Other	$364,000	$339,000
	5322400-Training - Tuition and Registration	$159,000	$149,000
	5324350-Rents and Leases	$5,074,000	$4,732,000
	5326900-Utilities - Other	$3,417,000	$3,187,000
	5340330-Consulting and Professional Services – Inter - Other	$1,044,000	$973,000
	5340580-Consulting and Professional Services - Ext - Other	$32,094,000	$29,931,000
	5344000-Consolidated Data Centers	$113,000	$105,000
	5346900-Information Technology - Other	$167,000	$156,000
	5368115-Office Equipment	$1,432,000	$1,336,000
	5390900-Other Items of Expense - Miscellaneous	$17,284,000	$16,120,000
	5490000-Other Special Items of Expense	$268,000	$250,000
Operating Expenses and Equipment Total		**$63,164,000**	**$58,908,000**
Grand Total		**$361,505,000**	**$337,147,000**

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

Exhibit I—Coalinga State Hospital[4]

		2023-24 Budget	2023-24 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$173,535,000	$171,446,000
	5100150-Earnings - Temporary Civil Service Employees	$1,000,000	$990,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$31,198,000	$30,822,000
Salaries and Wages Total		**$205,735,000**	**$203,258,000**
Staff Benefits	5150150-Dental Insurance	$241,000	$238,000
	5150200-Disability Leave - Industrial	$4,230,000	$4,179,000
	5150210-Disability Leave - Nonindustrial	$732,000	$723,000
	5150350-Health Insurance	$5,747,000	$5,678,000
	5150400-Life Insurance	$16,000	$16,000
	5150450-Medicare Taxation	$2,870,000	$2,835,000
	5150500-OASDI	$2,037,000	$2,012,000
	5150600-Retirement - General	$49,758,000	$49,158,000
	5150620-Retirement - Public Employees - Safety	$1,000	$1,000
	5150700-Unemployment Insurance	$153,000	$151,000
	5150750-Vision Care	$45,000	$44,000
	5150800-Workers' Compensation	$13,692,000	$13,527,000
	5150900-Staff Benefits - Other	$29,848,000	$29,488,000
Staff Benefits Total		**$109,370,000**	**$108,050,000**
Operating Expenses and Equipment	5301400-Goods - Other	$682,000	$674,000
	5302900-Printing - Other	$87,000	$86,000
	5304800-Communications - Other	$1,759,000	$1,738,000
	5306700-Postage - Other	$39,000	$39,000
	5308900-Insurance - Other	$66,000	$65,000
	5320490-Travel - In State - Other	$473,000	$467,000
	5320890-Travel - Out of State - Other	$2,000	$2,000
	5322400-Training - Tuition and Registration	$171,000	$169,000
	5324350-Rents and Leases	$5,227,000	$5,164,000
	5326900-Utilities - Other	$6,366,000	$6,289,000
	5340330-Consulting and Professional Services – Inter - Other	$310,000	$306,000
	5340580-Consulting and Professional Services - Extl - Other	$56,517,000	$55,836,000
	5344000-Consolidated Data Centers	$1,000	$1,000
	5346900-Information Technology - Other	$15,000	$15,000
	5368115-Office Equipment	$3,147,000	$3,109,000
	5390900-Other Items of Expense - Miscellaneous	$26,584,000	$26,264,000
	5415000-Claims Against the State	$69,000	$68,000
	5490000-Other Special Items of Expense	$709,000	$700,000
Operating Expenses and Equipment Total		**$102,224,000**	**$100,992,000**
Grand Total		**$417,329,000**	**$412,300,000**

[4]Budget and expenditure do not include reimbursements or reappropriations.

Exhibit I—Metropolitan State Hospital[5]

		2023-24 Budget	2023-24 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$166,383,000	$165,206,000
	5100150-Earnings - Temporary Civil Service Employees	$6,345,000	$6,300,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$29,550,000	$29,341,000
Salaries and Wages Total		**$202,278,000**	**$200,847,000**
Staff Benefits	5150150-Dental Insurance	$229,000	$228,000
	5150200-Disability Leave - Industrial	$1,921,000	$1,907,000
	5150210-Disability Leave - Nonindustrial	$299,000	$296,000
	5150350-Health Insurance	$5,334,000	$5,296,000
	5150400-Life Insurance	$13,000	$13,000
	5150450-Medicare Taxation	$2,800,000	$2,780,000
	5150500-OASDI	$1,574,000	$1,562,000
	5150600-Retirement - General	$26,934,000	$26,743,000
	5150700-Unemployment Insurance	$22,000	$22,000
	5150750-Vision Care	$41,000	$41,000
	5150800-Workers' Compensation	$11,892,000	$11,807,000
	5150900-Staff Benefits - Other	$25,926,000	$25,743,000
Staff Benefits Total		**$76,985,000**	**$76,438,000**
Operating Expenses and Equipment	5301400-Goods - Other	$1,066,000	$1,059,000
	5302900-Printing - Other	$119,000	$118,000
	5304800-Communications - Other	$3,517,000	$3,493,000
	5306700-Postage - Other	$43,000	$42,000
	5308900-Insurance – Other	$471,000	$468,000
	5320490-Travel - In State – Other	$368,000	$365,000
	5322400-Training - Tuition and Registration	$261,000	$259,000
	5324350-Rents and Leases	$40,000	$40,000
	5326900-Utilities – Other	$5,304,000	$5,267,000
	5340330-Consulting and Professional Services – Inter - Other	$718,000	$713,000
	5340580-Consulting and Professional Services - Ext - Other	$75,000	$74,000
	5344000-Consolidated Data Centers	$11,000	$11,000
	5346900-Information Technology – Other	$2,250,000	$2,235,000
	5368115-Office Equipment	$7,932,000	$7,876,000
	5490000-Other Special Items of Expense	$255,000	$253,000
Operating Expenses and Equipment Total		**$22,430,000**	**$22,273,000**
Grand Total		**$301,693,000**	**$299,558,000**

[5]Budget and expenditure do not include reimbursements or reappropriations.

Exhibit I—Napa State Hospital[6]

		2023-24 Budget	2023-24 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$194,866,000	$190,388,000
	5100150-Earnings - Temporary Civil Service Employees	$7,547,000	$7,374,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$36,384,000	$35,548,000
Salaries and Wages Total		**$238,797,000**	**$233,310,000**
Staff Benefits	5150150-Dental Insurance	$260,000	$254,000
	5150200-Disability Leave - Industrial	$5,051,000	$4,935,000
	5150210-Disability Leave - Nonindustrial	$423,000	$413,000
	5150350-Health Insurance	$6,439,000	$6,291,000
	5150400-Life Insurance	$13,000	$13,000
	5150450-Medicare Taxation	$3,382,000	$3,304,000
	5150500-OASDI	$1,692,000	$1,653,000
	5150600-Retirement - General	$51,137,000	$49,962,000
	5150700-Unemployment Insurance	$165,000	$161,000
	5150750-Vision Care	$49,000	$48,000
	5150800-Workers' Compensation	$16,349,000	$15,973,000
	5150900-Staff Benefits - Other	$34,727,000	$33,929,000
Staff Benefits Total		**$119,687,000**	**$116,936,000**
Operating Expenses and Equipment	5301400-Goods - Other	$1,044,000	$1,020,000
	5302900-Printing - Other	$64,000	$63,000
	5304800-Communications - Other	$263,000	$257,000
	5306700-Postage - Other	$44,000	$43,000
	5308900-Insurance - Other	$395,000	$386,000
	5320490-Travel - In State - Other	$285,000	$278,000
	5322400-Training - Tuition and Registration	$319,000	$312,000
	5324350-Rents and Leases	$14,716,000	$14,378,000
	5326900-Utilities - Other	$9,005,000	$8,798,000
	5340330-Consulting and Professional Services – Inter - Other	$1,785,000	$1,744,000
	5340580-Consulting and Professional Services - External - Other	$84,000	$82,000
	5346900-Information Technology - Other	$33,000	$32,000
	5368115-Office Equipment	$4,554,000	$4,449,000
	5390900-Other Items of Expense - Miscellaneous	$22,507,000	$21,990,000
	5415000-Claims Against the State	$72,000	$70,000
	5490000-Other Special Items of Expense	$1,050,000	$1,026,000
Operating Expenses and Equipment Total		**$56,220,000**	**$54,928,000**
Grand Total		**$414,704,000**	**$405,174,000**

[6]Budget and expenditure do not include reimbursements or reappropriations.

Exhibit I—Patton State Hospital[7]

		2023-24 Budget	2023-24 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$220,570,000	$219,978,000
	5100150-Earnings - Temporary Civil Service Employees	$15,475,000	$15,433,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$42,999,000	$42,883,000
Salaries and Wages Total		**$279,044,000**	**$278,294,000**
Staff Benefits	5150150-Dental Insurance	$217,000	$216,000
	5150200-Disability Leave - Industrial	$1,921,000	$1,916,000
	5150210-Disability Leave - Nonindustrial	$457,000	$456,000
	5150350-Health Insurance	$5,528,000	$5,513,000
	5150400-Life Insurance	$15,000	$15,000
	5150450-Medicare Taxation	$3,876,000	$3,866,000
	5150500-OASDI	$1,832,000	$1,827,000
	5150600-Retirement - General	$56,954,000	$56,801,000
	5150700-Unemployment Insurance	$64,000	$64,000
	5150750-Vision Care	$48,000	$48,000
	5150800-Workers' Compensation	$17,972,000	$17,924,000
	5150900-Staff Benefits - Other	$36,102,000	$36,005,000
Staff Benefits Total		**$124,986,000**	**$124,651,000**
Operating Expenses and Equipment	5301400-Goods - Other	$1,022,000	$1,019,000
	5302900-Printing - Other	$263,000	$262,000
	5304800-Communications - Other	$202,000	$201,000
	5306700-Postage - Other	$63,000	$63,000
	5308900-Insurance - Other	$60,000	$60,000
	5320490-Travel - In State - Other	$581,000	$579,000
	5320890-Travel - Out of State – Other	$1,000	$1,000
	5322400-Training - Tuition and Registration	$260,000	$259,000
	5324350-Rents and Leases	$9,882,000	$9,855,000
	5326900-Utilities - Other	$4,944,000	$4,931,000
	5340330-Consulting and Professional Services – Inter - Other	$912,000	$910,000
	5344000-Consolidated Data Centers	$19,000	$19,000
	5346900-Information Technology - Other	$103,000	$103,000
	5368115-Office Equipment	$1,573,000	$1,569,000
	5390900-Other Items of Expense - Miscellaneous	$19,637,000	$19,584,000
	5415000-Claims Against the State	$1,000	$1,000
	5490000-Other Special Items of Expense	$807,000	$805,000
Operating Expenses and Equipment Total		**$40,330,000**	**$40,221,000**
Grand Total		**$444,360,000**	**$443,166,000**

[7]Budget and expenditure do not include reimbursements or reappropriations.

Exhibit II—All Hospitals[8]

	2024-25 Budget	2025-26 Budget	2024-25 Projected Expenditure	2025-26 Projected Expenditure
4410010-Atascadero	$400,543,000	$371,432,000	$396,538,000	$367,718,000
4410020-Coalinga	$422,328,000	$415,792,000	$418,105,000	$411,634,000
4410030-Metro	$260,937,000	$263,046,000	$258,328,000	$260,416,000
4410040-Napa	$412,326,000	$406,926,000	$408,203,000	$402,857,000
4410050-Patton	$450,604,000	$440,656,000	$446,098,000	$436,249,000
Grand Total	**$1,946,738,000**	**$1,897,852,000**	**$1,927,272,000**	**$1,878,874,000**

[8]Budget and expenditure do not include reimbursements or reappropriations.

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

BACKGROUND

The Budget Act of 2024 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 2025–26 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 2024–25 fiscal year, the projected attrition rate for the 2025–26 fiscal year, and the rate of success pertaining to the number of hospital police officer cadet graduates of the OPS Police Academy."

Hospital Police Officer Positions

The table below displays the status of Hospital Police Officers (HPO) authorized positions as of March 1, 2025:

HPO Authorized Positions[1] as of March 1, 2025				
Hospitals	Filled	Vacant	FTE[2]	Vacancy Rate
Atascadero	94	35.9	129.9	27.64%
Coalinga	186	35.0	221.0	15.84%
Metropolitan	112	24.3	136.3	17.83%
Napa	93	66.9	159.9	41.84%
Patton	67	9.5	76.5	12.42%
Total	552	171.6	723.6	23.71%

Hospital Police Officer Attrition Rate

The table below displays the projected HPO attrition rates as of March 1, 2025, based on actual attrition rates and trends for fiscal years (FYs) 2022-23, 2023-24, and 2024-25:

[1] Only includes classification 1937 – Hospital Police Officer
[2] Authorized Positions as of March 2025

HPO Attrition Rates as of March 1, 2025					
Hospitals	FY 2024-25 FTE[3]	FY 2024-25 Attrition Rate[4]	Average Estimated Monthly Positions	FY 2025-26 Attrition Rate[5]	Average Estimated Monthly Positions
Atascadero	129.9	1.54%	2.0	1.42%	1.8
Coalinga	221.0	0.40%	0.9	0.41%	0.9
Metropolitan	136.3	1.00%	1.4	0.75%	1.0
Napa	159.9	0.57%	0.9	0.72%	1.1
Patton	76.5	1.20%	0.9	1.13%	0.9
Total	**723.6**	**0.84%**	**6.1**	**0.79%**	**5.7**

Cadet Graduation Rates

The table below displays actual graduation rates from cohorts conducted from FY 2021-22 through the present:

OPS Cadet Graduation Rates				
Academy	Academy Dates	Cadets Attended	Cadets Graduated	Graduation Rate
Academy 36	(05/03/21 – 08/12/21)	16	9	56.3%
Academy 37	(08/23/21 – 12/09/21)	10	4	40.0%
Academy 38	(12/28/21 – 04/17/22)	15	11	73.3%
Academy 39	(05/02/22 – 08/11/22)	24	18	75.0%
Academy 40	(08/23/22 – 12/08/22)	16	14	87.5%
Academy 41	(12/28/22 – 04/13/23)	22	19	86.4%

[3] Authorized Positions as of March 2025
[4] Projected attrition rate based on FY 2022-23, 2023-24, and 2024-25 data
[5] Projected attrition rate based on FY 2023-24, 2024-25, and 2025-26 data

Academy 42	(05/01/23 – 08/15/23)	18	15	83.3%
Academy 43	(08/28/23 - 12/12/23)	15	15	100.0%
Academy 44	(12/28/23 – 04/16/24)	9	8	88.9%
Academy 45	(04/29/24 – 08/13/24)	19	16	84.2%
Academy 46	(08/26/24 – 12/11/24)	14	10	71.4%
Academy 47	(12/31/24 – 04/24/25)	30	19	63.3%
Academy 48	(05/05/25 – 08/20/25)	44	TBD	TBD
	Total[6]	**208**	**158**	**76.0%**

HPO Recruitment Efforts

The Office of Protective Services (OPS) started working with vendors in December 2021 to establish contracts for assistance with HPO recruitment efforts and increase the total number of HPO applications received. In November 2023, DSH partnered with AllStar Talent for these services. As part of a digital marketing campaign, both Facebook and Google advertisements are utilized to increase awareness and leads for DSH to engage with prospective candidates. In addition, DSH continues to conduct online virtual Career Fairs and create videos and other media advertisements to broadcast and increase awareness of DSH peace officer employment opportunities. Advertisements are frequently refreshed to continue to attract new applicants.

To increase recruitment, DSH also converted their exam process from a proctored, in-person exam to a non-proctored, online exam. The non-proctored, online exam successfully went live on September 28, 2023. As of March 1, 2025, 4,131 have submitted applications for HPO positions. This is a significant increase from 279[7] HPO applications that were received in 2023 prior to the online exam going live. This represents a significantly higher number of candidates applying for HPO positions, which has resulted in the current Academy enrolling 44 cadets into the Academy. The goal of the streamlined, continuous online exam is to increase recruitment numbers and accelerate the recruitment process.

[6] Total does not include Academy 48
[7] Data from January 2, 2023, to August 2, 2023