



California Department of  
**State Hospitals**

ENHANCED TREATMENT PROGRAM  
DRAFT  
POLICIES AND PROCEDURES  
JUNE 2019



**Department of State Hospitals  
Enhanced Treatment Program (ETP)  
Draft Policies and Procedures  
June 2019**

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California Department of  
**State Hospitals**

**Enhanced Treatment Program**

**Section 1**

**Introduction**



# **DSH ENHANCED TREATMENT PROGRAM**

## **DRAFT POLICIES AND PROCEDURES**

### **JUNE 2019**

Assembly Bill 1340 (Achadjian, Statutes of 2014) authorized the Department of State Hospitals to establish and maintain pilot Enhanced Treatment Programs (ETPs), for the treatment of patients who are at high risk of most dangerous behavior, when safe treatment is not possible in a standard treatment environment. The goal of these pilot ETPs is to evaluate the effectiveness of concentrated, evidence-based clinical therapy and treatment in an environment designed to improve these patients' conditions and return them to the general patient population.

Senate Bill 85 (Committee on Budget, Statutes of 2015) requires the State Department of State Hospitals to submit written draft policies and procedures that will guide the operation of the Enhanced Treatment Program (ETP), including, but not limited to, admittance criteria, staffing levels, services to be provided to patients, a transition planning process, and training requirements, to the appropriate policy and fiscal committees of the Legislature and to the Joint Legislative Budget Committee.

This document contains the draft policies and procedures developed to guide the operation of the Enhanced Treatment Program and is current through June 2019. The draft Policy Directives were provided to employee bargaining units for 60-day review on February 15, 2019 and union representatives have had the opportunity to meet and discuss the policies. The California Office of Patient's Rights reviewed the Policy Directives and Program Procedures in December 2018 and their input was incorporated.

DSH previously submitted ETP draft policies and procedures in October 2017 as requested, in anticipation of the first ETP unit opening in 2018. Construction was unavoidably delayed, but now is underway. The first unit is expected to open in the Fall of 2019 therefore DSH has updated and is now resubmitting this document.



California Department of  
**State Hospitals**

**Enhanced Treatment Program**

**Section 2**

**Admissions**

# POLICY DIRECTIVE

<b>NUMBER</b>	3700
<b>TITLE</b>	Enhanced Treatment Program Admission and Initial Certification
<b>EFFECTIVE DATE</b>	
<b>SUPERSEDES</b>	New

## Policy Statement

The Department of State Hospitals’ (DSH) Policy Directives (PDs) provide guidance to comply with laws, regulations, codes, etc. PDs are issued and signed by the Director. It is the policy of DSH to expand its continuum of care by establishing the Enhanced Treatment Program (ETP) for patients who are at high risk of most dangerous behavior and who may benefit from concentrated, evidence-based clinical therapy, structured milieu therapy and/or treatment aimed at reducing the risk of violent behavior, with the goal of returning the patient to a standard treatment environment. DSH is committed to providing treatment in the least restrictive environment.

## Purpose

The purpose of the ETP Admission and Initial Certification PD is to provide guidance on identifying and triaging patients appropriate for admission to the ETP.

## Responsibility

**Executive Sponsor:** Deputy Director Clinical Operations

**Process Owner:** Chief, Data Analytics, Treatment & Assessment, Clinical Operations

## Background

DSH is authorized to implement and operate a pilot ETP to treat patients at high risk of most dangerous behavior to determine whether more intensive care in a higher-security setting is an effective way to reduce violence. The budget provides for the construction of four units, totaling 49 beds.

# POLICY DIRECTIVE

## Authority

1. Health and Safety Code section 1265.9
2. Welfare and Institutions Code sections 4005.1, 4027, and 4101

## Definitions

**Enhanced Treatment Program (ETP):** A pilot program authorized under Health and Safety Code section 1265.9, aimed at treating patients at high risk of most dangerous behavior, who may benefit from concentrated, evidence-based clinical therapy, structured milieu and/or treatment with the goal of reducing the risk of violent behavior in a standard treatment environment.

**Forensic Needs Assessment Panel (FNAP):** A panel that consists of a Psychiatrist, a Psychologist, and a Medical Director, none of whom are involved in the patient's treatment or diagnosis at the time of the hearing or placement evaluation meetings.

**Forensic Needs Assessment Team (FNAT):** 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 and are not part of the ETP treatment team.

**Individualized Behavioral Plan:** A type of behavioral plan developed by the treatment team in conjunction with the patient, to focus on changes patients and staff will make to create an environment that supports the patient in management of unsafe behaviors and progression towards safe conduct.

**Individualized Treatment Interventions:** All interventions provided to the patient on the ETP that are determined to address patient specific risk factors for highest risk of violence.

**Most Dangerous Behavior:** Includes aggressive acts that may cause substantial physical harm to others in an inpatient setting.

**Standard Treatment Environment:** Any DSH state hospital setting outside of the ETP.

**Standard Violence Risk Assessment Methodologies:** May include, but are not limited to, an analysis of past violence, delineation of static and dynamic violence risk factors, and utilization of valid and reliable violence risk assessment testing.

# POLICY DIRECTIVE

**Treatment Team:** The primary Psychiatrist, Psychologist, Clinical Social Worker, Rehabilitation Therapist, Registered Nurse, and Psychiatric Technician assigned to the patient on the ETP unit.

## Process

### I. Who May Be Referred

A patient may be referred for ETP treatment by a Psychiatrist or Psychologist from the standard treatment environment when all following conditions are met:

- A. The patient's treatment team has determined, utilizing standard violence risk assessment methodologies for clinically assessing violence risk, that the patient is at high risk for most dangerous behavior in a standard treatment environment. A determination of a patient's high risk for most dangerous behavior should include a consideration of the severity, frequency, and intensity of a patient's past violent behavior.
- B. Reasonable attempts at providing individualized treatment interventions aimed at reducing the patient's risk for aggression have been attempted without success or it is determined by the patient's treatment team that the patient's aggressive behavior and high violence risk preclude staff's ability to provide interventions safely in the standard treatment environment.
- C. There is no existing contract or memorandum of understanding that provides alternative and clinically appropriate treatment outside of the Department of State Hospitals.
- D. The referring treatment team concludes that the patient does not have medical issues that would contraindicate treatment on the ETP.
- E. The referring treatment team has completed the ETP Referral Form DSH-9220 including, but not limited to, a rationale for ETP placement, current violence risk formulation, summary of violence history, and summary of treatment history and progress.
- F. The completed ETP Referral Form DSH-9220 has been submitted by the referring treatment team or facility to the FNAT Supervising Psychologist and the FNAT Supervising Psychologist has reviewed the ETP Referral Form DSH-9220, determined the referral includes all requisite information, and approved the referral for initial evaluation.

# POLICY DIRECTIVE

## II. Initial Evaluation

- A. The FNAT Psychologist will conduct the initial evaluation of the referred patient to verify the need for treatment on an ETP. This initial evaluation shall be completed prior to a patient's placement into the ETP unless the FNAP determines that an emergency placement is necessary, in which case the initial evaluation shall be completed within three business days of placement in the ETP. The FNAT Psychologist's initial evaluation will include the following elements:
1. An interview of the patient's treatment team.
  2. A review of the patient's medical record.
  3. A review of the patient's history of violence.
  4. A current violence risk level.
  5. A recommendation about need for enhanced treatment.

## III. FNAP 90-Day Placement Evaluation Meeting

- A. The FNAP shall convene a placement evaluation meeting with the referring Psychiatrist or Psychologist, the patient, a Patients' Rights Advocate, and the FNAT Psychologist who conducted the initial evaluation, to determine whether the referred patient should be accepted for ETP treatment. The patient and Patients' Rights Advocate shall be notified at least 72 hours prior to the meeting as to the meeting's purpose, date, time, and location.
- B. The notice to the patient, Patients' Rights Advocate and Conservator if applicable, shall include a written explanation of the reasons, including specific behaviors and incidents that are relied on by the FNAP in making the placement evaluation decision. Instructions shall also be provided as to how a patient may submit documents to the FNAP to consider in making their placement evaluation decision.
- C. In the event a patient is unable to safely participate in the placement evaluation meeting in person, the referring hospital shall arrange for the patient to participate via an alternate modality, such as teleconference or telepresence.
- D. This meeting shall be conducted prior to a patient's placement into the ETP, unless an emergency placement is necessary.
- E. The FNAP shall review all material presented at the FNAP 90-Day Placement Evaluation Meeting and make a certification decision for 90 days of treatment in the ETP.
- F. The patient will be accepted for ETP treatment if the FNAP determines the following criteria are met:

## **POLICY DIRECTIVE**

1. The patient is considered at high risk of most dangerous behavior to staff or other patients;
2. Reasonable attempts at providing individualized treatment interventions aimed at reducing the patient's risk for aggression have been attempted without success or it is determined by the FNAP the patient's aggressive behavior and high violence risk preclude staff's ability to provide interventions safely in a standard treatment environment;
3. The patient does not have medical issues that would contraindicate treatment on the ETP; and
4. The referred patient has been triaged for ETP treatment, taking into consideration the number of ETP referrals across DSH, and the number of available ETP beds.

G. The FNAP will document their decision on the ETP Certification Form, DSH-9219 and provide it to the FNAT Supervising Psychologist. The FNAT Supervising Psychologist will, within three business days of the placement evaluation meeting, provide a copy of the FNAP ETP Certification form to the patient, Patients' Rights Advocate, Conservator (if applicable), and referring hospital transfer coordinator/designee.

H. The FNAT Supervisor will assign the patient to an FNAT Psychologist to conduct an in-depth violence risk assessment. The FNAT Supervisor will assign the patient to an FNAT Psychologist's treatment caseload. The FNAT Psychologists will have 20 calendar days to complete the risk assessment, except when it is an emergency placement. The FNAT Psychologist will identify dynamic risk factors that will be used in treatment planning.

### **V. Transfer of Patient**

A. A patient who has been certified for the ETP must be transported to the ETP no later than 30 calendar days after the initial FNAP 90-day certification decision has been made.

### **VI. Triage Procedure**

A. In the event a referral is made, and the FNAP has determined that a 90-day certification is appropriate, the FNAP shall be provided the status of current ETP patients and possible vacancies. The FNAP shall make the decision to certify based on the violence risk level of the patient that was referred together with the clinical assessment of the current ETP milieu.

# POLICY DIRECTIVE

## Roles and Responsibilities

The FNAT Supervising Psychologist reviews the ETP referral form for completeness prior to the initial evaluation by the FNAT Psychologist.

The FNAT Psychologist conducts the initial evaluation of the referral from the patient’s treatment team; participates in the FNAP 90-day Placement Evaluation Meeting; and completes the in-depth violence risk assessment.

The FNAP conducts the FNAP 90-day Placement Evaluation Meeting; reviews all information provided at the placement evaluation meeting; and provides written decisions regarding certification.

The Patients’ Rights Advocate participates in the FNAP 90-day Placement Evaluation Meeting.

The Referring Psychologist or Psychiatrist participates in the FNAP 90-day Placement Evaluation Meeting.

## Approval

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STEPHANIE CLENDENIN  
Director (A)

Date

## References

1. Health and Safety Code section 1265.9
2. Welfare and Institutions Code sections 4143 and 4144
3. Title 9 of the California Code of Regulations, sections 4801-5100
4. Policy Directive 3702, Enhanced Treatment Program Ongoing Certification
5. Policy Directive 3706, Enhanced Treatment Program Milieu Management Plan
6. Policy Directive 3704, Enhanced Treatment Program Treatment Planning
7. Policy Directive 3708, Enhanced Treatment Program Discharge and Transition
8. ETP Referral Form DSH-9220
9. ETP Certification Form DSH-9219

# POLICY DIRECTIVE

## Attachments

1. ETP FNAP Certification Decision Notification Grid

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Event	Timeframe	Notifier	Recipient
<b>FNAP 90-day Placement Evaluation Meeting</b>	Within 3 business days	FNAT Supervising Psychologist	Patient, Patients' Rights Advocate, Conservator (if applicable) & Referring Hospital
<b>FNAP One Year Placement Evaluation Meeting</b>	Within 24 hours		Patient, Patients' Rights Advocate, Conservator (if applicable), Referring Hospital & ETP Hospital
<b>FNAP One Year Continuation Placement Evaluation Meeting</b>	Within 24 hours		Patient, Patients' Rights Advocate, Conservator (if applicable), Referring Hospital & ETP Hospital
<b>Independent Medical Review Placement Evaluation Hearing</b>	Within 3 business days		Patient, Patients' Rights Advocate, Conservator (if applicable), Referring Hospital & ETP Hospital
<b>FNAP 90-day Treatment Summary Review</b>	Within 3 business days		Patient, Patients' Rights Advocate, Conservator (if applicable), Referring Hospital & ETP Hospital

# DEPARTMENT OF STATE HOSPITALS ENHANCED TREATMENT PROGRAM

## ETP OPERATING MANUAL

### SECTION – Admission and Certification

#### PROGRAM PROCEDURE No. ETP-OP-001



#### SUBJECT: ETP Admission and Initial Certification Procedures

Effective Date: 4/9/19

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This procedure is specific to the Enhanced Treatment Program (ETP).

- I. PURPOSE  
To provide clear procedures on identifying, referring, admitting and triaging patients appropriate for the ETP.
- II. DEFINITIONS
  - A. **Enhanced Treatment Program (ETP):** A pilot program authorized under Health and Safety Code section 1265.9, aimed at treating patients at high risk of most dangerous behavior, who are able to benefit from concentrated, evidence-based clinical therapy, structured milieu and/or treatment with the goal of reducing the risk of violent behavior in a standard treatment environment.
  - B. **Forensic Needs Assessment Panel (FNAP):** A panel that consists of a Psychiatrist, a Psychologist, and a Medical Director none of whom are involved in the patient's treatment or diagnosis at the time of the hearing or placement evaluation meetings.
  - C. **Forensic Needs Assessment Team (FNAT):** 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 and are not part of the ETP treatment team.
  - D. **Individualized Behavioral Plan:** A type of behavioral plan developed by the treatment team in conjunction with the patient, to focus on changes patients and staff will make to create an environment that supports the patient in management of unsafe behaviors and progression towards safe conduct.
  - E. **Individualized Treatment Interventions:** All interventions provided to the patient on the ETP that are determined to address patient specific risk factors for highest risk of violence.
  - F. **Most Dangerous Behavior:** Includes aggressive acts that may cause substantial physical harm to others in an inpatient setting.

- G. **Psychopharmacology Resource Network Consult (PRN) Consult:** A thorough review of current and past psychopharmacological treatment by a Psychopharmacology Resource Network Psychiatrist followed by evidence-based recommendations.
- H. **Standard Treatment Environment:** Any DSH state hospital setting outside of the ETP.
- I. **Standard Violence Risk Assessment Methodologies:** May include, but are not limited to, an analysis of past violence, delineation of static and dynamic violence risk factors, and utilization of valid and reliable violence risk assessment testing.
- J. **Treatment Team:** The primary Psychiatrist, Psychologist, Clinical Social Worker, Rehabilitation Therapist, Registered Nurse, and Psychiatric Technician assigned to the patient on the ETP unit.

### III. ETP REFERRAL

- A. A patient may be referred for ETP treatment when the following conditions are met:
  - 1. A Psychiatrist or Psychologist from the treating DSH facility determines, utilizing standard violence risk assessment methodologies for clinically assessing violence risk, that the patient is at high risk for most dangerous behavior in a standard treatment environment. A determination of a patient's high risk for most dangerous behavior should include a consideration of the severity, frequency, and intensity of a patient's past violent behavior.
  - 2. Reasonable attempts at providing individualized treatment interventions aimed at reducing the patient's risk for aggression have been attempted without success or it is determined by the patient's treatment team that the patient's aggressive behavior and high violence risk preclude staff's ability to provide interventions safely in the standard treatment setting.
  - 3. There is no existing contract or memorandum of understanding that provides alternative and clinically appropriate treatment outside of the Department of State Hospitals.
  - 4. The referring treatment team has completed a Psychopharmacology Resource Network (PRN) consult or has documented a justification for why the PRN consult was not completed and has made reasonable attempts to follow recommended interventions or has documented a reasonable rationale on why recommended interventions were not attempted.
  - 5. The referring team concludes the patient does not have medical issues that would preclude safe treatment on the ETP.

6. The referring treatment team has completed the ETP Referral Form DSH-9220 including, but not limited to, a rationale for ETP placement, current violence risk formulation, summary of violence history, and summary of treatment history and progress.

#### IV. REFERRING HOSPITAL ETP REFERRAL ROUTING

- A. Once the ETP Referral Form has been completed by the unit Psychologist or Psychiatrist, the form will be routed through Program Management who will review the form for completeness and adherence to the ETP referral and admissions criteria. Program Management will then route the referral to the Medical Director and/or Clinical Administrator for final determination whether the referral is necessary.
- B. Once the referring hospital has determined the referral is necessary, the Referral Form DSH-9220 will be submitted to the FNAT Supervising Psychologist with specific contact information for the referring hospital transfer coordinator/designee responsible for coordinating meetings between the treatment team and FNAT Psychologist.

#### V. FNAT REFERRAL REVIEW

- A. The FNAT Supervising Psychologist will forward the ETP referral to a FNAT Psychologist for an initial evaluation when the following conditions are met:
  1. A completed ETP Referral Form is submitted by the referring treatment team or facility to the FNAT Supervising Psychologist.
  2. The FNAT Supervising Psychologist has reviewed the ETP Referral Form and determined the referral includes all required information.
  3. The FNAT Supervising Psychologist has notified the Patients' Rights Advocate and Conservator, if applicable, that the patient has been referred for an ETP placement evaluation.
  4. The FNAT Supervising Psychologist will notify the referring hospital that the referral has been assigned for evaluation.

## VI. FNAT INITIAL EVALUATION

- A. The FNAT Psychologist will conduct the initial evaluation of the referred patient to verify the need for treatment on an ETP. The FNAT Psychologist's initial evaluation will include the following elements:
  1. An interview of the patient's treatment team.
  2. A review of the patient's medical record.
  3. A review of the patient's history of violence
  4. A current violence risk level
  5. A recommendation about need for enhanced treatment
- B. The FNAT Psychologist will forward the completed initial evaluation to the FNAT Supervising Psychologist.
- C. The FNAT Supervising Psychologist will notify the FNAP members and forward the referral documents and initial assessment to the FNAP members for their review.
- D. The referring hospital will notify the patient that he/she has been referred to the ETP and a placement evaluation meeting will be scheduled; and will inform the FNAT Supervising Psychologist that the patient has been notified.
- E. The FNAT Supervising Psychologist will then schedule the placement evaluation meeting and notify the FNAP members, referring hospital, Patients' Rights Advocate and Conservator, if applicable, at least 72 hours prior of the meeting's purpose, date, time and location.
- F. The referring hospital will notify the patient of the placement meeting date and provide the patient with a written explanation of the reasons, including specific behaviors and incidents that were relied upon in making the recommendation. Such notice shall be provided to the patient, at least 72 hours prior to the meeting date, and contain instructions on how to submit documents for consideration by the FNAP during the placement evaluation meeting.
- G. The referring hospital in coordination with the Patient's Rights Advocate will forward documents submitted by the patient for consideration by the FNAP to the FNAT Supervising Psychologist.

## VII. FNAP 90 DAY PLACEMENT EVALUATION MEETING

- A. A FNAP 90 Day Placement Evaluation Meeting will be convened to determine if the referred patient should be accepted for ETP treatment. The FNAP consists of a DSH-assigned Psychiatrist, Psychologist, and Medical Director. This meeting

will also include the referring Psychiatrist or Psychologist, the patient, the Conservator (if applicable), the Patients' Rights Advocate, and the FNAT Psychologist who completed the initial evaluation.

- B. In the event a patient is unable to safely participate in the placement evaluation meeting in person, the referring hospital shall arrange for the patient to participate via an alternate modality, such as teleconference or telepresence.
- C. This meeting shall be conducted prior to a patient's placement into the ETP, unless an emergency placement is necessary.
- D. The patient will be accepted for ETP treatment if the FNAP determines the following criteria are met:
  - 1. The patient is considered at high risk of most dangerous behavior to staff or other patients.
  - 2. Reasonable attempts at providing individualized treatment interventions aimed at reducing the patient's risk for aggression were attempted without success or it is determined by FNAP the patient's aggressive behavior and high violence risk preclude staff's ability to provide interventions safely in a standard treatment environment.
  - 3. The patient does not have medical issues that would preclude safe treatment on the ETP.
  - 4. The referred patient has been triaged for ETP treatment taking into consideration the number of ETP referrals across DSH and the number of available beds.

#### VIII. FNAP CERTIFICATION NOTIFICATION AND IN-DEPTH VIOLENCE RISK ASSESSMENT

- A. If the FNAP determines a patient does not meet ETP certification criteria, they will document this decision on the ETP Certification Form and provide it to the FNAT Supervising Psychologist. The FNAT Supervising Psychologist will, within three business days of the placement evaluation meeting, provide a copy of the FNAP ETP Certification form to the patient, Patients' Rights Advocate, Conservator (if applicable), and referring hospital transfer coordinator/designee.
- B. If the FNAP determines a patient does meet ETP certification criteria, they will document this decision on the ETP Certification Form DSH-9219 and provide it to the FNAT Supervising Psychologist. The FNAT Supervising Psychologist will, within three business days of the placement evaluation meeting, provide a copy of the FNAP ETP Certification form to the patient, Patients' Rights Advocate, Conservator (if applicable), referring hospital transfer coordinator/designee and ETP hospital.

1. The FNAT Supervisor will assign the patient to an FNAT Psychologist to conduct an in-depth violence risk assessment. The FNAT Supervisor will assign the patient to an FNAT Psychologist's treatment caseload.
2. The patient will be certified for 90 days of treatment in the ETP. Within seven business days of the FNAP ETP certification, the referring hospital will complete an ETP Transfer e-Packet Checklist and provide the packet to the receiving ETP.
3. The FNAT will have 20 calendar days to complete the in-depth violence risk assessment. The assigned FNAT Psychologist may utilize telepresence to interview the patient and complete the evaluation. The FNAT Psychologist will identify dynamic risk factors that will be used in treatment planning.
4. The patient will be transferred to the ETP within 30 calendar days of the FNAP certification decision.

#### IX. ETP ADMISSION

- A. Upon admission to the ETP, each patient will receive a psychiatric, nursing and medical admission assessment, per the ETP hospital's current requirements.
- B. The patient will be assigned to a milieu status in accordance with the ETP Milieu Management Plan.
- C. Within 72 hours of admission, the FNAT will meet with the designated ETP treatment team to discuss the risk factors and design a treatment plan.
- D. Following the 72-hour treatment team conference, the treatment team will meet with the patient weekly in treatment planning conferences to assess progress towards treatment goals.
- E. The FNAT Psychologist will review the treatment plan no less than every 10 days and update the plan in collaboration with the treatment team as needed.

#### X. EMERGENCY PLACEMENT AND CERTIFICATION PROCEDURE

##### A. Emergency Placement

1. In the event a patient presents an extremely high risk of dangerous behavior and cannot be safely treated in a standard treatment setting the FNAP may consider the patient for emergency placement.
2. The Executive Director (ED) of the referring hospital will contact the FNAT Supervising Psychologist and submit the ETP emergency placement packet.

3. The FNAT Supervising Psychologist will notify the Patients' Rights Advocate and Conservator, if applicable, that the patient has been referred for emergency ETP placement.
4. The five hospital EDs will convene to discuss the patient's case and circumstances to determine whether the respective patient's ED will advance the referral for emergency certification consideration by the FNAP. If there are beds available for emergency placement, the patient shall be admitted into the ETP as soon as transportation arrangements can be made.
5. If there are no beds available, the EDs will use the Monthly ETP Utilization Report containing information on patients nearing or currently eligible for discharge (if any). If the EDs determine that an emergency placement is appropriate, the EDs shall determine possible clinically appropriate patients for expedited transition/discharge to a standard treatment environment. The EDs will make a recommendation to the FNAP on the most appropriate patients ready for expedited discharge.
6. The FNAP will make a placement decision based on the nature of the emergency referral, the clinical assessment of the current ETP patients and potential vacancies in the ETP.
7. If the FNAP determines that an emergency placement is appropriate, the FNAT Supervising Psychologist will notify the referring hospital and the ETP hospital. If there is an ETP bed available, transportation arrangements will be made as soon as possible.
8. The referring hospital shall complete the ETP Transfer e-Packet Checklist prior to transport. The referring hospital shall hold a bed for the patient until the FNAP makes a certification decision (7 to 14 business days).

B. Expedited Discharge From the ETP to a Standard Treatment Environment

1. If a patient is identified by the FNAP for expedited discharge from the ETP to a standard treatment environment, the patient's aftercare plan will be completed as soon as possible and provided to the receiving hospital. The patient will be transported to the receiving hospital as soon as the aftercare plan and appropriate discharge documentation is completed and communicated to the receiving hospital.
2. During the first 30 days following discharge, the ETP team will communicate regularly with the receiving treatment team to assist with the patient's transition. Following the initial 30 days, the teams will communicate as necessary to assist transition.

### C. Emergency Placement Admission and Treatment Planning

1. Upon admission to the ETP, each patient will receive a psychiatric, nursing and medical admission assessment, per the ETP hospital's current requirements.
2. The patient will be assigned to a milieu status in accordance with the ETP Milieu Management Plan.
3. Upon admission, the FNAT will complete the initial evaluation and meet with the designated ETP treatment team to discuss the risk factors and design a treatment plan.
4. Within seven business days of placement in an ETP and with a minimum of 72-hour notice to the patient, Patient's Rights Advocate and Conservator if applicable, the FNAP will conduct a placement evaluation meeting to determine if the patient clinically requires ETP treatment.
5. The notice to the patient, Conservator if applicable and Patients' Rights Advocate shall include a written explanation of the reasons, including specific behaviors and incidents that are relied on the ETP recommendation. Instructions shall also be provided as to how a patient may submit documents to the FNAP to consider in making their placement evaluation.
6. Following the 72-hour treatment team conference, the treatment team will meet with the patient weekly in treatment planning conference to assess progress towards treatment goals.

### D. Emergency Placement FNAP Certification Notification and In-Depth Violence Risk Assessment

1. If the FNAP determines a patient does not meet ETP certification criteria, they will document this decision on the ETP Certification Form and provide it to the FNAT Supervising Psychologist. The FNAT Supervising Psychologist will, within three business days of the placement evaluation meeting, provide a copy of the FNAP ETP Certification form to the patient, Patients' Rights Advocate, Conservator (if applicable), referring hospital transfer coordinator/designee and ETP hospital. If a patient is not certified for treatment in the ETP, the patient will be transported back to the referring hospital as soon as possible, but no later than 5 business days.
2. If the FNAP determines a patient does meet ETP certification criteria, they will document this decision on the ETP Certification Form and provide it to the FNAT Supervising Psychologist. The FNAT Supervising Psychologist will, within three business days of the placement evaluation meeting, provide a copy of the FNAP ETP Certification form to the patient, Patients' Rights

Advocate, Conservator (if applicable), referring hospital transfer coordinator/designee and ETP hospital.

- a) The patient will be certified to the ETP for 90 days.
- b) The FNAT Supervising Psychologist will assign the patient to an FNAT Psychologist to conduct an in-depth violence risk assessment. The FNAT Supervising Psychologist will assign the patient to an FNAT Psychologist's treatment caseload.
- c) The FNAT Psychologist will complete the in-depth violence risk assessment within 7 business days of certification. The FNAT Psychologist will identify dynamic risk factors that will be used in treatment planning.

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California Department of  
**State Hospitals**

**Enhanced Treatment Program**

**Section 3**

**Services**

# POLICY DIRECTIVE

<b>NUMBER</b>	3704
<b>TITLE</b>	Enhanced Treatment Program Treatment Planning
<b>EFFECTIVE DATE</b>	
<b>SUPERSEDES</b>	New

## Policy Statement

The Department of State Hospitals’ (DSH) Policy Directives (PDs) provide guidance to comply with laws, regulations, codes, etc. PDs are issued and signed by the Director. It is the policy of DSH to expand its continuum of care by establishing the Enhanced Treatment Program (ETP) for patients who are at high risk of most dangerous behavior and who may benefit from concentrated, evidence-based clinical therapy, structured milieu therapy and/or treatment aimed at reducing the risk of violent behavior, with the goal of returning the patient to a standard treatment environment. DSH is committed to providing treatment in the least restrictive environment.

## Purpose

The purpose of the ETP Treatment Planning PD is to provide guidance on treatment and planning procedures to encourage patient improvement and recovery and provide a process for creating and implementing a treatment plan with regular clinical review and reevaluation of progress towards placement back into a standard treatment environment.

## Responsibility

**Executive Sponsor:** Deputy Director, Clinical Operations

**Process Owner:** Chief, Data Analytics, Treatment & Assessment, Clinical Operations

## Background

DSH is authorized to implement and operate a pilot ETP to treat patients at high risk of most dangerous behavior to determine whether more intensive care in a higher-security setting is an effective way to reduce violence. The budget provides for the construction of four units, totaling 49 beds.

# POLICY DIRECTIVE

## Authority

1. Health and Safety Code section 1265.9
2. Welfare and Institutions Code sections 4005.1, 4027, and 4101

## Definitions

**Clinical Indicators:** Specific clinical signs and/or behaviors manifested by the patient that indicate illness or behavioral instability.

**Enhanced Treatment Program (ETP):** A pilot program authorized under Health and Safety Code sections 1265.9 aimed at treating patients at high risk of most dangerous behavior, who may benefit from concentrated, evidence-based clinical therapy, structured milieu and/or treatment with the goal of reducing the risk of violent behavior in a standard treatment environment.

**Forensic Needs Assessment Team (FNAT):** 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 and are not part of the ETP treatment team.

**Milieu Management Plan (MMP):** A type of behavioral plan which includes the Milieu Status and Safety Communication Plan and is developed by the treatment team in conjunction with the patient, to focus on changes staff will make to create an environment that supports the patient in management of unsafe behaviors and progression towards safe conduct.

**Milieu Status:** A determination of when a locked patient room door may be used as clinically indicated and is determined to be the least restrictive management intervention for the patient's care and treatment. Milieu Status 1, 2 and 3 will be used to communicate the status.

Milieu status 3 – Unlocked patient room door

Milieu status 2 – Locked patient room door at specific times

Milieu status 1 – Locked ETP suite

**ETP Suite:** A locked patient room that includes a sink, commode and shower, to be utilized when a regular patient room is clinically contraindicated. When a patient is in Milieu Status 1, the ETP Suite is not considered "seclusion" as defined in Health and Safety Code 1180.1(e). However, the ETP Suite may be utilized as a restraint or seclusion room when necessary.

**Treatment Team:** The primary Psychiatrist, Psychologist, Clinical Social Worker, Rehabilitation Therapist, Registered Nurse, and Psychiatric Technician assigned to the patient.

# POLICY DIRECTIVE

## Process

- I. Upon admission to an ETP, a FNAT Psychologist who is not on the patient's treatment team shall complete an in-depth violence risk assessment and, in conjunction with the ETP treatment team, make an individual treatment plan for the patient based on the assessment.
  - A. The individual treatment plan shall:
    1. be in writing and developed in collaboration with the patient, when possible. The initial treatment plan shall be developed as soon as possible, but no later than 72 hours following the patient's admission. The comprehensive treatment plan shall be developed following a complete violence risk assessment, except during an emergency referral;
    2. be based on a comprehensive assessment of the patient's physical, mental, emotional, and social needs, and focused on mitigation of violence risk factors; and
    3. be reviewed and updated no less than every 10 days.

## II. Individual Treatment Plan

- A. The individual treatment plan shall include, but is not limited to, all the following:
  1. A statement of the patient's physical and mental condition, including all mental-health and medical diagnoses.
  2. Prescribed medication, dosage, and frequency of administration.
  3. Specific goals of treatment with intervention and actions that identify steps toward reduction of violence risk and observable, measurable objectives as documented in the MMP.
    - a) The MMP shall include:
      - i. Milieu Status - a determination as to whether it is clinically indicated to be the least restrictive treatment for the patient's room to be locked during certain times;
      - ii. goals a patient must achieve to move to less restrictive treatment; and
      - iii. what mechanisms will be utilized by the treatment team to assist the patient in reaching those goals.
  4. Identification of methods to be utilized, the frequency for conducting each treatment method, and the person(s) or discipline(s) responsible for each treatment method.
  5. Documentation of the success or failure in achieving stated objectives.
  6. Evaluation of the factors contributing to the patient's progress or lack of progress toward reduction of violence risk and a

# POLICY DIRECTIVE

statement of the multidisciplinary treatment decision for follow-up action.

7. An activity plan.
8. A plan for other services needed by the patient, such as care for medical and physical ailments, not provided by the treatment team.
9. Discharge criteria and goals for an aftercare plan in a standard treatment environment and a plan for post-ETP discharge follow-up.

### III. ETP Treatment Team

- A. An ETP patient shall receive treatment from a treatment team consisting of a psychiatrist, a psychologist, a nurse, a psychiatric technician, a clinical social worker, a rehabilitation therapist, and any other necessary staff who shall meet as often as necessary, (but no less than once a week) to assess the patient's response to treatment.
- B. The staff shall observe and note any changes in the patient's condition, and the treatment plan shall be modified in response to the observed changes.

### IV. Behavioral Health Assistance Module (BHAM)

- A. The ETP BHAM module is an electronic dashboard that facilitates treatment pathways, the completion of forensically driven documentation, and ETP-related notifications. It also provides a platform for data collection.
- B. The ETP treatment team shall develop the treatment plan using BHAM and the Lippincott Nursing Advisor. The treatment plan shall be prepared electronically in BHAM, printed, signed, and filed under the Treatment Plan tab in the patient's chart.

### V. Treatment Services

- A. The ETP treatment program shall include therapeutic, social, recreational, and vocational activities in accordance with the interests, abilities, and needs of the patients, including the opportunity for exercise.

# POLICY DIRECTIVE

- B. Treatment services provided may include but are not limited to:
  - 1. Emotion Regulation
  - 2. Substance Recovery
  - 3. Criminogenic Risk Factors
  - 4. Cognitive Impairment
  - 5. Sensory Modulation
  - 6. Behavior Principles
  - 7. Cognitive Behavioral Therapy (CBT)
  - 8. CBT for Psychosis (CBTp)
  - 9. Medication Education
  - 10. Rehabilitation Therapy, including Recreation, Music, Art, and/or Occupational Therapy

## Roles and Responsibilities

The FNAT Psychologist reviews the referral and transfer documentation, participates in treatment team conference meetings, and regularly reviews the treatment plan revisions and updates.

The ETP Team Psychiatrist reviews the referral and transfer documentation, participates in treatment team conference meetings as lead, and regularly reviews the treatment plan revisions and updates.

The ETP Team Psychologist reviews the referral and transfer documentation, participates in treatment team conference meetings, and regularly reviews the treatment plan revisions and updates.

The Treatment Team reviews the referral and transfer documentation, participates in team conference meetings, documents the patient’s progress towards meeting goals, and works in collaboration to create and maintain the MMP.

## Approval

\_\_\_\_\_  
STEPHANIE CLENDENIN  
Director (A)

# POLICY DIRECTIVE

## References

1. Health and Safety Code section 1265.9
2. Welfare and Institutions Code sections 4143 and 4144
3. Title 9 of the California Code of Regulations, sections 4801-5100
4. Policy Directive 3700, Enhanced Treatment Program Admission and Initial Certification
5. Policy Directive 3702, Enhanced Treatment Program Ongoing Certification
6. Policy Directive 3706, Enhanced Treatment Program Milieu Management Plan
7. Policy Directive 3708, Enhanced Treatment Program Discharge and Transition

# DEPARTMENT OF STATE HOSPITALS ENHANCED TREATMENT PROGRAM

## ETP OPERATING MANUAL

### SECTION – Treatment Planning

#### PROGRAM PROCEDURE No. ETP-OP-100

#### SUBJECT: ETP Treatment Planning



**Effective Date:** 4/9/19

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This procedure is specific to the Enhanced Treatment Program (ETP).

#### I. PURPOSE

To provide clear procedures on treatment and planning procedures to encourage patient improvement and recovery and provide a process for creating and implementing a treatment plan with regular clinical review and reevaluation of placement back into a standard treatment environment. Treatment plans are developed and reviewed on a regular basis in collaboration with the patient.

#### II. DEFINITIONS

- A. **Clinical Indicators:** Specific clinical signs and/or behaviors manifested by the patient that indicate illness or behavioral instability.
- B. **Enhanced Treatment Program (ETP):** A pilot program authorized under Health and Safety Code sections 1265.9 aimed at treating patients at high risk of most dangerous behavior, who are able to benefit from concentrated, evidence-based clinical therapy, structured milieu and/or treatment with the goal of reducing the risk of violent behavior in a standard treatment environment.
- C. **Forensic Needs Assessment Team (FNAT):** 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 and are not part of the ETP treatment team.
- D. **Milieu Management Plan (MMP):** A type of behavioral plan, which includes the Milieu Status and Safety Communication Plan and is developed by the treatment team in conjunction with the patient, to focus on changes staff will make to create an environment that supports the patient in management of unsafe behaviors and progression towards safe conduct.
- E. **Milieu Status:** A determination of when a locked patient room door may be used as clinically indicated and is determined to be the least restrictive management intervention for the patient's care and treatment. Milieu Status 1, 2 and 3 will be used to communicate the status.

- Milieu status 3 – Unlocked patient room door
- Milieu status 2 – Locked patient room door at specific times
- Milieu status 1 – Locked ETP suite

- F. **ETP Suite:** A locked patient room that includes a sink, commode and shower to be utilized when a regular patient room is clinically contraindicated. When a patient is in Milieu Status 1, the ETP Suite is not considered “seclusion” as defined in Health and Safety Code 1180.1(e). However, the ETP Suite room may be utilized as a restraint or seclusion room when necessary.
- G. **Safety Communication Plan:** A document that is utilized to monitor and communicate the patients Milieu Status, peer contact parameters, number and type of on/off unit escorts, level of staff monitoring; nursing and other considerations.
- H. **Treatment Team:** The primary Psychiatrist, Psychologist, Clinical Social Worker, Rehabilitation Therapist, Registered Nurse and Psychiatric Technician assigned to the patient.

### III. ETP TREATMENT TEAM

An ETP patient shall receive treatment from a treatment team consisting of a psychiatrist, a psychologist, a nurse, a psychiatric technician, a clinical social worker, a rehabilitation therapist, and any other necessary staff who shall meet as often as necessary, but no less than once a week, to assess the patient’s response to treatment.

### IV. INITIAL (72-HOUR) TREATMENT PLAN

- A. The FNAT Psychologist assigned to the patient will meet with the designated ETP treatment team to discuss the risk factors and design an initial treatment plan within 72 hours of admission.
- B. The initial treatment plan will use information from the initial and in-depth violence risk assessment, ETP Referral Form, Psychiatric Admission Assessment, Medical Admission Assessment and Nursing Admission Assessment.

### V. COMPREHENSIVE (WEEKLY) TREATMENT PLAN

- A. The treatment team will meet with the patient weekly in a treatment team conference to assess progress towards treatment goals.
- B. The Weekly Treatment Plan will be reviewed and updated weekly by the patient’s treatment team to reflect a patient’s progress, or lack of, towards treatment goals.
- C. The FNAT Psychologist will review the weekly treatment plan no less than every 10 days.
- D. The ETP Team Psychiatric Technician/Registered Nurse will:

1. Schedule the patient for each weekly treatment team conference.
2. Update the Treatment Plan following each treatment team conference.

## VI. TREATMENT PLAN

- A. The individual treatment plan shall be in writing, developed in collaboration with the patient, when possible, and be based on a comprehensive assessment of the patient's physical, mental, emotional, and social needs, and focused on mitigation of violence risk factors.
- B. The individual treatment plan shall include, but is not limited to, all of the following:
  1. A statement of the patient's physical and mental condition, including all mental health and medical diagnoses.
  2. Prescribed medication, dosage, and frequency of administration.
  3. Specific goals of treatment with interventions and actions that identify steps toward reduction of violence risk and observable, measurable objectives as documented in the MMP.
    - a) The MMP shall include:
      - i. Milieu Status - A determination as to whether it is clinically indicated to be the least restrictive treatment for the patient's room to be locked during certain times
      - ii. Goals a patient must achieve in order to move to less restrictive treatment
      - iii. What mechanisms will be utilized by the treatment team to assist the patient in reaching those goals
  4. Identification of methods to be utilized, the frequency for conducting each treatment method, and the person, or persons, or discipline, or disciplines, responsible for each treatment method.
  5. Documentation of the success or failure in achieving stated objectives.
  6. Evaluation of the factors contributing to the patient's progress or lack of progress toward reduction of violence risk and a statement of the treatment team decision for follow-up action.
  7. An activity plan.
  8. A plan for other services needed by the patient, such as care for medical and physical ailments, which are not provided by the treatment team.

9. Discharge criteria and goals for an aftercare plan in a standard treatment environment and a plan for post-ETP discharge follow up.

VII. BEHAVIORAL HEALTH ASSISTANCE MODULE (BHAM)

- A. The ETP BHAM module is an electronic dashboard that facilitates treatment pathways, the completion of forensically driven documentation, and ETP-related notifications. It also provides a platform for data collection.
- B. The ETP treatment team shall develop the treatment plan using BHAM and the Lippincott Nursing Advisor. The treatment plan shall be prepared electronically in BHAM, printed, signed and filed under the Treatment Plan tab in the patient's chart.

VIII. TREATMENT SERVICES

- A. The ETP treatment services shall include therapeutic, social, recreational, and vocational activities in accordance with the interests, abilities, and needs of the patients, including the opportunity for exercise.
- B. Treatment services provided may include, but are not limited to:
  1. Emotion Regulation
  2. Substance Recovery
  3. Criminogenic Risk Factors
  4. Cognitive Remediation
  5. Sensory Modulation
  6. Behavior Principles
  7. Cognitive Behavioral Therapy (CBT)
  8. CBT for Psychosis (CBTp)
  9. Medication Education
  10. Rehabilitation Therapy, including Recreation, Music, Art, and/or Occupational Therapy

# POLICY DIRECTIVE

<b>NUMBER</b>	3706
<b>TITLE</b>	Enhanced Treatment Program Milieu Management Plan
<b>EFFECTIVE DATE</b>	
<b>SUPERSEDES</b>	New

## Policy Statement

The Department of State Hospitals’ (DSH) Policy Directives (PDs) provide guidance to comply with laws, regulations, codes, etc. PDs are issued and signed by the Director. It is the policy of DSH to expand its continuum of care by establishing the Enhanced Treatment Program (ETP) for patients who are at high risk of most dangerous behavior and who may benefit from concentrated, evidence-based clinical therapy, structured-milieu therapy, and/or treatment aimed at reducing the risk of violent behavior, with the goal of returning the patient to a standard treatment environment. DSH is committed to providing treatment in the least restrictive environment.

## Purpose

The purpose of the ETP Milieu Management Plan PD is to provide guidance on establishing procedures that create a safe environment where effective therapy can be provided within the least restrictive environment.

## Responsibility

**Executive Sponsor:** Deputy Director, Clinical Operations

**Process Owner:** Chief, Data Analytics, Treatment & Assessment, Clinical Operations

## Background

DSH is authorized to implement and operate a pilot ETP to treat patients at high risk of most dangerous behavior to determine whether more intensive care in a higher-security setting is an effective way to reduce violence. The budget provides for the construction of four units, totaling 49 beds.

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## Authority

1. Health and Safety Code section 1265.9
2. Welfare and Institutions Code sections 4005.1, 4027, and 4101

## Definitions

**Clinical indicators:** Specific clinical signs and/or behaviors manifested by the patient that indicate illness or behavioral instability.

**Enhanced Treatment Program (ETP):** A pilot program authorized under Health and Safety Code sections 1265.9 aimed at treating patients at high risk of most dangerous behavior, who may benefit from concentrated, evidence-based clinical therapy, structured milieu and/or treatment with the goal of reducing the risk of violent behavior in a standard treatment environment.

**Forensic Needs Assessment Panel (FNAP):** A panel that consists of a Psychiatrist, a Psychologist, and a Medical Director, none of whom are involved in the patient's treatment or diagnosis at the time of the hearing or placement evaluation meetings.

**Forensic Needs Assessment Team (FNAT):** 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 and are not part of the treatment team.

**Milieu Management Plan (MMP):** A type of behavioral plan which includes the Milieu Status and Safety Communication Plan and is developed by the treatment team in conjunction with the patient, to focus on changes staff will make to create an environment that supports the patient in management of unsafe behaviors and progression towards safe conduct.

**Milieu Status:** A determination of when a locked patient room door may be used as clinically indicated and is determined to be the least restrictive management intervention for the patient's care and treatment. Milieu status 1, 2 and 3 will be used to communicate the status.

Milieu status 3 - Unlocked patient room

Milieu status 2 – Locked patient room door at specific times

Milieu status 1 – Locked ETP suite

**ETP Suite:** A locked patient room that includes a sink, commode and shower, to be utilized when a regular patient room is clinically contraindicated. When a patient is in Milieu Status 1, the ETP Suite is not considered "seclusion" as defined in Health and Safety Code 1180.1(e). However, the ETP Suite may be utilized as a restraint or seclusion room when necessary.

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**Safety Communication Plan:** A document that is utilized to monitor and communicate the patient’s Milieu Status, peer contact parameters, number and type of on/off unit escorts, level of staff monitoring; nursing and other considerations.

**Treatment Team:** The primary Psychiatrist, Psychologist, Clinical Social Worker, Rehabilitation Therapist, Registered Nurse and Psychiatric Technician assigned to the patient.

## Process

### I. Determining the Patient’s Initial Milieu Status

- A. Prior to admission, the treatment team and FNAT Psychologist will meet to review the available documentation pertaining to risk-management of the patient’s aggression.
  1. The treatment team will identify any pre-existing medical condition(s) or physical disabilities that would place the patient at greater medical or physical risk during Milieu Status 1/ETP Suite or Milieu Status 2 periods.
  2. The treatment team will identify history of trauma, sexual, or physical abuse that may place the patient at greater psychological risk during Milieu Status 1/ETP Suite or Milieu Status 2 periods.
- B. The treatment team Psychiatrist or, in their absence, the treatment team Psychologist, will interview the patient upon admission to the ETP and develop the initial admission MMP including the determination of the patient’s Milieu Status and shall complete the Safety Communication Plan.
- C. The patient may be admitted into Milieu Status 1, 2, or 3 as determined by the ETP treatment team psychiatrist or psychologist based on his/her review of the documentation and interview with the patient.
- D. The treatment team shall communicate to the patient his/her milieu status prior to the end of the admission day. The treatment team shall discuss the unsafe behaviors, expected patient behavior and supports in place to assist the patient to progress towards a less restrictive Milieu Status.

### II. Determining Changes to The Patient’s MMP

- A. The patient’s Milieu Status will be reviewed at shift changes, morning meetings, and treatment planning conferences.
- B. The treatment team shall update the Safety Communication Plan when changes are made to the patient’s MMP.

## POLICY DIRECTIVE

- C. Progress through Milieu Status 1, 2, and 3 is not necessarily sequential.
- D. The timeframe for a patient's progression to a less restrictive milieu status or reversion to a more restrictive milieu status shall be determined by the treatment team, individualized to each patient, based on individualized behavioral anchors, and documented in the MMP.
- E. A patient may be moved from a more restrictive to a less restrictive Milieu Status or from a less restrictive to a more restrictive Milieu Status based on his/ her behavior during the designated period.
- F. If new behaviors emerge, changes in Milieu Status may be delayed until the treatment team is able to provide input.
- G. A patient's progress towards achieving his/ her MMP goals will be assessed by nursing staff at least one time per shift and documented and communicated at each change of shift.

### III. Documenting Changes to The Milieu Status

- A. When it has been determined that a patient has successfully met the goals of his/her MMP or has regressed in meeting the goals of his/her MMP, changes shall be noted in the Milieu Management and Safety Communication Plans. The changes shall be included in the treatment team conference meetings and made available to all staff.
- B. The treatment team shall communicate with the patient, any changes to his/her milieu status, and discuss the unsafe behaviors, expected patient behavior and supports in place to assist the patient to progress towards a less restrictive Milieu Status.

### IV. Milieu Status

- A. Milieu Status 3 – Unlocked Patient Room Door
  - 1. Behavioral Anchors/Clinical Indicators will be individualized and may include but are not limited to the following types of behaviors:
    - a) Patient can safely manage his/her behavior(s) in the Milieu.
    - b) Preparing to transition out of the ETP.
  - 2. Monitoring
    - a) Rounds at least four times each hour at irregular intervals.
    - b) Each patient room shall allow visual access by staff 24 hours per day.
- B. Milieu Status 2 – Locked Patient Room Door at Specific Times
  - 1. Behavioral Anchors/Clinical Indicators will be individualized and may include, but are not limited to the following types of behaviors:
    - a) Uncooperative in following unit rules in a manner that endangers the safety of others

# POLICY DIRECTIVE

- b) Patient not able to safely modulate emotions and behaviors that may lead to physical aggression.
- c) Patient not able to respect personal space when prompted.
- d) Patient threatens physical violence against staff or peers.

## 2. Monitoring

- a) Rounds at least four times each hour at irregular intervals.
- b) Each patient room shall allow visual access by staff 24 hours per day.

### C. Milieu Status 1 – Locked ETP Suite

- 1. Behavioral Anchors/Clinical Indicators will be individualized and may include but are not limited to the following behaviors:

- a) Unable to safely interact with peers or staff.
- b) Provoking others to engage in physical violence.

## 2. Monitoring

- a) Rounds at least four times each hour at irregular intervals.
- b) Each patient room shall allow visual access by staff 24 hours per day.

## V. Locked Door Considerations

- A. Milieu Status 1/ETP Suite or Milieu Status 2 shall be implemented with an approved MMP when the locked door is the least restrictive option.
- B. Use of a locked door shall not act as a barrier to the provision of safe and appropriate care and treatment.
- C. Staff shall not threaten the use of a locked environment to attempt to gain compliance from a patient.
- D. A patient in a locked room retains all his/her rights unless a denial-of-rights is completed per hospital policy.

## VI. Staff Training

- A. All ETP staff will be trained on the MMP and their role in the implementation of the Milieu Management System.

## Roles and Responsibilities

The FNAT Psychologist reviews the referral and transfer documentation, participates in treatment team conference meetings, and regularly reviews the treatment plan revisions and updates. The FNAT Psychologist is not part of the treatment team.

# POLICY DIRECTIVE

The ETP Team Psychiatrist reviews the referral and transfer documentation, interviews the patient upon admission, and develops the initial admission MMP and Safety Communication Plan.

The ETP Team Psychologist, in the absence of the ETP Team Psychiatrist, reviews the referral and transfer documentation, interviews the patient upon admission, and develops the initial admission MMP and Safety Communication Plan.

The Treatment Team reviews the referral and transfer documentation, participates in team conference meetings, documents the patient’s progress towards meeting goals, and works in collaboration to create and maintain the MMP.

## Approval

\_\_\_\_\_  
STEPHANIE CLENDENIN  
Director (A)

\_\_\_\_\_  
Date

## References

1. Health and Safety Code section 1265.9
2. Welfare and Institutions Code sections 4143 and 4144
3. Title 9 of the California Code of Regulations, sections 4801-5100
4. Policy Directive 3700, Enhanced Treatment Program Admission and Initial Certification
5. Policy Directive 3702, Enhanced Treatment Program Ongoing Certification
6. Policy Directive 3704, Enhanced Treatment Program Treatment Planning
7. Policy Directive 3708, Enhanced Treatment Program Discharge and Transition
8. Safety Communication Plan

# DEPARTMENT OF STATE HOSPITALS ENHANCED TREATMENT PROGRAM



## ETP OPERATING MANUAL

### SECTION – Treatment Planning

#### PROGRAM PROCEDURE No. ETP-OP-101

#### SUBJECT: ETP MILIEU MANAGEMENT PLAN

**Effective Date:** 4/9/19

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This procedure is specific to the Enhanced Treatment Program (ETP).

#### I. PURPOSE

To create a safe environment for Enhanced Treatment Program (ETP) staff and patients where effective therapy can be provided within the least restrictive environment.

#### II. DEFINITIONS:

- A. **Clinical indicators:** Specific clinical signs and/or behaviors manifested by the patient that indicate illness or behavioral instability.
- B. **Enhanced Treatment Program (ETP):** A pilot program authorized under Health and Safety Code sections 1265.9 aimed at treating patients at high risk of most dangerous behavior, who are able to benefit from concentrated, evidence-based clinical therapy, structured milieu and/or treatment with the goal of reducing the risk of violent behavior in a standard treatment environment.
- C. **Forensic Needs Assessment Panel (FNAP):** A panel that consists of a Psychiatrist, a Psychologist, and a Medical Director, none of whom are involved in the patient's treatment or diagnosis at the time of the hearing or placement evaluation meetings.
- D. **Forensic Needs Assessment Team (FNAT):** 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 and are not part of the treatment team.
- E. **Milieu Management Plan (MMP):** A type of behavioral plan which includes the Milieu Status and Safety Communication Plan and is developed by the treatment team in conjunction with the patient, to focus on changes staff will make to create an environment that supports the patient in management of unsafe behaviors and progression towards safe conduct.

- F. **Milieu Status:** A determination of when a locked patient room door may be used as clinically indicated and is determined to be the least restrictive management intervention for the patient's care and treatment. Milieu status 1, 2 and 3 will be used to communicate the status.
- Milieu status 3 – Unlocked patient room door
  - Milieu status 2 – Locked patient room door at specific times
  - Milieu status 1 – Locked ETP suite
- G. **ETP Suite:** A locked patient room that includes a sink, commode and shower, to be utilized when a regular patient room is clinically contraindicated. When a patient is in Milieu Status 1, the ETP Suite is not considered "seclusion" as defined in Health and Safety Code 1180.1(e). However, the ETP Suite room may be utilized as a restraint room when necessary.
- H. **Safety Communication Plan (SCP):** A document that is utilized to monitor and communicate the patient's Milieu Status, peer contact parameters, number and type of on/off unit escorts, level of staff monitoring; nursing and other considerations.
- I. **Treatment Team:** The primary Psychiatrist, Psychologist, Clinical Social Worker, Rehabilitation Therapist, Registered Nurse and Psychiatric Technician assigned to the patient.

### III. MILIEU STATUS

- A. Patients move through the milieu on the ETP based on their MMP. The three milieu statuses are defined as:
1. Milieu Status 3 – Unlocked Patient Room Door
    - a) Behavioral Anchors/Clinical Indicators will be individualized and may include, but are not limited to the following types of behaviors:
      - i. Patient is able to safely manage his/her behavior(s) in the Milieu.
      - ii. Preparing to transition out of the ETP.
    - b) Monitoring:
      - i. Rounds at least four times each hour at irregular intervals.
      - ii. Each patient room shall allow visual access by staff 24 hours per day.
  2. Milieu Status 2 - Locked Patient Room Door at Specific Times
    - a) Behavioral Anchors/Clinical Indicators will be individualized and may include, but are not limited to the following types of behaviors:
      - i. Uncooperative in following unit rules in a manner that endangers the safety of others.
      - ii. Patient not able to safely modulate emotions and behaviors that may lead to physical aggression.
      - iii. Patient not able to respect personal space when prompted.
      - iv. Patient threatens physical violence against staff or peers.

- b) Monitoring:
  - i. Rounds at least four times each hour at irregular intervals.
  - ii. Each patient room shall allow visual access by staff 24 hours per day.

3. Milieu Status 1 - Locked ETP Suite

The ETP Suite is not seclusion or restraint and is considered a treatment level of care.

- a) Behavioral Anchors/Clinical Indicators will be individualized and may include, but are not limited to the following types of behaviors:
  - i. Unable to safely interact with peers or staff.
  - ii. Provoking others to engage in physical violence.
- b) Monitoring:
  - i. Rounds at least four times each hour at irregular intervals.
  - ii. Each patient room shall allow visual access by staff 24 hours per day.

B. Locked Door Considerations:

1. Milieu Status 1/ETP Suite or Milieu Status 2 shall be implemented in conjunction with an approved MMP and SCP when the locked door is the least restrictive option.
2. Use of the locked door must never act as a barrier to the provision of safe and appropriate care, treatments, and other interventions to meet the needs of patients.
3. Staff shall not threaten the use of locked door in an attempt to gain compliance from a patient.
4. A patient in a locked room retains all of his/her rights. The hospital promotes preservation of the patient's safety and maintenance of a patient's dignity while in a locked room. A denial of any right while in a locked room shall require the initiation of the Denial of Rights procedure. Each ETP hospital shall maintain a Denial of Rights policy and procedure.
5. Locked door shall not be used under the following circumstances:
  - a) The patient meets criteria for restraint and/or seclusion (i.e. imminently dangerous)
  - b) The patient exhibits self-harm behaviors/suicidal ideation (note: the patient's history of self-harm/suicidal ideation/suicide attempt does not preclude use).
  - c) For staff convenience.

#### IV. DETERMINING THE PATIENT'S INITIAL MILIEU STATUS

- A. Prior to admission, the Treatment Team and FNAT Psychologist will:
  - 1. Identify and consider any pre-existing medical condition(s) or any physical disabilities that would place the patient at greater medical or physical risk during Milieu Status 1/ETP Suite or Milieu Status 2 periods.
  - 2. Identify and consider history of trauma, sexual, or physical abuse that may place the patient at greater psychological risk during Milieu Status 1/ETP Suite or Milieu Status 2 periods.
  - 3. Develop an initial MMP draft, including a recommendation of what Milieu Status the patient should be placed in, and the initial SCP draft for admission.
- B. Prior to the end of the admission day, the treatment team Psychiatrist or, in their absence, the treatment team Psychologist, will interview the patient, finalize the initial MMP and complete the initial SCP in consultation with other ETP staff as needed.
- C. The patient may be admitted into any of the three Milieu Statuses. The individualized behavioral anchors identified by the treatment team and FNAT Psychologist will be utilized to determine the patient's initial Milieu Status.
- D. The treatment team will communicate to the patient their Milieu Status prior to the end of the admission day. If the patient is placed on Milieu Status 1 or 2, the treatment team will describe the unsafe behaviors, expected patient behavior and the supports in place to assist the patient to progress toward safe conduct and a less restrictive Milieu Status. This information will be documented in the MMP and Patient Education Log.

#### V. DETERMINING AND DOCUMENTING CHANGES TO PATIENT'S MILIEU STATUS

- A. Patients are not required to sequentially progress through all Milieu Statuses.
- B. Based on the patient's behavior within the designated timeframe, the treatment team may move the patient from a more restrictive to a less restrictive Milieu Status or from a less restrictive to a more restrictive Milieu Status.
- C. If new behaviors emerge, changes in Milieu Status may be delayed until the treatment team is able to provide input.
- D. The treatment team will determine the timeframe for the patient's successful progression to a less restrictive Milieu Status, or reversion to a more restrictive Milieu Status. This determination will be individualized for each patient based on individualized behavioral anchors and documented in the MMP.

- E. The treatment team will include a plan for progression and regression within and between milieu statuses in the MMP.
- F. If a patient is placed in restraint or seclusion, the treatment team will review and update the MMP the next business day.
- G. The treatment team, or in their absence the shift lead/designee, shall update the SCP to coincide with changes to the MMP, in consultation with other ETP staff as needed (e.g. HPO, supervisors, etc.).
- H. The SCP is not part of the patient chart and the most current version will be kept in the Shift Change binder. The Program Office shall retain electronic copies of the outdated SCPs for the length of the ETP Pilot.
- I. MMP Notes related to each patient's identified behavioral anchors/clinical indicators will be reviewed and the average score for those individualized behavioral anchors/clinical indicators will be reviewed and scored daily for the previous 24-hour period using the MMP Clinical Review Sheet.
- J. During normal business hours, the patient's MMP will be reviewed during the Clinical Morning Meeting. Outside of normal business hours, the MMP will be reviewed by the Shift Lead/designee, any available clinicians and level of care during the AM shift.
- K. The MMP Clinical Review Sheet will be submitted to the Unit Supervisor for review. Upon approval, the Unit Supervisor will submit the MMP Clinical Review Sheet to Program Management for processing and retention for the duration of the pilot. A copy of the MMP Clinical Review Sheet will be kept in the Kardex binder.
- L. The MMP will be documented in the patient chart.
  - 1. During normal business hours:
    - a) When it is determined that a patient has successfully met the goals of their MMP, the treatment team shall make changes to a less restrictive Milieu Status per the MMP and indicate the changes on the SCP. The changes shall be documented in the patient chart via an Interdisciplinary Note and communicated to the patient.
    - b) When it is determined that a patient has regressed in meeting the goals of their MMP, the treatment team shall make changes to a more restrictive Milieu Status as indicated per the MMP and update any changes on the SCP. The changes shall be documented in the patient chart via an Interdisciplinary Note and communicated to the patient.
  - 2. Outside normal business hours:
    - a) When it is determined that a patient has successfully met the goals of their Milieu Management Plan, the Shift Lead, in collaboration with the

Program Officer of the Day (POD) or designee shall make changes to a less restrictive Milieu Status per the MMP and update any change on the SCP. The patient's Milieu Status shall be re-evaluated by the treatment team the next business day. The changes shall be documented in the patient chart via an Interdisciplinary Note and communicated to the patient.

- b) When it is determined that a patient has regressed in meeting the goals of their MMP, the Shift Lead, in collaboration with the Program Officer of the Day (POD) or designee, shall make changes to a more restrictive Milieu Status per the MMP and update any change on the SCP. The patient's Milieu Status shall be re-evaluated by the Treatment Team the next business day. The changes shall be documented in the patient chart via an Interdisciplinary Note and communicated to the patient.

## VI. PROGRESS RATING SCALE

A. A Progress Rating Scale will be used to document a patient's progression or regression through their Milieu Status. The scale is as follows:

1. 0/Not Applicable – No maladaptive behavior exhibited i.e. patient slept through the night with no issue. This score does not count for or against the patient's progress towards meeting goals.
2. 1/Never – Patient has been offered treatment related to the objective but declines to participate and/or engage in treatment to address this objective at this time.
3. 2/Rarely – Patient has been introduced to concepts or skills related to the objective. Patient is not applying treatment concepts and/or does not seem to understand how they relate to this objective at this time.
4. 3/Sometimes– Patient has been introduced to concepts or skills related to the objective and can either verbally repeat concepts or behaviorally mimic staff members demonstrating the skill (i.e., staff takes deep breaths, patient takes deep breaths). At this level, patient does not demonstrate use of skill or ability to integrate concepts into his/her daily life without prompting.
5. 4/Often – With prompting by staff, patient can demonstrate use of skills learned related to this objective.
6. 5/Always– Patient uses skills learned related to this objective in his daily life with minimal or no prompting from staff.

## VII. TRAINING

All ETP staff shall be trained and aware of their role in the milieu management system.



California Department of  
**State Hospitals**

**Enhanced Treatment Program**

**Section 4**

**Transition**

# POLICY DIRECTIVE

<b>NUMBER</b>	3702
<b>TITLE</b>	Enhanced Treatment Program Ongoing Certification
<b>EFFECTIVE DATE</b>	
<b>SUPERSEDES</b>	New

## Policy Statement

The Department of State Hospitals’ (DSH) Policy Directives (PDs) provide guidance to comply with laws, regulations, codes, etc. PDs are issued and signed by the Director. It is the policy of DSH to expand its continuum of care by establishing the Enhanced Treatment Program (ETP) for patients who are at high risk of most dangerous behavior and who may benefit from concentrated, evidence-based clinical therapy, structured milieu therapy and/or treatment aimed at reducing the risk of violent behavior, with the goal of returning the patient to a standard treatment environment. DSH is committed to providing treatment in the least restrictive environment.

## Purpose

The purpose of the ETP Ongoing Certification PD is to provide guidance on identifying and triaging patients appropriate for ongoing certification and continued treatment in the ETP.

## Responsibility

**Executive Sponsor:** Deputy Director, Clinical Operations

**Process Owner:** Chief, Data Analytics, Treatment & Assessment, Clinical Operations

## Background

DSH is authorized to implement and operate a pilot ETP to treat patients at high risk of most dangerous behavior to determine whether more intensive care in a higher-security setting is an effective way to reduce violence. The budget provides for the construction of four units, totaling 49 beds.

# POLICY DIRECTIVE

## Authority

1. Health and Safety Code section 1265.9
2. Welfare and Institutions Code sections 4005.1, 4027 and 4101

## Definitions

**Enhanced Treatment Program (ETP):** A pilot program authorized under Health and Safety Code sections 1265.9 aimed at treating patients at high risk of most dangerous behavior, who may benefit from concentrated, evidence-based clinical therapy, structured milieu and/or treatment with the goal of reducing the risk of violent behavior in a standard treatment environment.

**Forensic Needs Assessment Panel (FNAP):** A panel that consists of a Psychiatrist, a Psychologist, and a Medical Director, none of whom are involved in the patient's treatment or diagnosis at the time of the hearing or placement evaluation meetings.

**Forensic Needs Assessment Team (FNAT):** 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 and are not part of the ETP treatment team.

**Individualized Behavioral Plan:** A type of behavioral plan developed by the treatment team in conjunction with the patient, to focus on changes the patient and staff will make to create an environment that supports the patient in management of unsafe behaviors and progression towards safe conduct.

**Individualized Treatment Interventions:** All interventions provided to the patient on the ETP that are determined to address patient specific risk factors for highest risk of violence.

**Most Dangerous Behavior:** Includes aggressive acts that may cause substantial physical harm to others in an inpatient setting.

**Standard Treatment Environment:** Any DSH state hospital setting outside of the ETP.

**Standard Violence Risk Assessment Methodologies:** May include, but are not limited to, an analysis of past violence, delineation of static and dynamic violence risk factors, and utilization of valid and reliable violence risk assessment testing.

**Treatment Team:** The primary Psychiatrist, Psychologist, Clinical Social Worker, Rehabilitation Therapist, Registered Nurse and Psychiatric Technician assigned to the patient.

# POLICY DIRECTIVE

## Process

### I. FNAP One-Year Placement Evaluation Meeting

- A. Prior to the expiration of the 90-Day Certification, the FNAP must convene a FNAP One-Year Placement Evaluation Meeting with a Psychologist from the patient's treatment team, a Patients' Rights Advocate, the patient, and the FNAT Psychologist who performed the in-depth violence risk assessment.
- B. A minimum of 72-hour notice of the meeting must be provided to the patient, Patients' Rights Advocate, Conservator (if applicable), and the ETP hospital.
- C. Notice to the patient, Patients' Rights Advocate and Conservator (if applicable) shall include a written explanation of the reasons, including specific behaviors and incidents that are relied on for the continued placement in the ETP. Instructions shall also be provided as to how a patient may submit documents to the FNAP to consider in making their placement evaluation.
- D. In the event a patient is unable to safely participate in the placement evaluation meeting in person, the referring hospital shall arrange for the patient to participate via an alternate modality, such as teleconference or telepresence.
- E. During the placement evaluation meeting, the FNAP shall consider all clinical progress reports from the FNAT Psychologist and the patient's ETP treatment team, which may include any reduction in the patient's risk for aggression, as well as any relevant information provided by the patient or the Patients' Rights Advocate.
- F. The FNAP shall review all material presented at the FNAP One-Year Placement Evaluation Meeting and determine whether the patient clinically requires continued treatment in the ETP or may be transferred to a standard treatment environment.
- G. If the FNAP determines that the patient is clinically appropriate to be transferred to a standard treatment environment, the referring hospital transfer coordinator/designee shall work with the ETP treatment team and the referring hospital to identify an appropriate placement.
- H. If the FNAP determines that the patient clinically requires continued treatment in the ETP, the patient shall be certified for further ETP placement of up to one year.

## **POLICY DIRECTIVE**

- I. The FNAP will document this decision on the ETP Certification Form, DSH-9219 and provide it to the FNAT Supervising Psychologist. The FNAT Supervising Psychologist will, no later than 24 hours after the One-Year Placement Evaluation Meeting, provide a copy of the FNAP ETP Certification form to the patient, Patients' Rights Advocate, Conservator (if applicable), the referring hospital transfer coordinator/designee, and the ETP hospital.

### **II. FNAP One-Year Continuation Placement Evaluation Meeting**

- A. Prior to the expiration of the one-year certification, the FNAP must convene a FNAP One-Year Continuation Placement Evaluation Meeting with the patient's treatment team, Patients' Rights Advocate, patient and the FNAT Psychologist who performed the in-depth violence risk assessment.
- B. A minimum of 72-hour notice of the meeting must be provided to the patient, Patients' Rights Advocate, Conservator (if applicable) and the ETP hospital.
- C. Notice to the patient, Patients' Rights Advocate and Conservator if applicable, shall include a written explanation of the reasons, including specific behaviors and incidents that are the basis for continued placement in the ETP. Instructions shall also be provided as to how a patient may submit documents to the FNAP to consider in making their placement evaluation.
- D. In the event a patient is unable to safely participate in the placement evaluation meeting in person, the referring hospital shall arrange for the patient to participate via an alternate modality, such as teleconference or telepresence.
- E. During the placement evaluation meeting, the FNAP shall consider all clinical progress reports from the FNAT Psychologist and the patient's ETP treatment team, which may include any reduction in the patient's risk for aggression, as well as any relevant information provided by the patient or the Patients' Rights Advocate.
- F. The FNAP shall review all material presented at the placement evaluation meeting and determine whether the patient clinically requires continued treatment in the ETP, or whether the patient may be transferred to a standard treatment environment.
- G. If the FNAP determines that the patient is clinically appropriate to be transferred to a standard treatment environment, the referring hospital transfer coordinator/designee shall work with the ETP treatment team and the referring hospital to identify an appropriate placement.

# POLICY DIRECTIVE

- H. If the FNAP determines that the patient clinically requires continued treatment in the ETP, the patient's case shall be referred outside of the Department of State Hospitals to a Forensic Psychiatrist or Psychologist for an independent medical review as to the patient's overall treatment plan and the need for ongoing ETP treatment as described below.
- I. The FNAP will document this decision on the ETP Certification Form and provide it to the FNAT Supervising Psychologist. The FNAT Supervising Psychologist will, no later than 24 hours after the One-Year Continuation Placement Evaluation Meeting, provide a copy of the FNAP ETP Certification form to the patient, Patients' Rights Advocate, Conservator (if applicable), the referring hospital transfer coordinator/designee and the ETP hospital. If a referral is being made to the Forensic Psychiatrist or Psychologist to conduct an independent review, the notice of the placement evaluation meeting decision shall also include a notice of the referral and instructions for the patient to submit information to the Forensic Psychiatrist or Psychologist that will be conducting the independent review.

### III. Independent Medical Review Placement Evaluation Hearing

If the FNAP determines that the patient requires continued treatment in the ETP beyond the expiration of the one-year certification, the following shall happen:

- A. The FNAT Supervising Psychologist shall provide all relevant patient's medical and psychiatric documents and records, along with any additional information submitted by the patient, to the Independent Forensic Psychiatrist or Psychologist conducting the independent medical review, within five business days from the date of the FNAP's written decision.
- B. The Independent Forensic Psychiatrist or Psychologist conducting the independent medical review shall coordinate with the FNAT Supervising Psychologist to schedule the hearing within 14 days of receipt of the patient's medical and psychiatric documents and records.
- C. The FNAT Supervising Psychologist shall ensure the patient, Patients' Rights Advocate, Conservator (if applicable) and ETP hospital have received written notification of the hearing.
- D. The notice must:
  - 1. Be provided a minimum of 72 hours in advance of the hearing;
  - 2. Advise the patient of his or her right to have a hearing, or to waive it;

## POLICY DIRECTIVE

3. Advise the patient of his or her right to assistance of a Patients' Rights Advocate or staff member at the hearing; and
  4. Require the attendance of at least one FNAP member who made the decision that the patient needs continued treatment in the ETP beyond the original one-year certification.
- E. The FNAT Supervising Psychologist shall also provide a minimum of 72-hour notice to any individual whose presence is requested by the Forensic Psychiatrist or Psychologist conducting the independent medical review to help assess the patient's overall treatment plan and the need for ongoing ETP treatment.
- F. If the patient waives his or her right to a hearing, the Forensic Psychiatrist or Psychologist conducting the independent medical review shall inform the FNAP whether the patient should be certified for ongoing ETP treatment.
- G. If the patient does not waive his or her right to a hearing, he or she shall be provided with the following:
1. An opportunity to present information, statements, or arguments, either orally or in writing, to show that the information relied on for the FNAP's determination for ongoing treatment is erroneous, or any other relevant information.
  2. If the patient elects to have the assistance of a Patients' Rights Advocate or a staff person, the requested person may provide assistance to the patient regarding the presentation of information identified in paragraph G.1. above, whether or not the patient is present at the hearing, unless the Forensic Psychologist or Psychiatrist conducting the hearing finds good cause why the requested person should not be present. If a staff member is selected by the patient, their role solely is limited to assisting with understanding the process and facilitating patient input.
- H. The conclusion reached by the Forensic Psychiatrist or Psychologist who conducts the independent medical review shall be in writing and provided to the FNAT Supervising Psychologist. The FNAT Supervising Psychologist will, no later than 3 business days after the Independent Medical Review Placement decision, provide a copy of the written decision to the patient, Patients' Rights Advocate, Conservator (if applicable), the referring hospital transfer coordinator/designee and the ETP hospital.
- I. If the Forensic Psychiatrist or Psychologist who conducts the independent medical review concludes that the patient requires ongoing ETP treatment, the patient shall be certified for further treatment for an additional year.

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- J. If the Forensic Psychiatrist or Psychologist who conducts the independent medical review determines that the patient no longer requires ongoing ETP treatment, the referring hospital transfer coordinator/designee shall work with the ETP treatment team and referring hospital to identify appropriate placement and transfer the patient within 30 days of determination.

## IV. FNAP 90-Day Treatment Summary Review

- A. When a patient has been certified for one year, the FNAP must review his or her treatment summary at least every 90 days to determine whether the patient continues to require treatment in the ETP.
- B. This decision must be in writing and provided within three business days of the review to the patient, Patients' Rights Advocate, patient's Conservator (if applicable) and the patient's treatment team.
- C. If the FNAP determines that the patient is clinically appropriate to be transferred to a standard treatment environment, the referring hospital transfer coordinator/designee shall work with the ETP treatment team and referring hospital to identify appropriate placement. The transfer must occur within 30 days of the decision.

## V. FNAP Review of Referral for Discharge by Patient's Treatment Team

- A. A patient's treatment team may make a referral to discharge an ETP patient upon a determination that a patient no longer requires ETP treatment. The recommendation must be made to the FNAP or FNAT Supervising Psychologist, who shall review the patient's medical and psychiatric records, as well as all relevant material upon which the patient's treatment team made the determination.
- B. The FNAT Supervising Psychologist shall convene a placement evaluation meeting with a minimum of 72-hour notice of the meeting to the patient, the Patients' Rights Advocate, patient's Conservator (if applicable) and the ETP hospital.
- C. The FNAP will document their decision on the ETP Certification Form and provide it to the FNAT Supervising Psychologist. The FNAT Supervising Psychologist will, within 24 hours of the placement evaluation meeting, provide a copy of the FNAP ETP Certification form to the patient, Patients' Rights Advocate, Conservator (if applicable), referring hospital transfer coordinator/designee and ETP hospital.

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- D. If the FNAP decides the patient no longer requires ETP treatment, the referring hospital transfer coordinator/designee will work with the ETP treatment team and referring hospital to identify appropriate placement. The transfer must occur within 30 days of the decision.

## Roles and Responsibilities

The FNAT Supervising Psychologist ensures 72-hour and placement evaluation meeting notices and decisions are provided to the patient, Patients’ Rights Advocate, referring hospital, and ETP hospital; convenes the FNAP placement evaluation meetings and summary review meetings; and provides all relevant information to the FNAP.

The FNAT Psychologist participates in FNAP placement evaluation meetings and summary review meetings.

The FNAP conducts placement evaluation meetings; reviews all information provided at the placement evaluation meeting; provides written decisions regarding certification; conducts summary review meetings; and provides the written decision.

The Patients’ Rights Advocate participates in FNAP placement evaluation meetings and assists the patient during certification meetings regarding extending ETP placement.

## Approval

\_\_\_\_\_  
STEPHANIE CLENDENIN  
Director (A)

\_\_\_\_\_  
Date

## References

1. Health and Safety Code section 1265.9
2. Welfare and Institutions Code sections 4143 4144, 5370.2, and 5510
3. Title 9 of the California Code of Regulations, sections 4801-5100
4. Policy Directive 3700, Enhanced Treatment Program Admission and Initial Certification
5. Policy Directive 3704, Enhanced Treatment Program Treatment Planning
6. Policy Directive 3706, Enhanced Treatment Program Milieu Management Plan
7. Policy Directive 3708, Enhanced Treatment Program Discharge and Transition

# POLICY DIRECTIVE

## 8. ETP Certification Form, DSH-9219

### Attachments

1. ETP FNAP Certification Decision Notification Grid

DRAFT



Event	Timeframe	Notifier	Recipient
<b>FNAP 90-day Placement Evaluation Meeting</b>	Within 3 business days	FNAT Supervising Psychologist	Patient, Patients' Rights Advocate, Conservator (if applicable) & Referring Hospital
<b>FNAP One Year Placement Evaluation Meeting</b>	Within 24 hours		Patient, Patients' Rights Advocate, Conservator (if applicable), Referring Hospital & ETP Hospital
<b>FNAP One Year Continuation Placement Evaluation Meeting</b>	Within 24 hours		Patient, Patients' Rights Advocate, Conservator (if applicable), Referring Hospital & ETP Hospital
<b>Independent Medical Review Placement Evaluation Hearing</b>	Within 3 business days		Patient, Patients' Rights Advocate, Conservator (if applicable), Referring Hospital & ETP Hospital
<b>FNAP 90-day Treatment Summary Review</b>	Within 3 business days		Patient, Patients' Rights Advocate, Conservator (if applicable), Referring Hospital & ETP Hospital

# DEPARTMENT OF STATE HOSPITALS ENHANCED TREATMENT PROGRAM

## ETP OPERATING MANUAL

### SECTION – Admission and Certification

#### PROGRAM PROCEDURE No. ETP-OP-002

#### SUBJECT: ETP Ongoing Certification



**Effective Date:** 4/9/19

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This procedure is specific to the Enhanced Treatment Program (ETP).

#### I. PURPOSE

To provide clear procedures for ongoing certification and continued treatment in the ETP.

#### II. DEFINITIONS

- A. **Enhanced Treatment Program (ETP):** A pilot program authorized under Health and Safety Code sections 1265.9 aimed at treating patients at high risk of most dangerous behavior, who are able to benefit from concentrated, evidence-based clinical therapy, structured milieu and/or treatment with the goal of reducing the risk of violent behavior in a standard treatment environment.
- B. **Forensic Needs Assessment Panel (FNAP):** A panel that consists of a Psychiatrist, a Psychologist, and a Medical Director none of whom are involved in the patient's treatment or diagnosis at the time of the hearing or placement evaluation meetings.
- C. **Forensic Needs Assessment Team (FNAT):** 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 and are not part of the ETP treatment team.
- D. **Individualized Behavioral Plan:** A type of behavioral plan developed by the treatment team in conjunction with the patient, to focus on changes the patient and staff will make to create an environment that supports the patient in management of unsafe behaviors and progression towards safe conduct.
- E. **Individualized Treatment Interventions:** All interventions provided to the patient on the ETP that are determined to address patient specific risk factors for highest risk of violence.
- F. **Most Dangerous Behavior:** Includes aggressive acts that may cause substantial physical harm to others in an inpatient setting.

- G. **Standard Treatment Environment:** Any DSH state hospital setting outside of the ETP.
- H. **Standard Violence Risk Assessment Methodologies:** May include, but are not limited to, an analysis of past violence, delineation of static and dynamic violence risk factors, and utilization of valid and reliable violence risk assessment testing.
- I. **Treatment Team:** The primary Psychiatrist, Psychologist, Clinical Social Worker, Rehabilitation Therapist, Registered Nurse and Psychiatric Technician assigned to the patient.

### III. FNAP ONE YEAR PLACEMENT EVALUATION MEETING

- A. Prior to the expiration of the 90 day certification, the FNAP must convene a FNAP One Year Placement Evaluation Meeting with a Psychologist from the patient's treatment team, a Patients' Rights Advocate, the patient, Conservator, if applicable and the FNAT Psychologist who performed the in-depth violence risk assessment.
  - 1. At least 14 days prior to the expiration of the 90 day certification, the FNAT Supervising Psychologist shall identify an FNAP and advise them of the upcoming placement evaluation meeting. The FNAT Supervising Psychologist will also notify the patient's treatment team and assigned FNAT Psychologist of the upcoming placement evaluation meeting.
  - 2. The FNAT Supervising Psychologist will ensure a minimum of 72-hour notice of the placement evaluation meeting is provided to the ETP hospital, the Patients' Rights Advocate and Conservator, if applicable. The ETP hospital shall advise the patient of the meeting date and inform the patient that any documents he/she wishes to submit to the FNAP for consideration must be submitted no later than one business day before the placement evaluation meeting date.
  - 3. Notice to the patient and Patients' Rights Advocate shall include a written explanation of the reasons, included behaviors and incidents that are relied on by the FNAP for continued placement on the ETP. Instructions shall also be provided as to how a patient may submit documents to the FNAP to consider in making their placement decision.
  - 4. In the event a patient is unable to safely participate in the placement evaluation meeting in person, the ETP shall arrange for the patient to participate via an alternate modality, such as telepresence or teleconference.
  - 5. The ETP Treatment Team in collaboration with the FNAT Psychologist will prepare a treatment plan that will include an updated risk summary and a recommendation for transfer to a standard treatment setting or ongoing ETP treatment at least 7 days prior to the placement evaluation meeting.

6. During the treatment placement evaluation meeting the FNAP shall consider all progress reports from the FNAT Psychologist and the patient's ETP Treatment Team as to the reduction in the patient's risk for aggression. The FNAP shall also consider any relevant information provided by the patient or the Patients' Rights Advocate.
7. If the FNAP determines that the patient is ready to be transferred to a standard treatment environment, the referring hospital transfer coordinator/designee will work with the ETP Treatment Team and referring hospital to identify appropriate placement within the referring hospital.
8. If the FNAP determines that the patient clinically requires continued treatment in the ETP, the patient shall be certified for further ETP placement of up to one year.
9. The FNAP will document this decision on the ETP Certification Form DSH-9219 and provide it to the FNAT Supervising Psychologist. The FNAT Supervising Psychologist will, within 24 hours of the placement evaluation meeting, provide a copy of the FNAP ETP Certification form to the patient, Patients' Rights Advocate, Conservator (if applicable), the referring hospital transfer coordinator/designee and the ETP hospital.

#### IV. FNAP ONE YEAR CONTINUATION PLACEMENT EVALUATION MEETING

- A. Prior to the expiration of the one-year certification, the FNAP must convene a FNAP One Year Continuation Placement Evaluation Meeting with the patient's treatment team, a Patients' Rights Advocate, the patient, Conservator, if applicable, and the FNAT Psychologist who performed the in-depth violence risk assessment.
  1. At least 14 days prior to the expiration of the One year certification the FNAT Supervising Psychologist shall identify an FNAP and advise them of the upcoming placement evaluation meeting. The FNAT Supervising Psychologist will also notify the patient's treatment team and assigned FNAT Psychologist of the upcoming placement evaluation meeting.
  2. The FNAT Supervising Psychologist will ensure a minimum of 72-hour notice of the placement evaluation meeting is provided to the ETP hospital, the Patients' Rights Advocate and Conservator, if any. The ETP hospital shall advise the patient of the placement evaluation meeting date and inform the patient that documents he/she wants to submit to the FNAP for consideration must be submitted no later than one business day before the placement evaluation meeting date.
  3. Notice to the patient, Patients' Rights Advocate and Conservator if applicable, shall include a written summary of the behaviors and incidents that will be considered by the FNAP in making the certification evaluation.

Instructions shall also be provided as to how a patient may submit documents to the FNAP to consider in making their placement evaluation.

4. In the event a patient is unable to safely participate in the placement evaluation meeting in person, the ETP shall arrange for the patient to participate via an alternate modality such as telepresence or teleconference.
5. The ETP Treatment Team in collaboration with the FNAT Psychologist will prepare a treatment plan that will include an updated risk summary and a recommendation for transfer to a standard treatment setting or ongoing ETP treatment at least 7 days prior to the placement evaluation meeting.
6. During the placement evaluation meeting the FNAP shall consider all progress reports from the FNAT Psychologist and the patient's ETP treatment team as to the reduction in the patient's risk for aggression. The FNAP shall also consider any relevant information provided by the patient or the Patients' Rights Advocate.
7. The FNAP shall review all material presented at the placement evaluation meeting and determine whether the patient clinically requires continued treatment in the ETP, or whether the patient may be transferred to a standard treatment environment.
8. If the FNAP determines that the patient is ready to be transferred to a standard treatment environment, the referring hospital transfer coordinator/designee will work with the ETP treatment team and referring hospital to identify appropriate placement within the referring hospital.
9. If the FNAP determines that the patient clinically requires continued treatment in the ETP, the patient's case shall be referred outside of the Department of State Hospitals to a Forensic Psychiatrist or Psychologist for an independent medical review as to the patient's overall treatment plan and the need for ongoing ETP treatment as described below.
10. The FNAP will document this decision on the ETP Certification Form DSH-9219 and provide it to the FNAT Supervising Psychologist. The FNAT Supervising Psychologist will, within 24 hours of the placement evaluation meeting, provide a copy of the FNAP ETP Certification form to the patient, Patients' Rights Advocate, Conservator (if applicable), the referring hospital transfer coordinator/designee and the ETP hospital. If a referral is being made to the forensic Psychiatrist or Psychologist to conduct an independent review, the notice shall include instructions for the patient to submit information to the Forensic Psychiatrist or Psychologist that will be conducting the independent review.

#### V. INDEPENDENT MEDICAL REVIEW PLACEMENT EVALUATION MEETING

- A. If the FNAP determines the patient requires continued treatment in the ETP beyond the expiration of the one-year certification the following shall happen:

1. The FNAT Supervising Psychologist shall provide all relevant patient's medical and psychiatric documents and records, along with any additional information submitted by the patient, to the independent Forensic Psychiatrist or Psychologist conducting the independent medical review, within five business days from the date of the FNAP's decision.
2. The Forensic Psychologist or Psychiatrist conducting the independent medical review shall provide the FNAT Supervising Psychologist with a written notice of the date and time for a hearing within 14 days upon receipt of the patient's medical and psychiatric documents and records.
3. The notice must:
  - a) Be provided at least 72 hours in advance of the hearing;
  - b) Advise the patient of his or her right to have a hearing, or to waive it;
  - c) Let the patient know of his or her right to assistance from a Patients' Rights Advocate or staff member at the hearing;
  - d) Require the attendance of at least one FNAP member who made the decision that the patient needs continued treatment in the ETP beyond the original one-year certification.
4. The FNAT Supervising Psychologist will coordinate with the independent evaluator to schedule the hearing.
5. The FNAT Supervising Psychologist shall ensure the patient, Patient's Rights Advocate and Conservator, if applicable, have received notification of the hearing.
6. The FNAT Supervising Psychologist shall also provide a minimum of 72-hour notice to any individual whose presence is requested by the Forensic Psychiatrist or Psychologist to help assess the patient's overall treatment plan and need for ongoing ETP treatment.
7. If the patient waives his or her right to a hearing, the Forensic Psychiatrist or Psychologist conducting the independent medical review shall inform the FNAP whether the patient should be certified for ongoing ETP treatment.
8. If the patient does not waive his or her right to a hearing the patient shall be provided with the following:
9. An opportunity for the patient to present information, statements, or arguments, either orally or in writing, to show either that the information relied on for the FNAP's determination for ongoing treatment is erroneous, or any other relevant information

10. If the patient elects to have the assistance of a Patients' Rights Advocate or staff person, the requested person may provide assistance to the patient regarding the presentation of information identified in paragraph VA9 above, whether or not the patient is present at the time of hearing, unless the Forensic Psychiatrist or Psychologist finds good cause why the requested person should not be present.
11. The conclusion reached by the Forensic Psychiatrist or Psychologist who conducts the independent medical review shall be in writing and provided to the FNAT Supervising Psychologist. The FNAT Supervising Psychologist shall provide written notice of the decision to the patient, Patients' Rights Advocate, the ETP hospital and the referring hospital within three business days of conclusion of the hearing.
12. If the Forensic Psychiatrist or Psychologist concludes that the patient requires ongoing ETP treatment, the patient shall be certified for an additional year.
13. If the Forensic Psychiatrist or Psychologist determines that the patient no longer requires ongoing ETP treatment, the referring hospital transfer coordinator/designee shall work with the referring hospital and ETP treatment team to identify appropriate placement in the referring hospital and transfer the patient within 30 days.

#### VI. FNAP 90 DAY TREATMENT SUMMARY REVIEW

- A. When a patient has been certified for one year, the FNAP must review his or her treatment summary at least every 90 days to determine whether the patient continues to require treatment in the ETP.
  1. At least 14 days prior to the due date, the FNAT Supervising Psychologist shall identify an FNAP and advise them the upcoming 90 Day Summary Review Meeting needs to be scheduled. The FNAT Supervising Psychologist will also notify the patient's treatment team and assigned FNAT Psychologist of the summary review meeting.
  2. The FNAT Supervising Psychologist will schedule the summary review meeting and notify the FNAP and FNAT of the date and time.
  3. The ETP Treatment Team in collaboration with the FNAT Psychologist will prepare a treatment plan that will include an updated risk summary and a recommendation for transfer to a standard treatment setting or ongoing ETP treatment at least 7 days prior to the summary review meeting.
  4. The FNAP will document this decision on the ETP Certification Form DSH-9219 and provide it to the FNAT Supervising Psychologist. The FNAT Supervising Psychologist will, within 3 business days of the summary review meeting, provide a copy of the FNAP ETP Certification form to the patient,

Patients' Rights Advocate, Conservator (if applicable), the referring hospital transfer coordinator/designee and the ETP hospital.

5. If the FNAP determines that the patient is ready to be transferred to a standard treatment environment, the referring hospital transfer coordinator/designee will work with the ETP treatment team and referring hospital to identify an appropriate placement within the referring hospital.

Attachment 1: ETP FNAP Certification Decision Notification Grid

DRAFT

# POLICY DIRECTIVE

<b>NUMBER</b>	3708
<b>TITLE</b>	Enhanced Treatment Program Discharge & Transition
<b>EFFECTIVE DATE</b>	
<b>SUPERSEDES</b>	New

## Policy Statement

The Department of State Hospitals’ (DSH) Policy Directives (PDs) provide guidance to comply with laws, regulations, codes, etc. PDs are issued and signed by the Director. It is the policy of DSH to expand the continuum of care by establishing the Enhanced Treatment Program (ETP) to provide treatment to patients who are at high risk of most dangerous behavior and who may benefit from concentrated, evidence-based clinical therapy, structured milieu therapy and/or treatment aimed at reducing the risk of violent behavior, with the goal of returning the patient to a standard treatment environment. DSH is committed to providing treatment in the least restrictive environment.

## Purpose

The purpose of the ETP Discharge and Transition PD is to provide guidance on identifying patients who can be discharged to a standard treatment environment and the procedures that will be used to transition the patient to his or her referring hospital.

## Responsibility

**Executive Sponsor:** Deputy Director, Clinical Operations

**Process Owner:** Chief, Data Analytics, Treatment & Assessment, Clinical Operations

## Background

DSH is authorized to implement and operate a pilot ETP to treat patients at high risk of most dangerous behavior to determine whether more intensive care in a higher-security setting is an effective way to reduce violence. The budget provides for the construction of four units, totaling of 49 beds.

# POLICY DIRECTIVE

## Authority

1. Health and Safety Code section 1265.9
2. Welfare and Institutions Code sections 4005.1, 4027, and 4101

## Definitions

**Enhanced Treatment Program (ETP):** A pilot program authorized under Health and Safety Code section 1265.9 aimed at treating patients at high risk of most dangerous behavior, and who may benefit from concentrated, evidence-based clinical therapy, structured milieu and/or treatment with the goal of reducing the risk of violent behavior in a standard treatment environment.

**Forensic Needs Assessment Team (FNAT):** A panel of Psychologists with expertise in forensic assessment or violent risk assessment, each of whom are assigned an ETP case or group of cases and are not part of the ETP treatment team.

**Forensic Needs Assessment Panel (FNAP):** A panel that consists of a Psychiatrist, a Psychologist, and a Medical Director, none of whom are involved in the patient's treatment or diagnosis at the time of the hearing or placement meetings.

**Standard Treatment Environment:** Any DSH state hospital setting outside of the ETP.

**Transition Plan:** Coordination between the ETP treatment team and the receiving treatment team on the transition of a patient throughout their stay and when determined as ready for discharge by the FNAP.

**Aftercare Plan:** A written plan describing those services and goals that should be provided to a patient following discharge, transfer, or release from an ETP to enable the patient to maintain stabilization or achieve an optimum level of functioning at the referring hospital.

## Process

### I. Who May Be Discharged

- A. A patient in the ETP may be discharged following an FNAP determination that the patient no longer requires treatment on the ETP. The FNAP shall base their decision on the following:
  1. Clinical progress reported by the FNAT Psychologist and/or the patient's treatment team indicating a reduction of the patient's

## **POLICY DIRECTIVE**

risk of aggression.

2. A determination that the patient is inappropriate for continued treatment on an ETP.
3. The identification of new issues that preclude the patient's treatment on an ETP.
4. A determination by the Independent Psychologist or Psychiatrist's Medical Review.

### **II. Discharge to The Referring Hospital**

- A. When the FNAP determines that the patient no longer clinically requires treatment in the ETP, the referring hospital transfer coordinator/designee shall work with the ETP treatment team and the referring hospital to identify appropriate placement.
- B. Upon notice of the discharge decision the following steps shall be taken:
  1. The referring hospital will, within two days of receiving the pending transfer notification, provide the ETP transfer coordinator/designee with the contact information of the receiving program management and unit treatment team;
  2. The ETP hospital program management and the referring hospital program management will ensure the transition and aftercare process is completed and determine the exact date of transfer;
  3. A written aftercare plan shall be developed via a treatment team process in collaboration with the FNAT Psychologist; and
  4. The patient shall be transferred within 30 days of the FNAP's decision.

### **III. Aftercare Planning**

- A. An aftercare plan for a standard treatment environment shall be developed, describing those services that should be provided to a patient following discharge, transfer, or release from an ETP to enable the patient to maintain stabilization or achieve an optimum level of functioning at the referring hospital.
- B. The ETP Treatment Team Clinical Social Worker shall be responsible for ensuring that the aftercare plan has been completed and documented in the patient's health record.
- C. Individualized assessment and aftercare planning begins at admission and continues throughout a patient's stay on the ETP.

# POLICY DIRECTIVE

- D. A copy of the patient’s aftercare plan shall be provided to the patient prior to discharge.

## Roles and Responsibilities

The FNAT Supervising Psychologist convenes the FNAP placement evaluation meetings and summary review meetings; provides relevant information to the FNAP; and notifies the FNAT Psychologist and ETP treatment team of a discharge decision.

The FNAT Psychologist participates in the placement evaluation meetings; works in collaboration with the treatment team to develop the transition and aftercare plans; and participates in meetings with the referring hospital to review the aftercare plan and discuss treatment recommendations.

The FNAP conducts placement evaluation meetings; reviews all information provided by the FNAT psychologist, ETP treatment team, patient, and Patients’ Rights Advocate (when applicable); and provides written placement decisions.

## Approval

\_\_\_\_\_  
STEPHANIE CLENDENIN  
Director (A)

Date

## References

1. Health and Safety Code section 1265.9
2. Welfare and Institutions Code sections 4143 4144, and 5510
3. Title 9 of the California Code of Regulations, sections 4801-5100
4. Policy Directive 3700, Enhanced Treatment Program Admission and Initial Certification
5. Policy Directive 3702, Enhanced Treatment Program Ongoing Certification
6. Policy Directive 3706, Enhanced Treatment Program Milieu Management Plan
7. Policy Directive 3704, Enhanced Treatment Program Treatment Planning

## Attachments

# POLICY DIRECTIVE

## 1. ETP FNAP Certification Decision Notification Grid

DRAFT



Event	Timeframe	Notifier	Recipient
<b>FNAP 90-day Placement Evaluation Meeting</b>	Within 3 business days	FNAT Supervising Psychologist	Patient, Patients' Rights Advocate, Conservator (if applicable) & Referring Hospital
<b>FNAP One Year Placement Evaluation Meeting</b>	Within 24 hours		Patient, Patients' Rights Advocate, Conservator (if applicable), Referring Hospital & ETP Hospital
<b>FNAP One Year Continuation Placement Evaluation Meeting</b>	Within 24 hours		Patient, Patients' Rights Advocate, Conservator (if applicable), Referring Hospital & ETP Hospital
<b>Independent Medical Review Placement Evaluation Hearing</b>	Within 3 business days		Patient, Patients' Rights Advocate, Conservator (if applicable), Referring Hospital & ETP Hospital
<b>FNAP 90-day Treatment Summary Review</b>	Within 3 business days		Patient, Patients' Rights Advocate, Conservator (if applicable), Referring Hospital & ETP Hospital

# DEPARTMENT OF STATE HOSPITALS ENHANCED TREATMENT PROGRAM

## ETP OPERATING MANUAL

### SECTION – Discharge and Transition

#### PROGRAM PROCEDURE No. ETP-OP-300

#### SUBJECT: ETP Discharge and Transition



**Effective Date:** 4/9/19

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This procedure is specific to the Enhanced Treatment Program (ETP).

I. PURPOSE

To provide clear procedures on transition and discharge of a patient from the ETP.

II. DEFINITIONS

- A. **Enhanced Treatment Program (ETP):** A pilot program authorized under Health and Safety Code section 1265.9 aimed at treating patients at high risk of most dangerous behavior, and who are able to benefit from concentrated, evidence-based clinical therapy, structured milieu and/or treatment with the goal of reducing the risk of violent behavior in a standard treatment environment.
- B. **Forensic Needs Assessment Team (FNAT):** A panel of Psychologists with expertise in forensic assessment or violent risk assessment, each of whom are assigned an ETP case or group of cases and are not part of the ETP treatment team.
- C. **Forensic Needs Assessment Panel (FNAP):** A panel that consists of a Psychiatrist, a Psychologist, and a Medical Director none of whom are involved in the patient's treatment or diagnosis at the time of the hearing or placement meetings.
- D. **Standard Treatment Environment:** Any DSH state hospital setting outside of the ETP.
- E. **Transition Plan:** Coordination between the ETP treatment team and the receiving treatment team on the transition of a patient throughout their stay and when determined as ready for discharge by the FNAP.
- F. **Aftercare Plan:** A written plan describing those services and goals that should be provided to a patient following discharge, transfer, or release from an ETP for the purpose of enabling the patient to maintain stabilization or achieve an optimum level of functioning at the referring hospital.

### III. WHO MAY BE DISCHARGED

- A. A patient in the ETP may be discharged following an FNAP determination that the patient no longer requires treatment on the ETP. The FNAP shall base their decision on the following:
  - 1. Clinical progress reported by the FNAT Psychologist and/or the patient's treatment team indicating a reduction of the patient's risk of aggression.
  - 2. A determination that the patient is inappropriate for continued treatment on an ETP.
  - 3. The identification of new issues that preclude the patient's treatment on an ETP.
  - 4. A determination by the Independent Psychologist or Psychiatrist's Medical Review.
- B. If the FNAP determines that the patient is ready to be transferred to a standard treatment setting, the referring hospital transfer coordinator/designee shall work with the ETP treatment team and the referring hospital to identify an appropriate placement in the referring hospital.
- C. The FNAP decision shall be in writing and provided as described in the ETP FNAP Certification Decision Notification Grid (Attachment 1).

### IV. DISCHARGE TO THE REFERRING HOSPITAL

- A. Once the FNAP decertifies the patient from the ETP, the FNAT Supervising Psychologist will notify the referring hospital of the FNAP decision as outlined in the ETP FNAP Certification Decision Notification Grid (Attachment 1).
- B. Within two business days of this notification, the referring hospital will provide the ETP transfer coordinator/designee contact information for the referring hospital's receiving treatment team and program management.
- C. The ETP Unit Supervisor (US)/designee will ensure the ETP Discharge e-Packet Checklist is complete and delivered to the ETP program management and the referring hospital's program management within seven days of the decision, unless it is an expedited discharge.
- D. The patient and the patient's medical record will be physically transferred to the referring hospital within 30 days of decertification. The patient shall receive a copy of the written aftercare plan prior to discharge.

### V. TRANSITION TO THE REFERRING HOSPITAL

- A. The patient will be included in the transition planning when the ETP treatment team determines this information is clinically appropriate.
- B. The ETP treatment team will work with the ETP Program Assistant/designee to ensure a transition process is completed.
- C. The ETP Program Director/designee will notify the ETP Clinical Administrator and the ETP transfer coordinator/designee that the patient has been decertified, clinically indicating transition back to the referring hospital. The ETP Program Director/designee will provide the ETP Clinical Administrator and ETP transfer coordinator/designee with the tentative clinical transitional time frame.
- D. The ETP Program Assistant will schedule a teleconference between the ETP treatment team and the referring hospital treatment team.
  - 1. The ETP treatment team, in collaboration with the FNAT Psychologist, shall complete the aftercare plan.
  - 2. The ETP Program Assistant shall send the completed aftercare plan to the referring hospital treatment team two (2) business days prior to the teleconference for their review.
- E. The ETP treatment team will provide the receiving treatment team with an overview of the patient's current treatment plan, inform them of the patient's progress, discuss the aftercare plan and discuss recommendations/suggestions. This discussion shall include a plan for post-ETP follow up.
- F. The ETP transfer coordinator/designee, ETP hospital program management and the referring hospital program management will ensure the transition and aftercare process is completed and determine the exact date of transfer, no later than 30 days following the FNAP decision

## VI. AFTERCARE PLANNING

- A. Individualized assessment and aftercare planning begins at admission and continues throughout a patient's stay on the ETP.
- B. A written aftercare plan for a standard treatment environment shall be developed by the treatment team in collaboration with the FNAT Psychologist prior to or at the time of discharge, transfer or release from an ETP.
  - 1. A written aftercare plan shall describe those services and goals that should be provided to a patient following discharge, transfer or release from an ETP for the purpose of enabling the patient to maintain stabilization or achieve an optimal level of functioning.
  - 2. Prior to or at the time of the discharge, transfer or release from an ETP, each patient shall be evaluated concerning the patient's need for aftercare services. This evaluation shall consider the patient's potential housing,

probable need for continued treatment, social services and need for continued medical and mental health care.

3. Aftercare plans shall include, but shall not be limited to, arrangements for medication administration and follow-up care.
4. The ETP Treatment Team Clinical Social Worker shall be responsible for ensuring that the aftercare plan has been completed and documented in the patient's health record.
5. The patient shall receive a copy of the patient aftercare plan prior to discharge.

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California Department of  
**State Hospitals**

**Enhanced Treatment Program**

**Section 5**

**Staffing**

**Department of State Hospitals – Atascadero**  
P.O. Box 7001  
Atascadero, CA 93423-7001



## **DSH-ATASCADERO ETP PROPOSED SCHEDULE**

0645-0700 – NOC / AM Shift Change  
0700-0745 – Lab Draws  
0700-0800 – Medications  
0745-0830 – Breakfast and Search of Person  
0800-0830 – SPT, US, TX Team Morning Meeting  
0800-0830 – Showers / Shaves  
0830-0900 – Therapeutic Community in Day Room  
0900-0945 - Team  
0900-0945 – Security Check of Patient’s Property / ADL time in rooms for Pts.  
0945-1040 – TX Session 1  
1050-1140 – TX Session 2  
1140-1200 - Quiet Time or Courtyard  
1145-1200 – Medications  
1200-1245 – Lunch and Search of Person  
1330-1345 – Quiet Time or Courtyard  
1345-1430 – TX Session 3  
1430-1515 – Quiet Time  
1445-1515 – AM / PM Shift Change  
1530-1620 – TX Session 4  
1630-1645 – Count  
1630-1700 - Medications  
1700-1745 – Showers / Shaves  
1745-1830 – Dinner and Search of Person  
1830-1900 – Therapeutic Community in Day Room  
1900-1945 – Courtyard  
1900-1945 – RT facilitated Group Activity  
1900-1945 – Security Check of Patient’s Property  
2000-2100 – Medications  
2100 – Bed Time  
2300 – PM / NOC Shift Change

**\*Schedule subject to change as needed.**

***“Caring Today for a Safe and Healthy Tomorrow”***

**DSH-Atascadero ETP DRAFT AM Shift Assignments 0645-1515**

<b>SPT</b>		<b>HPO1</b>		<b>HPO2</b>	
<b>Time</b>	<b>Task</b>	<b>Time</b>	<b>Task</b>	<b>Time</b>	<b>Task</b>
0645-0700	Shift Change	0600-0645	Rounds	0600-0645	Rounds
0700-0800	Scheduling	0645-0700	Shift Change	0645-0700	Shift Change
0800-0830	Morning Meeting	0700-0900	Dayroom Coverage	0700-0745	Labs
0830-0900	Ther. Community	0830-0900	Ther. Community	0745-0830	Meal/Searches
0900-1000	Security Inspections	0900-0945	Team Escorts	0830-0900	Ther. Community
1000-1200	Rounds/Relief	0945-1015	Rounds	0900-0945	Room Searches
1200-1300	Meal Break	1015-1050	Podiatry Escort	0945-1040	Group Coverage
1300-1400	PT4 Relief	1050-1140	Group Coverage	1040-1200	Rounds
1400-1445	Documentation	1140-1200	Courtyard	1200-1315	Dayroom Coverage
1445-1515	Shift Change	1200-1245	Pt. Lunch/Searches	1315-1330	Clinic Escort
		1245-1345	Rounds	1330-1345	Courtyard
		1345-1400	Group Coverage	1345-1400	Rounds
<b>RN</b>		<b>RN2</b>		<b>RN3</b>	
<b>Time</b>	<b>Task</b>	<b>Time</b>	<b>Task</b>	<b>Time</b>	<b>Task</b>
0645-0700	Shift Change	0645-0700	Shift Change	0645-0700	Shift Change
0700-0745	Labs	0700-0800	Documentation	0700-0830	Dayroom Coverage
0745-0830	Pt. Meal/Searches	0800-0830	Shaves	0830-0900	Ther. Community
0830-0900	Ther. Community	0830-0900	Ther. Community	0900-0945	Room Searches
0900-0945	Team Escorts	0900-1100	Rounds/Emerg. Responder	1000-1100	Meal Break
1015-1100	Podiatry Escort	1100-1200	Meal Break	1100-1300	Rounds/Emerg. Responder
1100-1300	A/V Monitoring	1200-1500	Dayroom Coverage	1330-1345	Courtyard
1300-1400	Meal Break	1445-1515	Shift Change	1345-1445	Documentation
1400-1445	Documentation			1445-1515	Shift Change
1445-1515	Shift Change				

## DSH-Atascadero ETP **DRAFT** AM Shift Assignments 0645-1515

PT1		PT2		PT3	
Time	Task	Time	Task	Time	Task
0645-0700	Shift Change	0645-0700	Shift Change	0645-0700	Shift Change
0700-0830	Dayroom Coverage	0700-0900	A/V Monitoring	0700-0800	Medication Assist
0830-0900	Ther. Community	0900-0945	Team Escorts	0800-0830	Showers
0900-0945	Documentation	0945-1040	Group Coverage	0830-0900	Ther. Community
0945-1045	Meal Break	1100-1200	Meal Break	0900-1100	A/V Monitoring
1050-1140	Group Coverage	1200-1300	Documentation	1100-1140	Documentation
1145-1200	Medication Assist	1300-1500	Rounds/Emerg. Responder	1140-1200	Courtyard
1200-1245	Pt. Lunch/Searches	1445-1515	Shift Change	1200-1300	Meal Break
1300-1500	A/V Monitoring			1315-1330	Clinic Escort
1445-1515	Shift Change			1345-1430	Group Coverage
				1445-1515	Shift Change

PT4	
Time	Task
0645-0700	Shift Change
0700-0930	Medication Pass
0930-1100	Inventory/Review Dr.'s Orders
1100-1300	Medication Pass
1300-1400	Meal Break
1400-1445	Doc Review
1445-1515	Shift Change

**DSH Clinical Staff Assignment**  
**ETP-Atascadero**  
**Shift 0800-1630 Mon-Fri**

0800-0830	Morning Meeting	Treatment Team
0830-0900	TC in dayroom	Treatment Team
0900-0945	Team/PRN Team	Treatment Team
0945-1040	Tx Group and/or 1 on 1 Therapy	Treatment Team
1050-1140	Tx Group and/or 1 on 1 Therapy	Treatment Team
1200-1300	Meal Break	Treatment Team
1300-1345	Documentation	Treatment Team
1300-1345	Sick Call/Documentation	Tx Team RN
1345-1430	Tx Group and/or 1 on 1 Therapy	Treatment Team
1445-1515	AM / PM shift change	Treatment Team
1530-1620	Tx Group and/or 1 on 1 Therapy	Treatment Team
1900-1945	Dayroom activity - this may be movie/TV time or an event facilitated by the RT	Rehabilitation Therapist

\*Schedule subject to change as needed.

**DSH-Staff Assignment for Individual Care  
ETP-Atascadero**

Clinical Review (Print): RN1  
 Clinical Review (Signature):  
 Shift Lead: SPT  
 Med Person: PT2

NOC Shift 2300-0700

HPO Shift 2200-0600

Task	SPT	PT1	RN1	HPO1	HPO2
A/V Monitor <i>2 hr. blocks</i>		2300-0100 0300-0500	0100-0300 0500-0700		
Documentation	0500-0600	0600-0645	2400-0100		
Early Med Assist	0600-0700				
Security Inspection & AED Log	0100				
NOC Audit			2315		
Chart Stuffing		0100			
Lab Prep			0400		
Rounds		0100-0300 0500-0700	2300-0100 0300-0500	2200-2400 0200-0400	2400-0200 0400-0600
Shift Change	2300 0645	2300 0645	2300 0645	2300	2300
Emergency Flow Sheet 1 <i>LOC + 1 backup</i>	X				
Off Unit Emergency Responder		0100-0300 0500-0700	2300-0100 0300-0500		

**Schedule subject to change as needed**

**Department of State Hospitals – Patton**

3102 E. Highland Avenue  
Patton, CA 92369

**DSH-PATTON ETP PROPOSED SCHEDULE**

0630-0645 – NOC / AM Shift Change (All nursing NOCs and AM's except 1:1 staff)  
 0645-0700 – Wake-up/contraband search (PT1, PT2, PT3, RN3, HPO1, HPO2)  
 0700-0730 – Labs, Vital Signs, Accu checks, Treatments (RN1, RN2, RN3, HPO2)  
 0700-0730 – Medication Pass (PT1, PT2, PT3, PT4, HPO1)  
 0730-0800 – Showers/ADLs (PT1, PT2, PT3, RN3, HPO1, HPO2)  
 0800-0830 – Breakfast (PT2, PT3, RN2, RN3, HPO2)  
 0800-0830— Morning Meeting (SPT, US, HSS, Clinical Staff, HPO1, PT1, PT4, RN1)  
 0830-0900 – Therapeutic Community in Day Room (US, SPT, HPO1, HPO2, Clinical Staff)  
 0830-0900— Documentation (PT1, PT2, PT3, RN1, RN2, RN3)  
 0900-0930 - Treatment Conferences (PT4, RN1, Clinical Staff)  
 0900-0930— Sick Call with MD (RN2, RN3)  
 0900-0915 – Specials/Ice/Hot Water (PT1, PT2, PT3, HPO1, HPO2)  
 0930-0945 – Courtyard (PT1, PT2, HPO1, HPO2)  
 0945-1045 - Group 1 (PT1, RN3, Clinical, HPO1, HPO2) \*PT2,PT3, RN1 @ Lunch 10-11\*  
 1045-1100– Break (PT1, RN3, HPO1, HPO2)  
 1100 -1200 -Group 2 (PT2, PT3, HPO1, HPO2, Clinical Staff)  
 \*PT1, PT4, RN2, RN3 @Lunch 11-12\*  
 1200-1215 – Contraband Search (PT1, PT2, PT3, HPO1, HPO2)  
 1200-1230—Vital Signs, Treatments, Accu Checks (RN1, RN2, RN3, HPO2)  
 1215-1230 – Count Time (SRPT, PT1, PT2, PT3, RN3, HPO1, HPO2)  
 1230-1300 – Medication/Lunch (PT1, PT2, PT3, PT4, RN3, HPO1, HPO2)  
 1300-1315 – Specials/Ice/Hot Water (PT1, PT2, PT3, HPO1, HPO2)  
 1315-1330 – Courtyard (PT1, PT2, PT3, HPO1, HPO2)  
 1330-1430 - Group 3 (PT1, PT2, PT3, HPO1, HPO2)  
 1430-1500 – Shift Change (All Nursing AM/PM, Clinical, US, HSS, HPO)  
 1500-1600 – Group 4 (Clinical Staff, HPO1, HPO2,)  
 1600-1700 – Structured Leisure (PT2, PT3, RN2, RN3, HPO1, HPO2)  
 1600-1630 – Treatment Team Meeting (SRPT, RN1, PT1, PT4, HSS, Clinical, US, HPO)  
 1700-1715 – Count/Contraband Search (PT1, PT2, PT3, RN3, HPO1, HPO2)  
 1715-1745 –Treatments, Vital Signs, Accu Checks (RN1, RN2, RN3, HPO1)  
 1715-1745 – Medications (PT1, PT3, PT4, HPO2)  
 1745–1815- Dinner (PT2, PT4, RN2, RN3, HPO1, HPO2) \*PT1, PT3, RN1 @Lunch 18-1900\*  
 1815-1830-Specials/Ice/Hot water (PT2, RN2, RN3, HPO1, HPO2)  
 1815-1830-Courtyard (PT2, PT4, RN3, HPO1, HPO2)  
 1830-1900-Showers, ADLs (PT2, PT4, RN2, RN3, HPO1, HPO2)  
 1900-1930-Vital Signs, Treatments, Accu Checks (PT1, RN1, RN2) \*PT2, RN3 @Lunch 19-20\*  
 1930–2000- Medication (PT1, PT3, RN1, HPO1, HPO2) \*RN2 @Lunch 1930-2030\*  
 2000-2100-Unstructured Leisure Activity (PT2, PT3, RN3, HPO1, HPO2)  
 2100-2130-Count/Contraband Search (SRPT, PT1, PT2, PT3, RN3, HPO1, HPO2)  
 2130-2200-Quiet/Reflection Time (PT1,PT2, PT3, RN3, HPO1, HPO2)  
 2200-Lights out  
 2200-2245-Documentation, debriefing, (All nursing except 1:1 staff, HPO1)  
 2245-2300-PM/NOC Shift Change (All Nursing except 1:1 staff, HPO2)

\*Schedule subject to change as needed.

***“Caring Today for a Safe and Healthy Tomorrow”***

**DSH- Clinical Staff Assignment  
ETP-Patton**
**Shift 0700-1730**

0700	Documentation/Review of Referrals/Planning	Treatment Team
0800-0830 RN1	Morning Meeting	SPT, US, HEE, Clinical Staff, HPO1, PT1, PT4,
0830-0900	TC	Clinical Team, HPO 1, HPO2, US, SPT
0900-0930	Treatment Team Conferences	PT4, RN1, Clinical Staff
0945-1045	Group Session 1 and/or 1 on 1 Therapy	PT1, RN3, Clinical, HPO1, HPO2
1100-1200	Group Session 2 and/or 1 on 1 Therapy	PT2, PT3, HPO1, HPO2, Clinical Staff
1300-1330	Caseload Check-in	Treatment Team
1330-1430	Group Session 3 and/or 1 on 1 Therapy	PT1, PT2, PT3, HPO1, HPO2, Clinical Staff
1430-1500	Shift Change	All Nursing AM/PM, Clinical, US, HSS, HPO
1500-1600	Group Session 4 and/or 1 on 1 Therapy	Clinical Staff, HPO1, HPO2
1600-1700	Structured Leisure Activity	RT
1600-1630	Treatment Team Meeting	SRPT, RN1, PT1, PT4, HSS, Clinical, US, HPO
1630-1730	Documentation/Case Management	Clinical

\*Schedule subject to change as needed.

**DSH Staff Assignment for Individual Care  
ETP-Patton**

<b>AM Shift 0630-1500</b>	<b>US, SRN, HPO SGT</b>							<b>Date:</b>	
	<b>Shift Lead: SPT</b>		<b>Meal: 1230</b>		<b>Shift Lead Relief: PT4</b>				
	<b>Med Person: PT4</b>		<b>Meal:1100</b>		<b>Med Relief: SPT</b>				
<b>Staff</b>	<b>RN1</b>	<b>RN2</b>	<b>RN3</b>	<b>PT1</b>	<b>PT2</b>	<b>PT3</b>	<b>SPT</b>	<b>HPO1</b>	<b>HPO2</b>
<b>Meal Break</b>	1000	1100	1100	1100	1000	1000	1100	Shift: HPO may be pulled for escorts/emergency	

<b>Shift Change</b>	x	x	x	x	x	x	x	x	X
<b>Medications Labs</b>	Treatments/ Vital Signs 0700 1200	Accucheck/ Labs 0700 1200	Vital Signs/Trea tments 0700 1200	Medline 0700	Medline 0700 1230	Medline 0700 1230		Medline 0700	
<b>Patient Meals</b>		Breakfast 0800 Lunch 1230	Breakfast 0800 Lunch 1230		Breakfast 0800 Lunch 1245	Breakfast 0800 Lunch 1245			Breakfast
<b>Morning Meeting</b>	0800			0800				0800	
<b>Therapeutic Community</b>							0830	0830	0830
<b>Room/Body Searches</b>				0645 1200	0645 1200	0645 1200		0645 1200	0645 1200
<b>Rounds/Q15/ Security Checks/ Emergency Equipment check (assigned as needed by SPT)</b>							X PT4 to cover rounds while SPT on Lunch.		
<b>TX Group Coverage</b>		Tx. Conferenc e with PT4	Group1 0945	Group1 0945 Group3 1330	Group2 1100 Group3 1330	Group2 1100		Group1 0945 Group2 1100 Group3 1330	Group1 0945 Group2 1100 Group3 1330
<b>Courtyard</b>				0930 1315	0930 1315	1315		0930 1315	0930 1315
<b>Showers/ADLS</b>			0730	0730	0730	0730		0730	0730
<b>Flow Sheets</b>			1230			0800			
<b>Escorts</b>			0800 EKG			1330 Dental			
<b>Specials/Ice/ Hot Water</b>				0900	0900	0900		0900	0900
<b>AV Monitoring</b>	0900-1100	1100-1300		0700-0900		1300-1500			



California Department of  
**State Hospitals**

**Enhanced Treatment Program**

**Section 6**

**Training**

DEPARTMENT OF STATE HOSPITALS  
ENHANCED TREATMENT PROGRAM

ETP OPERATING MANUAL

SECTION – Program Operations

PROGRAM PROCEDURE No. ETP-OP-205

SUBJECT: ETP Training Procedure

Effective Date: XXXX

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This procedure is specific to the Enhanced Treatment Program (ETP).

I. PURPOSE

To outline a system for training the staff who are assigned to work on or float to any ETP unit.

The focus of treatment on the ETP is to address the risk factors of each patient that are placing him/her at the highest risk for violence. Staff training in treatment modalities and intervention strategies for this population are an important component of successful implementation of the ETP.

II. INITIAL TRAINING

Staff assigned to work on the ETP will receive intensive training prior to the opening of each unit. Training topics include:

- A. Introduction to ETP Philosophy and Culture: An overview of the ETP history, design, philosophy, and treatment approaches.
- B. Team Building: The ETP includes newly formed units and treatment teams. Building unit teams with a shared purpose is a critical component of working effectively with patients who have a high risk for violence.
- C. Trauma Informed Care (TIC): *“TIC is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.”*-Substance Abuse and Mental Health Services Administration
- D. Positive Psychology: Positive psychology is the scientific study of what makes life most worth living.

- E. Motivational Interviewing (MI): MI is a patient centered method for enhancing intrinsic motivation to change health behavior by exploring and resolving ambivalence.
- F. Sensory Modulation: Training addresses collaborative, meaningful, trauma informed, recovery focused, sensory supportive treatment approaches.
- G. Criminogenic Risk Factors: ETP staff will be trained in Changing Lives Changing Outcomes, an evidence-based treatment that addresses mental illness, criminal thinking, and the relationship between the two.
- H. Dialectical Behavioral Therapy (DBT) Informed Skills: DBT is an evidenced based treatment that treats emotion dysregulation. The goal of Emotion Regulation treatment on the ETP is assist patients in learning how to manage their emotions without the use of violence, as well as support the efforts of the treating team and staff to reduce violence on the unit.
- I. De-escalation/Therapeutic Options (TO): Training addresses de-escalation techniques and skills to utilize when patients become emotionally dysregulated.
- J. Therapeutic Strategies and Interventions (TSI): TSI addresses how to intervene with patients in a therapeutic manner when patients start to escalate, and additional steps to take if hands-on interventions are needed.
- K. Transdisciplinary Approach: A team based model of care, with all disciplines viewed as having an equally important role in the patient's treatment and each team member having expanded knowledge of the role that each discipline plays on the team. Members of a transdisciplinary team achieve service integration by consulting one another. They do not abandon their discipline, but blend specific skills with other team members to focus on achieving integrated outcomes.
- L. Discipline Specific: Each staff discipline represented in the ETP team will teach the ETP staff what their job and function on the ETP will be, to enhance teamwork and collaboration.
- M. Social Skills and Support: Staff will learn how to assist patients in developing skills to appropriately interact with others.
- N. Substance Recovery Treatment: Staff will be trained in integrated, stage based, and evidence-based substance recovery treatment and assessment for patients with a substance use disorder diagnosis referred to the ETP.
- O. Patient's Rights: The Patient's Right's Advocate assigned to the ETP will provide an overview training on patient's rights.
- P. Behavioral Concepts: Staff will receive training in behavioral concepts and techniques to use in treatment planning with patients at high risk for violence.

- Q. Milieu Management and Safety Communication Plan: Staff will become familiar with these two components of behavioral treatment planning, developed by the treatment team in conjunction with the patient, to create an environment that supports the patient in managing unsafe behaviors and progressing toward safe conduct.
- R. Cognitive Remediation and Social Cognition: Cognitive remediation includes a variety of treatments that target social cognition, attention, memory, executive functioning, and language abilities.
- S. Behavioral Health Assistance Module (BHAM): The ETP BHAM module is an electronic dashboard that facilitates treatment pathways, the completion of forensically driven documentation, and ETP-related notifications. It also provides a platform for data collection.
- T. Hands On: Hands-on practical application training for staff assigned to the ETP will be provided. Topic areas are included in Attachment A.

### III. MAKEUP/MANDATORY TRAINING FOR ASSIGNED STAFF

- A. The courses listed below are mandatory ETP training. If staff assigned to the ETP miss any of these training days, they will need to make up the class. Staff onboarding after the activation of the unit will be required to complete the mandatory training.
  - 1. Philosophy/Positive Psychology/TIC/Transdisciplinary Approach (half day)
  - 2. BHAM (half day)
  - 3. Milieu Management Plan
  - 4. TO/TSI
  - 5. Patients Rights
  - 6. Operational Processes: Unit procedures including escorting, door and food port use, audio/visual monitoring, emergency response, and non-contact interview room use.
  - 7. Clinicians - Overview of Motivational Interviewing, DBT-informed skills, and background and implementation of the Changing Lives Changing Outcomes treatment program.

### IV. FLOAT STAFF ORIENTATION

- A. Staff who float to or work overtime on an ETP unit will be required to review a 60-minute video prior to working their first shift. This video will cover:
  - 1. Overview/History of the ETP
  - 2. Philosophy
  - 3. ETP unit structural layout
  - 4. Milieu management
  - 5. Patient movement

### V. NEW EMPLOYEE ORIENTATION (NEO)

- A. The float orientation video will be used in NEO to introduce all staff to the ETP so they will be available to float to the ETP units.

## VI. ONGOING/ANNUAL TRAINING

- A. ETP staff will attend hospital required annual training.
- B. Additional ETP-specific annual training will be determined during the first year of program implementation and adjusted based on ongoing program evaluation.

Cross Reference(s):

AB 1340 - Achadjian. Enhanced Treatment Programs

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**Enhanced Treatment Program**  
**Procedure ETP-OP-205: Training Procedure**  
**Attachment A – Hands-On Training**

- A. Admissions
  - 1. AB1340
  - 2. Placement Timeline:
    - a. 90 Day Placement
    - b. One-Year Placement
    - c. One Year Continuation Placement
    - d. Independent Review
    - e. 90 Day Treatment Summary Review
    - f. Emergency Placement
  - 3. Admission Process:
    - a. Site specific procedure
    - b. Receiving patient from R&R
    - c. Direct admit process
    - d. Timeframe for preparing initial Milieu Management Plan (MMP) & Safety Communication Plan
- B. Patient Orientation
  - 1. Initial Team
  - 2. New Admission Orientation (NAO) Groups
  - 3. Patient Orientation Handbook
- C. Discharge
  - 1. Utilization Management
  - 2. Transition Plan
  - 3. After care Plan
  - 4. Options for Discharge
- D. Discipline Specific Documentation and Processes
  - 1. LOC Documentation
    - a. RN documentation
    - b. RN sick call/Team RN
    - c. PT documentation
    - d. Team recorder
  - 2. Rehabilitation Therapist Documentation
  - 3. Social Work Documentation
  - 4. Psychologist and Forensic Needs Assessment Team (FNAT) Documentation
  - 5. Psychiatrist Documentation
- E. BHAM

1. Training for Trainers
2. Training for Non-ETP Staff
- F. Escorting/On & Off Unit/Courtyard
  1. Review Escorting Program Procedure
  2. On Unit Escort—Practice (various escort scenarios)
    - a. Lockers
    - b. Meals
    - c. Non-contact room
    - d. Groups
    - e. Courtyard
    - f. Sick call
    - g. MMP specific procedures i.e. enemy, limited interaction with peers
    - h. Phones
    - i. Activities of daily living
    - j. Showers
    - k. Shaves
  3. Off Unit Escort
    - a. Admission escort
    - b. Visiting escort
    - c. Site specific ETP visiting procedure
- G. A/V Monitoring
- H. Emergency Response
  1. Medical Emergency
    - a. Site specific emergency procedure
    - b. Alarm response procedure
    - c. Review staff responses on unit i.e. while in group or assigned to other tasks
    - d. Review off unit staff direction during emergencies
    - e. Review crime scene procedures and protocol
    - f. Post incident review of medical emergency
  2. Fire Drill
    - a. Review fire plan Administrative Directive (AD)
    - b. Simulate evacuation with 13 patients in various milieu statuses
  3. Pepper Spray & Decontamination
    - a. Review Nursing Procedure (NP) on care of the patient exposed to pepper spray
    - b. Review police directive on use of chemical agents
  4. Competency Test
- I. MMP/SCP/Incentive Plan/Behavior Plan
  1. MMP
  2. SCP
  3. Incentive Plan
  4. Behavior Plan

- 5. Competency Test
- J. Doors/Food Ports/Meals/Meal Count
  - 1. Door and Food Port Program Procedure
  - 2. Door and Food Port Operation
  - 3. Sanitation
  - 4. Door and Food Port Scenarios
- K. Shift Change/TC/Groups (mall, supplemental, leisure)
  - 1. Milieu Management (review skills for interacting with patients during Therapeutic Community (TC), groups & leisure activities)
  - 2. Staff Involvement (groups and group coverage)
  - 3. PM/NOC Patient Treatment (engaging with patients in locked door status)
- L. Search of Person & Property/Lockers/Mail/Phone Use
  - 1. Therapeutic Approach to Searches
  - 2. Police Perspective on Searches
- M. Unit/Security Awareness
- N. SIR Documentation in WaRMSS
  - 1. Review PowerPoint Presentation
  - 2. Review Video
  - 3. Practice Entering SIR Data into WaRMSS
- O. A Day in the Life of the ETP