Department of State Hospitals

2026-27

Governor's Budget
Proposals and Estimates

Submitted to:
California Department of Finance
January 10, 2026

Department of State Hospitals
2026-27 Governor's Budget
TABLE OF CONTENTS

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 small number of conserved individuals referred by the counties. These individuals are the responsibility of the counties to serve and the counties contract with DSH for the use of their beds. DSH also serves currently incarcerated persons 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 may return to the county jail, CDCR, or discharge to their community. When discharged to the community, 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 7,500 patients. In fiscal year (FY) 2024-25, DSH served, in total, over 13,800 patients, with 8,871 served across the state hospitals, 1,995 in JBCT, 723 in CIF, 899 in CBR contracted programs, 567 in Diversion contracted programs, and 824 in CONREP programs. 11,589 individuals were treated within a DSH inpatient program and 2,290 were served through DSH's outpatient programs**.** Through Early Access Stabilization Services (EASS) and Re-Evaluation services, during FY 2024-25, DSH initiated services for 3,554 patients in EASS, and off ramped 77 from a DSH commitment through DSH's Re-Evaluation program. In addition, 28 individuals were diverted from jail into county Diversion programs funded by DSH.

With over 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 their 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. 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

[1] See IST Solutions (Section C7) for more information

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 jail-based treatment programs, establish a robust continuum of care for DSH patients. Lastly, 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 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

BACKGROUND

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

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

- Departmental Regular/Ongoing Authorized Positions ties to the 4440-fiscal year (FY) 2025-26 Schedule 7A, FY 2024-25 Authorized Positions
- Temporary Help includes employees working second positions, retired annuitants, limited term, and permanent intermittent
- Total Authorized Positions contains the total Regular/Ongoing Authorized Positions and Temporary Help positions for specific classifications
- Contracted FTE and Overtime FTE contain FTE positions which have been converted from contract hours and overtime hours
- Total Filled FTE is the grand total of Total Filled Civil Service Positions, Temp Help Filled, Contracted FTE, and Overtime FTE
- Functional Vacancy FTE is the calculated difference between Total Filled Civil Service Positions and Total Filled FTE
- Functional Vacancy Rate is calculated by dividing Functional Vacancy FTE by Total Authorized Positions

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

- Clinical Services – Treatment Team and Primary Care: For the Staff Psychiatrist positions, state hospitals utilized temporary help and contract employees to staff 16% of the total authorized positions. These positions are a hard-to-fill classification at state hospitals, due in part to the nationwide shortage of psychiatrists. DSH was authorized to establish a psychiatry residency program at DSH-Napa in partnership with St. Joseph's Medical Center to assist with training more psychiatrists to work in the DSH system. The first cohort at DSH-Napa started in July 2021 and is now in its fourth year and has three cohorts for a total of 20 residents. Due to the success of the DSH-Napa Psychiatric Residency Program, DSH-Patton has recently been authorized to begin developing its own residency program. Additionally, DSH has been authorized to expand or develop fellowship programs across all five state hospitals to provide training for the unique needs of state hospital patients. For additional information regarding these initiatives please reference the Workforce Development update located in Section D1.

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

- Protective Services: The Protective Services BCP included in the Budget Act of 2020 states that DSH-Napa does not have sufficient position authority to cover the protective services posts necessary to fulfill essential police functions which is a driver for overtime for protective services classifications. While new positions were authorized by this BCP to provide additional protective services resources, these positions were phased in over several years and are still undergoing recruitment and hiring.

Department of State Hospitals	Hospital Position Report Average as of November 1, 2025									
Classifications	**Dept Regular/ Ongoing Authorized Positions[1]**	**Temporary Help**	**Total Authorized Positions**	**Total Filled Civil Service Positions[1]**	**Temp Help Filled**	**Contracted FTE**	**Overtime FTE[2]**	**Total Filled FTE**	**Functional Vacancy FTE[3]**	**Functional Vacancy Rate**
Clinical Services - Treatment Team and Primary Care										
Social Worker (9872, 9874)	277.2	0.0	277.2	220.2	0.7	0.0	0.0	220.9	56.3	20.3%
Rehab Therapist - Safety (8321, 8323, 8324, 8420, 8422)	278.7	0.0	278.7	239.6	0.7	0.0	4.6	244.9	33.8	12.1%
Psychologist-Clinical-Safety (9873)	238.2	0.0	238.2	170.1	0.7	0.9	0.0	171.7	66.5	27.9%
Staff Psychiatrist-Safety (7619)	228.1	0.0	228.1	175.8	0.9	35.7	0.0	212.4	21.0	9.2%
Nurse Practitioner-Safety (9700)	40.0	0.0	40.0	36.6	0.4	0.0	0.2	37.2	3.0	7.5%
Physician & Surgeon-Safety (7552)	125.0	0.0	125.0	103.2	1.4	6.0	0.0	110.6	14.4	11.5%
Total: Clinical Services - Treatment Team and Primary Care	**1,187.2**	**0.0**	**1,187.2**	**945.5**	**4.8**	**42.6**	**4.8**	**997.7**	**195.0**	**16.4%**
Clinical Services - Nursing										
Psychiatric Technician (8236, 8253, 8254, 8274)	3,516.3	137.6	3,653.9	2,590.8	146.3	135.7	519.0	3,391.8	400.0	10.9%

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

Registered Nurse-Safety (8094)	1,575.4	115.2	1,690.6	1,463.6	84.5	91.0	233.0	1,872.1	0.0	0.0%
Senior Psych Tech-Safety (8252)	368.0	1.3	369.3	377.6	3.2	0.0	99.0	479.8	0.0	0.0%
Total: Clinical Services - Nursing	**5,459.7**	**254.1**	**5,713.8**	**4,432.0**	**234.0**	**226.7**	**851.0**	**5,743.7**	**400.0**	**7.0%**
Protective Services										
Hosp Police Lieut (1935)	30.0	0.0	30.0	23.0	0.0	0.0	5.9	28.9	4.6	15.3%
Hosp Police Sgt (1936)	97.0	0.0	97.0	87.3	1.0	0.0	20.9	109.2	0.1	0.1%
Hosp Police Ofcr (1937)	723.8	0.0	723.8	605.0	5.4	0.0	144.4	754.8	27.4	3.8%
Total: Protective Services	**850.8**	**0.0**	**850.8**	**715.3**	**6.4**	**0.0**	**171.2**	**892.9**	**32.1**	**3.8%**

DEPARTMENT OF STATE HOSPITALS POPULATION

	CURRENT YEAR 2025-26					
	July 1, 2025 Actual Census	Previously Approved Adjustments CY 2025-26	2026-27 November Adjustment CY 2025-26	Census Adjustment	2026-27 May Revision Adjustment CY 2025-26	June 30, 2026 Projected Census
POPULATION BY HOSPITAL						
ATASCADERO	1,042	0	0	70	0	1,112
COALINGA	1,289	0	0	0	0	1,289
METROPOLITAN	793	0	0	98	0	891
NAPA	1,073	0	0	0	0	1,073
PATTON	1,319	10	0	0	0	1,329
TOTAL BY HOSPITAL	**5,516**	**10**	**0**	**168**	**0**	**5,694**
POPULATION BY COMMITMENT - SH						
Coleman - PC 2684[1]	190	0	0	70	0	260
IST - PC 1370	1,589	0	0	41	0	1,630
LPS & PC 2974	568	0	0	57	0	625
NGI - PC 1026	1,197	4	0	0	0	1,201
OMD - PC 2962	344	3	0	0	0	347
OMD - PC 2972	672	3	0	0	0	675
SVP - WIC 6602/6604	956	0	0	0	0	956
TOTAL BY COMMITMENT	**5,516**	**10**	**0**	**168**	**0**	**5,694**
CONTRACTED PROGRAMS						
JAIL BASED COMPETENCY TREATMENT	386	0	0	40	0	426
COMMUNITY BASED RESTORATION/ DIVERSION[2]	784	289	0	0	0	1,073
COMMUNITY INPATIENT FACILITIES	189	34	0	8	0	231
TOTAL - CONTRACTED PROGRAMS	**1,359**	**323**	**0**	**48**	**0**	**1,730**
CONREP PROGRAMS[3]						
CONREP SVP	22	9	0	0	0	31
CONREP NON-SVP	525	112	0	0	0	637
CONREP FACT PROGRAM	30	30	0	0	0	60
CONREP STEP DOWN FACILITIES	86	79	0	0	0	165
TOTAL - CONREP PROGRAMS	**663**	**230**	**0**	**0**	**0**	**893**
CY POPULATION AND CONTRACTED TOTAL	**7,538**	**563**	**0**	**216**	**0**	**8,317**

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

July 1, 2025 Actual: 2,948

June 30, 2026 Projected: 3,360

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.

DEPARTMENT OF STATE HOSPITALS POPULATION

	BUDGET YEAR 2026-27					
	July 1, 2026 Projected Census	Previously Approved Adjustments BY 2026-27	2026-27 November Adjustment BY 2026-27	Census Adjustment	2026-27 May Revision Adjustment BY 2026-27	June 30, 2027 Projected Census
POPULATION BY HOSPITAL						
ATASCADERO	1,112	0	0	0	0	1,112
COALINGA	1,289	0	0	0	0	1,289
METROPOLITAN	891	0	16	0	0	907
NAPA	1,073	0	0	0	0	1,073
PATTON	1,329	0	0	0	0	1,329
TOTAL BY HOSPITAL	**5,694**	**0**	**16**	**0**	**0**	**5,710**
POPULATION BY COMMITMENT - SH						
Coleman - PC 2684[1]	260	0	0	0	0	260
IST - PC 1370	1,630	0	4	0	0	1,634
LPS & PC 2974	625	0	0	0	0	625
NGI - PC 1026	1,201	0	6	0	0	1,207
OMD - PC 2962	347	0	6	0	0	353
OMD - PC 2972	675	0	0	0	0	675
SVP - WIC 6602/6604	956	0	0	0	0	956
TOTAL BY COMMITMENT	**5,694**	**0**	**16**	**0**	**0**	**5,710**
CONTRACTED PROGRAMS						
JAIL BASED COMPETENCY TREATMENT	426	0	0	0	0	426
COMMUNITY BASED RESTORATION/ DIVERSION[2]	1,073	79	0	0	0	1,152
COMMUNITY INPATIENT FACILITIES	231	0	0	0	0	231
TOTAL - CONTRACTED PROGRAMS	**1,730**	**79**	**0**	**0**	**0**	**1,809**
CONREP PROGRAMS[3]						
CONREP SVP	31	0	0	0	0	31
CONREP NON-SVP	637	0	0	-15	0	622
CONREP FACT PROGRAM	60	30	0	0	0	90
CONREP STEP DOWN FACILITIES	165	0	0	0	0	165
TOTAL - CONREP PROGRAMS	**893**	**30**	**0**	**-15**	**0**	**908**
BY POPULATION AND CONTRACTED TOTAL	**8,317**	**109**	**16**	**-15**	**0**	**8,427**

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

July 1, 2026 Projected: 3,360

June 30, 2027 Projected: 3,442

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.

POPULATION DATA
STATE HOSPITALS
POPULATION AND PERSONAL SERVICES ADJUSTMENTS
Informational Only

BACKGROUND

A change in position and expenditure authority in fiscal year (FY) 2025-26 and FY 2026-27 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, 2025, census as the baseline census for both FY 2025-26 and FY 2026-27. For the 2026-27 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 Persons Designated as 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 2025-26 and FY 2026-27 is based on the modified pending placement list value calculated for June 30, 2026, and June 30, 2027. Variables are specific to patient legal class and are calculated based on trends observed in the 12-month period ending August 31, 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 census for July 1, 2025, as well as the projected census for FY 2025-26 and FY 2026-27 for all DSH populations. The projected census for June 30, 2026 (FY 2025-26) and June 30, 2027 (FY 2026-27) reflects the 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, 2025 Census**	**June 30, 2026 Projected Census**	**June 30, 2026 Projected Pending Placement List**
IST[3]	2,948	3,360	312
LPS	568	625	123
NGI	1,197	1,201	9
OMD2962	344	347	46
OMD2972	672	675	5
SVP	956	956	2
Coleman[4]	190	260	N/A
Subtotal	*6,875*	*7,424*	*497*
CONREP[5]	663	893	N/A
Total	**7,538**	**8,317**	**497**
BUDGET YEAR			
Legal Class	**July 1, 2026 Projected Census**	**June 30, 2027 Projected Census**	**June 30, 2027 Projected Pending Placement List**
IST[3]	3,360	3,443	320
LPS	625	625	138
NGI	1,201	1,207	11
OMD2962	347	353	49
OMD2972	675	675	7
SVP	956	956	2
Coleman[4]	260	260	N/A
Subtotal	*7,424*	*7,519*	*527*
CONREP[5]	893	908	N/A
Total	**8,317**	**8,427**	**527**

[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 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 modest growth in referrals, with an increase of 0.4% in IST referrals as compared to the preceding year. In FY 2024-25 DSH experienced a decrease of 8% in IST referrals rates as compared to the prior year. This decrease coincides with the passage of Senate Bill (SB) 1323, which has created an option for the court, when it finds it is not in the interest of justice to restore an IST individual to competency, to not commit the defendant to DSH for restoration of competency services, and instead consider the individual for diversion, assisted outpatient treatment, CARE court, or conservatorship. As the change in law took effect on January 1, 2025, the decline in referrals may be attributed to the additional processes required to consider diversion or other non-DSH placement options. DSH will continue to monitor IST referral rates to determine if SB 1323 results in a sustained decrease in individuals referred to DSH for restoration of competency services.

Table 2: Average Monthly Referrals[6,7]

Fiscal Year	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	% Change[8]
IST	343	346	415	488	490	451	-8%
LPS	<11	***	<11	***	***	<11	-73%
NGI	<11	<11	<11	<11	<11	<11	-25%
OMD 2962	43	26	27	30	30	30	-1%
OMD 2972	<11	<11	<11	<11	<11	<11	-29%
SVP	<11	<11	<11	<11	<11	<11	35%
Coleman	46	16	16	17	51	59	16%
Total	**456**	**416**	**483**	**559**	**603**	**557**	**-7.4%**

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

[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] 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.

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 treatment and diversion options for felony ISTs, activation of community inpatient facility programs, expansion of existing Jail Based Treatment Program (JBTP) programs, and the addition of new JBTP 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 and the need to maintain isolation units as a necessary infection control measure. As the system recovered from the temporary COVID-19 surge, IST census continued to increase throughout the year, reaching over 2,900 by the end of June 2025.

Table 3: Patient Census

	6/30/2021	6/30/2022	6/30/2023	6/30/2024	6/30/2025	% Change[9]
IST[10]	1,951	2,096	2,843	2,824	2,969	5%
LPS[11]	789	707	584	550	567	3%
NGI	1,338	1,244	1,225	1,208	1,197	-1%
OMD 2962	415	383	334	333	343	3%
OMD 2972	716	685	710	696	669	-4%
SVP	939	956	954	951	957	1%
Coleman[12]	169	114	112	160	190	19%
Subtotal	*6,317*	*6,185*	*6,762*	*6,722*	*6,892*	*3%*
CONREP	647	714	733	697	667	-4%
Total	**6,964**	**6,899**	**7,495**	**7,419**	**7,559**	**2%**

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,

[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.

[10] IST census includes the following facilities and programs: state hospitals, community-based restoration program, diversion, jail-based competency treatment program, and community inpatient facilities.

[11] 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.

[12] Coleman census was impacted by COVID-19 related infection control measures and transfer protocols between DSH and CDCR.

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 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 275 as of 2026-27 Governor's Budget. 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 2024-25, DSH received an average of 451 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.

DEPARTMENT OF STATE HOSPITALS
COMMITMENT CODES

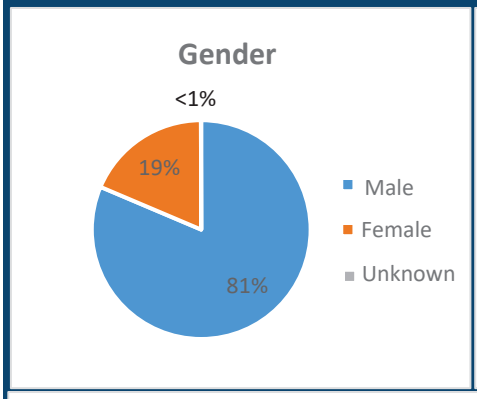
Legal Category	Legal Class Text	Code Section	Description
NGI	NGI PC1026	PC 1026	Not Guilty by Reason of Insanity
Other NGI	RONGI, RO1026	PC 1610	Temporary Admission while waiting for Court Revocation of PC1026 (NGI)
Other NGI	MNGI	WIC 702.3	Minor Not Guilty by Reason of Insanity
Other NGI	TANGI	PC 1610	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)

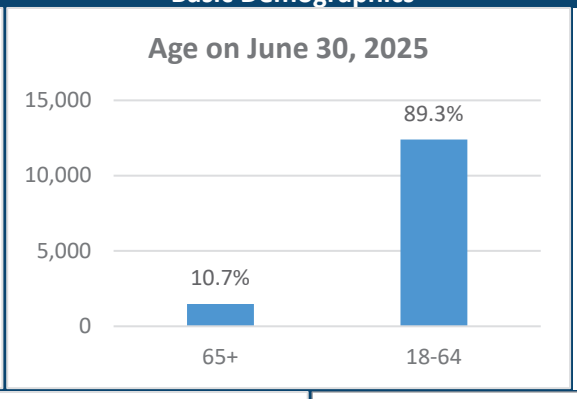
*Historical legal codes that are no longer admitted into DSH are excluded from this table.

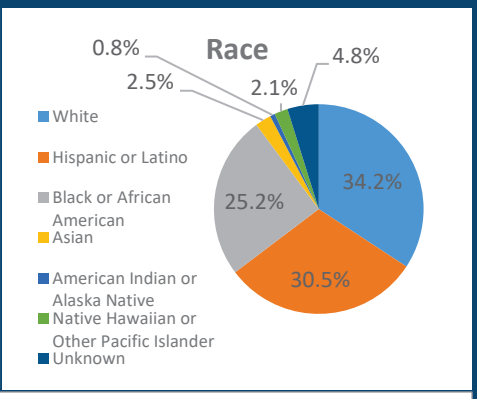
Demographic Snapshot: All Commitment Types

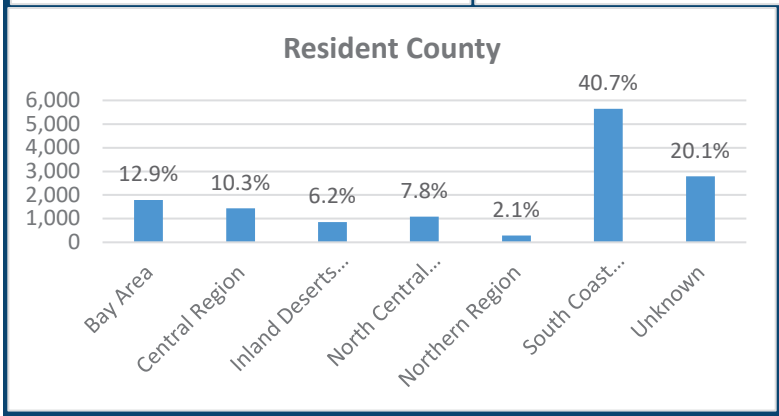
Patients Served from July 1, 2024 to June 30, 2025 is 13,879

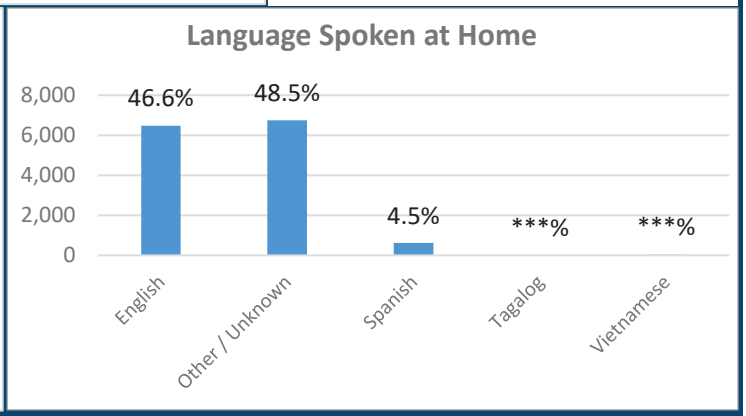
Basic Demographics

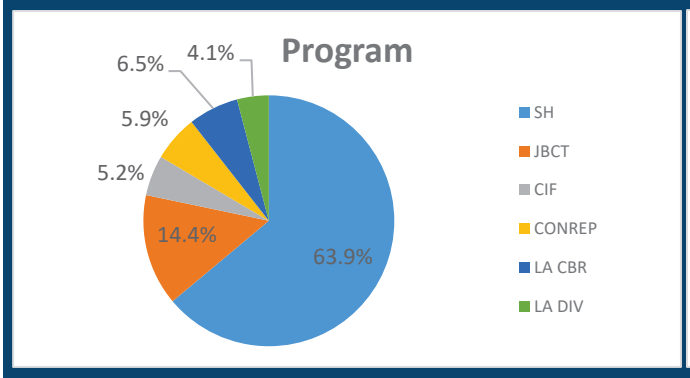


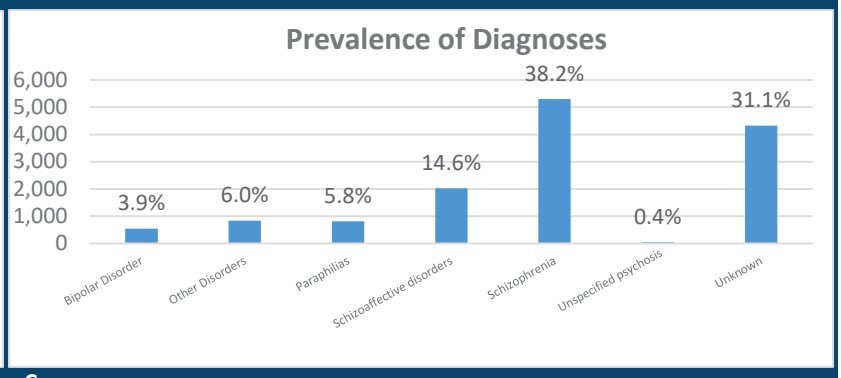












Summary

The data shown above is a combination of State Hospital (SH), Jail-Based Competency Treatment (JBCT) Programs, Conditional Release Program (CONREP), Community Inpatient Facility (CIF), LA Community Based Restoration (LA CBR), and LA Diversion (LA DIV) information. The DSH population is composed of 81% males and 19% 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, 2025. Approximately 34% identify as White, 25% Black, and 30.5% 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 64% of DSH patients were treated at a State Hospital (excluding transfers from other Programs) and 14% at a JBCT facility. Schizophrenia, Schizoaffective, and Paraphilia disorders are the three most common diagnoses for the DSH population, accounting for approximately 85% of the population with known diagnoses.

*Data has been de-identified in accordance with the DSH Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. De-Identification Legend: Counts between 1-10 are masked with "<11" or "fewer than eleven". Complimentary masking is applied using "***" where further de-identification is needed.*

RESEARCH, EVALUATION AND DATA INSIGHTS
DATA MONITORING AND STATISTICS

Patients Served by Race

Fiscal Year 2024-2025

		CDCR	IST	LPS	NGI	OMD[4]	SVP	Grand Total
DSH Inpatient and Outpatient Program's Patients Served by Count[1]	*White*	138	2,963	213	553	521	364	4,752
	Hispanic or Latino	156	2,631	197	485	461	297	4,227
	Black or African American	91	2,178	157	423	369	275	3,493
	Asian	***	237	<11	25	***	***	344
	Unknown	<11	250	***	225	104	***	671
	Native Hawaiian or Other Pacific Islander	***	191	***	25	***	***	287
	American Indian or Alaska Native	<11	76	<11	11	<11	<11	105
	TOTAL	419	8,526	652	1,747	1,520	1,015	**13,879**

		CDCR	IST	LPS	NGI	OMD[4]	SVP	Grand Total	2023 State of California[2]	2024 State of California[3]
DSH Inpatient and Outpatient Program's Patients Served by Percentage[1]	*White*	32.9%	34.8%	32.7%	31.7%	34.3%	35.9%	34.2%	34.6%	32.6%
	Hispanic or Latino	37.2%	30.9%	30.2%	27.8%	30.3%	29.3%	30.5%	39.8%	40.8%
	Black or African American	21.7%	25.5%	24.1%	24.2%	24.3%	27.1%	25.2%	5.3%	5.1%
	Asian	***%	2.8%	***%	1.4%	***%	***%	2.5%	15.1%	15.8%
	Unknown	***%	2.9%	***%	12.9%	6.8%	***%	4.8%	0.5%	0.6%
	Native Hawaiian or Other Pacific Islander	***%	2.2%	***%	1.4%	***%	***%	2.1%	0.3%	0.3%
	American Indian or Alaska Native	***%	0.9%	***%	0.6%	***%	***%	0.8%	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.

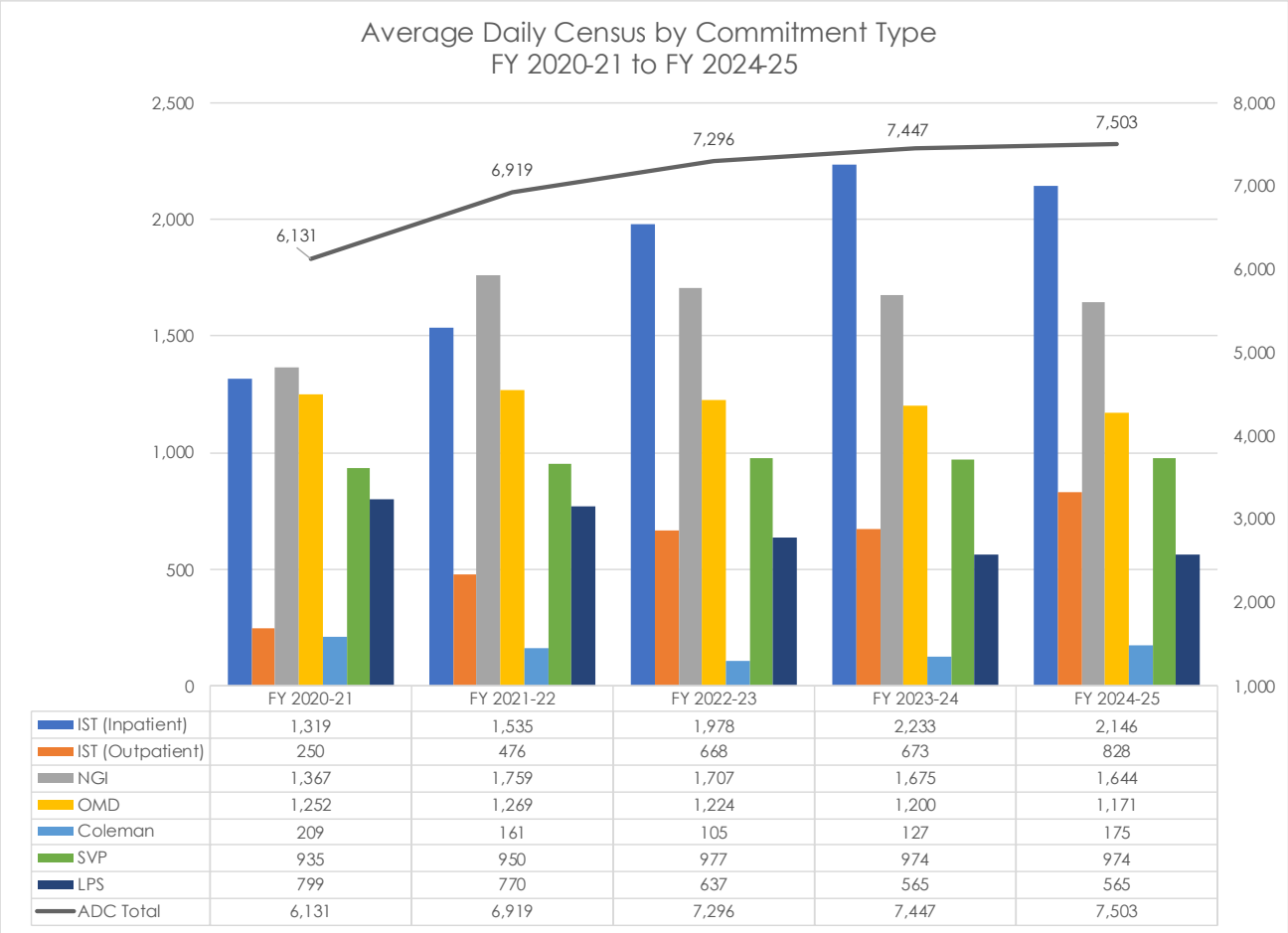
[2]Taken from U.S. Census Bureau 2023 American Community Survey (ACS 5-Year Estimates). Does not include 4.1% labeled "two or more races".

[3]Taken from U.S. Census Bureau 2024 American Community Survey (ACS 1-Year Estimates). Does not include 4.5% 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 persons designated as 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.*



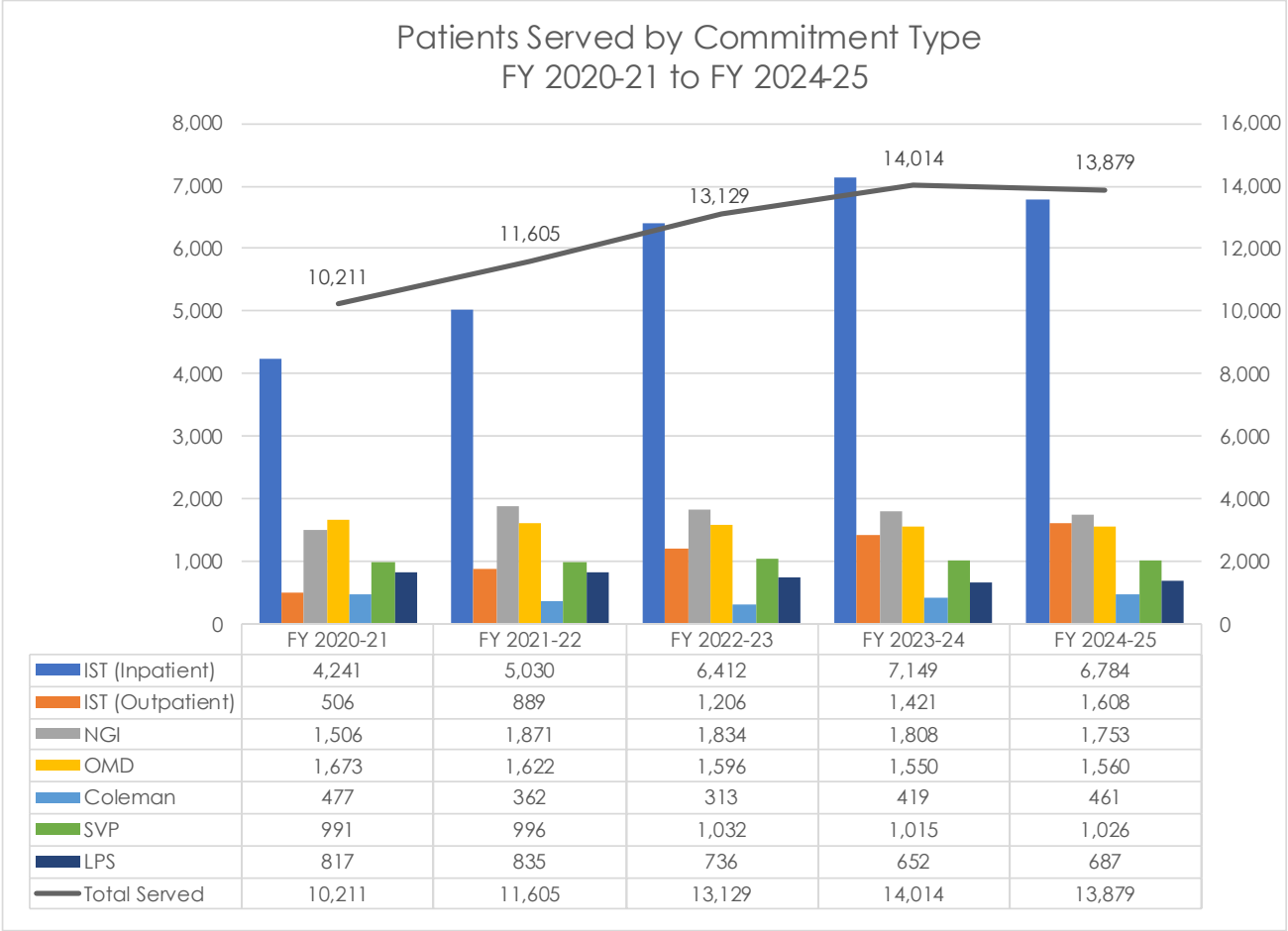
	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
IST (Inpatient)	1,319	1,535	1,978	2,233	2,146
IST (Outpatient)	250	476	668	673	828
NGI	1,367	1,759	1,707	1,675	1,644
OMD	1,252	1,269	1,224	1,200	1,171
Coleman	209	161	105	127	175
SVP	935	950	977	974	974
LPS	799	770	637	565	565
ADC Total	6,131	6,919	7,296	7,447	7,503

Data includes State Hospitals data in all years and for all commitments. Incompetent to Stand Trial (IST) (Inpatient) also includes Community Inpatient Facilities (CIF) and Jail-Based Competency Treatment (JBCT) Programs. IST Outpatient includes Community Based Restoration for all five years and Los Angeles County (LA) Diversion beginning in FY 2022-23. Conditional Release Program (CONREP), CONREP- persons designated as Sexually Violent Predators (SVP) and CONREP- Forensic Assertive Community Treatment (FACT) Program are included within IST (Outpatient), Not Guilty by Reason of Insanity (NGI), Offenders with a Mental Health Disorder (OMD), and SVP beginning FY 2021-22.

During fiscal year (FY) 2023-24, following the end of some COVID-19 pandemic protocols and a return to standard admission processes, average daily census increased by 2% compared to the prior year. This upward trend continued into FY 2024-25, reaching an average daily census of 7,503, representing nearly a 3% increase from FY 2022-23. Some COVID-19 protocols remain such as maintaining necessary isolation units when patients have tested positive for COVID-19 that continue to impact bed capacity.

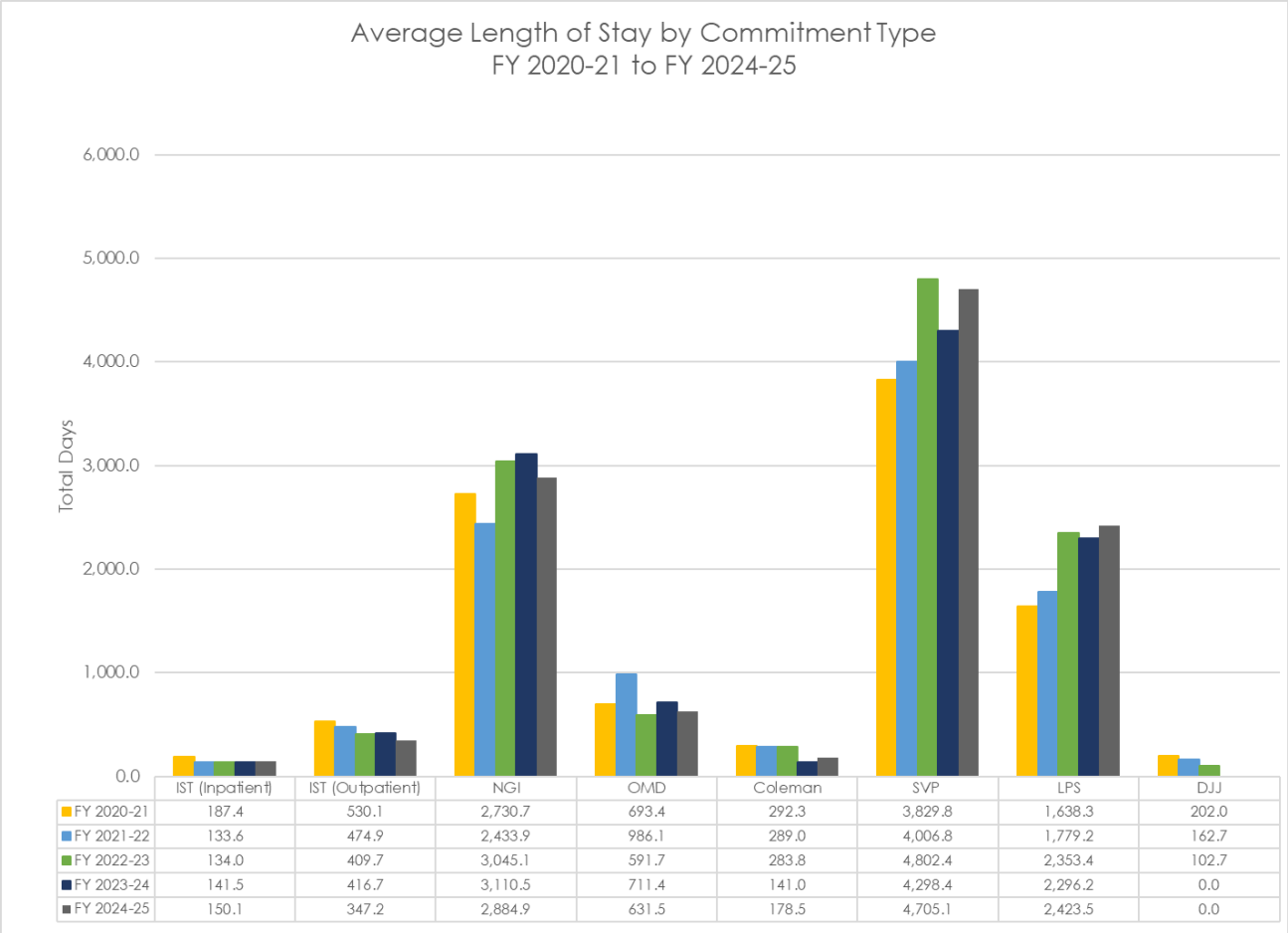
In FYs 2020-21 and 2021-22, COVID-19 significantly impacted both admissions and inpatient census. Admission rates declined due to the implementation of a 10-day isolation period prior to transfer, as well as recurring COVID-19 outbreaks that required quarantines. The need to establish Admission Observation Units (AOUs) and

other isolation spaces further constrained inpatient census. The 3% growth observed from FY 2022-23 to FY 2024-25 reflects DSH's efforts to strengthen its continuum of care through expansion of inpatient and outpatient programs, while maintaining necessary health and safety measures associated with COVID-19.



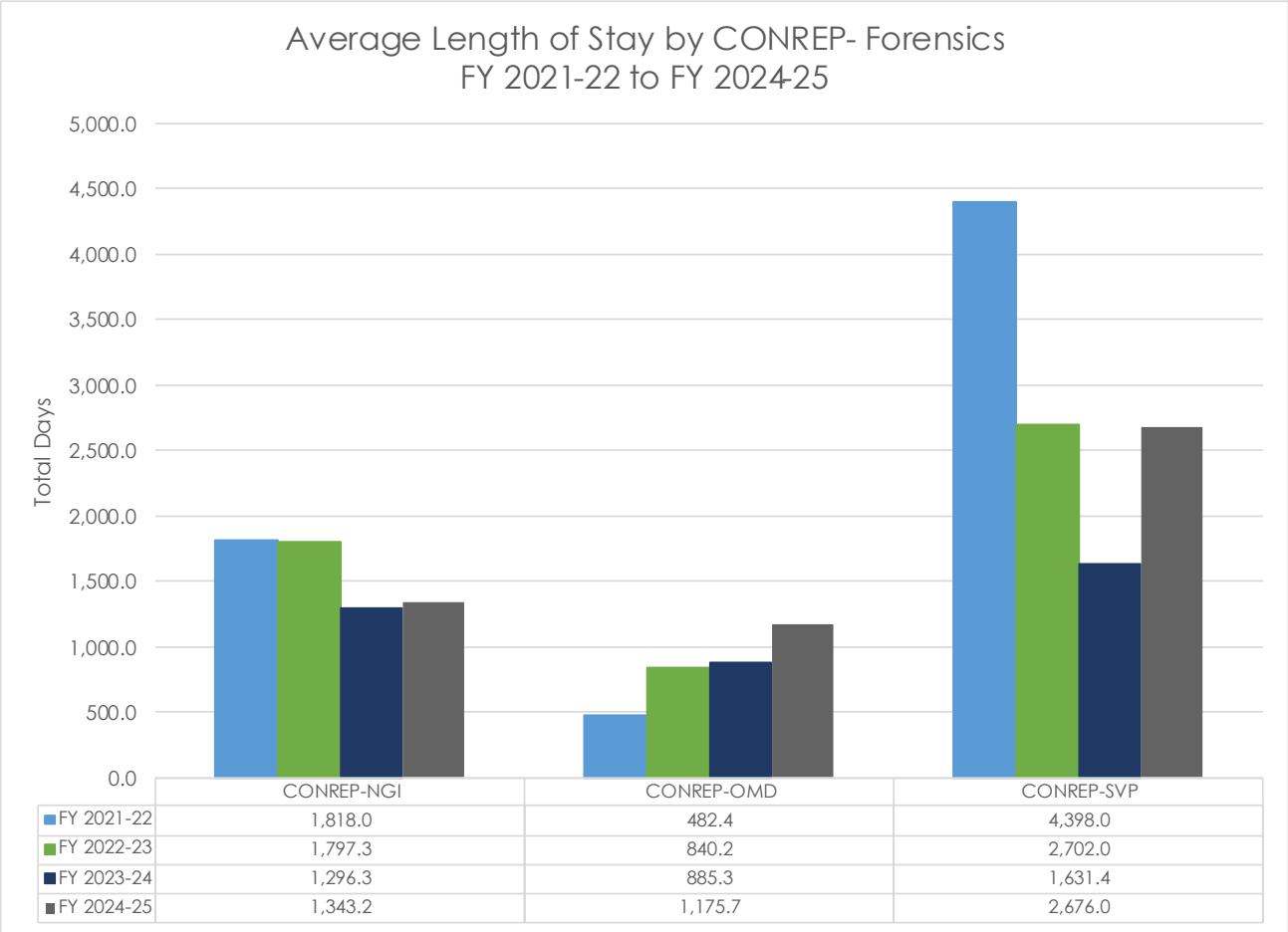
	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
IST (Inpatient)	4,241	5,030	6,412	7,149	6,784
IST (Outpatient)	506	889	1,206	1,421	1,608
NGI	1,506	1,871	1,834	1,808	1,753
OMD	1,673	1,622	1,596	1,550	1,560
Coleman	477	362	313	419	461
SVP	991	996	1,032	1,015	1,026
LPS	817	835	736	652	687
Total Served	10,211	11,605	13,129	14,014	13,879

Data includes State Hospitals data in all years and for all commitments. IST (Inpatient) also includes CIF and JBCT. IST Outpatient includes Community Based Restoration for all five years and LA Diversion beginning in FY 2022-23. CONREP, CONREP- SVP and CONREP- FACT Program are included within IST (Outpatient), NGI, OMD, and SVP beginning FY 2021-22.



	IST (Inpatient)	IST (Outpatient)	NGI	OMD	Coleman	SVP	LPS	DJJ
FY 2020-21	187.4	530.1	2,730.7	693.4	292.3	3,829.8	1,638.3	202.0
FY 2021-22	133.6	474.9	2,433.9	986.1	289.0	4,006.8	1,779.2	162.7
FY 2022-23	134.0	409.7	3,045.1	591.7	283.8	4,802.4	2,353.4	102.7
FY 2023-24	141.5	416.7	3,110.5	711.4	141.0	4,298.4	2,296.2	0.0
FY 2024-25	150.1	347.2	2,884.9	631.5	178.5	4,705.1	2,423.5	0.0

Data includes State Hospitals in all years and for all commitments. IST (Inpatient) also includes CIF and JBCT. IST (Outpatient) includes Community Based Restoration all five years and LA Diversion beginning in FY 2022-23. CONREP and CONREP-FACT Program are included within IST (Outpatient) beginning FY 2021-22. Department of Juvenile Justice (DJJ) patient population is no longer served by DSH per legislative changes.



	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
FY 2024-25	1,343.2	1,175.7	2,676.0

Beginning FY 2021-22 the above graph includes CONREP, CONREP-SVP, NGI, and OMD. IST patients treated in CONREP are reflected in the IST (Outpatient) graph on the page above. Variability in average length of stay may be influenced by small population sizes within certain commitment types, where a few outlier cases can significantly affect the overall average.

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 2026-27 Governor's Budget, the Department of State Hospitals (DSH) reports no adjustment to county bed billing reimbursement authority for fiscal year (FY) 2025-26 and ongoing.

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.

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).

At the 2025 Budget Act, DSH planned to expand the use of DSH beds by 69 for LPS patients. Effective in the new MOU July 1, 2025, DSH converted an IST unit at DSH-M to an LPS unit resulting in the overall LPS beds available from 556 to 581. After consolidating LPS patients from other DSH hospitals, this unit is expected to net approximately 25 additional LPS beds. Additionally, DSH continues to plan to activate an additional 46 bed unit to treat LPS patients. This increase in bed capacity will increase reimbursement collections, help address the LPS bed need 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.

The Budget Act of 2025 reported no adjustments to DSH reimbursement authority in FY 2024-25 and increased reimbursement authority by $13.4 million in FY 2025-26 and $21 million in FY 2026-27 and ongoing due to an increase in LPS acute bed capacity and negotiated daily bed rates. DSH also reported negotiations with the California Mental Health Services Authority (CalMHSA) concluded and 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 effective July 1, 2025.

Updated 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

JUSTIFICATION

As of the 2026-27 Governor's Budget, the updated daily beds rates for FY 2025-26 are in effect. DSH is also actively collaborating with CalMHSA on strategies, including the implementation of a new bed allocation methodology, to support counties in more effectively utilizing LPS beds.

As of the 2026-27 Governor's Budget, 65[1] DSH LPS patients were ready to transition to a lower level of care, and the county had not yet discharged them and an additional 134[2] LPS patients were referred to DSH for admission.

DSH projections for LPS and IST NR/MT reimbursement collections are derived from monthly billing actuals, average length of stay (ALOS), and daily bed rates for each level of acuity. DSH utilizes the most recent fiscal year billing data to project average monthly billing and ALOS for a full fiscal year. The projection methodology uses the following formula:

Average Monthly Billing	X	Daily Bed Rates	X	ALOS	X	Reimbursement Collections
(derived from actuals, represents average billing based on bed usage per patient and level of acuity within a month period)		(established through CalMHSA and individual county MOUs, and based on level of acuity)		(derived from actuals, adjusts for partial billing when patients transition from one level of acuity to another or are discharged within a month period)		(calculated per month and then applied to a full FY)

It is important to note that average monthly billing may be adjusted to account for anticipated increases in LPS bed capacity within a FY.

As of the 2026-27 Governor's Budget, DSH reports no adjustment to reimbursement authority for FY 2025-26 and ongoing. DSH will provide an update to the county bed billing reimbursement authority in the 2026-27 May Revision.

Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$177,630	$185,251	$185,251
Governor's Budget Request	$0	$0	$0
TOTAL	**$177,630**	**$185,251**	**$185,251**

*Dollars in thousands

[1] Data as of September 30, 2025
[2] Data as of December 1, 2025

STATE HOSPITAL
DSH – METROPOLITAN INCREASED SECURE BED CAPACITY
Program Update

SUMMARY

As of the 2026-27 Governor's Budget, the Department of State Hospitals (DSH) Skilled Nursing Facility (SNF) building restoration was completed in November 2025. The DSH-Metropolitan Increased Secure Bed Capacity (ISBC) project is in progress, with one unit activated in December 2025 and planned activation for the second unit in early 2026.

BACKGROUND

To provide additional capacity to address the ongoing system-wide forensic waitlist, particularly focusing on the Incompetent to Stand Trial (IST) patient waitlist, the 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 remained under construction and repairs.

In 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 2025, DSH reported a one-time savings of $10.3 million in FY 2024-25 due to continued construction delays associated with the SNF building. DSH also reported plans to activate one of the two units for LPS patients rather than for IST patients as originally planned due to increased demand for LPS beds.

JUSTIFICATION

As of the 2026-27 Governor's Budget, DSH reports the internal restorations, including electrical repairs, were completed and final regulatory approvals were obtained in November 2025. Correspondingly, SNF patients were relocated back to the SNF building in December 2025. This allows DSH-Metropolitan to proceed with the activation of Units 4 and 5 in the DSH-Metropolitan ISBC project, with one unit

activated in December 2025 and planned activation for the second unit in early 2026.

Completion Timeline Adjustment

Unit	# of Beds	Scheduled Completion as of the 2025-26 May Revision	Scheduled Completion as of 2026-27 Governor's Budget	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	May 2025	November 2025	In Progress
Unit 5	48	May 2025	November 2025	In Progress

Resource Table

Description	CY	BY	BY+
Current Service Level	$74,857	$74,857	$74,857
Governor's Budget Request	$0	$0	$0
TOTAL	**$74,857**	**$74,857**	**$74,857**

*Dollars in thousands

STATE HOSPITALS
ENHANCED TREATMENT PROGRAM (ETP) STAFFING
Program Update

SUMMARY

As of the 2026-27 Governor's Budget, the Department of State Hospitals (DSH) activated the Enhanced Treatment Program (ETP) unit at DSH-Patton (Unit 06) in October 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 2025 reflected a one-time savings of $571,000 in FY 2024-25 due to continued challenges with regulatory approvals. Unit construction completion was anticipated in May 2025, with unit activation in June 2025.

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.

As of the 2026-27 Governor's Budget, construction has been completed and DSH received licensing from the California Department of Public Health (CDPH). DSH-Patton Unit 06 has been activated and is serving patients as of October 2025. ETP Unit 06 is currently operating at 70% capacity as of December 1, 2025. DSH anticipates 8 out of 10 beds will be occupied by December 16, 2025.

Please see the table below for the completion timeline.

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

DSH-Patton Unit U-06	December 2023	October 2025	4-month delay

Resource Table

Description	**CY**	**BY**	**BY+**
Current Service Level	$16,144	$16,144	$16,144
Governor's Budget Request	$0	$0	$0
TOTAL	**$16,144**	**$16,144**	**$16,144**

*Dollars in thousands

STATE HOSPITALS
PATIENT-DRIVEN OPERATING EXPENSES & EQUIPMENT
Program Update

SUMMARY

Due to rising costs, the Department of State Hospitals (DSH) requests $19 million in fiscal year (FY) 2025-26 and $19.6 million in FY 2026-27 and ongoing for recognized increases in Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization as part of patient-driven operating expenses and equipment (OE&E).

BACKGROUND

DSH provides 24-hour, 7 days a week care and treatment for 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 patient driven operating expenses 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

In the Budget Act of 2025, DSH received $20.2 million in FY 2024-25 and $22 million in FY 2025-26 and ongoing for Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization due to increases in costs and changes in patient census.

JUSTIFICATION

As of the 2026-27 Governor's Budget, DSH requests $19 million in FY 2025-26 and $19.6 million in FY 2026-27 and ongoing to support the growing costs of Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization as part of patient-driven OE&E. 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 a per patient cost derived from FY 2024-25 actual expenditures for Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization only.

Increase in Per Patient Cost

Inflation continues to rise in 2025 and is expected to continue to increase in 2026[1]. Correspondingly, cost for care and treatment of DSH patients under patient-driven OE&E has increased significantly in FY 2024-25, with the highest increases in Outside Hospitalization and Pharmaceuticals. Per patient costs for Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization from FY 2023-24 to FY 2024-25 increased by $3,740 per patient, or 13%, to $32,780. The table below displays the increase in per patient cost for all categories within patient-driven OE&E.

Figure 1: All State Hospitals[2]

Budget Categories	FY 2023-24 Avg. Per Patient Cost	FY 2024-25 Avg. Per Patient Cost	Difference	% Change[3]
State Hospital Census	5,550	5,516	-34	-1%
Outside Hospitalization	$11,008	$13,460	$2,452	22%
Pharmaceuticals	$8,195	$9,300	$1,105	13%
Foodstuffs	$4,705	$4,800	$95	2%
Utilities	$5,132	$5,220	$88	2%
Total	**$29,040**	**$32,780**	**$3,740**	**13%**

[1] Please see Department of Finance Budget Letter (BL) 25-22, 2026-27 Price Letter, reflecting the impact of inflation on rising costs.
[2] Per patient costs and totals are rounded for display purposes.
[3] 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.

Allotment Adjustment for FY 2025-26

Between FY 2023-24 and FY 2024-25, the per patient cost for Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization increased by $3,740 to $32,780. As of the 2026-27 Governor's Budget, the projected patient census for FY 2025-26 decreased from 5,772 to the current projection of 5,694; a difference of 78 patients. To calculate the additional funding need for FY 2025-26, the abridged methodology follows a two-step process:

- Step One: The first step is calculating the additional need resulting from the increased per patient cost. The per patient cost difference ($3,740) is multiplied by the 2025-26 May Revision projected census (5,772), resulting in $21,587,280.

- Step Two: The second step is calculating the funding adjustment resulting from the decrease in patient census. The updated per patient cost ($32,780) is multiplied by the difference in patient census (-78), resulting in -$2,556,840**.**

The cost adjustment in FY 2025-26 is determined by adding steps one and two above, resulting in $19,030,440. The table below displays the cost adjustment.

FY 2025-26 Cost Adjustment	
Cost Adjustment for Increased Per Patient Cost	$21,587,280
Cost Adjustment for Updated Census	-$2,556,840
Total Cost Adjustment for FY 2025-26	$19,030,440

Allotment Adjustment for FY 2026-27

As of the 2026-27 Governor's Budget, the projected patient census for FY 2026-27 is 5,710, a projected increase of 16 patients from FY 2025-26. To calculate the additional funding need for FY 2026-27, the abridged methodology follows a similar two-step process to the one mentioned above.

- Step One: Given there is no change in per patient cost, there is no adjustment for step one.

- Step Two: The updated per patient cost ($32,780) is multiplied by the increase in patient census (16), resulting in $524,480.

The cost adjustment for FY 2026-27 is determined by adding steps one and two to the FY 2025-26 cost adjustment to account for any changes in per patient cost and/or projected patient census. This results in a funding request of $19,554,920 for FY 2026-27 and ongoing. The table below displays the cost adjustment.

FY 2026-27 Cost Adjustment	
Cost Adjustment for FY 2025-26	$19,030,440
Adjustment for Projected Census in FY 2026-27	$524,480
Total Cost Adjustment for FY 2026-27	**$19,554,920**

Conclusion

As of the 2026-27 Governor's Budget, DSH requests $19 million in FY 2025-26 and $19.6 million in FY 2026-27 and ongoing to support patient-driven OE&E due to continued rising costs.

DSH will continue to monitor costs and patient census and provide an update in the 2026-27 May Revision.

Resource Table

Description	CY	BY	BY+
Current Service Level	$168,012	$168,012	$168,012
Governor's Budget Request	$19,030	$19,555	$19,555
TOTAL	**$187,042**	**$187,567**	**$187,567**

*Dollars in thousands

BCP Fiscal Detail Sheet

(Dollars in Thousands)

BCP Title: Patient Driven Operating Expenses & Equipment **BR Name: 4440-026-ECP-2026-GB**

Budget Request Summary

	FY26					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5326 - Utilities	102	185	185	185	185	185
5340 - Consulting and Professional Services - External	13,102	13,318	13,318	13,318	13,318	13,318
539X - Other	5,826	6,052	6,052	6,052	6,052	6,052
Total Operating Expenses and Equipment	**$19,030**	**$19,555**	**$19,555**	**$19,555**	**$19,555**	**$19,555**
Total Budget Request	**$19,030**	**$19,555**	**$19,555**	**$19,555**	**$19,555**	**$19,555**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	19,030	19,555	19,555	19,555	19,555	19,555
Total State Operations Expenditures	**$19,030**	**$19,555**	**$19,555**	**$19,555**	**$19,555**	**$19,555**
Total All Funds	**$19,030**	**$19,555**	**$19,555**	**$19,555**	**$19,555**	**$19,555**

Program Summary

Program Funding						
4410010 - Atascadero	3,897	3,897	3,897	3,897	3,897	3,897
4410020 - Coalinga	4,501	4,501	4,501	4,501	4,501	4,501
4410030 - Metropolitan	1,648	2,173	2,173	2,173	2,173	2,173
4410040 - Napa	3,868	3,868	3,868	3,868	3,868	3,868
4410050 - Patton	5,116	5,116	5,116	5,116	5,116	5,116
Total All Programs	**$19,030**	**$19,555**	**$19,555**	**$19,555**	**$19,555**	**$19,555**

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

Program Update

SUMMARY

As of the 2026-27 Governor's Budget, DSH anticipates an updated total contracted caseload of 862 CONREP clients in fiscal year (FY) 2025-26 and 877 in FY 2026-27. DSH requests $2.1 million in FY 2026-27 and ongoing to support Golden Legacy's contract increases resulting from increased service rates and program service expansions.

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 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 in California. 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

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

[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.

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 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.

Budget Act of 2025

In the Budget Act of 2025, DSH reported one-time savings of $6.9 million in FY 2024-25 due to reduced census at Canyon Manor and the closures of the 30-bed FACT Alameda Regional Program and the A&A Health Services 20-bed STRP.

JUSTIFICATION

As of the 2026-27 Governor's Budget, DSH anticipates a total contracted caseload of 862 CONREP clients in FY 2025-26 and 877 in FY 2026-27. This contracted caseload includes 637 regular CONREP clients in FY 2025-26 and 622 in FY 2026-27 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:

- 35 STRP beds in FY 2025-26 and ongoing
  - 35-bed activated Southern CA STRP
- 60 FACT beds in FY 2025-26, 90 FACT beds in FY 2026-27
  - 30 activated beds in Southern CA Region - (San Diego County)
  - 30 activated beds in Northern CA Region - (Solano County)
  - 30 beds anticipated to activate in Central CA Region in January 2027 - (Fresno County)
- 106 Institute for Mental Disorder (IMD) beds in FY 2025-26 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
  - 24 beds activated in Northern CA MHRC in July 2025 with referrals anticipated to begin in January 2026

This contracted caseload reflects the total number of clients and beds available by the end of FY 2025-26 and FY 2026-27, which may vary based on activation timelines. Reflecting the projected client phase-in, DSH estimates an average census of 691 in FY 2025-26 and 721 in FY 2026-27.

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.

76-Bed Southern CA IMD Facility (Golden Legacy)

As of December 2025, the program is fully activated and 72 of the 76 contracted beds are currently filled, with additional referrals currently under review. As part of Golden Legacy's most recent renewal, DSH recognized two separate rate increases within the contract: the IMD Rate, which had not been updated since 2022, and an increase to the Quality Assurance Fee (QAF) rate. Both rates are required by the Department of Health Care Services (DHCS) that support the program's licensure and build in regular annual rate increases. The IMD rate increases by 3.5% annually as required by Assembly Bill (AB) 1054 and captures basic expenses to operate an IMD, while the QAF rate is published annually and supports the program's quality of

care. The budget authority for this program does not account for the incremental funding needed to support regular IMD and QAF rate adjustments, which led to a discrepancy between the program's funding allocation and need. This resulted in contract increases in FY 2025-26 of $1.6 million and $1.8 million in FY 2026-27.

Additionally, during recent oversight visits, there was a gap identified in the level of psychiatry services available. The current funding level for the contracted provider is insufficient to support a full-time psychiatrist for this program; and psychiatry services are currently facilitated via third-party Medi-Cal based providers. DSH has found the part-time providers are not meeting DSH treatment standards and that the program requires a dedicated, full-time psychiatrist position to appropriately meet the forensic treatment needs of the patients. To better support the program and raise psychiatry service standards to the required levels, DSH is requesting $300,000 in FY 2026-27 and ongoing.

DSH is proposing a one-time redirection of $1.6 million in unused funds from delayed CFRP activations in FY 2025-26 and is requesting $2.1 million in FY 2026-27 and ongoing to support the increased rates mandated by DHCS and the expansion of psychiatry services at the program.

30-Bed Northern CA IMD Facility (Canyon Manor)

Recruitment efforts to fill Canyon Manor's vacant licensed clinician were successful and the new incumbent started with the program in June 2025. Full clinical staffing has allowed for sufficient clinical oversight, and the program is now operating at its full program capacity. As of December 2025, 24 of the 30 contracted beds are filled, with an additional three referrals currently under review. DSH is closely monitoring the provider to ensure progress towards reaching full bed capacity and will provide a caseload update in the 2026-27 May Revision.

CONREP FACT Regional Program (CFRP)

CFRP-Sacramento officially closed in June 2025 and the program's remaining clients were transferred to their home CONREP programs or the new CFRP-Solano program. DSH is continuing to see success with the CFRP-San Diego program and has renewed the program's contract for an additional year. As of December 2025, CFRP-San Diego's census is at 25.

In response to the need for FACT beds in the Northern CA region, DSH contracted with a new provider to operate a 30-bed CFRP in Solano County. CRFP-Solano activated in March 2025 and initial client placements began in June 2025. One housing location is currently in operation and the second housing location secured, with the provider in the process of locating and securing a third housing location.

There have been challenges in finding sufficient qualified staff with appropriate licensure which has slowed activation and delayed filling all available beds. Core leadership positions within the program were hired in September 2025, and recruitment efforts for the remaining staff vacancies continue. As of December 2025, CFRP-Solano's census is at five and additional referrals are being reviewed, pending hire of additional program staff.

DSH continues to pursue opportunities for CFRP expansions statewide. A 30-bed program in Central CA is being explored, and negotiations are in the beginning stages. DSH is projecting the new program start-up activities will begin in January 2027, allowing time for contract negotiations, hiring, and housing location searches.

As a result of the CFRP-Sacramento closure and the delayed activation of CFRP-Central CA, DSH proposes to redirect a one-time savings of $4.5 million in FY 2025-26, of which $1.6 million will be used to support the increased bed rates for Golden Legacy and the remaining $2.9 million will be used to offset the increased costs of the traditional CONREP non-SVP programs. In FY 2026-27, DSH will be utilizing $2.8 million in available funds to support the activation of the new CFRP-Central CA and will redirect the remaining one-time savings of $1.7 million to support the increased costs of the traditional CONREP non-SVP programs.

Increasing CONREP Non-SVP 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 has significantly increased contracted personnel costs. Additionally, Senate Bill (SB) 525 (Durazo, Chapter 890, Statutes of 2023)[3], which incrementally increases the minimum wage for healthcare workers in certain healthcare settings, has been implemented statewide and includes CONREP non-SVP service providers. The inability to remain competitive in clinical recruitments and retain appropriately licensed staff has resulted in reduced census in response to clinical supervision ratio requirements. Concurrently, projected program operating costs supporting client care, including housing and medical services, have also risen beyond what was projected based on historical contracts.

These increases have outpaced the available funding and, as a result, community outpatient caseload for CONREP non-SVP programs are being reduced to offset these costs. In order to support these program cost increases, DSH is proposing to redirect $2.9 million in FY 2025-26 and $1.7 million in FY 2026-27 in savings resulting from the CFRP-Sacramento closure and the delayed CFRP-Central CA activation. DSH will continue monitoring these cost pressures and permanent funding will be considered as a future fiscal request.

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

Summary Table

Program Summary	CY	BY	BY+
CONREP FACT Regional Program (CFRP)	($4,500)	$0	$0
CONREP Traditional Programs and CFRP Central Ca Activation	$2,900	$0	$0
Golden Legacy	$1,600	$2,100	$2,100

Resource Table[1]

Description	CY	BY	BY+
Current Service Level	$48,508	$48,508	$48,508
Governor's Budget Request[2]	$0	$2,120	$2,120
TOTAL	**$48,508**	**$50,628**	**$50,628**

[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. These savings will be redirected to other program areas.

BCP Fiscal Detail Sheet

(Dollars in Thousands)

BCP Title: CONREP Non-SVP **BR Name: 4440-028-ECP-2026-GB**

Budget Request Summary

	FY26					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	0	2,100	2,100	2,100	2,100	2,100
Total Operating Expenses and Equipment	**$0**	**$2,100**	**$2,100**	**$2,100**	**$2,100**	**$2,100**
Total Budget Request	**$0**	**$2,100**	**$2,100**	**$2,100**	**$2,100**	**$2,100**

Fund Summary

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

Program Summary

Program Funding						
4420010 - Conditional Release Program	0	2,100	2,100	2,100	2,100	2,100
Total All Programs	**$0**	**$2,100**	**$2,100**	**$2,100**	**$2,100**	**$2,100**

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

SUMMARY

As of the 2026-27 Governor's Budget, 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, 2027.

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 with 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 was approximately 12 months from approved petition to placement in the community. However, in recent years, this average time to placement has been increasing and is currently approximately 18 months.

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, WIC 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 homeschool 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, now averages 25 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 Budget Act of 2025, DSH assumed conditional release of a total caseload of 31 persons designated as Sexually Violent Predators (SVPs) into the community by June 30, 2026, and reflected no position authority or funding changes for the CONREP SVP program.

JUSTIFICATION

As of the 2026-27 Governor's Budget, 22 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, 24 individuals with court-approved petitions are awaiting placement into the community and 16 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) 2026-27. Please refer to the table below which displays the total projected caseload for FY 2025-26 and FY 2026-27.

CONREP-SVP Projected Caseload for 2026-27 Governor's Budget[2]		
Description	Projected Caseload as of FY 2025-26	Projected Caseload as of FY 2026-27
Individuals currently in CONREP	22	25
Adjusted Caseload	9	6
Total	**31**	**31**

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

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 releases from CONREP, and upcoming delays due to court proceedings and/or community placement progress.

At this time, DSH requests no new resources through the 2026-27 Governor's Budget but will monitor costs and caseload to determine any future needs.

Resource Table

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

*Dollars in thousands

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 2026-27 Governor's Budget, DSH has identified one-time savings of $114 million in Fiscal Year (FY) 2023-24 specific to the cancellation of funding awarded to counties who have not progressed with their IST infrastructure project, as well as to revert remaining unobligated dollars. Funding was originally appropriated in FY 2023-24 with 5-year encumbrance authority. DSH has also identified one-time savings of $117.8 million in FY 2025-26 and $94.2 million in FY 2026-27 to reflect phased in activations of DSH Diversion/Community Based Restoration (CBR) Programs and serving lower census levels than the maximum budget projected to support.

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 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 within 28 days from the transfer of responsibility to DSH[2]. The court provided a specified timeline to meet that standard over three years, initially setting February 27, 2024, as the target date for fully implementing the requirement. On October 6, 2023,

[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.
[2] Date of service of the commitment packet to DSH for felony IST patients.

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, Jail Based Competency Treatment (JBCT), and Community Inpatient Facilities (CIF), to expand the DSH continuum of care for IST individuals. Additionally, statutory changes aimed at reducing the IST demand for services have been implemented to target growth in IST determinations (felony IST growth cap), and establish a comprehensive set of strategies and solutions, to ensure that 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.

In February 2020, Prior to the COVID-19 declared State of Emergency, DSH had 850 individuals pending placement into a DSH IST treatment program. In January 2022, the IST waitlist reached a high of 1,953. In the 2025-26 May Revision, DSH reported the waitlist had declined to 278, a reduction of 23% from the total waitlist reported in the 2025-26 Governor's Budget.

Justification

As of the 2026-27 Governor's Budget, there are 275[4] individuals on the waitlist. Furthermore, of the 275 individuals on the waitlist pending admission to a treatment bed, 149 are receiving substantive treatment services through EASS or other

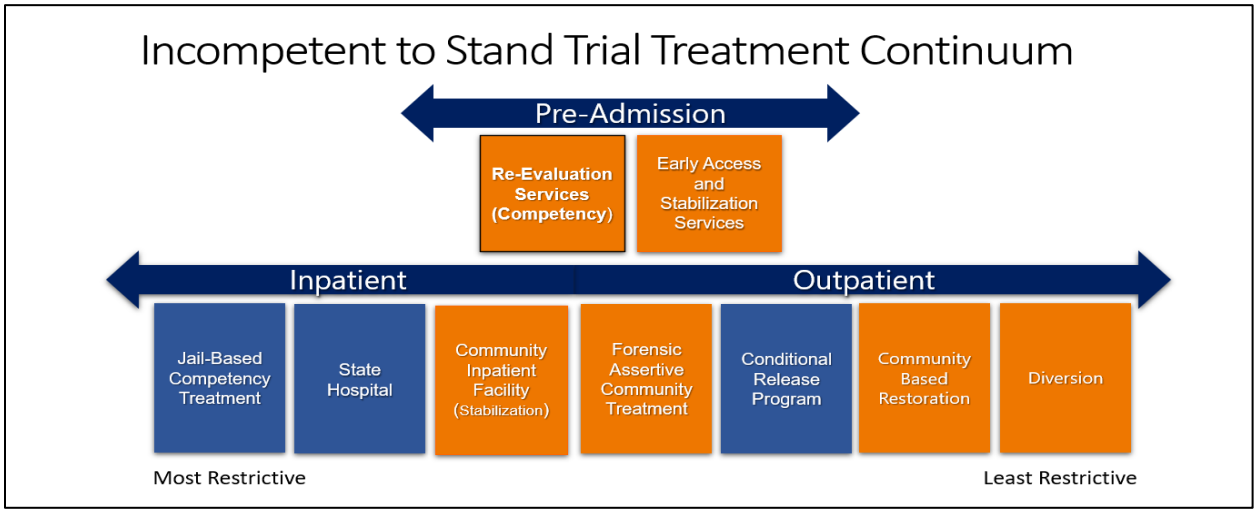
[3] In 2021, the Legislature enacted Welfare & Institutions Code (WIC) section 4147 through the passage of Assembly Bill 133 (Chapter 143, Statutes of 2021) and the Budget Act of 2021 (Chapter 69, Statutes of 2021), which charged the California Health & Human Services Agency (CalHHS) and DSH to convene 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.
[4] Data as of January 5, 2026

treatment programs. There are 106 individuals on the waitlist who have not yet begun receiving treatment services from a DSH program; of these individuals pending access to substantive services, 9 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 been 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 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,* as of March 1, 2025, DSH is required to provide substantive services toward restoration of competency to IST patients within 28 days of the IST individual's transfer of responsibility to DSH. DSH filed a report to the court on March 28, 2025, demonstrating substantial compliance with the court's order. As of December 2025, the court is reviewing the matter to determine whether DSH is in substantial compliance.

IST TREATMENT CONTINUUM

The following chart depicts the comprehensive continuum of IST services DSH has established and is continuing to build. 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 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. As of the 2025-26 May Revision, DSH executed a contract with Crestwood Behavioral Health, Inc. to remodel an existing building for the development of a 40-bed licensed MHRC located in Fresno County. DSH also executed a 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.

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.

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 2025-26[1]**
Sylmar	10/30/2023	24	22
BBHH	7/3/2023	29	28
ACH	7/3/2023	50	48
Priorities, Inc.	7/3/2023	16	15
SBHH	4/20/2022	78	74

[1]As of November 24, 2025

DSH 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 and was completed in July 2025 with expected program activation in December 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 are not eligible for diversion by providing competency treatment services to continue legal proceedings. Construction is anticipated for completion in December 2026, with program activation in Spring 2027.

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[5]. 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 Budget Act of 2025, DSH reported a total of 7,999 completed evaluations. DSH also reported providing 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.

Justification

As of the 2026-27 Governor's Budget, DSH has completed a total of 11,094 evaluations, of which:

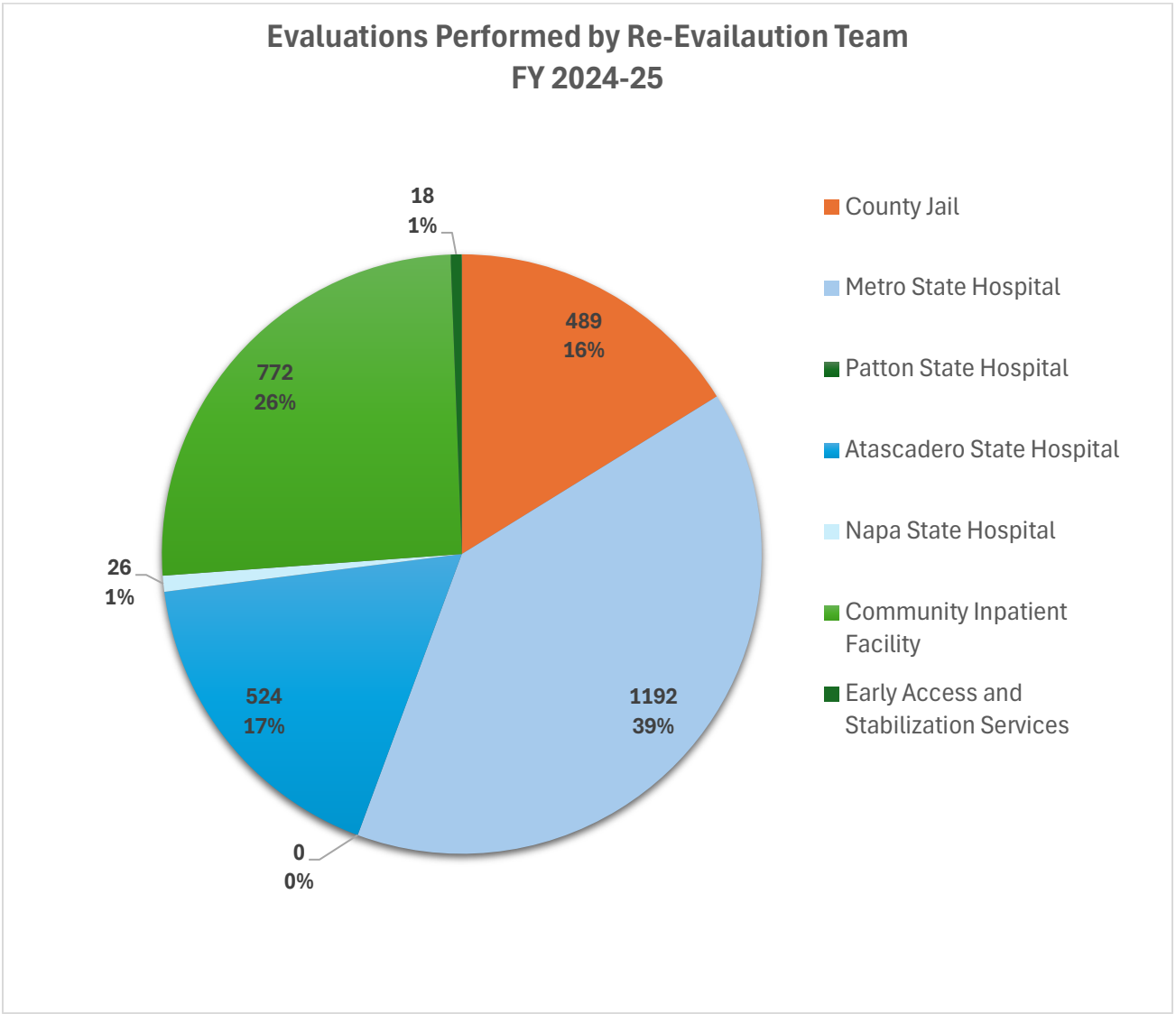
- 7,262 (65.5 %) were found not competent and continued competency restoration treatment
- 3,610 (32.5 %) were found restored to competency
- 161 (1.5 %) were found unlikely to be restored to competency
- 38 (<1.0%) were found not competent and returned to committing court
- 23 (<1.0%) were found competent and continue treatment to maintain 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,

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

significantly reducing wait times for individuals still requiring treatment. Re-Evaluation reports also allow the courts to consider different treatment options. 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 timely access to care. For example, of the 3,021 evaluations performed in FY 2024-25, 1,742 (57.7%), 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 at 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 2024-25.



As DSH continues to deploy these forensic evaluation resources flexibly and strategically to meet IST forensic evaluation needs across its system, DSH received authority to redirect savings from IST Solutions in FY 2025-26 and ongoing for operational costs including contracted forensic evaluators and other support costs associated with the IST Re-Evaluation Services Program.

DSH had an average daily census of 2,974 IST designated patients during FY 2024-25, with less than a 2% growth from 2,906 patients in FY 2023-24. In addition, as compared to the prior fiscal year, the average daily census increased overall by less than 1% in FY 2024-25.

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[6] which 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 Budget Act of 2022 established the EASS program 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 2025-26 May Revision, DSH reported activation of a new county program, bringing the total number of EASS programs to 56.

[6] In 2021, the Legislature enacted Welfare & Institutions (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.

Justification

As of November 25, 2025, DSH reports activation of a new county program, bringing the total number of EASS programs to 57. The following reflects updates as a result of EASS implementation:

- Total patients served: 9,234
- Total patients unenrolled[7]: 9,092
- Total restored while in EASS: 768 (8% of those who received services)

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

Background

The Budget Act of 2022 provided one-time infrastructure funding in FYs 2022-23 and 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-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[8].

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 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.

As a part of the Budget Act of 2025, DSH reported ongoing savings associated with counties that did not elect to enter into a permanent Diversion and/or CBR program. In addition, DSH received 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.

[7] 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.
[8] Dependent upon securing available housing.

Justification

As of the 2026-27 Governor's Budget, DSH has identified additional one-time savings of $117.8 million in 2025-26 and $94.2 million in 2026-27 to reflect phased in activation of DSH Diversion/CBR Programs and serving lower census levels than the maximum budget supports.

CBR and Diversion[9] 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 support 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 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 November 2025, 21 counties have executed contracts with DSH to serve up to 1,634 IST patients per year, and six

[9] 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.

counties have submitted Letters of Intent (LOI) to establish permanent programs to serve an additional 193 IST 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 Budget Act of 2023, DSH reported 32 counties had submitted LOIs to contract with DSH for these annual resources.

In the Budget Act of 2025, all 32 counties had executed contracts with DSH and DSH reported savings associated with the counties that did not elect to obtain County Stakeholder Workgroup Grants.

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

In the 2025-26 May Revision, DSH reported enacted legislation, SB 1323 effective January 1, 2025, which included amendments to modernize 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.

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 were encouraged to partner with neighboring counties to submit a joint application.

As of the 2026-27 Governor's Budget, the county stakeholder application submission period is closed. DSH has approved two project applications and is reviewing two additional applications to establish a total of up to 439 beds.

As of the 2026-27 Governor's Budget, DSH has identified one-time savings of $114 million related to the cancellation of FY 2023-24 funding awarded to counties who have not progressed with their IST infrastructure project and revert remaining

unobligated dollars. Funding was originally appropriated in FY 2023-24 with 5-year encumbrance authority.

Los Angeles County CBR and Diversion Program

DSH and the LA County Office of Diversion and Re-entry (ODR) executed a contract in Summer 2023 to significantly expand the county's CBR and Diversion program. In the 2025-26 May Revision, DSH reported total bed capacity expanding to 1,274 beds by FY 2026-27. To align with budget reductions in the 2025-26 May Revision, maximum bed capacity has been reduced to 1,005.

ODR will continue to establish beds to meet capacity 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 660 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 October 31, 2025, to reflect the total patients served.

LA County Program	10/31/22 Census	Admissions (11/1/22 – 10/31/2025	Total Patients Served	10/31/2025 Census
CBR	450	1,071	1,521	410
Diversion	159	337	496	18
Diversion (Non-DSH)[10]	0	539	539	372
CBR (Non-DSH)	0	79	79	57

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 June 30, 2025, the original 29 county pilot DSH Diversion programs have ended and 27 of them have entered into a new contract with DSH or are in the process of transitioning or planning to transition to permanent programs. As part of this planning process, DSH partnered with a California-based consulting group with county behavioral health expertise 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.

[10] Participants who are not committed to DSH but are eligible to participate in the DSH-funded diversion and programs. 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.

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, 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. A subsequent presentation was held on June 13, 2025, to provide county Justice Partners with program information as well as updates resulting from changes made to SB 1323.

Counties had several opportunities to submit an LOI to participate in the permanent program with a final due date of June 30, 2025. The following 21 counties executed contracts with DSH to implement a permanent program and serve up to 1,634 IST patients per year:

- Contra Costa
- Fresno
- Humboldt
- Kern
- Los Angeles
- Nevada
- Placer
- Riverside
- Sacramento
- San Bernardino
- San Francisco
- San Joaquin
- San Luis Obispo
- San Mateo
- Santa Barbara
- Santa Clara
- Sonoma
- Stanislaus
- Tuolumne
- Ventura
- Yolo

Two counties submitted LOIs to enter into an agreement with DSH for a permanent program beginning FY 2025-26 and four counties have submitted LOIs for agreements beginning FY 2026-27 to serve up to an additional 209 IST patients.

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 2025, 39 counties have executed contracts with DSH:

- Amador
- Butte
- Mariposa
- Mendocino
- San Bernardino
- San Diego
- Solano
- Sonoma

- Contra Costa
- Del Norte
- Fresno
- Humboldt
- Kern
- Kings
- Madera
- Marin
- Merced
- Modoc
- Mono
- Monterey
- Nevada
- Placer
- Riverside
- Sacramento
- San Joaquin
- San Luis Obispo
- San Mateo
- Santa Barbara
- Santa Clara
- Santa Cruz
- Shasta
- Siskiyou
- Stanislaus
- Sutter
- Tulare
- Tuolumne
- Ventura
- Yolo
- Yuba

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 Budget Act of 2025, 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. DSH also reported development of a three-year extension of the existing interagency agreement.

Justification

As of the 2026-27 Governor's Budget, the Interagency Agreement with DSH and the Judicial Council for the Alienist Training was not extended and expired on June 30, 2025.

<u>Care Coordination and Waitlist Management (CCWM)</u>

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 case management model for IST patient placement, using teams comprised of clinical and analytical staff, with the goal of building relationships with county stakeholders and using a patient-centered approach to place patients at 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).

Now that the backlog has been eliminated and the average length of stay in EASS is less than 28 days, regular case conferences are no longer necessary, and the small team approach has migrated to a whole-team approach to maintain the 28-day time to treatment timeline mandated by the court. This allows PMU to complete patient intake and placement in real-time and, in compliance with DSH's regulations, maintain commitment date order by placing patients with the oldest commitment dates first.

Starting in 2025, PMU began 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.

Justification

Care Coordination has been implemented to serve all 58 counties. PMU convenes a bi-weekly workgroup with stakeholders in LA County to address specific county challenges. For LA, PMU 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, lowered wait times and decreased the number of individuals pending placement specifically from LA County.

As of the 2026-27 Governor's Budget. PMU continues to explore ways to streamline referral processing and patient placement. This is especially important as DSH begins to implement an EHR solution, since referral intake is the beginning of a patient's

[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.

medical record and any intake process must integrate seamlessly with the EHR solution.

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.

As of the 2026-27 Governor's Budget, DSH continues to monitor IST referral rates and the potential impact of Proposition 36 implementation and will provide an update in the 2026-27 May Revision.

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[12], such as:

- 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.

A standardized packet of discharge documents to facilitate a warm handoff of IST patients to their transition location from a state hospital was established as a result of a collaborative workgroup session in August 2022, between DSH and 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 2026-27 Governor's Budget, no additional resources are requested to support these efforts.

DSH continues to enhance the discharge process as patients transition from a state hospital to a community-based setting. Standardized packets of IST discharge documents are being provided to the patients' transition location after discharge from a state hospital. Typically, the transition location is a return to the local jail of the county of commitment. Given that many IST individuals are released back to the community after their case is adjudicated, DSH has established a process to notify county behavioral health partners concurrent to the IST individuals' state hospital discharge. This notification process prompts county behavioral health that an IST individual is returning to the county jail so engagement and community discharge planning can be initiated. County behavioral partners can then request the standardized discharge records from DSH to ensure continuity of care.

In addition to these efforts, DSH has trained team members and established processes on how to complete and file Community Assistance Recovery and Empowerment (CARE) Court petitions for eligible IST patients who have been restored to competency. DSH reasonably believes will likely be released back to the community, and would benefit from the level of support and accountability offered thorough the CARE initiative. Connection to CARE is another important tool used to support continuity of treatment and housing for this vulnerable population.

<u>Felony IST Referral Growth Cap</u>

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. If annual IST caps are exceeded, counties will be subject to penalty fees which must then be redirected to upstream interventions aimed at reducing the number of new IST determinations in future years. 100% of the penalty fees are returned to the counties, upon submission and DSH approval of a required expenditure plan identifying how the county intends to apply the Growth Cap fees.

To implement the IST Growth Cap, DSH established operational policies, processes and timelines. This includes timeframes and protocols for data collection and reconciliation of IST determinations by the statutory deadline of September 30th each year; release of data to counties; dispute process to correct IST records; release of final invoices; and required submission of expenditure plans and annual expenditure reports.

Additionally, DSH established a methodology for counting IST determinations that considers multiple variables such as the timing of commitment and actions that impact IST commitments prior to DSH admission (e.g. court cancellations, restoration while in jail). Subsequent modifications to the methodology and DSH processes were incorporated following continued engagement with county representatives and feedback provided to DSH.

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.

Justification

As of the 2026-27 Governor's Budget, no additional resources are requested to support these efforts.

Annually, DSH collects IST determination data and reconciles the data for the prior fiscal year by September 30th in accordance with WIC 4336. By way of DSH policy, tentative final data reports are distributed to counties by the end of October which then opens a dispute window of up to 90 days which is an opportunity for counties to flag concerns with data and provide supporting documentation to DSH for consideration of potential corrections to the final numbers that would be used to assess the Growth Cap penalty fee. To date, DSH has released reconciled IST Growth Cap data and issued penalty invoices for fiscal years 2022-23 and 2023-24, and as of December 2025, DSH distributed final 2024-25 data reports to the counties.

Counties that were assessed penalty fees for fiscal years 2022-23 and 2023-24 are in early stages of utilizing the funds on the programs and interventions identified to help reduce future IST determinations. To that end, it is too early to draw conclusions

regarding the effectiveness of the Growth Cap policy. One significant outcome of the policy is that key county partners have access to specific, individual level IST data on a quarterly basis where fragmented data systems across multiple agencies made it difficult to track individuals who ultimately were committed as IST. Utilizing this data to track an IST individual's journey through the local behavioral health and justice systems can help inform county leaders on where to target funding investments and strengthen programs.

Independent Placement Panel (IPP)

Background

The Budget Act of 2022 included resources to pilot an independent placement panel (IPP), which sought to increase participation in the Conditional Release Program (CONREP) by individuals found Not Guilty by Reason of Insanity (NGI) or Offenders with Mental health Disorders (OMD), thereby increasing state hospital bed capacity for those on the IST waitlist. Roll out of the IPP began with development of an implementation plan which envisioned a phased in approach of supporting a select number of counties within each phase to deploy IPP services.

In November 2022, DSH formed a stakeholder workgroup consisting of several county CONREP Community Program Directors, DSH CONREP clinical staff, and state hospital discharge-planning teams to develop the IPP and finalize the implementation plan, with a specific focus on determining assessment and referral protocols, justice partner engagement, CONREP program training, technical assistance, and streamlining the referral process and patient records database. In June 2023, the IPP policies and procedures manual was completed and services commenced on July 1, 2023, covering six CONREPs representing 37 counties. The IPP pilot expanded to include three additional CONREP's on November 1, 2024, and January 1, 2025, for a total of nine programs and five additional counties, resulting in 42 counties participating in the IPP.

The IPP pilot is scheduled to sunset on June 30, 2026.

Justification

As of January 1, 2026, IPP will expand statewide to include the eight remaining CONREP's for a total of seventeen programs and 58 counties. As of December 15, 2025, IPP has received a total of 201 referrals, 188 of which had completed evaluations submitted to the courts. In addition to evaluating state hospital patients' readiness for step down to CONREP, IPP began conducting assessments of other DSH patients served within contracted IMD facilities to support additional referrals to both enhance utilization management of IMD beds and ensure DSH patients can be placed in the least restrictive, clinically appropriate setting.

The IPP has improved consistency, validity, and objectivity of CONREP placement evaluations and recommendation. Further, consolidating the provisions of CONREP placement evaluations at the state level ensures quality control, expanded and targeted use of statewide CONREP resources, and expanded CONREP access for all patients regardless of county. IPP evaluators, with their deep understanding of all CONREP programs, can match patients with programs that could otherwise not be considered. Additionally, using the IPP in lieu of the CONREP Community Program Director for these evaluations frees up critical and limited clinical community resources needed to support direct patient care within their outpatient programs.

The IPP has demonstrated a trajectory of expanded utility and productivity in efforts to step down DSH patients to lower levels of care. DSH is completing a formal evaluation of the IPP program and will provide an update on the effectiveness of the IPP pilot and a recommendation on whether to continue the program ongoing resource needs in the 2026-27 May Revision.

JAIL-BASED COMPETENCY TREATMENT PROGRAMS (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.

In the 2025-26 May Revision, DSH reported the operation of 433 JBCT beds across 24 counties. Additionally, DSH reported savings due to cancelled program expansions, cancelled program activations, and delayed program activations.

Justification

As of the 2026-27 Governor's Budget, no additional activations or delays are expected and DSH reports the continued operation of 433 JBCT beds across 24 counties.

Resource Table[13]

Description	FY 2025-26	FY 2026-27	FY 2027-28 and Ongoing
Current Service Level Total	**$634,967**	**$688,722**	**$708,460**
Community Inpatient Facilities	$155,264	$235,063	$205,063
2026-27 Governor's Budget	$0	$0	$0
Re-Evaluation	$12,979	$9,109	$8,958
2026-27 Governor's Budget	$0	$0	$0
IST Solutions	$388,480	$330,135	$391,963
2026-27 Governor's Budget	($117,800)	($94,200)	$0
JBTCT	$78,244	$114,415	$102,476
2026-27 Governor's Budget	$0	$0	$0
TOTAL	**$517,167**	**$594,522**	**$708,460**

[13] Dollars in thousands.

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
San Francisco	06/18/25

BCP Fiscal Detail Sheet

(Dollars in Thousands)

BCP Title: IST Solutions **BR Name: 4440-029-ECP-2026-GB**

Budget Request Summary

	FY26					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	-117,800	-94,200	0	0	0	0
Total Operating Expenses and Equipment	**-$117,800**	**-$94,200**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**-$117,800**	**-$94,200**	**$0**	**$0**	**$0**	**$0**

Fund Summary

Fund Source - State Operations						
0001 - General Fund	-117,800	-94,200	0	0	0	0
Total State Operations Expenditures	**-$117,800**	**-$94,200**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**-$117,800**	**-$94,200**	**$0**	**$0**	**$0**	**$0**

Program Summary

Program Funding						
4430060 - Community Based IST Programs	-117,800	-94,200	0	0	0	0
Total All Programs	**-$117,800**	**-$94,200**	**$0**	**$0**	**$0**	**$0**

STATE HOSPITALS
WORKFORCE DEVELOPMENT
Informational Only

SUMMARY

As of the 2026-27 Governor's Budget, 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) has been approved for ongoing accreditation since February 2021, and the first cohort of seven residents began their training in July 2021. Since July 1, 2024, DSH has been expanding the number of residents per class year from seven to ten for the psychiatry residency program with SJMC, with ten new residents identified in the March 2024-25 match cycle starting in the program July 1, 2025. This expansion of three additional residents per year, within four cohorts, currently yields a total of 31 residents participating annually for the 2025-2026 fiscal year. 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 five blocks of 160 hours each, totaling 800 hours. Over the course of these two years, residents have worked a total of 6,720 hours, equivalent to 3.8 FTE. Year 4 of the residency program included a total of 34 blocks of 80 hours each and therefore, residents worked a total of 2,720 hours. In all training years, residents have worked a total of 9,920 hours caring for DSH-Napa patients, equivalent to 5.46 FTE.

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.

After a successful onsite visit in March 2024, 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.

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

The Residency Program Director position was filled as of June 2025.

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 with invaluable opportunities to gain experience and familiarity with forensic populations and provide the Department with 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 May Revision, DSH implemented fellowship expansions and rotation offerings with the following universities:

- 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. 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 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 UCSF Forensic Psychiatry Fellowship rotation agreement was successfully executed in July 2024 and provides virtual statewide services.
- 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.
- The Stanford Geriatric Psychiatry Fellowship rotation agreement was successfully executed in March 2025, with DSH-Napa as the primary training rotation site.

DSH fellowship and resident rotations on existing contracts remain in progress.

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.

In May 2024, DSH executed an agreement with Kaiser Foundation Hospital and The Permanente Medical Group, Inc (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.

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 table below 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	22	11
Spring 2025	31	21	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	N/A	N/A	N/A
Fall 2023	12	3	TBD[3]
Spring 2024	N/A	N/A	N/A
Fall 2024[4]	23	TBD	TBD
Spring 2025	N/A	N/A	N/A
Fall 2025	Deferred until Fall 2026	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] Data expected for the 2026-27 May Revision
[4] Data expected for the 2027-28 Governor's Budget

DSH-Napa Residency Program

The program is in its fifth year with four years of cohorts, for a total of 31 residents participating annually. Based on data for Years 1 and 2 residents, each of the residents in Year 1 provide two blocks of 160 hours each, totaling 320 hours of care. Each of the 10 residents in Year 2 provides five blocks of 160 hours each, totaling 800 hours of patient care. Residents in Year 4 have varied hours in Napa based on their clinical and professional career interests. Over the course of this past year, the residents in all class years worked in Napa seeing patients with a total equivalent of 5.46 full- time equivalent (FTE).

DSH is preparing to participate in the March 2025-2026 match cycle to match 10 additional residents into the program that is expected to start July 1, 2026.

DSH-Patton Residency Program

In March 2024, DSH-Patton received a 4-year accreditation for the DSH-Patton residency program from ACGME through June 2028.

As of the 2026-27 Governor's Budget, DSH is working with a prospective university partner to begin a Southern California residency program at DSH-Patton, with the objective of the first year being a planning year, and for residents to begin rotations in July 2026, with four residents per cohort. DSH is working in collaboration with the university to develop final drafts of the Scope of Work and projected budget with the intention to have the five-year agreement finalized early Spring 2026.

Psychiatric Fellowships

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

Forensic Psychiatry Fellowship Rotations

- The Stanford Forensic Psychiatry Fellowship rotation agreement was successfully executed August 2025, with DSH-Atascadero as the primary training rotation site.

Public Psychiatry Fellowship Rotations

- DSH is working on a collaborative joint partnership with a public research university located in Southern California to develop a statewide Public Psychiatry Fellowship (PPF) program for some time in FY 2026-27, with DSH-Patton as the primary training location site.

In addition to the current partnerships above, DSH has been collaborating with a county partner to establish a Forensic Psychiatry Fellowship Program based at DSH-Coalinga.

Resident Rotations

DSH has continued to seek additional opportunities for resident rotations.

- As of the 2026-27 Governor's Budget, multiple contracts for psychiatry residency rotations through June 2030 are in development, with DSH-Metropolitan and DSH-Patton as the primary training rotation sites.

- Internal medicine resident rotation opportunities are also being explored.

In October 2025, DSH executed two resident rotations agreements – one with Charles R. Drew University of Medicine and Science (CDU) with DSH-Metropolitan as the primary training rotation site, and the other is with Kaiser Foundation Hospital & Southern California Permanente Medical Group with DSH-Patton as the primacy training rotation site.

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 physicians and county partners, including topics in psychopharmacology, perinatal care, and neurology.

As of the 2026-27 Governor's Budget, CEMA is in early conversations to explore establishing forensic academy and psychopharmacology certification programs at DSH. In an effort to expand CME offerings, DSH applied for an additional regularly scheduled lecture series through UCI and was approved. DSH is working on creating a new series that will focus on substance use disorder.

In August 2025, DSH partnered with the American Psychiatric Association (APA) to launch SMI CalAdviser. This new educational platform provides resources to individuals, families, and community partners who support people living with severe mental illness; issues continuing education credits to six clinical disciplines; and allows for prescribers to request consultations and advice on patient treatments. For this contract, CEMA is providing contract management support and acting as a liaison in ensuring DSH-partner access and conveying training needs.

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 was completed in November 2025. Two of the three units were reopened to SNF patients, with the activation date for the third SNF unit yet to be determined.

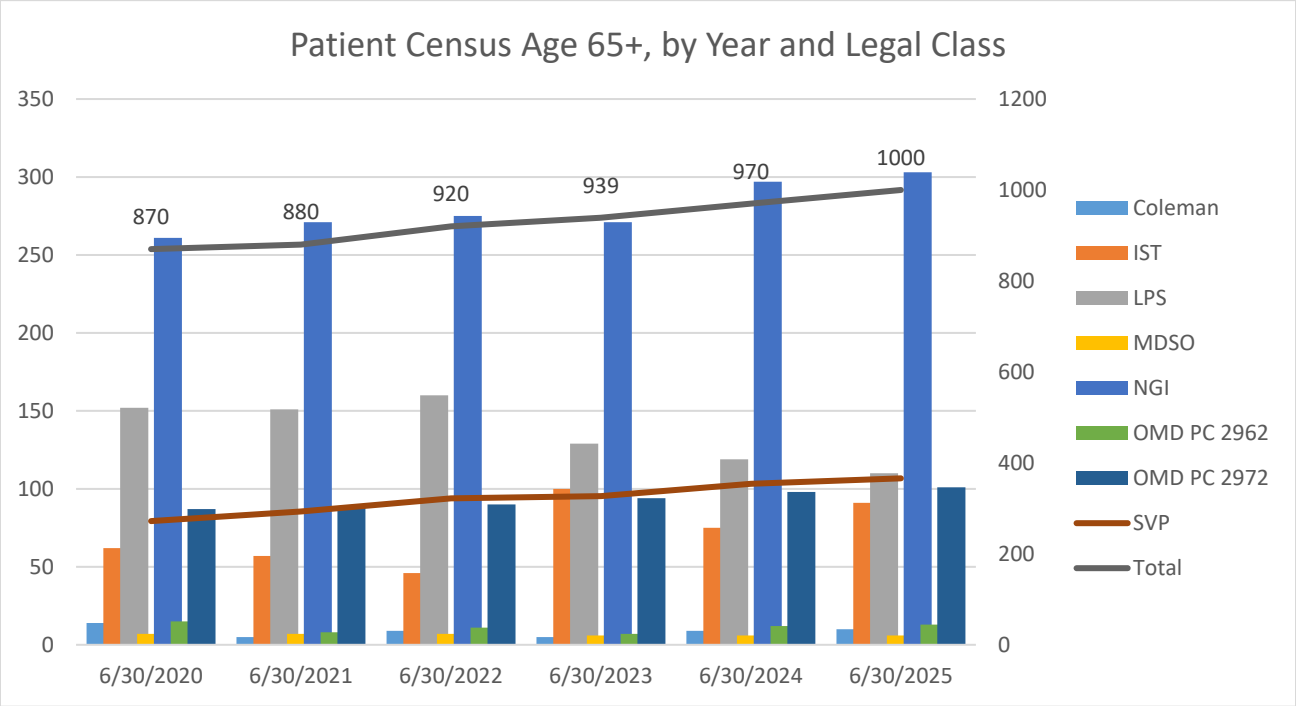
BACKGROUND

As the administrator of the nation's largest inpatient forensic mental health state hospital system, DSH is responsible for the daily care of over 7,500 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) 2024-25.

Commitment Type	Average Patient Days
Coleman/CDCR	198.3
Incompetent to Stand Trial (IST)	156.8
Lanterman-Petris Short (LPS)	2,073.8
Mentally Disordered Sex Offender (MDSO)	3,687.6
Not Guilty by Reason of Insanity (NGI)	3,990.5
Offender with Mental Health Disorder (OMD) PC 2962	304.0
OMD PC 2972	2,807.3
Sexually Violent Predators (SVP)	4,205.3

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 15% 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 of 18% of FY 2024-25 DSH patients, up from 13% in FY 2019-20.

Age Range	Patient Census Age 65+ as of June 30, 2025													
	2019		2020		2021		2022		2023		2024		2025	
	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	Count of Patients	% to Total Census
65-74	670	11%	715	13%	710	13%	736	14%	747	13%	760	14%	785	14%
75-84	126	2%	142	2%	156	3%	172	3%	179	3%	192	3%	194	4%
85-94	***	***%	***	***%	***	***%	***	***%	***	***%	***	***%	19	0.3%
Systemwide	**6,129**	**100%**	**5,718**	**100%**	**5,557**	**100%**	**5,316**	**100%**	**5,688**	**100%**	**5,559**	**100%**	**5,507**	**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, 2025, 48% 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, 2025, 24% 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, 2025, there were 64 active SNF beds at DSH-Metropolitan and 27 at DSH-Napa, for a combined total of 91 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 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 Budget Act of 2025, DSH reported the DGS study conducted at DSH-Coalinga to assess additional SNF capacity options was completed. DSH also anticipated the completion of SNF building restorations at DSH-Metropolitan in May 2025.

PROGRAM UPDATE

As of the 2026-27 Governor's Budget, DSH internal restorations and repairs of the DSH-Metropolitan SNF building was completed in November 2025. Two of the three units are re-activated and the SNF patients have been 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. After the completion of the DGS study at DSH-Coalinga regarding additional SNF capacity needs, DSH continues to evaluate options and next steps.

[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.

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

SUMMARY

The Department of State Hospitals (DSH) supported 29 county pilot Diversion programs throughout the length of the program which concluded on June 30, 2025. An additional 38 individuals were diverted to county-run programs since the 2025-26 May Revision, bringing the total number of diverted participants to 1,841.

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 were made to expand its footprint in the state and allow for additional treatment slots.

Funding for County Programs

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

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 with additional resources to expand the Diversion pilot program to new 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.

These five DSH Diversion programs were activated by October 2022. As of the conclusion of the program on June 30, 2025, Nevada County had enrolled a small number of contracted Diversion clients, while San Joaquin County had enrolled their maximum contracted amount of 26. Tulare County reported fewer than 11 of 13 enrolled Diversion clients, and Tuolumne County had fewer than 11 of 15 slots filled. Madera County did not enroll any Diversion clients into its program despite DSH's continued support in working through barriers[1].

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.

20 counties elected to participate, resulting in 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.

[1] 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 "fewer than 11" within the narrative.

At the conclusion of the program, 17 counties had participated in the program and billed DSH for a total of $16.3 million in Supplemental Housing funds.

Technical Assistance and Support

In July 2023, DSH began holding monthly meetings with all pilot counties to discuss any local barriers to diversion and provided support and technical assistance to navigate barriers by educating judicial officials on the referral process for IST Diversion and providing state-wide virtual and in-person trainings throughout the length of the program.

DSH continues to work with all counties to improve the quality of final reported data by analyzing the data submitted from all participating Diversion counties. The final quarterly report was due to DSH on September 30, 2025. Counties that have submitted incomplete or inaccurate reports are provided with additional support to assist 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 submit 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, align the collection and reporting of Diversion data with other DSH program reporting timelines, and 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 June 30, 2025, 1,841 eligible individuals have been diverted to a county-run program. The following table provides a high-level snapshot of Diversion program participants.

Diversion Program Participant Descriptive Data[2]		
Program Information	**Total Number**	**Percentage**
Total Enrolled as of 6/30/2025	1,906	100%
Total Ineligible	65	3.4%
Total Eligible	1,841	96.6%
At Risk vs. IST	**Total Number**	**Percentage**
At risk of IST	700	38.0%

[2] One county has not submitted FY 2024-25 Q1 through Q3 data to DSH.

IST	1,141	62.0%
Waitlist	**Total Number**	**Percentage**
Removed from DSH Waitlist	773	42.01%
Diagnosis	**Total Number**	**Percentage**
Schizophrenia	738	40.1%
Schizoaffective Disorder	598	32.5%
Bipolar Disorder	368	20.0%
Unspecified Schizophrenia Spectrum and Other Psychotic Disorder (OPD)	104	5.6%
Other	33	1.8%
Ethnicity	**Total Number**	**Percentage**
White	502	27.3%
People of Color	1,339	72.7%
Gender	**Total Number**	**Percentage**
Male	1,225	66.5%
Female	602	32.7%
Other	14	0.8%
Living Situation at Arrest[3]	**Total Number**	**Percentage**
Homeless	1,447	78.9%
Not Homeless	386	21.1%
Felony Charges	**Total Number**	**Percentage**
Assault/ Battery	594	32.3%
Theft	328	17.7%
Robbery	236	12.8%
Miscellaneous (primarily Vandalism)	191	10.4%
Criminal Threats	152	8.3%
Arson	135	7.3%
Other (primarily weapons, drugs, FTR)	118	6.4%
Obstruction of Justice	56	3.0%
Kidnapping	31	1.7%

Diversion Pilot Program Outcome & Predictive Data

Since the launch of the pilot in 2018 and through the conclusion of the program, enrollment in Diversion 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 June 30, 2025, from all participating counties, DSH analyzed the outcomes of the 1,841 eligible Diversion participants. Of these participants, 77 were not included for analysis because they had met eligibility criteria and started their respective Diversion programs but were terminated for a

[3] San Francisco and Santa Clara County did not provide data for all participants for this section in their quarterly reports.

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 less than two years	138	7.8%
Still in greater than two years	106	6.0%
Revoked/AWOL/Re-incarcerated	601	34.1%
Successful Completion	918	52.1%
Total	**1,764**	%
Length of Stay by Current Status		
	Average	**Standard Deviation**
Still In less than two years	562.78	-136.54
Still In greater than two years[4]	1,125.53	341.62
Revoked/AWOL/Re-incarcerated	231.93	-255.8
Successful Completion	612.52	131.06
Risk Assessment[5] Conducted		
	Total Number	**Percent**
Yes	661	68.9%
No	298	31.1%
Total	**959**	%
Development of Treatment Plan[6]		
	Total Number	**Percent**
Intensive evaluation[7]	803	86.0%
Formal RNR assessment[8]	107	11.5%
Both	24	2.6%
Total	**934**	%

Diversion Program Participant Outcome Data[9]		
Incompetent to Stand Trial	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked**

[4] A total of 106 participants were in the program for more than two years. DSH did not fund any participant for more than 24 months
[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
[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.

		Total (Percent)
IST	584 (61.9%)	360 (38.1%)
At risk of IST	335 (58.2%)	241 (41.8%)
Homeless	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
Yes	746 (59.9%)	500 (40.1%)
No	173 (63.6%)	99 (36.4%)
Abuse of Substances	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
Yes	762 (59.1%)	528 (40.9%)
No	140 (69.7%)	61 (30.3%)
Methamphetamine Use	**Successful Completion** Total (Percent)	**AWOL/Re-incarcerated/Revoked** Total (Percent)
Methamphetamine	433 (52.6%)	390 (47.4%)
No drug use/Other drugs	467 (70.1%)	199 (29.9%)

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.

The Diversion pilot program concluded on June 30, 2025, with one contract having ended in 2022, nine ending in 2024, and the remaining 19 in 2025. All contracts that ended in 2025 are in the process of being closed out, including collecting and analyzing final fiscal expenditure reports, participant data, and invoices. Currently, DSH is pending final fiscal expenditure reports from four counties. DSH will continue to work with those counties to ensure all reporting requirements have been fulfilled and provide final Pilot Program outcomes in 2026-27 May Revision.

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

SUMMARY

The Department of State Hospitals (DSH) continues to monitor persons designated as a Sexually Violent Predator (SVP) and Offenders with a Mental Health Disorder (OMD) referral trend. As of the 2026-27 Governor's Budget, DSH projects to receive 447 SVP and 2,023 OMD referrals in fiscal year (FY) 2025-26.

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

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

[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.

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, statute 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.

OMD Program

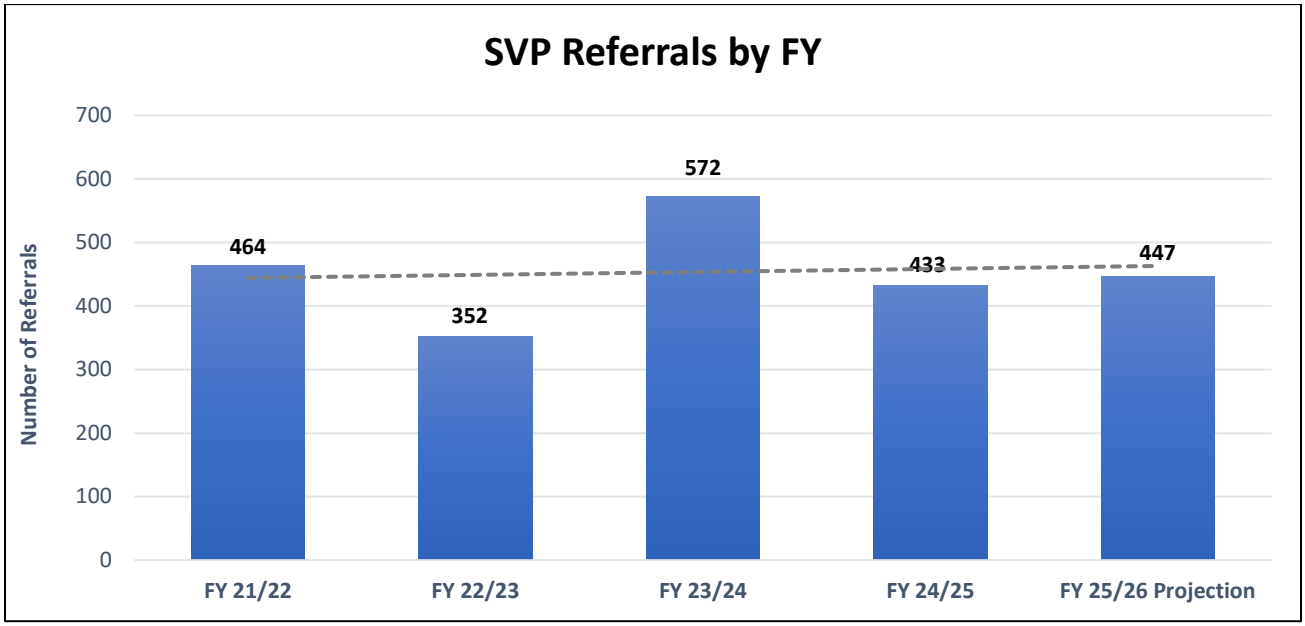
Pursuant to Penal Code (PC) 2960–2981, CDCR evaluators conduct a forensic evaluation of incarcerated persons who have a) been in CDCR mental health programs, and b) have a violent commitment offense, prior to the individual's release on parole. If the CDCR evaluator determines the inmate has a severe 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.

PROGRAM UPDATE

SOCP Program

DSH received 433 SVP evaluation referrals in FY 2024-25. This was a 24.3% decrease in referrals compared to FY 2023-24. As of the 2026-27 Governor's Budget, DSH projects 447 SVP referrals in FY 2025-26, which is an increase from referrals in FY 2024-25. The projection is based on the most recent 12 months of actual referrals received between December 2024 and November 2025.

The chart below shows the total SVP referrals received from FY 2021-22 through the projection for FY 2025-26.

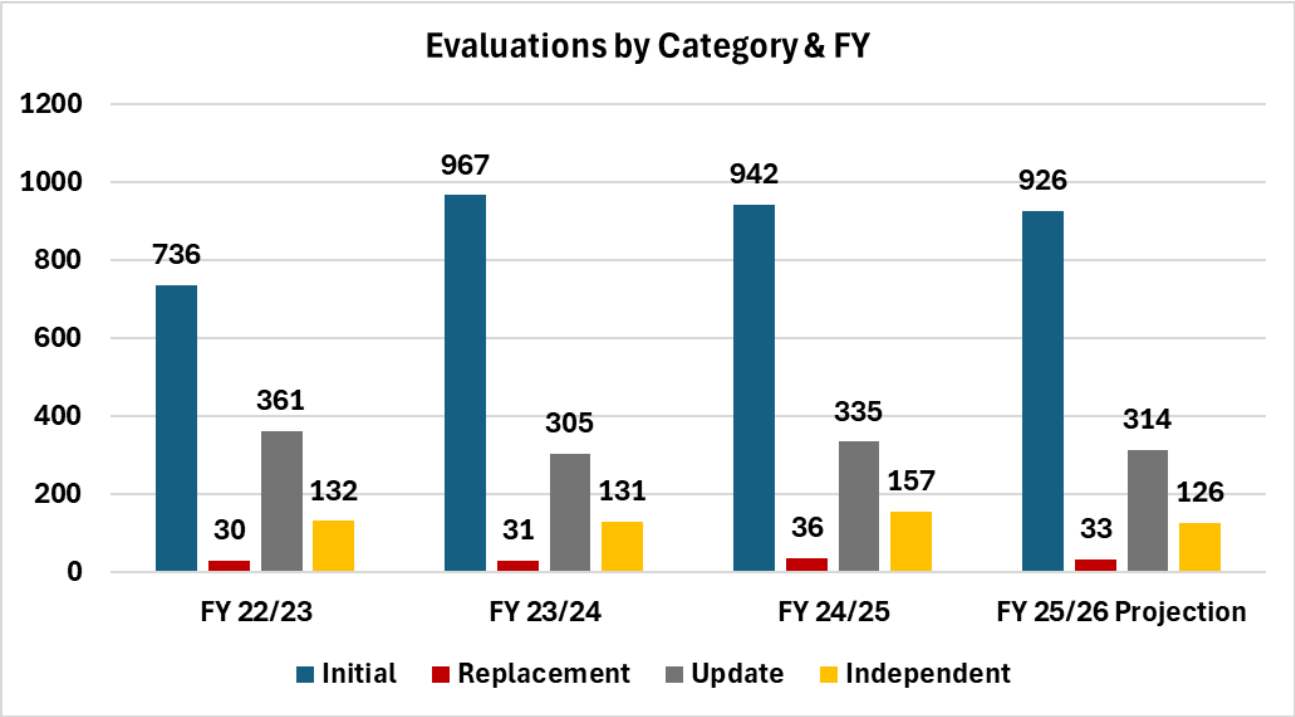


Note: The above actual referral totals are provided based on the FY the referral was received from CDCR/BPH.

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. As of the 2026-27 Governor's Budget, DSH is seeing a reduction in SVP referrals when compared to the last two FYs. The monthly referral average for FY 2025-26 projection is 37.3, which is slightly lower than the 37.9 monthly referral average for the last four FYs.

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).

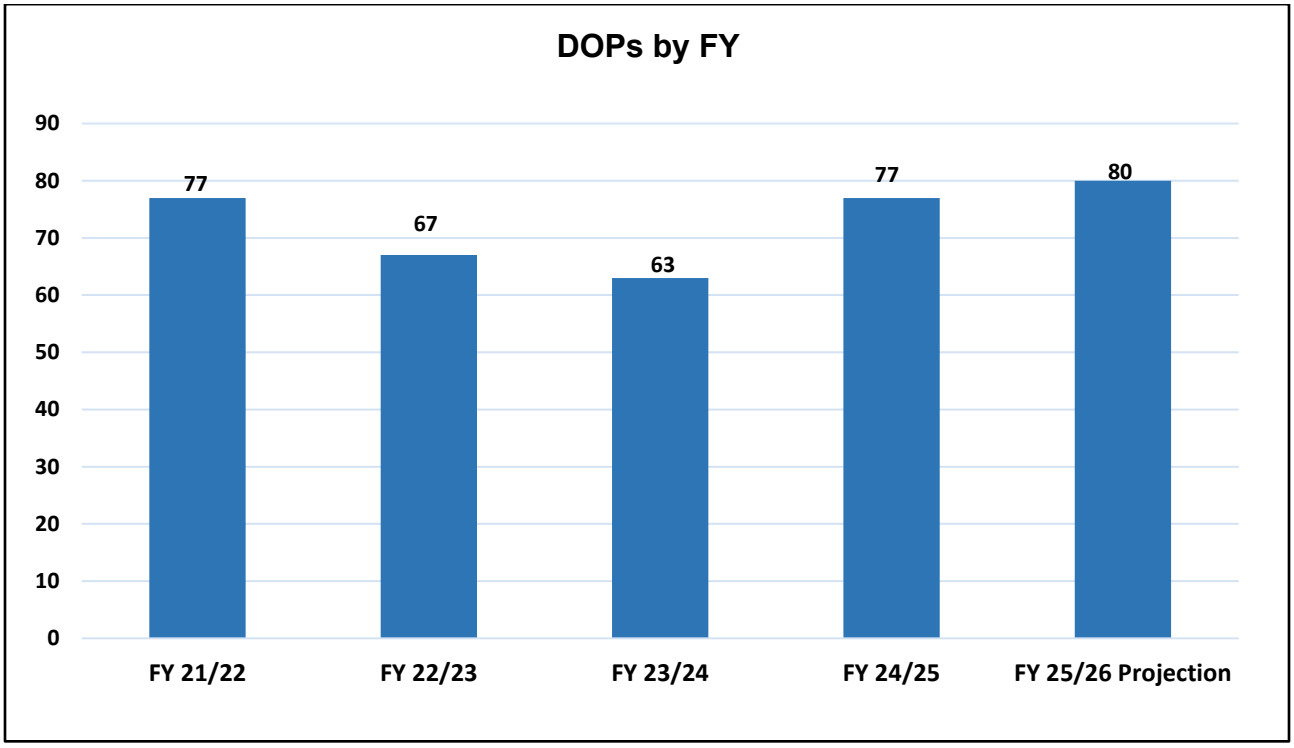
The chart below displays the total number of evaluations conducted by type of SVP evaluation, from FY 2022-23 to the projection for FY 2025-26, which is based on the most recent 12 months of actual evaluations conducted between December 2024 and November 2025.



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

In FY 2024-25, the initial evaluation referral rate was slightly lower than the rate in FY 2023-24. The evaluation rates are projected to remain at a lower rate in FY 2025-26.

The chart below shows the number of SVP DOP referrals from FY 2021-22 to the projection for FY 2025-26.



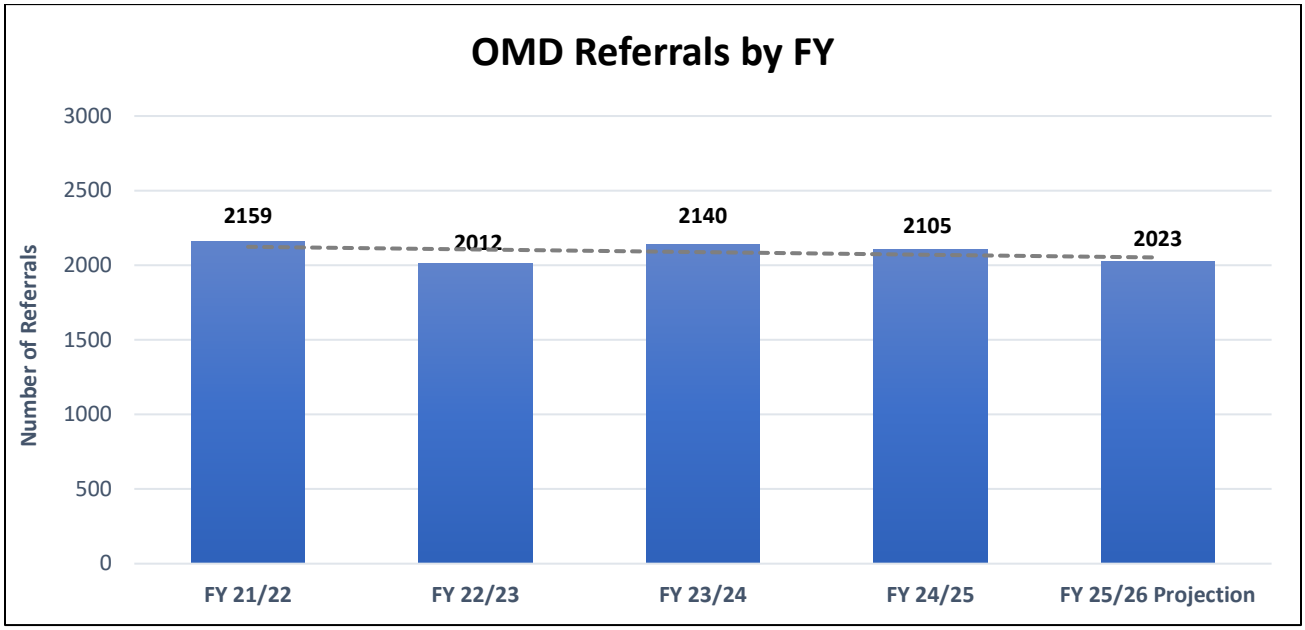
In FY 2024-25, DSH received a total of 77 DOP cases, equating to approximately 17.8% of the total SVP referrals received. Applying the same percentage to the projected 447 SVP referrals in FY 2025-26, DSH assumes a total of approximately 80 DOP cases in FY 2025-26.

Additionally, DSH evaluators testified in 175 SVP court cases during FY 2024-25. 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 700 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 2024-25, DSH received 2,105 OMD referrals for evaluation. This is approximately 1.6% lower than actual referral rates in FY 2023-24. Using the most recent 12 months of actual referrals received between December 2024 and November 2025, DSH projects 2,023 OMD referrals for FY 2025-26.

The following chart provides the total OMD referrals from FY 2021-22 to the projection for FY 2025-26.



As of the 2026-27 Governor's Budget, DSH is seeing a reduction in OMD referrals when compared to the last two FYs. The monthly referral average for the FY 2025-26 projection is 168.6. This is lower than the 175.3 monthly referral average for the last four FYs.

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 May Revision.

STATE HOSPITALS
MISSION-BASED REVIEW – TREATMENT TEAM AND PRIMARY CARE
Informational Only

SUMMARY

The Department of State Hospitals (DSH) reports a total of 49.7 Treatment Team and Primary Care positions for phase-in effective fiscal year (FY) 2025-26 as previously received from the Mission-Based Review (MBR) Staffing Study, and will provide an update in the 2026-27 May Revision.

BACKGROUND

In 2013, DSH initiated a comprehensive effort to evaluate staffing practices amongst the five State Hospitals. As part of the Treatment Team component of the study, the Clinical Staffing Study reviewed current staffing standards and practices, proposed new data-driven staffing methodologies to adequately support the current populations served, assessed relief factor coverage needs, and reviewed current staffing levels within core clinical and safety functions. As part of DSH's staffing study efforts, and in collaboration with the Department of Finance (DOF) Research and Analysis Unit through a Mission-Based Review, the four core areas of Treatment Planning and Delivery were examined:

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

The Budget Act of 2021 included a total request of 250.2 positions and $64.2 million, phased in across a five-year period, to support the workload of providing psychiatric and medical care treatment to patients committed to DSH.

In the Budget Act of 2022, DSH shifted 29.5 positions that were scheduled to be authorized in FY 2022-23 to January 1, 2026 (FY 2025-26) to allow time to recruit for positions already authorized.

In the Budget Act of 2023, DSH shifted 46.5 positions scheduled to be phased in FY 2023-24 to FY 2026-27 due to delays in hiring.

In the Budget Act of 2024, DSH shifted 31.4 positions that were scheduled to phase in FY 2024-25 until July 1, 2027 (FY 2027-28). DSH also reported various bargaining unit agreements were approved to increase compensation levels for multiple treatment team classifications.

JUSTIFICATION

As of the 2026-27 Governor's Budget, DSH reports 49.7 Interdisciplinary Treatment Team positions scheduled for phase-in FY 2025-26.

DSH continues to contract with CPS HR Consulting and participate in multiple job fairs and recruitment events as well as expand psychiatry residency and fellowship opportunities across all five state hospitals.

Interdisciplinary Treatment Team

A total of 180.4 positions were allocated to support the Interdisciplinary Treatment Team to be phased-in over five years.

As of November 1, 2025, a total of 73 positions have been established, including 20.2 positions that were phased in on July 1, 2025. DSH plans to phase-in 29.5 additional positions on January 1, 2026, for FY 2025-26.

DSH continues to actively recruit to fill these positions.

Primary Medical Care

A total of 31.9 positions were allocated to support Primary Medical Care.

As of February 29, 2024, all positions have been established.

Trauma-Informed Care

A total of 6.0 positions were allocated to support Trauma-Informed Care.

As of February 29, 2024, all positions have been completely phased in.

Clinical Executive Structure

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

Administrative Support Positions

A total of 6.0 positions were allocated to support Administrative Services.

As of February 29, 2024, all positions have been completely phased in.

Clinical Executive Leadership

A total of 12.0 positions were allocated to support Clinical Executive Leadership.

As of February 29, 2024, all positions have been completely phased in.

Discharge Strike Team

A total of 6.0 positions were allocated to support the Discharge Strike Team.

As of February 29, 2024, all positions have been completely phased in.

STATE HOSPITALS
DSH-COALINGA TELEPSYCHOLOGY PILOT
Informational Only

SUMMARY

In the Budget Act of 2025, The Department of State Hospitals (DSH) was authorized to pilot telepsychology services at DSH-Coalinga for three fiscal years starting fiscal year (FY) 2025-26. DSH plans to redirect 4.0 existing, vacant Psychologist positions at DSH-Coalinga to provide telepsychology services for this three-year pilot program. As of the 2026-27 Governor's Budget, DSH is in the preliminary stages of hiring 2.0 limited-term (LT) coordinators and purchasing the associated information technology (IT) equipment required to support telepsychology services. DSH will provide an update in the 2026-27 May Revision.

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.

In the Budget Act of 2025, DSH was authorized to pilot telepsychology services at DSH-Coalinga for three fiscal years starting fiscal year (FY) 2025-26, modeled off its successful telepsychiatry program. DSH received authority to utilize 4.0 existing, vacant Psychologist positions at DSH-Coalinga to provide telepsychology services to DSH patients. DSH also received $286,000 in FY 2025-26 through FY 2027-28 for 2.0 LT coordinators and $188,000 in FY 2025-26 and $56,000 through FY 2027-28 for the associated IT equipment required to support telepsychology services.

Staffing Resources – Coordinators

DSH received $286,000 in FY 2025-26 through FY 2027-28 for 2.0 LT Staff Services Analyst (SSA)/ Associate Governmental Program Analyst (AGPA) positions to serve as coordinators at a 1:2 ratio with telepsychologists in order to provide administrative and technical support for telepsychology services. 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.

Information Technology Equipment

Telepsychology services are provided through a video conferencing system which allows the psychologist to see their patient remotely. In order to utilize and effectively operate a video conferencing system, DSH received $188,000 in FY 2025-26 and $56,000 through FY 2027-28 for additional hardware and software. IT equipment includes 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.

PROGRAM UPDATE

In the Budget Act of 2025, DSH was authorized to pilot telepsychology services at DSH-Coalinga for three fiscal years starting fiscal year (FY) 2025-26 to maintain and expand access to treatment for DSH patients at DSH-Coalinga, a location where it has been historically difficult to recruit psychologists. DSH plans to utilize 4.0 existing, vacant Psychologist positions at DSH-Coalinga to provide telepsychology services for this three-year pilot program.

Staffing Resources – Coordinators

DSH received $286,000 in FY 2025-26 through FY 2027-28 for 2.0 LT Staff Services Analyst (SSA)/ Associate Governmental Program Analyst (AGPA) positions to serve as coordinators at a 1:2 ratio with telepsychologists in order to provide administrative and technical support for telepsychology services.

As of the 2026-27 Governor's Budget, DSH is in the early stages of the recruitment process for the 2.0 LT coordinators.

Information Technology Equipment

DSH received $188,000 in FY 2025-26 and $56,000 through FY 2027-28 for the additional hardware and software required to provide telepsychology services.

As of the 2026-27 Governor's Budget, DSH is working to purchase the necessary IT equipment to support telepsychology services.

DSH will provide an update in the 2026-27 May Revision.

STATE HOSPITALS
***COLEMAN* INCREASED REFERRALS**
Informational Only

SUMMARY

The Department of State Hospitals (DSH), in collaboration with the California Department of Corrections and Rehabilitation (CDCR), developed new methodologies to increase *Coleman* referrals from CDCR to DSH in an effort to increase DSH's *Coleman* census.

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.

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

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

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 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.

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

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.

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.

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 on September 16, 2024.

In the Budget Act of 2025, DSH received 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

As of the 2026-27 Governor's Budget, DSH has updated the table below to reflect all Coleman patient reviews. The table below displays the number of Coleman reviews by DSH and admissions by fiscal year from FY 2020-21 to FY 2024-25.

Fiscal Year	*Coleman* Patients Reviewed	Monthly Average Reviews	Admissions to State Hospitals	Monthly Average (Admissions)
2020-2021	265	22	197	16
2021-2022	305	25	193	16
2022-2023	308	26	199	17
2023-2024	824	69	307	26
2024-2025	948	79	301	25

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 was an increase of 208% for referrals and 52% for admissions when compared to FY 2022-23, which was 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 79% from October 2023 (102) to November 2025 (183). 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 with the "trial process" implementation, DSH has received approximately half of all of CDCR's ICF referrals made, which makes for an increase of 122%. This demonstrates DSH reviews a significant portion of the ICF referrals generated within CDCR that will increase in the near future. Additionally, DSH developed a presentation to better understand the DSH setting for Coleman class patients, that was shown to CDCR treatment teams, CDCR executive leadership, and other stakeholders. In addition, DSH toured three CDCR PIPs to further develop on-site partnership and answer any further questions or concerns treatment teams may have regarding transfer and treatment of Coleman patients in DSH.

Current population projections for CDCR suggest a population increase with the passage of Proposition 36[3]. When CDCR overall population increases, the CDCR mental health population increases, leading to an increase in ICF referrals.

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

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) incarcerated persons, who are transferred from CDCR to DSH 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 severe 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/or 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 a severe 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

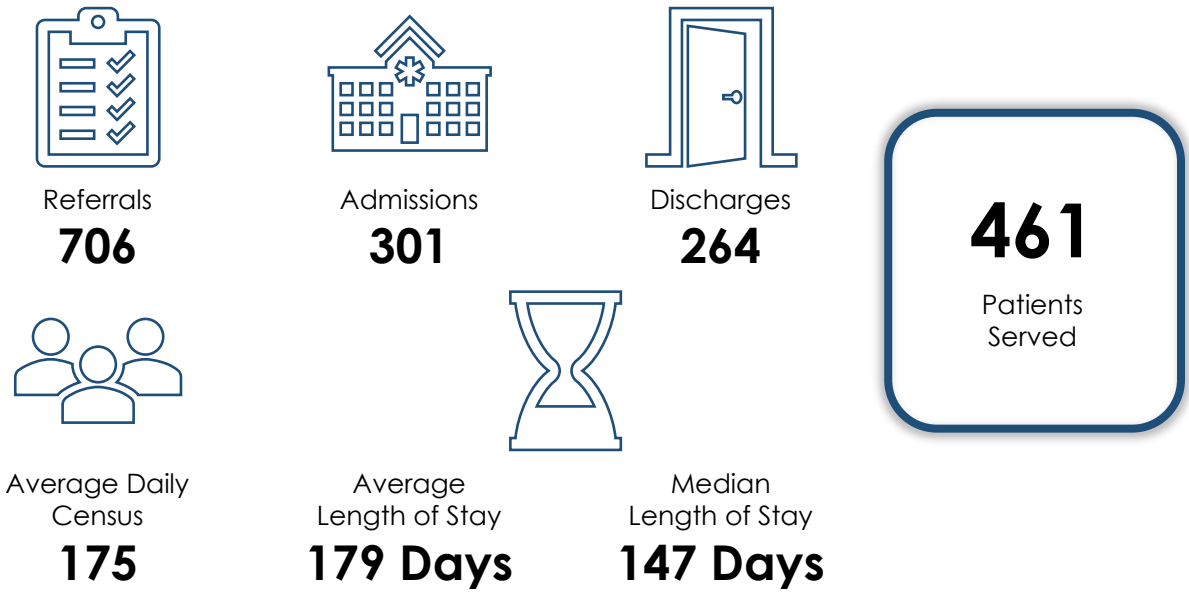
DSH provides treatment to *Coleman* patients through inpatient care within the state hospitals at DSH-Atascadero, DSH-Coalinga, and DSH-Patton.

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.

Fiscal Year (FY) 2024-25 Population Data

The visual below provides a summary of how Coleman patients moved through the DSH system in FY 2024-25. It begins with the number of referrals received from CDCR (706), followed by the patients admitted for treatment (301), and those ultimately discharged (264). In addition to this flow, the visual highlights the total number of patients served (461), the average daily census (175), the average length of stay (178.5 days), and the median length of stay (147.0 days).

FY 2024-25 Coleman Patient Data Summary



Population Data Detail

In FY 2024-25, the *Coleman* patient population increased 22%, with an average census of 157 patients in July 2024, and ending with an average census of 191 in June 2025. Table 1 below summarizes key statistics across the *Coleman* population including referrals, admissions, patients served, average daily census, average length of stay and discharges.

Table 1: *Coleman* Patient Data Summary

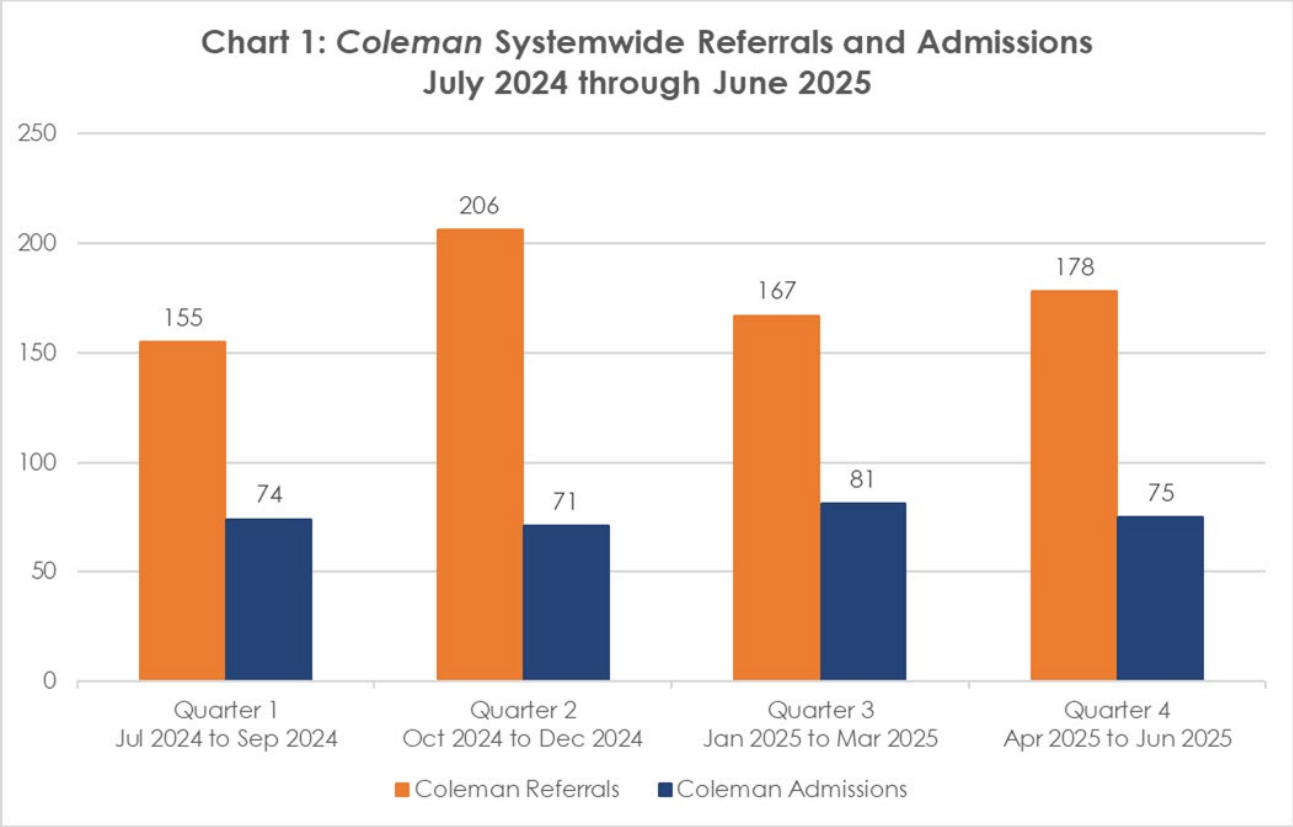
***Coleman* Patient Data**	**FY 2023-24**	**FY 2024-25**	**Percent Change from Prior FY[1]**
Patients Referrals[2]	611	706	16%
Admissions[3]	307	301	-2%
Patients Served[4]	419	461	10%
Average Daily Census	127	175	37%
Average Length of Stay	141	179	27%
Discharges	251	264	5%

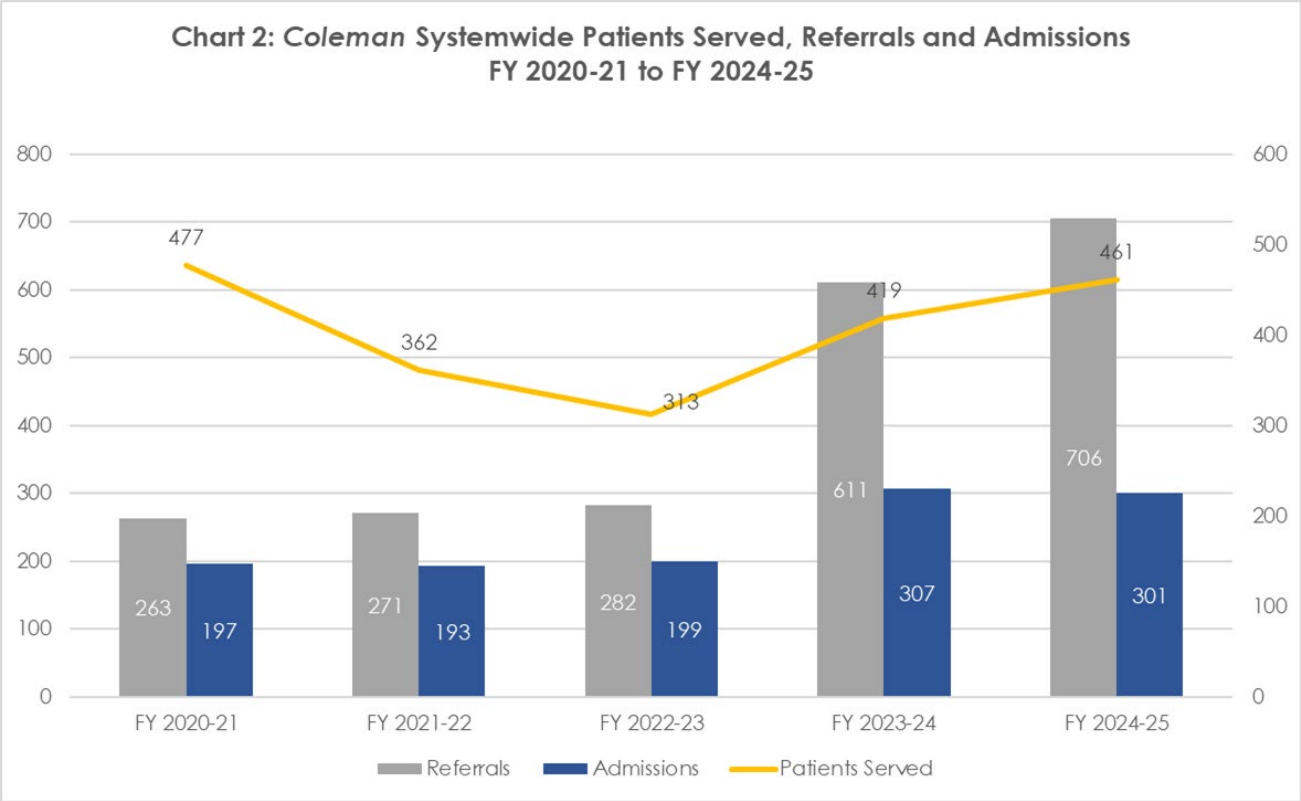
In FY 2024-25, DSH received 706 *Coleman* referrals for psychiatric stabilization treatment, reflecting the continued demand for inpatient mental health services from the CDCR population. This reflects an increase of 16% in referrals from the prior year. All patients referred for intermediate care treatment are subjected to court mandated timelines and must be admitted within 30 days, barring any medical holds. As a result of the CDCR referrals that were accepted, DSH admitted 301 *Coleman* Patients in FY 2024-25 with an average of 25 admissions per month. Chart 1 provides a closer look at how the admissions and referrals lined up by quarter for this population. On average, DSH received approximately 177 referrals per quarter and admitted approximately 75 individuals per quarter.

Subsequently, Chart 2 provides a five-year look at referrals, admissions, and patients served for historical trends of the *Coleman* population. Across the year, DSH served 461 *Coleman* patients in total. This is an increase of 10% from the prior year. While there was an increase in patients served, there was a slight decrease of 2% in admissions from the prior year. Higher length of stay during FY 2024-25 as compared to the prior fiscal year can be attributed to an increase in patients served throughout the year while having a slight drop in admissions. A contributing factor to the increase in patients served and longer lengths of stay in FY 2024-25 was also the implementation of the Long-Term Intermediate (LTI) program, which is designed to continue to house and treat patients on a longer-term basis who have been

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

previously referred to DSH and have demonstrated difficulty in reintegrating into CDCR's outpatient level of care due to the severity of their mental illness. The LTI was activated in September 2024 and by the end of the fiscal year had a census of 13 patients. During this time, the Pending Placement List (PPL) ranged from 12 to 23, with a final PPL being at 17 at the end of the fiscal year.





Discharge Data

In FY 2024-25, DSH discharged 264 *Coleman* patients with an average length of stay of 178.5 days and a median length of stay of 147 days. The length of stay increased by 26.5 percent as compared to the prior year of 141.0 days. When examining the length of stay on a quarterly basis, it shows that while length of stay was generally decreasing across the first three quarters, the last quarter of the fiscal year saw an increase of length of stay with patients being discharged between April and June 2025 staying at DSH for an average of 196.8 days. It is hypothesized that DSH is admitting *Coleman* patients with increased psychiatric severity which would increase average length of stay due to the time it takes to treat and stabilize higher acuity *Coleman* patients. Length of stay will continue to be monitored on a quarterly basis to determine any trends, if indicated. When looking at how many patients are discharged within the first year of their stay, 36% of *Coleman* patients are discharged within the first 90 days of their stay, 55% of the *Coleman* patients are discharged within the first 180 days of their stay and 89% of the *Coleman* patients are discharged within the first year of their stay. Table 3 displays more detailed data on length of stay and discharge counts by quarter.

Table 3: *Coleman* Patient Length of Stay by Quarter

Coleman **Length of Stay**	**Quarter 1** Jul to Sep 2024	**Quarter 2** Oct to Dec 2024	**Quarter 3** Jan to Mar 2025	**Quarter 4** Apr to Jun 2025	**Total**[5] FY 2024-25
Average Length of Stay	176.7	161.2	171.8	196.8	178.5
Median Length of Stay	163.5	106.0	152.0	164.5	147.0
Discharged Count	70	53	61	80	264

[5] 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 and that it is in the interest of justice to restore the individual to competency. 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: i) return to county custody once they have regained competency and can effectively assist in their trial proceedings, ii) are determined to be unlikely to be restored to competency in the foreseeable future, or iii) 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. 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.

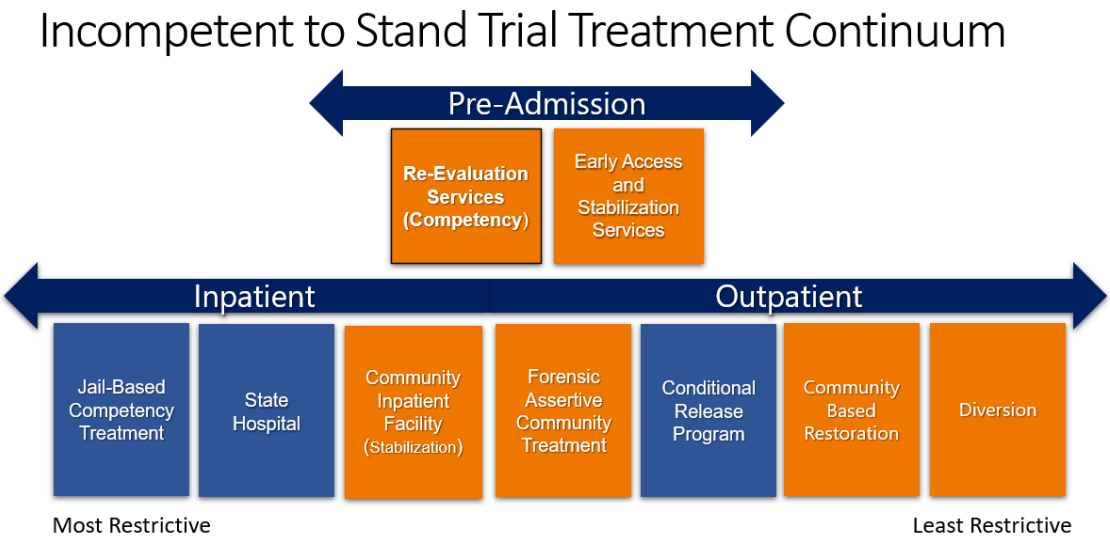
As defined in PC 1370(b)(1), a patient may be designated by their treatment team as unlikely to regain competency. Upon notification to the Sheriff of the county of commitment, the patient must be picked up within ten days and returned to county custody. Often, the county will pursue other means to ensure 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. Subsequently, 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 on felony charges across an expanded list of qualifying diagnoses. Additionally, in 2018 DSH was authorized to partner with Los Angeles (LA) County to establish the first community-based restoration program for individuals from LA County who were determined to be IST on felony charges. Utilizing the recent investments made, 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 Treatment (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.

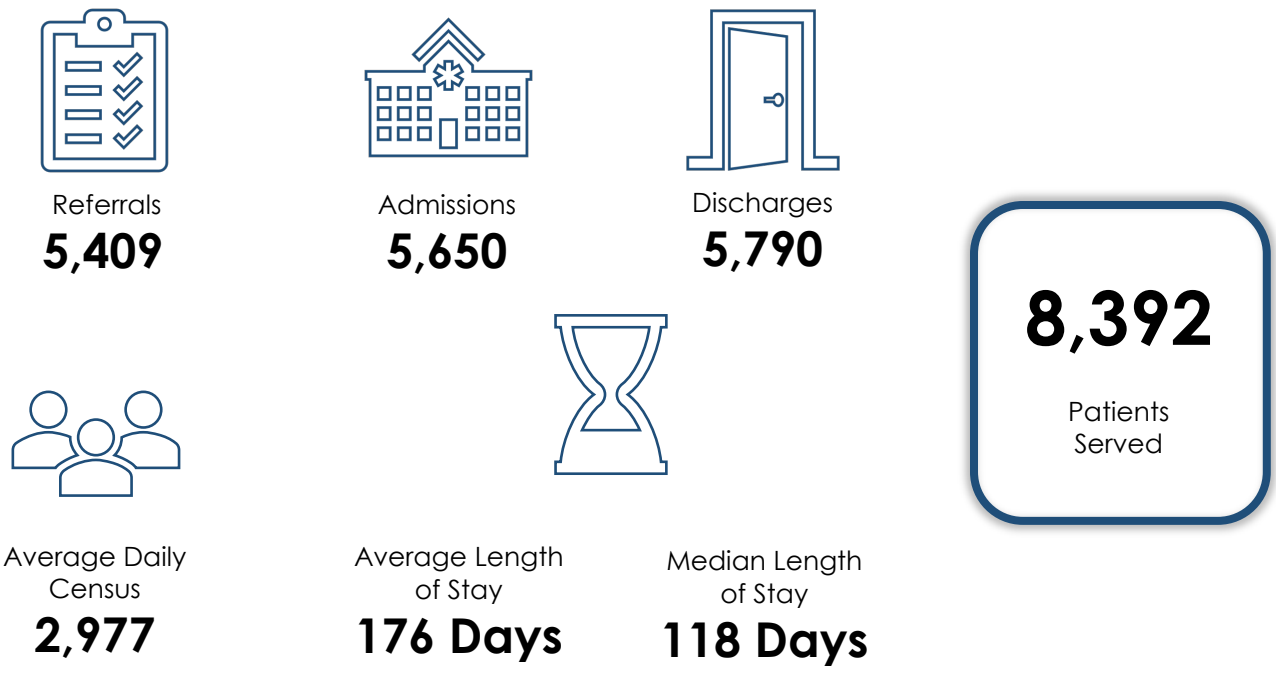
- Restoration of Competency: Restoration treatment includes group psychoeducation, individual therapy, medication evaluation and management, and statutorily required competency to stand trial evaluations and court reports.

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 custody of the county of commitment within ten days of the certificate of restoration filing.

FY 2024-25 Population Data

The visual below provides a summary of how Incompetent to Stand Trail (IST) patients moved through the DSH system in fiscal year (FY) 2024-25. It begins with the number of referrals received from the county court system (5,409), followed by the patients admitted for treatment (5,650), and those ultimately discharged (5,790). In addition to this flow, the visual highlights the total number of patients served (8,392), the average daily census (2,977), the average length of stay (176 days), and the median length of stay (118 days).

FY 2024-25 Incompetent to Stand Trial Patient Data Summary



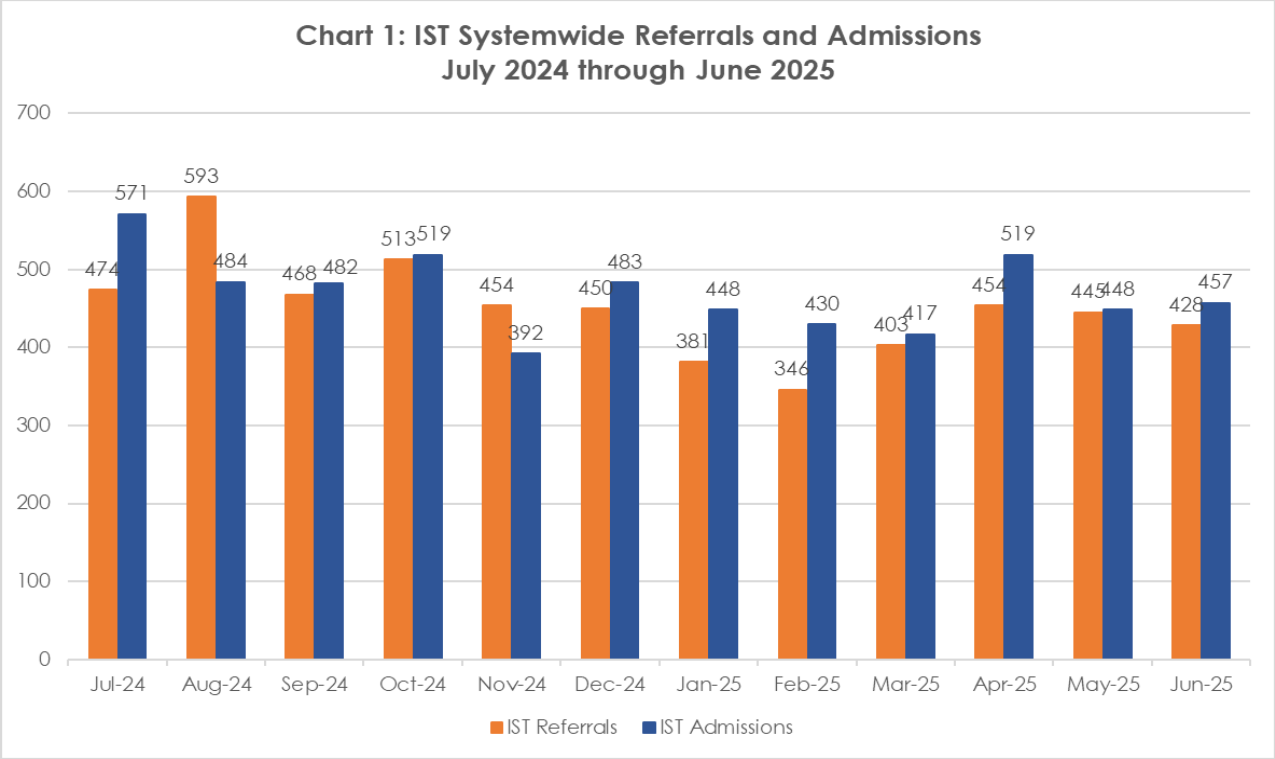
System-wide Metrics

In FY 2024-25, DSH treated 8,392 patients designated as IST, a decrease of 2% from prior year. DSH had an average daily census of 2,977 IST designated patients during FY 2024-25, with a 4% growth from 2,873 patients in July 2024, to 2,997 in June 2025. In addition, as compared to the prior fiscal year, the average daily census increased overall by 2% in FY 2024-25. The table below summarizes key statistics across the IST population.

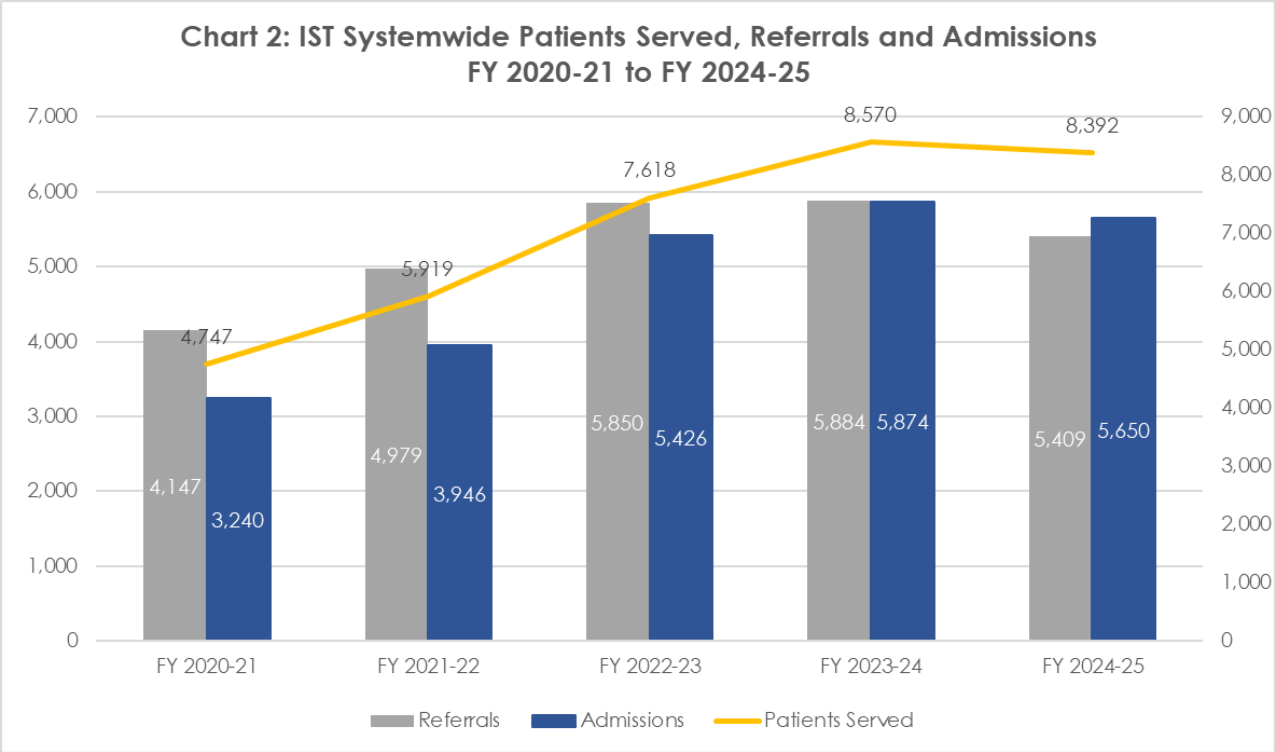
Table 1: System-wide IST Patient Data Summary

IST Patient Data	FY 2023-24	FY 2024-25	Percent Change from Prior FY
Patient Referrals[1]	5,884	5,409	-8%
Patient Admissions[2]	5,874	5,650	-4%
Patients Served[3]	8,570	8,392	-2%
Average Daily Census	2,906	2,977	2%

In FY 2024-25, 5,409 IST designated patients were committed to DSH for competency treatment; a decrease of 8% from FY 2023-24. Chart 1 below displays IST system-wide referrals and admissions for FY 2024-25. 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.



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



In FY 2024-25, the IST Pending Placement List (PPL) decreased by 25% from 383 patients in July 2024 to 287 patients in June 2025. The PPL has continued to decrease with 277 patients pending placement as of August 25, 2025. Due to the average monthly referrals, it is unlikely this current PPL 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 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
	1,454	1,779	894	425	287

Inpatient Program Metrics

DSH inpatient treatment programs include State Hospitals, JBTP, and Community Inpatient Facilities (CIF). During FY 2024-25, DSH inpatient programs treated on average 2,146 IST designated patients daily. In July 2024, the average daily census was 2,181 with a 1% decrease as compared to June 2025, with an average daily census of 2,152 patients. Table 3 (below) shows the IST Inpatient Data Summary for FY 2023-24 and FY 2024-25.

Table 3: IST Inpatient Data Summary

IST Inpatient Data	FY 2023-24	FY 2024-25	Percent Change from Prior FY
Patient Admissions[4]	5,045	4,710	-7%
Patients Served[5]	7,149	6,784	-5%
Average Daily Census	2,233	2,146	-4%

DSH inpatient programs admitted 4,710 IST designated patients in FY 2024-25 with an average of 393 admissions per month. Chart 3 displays inpatient program IST admissions by quarter and the average monthly admissions rate.

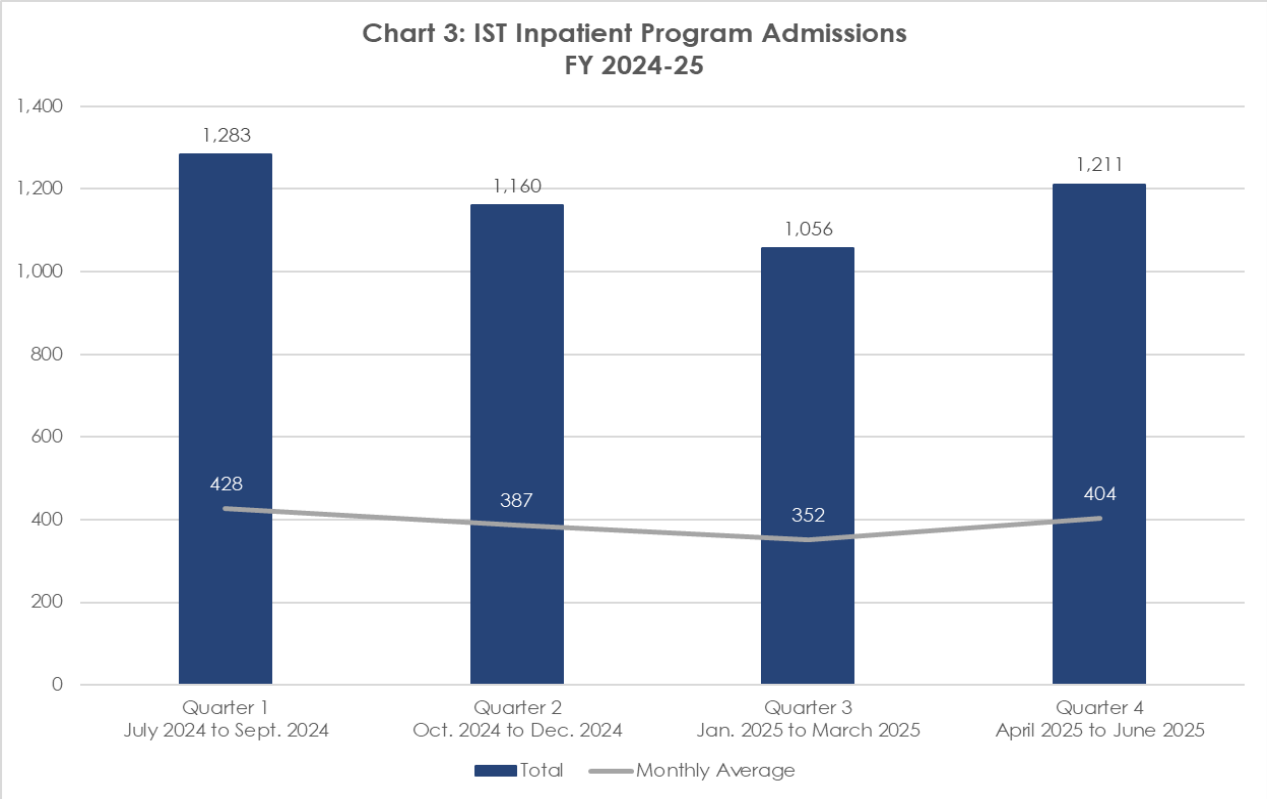


Table 4 below displays the number of IST designated patients treated across the year in inpatient programs for the past five years.

Table 4: IST Patients Served – Inpatient Programs[6]

Patients Treated/ Served	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
	4,241	5,030	6,412	7,149	6,784

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

Inpatient Discharge Data

DSH discharged 4,581 IST designated patients from inpatient programs with an average length of stay of 150 days and a median length of stay of 111 days across all programs. 42% of patients were discharged within the first 90 days of their stay, 73% discharged within the first 180 days of their stay and 91% 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	31%
181 - 365 days	19%
366 - 730 days (1 - 2 years)	9%
731+ days (2+ years)	0%

For patients yet to be discharged as of June 30, 2025, the average number of days in treatment are 131.2 days and the median days in treatment are 87.5 days. Table 6 displays Inpatient programs length of stay by quarter.

Table 6: IST Inpatient Length of Stay & Disposition Outcome by Quarter[7]

IST Inpatient Programs: Length of Stay	**Quarter 1** Jul to Sep 2024	**Quarter 2** Oct to Dec 2024	**Quarter 3** Jan to Mar 2025	**Quarter 4** Apr to Jun 2025	**Total[8]** FY 2024-25
Average Length of Stay	145.9	154.3	147.3	153.1	150.1
Median Length of Stay	110.0	112.0	111.0	111.0	111.0
Discharged Count[9]	1,201	1,179	1,132	1,069	4,581
IST Inpatient Programs: Disposition Outcomes					
Restored	*89%*	*88%*	*89%*	*89%*	*89%*
Unlikely to Restore	*7%*	*8%*	*9%*	*8%*	*8%*
Maximum Commitment	*4%*	*3%*	*2%*	*3%*	*3%*
Revocation	0.0%	<1%	<1%	0.0%	<1%
Case Dismissed	<1%	<1%	<1%	<1%	<1%

[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] Totals are based on raw data, which have been rounded for display purposes.
[9] Patient discharges exclude inpatient and outpatient program transfers.

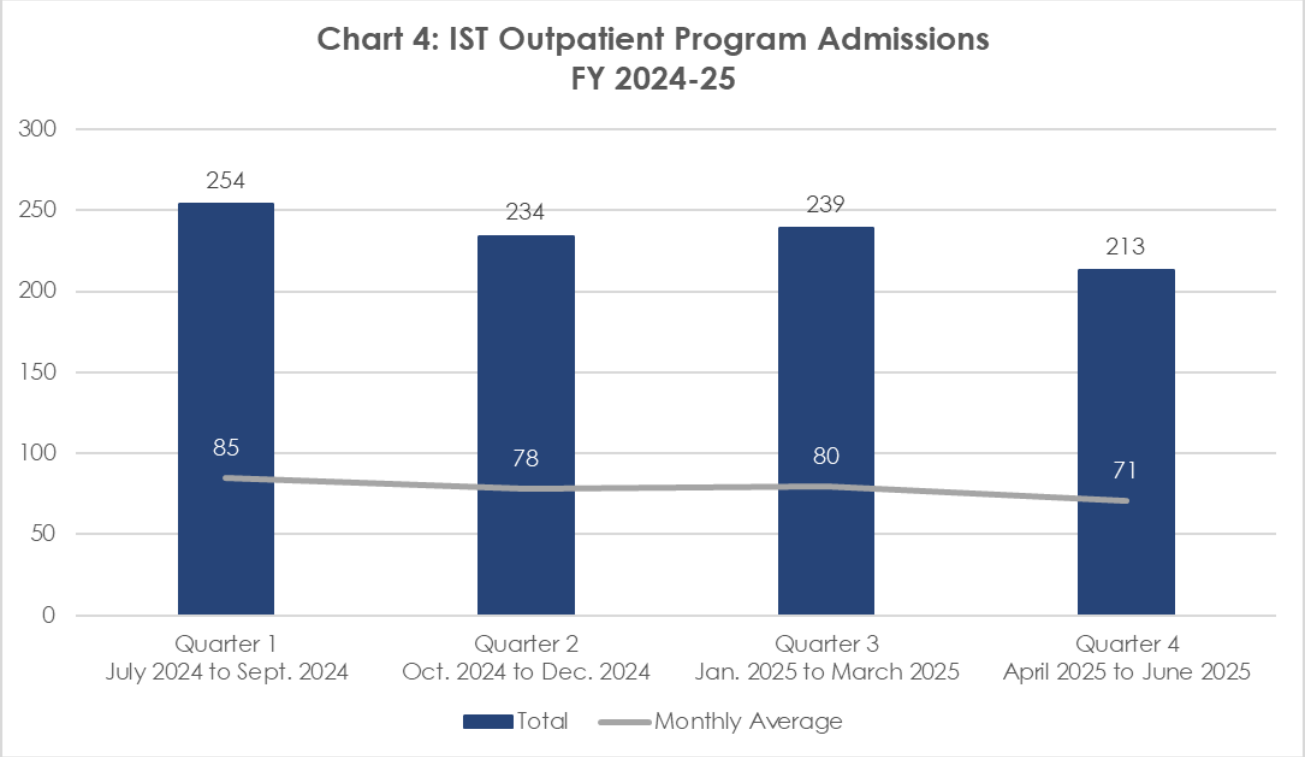
Outpatient Program Metrics

DSH outpatient treatment programs include CONREP, Community Based Restoration (CBR), and Diversion. During FY 2024-25 DSH outpatient programs treated 832 IST designated patients on average. In July 2024, the average census was 692 with a 22% increase to 845 patients by the end of the FY in June 2024.

Table 7: IST Outpatient Data Summary

IST Outpatient Data	FY 2023-24	FY 2024-25	Percent Change from Prior FY
Patient Admissions[10]	718	940	31%
Patients Served[11]	1,421	1,608	13%
Average Daily Census	673	832	24%

DSH outpatient programs admitted 940 IST designated patients in FY 2024-25, with an average of 78 admissions per month. Chart 4 displays IST outpatient program admissions by quarter.



[10] Patient admissions exclude inpatient and outpatient program transfers.
[11] 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[12]

Patients Treated/Served	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
	506	889	1,206	1,421	1,608

Outpatient Discharge Data

DSH discharged 616 IST patients from outpatient programs, with an average length of stay of 347.2 days, and a median length of stay of 272.5 days, across all programs. 35% of patients were discharged within the first 90 days of their stay, 44% discharged within the first 180 days of their stay, and 53% of patients discharged within the first year of their stay.

Table 9: IST Outpatient Length of Stay Distribution

Length of Stay	% of Patients[13]
0 - 90 Days	35%
91 - 180 Days	10%
181 - 365 days	8%
366 - 730 days (1 - 2 years)	44%
731+ days (2+ years)	3%

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

Table 10 displays outpatient length of stay by quarter.

Table 10: IST Outpatient Length of Stay & Disposition Outcome by Quarter[14]

IST Outpatient Programs: Length of Stay	**Quarter 1** Jul to Sep 2024	**Quarter 2** Oct to Dec 2024	**Quarter 3** Jan to Mar 2025	**Quarter 4** Apr to Jun 2025	**Total[15]** FY 2024-25
Average Length of Stay	339.5	302.2	378.9	380.9	347.2
Median Length of Stay	216.5	182.0	420.0	461.0	272.5
Discharged Count[16]	162	184	154	116	616
IST Outpatient Programs: Disposition Outcomes					
Restored	***%	***%	***%	***%	***%
Unlikely to Restore	***%	***%	***%	***%	***%
Maximum Commitment	*46%*	*39%*	*49%*	*49%*	*45%*
Revocation	*40%*	*44%*	*32%*	*28%*	*37%*
Case Dismissed	***%	***%	***%	***%	***%
Deceased	***%	***%	***%	***%	***%

IST Services Metrics

Early Access Stabilization Services

During FY 2024-25 DSH's Early Access Stabilization Services (EASS) Program provided IST services to 3,554 patients with eight newly participating counties and a total of 57 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** Jul to Sep 2024	**Quarter 2** Oct to Dec 2024	**Quarter 3** Jan to Mar 2025	**Quarter 4** Apr to Jun 2025	**Total[17]** FY 2024-25
IST Services Initiated	884	881	823	966	3,554
Newly Participating Counties	5	1	1	1	8
Total Participating Counties	54	55	56	57	57

[14] 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.
[15] Totals are based on raw data, which have been rounded for display purposes.
[16] Patient discharges exclude inpatient and outpatient program transfers
[17] Totals are based on raw data, which have been rounded for display purposes.

Re-Evaluation Services

IST Re-Evaluation Services completed 834 evaluations during FY 2024-25. Outcomes resulted in 16% IST patients found competent prior to admission, and 84% found retain and treat.

Table 12: IST Re-Evaluation Services Summary by Quarter[18]

IST Re-Evaluation Services	**Quarter 1** Jul to Sep 2024	**Quarter 2** Oct to Dec 2024	**Quarter 3** Jan to Mar 2025	**Quarter 4** Apr to Jun 2025	**Total[19]** FY 2024-25
IST Evaluations Completed (WIC 4335.2)	**126**	**162**	**76**	**122**	**486**
IST Found Competent	20%	14%	14%	16%	16%
IST Retain and Treat	80%	86%	86%	84%	84%
IST Unlikely to Restore	0.0%	0.0%	0.0%	0.0%	0.0%
IST Progress Reports Completed	**244**	**307**	**245**	**256**	**1,052**
IST Found Competent	***%	88%	83%	75%	89%
IST Unlikely to Restore	***%	***%	***%	***%	9%
IST Maximum Commitment	***%	***%	***%	***%	2%

[18] 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.
[19] Totals are based on raw data, which have been rounded for display purposes.

IST POPULATION DATA HIGHLIGHTS

Referral Growth

DSH has experienced a 31 percent growth in IST county referrals from FY 2019-20 through FY 2024-25.

Average Monthly Referrals	
FY 2019-20	343
FY 2020-21	346
FY 2021-22	415
FY 2022-23	488
FY 2023-24	490
FY 2024-25	451
6-Year ↑	31% ↑

KEY STATISTICS

2024-25 Patients Served
8,392
Inpatient
6,784
Outpatient
1,608
Decreased by 2% from FY 2023-24

2024-25 Admissions
5,650
Inpatient
4,710
Outpatient
940
Decreased by 2% from FY 2023-24

Expansion of and new IST Treatment and Services

- DSH increased IST treatment capacity by 1,420 beds since FY 2017-18 across State Hospitals, JBCT, CIF and CBR programs.
- DSH county funded Diversion program diverted 28 individuals.
- EASS and Re-evaluation Services provide increased access to competence evaluations and early access services. EASS has initiated services to 3,554 patients and Re-evaluation Services have conducted 486 re-evaluations finding 16% patients competent.

IST Referrals & Legislative Impact

DSH experienced an immediate decline in referrals following the passage of Senate Bill 1323[1]. It is not yet clear whether this impact will continue in future years.

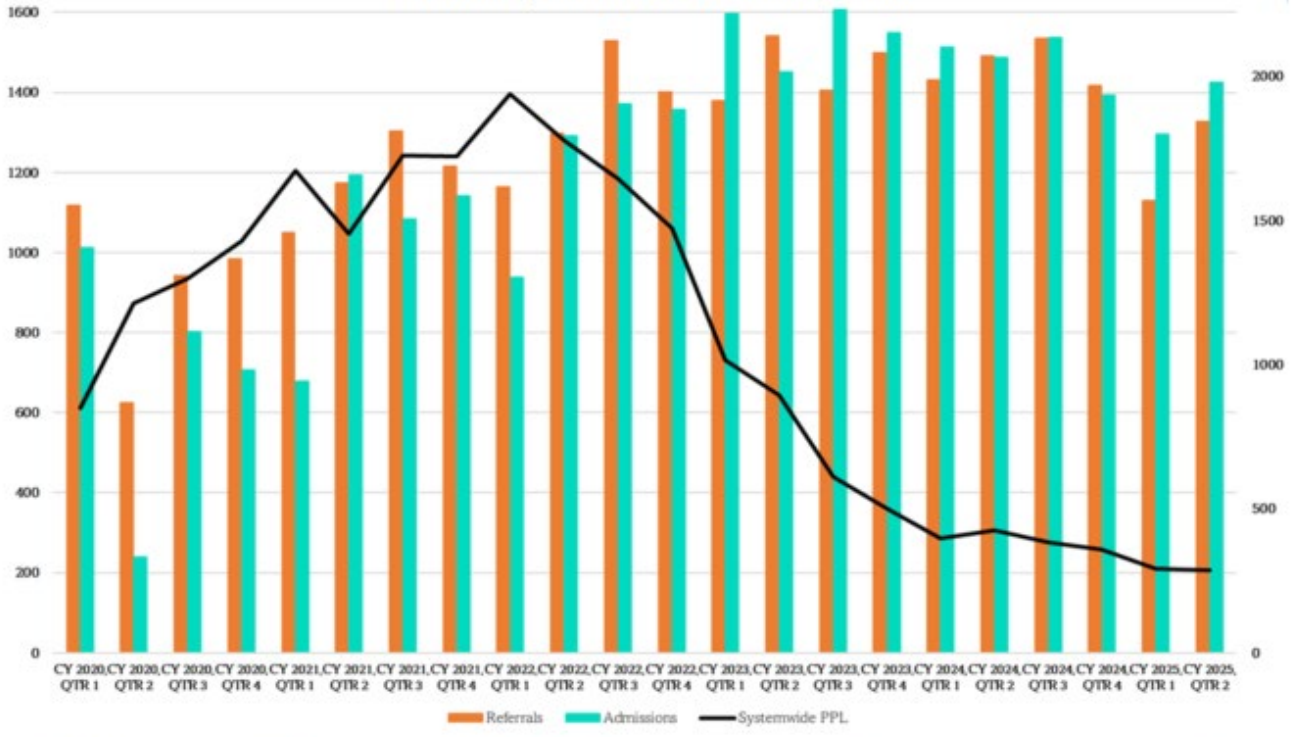
Decreased IST Waitlist

Due to rapid implementation of the IST Solutions, DSH has been able to continue increased admissions, paired with expansions within IST continuum which has led to a significant reduction in the IST waitlist.

PPL Trends

February 2020: 848
PPL High: 1,953
September 2025 : 300
85% Decrease

IST Waitlist, Referrals and Admission Trends



[1]Senate Bill 1323 has created an option for the court, when it finds it is not in the interest of justice to restore an IST individual to competency, to not commit the defendant to DSH for restoration of competency services, and instead consider the individual for diversion, assisted outpatient treatment, CARE court, or conservatorship.

POPULATION PROFILE
Lanterman-Petris-Short Patients

Description of Legal Class

Counties are responsible for the care of individuals conserved under the Lanterman-Petris-Short (LPS) Act. This population includes multiple civil commitment types of patients. The vast majority of such individuals served by DSH are:

Standard conservatorships – individuals with serious mental illness who are unable to provide for their basic needs

Murphy conservatorships – individuals who were incompetent to stand trial (IST) and were determined to be unable to be restored to competency; had a felony charge involving death, great bodily harm, or a serious threat to the physical well-being of another person, and; is a "substantial danger" to others due to their mental illness.

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. For both types of LPS patients, DSH serves as one of several treatment facility options counties may use in their role as the responsible entity for providing behavioral health services to LPS conserved individuals.

Legal Statutes and Commitments[1]

- Penal Code (PC) 2974 – Parolee from CDCR
- Welfare and Institutions Code (WIC) 5353 – Temporary Conservatorship
- WIC 5358 – Conservatorship
- WIC 5008(h)(1)(B) – Murphy Conservatorship (MURCON)
- 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

With the exception of those committed via WIC 5008(h)(1)(B), LPS conservatees have not been charged with a crime but are instead referred by county behavioral health

[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.

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 or with family, or 3) they have successfully petitioned the court to remove the conservatorship or a conservatorship is not renewed.

DSH Treatment Continuum & Services

Under 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, 83% of all LPS patients treated in DSH were committed under WIC 5353 under a temporary conservatorship or 5358 as conservatees. Table 1 below displays the percentage of LPS patients treated in DSH over the past five years by commitment type.

Table 1: LPS Patients Treated by Commitment Type

Commitment Type	**Percent of LPS Patients Treated[2]** (Past 5 years)
WIC 5353 - Temporary Conservatorship WIC 5358 - Conservatorship	83%
WIC 5008(h)(1)(B) - Murphy Conservatorship	17%
Other LPS	<1%

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

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

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

Programs

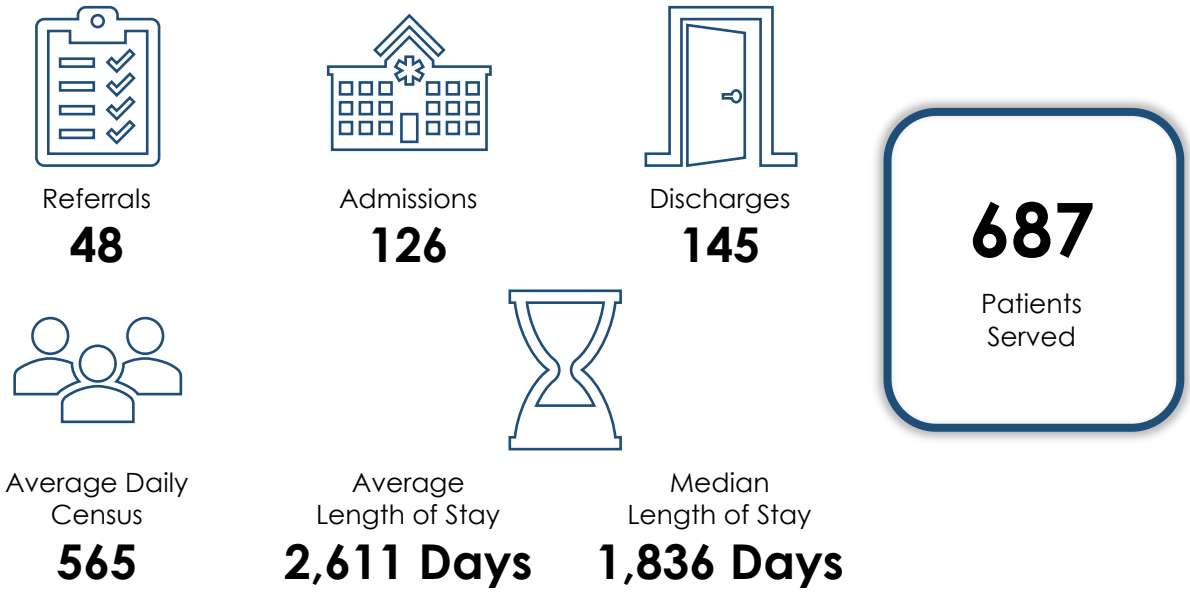
DSH provides inpatient treatment to LPS patients within the state hospitals.

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.

FY 2024-25 Population Data

The visual below provides a summary of the LPS patients for fiscal year (FY) 2024-25. DSH had 48 LPS referrals[3], 126 LPS admissions, and 145 LPS discharges in FY 2024-25. In total, DSH served 687 LPS patients and carried an average daily census (ADC) of 565. Of the LPS patients that were discharged, DSH observed an average length of stay of 2,611 days and the median length of stay 1836 days.

FY 2024-25 LPS Patient Data Summary



[3] The referrals count for FY 2024-25 excludes 102 LPS referrals received by DSH, which were cancelled as part of DSH's new LPS referral process. Refer to the note following Table 2 for additional context.

Population Data Detail

System-wide Metrics

Although DSH is not statutorily required to admit LPS patients as is the case with other legal classifications, the Department continues to collaborate with the California Mental Health Services Authority (CalMHSA) to identify opportunities for counties to maximize utilization of LPS beds[4]. In fiscal year (FY) 2024-25, DSH treated 687 LPS patients, a 5% increase from the prior year, while maintaining an ADC of 565 patients. The ADC remained steady throughout the year with a nominal increase of 1% between June 2024 (561 ADC) and July 2025 (564 ADC). The average length of stay rose slightly, from 2,296 days in FY 2023-24 to 2,423 days in FY 2024-25.

At the same time, admissions nearly doubled, increasing 97% year over year, while patient discharges rose by 14%. Although DSH did experience a significant decrease in the number of referrals, this is primarily due to the transition to a new standardized referral process implemented on July 1, 2025, requiring all counties to submit referrals through the LPS Referrals SharePoint Site, as part of this transition, DSH cancelled 130 referrals submitted under the old process and directed counties to resubmit them if admission to a DSH facility was still being sought after. Table 2 summarizes these year-over-year changes across the LPS population.

Table 2: LPS Patient Data Summary

LPS Patient Data	FY 2023-24	FY 2024-25	Percent Change from Prior FY
Patient Referrals[5, 6]	179	48	-73%
Patient Admissions[7]	64	126	97%
Patients Served[8]	652	687	5%
Average Daily Census	569	565	-1%
Average Length of Stay	2,296	2,423	6%
Patient Discharges	127	145	14%

[4] Beginning July 1, 2025, the maximum utilization increased to 625 beds.
[5] Patient referrals exclude inpatient program transfers and court returns.
[6] July 1, 2025, DSH implemented a new LPS referral process, which required that all referrals be submitted through the LPS Referrals SharePoint Site. As part of this transition, DSH cancelled 130 referrals that had been submitted under the old process and instructed counties to resubmit them through the new system if admission was still being sought. Of the cancelled referrals, 81 were re-referred to DSH through the new process.
[7] Patient admissions exclude inpatient program transfers.
[8] Patients served excludes inpatient program transfers.

Chart 1[9] displays LPS system-wide referrals and admissions by quarter for FY 2024-25.

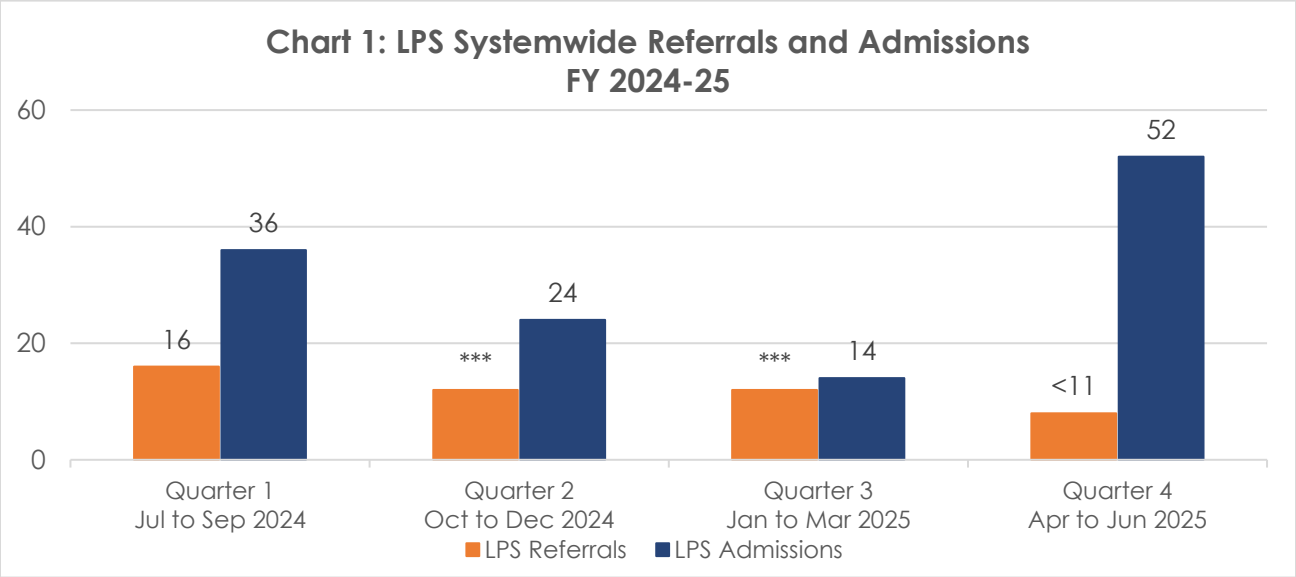
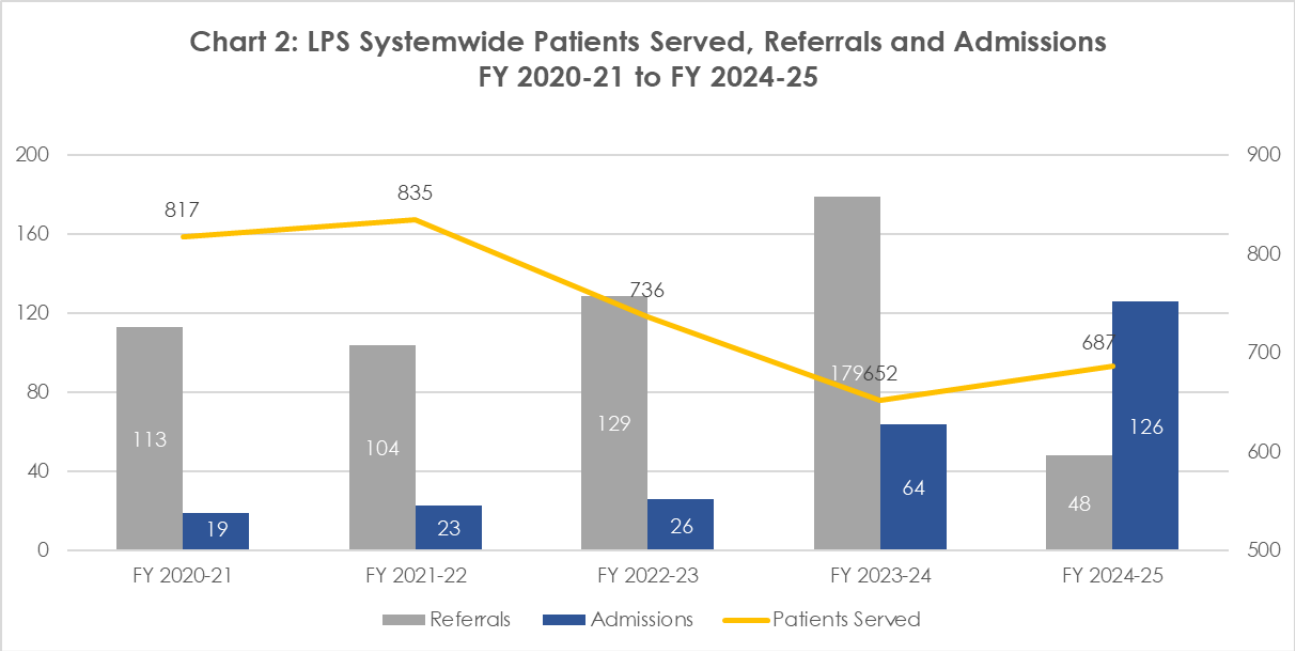


Chart 2 displays a five-year historical view of LPS population statistics including admissions, referrals, and patients served. Patients served declined by nearly 16% between FY 2020-21 (817) and FY 2024-25 (687), a reduction influenced in part by changes to the CalMHSA MOU that decreased the number of beds designated for LPS patients. Referrals fluctuated during this period, peaking at 179 in FY 2023-24 before declining to 48 in FY 2024-25 due to the transition to the new LPS referral process implemented July 1, 2025. Admissions, however, increased across the five-year period with considerable increases occurring within the last two years.

[9] Data has been de-identified in accordance with the DSH Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. De-Identification Legend: Counts between 1-10 are masked with "<11". Complimentary masking is applied using "***" where further de-identification is needed.



LPS patients referred and committed to DSH are added to the DSH system-wide LPS Pending Placement List (PPL) until a bed becomes available or a DSH bed is no longer needed. As of June 30, 2025, there were 167 patients pending placement, compared to 244 in the prior year, representing a 32% decrease. This marks the lowest PPL level in five years, down from a high of 317 patients in FY 2021-22. The reduction in FY 2024-25 is attributed to an increase in LPS discharges (see Table 2 for reference), which created capacity for more admissions from the PPL as well as centralized management of the waitlist which resulted in many individuals being removed from the PPL who were not eligible for DSH treatment due to no longer having an active conservatorship or no longer requiring DSH level of care. Table 3 below summarizes these annual trends.

Table 3: LPS System-wide Pending Placement List

LPS Patients Pending Placement	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
	297	317	311	244	167

Discharge Data

DSH discharged 145 LPS patients in FY 2024-25 with an average length of stay of 2,610.7 days (7.2 years) and a median length of stay of 1,836.0 days (5.0 years). The variation between average and median LPS length of stay highlights that a small number of patients with longer hospitalizations elevated the average above the midpoint. When looking at the duration of time of an LPS patient in DSH facility it shows that 8% discharged within the first year of their stay, 42% discharged between two and five years, and 50% stayed beyond five years. Table 4 below depicts the distribution of LPS patients discharged from DSH in FY 2024-25 by length of stay.

Table 4: LPS Patient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	8%
366 - 1,460 Days (2 - 4 years)	32%
1,461 - 1,825 days (4 - 5 years)	10%
1,826 - 3,650 days (5 - 10 years)	32%
3,651+ days (10+ years)	18%

Table 5 on the following page highlights quarterly trends of the LPS length of stay of patients that were discharged from a DSH facility during FY 2024-25. Quarterly patterns show variation in discharge lengths, with the average ranging from 6.2 years to 8.6 years. The median length of stay ranged from 3.9 years to 6.2 years. The quarterly trends mirrored what was observed in the annual trend where the longer-stay patients had an impact on the overall length of stay average. Discharges increased throughout the fiscal year with the exception of a drop in the third quarter.

Table 5: LPS Patient Length of Stay by Quarter

LPS Patient Length of Stay Days (Years)	**Quarter 1** Jul to Sep 2024	**Quarter 2** Oct to Dec 2024	**Quarter 3** Jan to Mar 2025	**Quarter 4** Apr to Jun 2025	**Total**[10] FY 2024-25
Average Length of Stay	2,601.9 (7.1 yrs.)	2,694.1 (7.4 yrs.)	3,129.9 (8.6 yrs.)	2,278.9 (6.2 yrs.)	2,610.7 (7.2 yrs.)
Median Length of Stay	1,729.0 (4.7 yrs.)	2,247.0 (6.2 yrs.)	1,952.0 (5.3 yrs.)	1,440.0 (3.9 yrs.)	1,836.0 (5.0 yrs.)
Discharged Count	33	41	24	47	145

LPS patients can be discharged to a variety of locations. Table 6 below displays the discharge location for the 145 patients discharged in FY 2024-25. The largest percentage of patients were discharged into a locked medical facility (45%), which could include a community skilled nursing facility. The next largest discharge category was out to the community (21%). The remaining patients were discharged to community outpatient treatment, a locked facility, became deceased, or were discharged to another unknown location.

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

Table 6: LPS Patient Discharges by Location[11]

Discharge Location	LPS	MURCON	Total FY 2024-25	Percent to Total
Community Outpatient Treatment	0	<11	**<11**	***%
Deceased	***	<11	****	***%
Discharged to Community	31	0	**31**	21%
Locked Facility: CDCR, Jail, Court	<11	<11	****	***%
Locked Medical Facility	65	0	**65**	45%
Other/Unknown	***	0	****	***%
Total Discharges	****	****	**145**	**100%**

[11] Data has been de-identified in accordance with the DSH Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. De-Identification Legend: Counts between 1-10 are masked with "<11". Complimentary masking is applied using "***" where further de-identification is needed.

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 have complex behavioral health conditions and their crimes may involve significant violence, treatment often 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 annually, 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) 2024-25, 342 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).

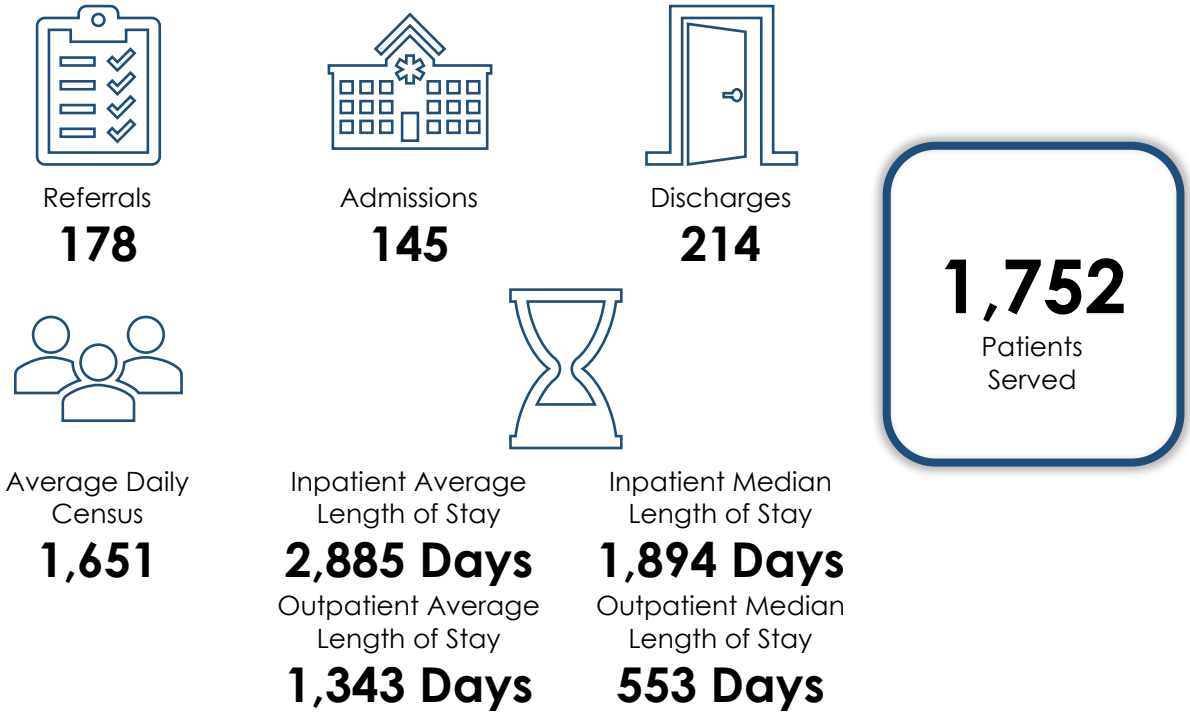
DSH NGI Treatment Programs	
State Hospitals (SH)	DSH's inpatient mental health hospital system provides psychiatric, medical, and psychosocial treatment services to forensic and civil patients housed at Atascadero, Coalinga, Metropolitan, Napa, and Patton state hospitals.

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.

FY 2024-25 Population Data

The visual below provides a summary of the NGI patients for fiscal year (FY) 2024-25. DSH had 178 NGI referrals, 145 NGI admissions, and 214 NGI discharges in FY 2024-25 across its inpatient and outpatient programs. In total, DSH served 1,752 NGI patients and carried an average daily census of 1,651. Of the NGI patients that were discharged, DSH observed an average length of stay of 2,885 days and a median length of stay of 1,894 days for inpatient programs. For outpatient programs DSH observed an average length of stay of 1,343 days and a median length of stay of 553 days.

FY 2024-25 NGI Patient Data Summary



Population Data Details

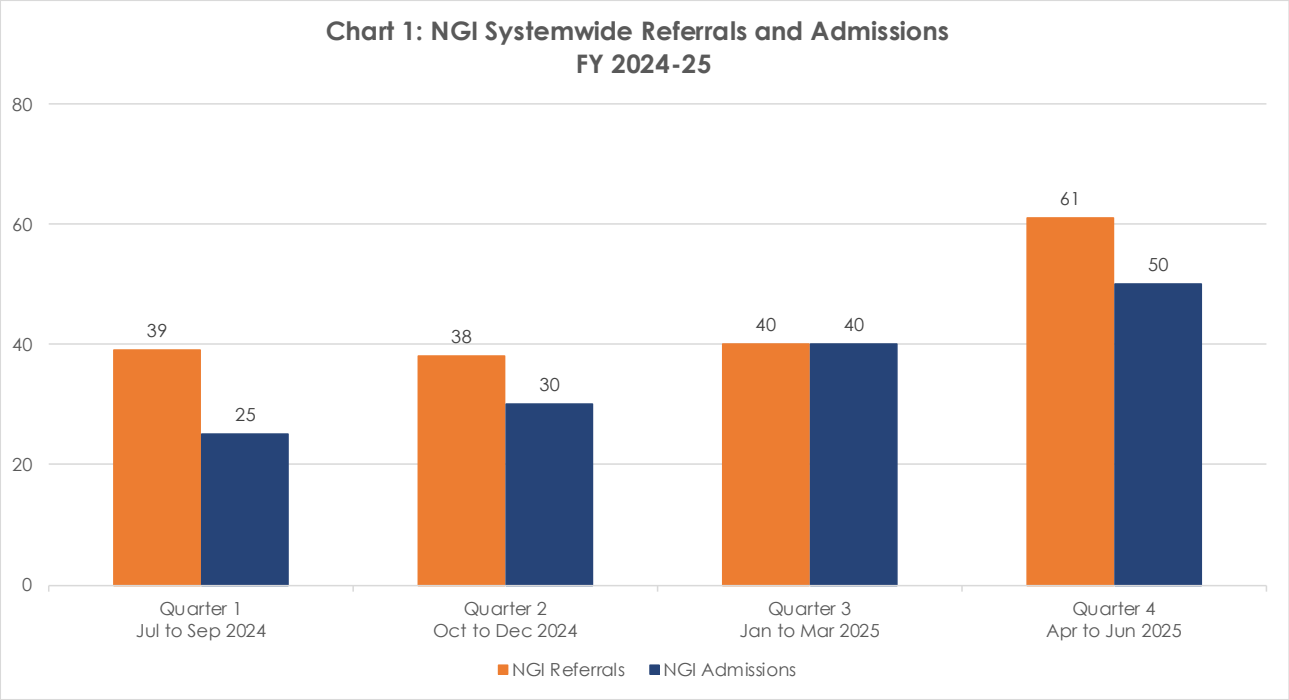
System-wide Metrics

In FY 2024-25 DSH served 1,752 patients designated as NGI across inpatient and outpatient programs, representing a 3% decrease from the prior year. Patient admissions declined by 29%, while the number of referrals declined by 30%. This decline in admissions contributed to an overall reduction in the NGI population, with the average daily census decreasing by 1% compared to FY 2023-24. Table 1 below summarizes these system-wide changes across the NGI population.

Table 1: System-wide NGI Patient Data Summary

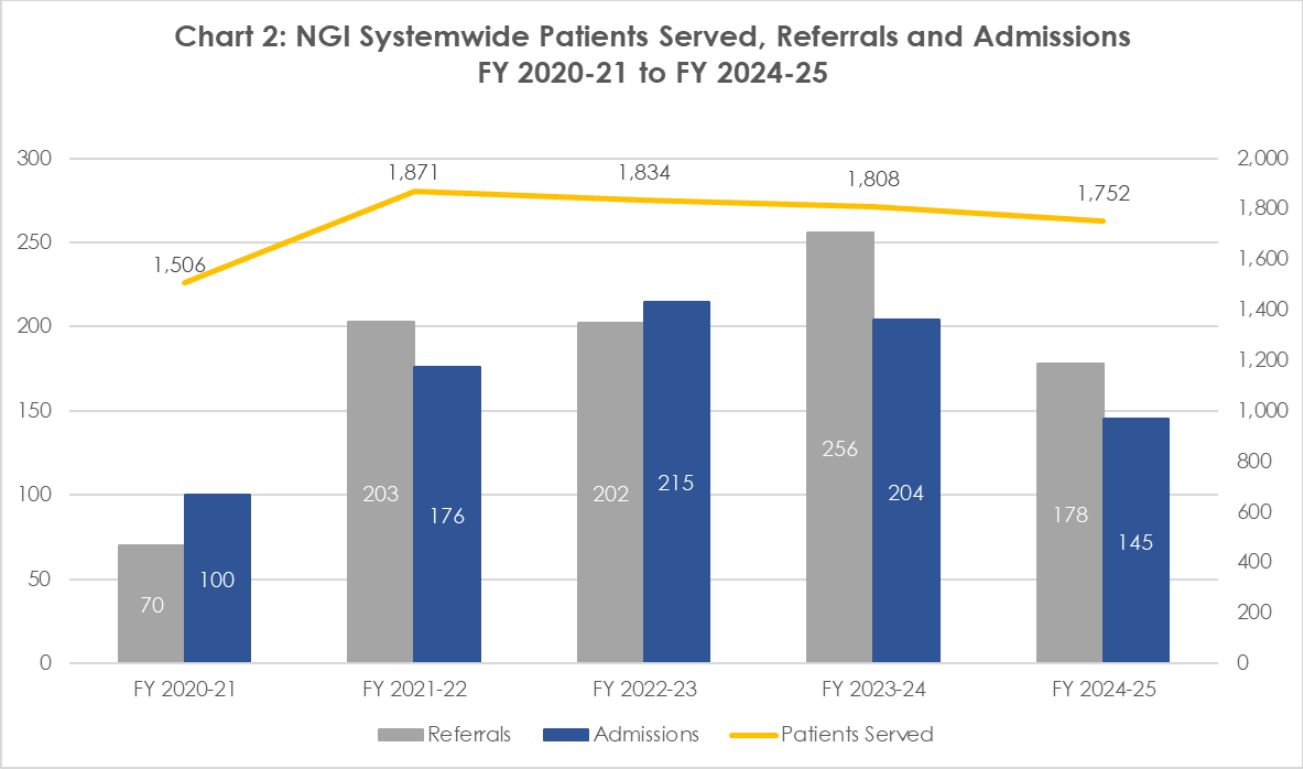
NGI Patient Data	FY 2023-24	FY 2024-25	Percent Change from Prior FY
Patient Referrals[2]	256	178	-30%
Patient Admissions[3]	204	145	-29%
Patients Served[4]	1,808	1,752	-3%
Average Daily Census	1,675	1,651	-1%

Chart 1 displays NGI system-wide referrals and admissions by quarter for FY 2024-25.



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

Chart 2[5] displays a five-year period of referrals and admissions for a broader historical view. A review of the NGI patient data over the past five years shows fluctuations in referrals, admissions, and total patients served. The number of patients served shows an increase between FY 2020-21 (1,506) and FY 2021-22 (1,871), largely reflecting the incorporation of outpatient program data beginning with FY 2021-22. Examining just the last four years for a comparative analysis, the NGI population has gradually declined each year, reaching 1,752 patients in FY 2024-25, a 6% decrease. The data indicates that both referrals and admissions have also decreased in recent years, contributing to the gradual decline in the overall NGI population.



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 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
	14	44	11	<11	<11

[5] Outpatient data is included beginning with FY 2021-22 (Chart 2).
[6] The pending placement list reflects patients pending inpatient treatment.
[7] Data has been de-identified in accordance with the DSH Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. De-Identification Legend: Counts between 1-10 are masked with "<11". Complimentary masking is applied using "***" where further de-identification is needed.

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 2024-25 DSH inpatient programs treated an average of 1,200 NGI-designated patients daily across the four state hospitals that serve this population. The year began with an average daily census of 1,210 patients in July 2024 and ended slightly lower at 1,196 patients in June 2025, reflecting a modest 1% decline. Overall, inpatient admissions fell by 16% compared to the prior year, while the total number of patients served decreased by 2%. Table 3 summarizes these year-over-year changes in inpatient admissions, patients served, and average daily census.

Table 3: NGI Inpatient Data Summary

NGI Inpatient Data	FY 2023-24	FY 2024-25	Percent Change from Prior FY
Patient Admissions[8]	69	58	-16%
Patients Served[9]	1,297	1,266	-2%
Average Daily Census	1,209	1,200	-1%

DSH Inpatient programs admitted 58 patients in FY 2024-25 with an average of 15 admissions per quarter. Chart 3[10] below displays inpatient program NGI admissions by quarter, showing that quarterly admissions have been incrementally increasing throughout the fiscal year.

[8] Patient admissions exclude inpatient program transfers.
[9] Patients served excludes other inpatient and outpatient program transfers.
[10] 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.

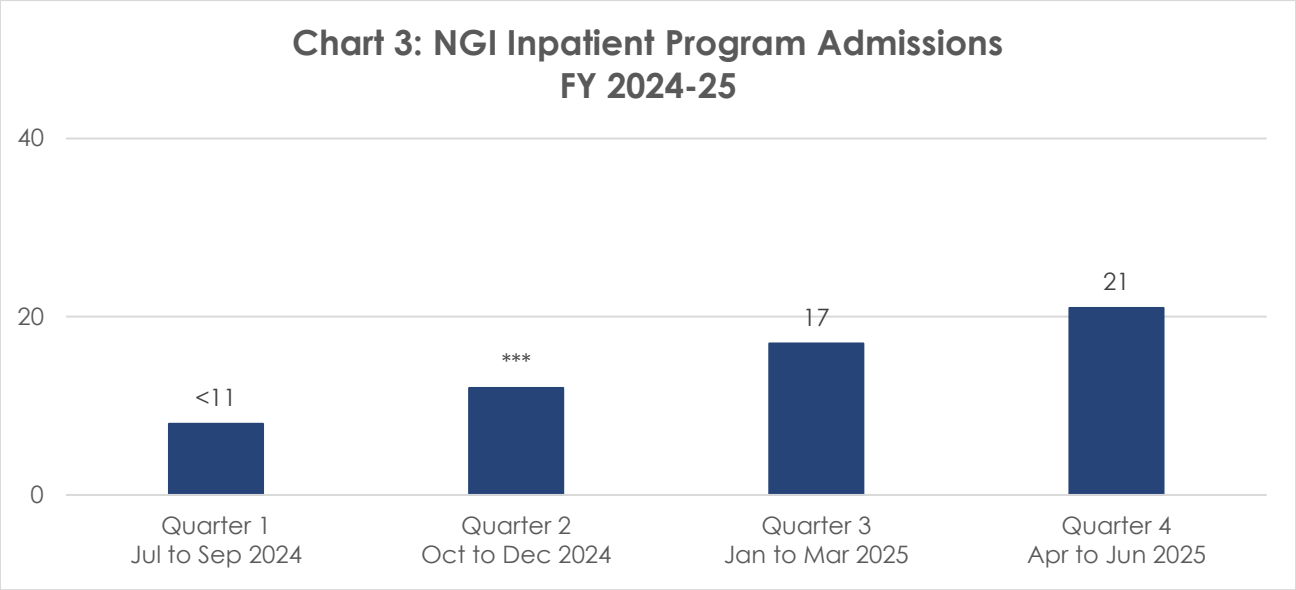


Table 4 below displays the number of NGI patients treated in inpatient programs within each FY for the past five years. Between FY 2020-21 and FY 2024-25 there has been a 16% decrease in NGI patients treated.

Table 4: NGI Patients Served – Inpatient Programs[11]

Patients Treated/ Served	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
	1,506	1,406	1,348	1,297	1,266

Inpatient Discharge Data

DSH discharged 117 NGI patients from inpatient programs with an average length of stay of 2,884.9 days (7.9 years) and a median length of stay of 1,894 days (5.2 years). When looking at the duration of time of an NGI patient in an inpatient treatment program it shows that 15% discharged within the first year of their stay, 34% discharged between two and five years, and 51% stayed beyond five years. Table 5 on the following page depicts the distribution of NGI patients discharged from inpatient programs in FY 2024-25 by length of stay.

Table 5: NGI Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	15%
366 - 1,825 Days (2 - 5 years)	34%
1,826 - 3,650 days (5 - 10 years)	31%
3,651+ days (10+ years)	20%

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

Table 6 highlights quarterly trends of NGI length of stay of patients that were discharged from inpatient programs during FY 2024-25. The data shows a downward trend in both average and median length of stay over the course of the year. In the first two quarters, the average length of stay exceeded 9.9 year, with median stays of 7.4 years and 5.7 years, respectively. This reflects the discharge of patients who had been in treatment for longer periods of time, elevating both the mean and median values early in the FY.

By quarter 3 and quarter 4, as patients with more moderate treatment durations were discharged, the length of stay dropped considerably. Median length of stay declined to 5.0 years in quarter 3 and further to 4.0 years in quarter 4, demonstrating a consistent reduction across the fiscal year. Overall, the annual average length of stay for discharged patients was 7.9 years, while the median length of stay was 5.2 years.

Table 6: NGI Inpatient Length of Stay by Quarter

NGI Inpatient Length of Stay Days (Years)	**Quarter 1** July to Sep 2024	**Quarter 2** Oct to Dec 2024	**Quarter 3** Jan to Mar 2025	**Quarter 4** Apr to Jun 2025	**Total**[12] FY 2024-25
Average Length of Stay	3,664.6 (10.0 yrs.)	3,628.5 (9.9 yrs.)	2,617.7 (7.2 yrs.)	1,961.6 (5.4 yrs.)	2,884.9 (7.9 yrs.)
Median Length of Stay	2,707.0 (7.4 yrs.)	2,072.0 (5.7 yrs.)	1,832.0 (5.0 yrs.)	1,442.0 (4.0 yrs.)	1,894.0 (5.2 yrs.)
Discharged Count	25	31	21	40	117

NGI designated patients can be discharged to a variety of locations including outpatient treatment programs. Table 7 below displays the discharge locations for the 117 patients discharged in FY 2024-25. Majority of patients were discharged to a community outpatient treatment (46%). The next largest discharge category was out to a locked facility (28%) including another state hospital, jail, court, or CDCR. The remaining 26% were discharged to the community, became deceased, or were discharged to another unknown location.

Table 7: NGI Inpatient Discharges by Location[13]

NGI Inpatient Discharge Location	**NGI** FY 2024-25	**Percent to Total**
Community Outpatient Treatment	54	46%

[12] Totals are based on raw data, which have been rounded for display purposes.
[13] Data has been de-identified in accordance with the DSH Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. De-Identification Legend: Counts between 1-10 are masked with "<11". Complimentary masking is applied using "***" where further de-identification is needed.

Locked Facility: CDCR, Jail, Court, Other State Hospitals	33	28%
Discharged to Community	17	15%
Deceased	13	11%
Other/Unknown	0	0%
Total Discharges	**117**	**100%**

Outpatient Program Metrics

CONREP is the DSH outpatient treatment program for patients committed as NGI. During FY 2024-25, DSH CONREP treated on average 452 NGI designated patients daily and has maintained a stable NGI census throughout the year with minor fluctuations. CONREP began the year with an average census of 461 in July 2024 and ended the year with an average census of 459 patients in June 2025.

Table 8: NGI Outpatient Data Summary

NGI Outpatient Data	FY 2023-24	FY 2024-25	Percent Change from Prior FY[14]
Patient Admissions[15]	135	87	-36%
Patients Served[16]	511	486	-5%
Average Daily Census	466	452	-3%

DSH outpatient programs admitted 87 NGI patients in FY 2024-25 with an average of 22 admissions per quarter. Chart 4 displays outpatient program NGI admissions by quarter.

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

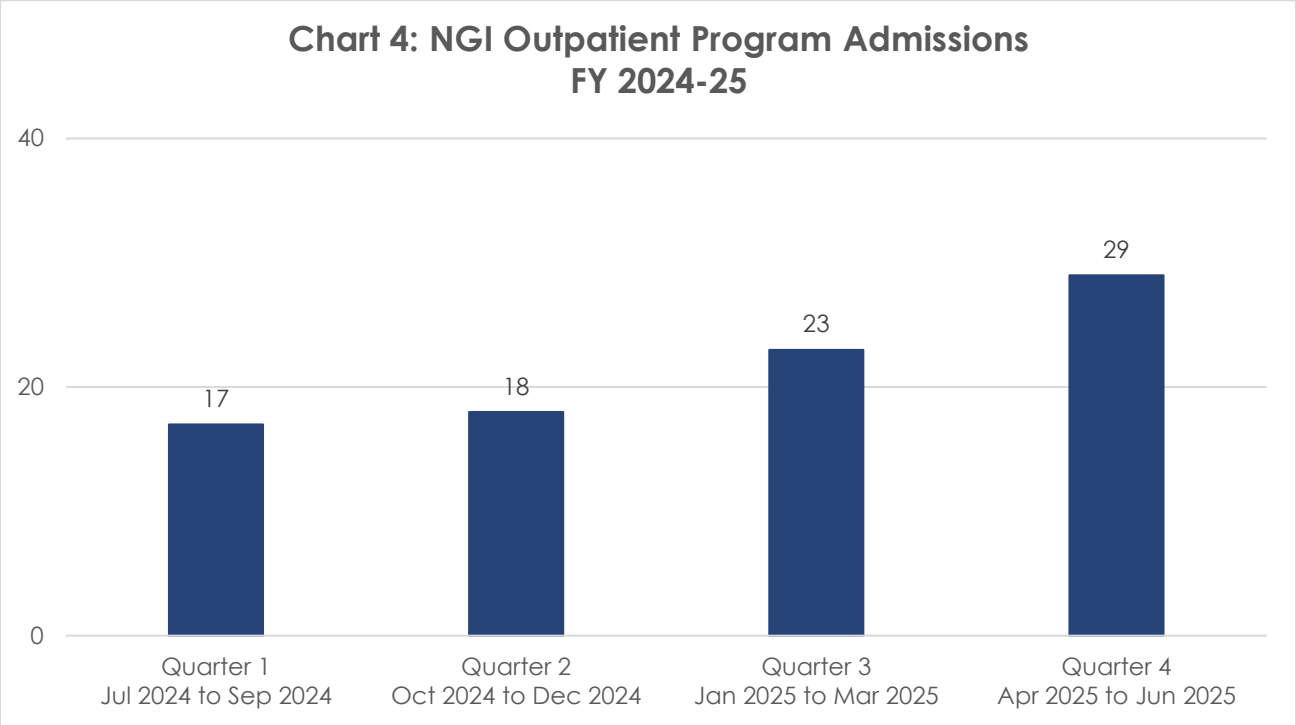


Table 9 below displays the number of NGI patients treated across the years in outpatient programs. The number of NGI patients treated annually in outpatient treatment has been increasing since FY 2021-22 and it reached a peak of 511 in the prior fiscal year (+10 percent increase). There was a decrease of 4.9% from the prior fiscal year as compared to FY 2024-25, but still an overall increase of 4.5% as compared to FY 2021-22

Table 9: NGI Patients Served – Outpatient Programs[17]

Patients Treated/Served	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
	465	486	511	486

Outpatient Discharge Data

DSH discharged 97 NGI patients from outpatient programs with an average length of stay of 1,343.2 days (3.7 years) and a median length of stay of 553.0 days (1.5 years) across all outpatient programs. When looking at the duration of time of an NGI patient in an outpatient treatment program it shows that 28% discharge within the first year of their stay, 54% discharge between two and five years, and 18% stayed beyond five years. Table 10 below depicts the distribution of NGI patients discharged from outpatient programs in FY 2024-25 by length of stay.

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

Table 10: NGI Outpatient Length of Stay Distribution

NGI Outpatient Length of Stay	% of Patients
0 - 365 Days (1 year)	28%
366 - 1,825 Days (2 - 5 years)	54%
1,826 - 3,650 days (5 - 10 years)	10%
3,651+ days (10+ years)	8%

Table 11 displays outpatient length of stay by quarter for FY 2024-25.

Table 11: NGI Outpatient Length of Stay by Quarter

NGI Outpatient Length of Stay Days (Years)	**Quarter 1** July to Sep 2024	**Quarter 2** Oct to Dec 2024	**Quarter 3** Jan to Mar 2025	**Quarter 4** Apr to Jun 2025	**Total**[18] FY 2024-25
Average Length of Stay	1,452.1 (4.0 yrs.)	1,597.1 (4.4 yrs.)	1,320.9 (3.6 yrs.)	1,058.3 (2.9 yrs.)	1,343.2 (3.7 yrs.)
Median Length of Stay	856.0 (2.3 yrs.)	464.5 (1.3 yrs.)	769.0 (2.1 yrs.)	484.0 (1.3 yrs.)	553.0 (1.5 yrs.)
Discharged Count	24	24	20	29	97

[18] 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.

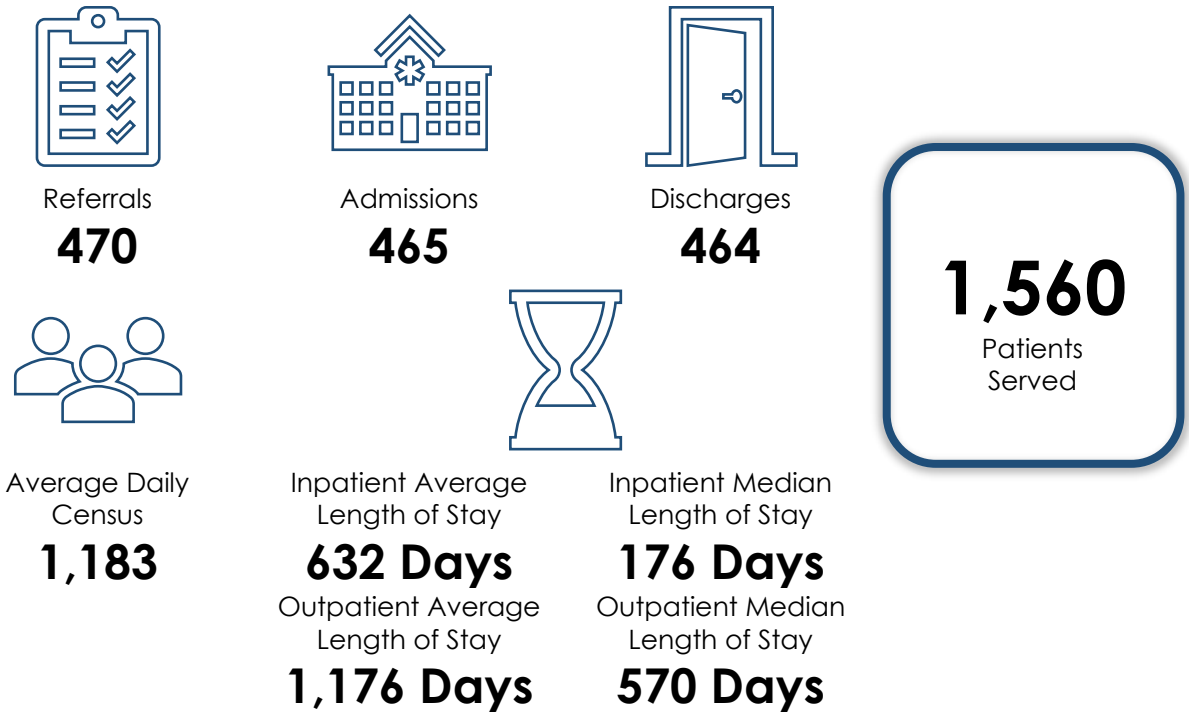
[1] Penal Code section 1606

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.

FY 2024-25 Population Data

The visual below provides a summary of the OMD patients for fiscal year (FY) 2024-25. DSH had 470 OMD referrals, 465 OMD admissions, and 464 OMD discharges in FY 2024-25 across its inpatient and outpatient programs. In total, DSH served 1,560 OMD patients and carried an average daily census of 1,183. Of the OMD patients that were discharged, DSH observed an average length of stay of 632 days and the median length of stay of 176 days for inpatient programs. For outpatient programs DSH observed an average length of stay of 1,176 days and a median length of stay of 570 days.

FY 2024-25 OMD Patient Data Summary



Population Data Details

State-wide Metrics

In FY 2024-25 DSH served 1,560 patients committed as OMD across inpatient and outpatient programs, representing a 1% increase from the prior year. Similarly, patient referrals and admissions remained stable with a 1% increase in referrals and a 3% decrease in admissions. The average daily census decreased slightly from 1,200 to 1,183 (1% decrease), reflecting minor year-over-year variation. Overall, these metrics indicate that the OMD population has remained at consistent levels across the last two years with minimal shifts in patient volume and census. Table 1 below summarizes these system-wide changes across the OMD population.

Table 1: System-wide OMD Patient Data Summary

OMD Patient Data	FY 2023-24	FY 2024-25	Percent Change from Prior FY[2]
Patient Referrals[3]	467	470	1%
Patient Admissions[4]	477	465	-3%
Patients Served[5]	1,550	1,560	1%
Average Daily Census	1,200	1,183	-1%

Chart 1 on the following page displays OMD system-wide referrals and admissions by month for FY 2024-25. Both referrals and admissions peaked in July 2024 before declining in August 2024 and stabilizing throughout the rest of the year. The lowest points occurred in February and March 2025, when both referrals and admissions experienced drops. Referrals and admissions are closely aligned due to DSH's statutory obligation to admit patients directly from prison upon completion of their sentence. Because these individuals cannot safely serve parole in the community until their severe mental disorder is in remission and stable, they are discharged directly to a state hospital to ensure continuity of care and public safety.

[2] Percentages are based on raw data, which have been rounded for display purposes.
[3] Patient referrals include inpatient program transfers.
[4] Patient admissions include inpatient and outpatient program transfers.
[5] Patients served excludes inpatient and outpatient program transfers.

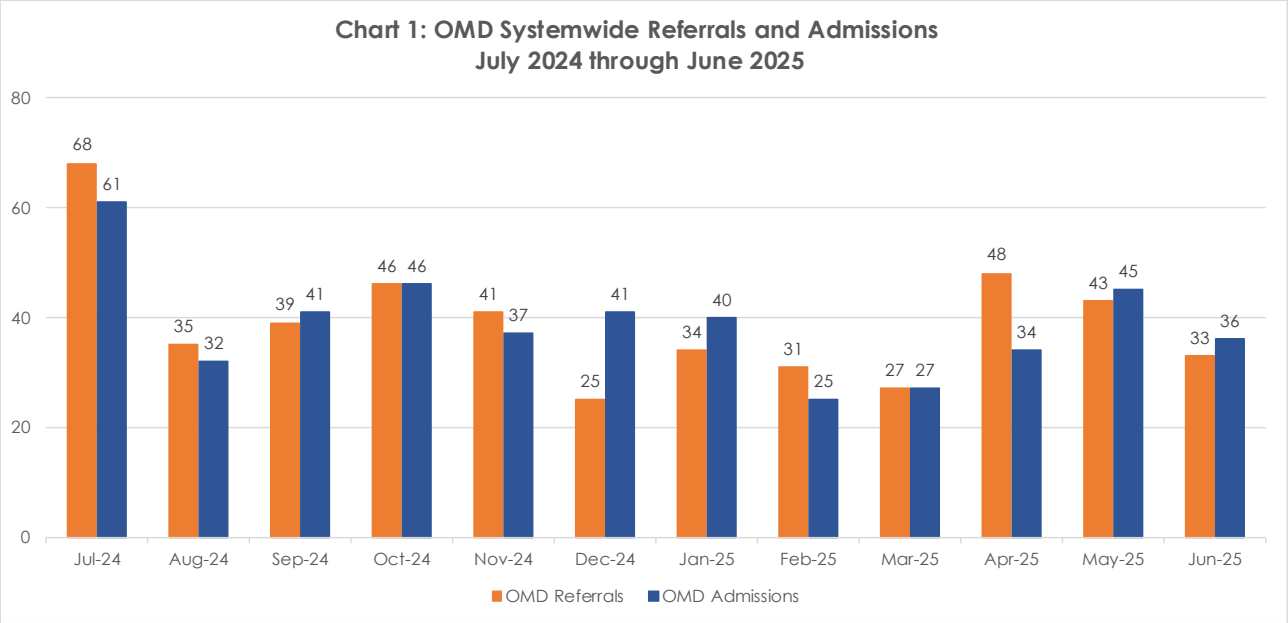
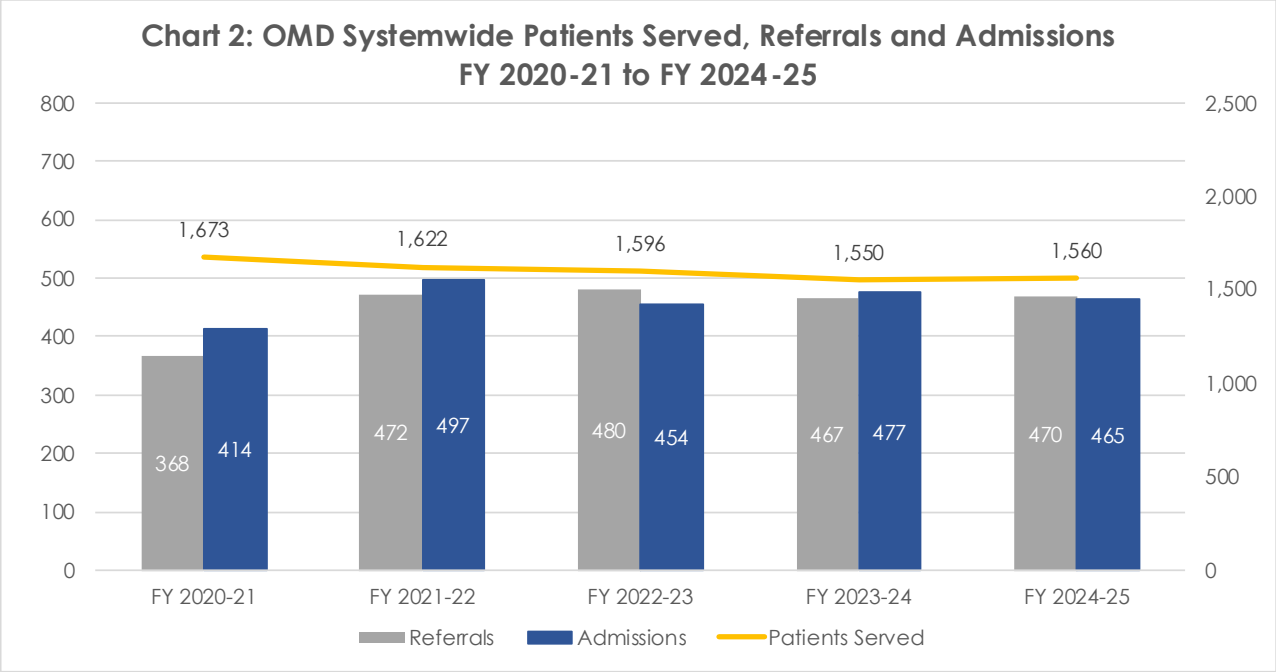


Chart 2[6] displays a five-year period of referrals and admissions for a broader historical view. A review this data shows very gradual decreases in total patients served. The number of referrals and admissions increased between FY 2020-21 and FY 2021-22, largely reflecting the incorporation of outpatient program data beginning with FY 2021-22. Examining just the last four years for a comparative analysis, the OMD population has gradually declined each year, reaching 1,560 patients served in FY 2024-25, a 4% decrease.



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

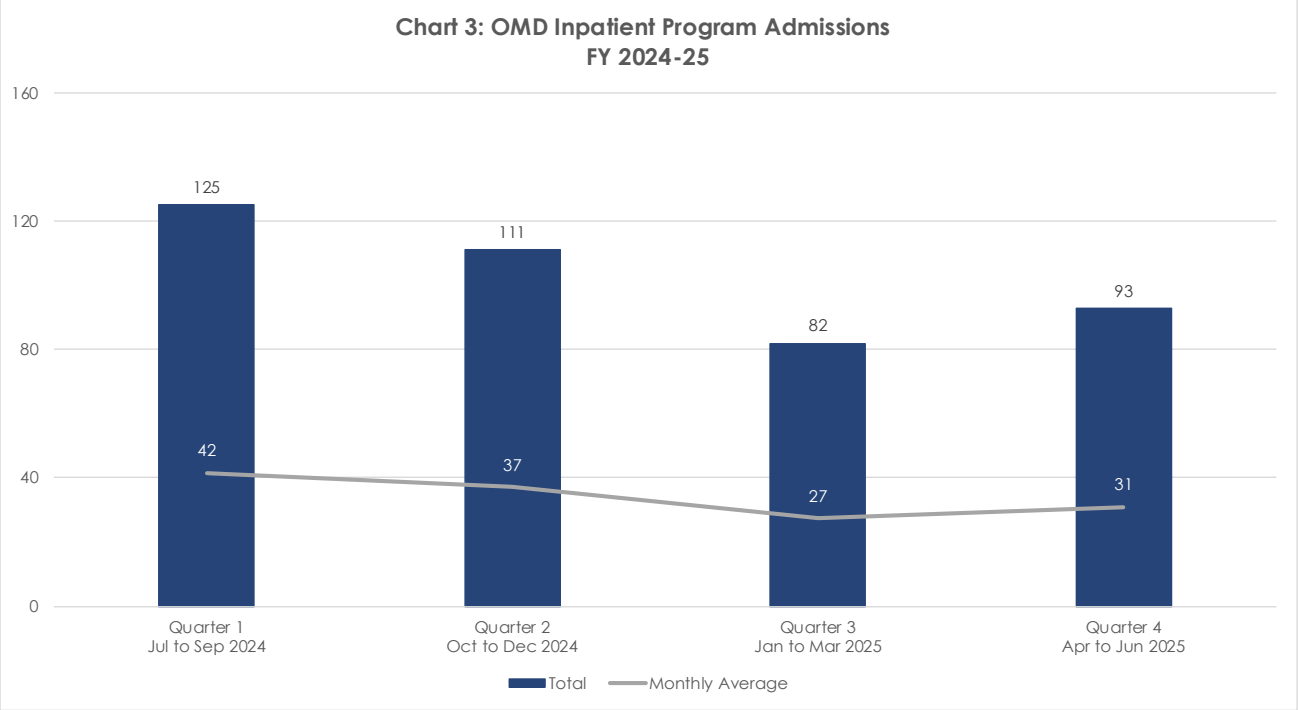
Inpatient Program Metrics

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 2024-25, the state hospitals treated an average of 1,017 OMD patients daily, with an average census of 1,025 in July 2024, and 1,010 in June 2025. Between FY 2020-21 and FY 2024-25 there has been a 17% decrease in OMD patients treated (1,673 to 1,384).

Table 2: OMD Inpatient Data Summary

OMD Inpatient Data	FY 2023-24	FY 2024-25	Percent Change from Prior FY[7]
Patient Admissions[8]	427	411	-4%
Patients Served[9]	1,383	1,384	0%
Average Daily Census	1,039	1,017	-2%

DSH inpatient programs admitted 411 OMD patients in FY 2024-25 with an average of 34 admissions per month. Chart 3 displays inpatient program OMD admissions by quarter, showing that admissions have incrementally declined throughout the fiscal year, with a small increase in quarter 4.



[7] Percentages are based on raw data, which have been rounded for display purposes.
[8] Patient admissions include inpatient and outpatient program transfers.
[9] Patients served excludes inpatient and outpatient program transfers.

PC 2962 Inpatient Data

Patients committed as PC 2962 make up 49% of the OMD patients treated within inpatient programs. During FY 2024-25 DSH inpatient programs treated an average of 330 patients committed under PC 2962. The year began with an average census of 325 patients in July 2024 and ended slightly higher at 339 patients in June 2025, reflecting an increase of 4%. Overall, inpatient admission for PC 2962 patients fell by 2% compared to the prior year, while the number of patients served increased by 2%, indicating less PC 2962 discharges as compared to the prior year. Table 3 summarizes these year-over-year changes in inpatient admissions, patients served, and average daily census for PC 2962 patients.

Table 3: PC 2962 Inpatient Data Summary

PC 2962 Inpatient Data	FY 2023-24	FY 2024-25	Percent Change from Prior FY[10]
Patient Admissions[11]	361	355	-2%
Patients Served[12]	663	676	2%
Average Daily Census	327	330	1%

DSH discharged 298 PC 2962 patients from inpatient programs, a 7% decrease from the prior year. Those discharged had an average length of stay of 259.0 days (0.7 years) and a median length of stay of 163.5 days (0.4 years). When looking at the duration of time of a PC 2962 patient in an inpatient treatment program, it shows that 63% discharged within the first 180 days of their stay and an additional 11% discharged between 181 and 365 days of their stay, totaling 74% discharged within the first year of their stay. Of the remaining PC 2962 patients, 22% were discharged between one and two years and 4% stayed beyond two years.

Table 4: PC 2962 Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 180 Days	63%
181 - 365 Days	11%
366 - 730 (1-2 yrs.)	22%
731 + (2+ yrs.)	4%

Table 5 reviews quarterly trends for PC 2962 patients in FY 2024-25, highlighting length of stay and discharge activity. The average length of stay increased over the course of the year, starting with 246.3 days in quarter 1 and increasing to 275.9 days in

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

quarter 4, with an annual average of 259.0 days. The median length of stay followed a similar upward trend, from 141.0 days in quarter 1 to 175.0 days in quarter 4, with an annual medial of 163.5 days. In contrast, discharge counts declined from 95 in Quarter 1 to 71 in quarter 4, totaling 298 discharges for the year. The combination of longer lengths of stay and fewer discharges point to a slowing rate of patient turnover.

Table 5: PC 2962 Inpatient Length of Stay by Quarter

PC 2962 Inpatient Programs: Length of Stay	**Quarter 1** Jul to Sep 2024	**Quarter 2** Oct to Dec 2024	**Quarter 3** Jan to Mar 2025	**Quarter 4** Apr to Jun 2025	**Total**[13] FY 2024-25
Average Length of Stay	246.3	259.1	258.8	275.9	259.0
Median Length of Stay	141.0	138.0	159.0	175.0	163.5
Discharged Count	95	69	63	71	298

PC 2962 patients can be discharged to a variety of locations including outpatient treatment programs. Table 6 below displays the discharge location for 298 patients discharged in FY 2024-25. Majority of patients were discharged to the community (84%). The next largest category was out to a locked facility (10%) including another state hospital, jail, court or CDCR. The remaining patients were discharged to a community outpatient treatment or another unknown location.

Table 6: PC 2962 Inpatient Discharges by Location[14]

PC 2962 OMD Inpatient Discharge Location	**Total** FY 2024-25	**Percent to Total**
Community Outpatient Treatment	<11	***%
Discharged to Community	251	84%
Locked Facility: CDCR, Jail, Court, Other State Hospitals	31	10%
Deceased	0	0%
Other/Unknown	***	***%
Total Discharges	**298**	**100%**

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

[14] 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.

PC 2972 Inpatient Data

Patients committed as PC 2972 make up 51% of the OMD patients treated within inpatient programs. During FY 2024-25 DSH inpatient programs treated an average of 687 patients committed under PC 2972. The year began with an average census of 701 patients in July 2024 and ended with a lower average census of 671 patients in June 2025, reflecting a decrease of 4%. Overall, inpatient admission for PC 2972 patients fell by 15% and patients served decreased by 2% as compared to the prior year. Table 7 summarizes these year-over-year changes in inpatient admissions, patients served, and average daily census for PC 2972 patients.

Table 7: PC 2972 Inpatient Data Summary

PC 2972 Inpatient Data	FY 2023-24	FY 2024-25	Percent Change from Prior FY
Patient Admissions[15]	66	56	-15%
Patients Served[16]	720	708	-2%
Average Daily Census	712	687	-4%

DSH discharged 116 PC 2972 patients from inpatient programs, a 3% decrease from the prior year. Those discharged had an average length of stay of 1,588.5 days (4.4 years) and a median length of stay of 731.0 days (2.0 years). When looking at the duration of time of a PC 2972 patient in an inpatient treatment program, it shows that 35% discharged within the first year of their stay, 39% stay between two and five years, and the remaining 26% of patients stay longer than five years. Table 8 below depicts the distribution of PC 2972 patients discharged from inpatient programs in FY 2024-25 by length of stay.

Table 8: PC 2972 Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	35%
366 - 1,825 Days (2 - 5 years)	39%
1,826 - 3,650 days (5 - 10 years)	12%
3,651+ days (10+ years)	14%

Table 9 presents quarterly trends for PC 2972 patients in FY 2024-25. The average length of stay fluctuates throughout the year, reaching a high of 3,309.6 days (9.1 years) before dropping down to 1,620.0 days (4.4 years) in quarter 4. The annual average was 1,588.5 days (4.4 years), reflecting the discharge of long-stay patients who increased the overall average. In contrast, the median length of stay provides a clearer picture of a typical patient experience with length of stay ranging from less than one year to a little over three years, landing at an annual average of two years.

[15] Patient admissions include inpatient and outpatient program transfers.
[16] Patients served excludes inpatient and outpatient program transfers.

Table 9: PC 2972 Inpatient Length of Stay by Quarter

PC 2972 Inpatient Programs: Length of Stay Days (Years)	**Quarter 1** July to Sep 2024	**Quarter 2** Oct to Dec 2024	**Quarter 3** Jan to Mar 2025	**Quarter 4** Apr to June 2025	**Total**[17] FY 2024-25
Average Length of Stay	1,077.5 (3.0 yrs.)	1,215.3 (3.3 yrs.)	3,309.6 (9.1 yrs.)	1,620.0 (4.4 yrs.)	1,588.5 (4.4 yrs.)
Median Length of Stay	64.0 (0.2 yrs.)	854.0 (2.3 yrs.)	1,159.0 (3.2 yrs.)	734.5 (2.0 yrs.)	731.0 (2.0 yrs.)
Discharged Count	51	20	19	26	116

PC 2972 patients can be discharged to a variety of locations including outpatient treatment programs. Table 10 below displays the discharge location for 116 patients discharged in FY 2024-25. Majority of patients were discharged to a locked facility (45%) including another state hospital, jail, court or CDCR. The next largest category was out to the community (31%). The remaining patients were discharged to a community outpatient treatment or became deceased.

Table 10: PC 2972 Inpatient Discharges by Location[18]

PC 2972 OMD Inpatient Discharge Location	**Total** FY 2024-25	**Percent to Total**
Community Outpatient Treatment	***	***%
Discharged to Community	36	31%
Locked Facility: CDCR, DJJ, Jail, Court, Other State Hospitals	52	45%
Deceased	<11	***%
Other/Unknown	0	0%
Total Discharges	**116**	**100%**

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

[18] 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 2024-25, DSH CONREP treated on average 166 OMD designated patients daily and has gradually increased the OMD census throughout the year. CONREP began the year with an average census of 160 in July 2024 and ended the year with an average census of 176 patients in June 2025, a 10% increase. Table 11 summarizes these year-over-year changes in outpatient admissions, patients served, and average daily census for OMD patients.

Table 11: OMD Outpatient Data Summary

OMD Outpatient Data	FY 2023-24	FY 2024-25	Percent Change from Prior FY[19]
Patient Admissions[20]	50	54	8%
Patients Served[21]	167	176	5%
Average Daily Census	161	166	3%

DSH outpatient programs admitted 54 OMD patients in FY 2024-25 with an average of 14 admissions per quarter. Chart 4[22] displays outpatient program OMD admissions by quarter.

[19] Percent change from prior fiscal year is based on raw data, which has been rounded to whole numbers for display purposes.
[20] Patient admissions include inpatient and outpatient program transfers.
[21] Patients served excludes inpatient and outpatient program transfers.
[22] Data has been de-identified in accordance with the DSH Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. De-Identification Legend: Counts between 1-10 are masked with "<11". Complimentary masking is applied using "***" where further de-identification is needed.

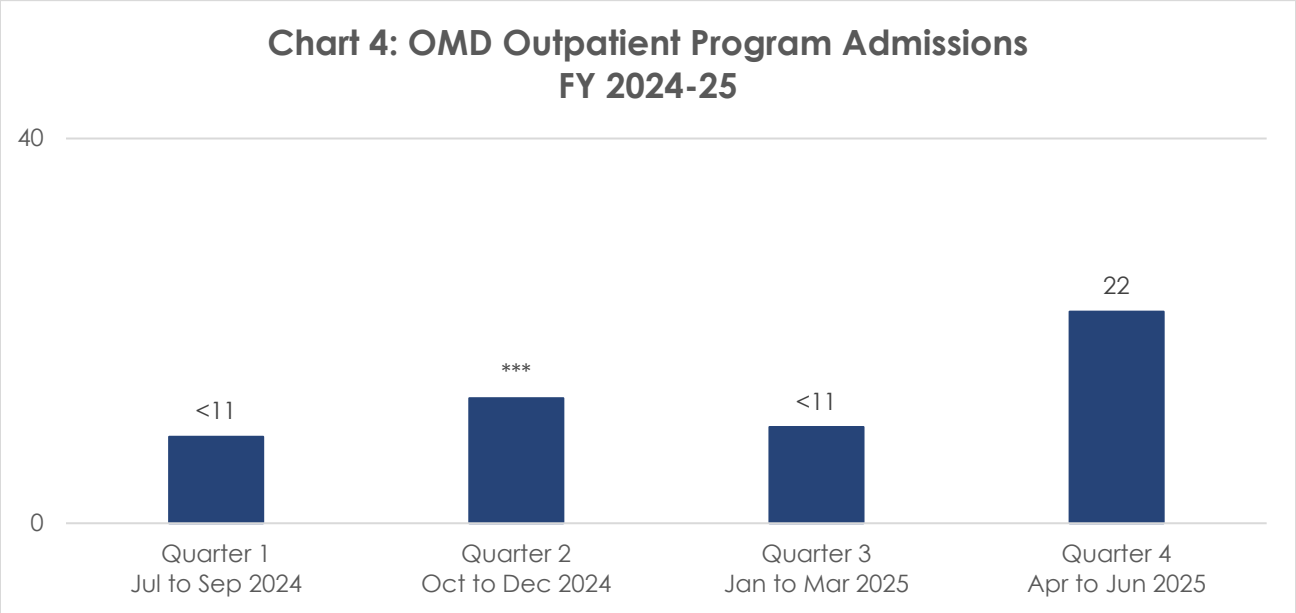


Table 12 below displays the number of OMD patients treated across the years in outpatient programs. The number of OMD patients treated annually in outpatient treatment has been increasing since FY 2021-22, reaching a peak of 176 in FY 2024-25, over a 22% increase.

Table 12: OMD Patients Served – Outpatient Programs[23]

Patients Treated/Served	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
	144	164	167	176

DSH discharged 50 OMD patients from outpatient programs with an average length of stay of 1,175.7 days (3.2 years) and a median length of stay of 570.0 days (1.6 years) across all outpatient programs. When looking at the duration of time on an OMD patient in an outpatient treatment program, it shows that 30% discharge within the first year of their stay, 26% discharge between one and two years, and 44% stayed beyond two years. Table 13 below depicts the distribution of OMD patients discharged from outpatient programs in FY 2024-25 by length of stay.

Table 13: OMD Outpatient Length of Stay Distribution

Length of Stay	% of Patients
0 - 365 Days (1 year)	30%
366 - 730 Days (1 – 2 years)	26%
730+ Days (2+ years)	44%

Table 14 displays outpatient length of stay by quarter for FY 2024-25.

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

Table 14: OMD Outpatient Length of Stay by Quarter[24]

OMD Outpatient Programs: Length of Stay Days (Years)	**Quarter 1** July to Sep 2024	**Quarter 2** Oct to Dec 2024	**Quarter 3** Jan to Mar 2025	**Quarter 4** Apr to June 2025	**Total[25]** FY 2024-25
Average Length of Stay	772.5 (2.1 yrs.)	2,053.7 (5.6 yrs.)	957.5 (2.6 yrs.)	940.5 (2.6 yrs.)	1,175.7 (3.2 yrs.)
Median Length of Stay	661.5 (1.8 yrs.)	1,026.0 (2.8 yrs.)	383.0 (1.0 yrs.)	552.0 (1.5 yrs.)	570.0 (1.6 yrs.)
Discharged Count	<11	***	***	24	50

[24] Data has been de-identified in accordance with the DSH Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. De-Identification Legend: Counts between 1-10 are masked with "<11". Complimentary masking is applied using "***" where further de-identification is needed.

[25] 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 probable 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 a 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

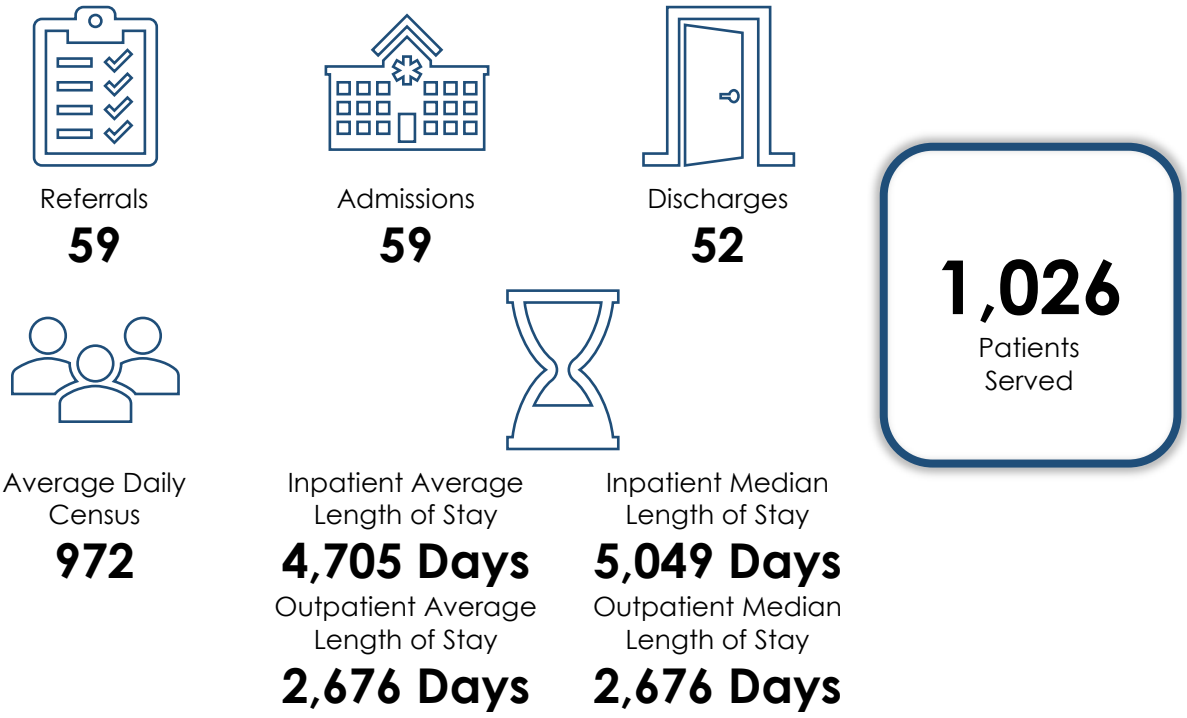
DSH provides treatment to SVP patients through inpatient care within state hospitals, at DSH-Coalinga (males) and DSH-Patton (females), and on an outpatient basis in CONREP.

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.

FY 2024-25 Population Data

The visual below provides a summary of the SVP patients for fiscal year (FY) 2024-25. DSH had 59 SVP referrals, 59 SVP admissions, and 52 SVP discharges in FY 2024-25 across its inpatient and outpatient programs. In total, DSH served 1,026 SVP patients and carried an average daily census of 972. Of the SVP patients that were discharged, DSH observed an average length of stay of 4,705 days and the median length of stay 5,049 days for inpatient programs. For outpatient programs DSH observed an average and median length of stay of 2,676 days.

FY 2024-25 SVP Patient Data Summary



Population Data Details

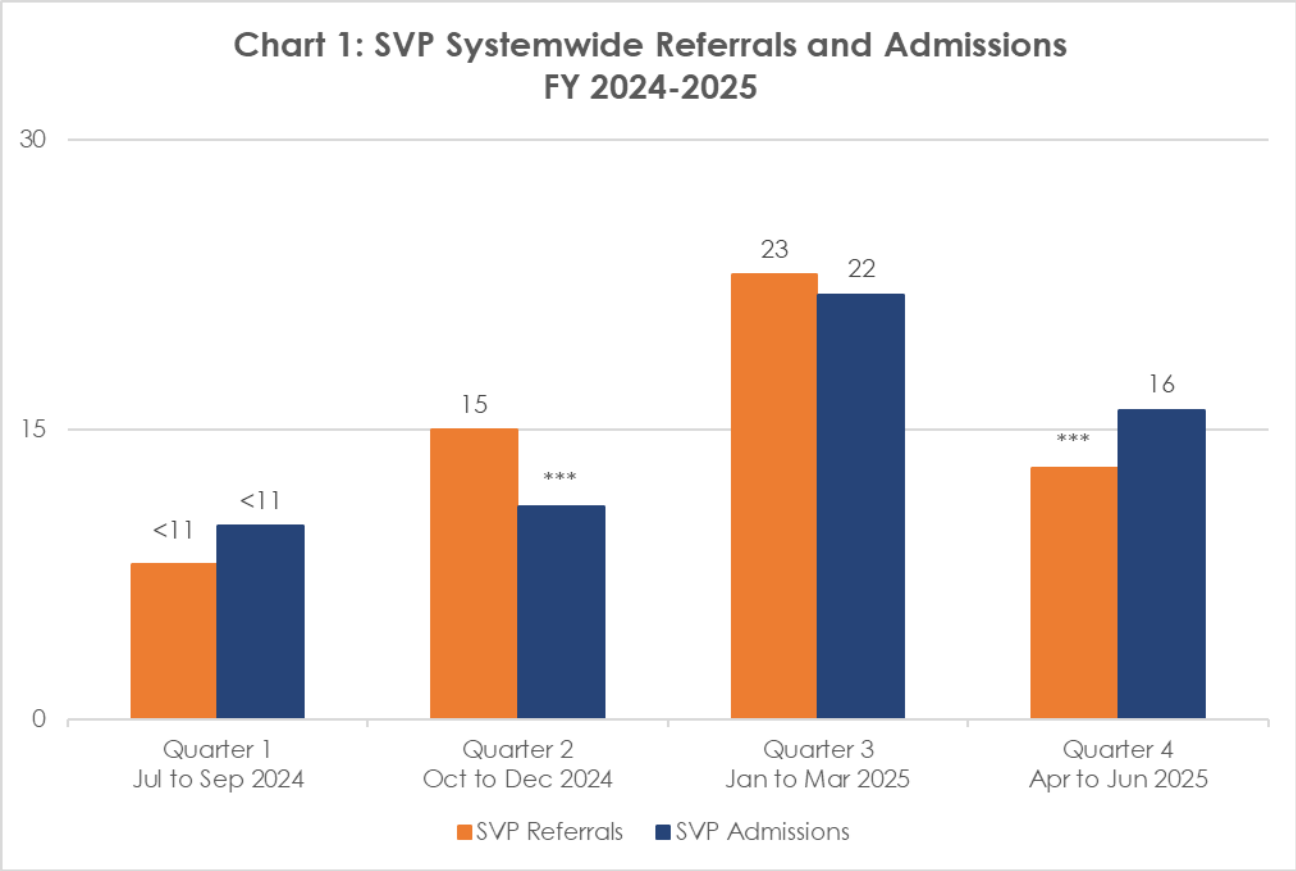
System-wide Metrics

In FY 2024-25 DSH served 1,026 patients committed as SVP across inpatient and outpatient programs, representing a 1% increase from the prior year. Patient referrals and admissions increased as well with a 40% increase in referrals and 31% increase in admissions. The average daily census has remained stable across the two years. Table 1 on the following page summarizes key statistics across the SVP population.

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

SVP Patient Data	FY 2023-24	FY 2024-25	Percent Change from Prior FY
Patient Referrals[2]	42	59	40%
Patient Admissions[3]	45	59	31%
Patients Served[4]	1,015	1,026	1%
Average Daily Census	974	972	0%

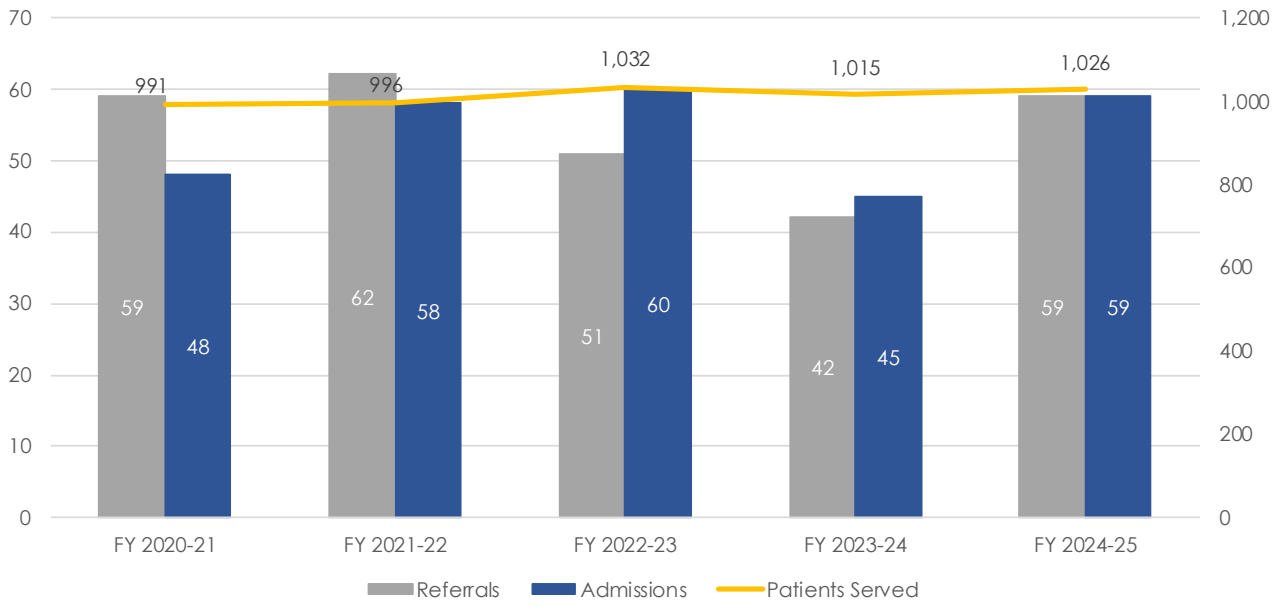
Chart 1[5] displays SVP system-wide referrals and admissions for FY 2024-25.



[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.
[2] Patient referrals exclude inpatient program transfers and court returns.
[3] Patient admissions exclude inpatient and outpatient program transfers.
[4] Patients served excludes inpatient and outpatient program transfers.
[5] Data has been de-identified in accordance with the DSH Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. De-Identification Legend: Counts between 1-10 are masked with "<11". Complimentary masking is applied using "***" where further de-identification is needed

Chart 2 displays a five-year period of referrals and admissions for a broader historic view[6]. A review of this data shows very gradual increases in total patients served. The number of referrals and admissions increased between FY 2020-21 and FY 2021-22, largely reflecting the incorporation of outpatient program data beginning with FY 2021-22. Examining just the last four years for a comparative analysis, the SVP population increased by 3%, reaching 1,026 in FY 2024-25.

Chart 2: SVP Systemwide Patients Served, Referrals and Admissions FY 2020-21 to FY 2024-25



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

Inpatient Program Metrics

Patients committed to DSH as SVP receive inpatient treatment at DSH-Coalinga. During FY 2024-25 DSH inpatient programs treated an average of 952 SVP-designated patients at DSH-Coalinga. The year began with an average daily census of 952 patients in July 2024 and ended slightly higher at 956 patients in June 2025, reflecting a less than 1% increase. Overall, inpatient admissions increased by 29% compared to the prior year, while the total number of patients served increased by 1%. A five-year trend of inpatient SVP patients served shows an increase of nearly 2% from 991 in FY 2020-21 to 1,007 in FY 2024-25. Table 2 summarizes year-over-year changes in inpatient admissions, patients served, and average daily census across the last two years.

Table 2: SVP Inpatient Data Summary

SVP Inpatient Data	FY 2023-24	FY 2024-25	Percent Change from Prior FY
Patient Admissions[8]	42	54	29%
Patients Served[9]	997	1,007	1%
Average Daily Census	955	952	0%

WIC 6602 Inpatient Data

Patients committed pursuant to WIC 6602 make up 43% of the SVP patients treated within inpatient programs. During FY 2024-25 DSH inpatient programs treated an average of 381 patients committed under WIC 6602. The year began with an average census of 379 patients in July 2024 and ended over 3% higher at 392 patients in June 2025. Overall, inpatient admissions for WIC 6602 patients increased by more than 50%, while the number of patients served increased by 2%. Table 3 summarizes these year-over-year changes in inpatient admissions, patients served, and average daily census for WIC 6602 patients.

Table 3: WIC 6602 Inpatient Data Summary[7]

WIC 6602 Inpatient Data	FY 2023-24	FY 2024-25	Percent Change from Prior FY
Patient Admissions[8]	30	***	***%
Patients Served[9]	418	428	2%

[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 exclude inpatient and outpatient program transfers.
[9] Patients served excludes inpatient and outpatient program transfers.

Average Daily Census	382	381	0%

DSH discharged 24 WIC 6602 patients from inpatient programs, a 4% decrease from the prior year. Those discharged had an average length of stay of 3,962.7 days (10.9 years) and a median length of stay of 4,006.5 days (11.0 years). Looking at the duration of time of a WIC 6602 patient in an inpatient treatment program, it shows that 46% discharged within ten years of their admission and 54% stayed beyond ten years.

Table 4: WIC 6602 Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 – 3,650 Days (0 – 10 years)	46%
3,651+ Days (10+ years)	54%

Table 5 reviews quarterly trends for WIC 6602 patients in FY 2024-25, highlighting length of stay and discharge activity. The average length of stay increased over the course of the year, starting with approximately 9.0 years in quarter 1 and increasing to approximately 13.5 years in quarter 4. The median length of stay followed a similar upward trend, from 9.4 years in quarter 1 to 16.0 years in quarter 4. Discharge counts across all four quarters have been fewer than 11 patients.

Table 5: WIC 6602 Inpatient Length of Stay by Quarter[10]

6602 Inpatient Programs: Length of Stay Days (Years)	**Quarter 1** Jul to Sep 2024	**Quarter 2** Oct to Dec 2024	**Quarter 3** Jan to Mar 2025	**Quarter 4** Apr to Jun 2025	**Total**[11] FY 2024-25
Average Length of Stay	3,292.8 (9.0 yrs.)	3,829.6 (10.5 yrs.)	3,770.5 (10.3 yrs.)	4,933.1 (13.5 yrs.)	3,962.7 (10.9 yrs.)
Median Length of Stay	3,417.0 (9.4 yrs.)	3,006.0 (8.2 yrs.)	4,004.5 (11.0 yrs.)	5,830.0 (16.0 yrs.)	4,006.5 (11.0 yrs.)
Discharged Count	<11	<11	<11	<11	24

WIC 6602 patients can be discharged to a variety of locations. Table 6 below displays discharge location for 24 patients discharged in FY 2024-25. Majority of patients were discharged to the community (46%). This includes patients that were conditionally and unconditionally discharged. The remaining patients were discharged to another unknown location or became deceased.

[10] 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.
[11] Totals are based on raw data, which have been rounded for display purposes.

Table 6: WIC 6602 Inpatient Discharges by Location[12]

6602 Inpatient Programs: Discharge Location	Total FY 2024-25	Percent to Total
Deceased	<11	***%
Discharged to Community	11	46%
Other/Unknown	<11	***%
Total Discharges	**24**	**100%**

WIC 6604 Inpatient Data

Patients committed pursuant to WIC 6604 make up 57% of the SVP patients treated within inpatient programs. During FY 2024-25 DSH inpatient programs treated an average of 571 patients committed under WIC 6604. The year began with an average census of 574 patients in July 2024 and ended 2% less at 565 patients in June 2025. Overall, inpatient admissions for WIC 6604 patients decreased by about 50%, while the number of patients served remained the same. Table 7 summarizes these year-over-year changes in inpatient admissions, patients served, and average daily census for WIC 6604 patients.

Table 7: WIC 6604 Inpatient Data Summary[13]

WIC 6604 Inpatient Data	FY 2023-24	FY 2024-25	Percent Change from Prior FY
Patient Admissions[14]	12	<11	***%
Patients Served[15]	579	579	0%
Average Daily Census	573	571	0%

DSH discharged 27 WIC 6604 patients from inpatient programs, a 29% increase from the prior year. Those discharged had an average length of stay of 5,365.1 days (4.7 years) and a median length of stay of 5,289.0 days (14.5 years). Looking at the duration of time of a WIC 6604 patient in an inpatient treatment program, it shows that most of the patients stay beyond ten years.

[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.
[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 exclude inpatient and outpatient program transfers.
[15] Patients served excludes inpatient and outpatient program transfers.

Table 8: WIC 6604 Inpatient Length of Stay Distribution

Length of Stay	% of Patients
0 – 3,650 Days (0 – 10 years)	19%
3,651+ Days (10+ years)	81%

Table 9 on the following page reviews quarterly trends for WIC 6604 patients in FY 2024-25, highlighting length of stay and discharge activity. The average length of stay ranged from a low of 13.2 years in quarter 3 to a high of 16.9 years in quarter 4, with an overall average of 14.7 years. The median length of stay followed a similar pattern, ranging from a low of 12.0 years in quarter 3 to a high of 18.6 years in quarter 4, resulting in an annual median of 14.5 years. Discharge counts remained low with fewer than 11 patients discharged per quarter and 27 discharges in total for the year. The data highlights the extremely long stays and limited turnover within the WIC 6604 population.

Table 9: WIC 6604 Inpatient Length of Stay by Quarter[16]

6604 Inpatient Programs: Length of Stay Days (Years)	**Quarter 1** Jul to Sep 2024	**Quarter 2** Oct to Dec 2024	**Quarter 3** Jan to Mar 2025	**Quarter 4** Apr to Jun 2025	**Total[17]** FY 2024-25
Average Length of Stay	5,755.0 (15.8 yrs.)	5,163.7 (14.1 yrs.)	4,828.6 (13.2 yrs.)	6,165.9 (16.9 yrs.)	5,365.1 (14.7 yrs.)
Median Length of Stay	5,372.0 (14.7 yrs.)	6,414.0 (17.6 yrs.)	4,388.0 (12.0 yrs.)	6,802.0 (18.6 yrs.)	5,289.0 (14.5 yrs.)
Discharged Count	<11	<11	<11	<11	27

WIC 6604 patients can be discharged to a variety of locations. Table 10 displays discharge location for 27 patients discharged in FY 2024-25. Majority of patients became deceased while the remaining were discharged to the community or to community outpatient treatment. Looking at a five-year trend, 21% of WIC 6604 patients get discharged to the community or community outpatient treatment.

[16] Data has been de-identified in accordance with the DSH Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. De-Identification Legend: Counts between 1-10 are masked with "<11". Complimentary masking is applied using "***" where further de-identification is needed

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

Table 10: WIC 6604 Inpatient Discharges by Location[18]

6604 Inpatient Programs: Discharge Location	Total FY 2024-25	Percent to Total
Community Outpatient Treatment	<11	***%
Discharged to Community[19]	<11	***%
Deceased	20	78%
Total Discharges	**27**	**100%**

Outpatient Program Metrics

CONREP is the DSH outpatient treatment program for patients committed as SVP. During FY 2024-25, DSH CONREP treated on average 20 SVP designated patients daily and has gradually increased the SVP census throughout the year. CONREP began the year with an average census of 19 in July 2024 and ended the year with an average census of 22 patients in June 2025, a 16% increase. Table 11 summarizes year-over-year changes in outpatient patients served and average daily census for SVP patients.

Table 11: SVP Patients Served – Outpatient Programs[20]

SVP Outpatient Programs Data	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
Admissions[21]	<11	<11	<11	<11
Patients Served[22]	15	19	18	19
Average Daily Census	17	21	19	20

DSH discharged fewer than 11 SVP patients from outpatient programs with an average length of stay of 2,676 days, 7.3 years. All the discharged patients stayed in an outpatient program for more than five years.

[18] Data has been de-identified in accordance with the DSH Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. De-Identification Legend: Counts between 1-10 are masked with "<11". Complimentary masking is applied using "***" where further de-identification is needed

[19] Fewer than 11 patients were conditionally discharged to the community.

[20] Data has been de-identified in accordance with the DSH Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. De-Identification Legend: Counts between 1-10 are masked with "<11". Complimentary masking is applied using "***" where further de-identification is needed

[21] Patient admissions exclude inpatient and outpatient program transfers.

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

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) 2024-25, DSH-Atascadero served 1,805 patients. The commitment categories of patients treated at DSH-Atascadero are as follows:

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

HOSPITAL STAFF

Approximately 2,206 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 seven 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 seven 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 Touro University California College of Pharmacy, California North State University, Loma Linda University (LLU), University of the Pacific (UOP), Western University of Health Science, Chapman University, and Marshall B. Ketchum.

[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) 2024-25, DSH-Coalinga served 1,445 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	PC 2972
Coleman/CDCR	PC 2684
Not Guilty by Reason of Insanity	PC 1026
Mentally Disordered Sex Offenders	WIC 6316/6331
Persons Designated as Sexually Violent Predators	WIC 6602/6604

HOSPITAL STAFF

Approximately 2,485 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 seven 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 •Art Therapy Internship Program •Music Therapy Internship Program
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.

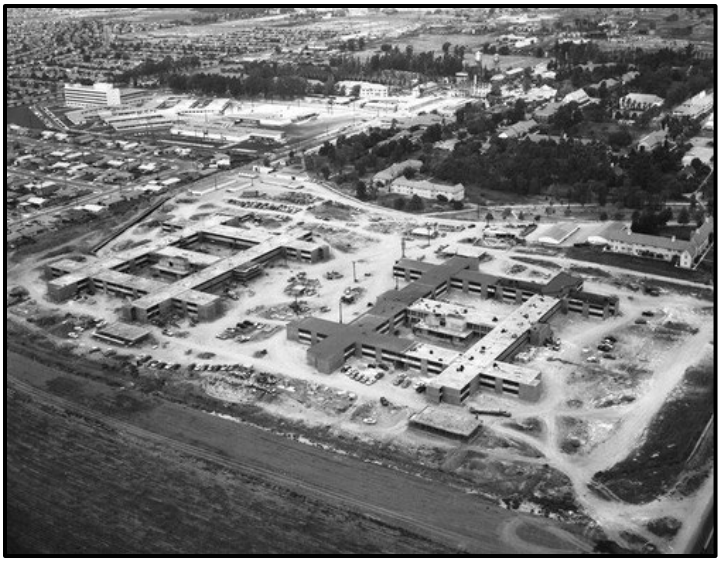
[2] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with seven pharmacy schools. The preceptor at each of the hospitals will communicate with the schools to determine when to send students for their clinical rotations. The contracted schools are Touro University California College of Pharmacy, California North State University, Loma Linda University (LLU), University of the Pacific (UOP), Western University of Health Science, Chapman University, and Marshall B. Ketchum.

[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) 2024-25, DSH-Metropolitan served 1,880 patients. The commitment categories of patients treated at DSH-Metropolitan are as follows:

Patient Commitments	Code Section
Incompetent to Stand Trial	PC 1370
Lanterman-Petris-Short	WIC 5000 Sec.
Offender with a Mental Health Disorder	PC 2972
Not Guilty by Reason of Insanity	PC 1026

HOSPITAL STAFF

Approximately 2,336 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 seven 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); CSU Northridge (Volunteer Positions); University of the Pacific; Berklee College of Music •Recreation Therapy (Volunteer Positions) CSU Long Beach internship; CSU Sacramento internship
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 seven 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 Touro University California College of Pharmacy, California North State University, Loma Linda University (LLU), University of the Pacific (UOP), Western University of Health Science, Chapman University, and Marshall B. Ketchum.

[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 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) 2024-25, DSH-Napa served 1,717 patients. The commitment categories of patients treated at DSH-Napa are as follows:

Patient Commitments	Code Section
Incompetent to Stand Trial	PC 1370
Lanterman-Petris-Short	WIC 5000 Sec.
Offender with a Mental Health Disorder	PC 2972
Not Guilty by Reason of Insanity	PC 1026
Recommitment After Expiration of Prison Term (Must have concurrent W&I commitment)	PC 2974

HOSPITAL STAFF

Approximately 2,684 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 seven pharmacy schools.
Psychiatric Technicians [2]	•Psychiatric Technician Apprentice •Pre-Licensed Psychiatric Technicians •Psychiatric Technician Programs Clinical Rotation
Psychiatry	•UC Davis, Psychiatry and Law •Touro University •Clinical Clerkships for Medical School Graduates •Residency Program with St. Joseph Medical Center •PGY-4 Psychiatry resident rotations with Oakland Kaiser Permanente Residency Program •Psychiatry Geriatric Fellowship rotations
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 seven 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 Touro University California College of Pharmacy, California North State University, Loma Linda University (LLU), University of the Pacific (UOP), Western University of Health Science, Chapman University, and Marshall B. Ketchum.

[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) 2024-25, DSH-Patton served 2,024 patients. The commitment categories of patients treated at DSH-Patton are as follows:

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

HOSPITAL STAFF

Approximately 2,611 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 constellation 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.

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.

DSH-Patton also treats civilly committed patients under the Lanterman-Petris-Short (LPS) Act, with treatment focused on increasing independent living skills and activities of daily living, while also decreasing impulsivity and the risk of violence, so that they may be safely treated in the community.

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 modeling an environment of safety and security for all patients, staff, and the community in an atmosphere of dignity and respect.

Enhanced Treatment Program (ETP)

The ETP is designed to provide enhanced treatment in a secure setting for patients at the highest risk of most dangerous behavior. The ETP is intended to provide increased therapy opportunities within a structured, least restrictive environment. The ETP is to be utilized when safe treatment is not possible in a standard treatment environment 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. The Budget Act of 2024 reported the project had been rephased and a critical milestone was reached that gained State Fire Marshal approval allowing the project to continue unimpeded. Estimated construction completion is projected for April 2025.

The ETP model allows enhanced treatment, staffing, and security and implements admissions and treatment planning processes to identify and address patients' violence risk factors. The ETP model also 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 Psychiatric Museum

In 2025, the DSH-Patton Museum proudly celebrates its 10th anniversary. Over the past decade, the museum has proven to be a vital extension to the hospital's mission, serving as educational and cultural resources for the community. It has welcomed community members, students, mental health professionals, authors, and researchers, offering them an opportunity to better understand the 132 years of history and service provided by Patton State Hospital.

The museum preserves and presents a unique collection of artifacts that not only highlight the hospital's history, but also reflects the broader, complex story of psychiatry. By doing so, it creates space for transparency, dialogue and education about past psychiatric practices, some of which are no longer in use, but remain important to remember and learn from. Recently, the museum has hosted several high school groups, giving students the opportunity to learn directly from professionals across fields such as law enforcement, social work, rehabilitation, psychology, and psychiatry. These experiences allow young people to connect history with modern practices and gain meaningful insights into the diverse roles that support forensic mental health care today. Overall, the museum's approach is thoughtful and honest, helping visitors confront difficult histories while reinforcing today's values of dignity, respect, and the reduction of stigma surrounding mental illness.

Most importantly, the museum bridges the past with the present. It underscored our hospital's ongoing commitment to compassionate care, while offering a lens through which visitors can understand how mental health services have evolved. The DSH-Patton Museum is not just a record of history, it is a living tool for education, awareness, and community engagement, aligning directly with our mission and values.

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 is licensed as an Acute Psychiatric Hospital (APH) by the California Department of Public Health (CDPH)– Licensing and Certification Unit governed by the provisions of the Health and Safety Code of California/Title 22 (California Code of Regulations) and its requirements to operate and maintain Acute Psychiatric Care and Intermediate Care bed classifications. DSH-Patton meets the APH definition by demonstrating a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders, including medical, nursing, rehabilitative, pharmacy, and dietary services. DSH-Patton is licensed to provide services for 1,287 patients, and with additional housing not to exceed total 1,530 patient beds, in adherence to the Welfare and Institutions Code, Section 4107 (c) defining the joint plan between the California Department of Corrections and Rehabilitation and the Department of State Hospitals DSH-Patton's licensing operation also includes Physical Therapy, Radiological Services, Social Services, and Speech Pathology. The hospital maintains licensure through frequent on-site surveys that include a robust review on the hospital's safety, environment, effectiveness, and quality of healthcare, every three years for Acute units and two years for Intermediate Care units. Communication, education, performance improvement studies, quality improvement analysis, and risk management awareness and interventions are additional priorities to the hospital's continued emphasis for optimal patient care and treatment.

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 seven 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 seven 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 Touro University California College of Pharmacy, California North State University, Loma Linda University (LLU), University of the Pacific (UOP), Western University of Health Science, Chapman University, and Marshall B. Ketchum.

[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 2025-26

January 10, 2026






DIRECTOR
Stephanie Clendenin

EXECUTIVE SUMMARY

Pursuant of the Budget Act of 2025, 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 2025 which requires DSH to provide a year-end summary and an operating budget for each state hospital with the fiscal year (FY) 2026-27 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 2024-25 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 Treatment Programs (JBTP), 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 to over 7,500 patients, in FY 2024-25, DSH served over 13,800 patients, with 8,871 served across the state hospitals, 1,995 in JBTP, 723 in CIF, 899 in CBR contracted programs, 567 in Diversion contracted programs, and 824 in CONREP programs. 11,589 individuals were treated within a DSH inpatient program and 2,290 served through DSH's outpatient programs. Through Early Access Stabilization (EASS) and Re-evaluation services, during FY 2024-25 DSH initiated services for 3,554 patients in EASS, and off ramped 77 through DSH's Re-evaluation program. In addition, during FY 2024-25, 28 individuals were diverted into county programs funded by DSH.

SUMMARY OF AUTHORIZED AND VACANT POSITIONS

The following table provides a summary of the authorized and vacant positions for the state hospital system as of November 1, 2025.

State Hospital	Authorized Positions	Vacant as of 11/1/2025	Vacancy[1] Percent
Atascadero	2,196.4	439.6	20.0%
Coalinga	2,444.2	434.6	17.8%
Metropolitan	2,195.6	333.7	15.2%
Napa	2,568.2	476.4	18.5%
Patton	2,525.1	213.2	8.4%
Totals	**11,929.5**	**1,897.5**	**15.9%**

[1] 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 2026-27 Governor's Budget Estimate.

AUTHORIZED VERSUS VACANT POSITIONS BY CLASSIFICATION

As of November 1, 2025, DSH's vacancy rate is 15.9 percent. Item 4440-011-0001, Provision 9 requires DSH to provide the number of authorized and vacant classifications, including psychiatric technicians, nurses, physicians, psychiatrists, social workers, and rehabilitation therapists. The following table provides a summary of the authorized and vacant positions for those classifications.

		Atascadero		Coalinga		Metropolitan		Napa		Patton	
Class Title	Class Code	Authorized	Vacant	Authorized	Vacant	Authorized	Vacant	Authorized	Vacant	Authorized	Vacant
Staff Psychiatrist	7619	35.5	21.5	22.7	8.7	59.6	17.6	53.8	2.1	64.7	6.5
Psychologist	9873	41.5	6.5	32.7	19.7	42.0	9.0	49.4	0.9	58.4	9.8
Senior Psychiatric Technician	8252	97.5	11.5	92.0	9.0	78.8	22.8	80.0	11.0	87.0	0.0
Rehabilitation Therapist	Various	48.5	7.5	42.7	5.7	56.8	14.2	63.4	1.8	72.0	8.0
Registered Nurse	8094	232.6	34.6	229.0	9.2	290.7	7.7	480.2	23.3	364.1	19.1
Clinical Social Worker	9872	44.7	11.7	43.7	18.7	61.1	12.1	60.6	4.1	71.2	3.7
Psychiatric Technician	8253	637.4	187.4	683.9	189.9	486.9	117.9	412.9	150.4	741.7	56.7
Physician/Surgeon	7552	17.5	1.0	25.0	15.5	25.2	1.8	26.7	0.7	31.0	2.0

TEMPORARY HELP BLANKET POSITIONS

Temporary help blanket positions are utilized to offset vacancies and overtime. The following table provides a summary of authorized temporary help blanket positions for the state hospitals as of November 1, 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 2024-25. For FY 2025-26 and FY 2026-27, 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]

		2024-25 Budget	2024-25 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$893,468,000	$883,693,000
	5100150-Earnings - Temporary Civil Service Employees	$30,874,000	$30,599,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$136,384,000	$135,143,000
Salaries and Wages Total		**$1,060,726,000**	**$1,049,435,000**
Staff Benefits	5150150-Dental Insurance	$1,039,000	$1,028,000
	5150200-Disability Leave – Industrial	$14,817,000	$14,680,000
	5150210-Disability Leave - Nonindustrial	$3,764,000	$3,714,000
	5150350-Health Insurance	$29,167,000	$28,830,000
	5150400-Life Insurance	$66,000	$66,000
	5150450-Medicare Taxation	$15,062,000	$14,900,000
	5150500-OASDI	$7,534,000	$7,446,000
	5150600-Retirement – General	$192,195,000	$190,106,000
	5150620-Retirement - Public Employees - Safety	$1,000	$1,000
	5150700-Unemployment Insurance	$457,000	$453,000
	5150750-Vision Care	$221,000	$218,000
	5150800-Workers' Compensation	$69,817,000	$69,069,000
	5150900-Staff Benefits – Other	$172,613,000	$170,731,000
Staff Benefits Total		**$506,753,000**	**$501,242,000**
Operating Expenses and Equipment	5301400-Goods – Other	$4,603,000	$4,546,000
	5302900-Printing – Other	$854,000	$847,000
	5304800-Communications – Other	$1,749,000	$1,730,000
	5306700-Postage – Other	$166,000	$164,000
	5308900-Insurance – Other	$836,000	$824,000
	5320490-Travel - In State – Other	$1,811,000	$1,792,000
	5320890-Travel - Out of State - Other	$7,000	$7,000
	5322400-Training - Tuition and Registration	$1,362,000	$1,346,000
	5324350-Rents and Leases	$35,939,000	$35,414,000
	5326900-Utilities – Other	$26,697,000	$26,423,000
	5340330-Consulting and Professional Services – Inter - Other	$4,047,000	$3,999,000
	5340580-Consulting and Professional Services - Ext - Other	$177,789,000	$176,258,000
	5344000-Consolidated Data Centers	$82,000	$80,000
	5346900-Information Technology - Other	$103,000	$101,000
	5368115-Office Equipment	$16,407,000	$16,210,000
	5390900-Other Items of Expense - Miscellaneous	$104,099,000	$103,118,000
	5415000-Claims Against the State	$10,000	$10,000
	5490000-Other Special Items of Expense	$2,696,000	$2,682,000
	5342600-Departmental Services - Other	$2,000	$2,000
Operating Expenses and Equipment Total		**$379,259,000**	**$375,553,000**
Grand Total		**$1,946,738,000**	**$1,926,230,000**

[1]Budget and expenditure do not include reimbursements or reappropriations.

Exhibit I—Atascadero State Hospital[2]

		2024-25 Budget	2024-25 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$167,359,000	$162,685,000
	5100150-Earnings - Temporary Civil Service Employees	$3,164,000	$3,075,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$19,796,000	$19,244,000
Salaries and Wages Total		**$190,319,000**	**$185,004,000**
Staff Benefits	5150150-Dental Insurance	$177,000	$173,000
	5150200-Disability Leave - Industrial	$1,674,000	$1,627,000
	5150210-Disability Leave - Nonindustrial	$1,308,000	$1,272,000
	5150350-Health Insurance	$6,083,000	$5,913,000
	5150400-Life Insurance	$13,000	$13,000
	5150450-Medicare Taxation	$2,726,000	$2,650,000
	5150500-OASDI	$1,681,000	$1,634,000
	5150600-Retirement - General	$35,592,000	$34,598,000
	5150700-Unemployment Insurance	$112,000	$109,000
	5150750-Vision Care	$45,000	$44,000
	5150800-Workers' Compensation	$13,848,000	$13,462,000
	5150900-Staff Benefits - Other	$30,670,000	$29,814,000
Staff Benefits Total		**$93,929,000**	**$91,309,000**
Operating Expenses and Equipment	5301400-Goods - Other	$841,000	$818,000
	5302900-Printing - Other	$149,000	$145,000
	5304800-Communications - Other	$542,000	$527,000
	5306700-Postage - Other	$39,000	$38,000
	5308900-Insurance - Other	$134,000	$130,000
	5320490-Travel - In State - Other	$374,000	$363,000
	5322400-Training - Tuition and Registration	$241,000	$234,000
	5324350-Rents and Leases	$13,057,000	$12,693,000
	5326900-Utilities - Other	$3,805,000	$3,698,000
	5340330-Consulting and Professional Services – Inter - Other	$802,000	$779,000
	5340580-Consulting and Professional Services - Ext - Other	$31,827,000	$30,937,000
	5344000-Consolidated Data Centers	$58,000	$56,000
	5346900-Information Technology - Other	$85,000	$83,000
	5368115-Office Equipment	$2,319,000	$2,254,000
	5390900-Other Items of Expense - Miscellaneous	$16,843,000	$16,373,000
	5415000-Claims Against the State	$2,000	$2,000
	5490000-Other Special Items of Expense	$175,000	$170,000
	5342600-Departmental Services - Other	$2,000	$2,000
Operating Expenses and Equipment Total		**$71,295,000**	**$69,302,000**
Grand Total		**$355,543,000**	**$345,615,000**

[2]Budget and expenditure do not include reimbursements or reappropriations.

Exhibit I—Coalinga State Hospital[3]

		2024-25 Budget	2024-25 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$173,372,000	$173,042,000
	5100150-Earnings - Temporary Civil Service Employees	$795,000	$793,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$30,991,000	$30,932,000
Salaries and Wages Total		**$205,158,000**	**$204,767,000**
Staff Benefits	5150150-Dental Insurance	$240,000	$240,000
	5150200-Disability Leave - Industrial	$4,322,000	$4,314,000
	5150210-Disability Leave - Nonindustrial	$940,000	$938,000
	5150350-Health Insurance	$6,167,000	$6,155,000
	5150400-Life Insurance	$15,000	$15,000
	5150450-Medicare Taxation	$2,887,000	$2,881,000
	5150500-OASDI	$1,912,000	$1,908,000
	5150600-Retirement - General	$39,475,000	$39,399,000
	5150620-Retirement - Public Employees - Safety	$1,000	$1,000
	5150700-Unemployment Insurance	$129,000	$129,000
	5150750-Vision Care	$45,000	$45,000
	5150800-Workers' Compensation	$15,015,000	$14,986,000
	5150900-Staff Benefits - Other	$33,888,000	$33,823,000
Staff Benefits Total		**$105,036,000**	**$104,834,000**
Operating Expenses and Equipment	5301400-Goods - Other	$590,000	$589,000
	5302900-Printing - Other	$248,000	$248,000
	5304800-Communications - Other	$795,000	$793,000
	5306700-Postage - Other	$21,000	$21,000
	5308900-Insurance - Other	$59,000	$59,000
	5320490-Travel - In State - Other	$496,000	$495,000
	5320890-Travel - Out of State - Other	$7,000	$7,000
	5322400-Training - Tuition and Registration	$192,000	$192,000
	5324350-Rents and Leases	$3,809,000	$3,802,000
	5326900-Utilities - Other	$5,484,000	$5,473,000
	5340330-Consulting and Professional Services – Inter - Other	$264,000	$263,000
	5340580-Consulting and Professional Services - Extl - Other	$69,083,000	$68,950,000
	5344000-Consolidated Data Centers	$1,000	$1,000
	5346900-Information Technology - Other	$5,000	$5,000
	5368115-Office Equipment	$3,457,000	$3,450,000
	5390900-Other Items of Expense - Miscellaneous	$26,596,000	$26,545,000
	5415000-Claims Against the State	$5,000	$5,000
	5490000-Other Special Items of Expense	$1,022,000	$1,020,000
Operating Expenses and Equipment Total		**$112,134,000**	**$111,918,000**
Grand Total		**$422,328,000**	**$421,519,000**

[3]Budget and expenditure do not include reimbursements or reappropriations.

Exhibit I—Metropolitan State Hospital[4]

		2024-25 Budget	2024-25 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$152,739,000	$149,215,000
	5100150-Earnings - Temporary Civil Service Employees	$5,829,000	$5,694,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$18,303,000	$17,880,000
Salaries and Wages Total		**$176,871,000**	**$172,789,000**
Staff Benefits	5150150-Dental Insurance	$188,000	$183,000
	5150200-Disability Leave - Industrial	$2,173,000	$2,123,000
	5150210-Disability Leave - Nonindustrial	$378,000	$369,000
	5150350-Health Insurance	$4,906,000	$4,792,000
	5150400-Life Insurance	$11,000	$11,000
	5150450-Medicare Taxation	$2,525,000	$2,467,000
	5150500-OASDI	$1,139,000	$1,112,000
	5150600-Retirement - General	$32,621,000	$31,868,000
	5150700-Unemployment Insurance	$24,000	$24,000
	5150750-Vision Care	$37,000	$36,000
	5150800-Workers' Compensation	$10,009,000	$9,778,000
	5150900-Staff Benefits - Other	$30,359,000	$29,658,000
Staff Benefits Total		**$84,370,000**	**$82,421,000**
Operating Expenses and Equipment	5301400-Goods - Other	$1,157,000	$1,130,000
	5302900-Printing - Other	$135,000	$132,000
	5304800-Communications - Other	$65,000	$64,000
	5306700-Postage - Other	$19,000	$19,000
	5308900-Insurance – Other	$265,000	$259,000
	5320490-Travel - In State – Other	$274,000	$268,000
	5322400-Training - Tuition and Registration	$320,000	$312,000
	5324350-Rents and Leases	$3,830,000	$3,742,000
	5326900-Utilities – Other	$4,225,000	$4,128,000
	5340330-Consulting and Professional Services – Inter - Other	$632,000	$618,000
	5340580-Consulting and Professional Services - Ext - Other	$8,653,000	$8,454,000
	5344000-Consolidated Data Centers	$8,000	$8,000
	5346900-Information Technology – Other	$2,000	$2,000
	5368115-Office Equipment	$4,499,000	$4,395,000
	5390900-Other Items of Expense - Miscellaneous	$13,504,000	$13,192,000
	5415000-Claims Against the State	$1,000	$1,000
	5490000-Other Special Items of Expense	$107,000	$104,000
Operating Expenses and Equipment Total		**$37,696,000**	**$36,828,000**
Grand Total		**$298,937,000**	**$292,038,000**

[4]Budget and expenditure do not include reimbursements or reappropriations.

Exhibit I—Napa State Hospital[5]

		2024-25 Budget	2024-25 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$180,674,000	$179,516,000
	5100150-Earnings - Temporary Civil Service Employees	$6,708,000	$6,665,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$29,882,000	$29,690,000
Salaries and Wages Total		**$217,264,000**	**$215,871,000**
Staff Benefits	5150150-Dental Insurance	$227,000	$225,000
	5150200-Disability Leave - Industrial	$4,841,000	$4,810,000
	5150210-Disability Leave - Nonindustrial	$565,000	$562,000
	5150350-Health Insurance	$6,097,000	$6,058,000
	5150400-Life Insurance	$12,000	$12,000
	5150450-Medicare Taxation	$3,125,000	$3,105,000
	5150500-OASDI	$1,358,000	$1,349,000
	5150600-Retirement - General	$38,469,000	$38,222,000
	5150700-Unemployment Insurance	$154,000	$153,000
	5150750-Vision Care	$44,000	$43,000
	5150800-Workers' Compensation	$14,889,000	$14,793,000
	5150900-Staff Benefits - Other	$38,025,000	$37,781,000
Staff Benefits Total		**$107,806,000**	**$107,113,000**
Operating Expenses and Equipment	5301400-Goods - Other	$924,000	$918,000
	5302900-Printing - Other	$13,000	$13,000
	5304800-Communications - Other	$176,000	$175,000
	5306700-Postage - Other	$46,000	$45,000
	5308900-Insurance - Other	$324,000	$322,000
	5320490-Travel - In State - Other	$250,000	$249,000
	5322400-Training - Tuition and Registration	$263,000	$262,000
	5324350-Rents and Leases	$9,935,000	$9,871,000
	5326900-Utilities - Other	$8,791,000	$8,734,000
	5340330-Consulting and Professional Services – Inter - Other	$1,539,000	$1,529,000
	5340580-Consulting and Professional Services - Ext - Other	$46,713,000	$46,414,000
	5346900-Information Technology - Other	$8,000	$8,000
	5368115-Office Equipment	$3,111,000	$3,091,000
	5390900-Other Items of Expense - Miscellaneous	$21,582,000	$21,444,000
	5415000-Claims Against the State	$2,000	$2,000
	5490000-Other Special Items of Expense	$579,000	$575,000
Operating Expenses and Equipment Total		**$94,256,000**	**$93,652,000**
Grand Total		**$419,326,000**	**$416,636,000**

[5]Budget and expenditure do not include reimbursements or reappropriations.

Exhibit I—Patton State Hospital[6]

		2024-25 Budget	2024-25 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$219,324,000	$219,235,000
	5100150-Earnings - Temporary Civil Service Employees	$14,378,000	$14,372,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$37,412,000	$37,397,000
Salaries and Wages Total		**$271,114,000**	**$271,004,000**
Staff Benefits	5150150-Dental Insurance	$207,000	$207,000
	5150200-Disability Leave - Industrial	$1,807,000	$1,806,000
	5150210-Disability Leave - Nonindustrial	$573,000	$573,000
	5150350-Health Insurance	$5,914,000	$5,912,000
	5150400-Life Insurance	$15,000	$15,000
	5150450-Medicare Taxation	$3,799,000	$3,797,000
	5150500-OASDI	$1,444,000	$1,443,000
	5150600-Retirement - General	$46,038,000	$46,019,000
	5150700-Unemployment Insurance	$38,000	$38,000
	5150750-Vision Care	$50,000	$50,000
	5150800-Workers' Compensation	$16,056,000	$16,050,000
	5150900-Staff Benefits - Other	$39,671,000	$39,655,000
Staff Benefits Total		**$115,612,000**	**$115,565,000**
Operating Expenses and Equipment	5301400-Goods - Other	$1,091,000	$1,091,000
	5302900-Printing - Other	$309,000	$309,000
	5304800-Communications - Other	$171,000	$171,000
	5306700-Postage - Other	$41,000	$41,000
	5308900-Insurance - Other	$54,000	$54,000
	5320490-Travel - In State - Other	$417,000	$417,000
	5322400-Training - Tuition and Registration	$346,000	$346,000
	5324350-Rents and Leases	$5,308,000	$5,306,000
	5326900-Utilities - Other	$4,392,000	$4,390,000
	5340330-Consulting and Professional Services – Inter - Other	$810,000	$810,000
	5340330-Consulting and Professional Services – Ext - Other	$21,513,000	$21,503,000
	5344000-Consolidated Data Centers	$15,000	$15,000
	5346900-Information Technology - Other	$3,000	$3,000
	5368115-Office Equipment	$3,021,000	$3,020,000
	5390900-Other Items of Expense - Miscellaneous	$25,574,000	$25,564,000
	5490000-Other Special Items of Expense	$813,000	$813,000
Operating Expenses and Equipment Total		**$63,878,000**	**$63,853,000**
Grand Total		**$450,604,000**	**$450,422,000**

[6]Budget and expenditure do not include reimbursements or reappropriations.

Exhibit II—All Hospitals[7]

	2025-26 Budget	2026-27 Budget	2025-26 Projected Expenditure	2026-27 Projected Expenditure
4410010-Atascadero	$381,481,000	$384,347,000	$377,666,000	$380,504,000
4410020-Coalinga	$427,136,000	$433,693,000	$422,865,000	$429,356,000
4410030-Metro	$271,171,000	$277,266,000	$268,459,000	$274,493,000
4410040-Napa	$418,102,000	$421,570,000	$413,921,000	$417,354,000
4410050-Patton	$451,541,000	$456,825,000	$447,026,000	$452,257,000
Grand Total	**$1,949,431,000**	**$1,973,701,000**	**$1,929,937,000**	**$1,953,964,000**

[7]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 2025 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 2026-27 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 2025-26 fiscal year, the projected attrition rate for the 2026-27 fiscal year, and the rate of success pertaining to the number of hospital police officer cadet graduates of the OPS Police Academy."

Hospital Police Officer Positions

The table below displays the status of Hospital Police Officers (HPO) authorized positions as of November 1, 2025:

HPO Authorized Positions[1] as of November 1, 2025				
Hospitals	Filled	Vacant	FTE[2]	Vacancy Rate
Atascadero	98.0	31.9	129.9	24.56%
Coalinga	199.0	22.0	221.0	9.95%
Metropolitan	128.0	8.1	136.1	5.95%
Napa	106.0	52.9	158.9	33.29%
Patton	73.0	3.5	76.5	4.58%
Total	**604.0**	**118.4**	**722.4**	**16.39%**

Hospital Police Officer Attrition Rate

The table below displays the projected HPO attrition rates as of November 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 November 2025

HPO Attrition Rates as of November 1, 2025					
Hospitals	FY 2025-26 FTE[3]	FY 2025-26 Attrition Rate[4]	Average Estimated Monthly Positions	FY 2026-27 Attrition Rate[5]	Average Estimated Monthly Positions
Atascadero	129.9	1.41%	1.8	1.33%	1.7
Coalinga	221.0	0.81%	1.8	0.62%	1.4
Metropolitan	136.1	0.61%	0.8	0.76%	1.0
Napa	158.9	0.94%	1.5	0.86%	1.4
Patton	76.5	0.92%	0.7	0.86%	0.7
Total	**722.4**	**0.91%**	**6.6**	**0.86%**	**6.2**

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 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%
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%

[3] Authorized Positions as of November 2025
[4] Projected attrition rate based on FY 2023-24, 2024-25, and 2025-26 data
[5] Projected attrition rate based on FY 2024-25, 2025-26, and 2026-27 data

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	36	81.8%
Academy 49	(08/25/25 – 12/11/25)	41	TBD	TBD
	Total[6]	**211**	**170**	**80.6%**

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 November 1, 2025, DSH has received 2,437 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 41 cadets into the Academy.

In recent years, DSH has seen an increase in the number of cadets enrolled in the HPO academy and lower vacancy rates in HPO positions as a result of these recruitment efforts. The overall DSH vacancy rate for HPO positions decreased from 21.7% on November 1, 2022 to 16% as of October 1, 2025.

[6] Total does not include Academy 49
[7] Data from January 2, 2023, to August 2, 2023

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

EXECUTIVE SUMMARY

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

DSH was originally authorized to establish four ETP units, totaling 49 beds. Three 13-bed units were to be provided at DSH-Atascadero, and one 10-bed treatment unit would be at DSH-Patton. One unit at DSH-Atascadero began admitting patients on September 14, 2021. As the remaining three units are not yet completed or activated, this report covers activity for the operation of the first activated ETP unit at DSH-Atascadero, in accordance with reporting requirements established in AB 1340.[1]

The current reporting period ranges from October 1, 2024, to September 30, 2025. For comparison, the report also presents cumulative data from activation of the ETP on September 14, 2021, up to the end of the current reporting period. The data reflects patient characteristics including gender, ethnicity, age on admission, legal group, and years at DSH. Data also includes information on staffing requirements, staff-to-patient ratios, as well as staff turnover. Data on restraint and seclusion use and serious injuries is also provided. The report also includes information regarding patients' rights complaints received as provided by the Disability Rights California, California Office of Patients' Rights, and the resolution to these issues. Finally, the report includes information regarding training provided to ETP staff, as well as the training offered to staff who are primarily assigned to other units but could be asked to provide support in the ETP.

Recommendations based on the findings are outlined at the conclusion of this report.

[1] Status updates on the construction and activation of each ETP unit is provided in the ETP Staffing estimate (see Section C3).

BACKGROUND

Assembly Bill 1340 (Achadjian, Statutes of 2014) authorized DSH to establish a pilot ETP for those patients determined to be at highest risk for severe physical violence against other patients and hospital staff, and who cannot be safely treated in a standard treatment environment. The ETP provides treatment and support intended to return patients to a standard treatment environment and prevent future aggression, while increasing safety in the facility and protecting patients and staff from harm. As such, the ETP provides enhanced treatment, staffing, security, and implements admissions and treatment planning processes to identify and address patients' violence risk factors.

This report covers program activity since activation of the first activated ETP unit at DSH-Atascadero, in accordance with reporting criteria established in AB 1340. Specifically, Section 4145 of the Welfare and Institutions Code reads:

> *4145. (a) The State Department of State Hospitals shall monitor the pilot enhanced treatment programs (ETP), evaluate outcomes, and report on its findings and recommendations. This report shall be provided to the fiscal and policy committees of the Legislature annually, beginning on January 10 of the first year after which the first ETP is opened and services have commenced, and shall be in compliance with Section 9795 of the Government Code. The evaluation shall include, but is not limited to, all of the following:*
>
> *(1) Comparative summary information regarding the characteristics of the patients served.*
> *(2) Compliance with staffing requirements.*
> *(3) Staff classification to patient ratio.*
> *(4) Average monthly occupancy.*
> *(5) Average length of stay.*
> *(6) The number of residents whose length of stay exceeds 90 days.*
> *(7) The number of patients with multiple stays.*
> *(8) The number of patients whose discharge was delayed due to lack of available beds in a standard treatment environment.*
> *(9) Restraint and seclusion use, including the number of incidents and duration, consistent with paragraph (3) of subdivision (d) of Section 1180.2 of the Health and Safety Code.*
> *(10) Serious injuries to staff and residents.*
> *(11) Serious injuries to staff and residents related to the use of seclusion and restraints as defined under Section 1180 of the Health and Safety Code.*
> *(12) Staff turnover.*
> *(13) The number of patients' rights complaints, including the subject of the complaint and its resolution.*
> *(14) Type and number of trainings provided for ETP staff.*

(15) Staffing levels for ETPs.

In response to the reporting requirements as identified in Section 4145, DSH has established data tracking and collection methodologies to capture the information required. This report details the methodology used and describes the data captured for the collection period ending on September 30, 2025. The data contained in this report is limited to what is permitted under the Health Insurance Portability and Accountability Act (HIPAA), and state privacy laws, when disclosure of health information is required by law.

I. Methodology

This current reporting period ranges from October 1, 2024, to September 30, 2025. Data from the current reporting period will be presented alongside cumulative data collected throughout activation of the ETP, beginning September 14, 2021, through September 30, 2025. The data included in this report 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.

Existing DSH enterprise data collection practices were relied upon for reporting of items identified in Section 4145(a) (1-12) and (14-15). The requested information was operationalized considering current DSH policy and procedures related to data collection and verification. Data was collected using existing software and was independently verified using tracking sheets developed specifically for this reporting requirement.

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

II. Summary of Data

Patient Characteristics

Gender	Reporting Period 10/1/24 to 9/30/25	Cumulative 09/14/21 to 9/30/25
Male	<11 (100%)[a]	*** (100%)[b]
Female[c]	0 (0%)	0 (0%)

[a] Admissions during this reporting period.

[b] Total patients served on the ETP.

[c] The DSH-Patton ETP unit designed to serve female patients activated in October 2025.

Ethnicity	Reporting Period 10/1/24 to 9/30/25	Cumulative 9/14/21 to 9/30/25	DSH[a]	CA[b]
	N (%)	N (%)	%	%
Asian	0 (%)	<11 (***%)	5%	16%
Black or African American	0 (%)	<11 (***%)	24%	5%
Hispanic or Latino	<11 (100%)	12 (39%)	28%	41%
White	0 (0%)	<11 (***%)	40%	33%
Other/Unknown	0 (%)	<11 (***%)	3%	5%

[a] DSH resident census as of 9/30/2025.
[b] CA census population estimates as of July 1, 2024. DP05: ACS Demographic - Census Bureau Table

Age	Reporting Period 10/1/24 to 9/30/25	Cumulative 9/14/21 to 9/30/25	DSH[a]
	N (%)	N (%)	N (%)
18-29	0 (0%)	<11 (***%)	410 (7%)
30-41	<11 (***%)	*** (***%)	1542 (28%)
42-53	<11 (***%)	14 (45%)	1352 (25%)
54-65	0 (0%)	0 (0%)	1296 (24%)
66-77	0 (0%)	0 (0%)	791 (14%)
78-90	0 (0%)	0 (0%)	113 (2%)
91+	0 (0%)	0 (0%)	2 (<1%)
Mean Age (years)	36.33	39.35	49.33

[a] DSH patient census as of 9/30/2025.

Legal Group	Reporting Period 10/1/24 to 9/30/25	Cumulative 9/14/21 to 9/30/25	DSH[a]
	N (%)	N (%)	N (%)
Incompetent to Stand Trial	0 (0%)	<11 (***%)	1600 (29%)
Not Guilty by Reason of Insanity	0 (0%)	<11 (***%)	1199 (22%)
Offender with a Mental Health Disorder	0 (0%)	<11 (***%)	1001 (18%)
Lanterman-Petris- Short Act	<11 (100%)	16 (52%)	558 (10%)
Sexually Violent Predator	0 (0%)	<11 (***%)	954 (17%)
Coleman[b]	0 (0%)	0 (0%)	194 (4%)

[a] DSH patients' information on census as of 9/30/2025.
[b] Per Enhanced Treatment Program Emergency Regulations (California Code of Regulations, Title 9, Division 1, Chapter 17, Article 2, Section 4900), a patient may be referred to the Enhanced Treatment Program if there is no existing contract or memorandum of understanding that provides alternative and clinically appropriate treatment outside of DSH. *Coleman* patients are eligible for treatment in the CDCR Psychiatric Inpatient Programs.

Years at DSH – Current Admission[a,b]	Reporting Period 10/1/24 to 9/30/25	Cumulative 9/14/21 to 9/30/25	DSH[c]
	N (%)	N (%)	N (%)
0-5	<11 (***%)	21 (68%)	3554 (65%)
6-10	<11 (***%)	<11 (***%)	692 (13%)
11-15	0 (0%)	<11 (***%)	425 (8%)
16-20	<11 (***%)	<11 (***%)	511 (9%)
21-24	0 (0%)	<11 (***%)	94 (2%)
25+	0 (0%)	0 (0%)	230 (4%)
Mean:	4.96	5.33	6.22

[a] This data captures years at DSH *prior* to ETP Admission.
[b] "Current Admission" includes hospital years during most recent commitment that did not result in a discharge from DSH.
[c] DSH patients' information on census as of 9/30/2025.

Years at DSH – Overall[a,b]	Reporting Period 10/1/24 to 9/30/25	Cumulative 9/14/21 to 9/30/25
	N (%)	N (%)
0-5	<11 (***%)	13 (42%)
6-10	<11 (***%)	<11 (***%)
11-15	<11 (***%)	<11 (***%)
16-20	<11 (***%)	<11 (***%)
21-24	<11 (***%)	<11 (***%)
25+	0 (0%)	0 (0%)
Mean:	8.09	8.91

[a] This data captures years at DSH *prior* to ETP Admission.
[b] "Overall" includes hospital years during all DSH commitments. Individuals committed to DSH may have had multiple commitment periods during their lifetime.

All patients (residents) currently or formerly admitted to the ETP are male. A unit that can accommodate female activated in October 2025. ETP patients' (residents) mean age is 39.35 years, which is about 10 years below the DSH wide age average. ETP patients (residents) come from Asian, Black or African American, Hispanic or Latino, White, and Other or Unknown ethnic backgrounds. The ethnic distribution of the total ETP patients served (residents) generally aligns with DSH patient mix, except for a larger segment of White patients (residence) receiving care in the standard treatment environment compared to the ETP. The ethnic distribution of ETP patients differs from the overall CA population with a lower representation of Asian individuals and a higher representation of Black or African American individuals on the ETP. The primary legal commitment for patients (residents) in the ETP are: Not Guilty by Reason of Insanity (NGI), Offenders with Mental Disorders (OMD), Incompetent to Stand Trial (IST), persons designated as Sexually Violent Predators (SVP), and Lanterman-Petris-Short (LPS) Act Conservatees. Compared to the overall DSH population, the ETP serves a significantly higher percentage of LPS patients (residents) and a lower percentage of IST and SVP patients (residents). Since their most recent DSH

admission, ETP patients (residents) have spent an average of 5.33 years at DSH, which is similar to the average length of stay throughout DSH at 6.22 years. However, as some ETP patients (residents) have been admitted to DSH on multiple occasions, their combined average time spent in DSH is 8.91 years. There is no DSH systemwide comparison statistic available for length of stay across different admissions.

Compliance with Staffing Requirements

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

During the reporting period from September 14, 2021, through September 30, 2024, the ETP maintained a staff-to-patient ratio of one to five or lower. This ratio was maintained during the current reporting period from October 1, 2024, to September 30, 2025.

Staff Classification to Patient Ratio

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

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

Staff Classification	Staff-to-Patient Ratio[a]
Level-of-Care Staff[b]	
AM Shift	1 : 1.5
PM Shift	1 : 1.5
NOC Shift	1 : 3.0
Hospital Police Officer	1 : 6.5
Rehabilitation Therapist	1 : 6.5
Psychologist	1 : 6.5
Psychiatrist	1 : 13.0
Social Worker	1 : 13.0
FNAT Psychologist	1 : 6.5

[a] This ratio stayed consistent from September 14, 2021 through September 30, 2025
[b] Level of Care staff include Psychiatric Technicians and Registered Nurses.

Occupancy

Average Monthly Occupancy	N
October 2024	12.00
November 2024	12.87
December 2024	13.00
January 2025	13.00
February 2025	13.00
March 2025	12.90
April 2025	12.87
May 2025	13.00
June 2025	12.83
July 2025	12.74
August 2025	13.00
September 2025	13.00
Average Oct 2024 – Sept 2025:	12.85
Average Sept 2021 – Sept 2025:	12.03

Average Length of Stay[a]	Reporting Period 10/1/24 to 9/30/25	Cumulative 9/14/21 to 9/30/25
	Days	Days
DSH-Atascadero ETP Current Patients	332.08 ± 80.95	301.82 ± 102.50
DSH-Atascadero ETP Discharged Patients	190.50 ± 109.60	151.17 ± 95.81
Total	313.20 ± 94.64	261.94 ± 120.40

[a] Days are full days and Standard Deviation.

Other Occupancy	Reporting Period 10/1/24 to 9/30/25	Cumulative 9/14/21 to 9/30/25
The number of patients (residents) whose length of stay exceeds 90 days.	14	28
The number of patients (residents) with multiple ETP stays.	<11	<11
The number of patients (residents) whose discharge was delayed due to lack of available beds in a standard treatment environment.	0	0

The ETP began accepting patients on September 14, 2021. Since then, there have been a total of 33 admissions and 18 discharges of individual patients (residents). Between October 1, 2024, and September 30, 2025, there were fewer than 11

admissions and fewer than 11 discharges. At the end of this reporting period on September 30, 2025, there were 13 patients (residents) on the unit.

14 patients' (residents') length of stay exceeded 90 days during this reporting period. None of the ETP discharges were delayed due to lack of available beds in a standard treatment environment.

Restraint and Seclusion Use

Patients (residents) may be placed in seclusion or restraint for being an imminent danger to themselves or to others and after less restrictive interventions have been exhausted or were unsuccessful.

Cumulatively, since activating the ETP on September 14, 2021, to the end of this reporting period on September 30, 2025, there were fewer than 11 incidents of seclusion and *** incidents of both ambulatory and non-ambulatory (5-point bed restraint) restraints. 47 (30%) incidents of non-ambulatory restraints used during the cumulative period were related to patients (residents) being deemed an imminent danger to others, while 110 (70%) incidents of non-ambulatory restraint use were related to imminent danger to self. There were fewer than 11 incidents of seclusion involving fewer than 11 patients for a total of 195.41 hours. Five of these incidents occurred prior to September 30, 2022, when staff were still becoming familiar with the inherent security features of the ETP. Fewer than 11 episodes of seclusion occurred during this reporting period while a psychiatrist unfamiliar with the ETP proceedings was covering the unit.

Since activation, 157 incidents of non-ambulatory restraints occurred in the ETP. Five-point restraint usage lasted for a combined 2001.6 hours. These 157 restraint incidents involved 13 of the total *** patients admitted to the ETP. 38% of patients involved in the restraint incidents accounted for 127 (80%) of these incidents and 1839.26 (91.8%) of the total restraint hours. There were also fewer than 11 incidents of ambulatory restraint use which lasted for a combined total of 6.56 hours. There have been no ambulatory restraint hours since the end of the September 2022 reporting period.

During the current reporting period from October 1, 2024, to September 30, 2025, there were 45 incidents of non-ambulatory restraints use. Fewer than 11 of these non-ambulatory restraints use incidents were related to patients (residents) being deemed an imminent danger to others. The rest of the incidents of non-ambulatory restraint use were related to imminent danger to self. The total time of non-ambulatory restraint use during this reporting period was 585.01 hours. There were no incidents of ambulatory restraint usage and fewer than 11 incidents of seclusion during this period.

Restraint and Seclusion Use	Reporting Period 10/1/24 to 9/30/25		Cumulative 9/14/21 to 9/30/25	
	N[a]	Duration[b]	N[a]	Duration[b]
Seclusion	<11	186.28	<11	195.41
Ambulatory Restraint	0	0.00	<11	6.56
Non-Ambulatory Restraint	45	585.01	157	2001.60
Total	***	771.29	***	2203.57

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

Non-Ambulatory Restraint Frequency and Duration[a]						
	Reporting Period 10/1/24 to 9/30/25			Cumulative 09/14/21 to 9/30/25		
	N[b]	%	Duration[c]	N	%	Duration
Danger to Others	<11	***%	96.74	47	30%	586.26
Danger to Self	***	***%	488.27	110	70%	1415.34

[a] Non-ambulatory Restraint while patient is located on the ETP Unit.
[b] Number of distinct incidents requiring non-ambulatory restraint of a patient.
[c] Time in hours.

Rates of ETP patient (resident) non-ambulatory restraint use per month were obtained for the six months prior to ETP admission and were compared to non-ambulatory restraint use during ETP placement.

During the reporting period from October 1, 2024, to September 30, 2025, rates for frequency and duration of non-ambulatory restraint use significantly decreased following admission to the ETP. Rates in the frequency of non-ambulatory restraint use decreased by 96.5% for patients receiving treatment during this reporting period, compared to the six months prior to admission. Furthermore, patients who received treatment on the ETP during this reporting period spent a total of 3395.72 hours in non-ambulatory restraints within six months prior to their admission. During the twelve months captured in this reporting period these same patients spent 585.01 hours in non-ambulatory restraints.

Findings are similar for changes in duration and frequency of non-ambulatory restraint use throughout the length of the program's existence. From September 14, 2021, to September 30, 2025, frequency rates of non-ambulatory restraint use decreased by 89%. Patients who received treatment on the ETP since inception of the program spent a total of 5896.75 hours in non-ambulatory restraints within six

months prior to their admission, which decreased to 2001.60 hours following ETP placement.

These findings align with the goal of the ETP to provide less restrictive care by reducing the frequency and duration of non-ambulatory restraint use.

Non-Ambulatory Restraint Rate and Duration Prior to ETP vs. During ETP Placement											
Reporting Period 10/1/24 to 9/30/25						**Cumulative 09/14/21 to 9/30/25**					
Prior to ETP Admission			During ETP Placement			Prior to ETP Admission			During ETP Placement		
N[a]	Rate[bc]	Duration[d]	N	Rate	Duration	N	Rate	Duration	N	Rate	Duration
162	0.0715	3395.72	45	0.0025	585.01	327	0.0666	5896.75	157	0.0070	2001.60

[a] Number of distinct incidents requiring non-ambulatory restraint of a patient.
[b] Rates of aggression are calculated per 1 patient day.
[c] Pre ETP Admission data was not available for one patient.
[d] Time in hours.

Serious Injuries to Staff and Patients (Residents)

Serious injuries to staff and patients (residents) were defined based on DSH Policy Directive #9500, Incident Management System. Injuries that met the following criteria are reported in the data below:

> *"Medical Treatment Required: The injury received is severe enough to require medical treatment (medical treatment beyond first aid and other than diagnostic of assessment; i.e. sutures, broken bones, may include new prescriptions specific to the treatment related to the injury sustained in the incident, beyond over-the-counter medication) by a licensed medical physician, osteopath, podiatrist, dentist, physician's assistant, or nurse practitioner, but the treatment required is not serious enough to warrant or require hospitalization; further, the treatment received may be provided within the facility or provided outside the facility where it may range from treatment at a doctor's private office through treatment at the emergency room of a general acute care hospital."*
>
> *"Hospitalization Required: The injury received is so severe that it requires medical intervention and treatment as well as care of the injured patient at a general acute care hospital outside the facility; this severity level requires that the injured patient be formally admitted to the hospital and assigned to a bed on a unit outside of the emergency room."*

Serious injury to staff and patients (residents) related to the use of seclusion and restraint was defined per Health and Safety Code 1180.1 (g), "*Serious injury*" *means significant impairment of the physical condition as determined by qualified*

medical personnel, and includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, or injuries to internal organs."

Based on this definition, there were fewer than 11 incidents that resulted in serious injuries to staff between October 1, 2024, and September 30, 2025. None of these incidents resulted in injuries requiring hospitalization. Majority of those injuries to staff were related to the use of seclusion and restraint. During this review period, there were fewer than eleven serious injuries to a patient (resident). These fewer than eleven injuries occurred because of self-injury.
Cumulatively, since activation of the ETP on September 14, 2021, through September 30, 2025, there were 26 incidents resulting in serious injury to staff. Eighteen of these injuries were due to physical aggression by fewer than 11 patients; and eight of these injuries were related to the use of seclusion or restraint. None of these injuries required hospitalization. There were a total of fewer than 11 serious injuries to patients (residents). Fewer than 11 of these injuries were the result of patient aggression to self; fewer than 11 injuries occurred related to the use of seclusion and restraint. None of these injuries required hospitalization. Fewer than 11 injuries resulted from use of restraint and seclusion within the October 2022 to September 2023 reporting period. The fewer than 11 injuries occurred during the stabilization process.

To summarize, there were a total of 36 serious injuries to either staff or patients (residents) that occurred since activation of the ETP on September 14, 2021, to September 30, 2025. There were 18 aggressive incidents resulting in serious injury to staff (as defined by Policy Directive #9500) during that period. There were fewer than 11 serious injuries to staff (as defined by Health and Safety Code 1180.1(g)) related to the use of seclusion or restraint. There were fewer than 11 incidents of patient aggression to self that resulted in serious injuries to patients (residents) (as defined by Policy Directive #9500.). Fewer than 11 serious patient injuries (defined by Health and Safety Code 1180.1(g)) occurred during stabilization of patients (residents). None of these 36 incidents required hospitalization. There were no aggressive acts to other patients (residents) resulting in serious injury during the review period.

Serious Injuries	Reporting Period 10/1/24 to 9/30/25	Cumulative 9/14/21 to 9/30/25
	N	N
All Serious Injuries to Staff[a]	<11	***
All Serious Injuries to Patients (Residents)[a]	<11	<11
Serious injuries to Staff related to the use of seclusion and restraints[b,c]	<11	<11
Serious injuries to Patients (Residents) related to the use of seclusion and restraints[b,c]	0	<11

Serious Injuries to Patients (Residents) as a result of self-injurious behavior[a,d]	<11	<11
Total[e]:	***	36

[a] Serious injury is defined as requiring medical care beyond first aid or overnight stay in a hospital as defined by Policy Directive #9500.
[b] Serious injury as defined by Health and Safety Code 1180.1(g).
[c] These injuries occurred during stabilization and containment. The patient was not placed in full-bed restraints following this incident. These numbers are also accounted for in Rows 1&2.
[d] Injuries due to self-harm behaviors are not included in the total, as they are accounted for in the overall frequency count for serious injuries to patients (residents).
[e] Total number of serious injuries includes all serious injuries to staff and patients Rows 1&2.

For each reporting period, rates of patient aggression toward self and others, as well as resulting injuries were calculated. These variables were also calculated for each patient in the six months prior to ETP admission. This allowed for calculation of rates of change in aggression and injuries following admission to the ETP.

Rates of Aggression and Injury Prior to ETP vs. During ETP Admission[a]										
	Reporting Period 10/1/24 to 9/30/25					**Cumulative 09/14/21 to 9/30/25**				
	Prior to ETP Admission		During ETP Admission			Prior to ETP Admission		During ETP Admission		
	N	Rate	N	Rate	Change	N	Rate	N	Rate	Change[d]
Physical Aggression towards Staff	108	0.0476	25	0.0046	-90%	250	0.0509	222	0.0124	-76%
Physical Aggression towards Peers	***	***	<11	***	-97%	145	0.0295	26	0.0015	-95%
Serious Injuries to Staff[b]	***	***	<11	***	-85%	30	0.0061	26	0.0015	-76%
Serious Injuries to Peers[b]	<11	***	0	0.0000	-100%	<11	***	0	0.0000	-100%
Physical Aggression towards Self	<11	***	47	0.0030	NA[d]	23	0.0047	143	0.0062	+33%
Serious Injuries towards Self[c]	0	0.0000	<11	***	0%	<11	***	<11	***	+125%

[a] Rates of aggression are calculated per 1 patient day.
[b] Serious injury is defined as requiring medical care beyond first aid or overnight stay in a hospital as defined by Policy Directive #9500.

[c] Percent change is calculated from non-rounded values.
[d] Pre ETP Admission data for aggression towards self was not available for one patient. The rate of change therefore cannot be meaningfully calculated.

Compared to the six months prior to admission, patients receiving treatment on the ETP between October 1, 2024, to September 30, 2025, had a 90% decrease in rate of aggression towards staff, and a 97% decrease in aggression towards peers. Cumulative results covering the period from September 14, 2021, to September 30, 2025, show a 76% reduction in rate of aggression towards staff and a 95% reduction in rate of aggression towards peers. Furthermore, the severity of injuries resulting from these aggressive acts decreased by 100% for patient to patient (resident) aggression. The severity of injuries to staff decreased by 76%.

This data highlights that the ETP is meeting its goal for reduction of severe physical aggression towards both staff and patients, and that rates of injury severity correspond accordingly.

Rates of physical aggression towards self increased while patients were on the ETP, as did the injuries that occurred as a result. Since activation of the ETP on September 14, 2021, there have been 143 self-harm incidents resulting in serious injuries. Fewer than 11 of the total *** ETP patients were responsible for all self-harm incidents.

The ETP was established as a treatment program addressing physical violence towards others. In many patients, physical violence towards others is accompanied by physical aggression towards self. Thus, the ETP initially accepted referrals for patients who, in addition to high levels of physical aggression towards others, also engaged in self-harm behaviors. Our data showed that patients who had a significant history of self-harm in the standard treatment environment experienced an increase in those behaviors following ETP placement. Due to the observed increase in self-harm behaviors following placement in the ETP, the selection process for admission was adjusted to admit individuals with self-harm behavior only after extensive review. Over time, we learned that excluding patients who experience both aggression to others and to self does not meet operational needs of the DSH facilities. Therefore, the ETP is slowly transitioning to accepting more patients who present with self-injurious behavior in addition to predominant violence towards others. Efforts to establish treatment programming to better accommodate the needs of patients who are both at risk for danger to others and to self are underway.

Staff Turnover

During the current reporting period of October 1, 2024, through September 30, 2025, 8.0 registered nurses left the ETP. 5.0 of these nurses transferred during the SEIU new post-and bin process. The other 3.0 nurses transferred to other units within the facility. During this same period, 7.0 psychiatric technicians left the ETP, 1.0 psychiatric

technicians separated from state service, 5.0 transferred to other units inside the facility, and 1.0 transferred to another facility but remained in state service.

During this reporting period, 1.0 registered nurse was hired into the ETP. Eight registered nurses transferred into the ETP from other units within the facility. Of the registered nursing transferring into the ETP 4.0 transferred during the SEIU new post and bid process. Eight psychiatric technicians transferred into the ETP from other units within the facility.

Cumulatively, from activation of the ETP on September 14, 2021, through the end of this most recent reporting period on September 30, 2025, 18.0 registered nurses left the ETP; 7.0 registered nurses left employment with DSH, 1.0 transferred to another DSH facility, 10.0 registered nurses transferred to other units within the facility. During this time, 34.0 psychiatric technicians left the ETP; 4.0 promoted to a position outside the ETP, 12.0 left employment with DSH, 3.0 transferred to another DSH facility, and 15.0 transferred to other units within the facility.

During the reporting period from September 14, 2021, through September 30, 2025, 7.0 registered nurses were hired to the ETP as well as 7.0 psychiatric technicians. An additional 10.0 registered nurses and 30.0 psychiatric technicians transferred into the ETP from other units within the facility.

Changes in clinical staff first occurred within the period of October 1, 2022, to September 30, 2023. One social worker left the ETP to transfer to another unit, and 0.75 social worker transferred into the ETP. That social worker was re-assigned to another unit and replaced by another social worker who also provided 0.75 coverage. In September 2024, one of the original social workers returned to the unit and continues to provide 0.75 coverage. The staffing changes related to social work were due to re-assignments to meet operational need. Recruitment is in process for additional social work resources.

In July 2023 1.0 Psychologist retired from state service, and 0.9 Senior Supervising Psychologist provided coverage for 13 months until 1.0 Psychologist transferred to the ETP from another unit. Since activation of the ETP in 2021, 2.0 FNAT psychologists left the ETP. In December 2022 1.0 FNAT psychologist left state service, 1.0 FNAT psychologist transferred to another division within DSH on a limited term assignment. 1.0 FNAT psychologist was hired. One remaining FNAT psychologist position provided temporary relief (filling behind another psychologist on family leave) and was not refilled.

On July 1, 2024, 1.0 Psychiatrist went on extended leave and then took an out-of-class assignment. During the period October 1, 2024, to September 30, 2025, psychiatric coverage was provided by various psychiatrists within the facility.

Patients' Rights Complaints

The Disability Rights California, California Office of Patients' Rights provided information pertaining to patients' rights complaints received from October 1, 2024, to September 30, 2025. During this period eight patients made a total of 35 complaints.

Complaint Category	Patients	Complaints
Access and Use of Personal Possessions/ Keep and Spend Reasonable Sum of Money	<11	<11
Advocacy Services/ Legal/ Mental Health Treatment	<11	<11
Daily Living	<11	<11
Dignity / Privacy / Respect / Humane Care	<11	<11
Medical Care and Treatment/Medication Side Effects	<11	<11
Packages	<11	<11
Physical Exercise/Recreation/Out of Doors	<11	<11
Religious Freedom and Practice	<11	<11
Restraint/Visiting	<11	<11
Telephones/Confidential Use	<11	<11
Totals [a]	***	**35**

[a] Patients are counted once for the total; the same patient may have submitted multiple complaints for different problem codes.

Access / Use of Personal Possessions

- Complaints were regarding missing property and reimbursement for lost property.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved these complaints by reviewing hospital records, providing information on the whereabouts of the property, providing patients with information on how to self-advocate, requesting updates from hospital staff, and offering assistance on submitting an appeal to the hospital Executive Director.

Advocacy Services/ Mental Health Treatment

- Complaints were regarding process and outcome of ETP certification hearings, including independent medical reviews. Complaints also requested information about conservatorship, psychiatric medications, and options for transferring out of the ETP unit.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved these complaints by informing the patient of their rights, discussing ETP certification hearings and independent medical reviews, including

related advocacy efforts and decertification timelines. PRA also attended treatment team meetings, spoke with the treatment staff, provided information on conservatorship, and encouraged patients to self-advocate with their care provider.

Daily Living

- Complaints were regarding staff not answering the intercom, no hot water in the shower, missing food in meals, problems with staff, and the cleanliness of living spaces.
    - Resolutions: The Patients' Rights Advocate (PRA) encouraged patients to reach out to staff if they are having any issues with water temperature or for any missing items in their meals. The PRA also informed patients that the living spaces are cleaned weekly and as needed by the janitorial staff, and that they also have the option of requesting cleaning supplies from staff when needed. The PRA resolved complaints about the intercom by speaking with staff on the unit regarding these concerns and testing the intercom system with patients to ensure it is functioning properly.

Dignity / Privacy / Respect / Humane Care

- Complaints were regarding staff interactions with patients, privacy issues, and staff not addressing negative interactions between patients.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved these complaints by visiting the unit and discussing concerns with staff and patients. Patients were advised to continue to communicate their concerns with staff, shift leads, the unit supervisor, and/or their treatment team, most of whom were already aware of patient concerns.

Medical Care and Treatment/Medication Side Effects

- Complaints were regarding medication side effects, need for medical items, and prescribed medications.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved these complaints by raising concerns with nursing staff, attending treatment team meetings and speaking with the patient, and encouraging patients to continue to report any pain or discomfort to staff. The PRA provided information to the patients regarding the process for scheduled and as-needed (PRN) medications.

Packages

- Complaint was regarding delays in receiving a package.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved this complaint by speaking to the packaging department and informing the patient that the package was processed and out for delivery to the unit on the day following the complaint.

Physical Exercise/Recreation/Out of Doors

- Complaints were regarding not being able to go outside to the courtyard and not having the ability to participate in weightlifting groups.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved these complaints by reviewing documentation, communicating with staff, and confirming outdoor access was being offered daily. The PRA also advocated for patient's expressed interest to participate in physical exercise groups; this was not approved; however, patient was offered individual access to the weight room as an alternative.

Religious Freedom and Practice

- Complaints were regarding religious services.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved these complaints by advocating for coordination of access to religious services, either in-person or remotely. Patient was able to attend religious services remotely through the Patient Education Network channel on the unit's television

Restraint/Visiting

- Complaint was requesting the ability to visit his family in-person and to be escorted to the Visiting Room without the use of custodial restraints.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved this complaint by informing the patient about the milieu management plan and of the process for being escorted off the ETP unit to the Visiting Room, and by supporting the patient in their self-advocacy efforts to make this request to the Treatment Team. PRA followed up with treatment staff, and the patient was eventually able to be escorted to the Visiting Room, without the use of custodial restraints, to visit his family.

Telephones/Confidential Use (and Medication Side Effects)

- Complaints were regarding adjusting timing of scheduled medications to be able to speak to family in the evening, and a patient answering phone calls and impersonating another patient.
    - Resolutions: The Patients' Rights Advocate (PRA) resolved these complaints by attending treatment team meetings and communicating with staff to patient's concerns about how the medication side effects were impacting patient's ability to get phone calls from his family during evening phone hours. Medication times were adjusted as per patient's request. Complaint about another patient impersonating peers was resolved by a patient being decertified from the ETP.

ETP Staff Training

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

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

- ETP Background, Philosophy & Culture
- ETP Positive Psychology
- ETP Trauma Informed Care
- ETP Motivational Interviewing
- ETP Sensory Modulation
- ETP Admission and Discharge Process
- ETP New Admission Orientation Process
- ETP Cognitive Remediation
- ETP Milieu Management Skills (DBT)
- ETP Treatment of Criminogenic Risk
- ETP Transdisciplinary Approach
- ETP Discipline Specific Duties
- ETP Writing a Behavior Plan
- ETP Coping Skills and Unit Privileges
- ETP Specific Charting Requirements
- ETP Incident Management Overview
- ETP Risk Assessment Process & Application
- ETP Patient's Rights
- ETP Therapeutic Options
- ETP Therapeutic Strategies and Interventions Theory
- ETP Social Skills Training for Schizophrenia
- ETP Operational Processes

In addition, an abbreviated videotaped training was created for staff whose primary work assignment is the ETP, but who did not have the opportunity to attend the full ETP academy. Seventeen staff completed this training during the reporting period of October 1, 2024, through September 30, 2025. Cumulatively, 56 staff completed this video training during the reporting period of September 14, 2021, through September 30, 2025. Courses recorded and provided to staff included:

- ETP Positive Psychology
- ETP Trauma Informed Care
- ETP Motivational Interviewing
- ETP Therapeutic Options
- ETP Transdisciplinary Approach
- ETP Social Skills Training for Schizophrenia
- ETP Risk Assessment Process & Application

- ETP Specific Charting Requirements
- ETP Operational Processes

Lastly, a one-hour orientation to working on the ETP was developed for those whose primary work assignment is elsewhere, but who may be asked to provide treatment coverage on the ETP. 565 staff completed this training prior to the activation of the ETP. 1052 level-of-care (e.g., licensed nurses and psychiatric technicians) and clinical (e.g., psychiatrists, psychologists, social workers, rehabilitation therapists) staff completed this training during the reporting period of September 14, 2021, through September 30, 2023. This video included:

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

On November 23, 2023, a revised version of this video was created. By September 30, 2024, 585 level-of-care (e.g., licensed nurses and psychiatric technicians) and clinical (e.g., psychiatrists, psychologists, social workers, rehabilitation therapists) staff have completed this training. Courses provided in the updated video are:

- ETP Trauma Informed Care
- ETP Milieu Management Plan
- ETP Structure and Processes

This training is provided for all new level-of-care and clinical staff at DSH-Atascadero. Due to changes in the recording procedures for training provided at DSH-Atascadero, the updated number of persons having received this training is unavailable for this recording period.

In anticipation of ETP activation at DSH-Patton in October 2025, 55 ETP staff participated in a seven-week in-person training academy from February 11, 2025 through March 28, 2025 aimed at providing specialized skills to address the needs of the patient populations served through the ETP. Training was offered with a focus on evidence-based treatments to address common risk factors for violence. Due to delays in activation, another abbreviated one-week training academy was held in October 2025 for 35 staff. The data below details the training topics presented during the initial training academy, held from February 11, 2025, through March 28, 2025.

- ETP Background, Philosophy & Culture
- ETP Positive Psychology
- ETP Trauma Informed Care
- ETP Motivational Interviewing
- ETP Introduction to Behavior: "Language of Behavior" and Behavioral Concepts
- ETP Fundamentals of Psychiatric Symptoms

- ETP HIMD
- ETP Sensory Modulation
- ETP Admission and Discharge Process
- ETP MAT and ECT
- ETP Milieu Management Skills (DBT)
- ETP Cognitive Remediation
- ETP Treatment of Criminogenic Risk
- ETP The Roles of Disciplines in the ETP
- ETP Tactical Communication
- ETP Patient's Rights
- ETP Risk Assessment Process & Application
- ETP Specific Charting Requirements
- ETP Therapeutic Options
- ETP Incident Management Overview
- ETP Therapeutic Strategies and Interventions Theory
- ETP Substance Recovery & Stages of Change
- ETP Additional Strategies for Identifying Aggression Before It Begins
- ETP Dynamic Appraisal of Situational Aggression (DASA)
- ETP Unit Orientation
- ETP Treatment for Transgender Patients
- ETP Behavioral Treatment Planning & Incentive Plans
- ETP CBT for Psychosis
- ETP Practical Clinical Interviewing
- ETP General Nutrition and Mental Health
- ETP The Use of Psychiatric Medication in the Reduction of Violence
- ETP Social Skills Training for Schizophrenia

In addition, an abbreviated in-person training was created for staff whose primary work assignment is the ETP, but who did not have the opportunity to attend the full ETP academy. Eight staff completed this training between October 13, 2025 and October 17 2025. Training topics included:

- ETP Orientation
- ETP Transdisciplinary Approach
- ETP Unit Orientation
- ETP ECT
- ETP Operational Processes
- ETP DASA
- ETP Trauma Informed Care
- ETP Philosophy
- ETP Milieu Status
- ETP Escorting
- ETP Positive Psychology
- ETP Patients' Rights
- ETP Behavior Documentation
- ETP Radio Communications

A 20-minute orientation to working on the ETP at DSH-Patton was developed for those whose primary work assignment is elsewhere, but who may be asked to provide treatment coverage on the ETP.

In addition to the formalized training outlined above, ETP team members received informal consultation from subject matter experts outside of DSH. Department of Development Services as well as consultants under contract with DSH assisted ETP

team members with honing their skills in the treatment of complex psychopathology and behavioral issues. Consultations provided included advanced psycho pharmacology, Dialectical Behavior Therapy, Cognitive Behavioral Therapy for Psychosis, Behavioral Analysis, and Cognitive Remediation. In 2023, 14 level-of-care and 7 clinical staff members participated in a half-day resiliency training aimed at providing coping skills while working in a highly acute environment.

During this reporting period, 13 level of care, eight clinical, and six management staff attended a four-hour training on the implementation of the Dynamic Appraisal of Situational Aggression (DASA) and the associated Aggression Prevention Protocol.

Staffing Levels for ETPs

The table below summarizes the number of staff permanently assigned to provide direct patient care on the ETP and their classifications. Included are positions currently filled, as well as those being actively recruited as of September 30, 2025.

ETP Permanent Staff[a]	Filled	Vacant
Registered Nurse	11	0
Psychiatric Technician (includes Senior Psychiatric Technician)	28	5
Licensed Vocational Nurse	1	0
Psychiatrist	1[b]	0
Psychologist	2	0
Social Worker	1	0
Rehabilitation Therapist	2	0
FNAT Psychologist	4	0
Hospital Police Officers	10	0
Unit Supervisor	1	0

[a] Staff permanently assigned to the ETP, not including coverage to meet required staff-to-patient ratios.
[b] Providing temporary coverage for staff on leave.

FINDINGS AND RECOMMENDATIONS

The ETP was conceived of as a setting to manage severe physical aggression, with units designed and constructed with environmental controls to allow for management of aggression using least restrictive practices. The foremost goals of the ETP are to reduce episodes of aggression and associated injury severity, and to reduce the use of restraints.

Since implementation on September 14, 2021, the ETP has met these goals. Patients (residents) engage in significantly less aggression towards others after being admitted to the ETP compared to when they received care in the standard

treatment environment. Our data shows that following ETP admission, the rates of aggressive incidents towards staff decreased by 76%, while aggressive acts towards other patients decreased by 95%. Serious injuries to staff decreased by 76%, and serious injuries to patients due to aggression by peers were altogether eliminated.

Patients (residents) also are placed in non-ambulatory restraints less frequently and for shorter periods of time after being placed in the ETP. Since activation of the ETP on September 14, 2021, through September 30, 2025, there have been a total of 157 episodes of non-ambulatory restraint use. 47 (30%) of these were related to aggressive acts towards others, and 110 (70%) of restraint use was related to self-injurious behavior.

Of note is that 50 (32%) of the 157 non-ambulatory restraint incidents occurred within the first three months of activation. During the first three months of activation, staff were still getting accustomed to utilizing the unique features and treatment enhancements of the ETP. Consequently, staff were educated about ETP-specific procedures of locking the patient room door as a less restrictive alternative to manage aggressive behavior.

Since the first year of ETP operations, DSH has noticed a significant decrease in the use of non-ambulatory restraints. While there were 84 non-ambulatory restraint episodes between September 14, 2021, to September 30, 2022, there were 21 non-ambulatory restraint episodes between October 1, 2022, to September 30, 2023, and fewer than 11 non-ambulatory restraint episodes from October 1, 2023, and September 30, 2024. These data highlighted that, since ETP activation, clinicians and staff have become more proficient in using their skills to reduce the incidents of severe physical violence and limit their reliance on restraint use.

In the current reporting period from October 1, 2024, to September 30, 2025 there were 45 non-ambulatory restraint episodes. In previous years DSH learned that around 70% of non-ambulatory restraint use was due to patients (residents) engaging in self-harm behaviors.

The ETP referral process was adjusted to increase screening for self-injurious behavior. While this approach has significantly reduced the need for non-ambulatory restraints it no longer met the needs of the DSH facilities who continued to face a threat to staff and patient (resident) safety by those who engage in both aggression towards others and self.

The aim over the next reporting period is to further develop staff skills in treating patients who are at risk for self-injurious behavior to reduce the need for restraints and utilize the unique features of the ETP environment instead.

Overall, data supports that compared to the standard treatment environment, the ETP is successful in meeting its goals for reduction of severe physical aggression towards others, reducing the frequency of resulting serious injuries, and also reducing the frequency on non-ambulatory restraint use.

An additional goal is to continue to address ongoing staff recruitment and retention. This objective is addressed within the DSH statewide strategic plan goal towards establishing a great workplace to align with the goals and mission of the Department. While not specific to the ETP, this concentrated focus to recruit a talented workforce and create centers of professional training and excellence at the state hospitals will broaden the potential applicant pool for ETP positions.

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

BACKGROUND

The Budget Act of 2019 added the following Provisional Language:

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

In response to the Provisional Language, the Department of State Hospitals (DSH) and the Judicial Council worked to ensure the Superior Courts of California data related to Penal Code (PC) section 1001.36 is transmitted and incorporated into the county data sets collected from the pre-trial diversion program (per Welfare and Institutions Code (WIC) 4361). This report describes the methodologies employed by both departments to collect the data required by WIC 4361 and the Provisional Language, as well as challenges encountered. Additionally, a high-level summary of the data collected as of June 30, 2025, is provided.

2026-27 GOVERNOR'S BUDGET REPORT

Judicial Council Data Collection Methodology

Pursuant to the Supplemental Report of the 2019 Budget Act regarding Assembly Bill 1810 (Stats. 2018, Ch. 34), trial courts are required to work with the Judicial Council of California to provide data pursuant to mental health diversion programs set forth in PC 1001.36. The Judicial Council is to make this data available to the Legislature and DSH on an annual basis, beginning January 1,

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

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

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

Judicial Council Data Collection Challenges

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

DSH Data Collection Methodology

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

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

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

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

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

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

As of June 30, 2025, the DSH Diversion Pilot Program ended and DSH is no longer collecting data for the program. The Budget Act of 2022 allocated ongoing funding to establish the DSH Felony Mental Health Diversion as a permanent program and as of FY 2024-25, DSH began collecting data for the permanent Diversion Program on a monthly basis according to an updated master data dictionary and secure collection process.

Data Collection Challenges

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

In FY 2019-20, data collection for this program was also impacted by COVID-19. Numerous counties which had planned to activate programs and begin diverting individuals before June 30, 2020, were delayed due to the numerous impacts of the pandemic, including court closures, and resource constraints in the county, mass releases of inmates at the local jails and virus outbreaks at the jails. These delays reduced the number of counties reporting to DSH in FY 2019-20. As of Fall 2022, all DSH-contracted programs were activated and reporting data to DSH.

SUMMARY OF REPORTED DATA

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

FY 2018-19

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

FY 2018-19 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	N/A
PC 1001.36 Petitions Received (Felony)	N/A
PC 1001.36 Petitions Granted	N/A
PC 1001.36 Petitions Granted (Felony)	N/A
PC 1001.36 Petitions Denied	N/A
PC 1001.36 Petitions Denied (Felony)	N/A
PC 1001.36 Petitions Denied due to Statute	N/A
PC 1001.36 Petitions Denied due to Statute (Felony)	N/A
PC 1001.36 Successful Completions	N/A
PC 1001.36 Successful Completions (Felony)	N/A
PC 1001.36 Unsuccessful Terminations	N/A
PC 1001.36 Unsuccessful Terminations (Felony)	N/A
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	34
WIC 4361 Diversion Started	29
WIC 4361 Unsuccessful Terminations	0
WIC 4361 Successful Completions	0

FY 2019-20

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

FY 2019-20 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	1,923*
PC 1001.36 Petitions Received (Felony)	563
PC 1001.36 Petitions Granted	680
PC 1001.36 Petitions Granted (Felony)	222
PC 1001.36 Petitions Denied	246
PC 1001.36 Petitions Denied (Felony)	99
PC 1001.36 Petitions Denied due to Statute	93
PC 1001.36 Petitions Denied due to Statute (Felony)	48
PC 1001.36 Successful Completions	78
PC 1001.36 Successful Completions (Felony)	30
PC 1001.36 Unsuccessful Terminations	62
PC 1001.36 Unsuccessful Terminations (Felony)	<11**
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	114
WIC 4361 Diversion Started	115
WIC 4361 Unsuccessful Terminations	<11
WIC 4361 Successful Completions	0

*FY 2019-20 Petitions Received Statewide Total has been updated following receipt of updated data for this reporting period from the Judicial Council

** Data has been de-identified in accordance with the DSH Data De-Identification Guidelines. Values are aggregated and masked to protect confidentiality of the individuals summarized in the data. De-Identification Legend: Counts between 1-10 are masked with "<11" or "fewer than eleven". Complimentary masking is applied using "***" where further de-identification is needed.

FY 2020-21

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

FY 2020-21 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	2,279*
PC 1001.36 Petitions Received (Felony)	1,312
PC 1001.36 Petitions Granted	1,415
PC 1001.36 Petitions Granted (Felony)	624
PC 1001.36 Petitions Denied	735
PC 1001.36 Petitions Denied (Felony)	455
PC 1001.36 Petitions Denied due to Statute	413
PC 1001.36 Petitions Denied due to Statute (Felony)	269
PC 1001.36 Successful Completions	658
PC 1001.36 Successful Completions (Felony)	219
PC 1001.36 Unsuccessful Terminations	164
PC 1001.36 Unsuccessful Terminations (Felony)	86
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	258
WIC 4361 Diversion Started	259
WIC 4361 Unsuccessful Terminations	38
WIC 4361 Successful Completions	44

*FY 2020-21 Petitions Received Statewide Total has been updated following receipt of updated data for this reporting period from the Judicial Council

FY 2021-22

DSH collected data throughout the fiscal year. All 24 contracted programs reported data through Quarter 4 (April-June) of 2022.

FY 2021-22 Totals*	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	4,133*
PC 1001.36 Petitions Received (Felony)	2,303
PC 1001.36 Petitions Granted	2,676
PC 1001.36 Petitions Granted (Felony)	1,455
PC 1001.36 Petitions Denied	980
PC 1001.36 Petitions Denied (Felony)	577
PC 1001.36 Petitions Denied due to Statute	507
PC 1001.36 Petitions Denied due to Statute (Felony)	294
PC 1001.36 Successful Completions	1,011
PC 1001.36 Successful Completions (Felony)	322
PC 1001.36 Unsuccessful Terminations	293
PC 1001.36 Unsuccessful Terminations (Felony)	151
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	409
WIC 4361 Diversion Started	389
WIC 4361 Unsuccessful Terminations	134
WIC 4361 Successful Completions	116

*FY 2021-22 Petitions Received Statewide Total has been updated following receipt of updated data for this reporting period from the Judicial Council

FY 2022-23

DSH collected data throughout the fiscal year and activated five additional county programs. All 29 contracted programs activated by Fall 2022 and 23 contracted programs reported data through Quarter 4 (April-June) of FY 2022-23.

FY 2022-23 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	5,393
PC 1001.36 Petitions Received (Felony)	2,839
PC 1001.36 Petitions Granted	3,313
PC 1001.36 Petitions Granted (Felony)	1,634
PC 1001.36 Petitions Denied	815
PC 1001.36 Petitions Denied (Felony)	467
PC 1001.36 Petitions Denied due to Statute	455
PC 1001.36 Petitions Denied due to Statute (Felony)	273
PC 1001.36 Successful Completions	1,140
PC 1001.36 Successful Completions (Felony)	405
PC 1001.36 Unsuccessful Terminations	472
PC 1001.36 Unsuccessful Terminations (Felony)	208
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	576
WIC 4361 Diversion Started	620
WIC 4361 Unsuccessful Terminations	210
WIC 4361 Successful Completions	159

*FY 2022-23 Petitions Received Statewide Total has been updated following receipt of updated data from this reporting period from the Judicial Council

FY 2023-24

DSH collected data throughout the fiscal year. 28 contracted programs reported data through Quarter 3 (July-March) of FY 2023-24. 25 contracted programs reported data in Quarter 4 (April-June) of FY 2023-24.

FY 2023-24 Totals	
Judicial Council Data	**Statewide Total***
PC 1001.36 Petitions Received	8,238
PC 1001.36 Petitions Received (Felony)	4,600
PC 1001.36 Petitions Granted	5,685
PC 1001.36 Petitions Granted (Felony)	3,258
PC 1001.36 Petitions Denied	1,807
PC 1001.36 Petitions Denied (Felony)	1,077
PC 1001.36 Petitions Denied due to Statute	725
PC 1001.36 Petitions Denied due to Statute (Felony)	413
PC 1001.36 Successful Completions	1,945
PC 1001.36 Successful Completions (Felony)	750
PC 1001.36 Unsuccessful Terminations	737
PC 1001.36 Unsuccessful Terminations (Felony)	394
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	232
WIC 4361 Diversion Started	247
WIC 4361 Unsuccessful Terminations	134
WIC 4361 Successful Completions	276

*FY 2023-24 Statewide Totals have been updated following receipt of updated data for this reporting period from the Judicial Council

FY 2024-25

DSH collected data throughout the fiscal year. 20 contracted programs reported data through Quarter 3 (July-March) of FY 2024-25. 13 contracted programs reported data in Quarter 4 (April-June) of FY 2024-25.

FY 2024-25 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	11,283
PC 1001.36 Petitions Received (Felony)	6,478
PC 1001.36 Petitions Granted	7,548
PC 1001.36 Petitions Granted (Felony)	4,042
PC 1001.36 Petitions Denied	1,792
PC 1001.36 Petitions Denied (Felony)	1,475
PC 1001.36 Petitions Denied due to Statute	919
PC 1001.36 Petitions Denied due to Statute (Felony)	459
PC 1001.36 Successful Completions	3,088
PC 1001.36 Successful Completions (Felony)	1,353
PC 1001.36 Unsuccessful Terminations	1,007
PC 1001.36 Unsuccessful Terminations (Felony)	523
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	34
WIC 4361 Diversion Started	34
WIC 4361 Unsuccessful Terminations	36
WIC 4361 Successful Completions	210

Number of Counties Reporting by Quarter

The first table below provides a summary of the total number of counties reporting data each quarter. The following tables display a more detailed count of the total number of counties reporting on each data element by fiscal year quarter, from 2018-19 through 2024-25.

Summary of Total Counties Reporting		
Numbers of Counties Reporting	**Judicial Council**	**DSH***
Q3 2018 (January through March)	**	2
Q4 2018 (April through June)	**	2
Q1 2019 (July through September)	25	3
Q2 2019 (October through December)	24	3
Q3 2020 (January through March)	40	4
Q4 2020 (April through June)	41	5
Q1 2020 (July through September)	43	11
Q2 2020 (October through December)	43	12
Q3 2021 (January through March)	44	19
Q4 2021 (April through June)	44	24
Q1 2021 (July through September)	49	24
Q2 2021 (October through December)	47	24
Q3 2022 (January through March)	49	24
Q4 2022 (April through June)	48	24
Q1 2022 (July through September)	47	24
Q2 2022 (October through December)	50	24
Q3 2023 (January through March)	48	23
Q4 2023 (April through June)	49	23
Q1 2023 (July through September)	50	28
Q2 2023 (October through December)	49	28
Q3 2024 (January through March)	52	28
Q4 2024 (April through June)	53	25
Q1 2024 (July through September)	53	20
Q2 2024 (October through December)	53	17
Q3 2025 (January through March)	50	16
Q4 2025 (April through June)	47	13

***** As of June 30, 2024, nine counties' contract terms ended with DSH.

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

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

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

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

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

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

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

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

January - March 2021				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	43	11	4	0
PC 1001.36 Petitions Received (Felony)	41	13	4	0
PC 1001.36 Petitions Granted	44	10	4	0
PC 1001.36 Petitions Granted (Felony)	42	12	4	0
PC 1001.36 Petitions Denied	43	11	4	0
PC 1001.36 Petitions Denied (Felony)	41	13	4	0
PC 1001.36 Petitions Denied due to Statute	36	18	4	0
PC 1001.36 Petitions Denied due to Statute (Felony)	35	19	4	0
PC 1001.36 Successful Completions	43	11	4	0
PC 1001.36 Successful Completions (Felony)	41	13	4	0
PC 1001.36 Unsuccessful Terminations	43	11	4	0
PC 1001.36 Unsuccessful Terminations (Felony)	41	13	4	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	19	0	0	0
WIC 4361 Diversion Started	19	0	0	0
WIC 4361 Unsuccessful Terminations	19	0	0	0
WIC 4361 Successful Completions	19	0	0	0

April - June 2021				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	43	11	4	0
PC 1001.36 Petitions Received (Felony)	41	13	4	0
PC 1001.36 Petitions Granted	44	10	4	0
PC 1001.36 Petitions Granted (Felony)	43	11	4	0
PC 1001.36 Petitions Denied	41	12	5	0
PC 1001.36 Petitions Denied (Felony)	41	13	4	0
PC 1001.36 Petitions Denied due to Statute	36	18	4	0
PC 1001.36 Petitions Denied due to Statute (Felony)	35	18	5	0
PC 1001.36 Successful Completions	43	11	4	0
PC 1001.36 Successful Completions (Felony)	41	13	4	0
PC 1001.36 Unsuccessful Terminations	43	11	4	0
PC 1001.36 Unsuccessful Terminations (Felony)	41	13	4	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	0	0
WIC 4361 Diversion Started	24	0	0	0
WIC 4361 Unsuccessful Terminations	24	0	0	0
WIC 4361 Successful Completions	24	0	0	0

Fiscal Year 2021-22				
July - September 2021				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	48	6	4	0
PC 1001.36 Petitions Received (Felony)	47	7	4	0
PC 1001.36 Petitions Granted	49	5	4	0
PC 1001.36 Petitions Granted (Felony)	47	7	4	0
PC 1001.36 Petitions Denied	46	8	4	0
PC 1001.36 Petitions Denied (Felony)	45	9	4	0
PC 1001.36 Petitions Denied due to Statute	42	12	4	0
PC 1001.36 Petitions Denied due to Statute (Felony)	41	13	4	0
PC 1001.36 Successful Completions	46	7	5	0
PC 1001.36 Successful Completions (Felony)	44	9	5	0
PC 1001.36 Unsuccessful Terminations	47	7	4	0
PC 1001.36 Unsuccessful Terminations (Felony)	45	9	4	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	0	0
WIC 4361 Diversion Started	24	0	0	0
WIC 4361 Unsuccessful Terminations	24	0	0	0
WIC 4361 Successful Completions	24	0	0	0

October - December 2021				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	46	8	4	0
PC 1001.36 Petitions Received (Felony)	45	10	3	0
PC 1001.36 Petitions Granted	47	7	4	0
PC 1001.36 Petitions Granted (Felony)	45	9	4	0
PC 1001.36 Petitions Denied	45	9	4	0
PC 1001.36 Petitions Denied (Felony)	44	10	4	0
PC 1001.36 Petitions Denied due to Statute	40	14	4	0
PC 1001.36 Petitions Denied due to Statute (Felony)	39	15	4	0
PC 1001.36 Successful Completions	45	9	4	0
PC 1001.36 Successful Completions (Felony)	43	11	4	0
PC 1001.36 Unsuccessful Terminations	46	8	4	0
PC 1001.36 Unsuccessful Terminations (Felony)	44	10	4	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	0	0
WIC 4361 Diversion Started	24	0	0	0
WIC 4361 Unsuccessful Terminations	24	0	0	0
WIC 4361 Successful Completions	24	0	0	0

January - March 2022				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	47	5	6	0
PC 1001.36 Petitions Received (Felony)	47	5	6	0
PC 1001.36 Petitions Granted	49	3	6	0
PC 1001.36 Petitions Granted (Felony)	48	4	6	0
PC 1001.36 Petitions Denied	46	6	6	0
PC 1001.36 Petitions Denied (Felony)	45	7	6	0
PC 1001.36 Petitions Denied due to Statute	42	10	6	0
PC 1001.36 Petitions Denied due to Statute (Felony)	41	11	6	0
PC 1001.36 Successful Completions	47	5	6	0
PC 1001.36 Successful Completions (Felony)	46	6	6	0
PC 1001.36 Unsuccessful Terminations	48	4	6	0
PC 1001.36 Unsuccessful Terminations (Felony)	46	5	7	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	0	0
WIC 4361 Diversion Started	24	0	0	0
WIC 4361 Unsuccessful Terminations	24	0	0	0
WIC 4361 Successful Completions	24	0	0	0

April - June 2022				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	46	6	5	1
PC 1001.36 Petitions Received (Felony)	47	6	4	1
PC 1001.36 Petitions Granted	48	4	5	1
PC 1001.36 Petitions Granted (Felony)	46	6	5	1
PC 1001.36 Petitions Denied	46	6	5	1
PC 1001.36 Petitions Denied (Felony)	44	8	5	1
PC 1001.36 Petitions Denied due to Statute	41	11	5	1
PC 1001.36 Petitions Denied due to Statute (Felony)	40	12	5	1
PC 1001.36 Successful Completions	46	6	5	1
PC 1001.36 Successful Completions (Felony)	44	8	5	1
PC 1001.36 Unsuccessful Terminations	47	5	5	1
PC 1001.36 Unsuccessful Terminations (Felony)	45	7	5	1
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	0	0
WIC 4361 Diversion Started	24	0	0	0
WIC 4361 Unsuccessful Terminations	24	0	0	0
WIC 4361 Successful Completions	24	0	0	0

*FY 2021-22 Totals have changed because the Judicial Council has provided updated data for this reporting period.

Fiscal Year 2022-23				
July-September 2022				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	46	5	5	2
PC 1001.36 Petitions Received (Felony)	44	7	5	2
PC 1001.36 Petitions Granted	47	4	5	2
PC 1001.36 Petitions Granted (Felony)	45	6	5	2
PC 1001.36 Petitions Denied	44	7	5	2
PC 1001.36 Petitions Denied (Felony)	42	8	6	2
PC 1001.36 Petitions Denied due to Statute	38	13	5	2
PC 1001.36 Petitions Denied due to Statute (Felony)	37	14	5	2
PC 1001.36 Successful Completions	45	6	5	2
PC 1001.36 Successful Completions (Felony)	43	8	5	2
PC 1001.36 Unsuccessful Terminations	45	6	5	2
PC 1001.36 Unsuccessful Terminations (Felony)	43	8	5	2
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	0	0
WIC 4361 Diversion Started	24	0	0	0
WIC 4361 Unsuccessful Terminations	24	0	0	0
WIC 4361 Successful Completions	24	0	0	0

October-December 2022				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	47	3	7	1
PC 1001.36 Petitions Received (Felony)	47	4	6	1
PC 1001.36 Petitions Granted	50	1	6	1
PC 1001.36 Petitions Granted (Felony)	48	3	6	1
PC 1001.36 Petitions Denied	47	3	7	1
PC 1001.36 Petitions Denied (Felony)	45	5	7	1
PC 1001.36 Petitions Denied due to Statute	43	7	7	1
PC 1001.36 Petitions Denied due to Statute (Felony)	41	9	7	1
PC 1001.36 Successful Completions	48	3	6	1
PC 1001.36 Successful Completions (Felony)	45	5	7	1
PC 1001.36 Unsuccessful Terminations	47	3	7	1
PC 1001.36 Unsuccessful Terminations (Felony)	45	5	7	1
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item* Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	24	0	1	4
WIC 4361 Diversion Started	24	0	1	4
WIC 4361 Unsuccessful Terminations	24	0	1	4
WIC 4361 Successful Completions	24	0	1	4

*Data from Solano County not included due to discrepancies in data reporting.

January-March 2023				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	46	3	5	4
PC 1001.36 Petitions Received (Felony)	46	4	4	4
PC 1001.36 Petitions Granted	48	1	5	4
PC 1001.36 Petitions Granted (Felony)	46	3	5	4
PC 1001.36 Petitions Denied	47	3	4	4
PC 1001.36 Petitions Denied (Felony)	45	5	4	4
PC 1001.36 Petitions Denied due to Statute	40	9	5	4
PC 1001.36 Petitions Denied due to Statute (Felony)	39	10	5	4
PC 1001.36 Successful Completions	46	3	5	4
PC 1001.36 Successful Completions (Felony)	44	5	5	4
PC 1001.36 Unsuccessful Terminations	45	4	5	4
PC 1001.36 Unsuccessful Terminations (Felony)	43	6	5	4
DSH Data*	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	23	0	0	5
WIC 4361 Diversion Started	23	0	0	5
WIC 4361 Unsuccessful Terminations	23	0	0	5
WIC 4361 Successful Completions	23	0	0	5

*DSH's contract with Santa Cruz County ended in Fall 2022. County no longer has an obligation to report data to DSH.

April-June 2023				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	43	4	1	10
PC 1001.36 Petitions Received (Felony)	41	5	2	10
PC 1001.36 Petitions Granted	44	2	2	10
PC 1001.36 Petitions Granted (Felony)	42	4	2	10
PC 1001.36 Petitions Denied	42	4	2	10
PC 1001.36 Petitions Denied (Felony)	40	6	2	10
PC 1001.36 Petitions Denied due to Statute	36	10	2	10
PC 1001.36 Petitions Denied due to Statute (Felony)	35	11	2	10
PC 1001.36 Successful Completions	42	4	2	10
PC 1001.36 Successful Completions (Felony)	40	6	2	10
PC 1001.36 Unsuccessful Terminations	42	4	2	10
PC 1001.36 Unsuccessful Terminations (Felony)	40	6	2	10
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	23	0	0	5
WIC 4361 Diversion Started	23	0	0	5
WIC 4361 Unsuccessful Terminations	23	0	0	5
WIC 4361 Successful Completions	23	0	0	5

Fiscal Year 2023-24				
July - September 2023				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	49	6	3	0
PC 1001.36 Petitions Received (Felony)	48	7	3	0
PC 1001.36 Petitions Granted	50	4	4	0
PC 1001.36 Petitions Granted (Felony)	48	6	4	0
PC 1001.36 Petitions Denied	48	6	4	0
PC 1001.36 Petitions Denied (Felony)	46	8	4	0
PC 1001.36 Petitions Denied due to Statute	39	15	4	0
PC 1001.36 Petitions Denied due to Statute (Felony)	38	16	4	0
PC 1001.36 Successful Completions	48	6	4	0
PC 1001.36 Successful Completions (Felony)	46	8	4	0
PC 1001.36 Unsuccessful Terminations	48	6	4	0
PC 1001.36 Unsuccessful Terminations (Felony)	46	8	4	0
DSH Data	Total Counties Reporting	Data Unavailable	Item Left Blank	No Data Received
WIC 4361 Diversion Orders	28	0	0	0
WIC 4361 Diversion Started	28	0	0	0
WIC 4361 Unsuccessful Terminations	28	0	0	0
WIC 4361 Successful Completions	28	0	0	0

October - December 2023				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	47	7	4	0
PC 1001.36 Petitions Received (Felony)	46	9	3	0
PC 1001.36 Petitions Granted	49	5	4	0
PC 1001.36 Petitions Granted (Felony)	47	7	4	0
PC 1001.36 Petitions Denied	45	8	5	0
PC 1001.36 Petitions Denied (Felony)	44	10	4	0
PC 1001.36 Petitions Denied due to Statute	39	15	4	0
PC 1001.36 Petitions Denied due to Statute (Felony)	38	16	4	0
PC 1001.36 Successful Completions	47	7	4	0
PC 1001.36 Successful Completions (Felony)	45	8	5	0
PC 1001.36 Unsuccessful Terminations	45	9	4	0
PC 1001.36 Unsuccessful Terminations (Felony)	45	9	4	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	28	0	0	0
WIC 4361 Diversion Started	28	0	0	0
WIC 4361 Unsuccessful Terminations	28	0	0	0
WIC 4361 Successful Completions	28	0	0	0

January - March 2024				
Judicial Council Data	**Total Counties Reporting***	**Data Unavailable***	**Item Left Blank**	**No Data Received***
PC 1001.36 Petitions Received	50	5	3	0
PC 1001.36 Petitions Received (Felony)	49	6	3	0
PC 1001.36 Petitions Granted	52	3	3	0
PC 1001.36 Petitions Granted (Felony)	50	5	3	0
PC 1001.36 Petitions Denied	50	5	3	0
PC 1001.36 Petitions Denied (Felony)	48	7	3	0
PC 1001.36 Petitions Denied due to Statute	40	15	3	0
PC 1001.36 Petitions Denied due to Statute (Felony)	39	16	3	0
PC 1001.36 Successful Completions	51	4	3	0
PC 1001.36 Successful Completions (Felony)	49	6	3	0
PC 1001.36 Unsuccessful Terminations	50	5	3	0
PC 1001.36 Unsuccessful Terminations (Felony)	48	7	3	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	28	0	0	0
WIC 4361 Diversion Started	28	0	0	0
WIC 4361 Unsuccessful Terminations	28	0	0	0
WIC 4361 Successful Completions	28	0	0	0

*FY 2023-24 Totals have been changed because the Judicial Council has provided updated data for this reporting period.

April - June 2024				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	48	3	3	4
PC 1001.36 Petitions Received (Felony)	46	5	3	4
PC 1001.36 Petitions Granted	49	2	3	4
PC 1001.36 Petitions Granted (Felony)	47	4	3	4
PC 1001.36 Petitions Denied	48	3	3	4
PC 1001.36 Petitions Denied (Felony)	46	5	3	4
PC 1001.36 Petitions Denied due to Statute	39	12	3	4
PC 1001.36 Petitions Denied due to Statute (Felony)	38	13	3	4
PC 1001.36 Successful Completions	48	3	3	4
PC 1001.36 Successful Completions (Felony)	46	5	3	4
PC 1001.36 Unsuccessful Terminations	48	3	3	4
PC 1001.36 Unsuccessful Terminations (Felony)	46	5	3	4
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	25	0	0	3
WIC 4361 Diversion Started	25	0	0	3
WIC 4361 Unsuccessful Terminations	25	0	0	3
WIC 4361 Successful Completions	25	0	0	3

Fiscal Year 2024-25*				
July - September 2024				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	51	4	3	0
PC 1001.36 Petitions Received (Felony)	48	7	3	0
PC 1001.36 Petitions Granted	53	2	3	0
PC 1001.36 Petitions Granted (Felony)	50	5	3	0
PC 1001.36 Petitions Denied	50	5	3	0
PC 1001.36 Petitions Denied (Felony)	48	7	3	0
PC 1001.36 Petitions Denied due to Statute	43	12	3	0
PC 1001.36 Petitions Denied due to Statute (Felony)	43	12	3	0
PC 1001.36 Successful Completions	52	3	3	0
PC 1001.36 Successful Completions (Felony)	50	5	3	0
PC 1001.36 Unsuccessful Terminations	50	5	3	0
PC 1001.36 Unsuccessful Terminations (Felony)	48	6	4	0
DSH Data	Total Counties Reporting	Data Unavailable	Item Left Blank	No Data Received
WIC 4361 Diversion Orders	20	0	0	0
WIC 4361 Diversion Started	20	0	0	0
WIC 4361 Unsuccessful Terminations	20	0	0	0
WIC 4361 Successful Completions	20	0	0	0

*As of June 30, 2025, Nine counties' contract terms ended with DSH

October - December 2024				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	52	3	3	0
PC 1001.36 Petitions Received (Felony)	49	6	3	0
PC 1001.36 Petitions Granted	53	2	3	0
PC 1001.36 Petitions Granted (Felony)	49	6	3	0
PC 1001.36 Petitions Denied	51	4	3	0
PC 1001.36 Petitions Denied (Felony)	49	6	3	0
PC 1001.36 Petitions Denied due to Statute	42	13	3	0
PC 1001.36 Petitions Denied due to Statute (Felony)	42	13	3	0
PC 1001.36 Successful Completions	52	3	3	0
PC 1001.36 Successful Completions (Felony)	49	6	3	0
PC 1001.36 Unsuccessful Terminations	51	4	3	0
PC 1001.36 Unsuccessful Terminations (Felony)	47	7	4	0
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	17	0	0	3
WIC 4361 Diversion Started	17	0	0	3
WIC 4361 Unsuccessful Terminations	17	0	0	3
WIC 4361 Successful Completions	17	0	0	3

January - March 2025				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	49	4	1	4
PC 1001.36 Petitions Received (Felony)	46	7	1	4
PC 1001.36 Petitions Granted	50	3	1	4
PC 1001.36 Petitions Granted (Felony)	47	6	1	4
PC 1001.36 Petitions Denied	46	7	1	4
PC 1001.36 Petitions Denied (Felony)	44	9	1	4
PC 1001.36 Petitions Denied due to Statute	40	13	1	4
PC 1001.36 Petitions Denied due to Statute (Felony)	38	14	2	4
PC 1001.36 Successful Completions	48	5	1	4
PC 1001.36 Successful Completions (Felony)	45	8	1	4
PC 1001.36 Unsuccessful Terminations	47	6	1	4
PC 1001.36 Unsuccessful Terminations (Felony)	44	9	1	4
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	16	0	0	4
WIC 4361 Diversion Started	16	0	0	4
WIC 4361 Unsuccessful Terminations	16	0	0	4
WIC 4361 Successful Completions	16	0	0	4

April - June 2025				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	47	3	2	6
PC 1001.36 Petitions Received (Felony)	45	5	2	6
PC 1001.36 Petitions Granted	47	3	2	6
PC 1001.36 Petitions Granted (Felony)	45	5	2	6
PC 1001.36 Petitions Denied	45	5	2	6
PC 1001.36 Petitions Denied (Felony)	44	6	2	6
PC 1001.36 Petitions Denied due to Statute	39	11	2	6
PC 1001.36 Petitions Denied due to Statute (Felony)	39	11	2	6
PC 1001.36 Successful Completions	46	4	2	6
PC 1001.36 Successful Completions (Felony)	44	6	2	6
PC 1001.36 Unsuccessful Terminations	46	4	2	6
PC 1001.36 Unsuccessful Terminations (Felony)	44	6	2	6
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	13	0	0	7
WIC 4361 Diversion Started	13	0	0	7
WIC 4361 Unsuccessful Terminations	13	0	0	7
WIC 4361 Successful Completions	13	0	0	7

STATE HOSPITALS
AB 310 Department of State Hospitals: Civil Service Psychiatrists
An Annual Report to the Fiscal and Policy Committees of the Legislature in Accordance with Section 4148 (a) of the Welfare and Institutions Code (WIC)
Informational Only

BACKGROUND

Assembly Bill 310 (Arambula, Statutes of 2024) instructs Department of State Hospitals (DSH) to provide a report to the California State Legislature providing amounts expended during the 2024–25 fiscal year, pursuant to Article 10.15 of the Bargaining Unit 16 Memorandum of Understanding between the State of California and the Union of American Physicians and Dentists, related to the following:

(1) The amount budgeted for civil service psychiatrists.
(2) The amount expended for civil service psychiatrists.
(3) The amount expended on civil service psychiatrists working additional caseload.
(4) The number of civil service psychiatrists who participated in working additional caseload.
(5) The amount expended on contract psychiatrists.

In response to the reporting requirements as identified in Section 4148, DSH has established data tracking and collection methodologies to capture the information required. This report details the methodology used and describes the data captured for the collection period ending on June 30, 2025.

I. Methodology

The amounts budgeted and expended for civil service psychiatrists are determined using the Schedule 7A, which is a summary version of the State Controller's Office (SCO) detailed Schedule 8 position listing for each department. The number of civil service psychiatrists working additional caseload and the amount expended is captured using reports from the Management Information Retrieval System (MIRS). MIRS is a SCO human resources data information system, which allows users to generate pre-written reports or create ad hoc reports for employment history, payment history, employer sponsored deductions, leave accounting and position inventory. The amount expended on contract psychiatrists is tracked using the DSH Department Position Report (DPR). The DPR is a monthly report which provides all departmental data related to positions as reported by individual hospitals and compiled by the Budgets and Fiscal Forecasting team at Headquarters in Sacramento.

II. Summary of Data

(1) The amount budgeted for civil service psychiatrists. **$111,256,179**
(2) The amount expended for civil service psychiatrists. **$93,771,828**
(3) The amount expended on civil service psychiatrists working additional caseload. **$805,402**
(4) The number of civil service psychiatrists who participated in working additional caseload. **13.0**
(5) The amount expended on contract psychiatrists. **$25,306,535**