December 31, 2025

Mandi Posner, Deputy Director
Center for Health Care Quality
California Department of Public Health

Provided via email to: CHCQRegulations@cdph.ca.gov

Dear Deputy Director Posner:

On behalf of nearly 400 hospitals and health systems, including 32 free-standing acute psychiatric hospitals and 72 general acute care hospitals with psychiatric units, the California Hospital Association (CHA) recommends the following changes to the California Department of Public Health (CDPH) draft regulations on acute psychiatric hospital staffing released Dec. 22, 2025.

The draft regulations do not reflect either the numerical ratio or team composition recommendations CHA shared in letters to the department on May 20, 2025 and June 16, 2025 — a threat to both access to care and critical mental health worker jobs. Again, no substantial research ties psychiatric hospital safety indicators to nursing staffing levels; rather, a multidisciplinary team approach with a mix of licensed and non-licensed staff has been shown to enhance safety. Modern inpatient psychiatric care requires this team-based approach that includes mental health workers, who serve alongside nurses, psychiatric techs, licensed therapists, social workers, and others.

Of even greater concern is the fact that CDPH proposes requiring all licensed psychiatric hospitals to comply with these new staffing ratios only 30 days from today, by Jan. 31, 2026. Holding all facilities to a breakneck timeline is not only unnecessary but will surely make access to inpatient care even more difficult as hospitals reduce beds to come into compliance. The hiring process for health facilities usually spans several months, encompassing position postings, candidate interviews, background checks, and comprehensive onboarding and training prior to assigning staff to patient care. With dozens of facilities trying to hire licensed nurses from the same pool at a time when there is a massive national workforce shortage, psychiatric inpatient beds could be offline for extended periods of time until all required staff are in place.

California cannot afford to jeopardize its already insufficient access to inpatient psychiatric care by requiring immediate compliance with the proposed staffing ratios.

(1) CHA urges CDPH to amend the regulations to permit a one-year period during which psychiatric hospitals must comply.

This can be accomplished by simply adding, "Commencing January 1, 2027," to the beginning of the following provision on page 4 of the draft regulations where the numerical ratios are provided. Specifically, amend subdivision (h) of Section 71215 of Title 22 to read:

> *"(h) **Commencing January 1, 2027,** the hospital shall maintain, at all times, the following minimum nurse-to-patient ratios*:
> *(1) At least one licensed nurse for every six adult patients.*
> *(2) At least one licensed nurse for every five patients below the age of eighteen."*

- **The California Department of Public Health (CDPH) has the authority to add a reasonable future date by which compliance must be met, while still meeting its statutory requirement to promulgate these regulations.**
  Assembly Bill 116 (Committee on Budget, Chapter 21, Statutes of 2025) requires CDPH to **adopt** emergency regulations by Jan. 31, 2026, and to adopt permanent regulations by July 31, 2027. The statute does not require facilities to comply on the same date the regulations are promulgated. Specifically, paragraph (2), subdivision (k) of Section 1276.4 of Health and Safety Code states: "*The department shall adopt emergency regulations pursuant to this subdivision no later than January 31, 2026. The department may readopt any emergency regulation authorized by this subdivision that is the same as, or substantially equivalent to, an emergency regulation previously adopted under this subdivision.*"

- **There is a precedent for providing a feasible ramp-up period in other health facility licensing regulations.**
  The Title 22 nurse-patient ratios regulations for general acute care hospitals promulgated by CDPH two decades ago provided varying dates by which units of hospitals had to comply. For example, paragraphs 10 through 12 in subdivision (a) of Section 70217 provide that step-down, telemetry, and specialty units had to comply with nurse-patient ratios by Jan. 1, 2008, while medical surgical units had to comply by Jan. 1, 2005.

- **Absent the appropriate time to comply, some psychiatric facilities will close licensed beds.**
  The ratios fail to account for the acute and growing nursing shortage in California and across the country, which will make compliance challenging. In the face of months-long hiring, onboarding, and training timelines — as well as steep financial penalties for not meeting these ratios — some psychiatric hospitals would simply be forced to close licensed beds.

  Diminishing access to inpatient psychiatric care — when 24 counties in California already have no psychiatric beds at all and only 15 counties have beds for adolescents — runs counter to billions of

dollars in behavioral health infrastructure investments the Newsom Administration, the Legislature, and a vast majority of voters approved when passing Proposition 1 in 2024.

- **Patients in crisis will suffer and emergency department boarding will worsen if psychiatric facilities are forced to close licensed beds.**
  Every day, California hospital emergency departments treat patients experiencing suicidal thoughts or injuries from self-harm — in fact, self-harm is now the third leading cause of injury-related emergency department visits. According to HCAI's California Hospital and Workforce Behavioral Health Data Snapshot, patients with behavioral health diagnoses account for 1 in every 3 inpatient hospitalizations and 1 in every 5 hospital emergency department visits.

  Not only are hospitals seeing more Californians in mental health crisis, but both youth and adults already spend disproportionately more time waiting in the emergency department than other patients. While the national quality standard for emergency hospital care is four hours or less, it is common for people in mental health crisis to languish in a hospital emergency department for days or even weeks while waiting for an inpatient mental health treatment bed to become available. Given that California's *existing* bed shortages are already a major driver of these long waits, now is not the time to make access to psychiatric inpatient care even more difficult by imposing immediate and unattainable compliance with new staffing ratios.

(2) CHA urges CDPH to consider establishing a differential ratio for nighttime shifts when most patients are asleep.

CHA is hearing grave concerns from some psychiatric facilities about the requirement these ratios be in place "at all times." They are concerned that the 1:6 and 1:5 Registered Nurse (RN)-focused ratios at nighttime are not only unnecessary — while most patients are asleep — but the cost and time to hire more RNs to cover these nocturnal shifts will be prohibitive and lead facilities to close licensed beds. In acute psychiatric hospitals, nighttime care is clinically distinct from daytime care. The primary therapeutic goal overnight is patient safety and, importantly, supporting sleep, which is a foundation of health and well-being. Nurse-patient ratios should provide flexibility to account for increased or diminished patient acuity and nighttime clinical needs, rather than simply replicating daytime staffing patterns when all patients are ambulatory and actively participating in individual and group therapeutic activities.

Furthermore, nighttime staffing in psychiatric hospitals does not require clinical patient assessments conducted by licensed nurses since patients are asleep. Overnight patient observation ("rounding") is currently safely conducted primarily by mental health workers either every five minutes or every 15 minutes, depending on the patient. Patient observation through rounding is the primary tool an acute psychiatric hospital uses to ensure patients are safe at all hours of the day and night. These team members must immediately report any behavior changes they observe to nursing staff. Several nurses are not needed to oversee nocturnal rounding.

In response to the concerns some have raised about patients' safety or suicide risk at night, there is no strong or consistent evidence in scientific literature indicating suicide in psychiatric hospitals occurs at a higher rate during the night shift or overnight hours. On the contrary, studies show that suicide risk is generally higher in the first week of admission and soon after discharge, but there is no documentation of any prevalence during night versus day shifts.

CHA appreciates the opportunity to provide these recommendations and looks forward to answering any questions you may have. Thank you for your consideration.

Sincerely,

Kirsten Barlow

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