

**NAMI CA Town Hall with Department of State Hospitals | July 14, 2020  
Follow Up Q&A**

**QUESTION: What are plans for future growth of new facilities for long-term hospitalization needs?**

RESPONSE: There are no plans to open a new state hospital. Since 2012, DSH has responded to an increase in demand by increasing the capacity of existing hospitals by activating more than 400 beds, added more than 300 beds in jail-based programs and over 200 beds in a community-based program in LA County. DSH has also responded to the increased demand through efforts to reduce the length of stay for patients and by creating a centralized referral system that helps DSH move patients into and out of treatment more rapidly. DSH continues to work with counties across the state to open or expand diversion and alternative programs (such as Jail-Based Competency Treatment (JBCT) programs).

**QUESTION: How can NAMI help for future expansion?**

RESPONSE: NAMI can assist DSH by continuing to support their community-led efforts to expand diversion and alternative programs for treatment of mental illness.

**QUESTION: Does DSH have State oversight of any other mental health care? Who does?**

RESPONSE: In 2012, Governor Brown and the Legislature transferred the oversight of community based mental health care programs to the Department of Health Care Services and other state agencies.

**QUESTION: Is there any relationship between DSH and private psychiatric hospitals?**

RESPONSE: None. However, some conserved patients may be transferred from DSH to private psychiatric hospitals, or vice versa, when it is determined that one setting is more clinically appropriate and the least restrictive placement to meet the patient's treatment needs.

**QUESTION: How many conditional release SVP individuals do you have?**

RESPONSE: As of July 20, 2020, there were 15 individuals who were actively participating in the SVP CONREP program while living in communities across California.

**QUESTION: The rate of forensic population in state hospital in CA vs other states is alarming. Also, the IST referrals to state hospital in CA are absurdly increasing. What are the causes for these statistics? Is state hospital being using poorly and differently than other states?**

RESPONSE: As Stephanie's presentation showed, the increase in patients referred to DSH as Incompetent to Stand Trial (IST) and other forensic patients are not unique to California. Research by DSH indicates that a large percentage of patients referred to DSH as IST were homeless at the time of their arrest and had not accessed community mental health treatment in the six months prior to their arrest.

**QUESTION: Why is your SVP population housed indefinitely as apples to the other populations in the state even though the recidivism rate for these folks is the lowest?**

RESPONSE: In 2006, Proposition 83 changed California state law related to individuals committed as sexually violent predators (SVP) to the Department of State Hospitals. Among other things, it changed the prior 2-year involuntary commitment term to an indeterminate commitment and called for the Department of State Hospitals to provide annual reviews and the ability to petition the court for conditional or unconditional release.

**QUESTION: What is def of IST? What qualifiers/characteristics?**

RESPONSE: Pursuant to Penal Code section 1367, subdivision (a), a defendant is mentally incompetent if, as a result of a mental health disorder or developmental disability, the defendant is unable to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a rational manner.

**QUESTION: I hoped that this helped most listeners but not much was talked about Coalinga Hospital and why it's so difficult for these residents to get conditional release or have a less commitment assessment so they can live in the community.**

RESPONSE: According to the Sexually Violent Predator Act, to be eligible to be considered for the SVP Conditional Release Program (SVP CONREP), an individual must first have been determined by a court to be an SVP and committed for at least one year to DSH as an SVP. Individuals who are committed to DSH based on probable cause, pending a hearing or trial to determine if they are an SVP are not eligible to participate in the Conditional Release program.

The SVP CONREP program is a rigorous treatment program that requires the convicted sexual predator to acknowledge their criminal history and criminal behavior and to work closely with a treatment team inside of the hospital in order to develop skills to prevent this behavior in the future. Once placed in the community, the patients continue to be closely monitored and continue in their treatment. There are various reasons why an individual may not progress to conditional release in the community, including not participating in treatment in the hospital or a patient continues to require treatment in a state hospital to further reduce the patient's risk of reoffending if released to the community.

**QUESTION: Is my son getting any CONREP services after over 5 years in Metro?**

RESPONSE: DSH cannot respond to this question in a Question and Answer setting because doing so might violate a patient's right to privacy. If a parent has questions about a relative's treatment, that parent should contact the hospital directly and request to discuss the matter with the patient's social worker or member of the treatment team. DSH will need a release of information in order to include

a family member in discussions about recovery and treatment. Whether a person obtains CONREP services is not determined by how many years someone has been at the hospital, but whether or not they qualify for community placement clinically.

**QUESTION: I'm interested in knowing how the civil patients come in via LPS obviously by judge but what is a normal scenario for this type situation and how difficult the path is to get this type of assistance as some people need to be hospitalized at the state level always with a goal to rehabilitate.**

RESPONSE: There are two ways LPS patients are admitted to DSH. First, individuals who are receiving competency treatment at DSH pursuant to Penal Code section 1370, and are subsequently found substantially unlikely to be restored to competence in the foreseeable future, or whose Penal Code section 1370 commitment maxes out, can have their commitment converted to a civil LPS commitment by Court order. Second, LPS conservatorships can also be initiated from the community. These cases typically begin as emergency psychiatric holds. Then, in cases when it is deemed clinically appropriate, they are referred for a conservatorship. This conservatorship is also ultimately authorized by Court order. In both circumstances, the Court, in addition to authorizing the conservatorship, sets a level of care, also referred to as least restrictive placement, for the LPS patient based on the patient's individual needs for treatment. DSH is one of the multiple options for placement. Based on the Court's determination, the conservator responsible for the patient is tasked with locating a facility within the court's determined level of placement. When that placement has been determined as DSH, the conservator can refer the conservatee for placement at DSH-Napa or DSH-Metropolitan. Usually, the referral is sent to the hospital that is geographically closest to the committing county. Any change in placement may require court involvement.

**QUESTION: Is the low percentage of civil LPS patients due to the fact that it is almost next to impossible to get the help they need?**

RESPONSE: The low percentage of civil LPS patients in state hospitals is not reflective of the ability to treat those patients. It is reflective of changes in the law enacted in the 1980s that transferred the responsibility for the treatment of civilly committed individuals to the local jurisdictions (the county and city programs). Additionally, the LPS patients at DSH make up only a portion of LPS commitments statewide. DSH is only one of several placement options available for LPS patients.

**QUESTION: Can the residential program be available to a person from the prison system in their EOP, been to the state hospital and imprisoned for more than 12 years?**

RESPONSE: Individuals who have been committed to the Department of State Hospitals as Offenders with Mental Health Disorders after their prison term at the California Department of Corrections and Rehabilitation has ended can qualify for placement in DSH's conditional release program when they are determined to be ready for community outpatient treatment.

**QUESTION: I am not sure if you covered this, but can someone tell me how the civilian LPS referrals come into state hospitals? What is the reason they are referred the path they come in?**

RESPONSE: There are two ways LPS patients are admitted to DSH. First, individuals who are receiving competency treatment at DSH pursuant to Penal Code section 1370, and are subsequently found substantially unlikely to be restored to competence in the foreseeable future, or whose Penal Code section 1370 commitment maxes out, can have their commitment converted to a civil LPS commitment by Court order. Second, LPS conservatorships can also be initiated from the community. These cases typically begin as emergency psychiatric holds. Then, in cases when it is deemed clinically appropriate, they are referred for a conservatorship. This conservatorship is also ultimately authorized by Court order. In both circumstances, the Court, in addition to authorizing the conservatorship, sets a level of care, also referred to as least restrictive placement, for the LPS patient based on the patient's individual needs for treatment. DSH is one of the multiple options for placement. Based on the Court's determination, the conservator responsible for the patient is tasked with locating a facility within the court's determined level of placement. When that placement has been determined as DSH, the conservator can refer the conservatee for placement at DSH-Napa or DSH-Metropolitan. Usually, the referral is sent to the hospital that is geographically closest to the committing county. Any change in placement may require court involvement.

**QUESTION: How many African American Males are admitted based on being gravely disabled?**

RESPONSE: During Fiscal Year 2018-19, a total of 15 African American males were admitted to DSH as an LPS commitment type.

**QUESTION: Can you break down the 148.7 ALOS for the State into the main groups, ie NGI, vs Hospitals Incompetent to Stand Trial. etc.? (SLIDE 20)**

RESPONSE: 100 percent of the 148.7 ALOS are Incompetent to Stand Trial patients.

**QUESTION: Is DSH involved with any kind of research around finding interventions that help people with mental illness? Are they familiar with the Patient-Centered Outcomes Research Institute (PCORI)? PCORI is a research institute based in Washington D.C. Since its inception in 2010, it has funded close to \$2.6 billion in research and research related projects. PCORI helps people make informed healthcare decisions, and improves healthcare delivery and outcomes, by producing and promoting high-integrity, evidence-based information that comes from research guided by patients, caregivers, and the broader healthcare community. The research is patient centered.**

RESPONSE: DSH has research partnerships with several different entities including UC Davis, Texas A&M University, and the Substance Abuse and Mental Health Services Administration (SAMHSA). These partnerships have focused on better understanding how to treat individuals who are in one of our hospitals for competency restoration, how to more effectively provide cognitive rehabilitation and dialectical behavior therapy programs, to help to reduce recidivism, and the adoption of a trauma informed care approach to providing a more effective therapeutic approach and milieu to our patients.

**QUESTION: What is the process for hospitals to start using neurofeedback as another treatment?**

RESPONSE: Currently DSH does not provide neurofeedback treatment.

**QUESTION: I am a concerned parent and would love to be a part of my son's recovery and treatment. I like seeing that you are including family but this I was told are a part of incoming pre-trial and my son is going through court dates after being brought from prison. Do you have any advice for me?**

RESPONSE: If a parent has questions about a relative's treatment and providing support for the patient, DSH recommends the parent should contact the hospital directly and request to discuss the matter with the patient's social worker or member of the treatment team. DSH will need a release of information in order to include a family member in discussions about recovery and treatment.

**QUESTION: Why do State Hospitals use 1st generation antipsychotics that cause extra pyramidal effects and Tardive Dyskinesia?**

RESPONSE: DSH psychiatrists carefully consider each patient's previous course of treatment and mindfully compares the benefits and possible risks of each medication that they prescribe to their patients. Doctors *regularly* screen patients for Tardive Dyskinesia and other side effects of commonly used antipsychotic medications using evidenced-based and scientifically validated tools, such as the Abnormal Involuntary Movement Scale (AIMS).

**QUESTION: How many patients in CONREP are released/graduated from CONREP per year per county or in the State. Are these statistics published?**

RESPONSE: The number of CONREP discharges, varies based on legal commitment type (Not Guilty by Reason of Insanity (NGI); Offenders with Mental Health Disorders (OMD); Incompetent to Stand Trial (IST)). Here are some averages for the last four fiscal years from 2016-17 through 2019-20:

- Restoration of Sanity (individuals committed as NGI) average = 27 per year
- Decertification (individuals who no longer meet the statutory criteria to be committed as OMD) = 6 per year
- Restoration of Competency (Individuals committed as IST) = 25 per year

There are some other discharge categories, but the numbers above represent the common discharges. Restoration of Sanity and OMD decertification involve transition to community-based services and unconditional release. Restoration of Competency prepares the individual to proceed with the judicial process.

**QUESTION: Our county has an AB 1810 diversion program and is considering JBCT. There appears to be a gap in not having a community-based competency program such as LA County has. What is your intention to incentivize this program throughout the state? It would be very helpful to have it available.**

RESPONSE: The LA Community-Based Restoration Program (CBR) is the first DSH-funded program of its kind in the state. DSH is encouraged by the success of the program and continues to monitor its progress and consider expansion to other counties, however at this time DSH does not currently have funding or immediate plans for expansion.

**QUESTION: What part of CONREP connects with other community programs that can offer wraparound services to the client in being successful after leaving CONREP?**

RESPONSE: Each CONREP program in the community is staffed with a treatment team and Community Program Director. As a participant progresses in CONREP treatment, that individual's treatment plan will be gradually adjusted to reflect CONREP's "supported" and "aftercare" levels of service if future discharge is a realistic goal for the individual CONREP consumer. These more advanced CONREP service levels include focus on and support for a gradual transition to living more independently in the community and linkage to other publicly available community-based services. For most counties and most CONREP participants this means linkage to county behavioral health services, and identifying the psychiatrists, therapists, programs, and pharmacies the individual will use when restored to sanity or unconditionally released. In addition to county behavioral health services, each county also has other unique options including wellness programs and day programs that the individual can continue to use after their time with CONREP. Many of these day programs and wellness programs are key to successful transition, because the individual can establish their connection and attend these programs before and after discharge from CONREP, which helps with continuity. While each CONREP is unique, many also utilize the services of the Department of Rehabilitation, which help the CONREP participant identify education and employment options that can be continued after discharge.

**QUESTION: What did Phase 2 and Phase 3 mean in the presentation about Diversion?**

RESPONSE: Round 2 and Round 3 referred to funding rounds for the DSH Diversion program, which provides funding to counties to develop new or expand existing diversion programs to serve individuals who have been or are likely to be found incompetent to stand trial on felony charges. The first round of funding (up to \$91.0 million) was guaranteed to the fifteen counties with the highest rates of IST referrals to DSH the year the proposal was developed. DSH set aside \$8.5 million for all other counties to apply for through a competitive process; this was Round 2. Round 3 was a second competitive process open to any county not already receiving funding from DSH to compete for any remaining unclaimed funds.

**QUESTION: What is the budget amount and FTE used by DSH to provide CONREP oversight?**

RESPONSE: The overall CONREP (Non-SVP) budget for Fiscal Year 2020-21 is \$43 million. The breakdown is \$2.1 million in DSH personnel costs, which includes salary and benefits for 9.4 full-time equivalents (FTE), as well as \$160,000 in operating expenses and equipment costs. This budget also includes \$41 million for external contracts for providing services to clients. The FTE ratio within the CONREP programs is approximately ten clients to one clinician.

**QUESTION: Clarification on my question: Where is Stanislaus County at as far as cooperation in DSH Diversion program?**

RESPONSE: At this time, Stanislaus County has chosen not to participate in the DSH Diversion program.