SAN LUIS OBISPO COUNTY MENTAL HEALTH SERVICES: A SAFE HARBOR OR A PERILOUS JOURNEY FOR THOSE IN NEED?

SUMMARY

The 2021-2022 San Luis Obispo County Civil Grand Jury investigated specific aspects of the mental health services provided by the County and its contractors and found four discrete areas that require immediate attention and action in order to ensure the safety and security of County residents experiencing mental health issues and the professional staff who provide such services to them.

INTRODUCTION/PURPOSE

The 2021-2022 San Luis Obispo County Civil Grand Jury (Grand Jury) received complaints about the ways in which mental health services were being administered in our County.

The Grand Jury opened an investigation focused on the ways in which County law enforcement agencies process persons experiencing mental illness under the auspices of California Welfare & Institutions Code Section 5150, which provides for the involuntary hold and treatment of persons who are deemed a danger to themselves, a danger to others, or who are gravely disabled. Our focus shifted as the result of several factors:

1. The Grand Jury discovered inconsistencies between espoused County policies and the actual delivery of care for persons experiencing mental health issues.

2. The Grand Jury learned there is no discernable consistency in terms of how persons experiencing mental health issues are brought into the County's mental health services system. When peace officers detain an individual under W&I Section 5150, regardless of which law enforcement agency is involved, the individual officer will transport the person to the nearest hospital emergency room, complete the required paperwork, and leave the affected person in the care of emergency room staff. From that point on, the person (now

a custodial patient) and the attending medical staff will have no idea what fate awaits. The only certainty is that it may take from several hours to several weeks spent in an emergency room bed before the patient receives the care they need to properly address their mental health issues.

3. The Grand Jury discovered and, in one instance, witnessed significant safety and security issues related to the care of persons experiencing mental health issues who may exhibit the potential for violent behavior which poses a threat to themselves, other patients, and the professional staff who provide treatment services.

4. The County has no services available to treat juveniles who experience acute mental health issues and are detained under W&I Section 5585, the juvenile equivalent of a 5150 hold. As a result, all youths in SLO County experiencing serious mental health issues are transported to facilities in Los Angeles, Sacramento, and other distant locations, away from family, school, church, and their other support networks.

After reviewing the data collected, the Grand Jury reoriented its investigation to examine each of the foregoing issues. This report documents our findings and recommendations.

AUTHORITY

The issuance of this report is authorized under investigative powers of the Grand Jury pursuant to California Penal Code Sections 919, 921, and 925.

BACKGROUND

In January, 2018, California gubernatorial candidate Gavin Newsom observed that the State allocates more than $2 billion each year for mental health services, but still falls short, “Because we lack the bold leadership and strategic vision necessary to bring the most advanced forms of care to scale across the state. We lack the political will necessary to elevate brain illness as a top-

tier priority."[1] Then candidate Newsom could have been talking not just about the State, but about many of its counties, including San Luis Obispo County.

Despite the availability of significant funding via California's Mental Health Services Act, and with an annual operating budget of nearly $70 million, our investigation revealed a County mental health system that shows signs of being "hollowed out", with many critical functions being contracted out to private providers and seemingly insufficient concurrent efforts to effectively coordinate and collaborate among the many internal and external stakeholders.

METHODS/PROCEDURES

For this investigation, the Grand Jury interviewed 16 people involved with the delivery of mental health services in SLO County. Interviewees included doctors, nurses, hospital executives, County executives, unit supervisors and managers, security officers, and psychiatric care specialists. Additionally, members of the Grand Jury provided information from their personal interactions with County mental health services. The picture that emerged from their testimony was of a mental health system in need of significant change in a number of critical areas. Also of note was the gap between actual and espoused County policy regarding issues related to mental health services provided by the County.

The Grand Jury heard testimony time after time from actual service providers about actions they either took or were unable to take that reflected a direct contradiction to established County policy. Instances of such contradictions are highlighted in this report as are recommendations for remedying the underlying conditions.

Despite what we heard and read from County leaders, the Grand Jury found evidence of what Michael Lipsky wrote in his textbook, *Street Level Bureaucracy*, that, "The decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively *become* the public policies they carry out."

[1] Breakdown: California's mental health system, explained. By Jocelyn Wiener. April 30, 2019, CALMATTERS.

In addition to the aforementioned interviews, the Grand Jury reviewed data available on SLO County and State of California websites, archived and contemporary news reports, previous Grand Jury reports, videos and photos of incidents that occurred within SLO County, emails, texts, budget documents, policies, procedures, and other data.

NARRATIVE

In 2021, the Grand Jury inspected the San Luis Obispo County Psychiatric Health Facility (PHF) as part of its annual duty to examine all detention facilities within the County. PHF is a state-licensed 16-bed psychiatric facility that is the designated County treatment center for persons on psychiatric holds. Jurors noted the following:

- All persons committed to the PHF on W&I Section 5150 holds shared the same open spaces.
- Males and females share the same open spaces. They are segregated in sleeping quarters.
- The PHF (and the County) do not provide mental health services for juveniles experiencing acute psychiatric issues.
- No dedicated security personnel were on station at the PHF during the entire time of our inspection.
- A patient followed Grand Jurors throughout the inspection verbalizing a desire to "shoot you in the head."
- PHF staff shared information regarding inmates from the County Jail who had instigated violent behavior in the presence of other patients resulting in injuries to staff and damage to County property.
- PHF staff indicated that when deputies from the SLO County Sheriff's Office transport inmates from the Main Jail to the PHF, they then depart to return to their normal duties leaving the inmates in the care and custody of PHF staff regardless of the inmate's propensity or potential for violence.
- While the County has contracted for one private security officer to be present at the PHF 24/7, the contracting agency has (as of this writing) been unable to provide around the clock coverage with even one. Additionally, there is no coverage when the on-duty security officer takes a meal break.

Collectively, the information obtained, and the concerns expressed by Grand Jurors and by PHF staff during the inspection, resulted in a course-change for an already underway investigation into certain aspects of the County's mental health services. Where the Grand Jury had been looking at the way in which local law enforcement agencies worked with County mental health services in dealing with persons experiencing mental health issues, the aperture was widened to examine four specific issues:

1. The delivery of mental health services for persons held under Welfare & Institutions Code Section 5150 by County Behavioral Health through its use of the PHF, the Crisis Support Unit (CSU), the Mental Health Evaluation Team (MHET) and related activities.
2. The intake process for getting persons experiencing mental health issues who are being held under Welfare & Institutions Code Section 5150 to the right place as quickly, safely, and efficiently as possible.
3. The safety and security of all involved with the delivery and use of mental health services in SLO County.
4. The treatment of Juveniles held under California Welfare & Institutions Code Section 5585 requiring acute mental health services in SLO County.

There are several common ways in which a person in San Luis Obispo County becomes subject to detention under the provisions of Section 5150 and 5585 of the California Welfare & Institutions Code:

- A family member, concerned for the well-being of a loved one, observes behavior that appears to represent a threat to themselves, their loved one, or to others and either calls 911 for assistance, or drives the person to a local hospital emergency room for help.
- A County resident observes an individual exhibiting behavior that represents a threat to that person, to the resident, or to others and calls 911 for assistance.
- A peace officer encounters a person who exhibits behavior that represents a threat to themselves, to others, or the person appears to be gravely disabled.

- A mental health worker transports a person exhibiting behavior that represents a threat to themselves, to others, or a person who appears to be gravely disabled to a hospital emergency room.
- An individual walks into a hospital emergency room, one of three County outpatient clinics, or to the County's Crisis Stabilization Unit, and requests help for a mental health issue.

In each of the foregoing instances, the person requiring help with a mental health issue will, at some point, be evaluated by a qualified individual who will make the determination as to whether that person can be lawfully detained under the provisions of Section 5150 or 5585 of the California Welfare & Institutions Code (Hold or Held). If a Hold is initiated, the person is considered to be in the care and custody of the holding authority. The first stop for all Held persons is at one of the four private hospitals located throughout SLO County. It is at this critical early inflection point that the Grand Jury found significant lack of responsiveness by the County and many opportunities for improvement in how mental health services are delivered in our county.

How Persons on Psychiatric Holds Receive Mental Health Services

None of our four hospitals is equipped to deal independently, effectively, and efficiently with persons experiencing mental health issues who are subject to a Hold. The duties and responsibilities of emergency medical service providers are mandated by law. However, absent any alternative resources from SLO County Behavioral Health Services, and in order to comply with the requirements of the federal Emergency Medical Treatment and Active Labor Act (1985), they have no choice and must accept any and all persons who are subject to Holds.

None of the hospitals has chosen to have licensed psychiatrists or psychiatric health specialists on the premises on a 24/7 basis. Some have no psychiatric services at all. The Mental Health Evaluation Team (MHET), as part of County services, has mental health staff at three of the four hospitals on a part-time basis. And while all medical doctors have some level of familiarity with mental health issues, as one medical professional the Grand Jury interviewed put it, "Asking a physician to address a mental health issue is like asking a plumber to solve an electrical issue."

None of the hospitals has specialized personnel and spaces exclusively dedicated to confining and caring for the needs of persons who have been placed on Holds.[2] And none of the hospitals in SLO County has staff who are dedicated to providing specialized security for the many safety issues that may occur when dealing with individuals who are Held, sometimes against their will. Rather, responding to the safety and security needs of a person experiencing an acute psychiatric episode is a challenge borne by well-intended professionals who are responding to requirements that are well outside the boundaries of the fields they were trained in.

The SLO County Behavioral Health Services agency has primary responsibility for providing services to persons experiencing mental health issues, including all persons on 5150 and 5585 Holds. On paper there appears to be a wealth of resources being applied to the challenges associated with providing services to people on Holds within our county. In practice, however, those services appear to be out of reach for many of our most at risk residents.

The Grand Jury heard testimony about instances in which inmates from the Main Jail were transported to the PHF for treatment of mental health issues so they might be prepared to participate in their judicial proceedings. Such inmates are transported in restraints by two deputies. Upon arrival at the PHF the deputies remove the restraints and, as long as the inmate is not actively engaging in violent behavior, they depart, leaving PHF staff to care for and control the inmate. And while policy states that only misdemeanants can be admitted from the Main Jail to the PHF, leading some to believe that there is little risk of physical violence associated with such inmates, the reality is that some are actually violent felons who have had their charges reduced to misdemeanors as the result of a plea bargain or other legal maneuvers. As a result, individuals with a high potential for violence who are experiencing mental health issues are housed in an open setting with other clients, old and young, male and female, who have no history of violence and are only hoping for help with their mental health issues.

The PHF is reserved for only a portion of our County's population; people on MediCal, misdemeanants from the County Jail, and persons deemed indigent. As previously mentioned,

[2] A May 23, 2022 article in the SLO County Tribune reports that French Hospital has recently dedicated space for psychiatric care in their emergency room.

misdemeanants from the County Jail are transported to the PHF by deputies. For Held persons, in one of the other two categories, the transition from one of the four hospital emergency rooms to the PHF can be exasperating and arduous.

Upon notice of a Held person at one of the hospitals, a staff member from the PHF or from the MHET will respond to the emergency room and conduct an evaluation. Depending on their workload at the time, it can sometimes take hours before they arrive at the emergency room. If articulated criteria and requirements are met and if the Held person is medically cleared, and if there is an available bed at the PHF, the Held person will be transported to the PHF where they will be detained pending treatment and determination of a care or disposition plan.

For Held persons who have private insurance, the elderly, and juveniles, the process of receiving help with their mental health issues is not nearly so easily articulated. In fact, some might describe that process as a tortuous gauntlet that no one should have to endure, especially at such a vulnerable and critical time in their lives.

Unintended Consequences of Current County Policies

Through interviews with staff employed by all four hospitals within the County, the Grand Jury discovered that it is not uncommon for Held persons who do not qualify for placement in the PHF to spend from hours to days and sometimes weeks confined to a bed in one of the four emergency rooms in SLO County. The COVID response impacted this to some degree but the process of finding a treatment facility is arduous and time consuming. When the PHF is full or admissions are restricted due to staff shortages, even those in accepted categories can be subject to confinement in an emergency room bed for unreasonably long periods of time. In one case, a Held person was confined to an emergency room bed for three weeks. Why? If a Held person cannot be transferred to the PHF because they don't fit the criteria or the PHF is full or closed to new admissions, that person must be transported to a private licensed care facility outside of SLO County. And finding a facility that will take them is often a long, convoluted, and arduous proposition. In the meantime, the Held person waits. And while they are waiting, the unintended consequences of current SLO County mental health policies cause negative second and third order

effects that impact many aspects of an individual hospital's ability to provide timely and effective services to other patients in need of emergency medical care.

The number of nurses on duty in our four emergency rooms is determined by the number of patient beds in each. The required ratio is one emergency room nurse per four patient beds. So, for example, Sierra Vista Medical Center, which has 12 beds in its emergency room, must have three nurses on duty whenever there are more than eight patients admitted to the ER. When a Held person is admitted to the emergency room, a nurse and another hospital staff member, colloquially referred to as a "sitter", must attend that person at all times.

If a 12-bed emergency room has three nurses on duty and a Held person is admitted, the hospital must reduce the number of available beds from 12 to 8 until such time as another nurse can either be assigned from a different department or can be summoned to report for duty. The resulting reduced emergency room capacity means longer wait times for patients experiencing medical emergencies who are consigned to long delays while sitting in the lobby. And whether the Held person is confined to an emergency room bed for three hours or three days or three weeks, an assigned nurse and sitter are literally staying with them around the clock, day after day. They are not providing mental health care because they are not trained and certified to do so. They are not providing medical care to other patients because they are essentially "offline" while monitoring the Held patient. They are simply sitting. And while they sit, a convoluted, overly complex system is struggling to figure out where outside of SLO County the Held person can be placed for treatment and how they can be transported there.

When the Grand Jury began its investigation, out-of-county placements for Held persons was a job accomplished by County or contract staff who would call, fax, and email up to 200 licensed facilities located throughout California looking for any that had an available bed and a willingness to accept the Held person. Licensed private facilities are able to establish their own criteria for acceptance, so it is not uncommon to find they require medical tests and physical conditions that have little or nothing to do with mental health status but are designed to ensure the patient populations they serve are in no way compromised by issues such as communicable diseases or

other medical conditions. The net effect of these policies is that a significant percentage of prospective placements are unable to qualify for admission.

When an out-of-county facility agrees to accept a Held person that SLO County is seeking placement for, the next challenge is to arrange for transportation from the hospital emergency room to the distant location, which may be in Sacramento, Los Angeles, Bakersfield, or elsewhere in the state. Historically, that has meant tasking a mental health staff member of the PHF or the MHET who has to leave their regularly assigned duties in order to drive to the hospital emergency room, pick up the Held person, and transport them by car or van to the receiving facility; a drive that could be more than five hours in length one way. All the while, the PHF or MHET is operating one professional staff person short while that person is serving as a driver on a distant mission.

As referenced earlier in this report, hospital emergency rooms are not designed as custodial settings. And while all emergency room medical personnel receive some training on de-escalation and restraining violent patients, they are not, nor are they expected to be, proficient at unarmed defensive tactics. Even though the vast majority of persons having a mental health emergency are not violent, when a Held person becomes physically aggressive, staff often have to resort to brute strength of numbers to overpower the person and restrain them until an authorized medical professional can forcibly administer a medication to calm them. While staff is trained to verbally de-escalate the situation, it is not always possible to do so.

When a Held person gets violent beyond the ability of hospital staff's control, they will often call 911 and request assistance from law enforcement. For the hospitals in San Luis Obispo, law enforcement response times can be measured in moments to minutes. For the hospitals in Templeton and Arroyo Grande, the wait for law enforcement assistance can be agonizingly and dangerously long. With minimal, and occasionally no dedicated professional security on premise, nurses report there are times when they are fearful for their safety, the safety of the Held person, and the safety of other patients. The Grand Jury heard testimony of nurses and doctors being punched, slapped, and spat upon by Held persons.

Hospitals do employ security officers but the qualifications and the legal and procedural constraints for these positions are such that during violent confrontations with a Held person, they often need to be supplemented by other staff members. In one case reported to the Grand Jury, a hospital CEO responded from his office to assist in the control of a violent Held person. Another incident recounted by a medical professional involved a Held person who lost control of his temper and became physically aggressive due to the fact that he had been held in an emergency room bed for nearly a week with no treatment and no prospect of transfer to a facility where he could receive appropriate treatment. One doctor interviewed by the Grand Jury reported that he was aware of four staff members at one hospital who had been injured by Held persons in the last year alone. While such incidents do not happen often, the fact that they do happen deserves reporting so that a complete picture of staff impact and patient care is presented to the public.

In all cases Held persons who are confined to hospital emergency room beds for hours, days or weeks are not receiving the mental health treatment they need. They are simply being warehoused, at significant expense to the hospital, the County, and to the tax-paying residents of SLO County. On top of that, the Held person is at risk of spiraling deeper into the issues that caused their condition in the first place and their families are left angst-filled and wondering about a system that would allow such conditions to exist.

In addition to taking hospital emergency room staff away from their primary medical duties, prolonged stays by Held persons have countless other negative systemic impacts on the orderly administration of medical services in SLO County. For example, Charge Nurses often must defer working on their normally assigned duties in order to make numerous phone calls to check on the status of placement efforts concerning Held persons. Sometimes those calls go to the PHF, sometimes to the MHET, and sometimes to distant facilities to determine the status of a proposed transfer or to check on the many different tests, forms, and procedures that must be accomplished and accommodated before a placement can be made.

In every case when a Held person is moved into an emergency room bed, the area around the bed must be adjusted to remove all cords, sensitive medical equipment, and anything that could potentially be damaged or used as a weapon by the Held person to harm themselves or others.

Such requirements are time consuming and fraught with potential liability issues. In short, for many more reasons than are described within this report, a hospital emergency room bed is a poor location in which to secure a Held person for an extended period of time. And it should be noted that during the hours to weeks that an emergency room bed is occupied by a Held person, it is not available for patients experiencing medical emergencies for which hospital staff is trained and prepared to treat.

Given that one of our hospitals reports that Held persons, on average, occupy an emergency room bed for at least 24 hours, and given that the average medical patient occupies an emergency room bed for two to three hours, that hospital is potentially losing the ability to serve up to eight patients experiencing medical emergencies for every person admitted on a Hold. On occasion, the circumstances and impacts can be drastic.

A recent COVID issue that caused the PHF to stop admitting persons on Holds resulted in a backlog of seven persons on Holds at one of our hospitals. The most recent had been in an emergency room bed for 18 hours. One person on a Hold had been occupying an emergency room bed for seven days. Each required nurses and sitters throughout the course of their stays and those seven emergency room beds were unavailable for medical emergencies.

Crisis Stabilization Unit (CSU) Issues

If while at the emergency room a PHF or MHET staff member determines that the Held person is in need of mental health services but does not meet the criteria for a Hold, they will, in keeping with County policy and State regulation of providing the least restrictive available care, contact the CSU. The CSU is a state licensed four-bed, unsecured facility intended to provide support to persons experiencing mental health issues that do not warrant a custodial setting. Ideally, the person would be transported to the CSU where they would be cared for by a staff that includes a nurse and staff trained and licensed to provide mental health services.

The CSU is staffed and operated by the Sierra Mental Wellness Group (SMWG) under contract to SLO County. The Grand Jury visited the CSU in 2022. The facility consists of a large room that doubles as a lobby and a sleeping area with oversized chairs that fold out into beds that can

accommodate four patients. The original County contract for the CSU stipulated that a registered nurse be at the facility full-time. The Grand Jury heard testimony that SMWG was unable to meet that requirement as the registered nurse who served as the CSU supervisor was also serving in the same role for a Nevada County CSU. As such, she was only at the SLO County CSU 14 days per month. In late 2021 an amendment to the contract was adopted stipulating that either a registered nurse, a psychiatric technician, or other psychiatric service provider be at the facility when clients are present.

The County contract with SMWG for operation of the CSU calls for access to a psychiatrist. There is no psychiatrist on duty at the CSU. A contract psychiatrist is available via telemedicine.

CSU staff advised the Grand Jury that their average occupancy is approximately one person per day, up to an average maximum of 45 clients per month. Their capacity would support up to 120 clients per month. As such, the CSU appears to be a grossly under-utilized resource. The original contract for the CSU indicated it was intended as an eight-bed facility. At the time of the Grand Jury inspection, there were only four convertible chair/beds in the lobby area and staff indicated that was all they were authorized.

The CSU is an unsecured, 24/7 facility. SLO County policy and State regulation dictate that clients of the CSU are free to depart if they so desire. If a client exhibiting potentially threatening behavior decides to depart the CSU, written policy directs staff to allow the client to depart and, if warranted, to call 911 to request law enforcement response for assistance. In practice, however, the Grand Jury heard interview testimony that it was not uncommon for a CSU staff member to follow such clients onto the street and keep them under observation until law enforcement arrived.

During the course of our investigation, the Grand Jury learned of several incidents involving SMWG staff at the CSU that provided serious cause for concern as described below.

The CSU is equipped with cameras that record activity taking place in the lobby/sleeping area. The cameras have been used for safety and security purposes and so that authorized staff can

review incidents involving persons in the care of the CSU. Historically, the cameras have been checked by the PHF supervisor when assessing workload conditions at the CSU.

In early August, 2021, PHF staff contacted the CSU about taking a placement from an area hospital. CSU staff advised they were busy and could not take the person. Unaware that any clients were in the CSU at that time, PHF staff checked the cameras and saw that the CSU was empty except for SMWG staff members. When questioned about the situation, CSU staff responded by taping sheets of paper over the cameras, rendering them useless. The Grand Jury is aware, and has video evidence, of at least two cases in which CSU cameras were covered by SMWG staff. In both instances, SMWG staff can be seen appearing to relax, on their phones or talking with each other. There does not appear to be client-related work underway.

The Grand Jury is also in possession of photographs depicting a SMWG staff member making an obscene hand gesture in the direction of a County employee with whom they had just interacted.

Taken collectively, these incidents paint a concerning view of the level of friction and animosity between contract and County staff members who are charged with providing services to people who are among the most vulnerable in our County. Additionally, the video camera incidents represent an almost reckless disregard for the safety and security of both staff and the public they are employed to serve.

The Grand Jury inquired as to how the camera-covering incidents were resolved but was told only that steps had been taken to ensure it would not happen again. The County declined to provide specific details. We subsequently learned that PHF access to the camera feeds had been discontinued at the direction of a County Behavioral Health Administrator.

County Mental Health Outpatient Services

While the focus of this Grand Jury investigation was primarily on how Held persons get into SLO County's mental health services system, we were surprised to find that because of the way those services are currently deployed, the County has created something of a revolving door that almost ensures that people experiencing mental health issues will cycle through the system again and

again in a virtually endless loop. The challenge is well illustrated by the scarcity of resources applied to the County's mental health outpatient services.

On paper the SLO County mental health outpatient services look fairly robust. The County maintains three outpatient clinics with one each located in San Luis Obispo, Arroyo Grande, and Paso Robles. The three outpatient clinics are staffed by a total of 22.5 mental health professionals. 11.5 are mental health therapists and 11 are mental health technicians.

The caseload of the County outpatient clinics is comprised of persons referred by the PHF, the CSU, by area hospitals, and of people who walk in off the street seeking help.

The mental health therapists and mental health technicians are trained and licensed to perform different but complementary functions. Put simply, the former provides therapy sessions for persons experiencing mental health issues. The latter provides medications as indicated and directed. Working in concert, the two attempt to manage an overwhelming caseload that, at the time of the Grand Jury investigation, consisted of 1,633 persons experiencing severe and persistent mental health issues.

It should be noted that each therapist in the outpatient clinics is struggling to provide services to 150 patients. The recommended caseload for a psychiatric therapist is 25 to 30 patients. Out of necessity, the 11 psychiatric technicians are stepping in to help carry the load. And while they are performing functions that are not authorized under their licensure and that could expose the County to significant potential liability issues, they are, nonetheless, making a good-faith effort to help ensure that persons in their care who are experiencing mental health issues do not spiral down to the point where they wind up entering the system at the front end yet again.

In addition to the three outpatient clinics, SLO County contracts with as many as 70 private practice mental health professionals who are supposed to be available to see County referred clients on an as-needed basis. Once again, on paper it looks as though the County has a robust set of partners in the private sector who can absorb a fair share of the caseload. In practice, however, most of those partners fill their practices with clients experiencing mild to moderate mental health

issues. When the PHF, for example, tries to refer a client who is experiencing severe and persistent mental health issues, they often find the County's private network providers claiming their practice is "full" and there is no room for the more severely affected client. It is not uncommon for such severely affected clients to wait months before they can see a therapist. During that time they have been released to the street and effectively disappear from the County's system until they turn up again at one of the four hospital emergency rooms or at the County Jail.

On top of all the information related in this report, we have not even tried to quantify the impact of COVID. Suffice to say, a Held person with COVID is looking at a minimum stay of ten days in an emergency room bed. And the County will be hard pressed to find an out-of-county placement once they are cleared, particularly if they have been through the system previously.

CONCLUSIONS

Persons experiencing mental health issues in SLO County who are placed on involuntary holds are facing a challenge to be treated in a timely, safe, and effective manner when they enter the County-managed mental health care system. There is a demonstrable risk that both their mental and physical conditions may suffer due to a number of issues that are identified in the Findings section of this report.

Against that backdrop, the Grand Jury found numerous examples of dedicated County employees who are committed to providing the best possible care under often exasperating circumstances caused by the County leadership's unwillingness or inability to provide the appropriate number of professional staff and facilities required to meet the needs of those among us who experience mental health issues. To date, County leadership has failed to ensure that espoused policies and stated goals are appropriately funded and properly managed and executed.

As referenced earlier in this report, the Grand Jury initially focused its investigation on the manner in which local law enforcement agencies interacted with SLO County mental health services while dealing with Held persons. That focus underwent fundamental change when we discovered what happens when a person enters the County system through a hospital emergency room. The issues proved to be extraordinarily broad and complex, leaving little time for the 2021-2022 Grand Jury

to conduct the kind of far-reaching, comprehensive investigation this important topic deserves. The Grand Jury, was, however, able to examine and report on several critically important issues after conducting 16 interviews with key stakeholders from the executive to the line level across many of the involved agencies, both public and private, and reviewing hundreds of pages of documents and numerous county, state, federal, and private websites. But many issues remain unaddressed with respect to the manner in which SLO County provides services to those experiencing mental health issues. Therefore, the 2021-2022 SLO County Civil Grand Jury strongly recommends that as soon as it is impaneled, the 2022-2023 Grand Jury use this report as a jumping off point to continue with a new and more comprehensive investigation into this topic with a deeper examination of the issues raised herein as well as a suggested emphasis on the human and financial costs of the current County approach to the delivery of mental health services. For example, the Grand Jury may want to conduct post-exit interviews with professional staff who have voluntarily separated from County employment over the past three or four years to determine the factors that influenced their departure. The Grand Jury may also want to examine factors affecting the cycle of re-admittance for people who have been subject to more than one Hold. It also may want to interview mental health patient rights advocates and prior mental health patients.

FINDINGS

F1. SLO County has failed to create and maintain a safe, orderly, effective and efficient means for ensuring that persons experiencing mental health issues receive the care they need, when they need it. The average and sometimes extended time periods Held persons spend in local emergency rooms prior to placement in an appropriate treatment facility is unacceptable as demonstrated by records from multiple emergency room encounters.

F2. By relying on the four private hospital emergency rooms as the primary point of intake for persons experiencing mental health issues, SLO County has created a situation in which the quality and capacity of other emergency medical care within our county is at constant risk of degradation due to a variety of factors all relating to the requirement that those hospitals provide psychiatric services as primary care facilities for which they have little or no dedicated expertise or resources.

F3. SLO County does not provide adequate resources to ensure the safety and security of both County and contractor staff who work in mental health services facilities and hospitals based on documented incidents.

F4. Despite an almost dizzying array of scheduled interagency, inter and intra-departmental meetings, teams, and working groups, SLO County fails to provide the kind of unified, integrated, and "single" voice leadership needed to ensure that espoused policy regarding the delivery of mental health services in a manner that meets the needs of our community while simultaneously respecting and appropriately protecting the professionals who strive to provide such services.

F5. SLO County is entirely dependent on private service providers located outside of our County to provide beds and treatment for all Held juveniles and for those adults who don't fit the criteria for acceptance at the PHF.

RECOMMENDATIONS

R1. SLO County should commit to creating a single, integrated and unified mental health services center that houses the PHF, the CSU, the MHET, outpatient coordination, juvenile mental health services, and that includes a medical health triage and screening facility where all Held persons, regardless of age, categorization or insurance status, can be medically cleared prior to placement in an appropriate section of the mental health facility.

R2. SLO County should relieve the four private hospitals in our County of the responsibility for warehousing Held persons.

R3. SLO County should seek the financial resources needed to hire and retain outpatient mental health services professional staff in sufficient number to allow for reasonable and customary caseload management ratios.

R4. SLO County should seek the financial resources needed to hire and retain mental health services professional staff in sufficient number to meet the needs of Held juveniles within our county.

R5. The SLO County Sheriff's Office, SLO County Behavioral Health Services, and the SLO County Board of Supervisors should jointly devise and implement a plan to ensure that properly trained and certified correctional officers are assigned in sufficient number to provide for the safety and security of all staff and Held persons when such persons are in the County's care and custody no matter which facility is responsible for the patient.

REQUIRED RESPONSES

The San Luis Obispo County Board of Supervisors is required to respond to all recommendations.

San Luis Obispo County Behavioral Health Services is required to respond to all recommendations.

The San Luis Obispo County Sheriff's Office is required to respond to R5.

AGENCY RESPONSE REQUIREMENTS

The Penal Code Section 933.05 that specifies the format and methodology for agency responses is listed below. All agency respondents are required to respond to all findings and recommendations in the following manner:

- If the respondent disagrees wholly or partially with an item, the respondent must elaborate on the portion of the item that they disagree with and provide an explanation.
- If a respondent notes that an item will be implemented in the future, the response must include a timeframe for implementation.
- If a respondent notes that an item requires further analysis, the agency must include in the response an explanation of and the scope of what will be studied, and the timeframe needed for the study. The timeframe for follow-up from the agency cannot exceed six months.

- If the item will not be implemented or is not reasonable, the respondent is required to provide a detailed explanation.

933.05 Findings and Recommendations

(a) For purposes of subdivision (b) of Section 933, as to each Grand Jury finding, the responding person or entity shall indicate one of the following:
  (1) The respondent agrees with the finding.
  (2) The respondent disagrees wholly or partially with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reasons therefore.

(b) For purposes of subdivision (b) of Section 9ss, as to each Grand Jury recommendation, the responding person or entity shall report one of the following actions:
  (1) The recommendation has been implemented, with a summary regarding the implemented action.
  (2) The recommendation has not yet been implemented, but will be implemented in the future, with a timeframe for implementation.
  (3) The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or study, and a timeframe for the matter to be prepared for discussion by the officer or head of the agency or department being investigated or reviewed, including the governing body of the public agency when applicable. This timeframe shall not exceed six months from the date of publication of the Grand Jury Report.
  (4) The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation therefore.

Presiding Judge	Grand Jury
Honorable Craig van Rooyen Superior Court of California 1035 Palm Street, Room 355 San Luis Obispo, CA 93408-1000	San Luis Obispo County Civil Grand Jury P.O. Box 4910 San Luis Obispo, CA 93403-4910