OUR COUNTY CAN DO BETTER: THE CRISIS INSIDE THE WALLS OF THE PSYCHIATRIC HEALTH FACILITY

This report on the Psychiatric Health Facility (PHF) reveals that San Luis Obispo County's mentally ill residents are treated for serious mental health crises in an antiquated and unsafe facility.

SUMMARY

The San Luis Obispo County Grand Jury has the authority and responsibility to inspect County facilities and report on any issues. There have been numerous discussions at recent Board of Supervisors meetings concerning the treatment of mentally ill inmates at the jail. During these discussions, little has been said concerning the PHF and how inmates impact the PHF's other patients. The 2017-2018 Grand Jury believed it imperative to inspect the County PHF in light of the increase in the number of inmate patients and the limitation on the total number of patient beds available. Members of the Grand Jury toured the facility, inspected the physical plant (including areas for therapy and recreation), and reviewed Behavioral Health's current processes and procedures.

The following areas and processes were the primary concentration:

- staffing levels
- safety of staff, patients, and inmates
- treatment of the inmates
- impact of the inmates on other patients and their treatments
- security of the facility

The PHF serves jail inmates who are judged to be a danger to themselves or others due to mental illness or accused of misdemeanor crimes and judged to be incompetent to stand trial. When an

inmate requires outside medical treatment, a correctional deputy or a local security person is assigned to that inmate. This is not the case with inmates requiring treatment for mental illness. These inspections and reviews have resulted in several recommendations. The most significant of these recommendations are to generate a plan to replace the PHF with a modern facility, expand the existing PHF to allow more effective treatment in the meantime, and take action to reduce the housing of inmates at the facility by building a similar facility at the county jail.

PURPOSE

The primary purpose of this report is to provide an independent perspective of the PHF facility and recommend alternatives for future treatment facilities in our County. It began as an inspection report to assess the impact of inmates on the facility but changed as the inspection revealed a more serious issue: the size and condition of the facility.

ORIGIN

This report was originated at the request of Grand Jury members, based upon citizen complaints and recent events concerning the treatment of Behavioral Health patients within our County.

AUTHORITY

The issuance of this report is authorized under the investigative powers of the Grand Jury pursuant to California Penal Code §§ 919, 922 and 925.

METHOD/PROCEDURE

The Grand Jury performed an inspection at the PHF, and interviewed several officials during the visit. A follow-up visit was also performed to verify that the immediate safety concerns had been corrected. Representatives of the PHF provided written answers to questions prompted by the inspections. The Grand Jury also interviewed individuals associated with PHF management and performed internet searches related to similar facilities within the state and state regulations

concerning mental health treatments. In conjunction with other duties, the Grand Jury toured the Atascadero State Hospital and the mental health hospital facility at the California Men's Colony.

BACKGROUND

The focus of this report was the physical condition of the PHF facility, its capability to house inmates, and fitness to perform the function of treating mentally ill patients who are currently in crisis, including restoring patients to competency and stability. The report does not examine the medications, therapies or actual treatment of mental illness, but is limited to the appropriateness of the facility and procedures to enable safe and effective treatment of patients and options to provide the needed services to County residents. This report is organized by first recapping the observations of the facility and document inspections as well as discussions with staff, then a formulation of findings and recommendations.

NARRATIVE

PHF Inspection

This was the first inspection of the PHF by the San Luis Obispo County Grand Jury in recent years. The PHF is a hospital facility but continues to house inmates who have been deemed unfit to stand trial due to mental illness (Penal Code 1370) and inmates who have been deemed a danger to themselves or others based upon mental illness (Welfare & Institutions Code 5150). The PHF is operated by County Health Agency's Behavioral Health, therefore in the purview of the Grand Jury and is relevant to inspections of both the County Jail and the Juvenile Detention Facility. The PHF staff also provided the Grand Jury with the written policies and procedures for use in our evaluations.

The inspection was performed on the facility in the old County hospital complex, which has been closed as a hospital for approximately 15 years. It is adjacent to one of the County behavioral health outpatient clinics. Six representatives from the Grand Jury inspected the facility and two

returned for the follow-up inspection. The Grand Jury members who visited the facility were utterly dismayed that a County facility in this poor condition could be used to treat patients.

OBSERVATIONS

Facility

The PHF facility is licensed by the California Department of Health Care Services (DHCS), who regularly inspect the facility for cleanliness and patient services. The overall facility is old and is not well maintained. The facility houses walk-in patients, W&IC 5150 patients or inmates, and PC 1370 inmates. The inmate patients are generally treated the same as all other patients, except that anyone charged with being a sexual predator is always escorted. Any juvenile residents are housed in an administration area, separated from adult patients. Inmate patients are not accompanied by security personnel, as they would be in a medical treatment facility. The policy has recently changed to not permit juvenile patients if inmates are currently housed. This causes many juvenile patients to be treated out of the County. This can conflict with treatment involving family therapy or counseling.

The facility appeared crowded and does not contain dedicated spaces for therapy, physical exercise, or other treatments. The PHF houses up to 16 full time patients and has up to 10 staff members. The 16-bed limit on the PHF is from a Medicaid rule for psychiatric facilities not attached to a hospital. There is no area with sufficient room for normal physical activity as part of therapy or treatment, nor is there an area with dedicated treatment or therapy rooms. The medical examination room doubles as an administrative office, due to the extreme lack of space. There is one conference room and a common area, both of which are also used for therapy.

At the time of the inspection, supplies were stacked high enough to impede the pattern of the fire sprinklers, and cleaning supplies were stored near one of the emergency exits. The minor health and safety issues were addressed with the staff and were found to be corrected in the subsequent inspection. There is very limited natural lighting within the facility, and the standard office type lighting contributes to the dingy appearance. The damaged ceiling tiles accentuate this appearance.

Video cameras operate within the facility; however, there is only one video monitor in operation and it is at the staff desk. The surveillance system has low resolution and appears to be quite old.

The PHF has six emergency exits that are automatically unlocked if the alarm is activated. An evacuation of the facility during the second or third shifts presents a risk to the surrounding community if inmate patients are present. Procedures are in place to sweep the facility from one end to the other, keeping the patients (and inmates) with staff members. During this process or after exiting the facility, the inmates would have a nearly unfettered path for escape. With a ratio of up to four patients to each staff member and without the ability to apply mechanical restraints (such as shackles or handcuffs), there is little to prevent an inmate or group of inmates from deciding to leave. During this time of heightened stress on all patients, the staff is put in an untenable situation: one type of an emergency can cause a second type of emergency.

Staff

The number and distribution of staff is in accordance with the County practices and procedures and meets the state's minimum criteria. While the staff appears to be dedicated to the welfare of the patients, this level of staffing can leave as few as three or four mental health professionals on duty for the overnight shifts. There are no Sheriff's Deputies or Correctional Officers on staff at the facility at any time. The staff is trained in the ProACT de-escalation techniques, which includes 16 hours of training. In the event of a medical emergency with an inmate-patient, the inmate will be accompanied by a member of the PHF staff or local law enforcement, if available.

County Policies and Procedures

The County policies follow state regulations and allow staff levels as low as three for the third shift (midnights) and four for second shift (evenings). Day shift staff must have at least seven. In the event of an emergency, all six exits are unlocked and staff directs patients to the nearest safe exit. Safety of patients is the main priority; no provisions are made for control or segregation of inmates with respect to other patients. During the second or third shifts, there is not enough staff to monitor the unlocked exits while an emergency evacuation is taking place. Evacuation drills are held monthly to train the staff in dealing with patients in an evacuation scenario.

The Behavioral Health staff at the jail now begins treatment prior to transporting inmates to the PHF; immediate communication with the PHF is established concerning inmate care, providing continuity of care for the inmate.

CONCLUSIONS

The Grand Jury observations of the PHF show an antiquated facility that does not meet the crisis needs of the County's mentally ill population. While the staff at the facility is dedicated, there can be insufficient staff present at times to ensure safety and provide optimal treatment.

FINDINGS

F1. The PHF is staffed with dedicated professionals whose attitude toward their patients is in keeping with the goal of recovery.

F2. The PHF facility is woefully inadequate for a psychiatric hospital.

F3. There is not enough room for the programs and therapies required towards a goal of recovery; a separate and dedicated area is lacking for both treatment rooms and physical exercise.

F4. The facility lacks adequate natural lighting and is excessively dreary when compared to a modern psychiatric hospital.

F5. In the event of an emergency requiring evacuation during the night or evening, the required staffing is insufficient for the safety of the patients, staff, and community. In an area-wide emergency, law enforcement may not be able to respond.

F6. Inmates in the patient population impact other patients and may require full time supervision within the facility.

F7. The outdoor area is inadequate for the number of patients served and doesn't provide space for exercise.

F8. If an inmate patient commits a violent act toward staff or another patient, there is no peace officer present to intervene. The staff member or patient may report the act in the same way a private citizen would by calling the San Luis Obispo City Police.

RECOMMENDATIONS

R1. Even though the PHF second and third shifts meet minimum State standards, staffing levels should be increased for staff, patient, and community safety reasons.

R2. The San Luis Obispo County Jail should have its own dedicated psychiatric hospital facility, serving only inmates. This would limit the number of inmates admitted as patients in the PHF. When inmates are admitted to the new PHF, a correctional deputy should be assigned.

R3. The County should find or build a new psychiatric hospital facility, with sufficient room for patient treatment and recovery. Funding could come from reserves sources (County and/or MHSA) or pursuing a state grant.

Recognizing that R2 and R3 may take a considerable amount of time to be implemented, the following short-term recommendations are made to address some of the more immediate problems:

R4. The current lighting should be replaced with natural spectrum lights (preferably LEDs). The facility interior should be painted and the ceiling tiles replaced/repaired to provide an improved therapeutic environment.

R5. Upgrade video surveillance capabilities.

R6. The facility should annex additional area from the adjacent County facilities, adding the treatment and therapy environments to improve effectiveness and safety.

COMMENDATIONS

The staff and management of the PHF are commended for their dedication to doing the best possible job with such limited and antiquated resources.

REQUIRED RESPONSES

The following people are required to respond to the findings and recommendations within the timeframe shown and in accordance with the California Penal Code section 933.05.

The Health Agency is required to respond to F2, F3, F4, F5, F6, F7, R1, R2, R3, R4, R5, R6.
The Board of Supervisors is required to respond to R2, R3.

The responses shall be submitted to the Presiding Judge of the San Luis Obispo County Superior Court by July 10, 2018. Please provide a paper copy and an electronic version of all responses to the Grand Jury.

Presiding Judge	Grand Jury
Presiding Judge Ginger E. Garrett Superior Court of California 1035 Palm Street Room 355 San Luis Obispo, CA 93408	San Luis Obispo County Grand Jury P.O. Box 4910 San Luis Obispo, CA 93403