TEENS IN MENTAL HEALTH CRISIS: FROM 911 TO THE EMERGENCY ROOM DOOR

Issue | Summary | Glossary | Background | Discussion | Findings Recommendations | Requests for Responses | Methodology | Appendixes | Responses

ISSUE

Law enforcement, emergency medical responders, and schools all play a part in how a teen in psychiatric crisis gets help. How do these entities handle the intervention? Could these efforts be improved?

SUMMARY

In 2015, an estimated 740 San Mateo County youth under the age of 18 experienced psychiatric emergencies severe enough to require a trip to the emergency room.[1] Because some adolescents went more than once, the number of visits totaled almost 1,000. According to many experts, the teens' initial experience of receiving help significantly affects their treatment at the hospital, their re-entry into everyday life, and their willingness to go to the emergency room again should the need arise.

Various public agencies, including 911 dispatch, police, emergency medical personnel, and schools, are in a position to impact and improve on a teen's experience with a psychiatric emergency. While 911 dispatch is the gateway to help, some County entities involved with youth have concerns about contacting 911 because of the risk of emergency vehicles arriving with lights and sirens activated. The Grand Jury recommends that the San Mateo County Office of Public Safety Communications reach out to County agencies involved with youth, as well as to the general public, to educate all as to the best way to ensure 911 dispatch responds to all adolescent psychiatric emergencies in the most discreet manner possible.

According to mental health experts in the County, the SMART car program, formally known as San Mateo County Mental Assessment and Referral Team, is the best and most discreet transport for a teen in crisis. SMART cars are staffed by specially trained emergency medical technicians who have broad experience in dealing with a variety of psychiatric emergencies. The Grand Jury recommends that SMART be expanded as soon as possible so that both SMART cars are available during the critical hours of 3:00 p.m. to 8:00 p.m.

As a result of the County's inadequate collection of information regarding SMART availability and response rates, the Grand Jury was unable to determine whether to recommend a more extensive expansion of the SMART program. As a result, the Jury recommends that the Board of Supervisors direct County staff to develop an improved system of data collection and analysis so that, by the beginning of the 2017 school year, it can determine how much expansion is justified.

[1] Data provided by senior staff at the two psychiatric emergency rooms in San Mateo County: San Mateo Medical Center and Mills-Peninsula Medical Center.

The Grand Jury found that 90% of youth are discharged from County emergency rooms within 24 hours of arrival. The SMART program includes some of the elements necessary to avoid these short-term emergency hospitalizations altogether. The County already provides in-home and respite services to adults but not to teens. The Grand Jury recommends the County consider using SMART as a starting point to establishing such services for youth.

Finally, Crisis Intervention Team (CIT) training, a 40-hour course sponsored by the San Mateo County Sheriff's Office, addresses mental health issues and outlines best practices for law enforcement in dealing with psychiatric emergencies. The Grand Jury recommends the Sheriff's Office expand training to make it more available to police and to all public entities involved in youth mental health.

GLOSSARY

Behavioral Health and Recovery Services: BHRS, part of the County of San Mateo's Health System, is the public agency overseeing mental health and substance abuse services for San Mateo County. Its primary clients are Medi-Cal patients.

Child/Children/Youth/Adolescent: For the purposes of this report, the terms *child*, *children, teen*, *youth,* and *adolescent* refer to anyone under the age of 18.

Crisis Intervention Team Training: Sponsored by the Sheriff's Office, CIT is a 40-hour classroom course intended primarily for law enforcement personnel; the course provides background on mental illness and best practices for addressing mental health crises in the field.

Psychiatric Emergency Services: PES facilities are located in hospital emergency rooms. Staffed with specially trained personnel, PES provides temporary emergency treatment to patients suffering from a mental health crisis. In San Mateo County, PES facilities are located at San Mateo Medical Center in San Mateo and Mills-Peninsula Medical Center in Burlingame.

Office of Public Safety Communications: The PSC serves as the dispatch center for police, fire, and ambulance for jurisdictions generally under the County Sheriff's Office. In addition, PSC is the only dispatcher for ambulance and SMART in the County. Fourteen cities within the County operate their own police 911 dispatch; they must call PSC if they need an ambulance or SMART.

SMART Program: Created in 2005, SMART (for San Mateo County Mental Health Assessment and Referral Team) is an in-the-field program whose purpose is to assess and assist in mental-health crisis situations. Trained emergency staff is dispatched in a medically equipped van by PSC to help both adults and children on the spot and potentially avoid the trauma of emergency rooms.

BACKGROUND

The 2014-2015 San Mateo County Grand Jury investigated how schools address the mental health needs of the 94,000 students in the County.[2] The Grand Jury learned that schools have a less-than-uniform approach to student mental health, even though school is where adolescents spend much of their day. In one district alone, the symptoms of some 130 students required them to be transported to the emergency room for mental health issues directly from school during the 2014-2015 school year.[3] This year's Grand Jury was heartened to learn that in April 2016 the San Mateo Union High School District received a $1.49 million grant from Peninsula Health Care District for a pilot program supporting student mental health.[4]

In light of the prior Grand Jury's findings, this year's 2015-2016 Grand Jury elected to study what happens to San Mateo County teens in psychiatric crisis. When a youth needs emergency treatment for a mental health issue, how do adults respond and what does the journey to the hospital look like?

DISCUSSION

In September 2014, Sue's 14-year-old daughter was on the phone with a suicide hotline counselor and contemplating a trip to the Caltrain tracks nearby.[5] The hotline counselor took immediate action, calling for police assistance. The first Sue knew about it was when two responders arrived at her door. "It was a man and a woman. They were very kind and respectful," recalled Sue. "I'd like to know who they are and thank them because I believe they saved my daughter's life."

About 71% of minors nationwide presenting to ERs with psychiatric emergencies are in their teens, with an average age of 14.6 years. The experience itself can be unpleasant, even traumatic, and so fraught with fear that it can affect the youth's hospital treatment, re-entry into everyday life, and willingness to cooperate with treatment in the future.[6] The uncertainty can depend on the interplay of many factors before the teen ever reaches the ER: where the emergency occurs, who places the call, and what kind of response team and vehicle are dispatched to the scene.

There are two psychiatric emergency service centers (PES)—one at San Mateo Medical Center in San Mateo and another at Mills-Peninsula Medical Center in Burlingame. In 2015, they treated an estimated 743 children under age 18 in 2015 for escalating mental illness issues.

---

[2] Superior Court of California, San Mateo County 2014-2015 Civil Grand Jury, "Student Mental Health: Are Schools Doing Enough?" June 2015. http://www.sanmateocourt.org/documents/grand_jury/2014/mental_health.pdf.

[3] San Mateo Union High School District, *5150 Assessment Data*, Youth Service Bureaus of the YMCA, January 15, 2015.

[4] Peninsula Health Care District, "Peninsula Health Care District Approves $1.49 in Funding to Support School-Based Teen Mental Health Program," April 28, 2016. http://www.peninsulahealthcaredistrict.org/wp-content/uploads/mental-health-press-release-fnl.pdf.

[5] Sue is a current resident of San Mateo County, but her name has been changed to protect the family's identity: interview by the Grand Jury.

[6] AHC Media, "Children with Mental Health Issues in the Emergency Department," August 2, 2009. http://www.ahcmedia.com/articles/113981-children-with-mental-health-issues-in-the-emergency-department.

The journey to PES and the experience once there is usually an adolescent's first brush with psychiatric treatment. "I am appalled at the number of young people who have their first contact with psychiatric care in a PES or ER," said one senior psychiatric professional who has been working in San Mateo County for many years. Until mental health is fully integrated into the preventative health care system where it can be identified and treated early, PES, for better or worse, is likely to be the gateway to recovery.[7]

911 Response—Lights and Sirens?

The current emergency response system in San Mateo County has potential issues significant for anyone, especially adolescents, in a mental health crisis. One is the public nature of the usual lights-and-sirens approach that comes with calling 911 for emergencies that would benefit from a more sensitive and discreet response. Another is the skill and experience level of the first responders who are called to a scene with only a basic understanding of the situation.

The 911 operators have two choices when dispatching help: send only the police to secure the scene and assess the situation, or call for an ambulance and/or fire vehicle in addition to police. The San Mateo County Office of Public Safety Communications (PSC), located in Redwood City, operates 911 dispatch for calls from East Palo Alto, Half Moon Bay, Millbrae, Portola Valley, San Carlos, Woodside, and the unincorporated areas of San Mateo County. PSC is also the only entity in the County that dispatches ambulances. Fourteen other cities in the County operate their own emergency dispatch centers (see Figure 1). City operators can send out local police to assess the situation, but the police must contact PSC for an ambulance if necessary. In the absence of an ambulance, the police can transport a teen, willing or not, to the hospital themselves if they determine that medical transport is unnecessary.[8]

[7] Senior medical professional from Mills-Peninsula Medical Center: interview by the Grand Jury.

[8] In order for unwilling adolescents to be taken to an emergency room, responders must make a determination that they are a danger to themselves or others. This procedure is known as a 5150 hold. Only police and certain other mental health professionals have legal authority to make the 5150 designation. A 5150 hold allows an unwilling child to be transported to an emergency facility and held there up to 23 hours and 59 minutes. The child must be formally admitted to an inpatient unit in order to be held more than 24 hours. Hospital officials must try to obtain the consent of the child's parents but can treat the child even without consent.

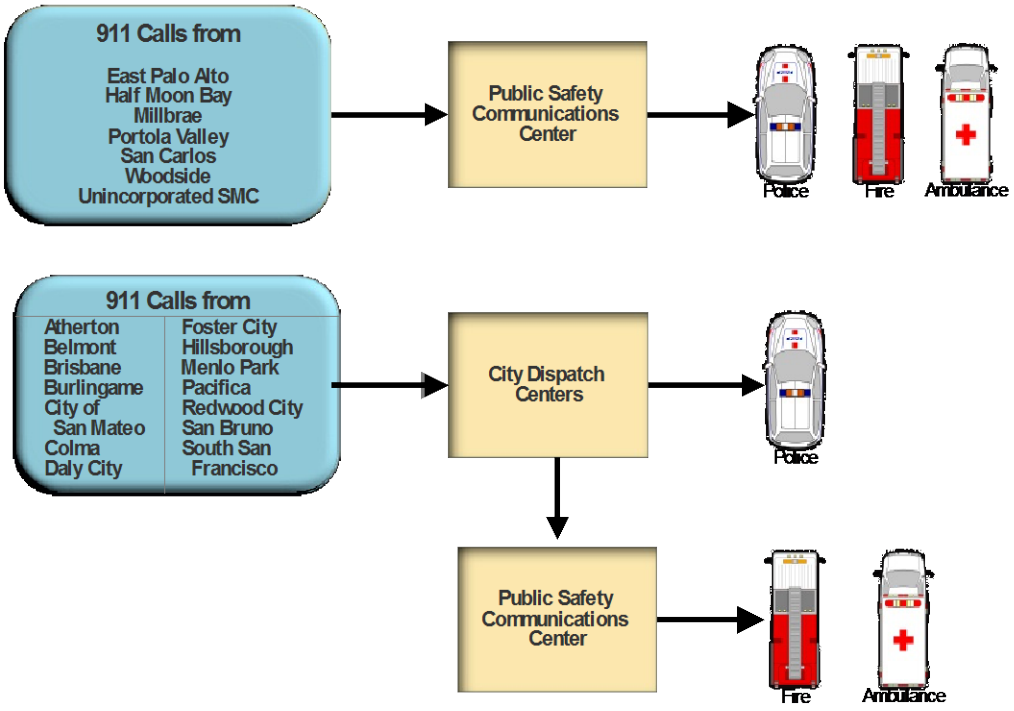

Figure 1. San Mateo County 911-Dispatch System

Teens in crisis go to San Mateo County Medical Center (SMMC), located at 37th Avenue in San Mateo, or Mills-Peninsula Medical Center, a privately run hospital on Trousdale Avenue in Burlingame. San Mateo County operates SMMC itself. The County contracts with Mills-Peninsula for emergency services.[9] In general, SMMC handles emergencies originating south of Highway 92; Mills-Peninsula Burlingame handles those north of Highway 92. From January to December 2015, more than 350 youth in psychiatric crisis entered each hospital, totaling an estimated 743 adolescents (see Table 1). Because some of these teens experienced repeat episodes, there were almost 1,000 visits to PES countywide in 2015.

[9] For 2014-2016, the County has a two-year contract with Mills-Peninsula Medical Center that is capped at $1.7 million.

Table 1. Youth Admissions to PES in San Mateo County

		2012	2013	2014	2015
Youth Visits Mills-Peninsula Medical Center PES	**Number of Youth***	340	368	351	387
	Total Visits	442	478	456	503
	Visits Less Than 24 Hrs	392	424	399	437
	% of Visits Less Than 24 Hrs	89%	89%	88%	87%
Youth Visits San Mateo Medical Center PES	**Number of Youth**	281	322	327	356
	Total Visits	365	421	421	449
	Visits Less Than 24 Hrs	349	401	391	412
	% of Visits Less Than 24 Hrs	96%	95%	93%	92%

Source: Data from San Mateo Medical Center and Mills-Peninsula Medical Center
*Grand Jury estimates based on Mills-Peninsula data for "Total Youth Visits." Mills-Peninsula PES was unable to provide data on the number of individual youth. See Methodology for how the Grand Jury arrived at estimates.

Hospital medical professionals informed the Grand Jury that the intake process is much smoother if a child arrives in a calm state. This is because medical personnel can more quickly establish a rapport, likely making treatment easier and more effective. If the entry is chaotic or violent, emergency treatment is much more complicated and time-consuming.[10]

From the patient's perspective, a traumatic experience can have far-reaching effects. One mother describes a call she made for her son several years ago: "I called 911 and everyone came: fire trucks, police, sirens. Two of the officers were very good." But there was a third, she added, whose manner set her son off and "he became very distraught." The two other officers realized this and asked the third officer to leave. Because of this early experience, this mother's son fights going to the hospital despite repeated psychiatric emergencies.[11]

The Preferred Response—No-Lights No-Sirens

Officials from PSC say they routinely make a no-lights no-sirens dispatch for mental health emergencies when the patient is non-violent. Getting such a response, however, can depend on whether police have arrived first, assessed the situation, and called PSC with a confirmation that such a response is appropriate. However, callers who dial PSC 911 dispatch directly must know the best way to describe their situation to dispatchers to get a low-key response. Frequently they do not. PSC is now taking initial steps to educate the public. In May 2016, PSC used social media in an experimental effort to do so, for the first time.[12] For their part, the PSC dispatchers

[10] Medical professional from San Mateo Medical Center: interview by the Grand Jury.
[11] A resident of San Mateo County: interview by the Grand Jury.
[12] Official from PSC: interview by the Grand Jury.

are trained to ask a series of scripted questions quickly and weigh the information they get from the caller. Further complicating the process, the caller may be upset and experiencing quickly shifting circumstances that are difficult to describe.[13]

This makes emergency psychiatric situations "fluid" by nature and a specific response cannot always be guaranteed even if callers use the right words.[14] Experienced mental health workers who know just what to say cannot always succeed: "We had two almost identical situations involving two different 911 calls in different cities. We described them in the same way and got two entirely different responses: one was great and the other was heartbreaking to watch."[15]

An ambulance rolling to the scene can add another layer of unpredictability because medical emergency protocol takes precedence over all other considerations. If a call is made from a public place such as a high school, the stakes can be high for a student who must come back after the crisis and face classmates' memories of a very public departure. That was the case in 2014 at a local high school, when counselors called for help. "The police and an ambulance came and we were told the child had to be strapped on the gurney," said a school official on the scene.

The student was cooperative and wanted to go to the hospital. The counselors argued against the gurney, recommending that the student be allowed to walk to the ambulance. Even so, the paramedics insisted on the gurney protocol. By this time, lunch period had begun. The student was rolled out of the school's front door on the gurney.

"There were many more eyes on the situation than needed to be," said the school official, who noted that schools make an effort to ensure students are not transported during a passing or lunch period.

Other public agencies have technical reasons for avoiding 911, including StarVista, a community-based organization that operates crisis hotlines and provides many other mental health services to San Mateo County. Because of the limits of cell phone technology, StarVista instructs teens to call local police emergency numbers rather than 911 if they are alone and in crisis. StarVista provides teens with the local police number and remains on the line until the number is programmed into the cell phone.

The School Resource Officer Can Smooth the Way

Because of situations just described, many schools have developed alternative methods for handling emergency situations in the student's best interest. Some schools have a School Resource Officer (SRO) either on site or in the neighborhood who can quickly take charge. SROs are officers from the local police department who are specially trained and assigned to be on campus to provide school-appropriate law enforcement assistance.

---

[13] Ibid.
[14] Ibid.
[15] Official from StarVista: interview by the Grand Jury.

"Our SROs are part of our community," said one counselor who noted that mutual trust between the officer and school is the foundation of the relationship. "Our kids trust them. And if an SRO is involved, parents feel less like it's a punitive situation for their child."[16]

SROs work out of San Mateo County schools, at both middle and high school levels. In most districts, SROs are assigned to multiple schools, splitting time at each. Some schools have no SROs at all. The SRO, if available, can determine whether a student should go to the hospital, if the transport should be made in the police vehicle, or if they should call for an ambulance. Similarly, the Grand Jury learned that experienced school personnel will sometimes place a call to the local police rather than call 911 if the SRO is unavailable. "We don't want to risk fire trucks and sirens by calling 911," said one counselor.

Other County Efforts

The concern over student privacy is at the heart of recent efforts to update school district protocols for addressing and reporting psychiatric emergencies, especially for schools that do not have access to an SRO. The County Office of Education (COE) has organized a working group to develop standards it hopes all schools will agree to and follow when seeking help. The group began meeting in November 2015, and consists of teachers, school administrators, law enforcement personnel, SROs, and mental health officials from across the County.

The aim is to create a checklist of concerns from calling for help to what to do when the police or emergency vehicle arrives at the school.[17] For example, administrators might be advised to meet the police at the school entrance and guide them to a more private back door. Schools might be urged to form a go-to committee of available personnel—an administrator, counselor, SRO, teacher—that would take charge during all psychiatric emergencies on campus. The COE group expects to publish its checklist by the end of the 2015-2016 school year and is planning to hold training sessions for school personnel beginning next school year.

Another effort, sponsored by Behavioral Health and Recovery Services (BHRS) seeks to bring together various agencies that come in contact with people of all ages who are suffering mental health issues. Called BHRS Crisis Collaboration, the group meets periodically and looks for ways for involved agencies to work together in support of patients in crisis. One tangible result of these meetings was the publication of a brochure outlining procedures for the public to use when calling 911 for psychiatric emergencies. To minimize the chances of lights and sirens, it advises callers to use words such as "behavioral emergency" and to request a "CIT officer." The brochure is distributed to the public from facilities that treat mentally ill patients including mental health clinics and PES facilities.

CIT Training: A Step Toward Better Outcomes

Even the most well thought-out plan can produce mixed results, depending on how officers react to the scene. Based on a nationwide program, Crisis Intervention Team (CIT) training in San

[16] Official from a San Mateo County high school: interview by the Grand Jury.
[17] Official from the San Mateo County Office of Education: interview by the Grand Jury.

Mateo County is a 40-hour course, sponsored by the County Sheriff's Office, which can help improve outcomes. The course covers specialized techniques on how to handle psychiatric emergencies in a sensitive manner. Included in the 40 hours is a 1.5-hour presentation by a BHRS representative on special considerations for minors. Officials note that the topic of how to interact with minors is also woven throughout the course elements.[18] (See *Appendix B: Curriculum—Crisis Intervention Team Training* for a detailed listing of topics included in the training program.)

Historically, the San Mateo County Sheriff's Office offered CIT training twice a year. In 2015, courses were offered four times in response to demand. Three sessions are planned for 2016. Since the training's advent in 2005, approximately 800 city officers and County deputies have taken the course.

Based on its investigation, the Grand Jury learned that the overall attendance rate for law enforcement personnel at CIT training is low. Only 20% of law enforcement officers in San Mateo County are CIT trained, according to statistics from the California Institute for Behavioral Health Solutions.[19] About 35% of Sheriff's deputies have taken it.

The reasons for low attendance are varied. For example:

- CIT training is not a requirement for local law enforcement.[20]
- Police department leadership must be committed to enrolling officers.
- Departments must cover the shifts of officers taking time off for the course. The personnel covering such shifts generally do so at overtime rates, which can present a financial burden on police departments.
- Some involved say that the subject area is secondary to the basic police mission of "arrive quickly and control the situation."

New officers are usually not enrolled in CIT because it is thought that on-the-job experience is required to fully absorb the concepts. This is a significant factor for local law enforcement agencies that are going through a period of turnover from experienced officers who are retiring to younger new hires.[21]

Beginning August 2016, additional mental health awareness training will be included in POST (Police Officer Standards and Training) as a regular part of police officer training for new recruits statewide. The training will increase the current requirement of six hours to 15 hours of behavioral health instruction out of a total of 644 hours of basic academy training.[22] According to the new guidelines, all police officers must take at least three hours of behavioral health continuing education annually.

---

[18] Official from the San Mateo County Sheriff's Office: interview by the Grand Jury.

[19] California Institute for Behavioral Health Solutions, "Crisis Intervention Training: Current Practices and Recommendations for California," September 2015.

[20] Official from the San Mateo County Sheriff's Office: interview by the Grand Jury.

[21] Ibid.

[22] Carmen Lee, "California Enacts Mental Health Training Legislation for Peace Officers," People with Disabilities Foundation, fall 2015. http://www.pwdf.org/update-california-enacts-mental-health-training/.

While the extra hours of mental health awareness training required by POST are a positive step, attending CIT has benefits beyond the skills learned in the classroom. Past participants informed the Grand Jury, for example, that the four-day training can be a valuable forum where police, emergency responders, and others in the field can share experiences, exchange perspectives, and learn from each other. "We have an excellent relationship with our police departments," said a County first response supervisor, who views CIT as a joint effort between police and emergency medical responders. Attending training together gives insight into the specialized roles and responsibilities and allows them "to see an emergency through each other's eyes."[23]

Studies show that collaboration and support from police leadership is critical for change. "The training is great, but it's not magic," said Laura Usher, coordinator of CIT training for the National Alliance on Mental Illness, adding that "full backing" by leadership is an important component for success. "The thing that actually transforms the way the system works is when everyone gets together."[24]

In addition, many working in the field of mental health believe that even 40 hours of specialized CIT training should be reinforced with shorter refresher sessions. A school counselor said, "Regular police don't always have the opportunity to practice it every day and build on what they learned in the class."[25]

SMART Car Is On Call for Adults, Children

No matter how well-trained the responding officer is, adolescents and their parents can harbor a negative view of being a passenger in a police car for any reason, even if they are going to the hospital for help. "There is a stigma to riding in the back of a police car," said a school official who has observed many such situations.

About 10 years ago, the County began an in-the-field program to assess and assist in mental health crisis situations. Known as SMART, for "San Mateo County Mental Health Assessment and Referral Team," the idea was to send trained emergency staff to help both adults and children on the spot with the potential to avoid the trauma of emergency rooms. Since its inception in 2005, SMART has also developed a reputation as the best way to transport those in crisis to the hospital, or avoid the need for going to the PES altogether.[26]

---

[23] AMR (American Medical Response): interview by the Grand Jury.

[24] Erica Goode, "For Police, a Playbook for Conflicts Involving Mental Illness," *New York Times,* April 26, 2016. http://www.nytimes.com/2016/04/26/health/police-mental-illness-crisis-intervention.html?_r=0.

[25] High school counselors: interviews by the Grand Jury.

[26] High school counselors; BHRS, AMR officials; Sheriff's Office; StarVista personnel: interviews by the Grand Jury.

A SMART team consists of two specially trained emergency medical staff who arrive on the scene in a modified SUV-type vehicle (see Figure 2). Unlike a regular ambulance, the SMART car is not equipped with lights and sirens, so its arrival will always be comparatively discreet. American Medical Response, with headquarters in Burlingame, operates ambulances for San Mateo County and oversees the County's two SMART cars.

Figure 2. A San Mateo SMART Car

In addition to enhanced CIT training, SMART staff undergoes further instruction on record keeping, privacy issues, and other special considerations unique to mental health crisis situations. SMART staff is also qualified to make mental health assessments and to transport patients to the hospital if necessary.

SMART began as a 24-hour per day single-vehicle program. As a result of the 2008 economic downturn, SMART car hours were cut to 12 hours per day, operating from 7:00 a.m. to 11:00 p.m. A second vehicle was added in April 2014, with funding from the County's Measure A sales tax. Currently, SMART cars operate 7:00 a.m. to 10:00 p.m., with at least one car. Both cars are available from 10:00 a.m. to 7:00 p.m. This only partially includes the widely-acknowledged critical and high-volume time period of 3:00 p.m. to 8:00 p.m.[27] Only one SMART car operates from 7:00 p.m. to 8:00 p.m., a period when the need for two cars is highest.

[27] Officials from AMR, BHRS, EMQ FamiliesFirst in Santa Clara County: interviews by the Grand Jury.

SMART car service is fully funded by the County and, according to those interviewed by the Grand Jury, is completely free of charge for all patients, in contrast to a regular ambulance, which even insured patients must pay for out of pocket if insurance deductibles have not been met. This free service can be significant for low-income teens who might not seek help because of worry that calling 911 could summon an ambulance that may burden the family finances.[28]

A Call to Police Is the Gateway to SMART

As the 911 emergency vehicle dispatch agency, PSC is the only entity in the County that can send a SMART car on a call. Typically, it does so after police have arrived to secure and assess the scene. It is PSC's stated policy to send out a SMART car to a psychiatric emergency, instead of a regular ambulance, if it is available and if the patient is nonviolent and does not require restraints. It will dispatch SMART along with a regular ambulance if the patient is violent. However, PSC does not give priority to adolescents when dispatching SMART. Additionally, AMR, BHRS, and PSC do not keep statistics on what percentage of all SMART dispatches is for youth rather than adults.

One practical result of collaboration at CIT training has been the willingness of police to wait for the arrival of a SMART car before making a mental health determination. Before the advent of SMART, it was much more common for law enforcement officials to transport patients to PES automatically. The Grand Jury was informed that because of the chaos surrounding mental health crises and the trauma of teens witnessing out-of-control patients, experts generally agree that PES should be avoided if at all possible, especially for adolescents.[29]

County Services for Adults but Not for Teens

A program operated by the Sheriff's Office for adults, Psychiatric Emergency Response Team (PERT) is designed primarily to serve psychiatric patients who have come to the attention of law enforcement. In service for about a year, PERT is a type of mobile response, staffed by a BHRS social worker and a law enforcement official expert in CIT. The team's mission is to keep patients out of PES or jail by linking them with County mental health services. The team can assist with treatment plan compliance, medications, and family issues, all in efforts to prevent relapses.

In addition, the County is converting an existing facility near SMMC into a respite center for adults. Called Serenity House, it will provide up to 10 patients at a time with up to 10 days of stabilization services outside a hospital or jail setting. Funding of $2.4 million comes from Measure A funds. The aim is to provide treatment before the patient deteriorates into crisis.[30] Presently, the County does not offer mobile PERT services or Serenity House services to youth.

---

[28] Official from StarVista: interview by the Grand Jury.

[29] Officials from BHRS, AMR, EMQ FamiliesFirst: interviews by the Grand Jury.

[30] Bill Silverfarb, "County Finds Space for Mental Health Center: San Mateo Facility Would Be Alternative to Jail, Hospital," *San Mateo Daily Journal*, May 18, 2015. http://www.smdailyjournal.com/articles/lnews/2015-05-18/county-finds-space-for-mental-health-center-san-mateo-facility-would-be-alternative-to-jail-hospital/1776425143485.html.

BHRS provides some after-crisis services to Medi-Cal-qualified youth through its Youth Case Management (YCM) system. As part of that service, San Mateo Medical Center automatically notifies YCM if any teen comes into its psychiatric emergency room. (BHRS is working on a similar system between Mills-Peninsula and YCM.) If the adolescent is Medi-Cal qualified, then YCM will follow up with his or her family to ensure the child receives clinic appointments, medications, and counseling if needed. Teens with private insurance are not offered these services and are instead referred to their outside providers.

Even though about 90% of youth mental crises are resolved less than 24 hours after arriving at PES (see Table 1), the County does not have any sort of short-term crisis stabilization facility that would keep children out of the hospital altogether. In contrast, Santa Clara County contracts with EMQ FamiliesFirst, a community-based organization that operates a respite center for the specific purpose of avoiding short-term adolescent hospitalizations if possible.

However, SMART responders can and do serve any youth in crisis regardless of insurance status, with some of these expanded services. SMART staff called to a crisis scene is frequently able to work out alternatives to an automatic PES transport. This could be a ride home, a call to a parent, or an appointment with a trusted therapist. Police and ambulance responders, whose mission is to move on to the next crisis, do not have this flexibility.[31] In addition, the SMART medic can follow up with patients and family members and help create an action plan linking Medi-Cal patients with County mental health services. Because SMART can spend as much time as a patient needs and has broad scope on how it handles calls, it can act as a type of informal mobile crisis stabilization unit, meeting youth where they are and getting them the help they need.

This informal service is seen as another benefit to youth whose parents would strongly resist allowing their child to be taken to PES. According to SMART staff, the reasons for resistance range from cultural bias against acknowledging mental illness, abuse, stigma, embarrassment, limited private insurance, and wanting to avoid any record of PES admission.

SMART's ability to offer such expanded services on calls is limited, however. The Grand Jury learned this first hand after spending about an hour on a recent afternoon observing operations at the fast-paced Office of Public Safety Communications. Four psychiatric emergency calls came in and only one SMART car was on duty. The second car was out of service. SMART began by responding to a call from Carlmont High School. That student was released to the parents, but school staff asked SMART to stay and address a situation involving a second student. The PSC dispatcher on duty learned this after calling for SMART to respond to a crisis at another location. The dispatcher ended up sending a regular ambulance in response to that call and to another call that came in later. Both involved adults.

BHRS data confirms SMART's limited availability. For the fiscal year ended in June 2015, SMART responded to only 28% of the total number of calls for psychiatric emergency (see Table 2). According to BHRS, SMART is not able to respond to most calls for administrative reasons including out-of-hours calls, vehicles being serviced, personnel absent, personnel

[31] Official from BHRS: interview by the Grand Jury.

reassigned, and vehicles responding to other calls.[32] Even so, BHRS data indicated it actually responded to only 79% of the calls to which it could have responded.

Table 2. San Mateo County SMART Response Rates to Adults/Adolescents Psychiatric Emergencies

		FY 2014-2015					FY 2015-2016
		Q1	**Q2**	**Q3**	**Q4**	**Year**	**Q1**
Actual Response Rate	**No. of Psychiatric Calls**	874	843	786	877	3,380	1,109
	No. of Calls SMART Responded to	244	236	214	238	932	303
	% of Total	28%	28%	27%	27%	28%	27%
SMART Availability	**No. of Psychiatric Calls**	874	843	786	877	3,380	1,109
	No. of Calls SMART Able to Respond to*	306	295	275	307	1,183	388
	% of Total	35%	35%	35%	35%	35%	35%
SMART Response Rate Based on Availability	**No. of Calls SMART Able to Respond to**	306	295	275	307	1,183	388
	No. of Calls SMART Did Respond to	244	236	214	238	932	303
	% of Total	80%	80%	78%	78%	79%	78%

Source: Interviews with senior BHRS staff.
*See Appendix A for a complete explanation of SMART availability.

Despite their limited availability, SMART personnel have a valuable capability to advocate for a youth in crisis and negotiate complex situations to the best solution for all. That was the case in an incident involving a 17-year-old who contacted a school official and described his extreme anxiety and suicidal thoughts. By the time SMART arrived, the youth's mother was on scene arguing against a trip to the hospital. SMART responders addressed the mother's concerns during a private conversation and she finally saw her son's request for help in a positive light. The ride to the hospital started with a hug between mother and son.

[32] Data provided by BHRS.

FINDINGS

F1. Only about 20% of all law enforcement officers in San Mateo County are CIT-trained. There are significant barriers to enrolling officers.

F2. Beyond the training itself, CIT is an important forum where all who deal with children in crisis—EMTs, SMART staff, schools, police—can learn from each other.

F3. The SMART car program is unique and highly effective at managing mental health emergencies in a sensitive manner, keeping adults and adolescents out of emergency rooms whenever possible.

F4. SMART can provide temporary post-crisis services, sometimes including in-person follow-up. BHRS provides on-going case-management services only to children who qualify for Medi-Cal.

F5. Behavioral Health and Recovery Services provides adult residents with crisis-stabilization services, in-home follow-up, and a specialized mental health respite center as an alternative to Psychiatric Emergency Services hospitalization. No such programs exist for teens, even though 90% are discharged from the hospital within 24 hours.

F6. Data collection by the County on SMART program response rates and PES adolescent admissions at Mills-Peninsula Medical Center is not comprehensive or consistent.

F7. Schools and other public agencies are often reluctant to use the 911-dispatch system because of the detrimental effects on adolescents when first responders arrive on the scene with lights and sirens activated.

F8. The County's Office of Public Safety Communications does not have a systematic outreach program to the public and to County entities that deal with adolescents on the best way to call 911 when a no-lights no-sirens response is appropriate.

RECOMMENDATIONS

R1. The Sheriff's Office should devise a plan by year-end 2016 to expand CIT training to include school representatives and those from other public agencies that deal with children in crisis. Additional CIT training sessions should be added if necessary so that law enforcement agencies can continue to encourage attendance by their officers. The plan should: (a) include ways to encourage those in leadership positions at police departments, schools, and other public agencies to attend; and (b) include refresher courses.

R2. Planners for CIT training—the Sheriff's Office and Behavioral Health and Recovery Services—should amend the curriculum to include techniques for dealing with situations unique to schools and other public agencies working in the area of youth mental health.

R3. Behavioral Health and Recovery Services should extend as soon as possible the two-car SMART program by at least one hour so that the high-volume time between 3:00 p.m. and 8:00 p.m. is fully staffed by both SMART cars.

R4. The Board of Supervisors should direct the County's Health System to institute an improved system of data collection and analysis regarding SMART response rates and

adolescent PES admissions at Mills-Peninsula Medical Center, with such collection to start no later than October 1, 2016.

R5. The Board of Supervisors and Behavioral Health and Recovery Services should use the data obtained as a result of R4 to determine by the beginning of the 2017-2018 school year whether to expand the non-emergency aspects of the SMART program significantly and/or augment it with other services such as a respite center and in-home services regardless of insurance status.

R6. The Board of Supervisors should direct the County's Office of Public Safety Communications to devise a comprehensive plan to educate and collaborate with County entities and the public on the best way to call for help in a psychiatric emergency. The plan should be completed by year-end 2016.

REQUEST FOR RESPONSES

Pursuant to Penal Code Section 933.05, the Grand Jury requests responses as follows:

From the following governing bodies:

- San Mateo County Sheriff's Office—R1, R2
- San Mateo County Board of Supervisors—R2, R3, R4, R5, R6

The governing bodies indicated above should be aware that the comment or response of the governing body must be conducted subject to the notice, agenda and open meeting requirements of the Brown Act.

To avoid the perception of a possible conflict of interest, one Grand Juror was recused from participating in any aspect of this report, including but not limited to, investigation, preparation, and voting on its acceptance.

METHODOLOGY

Documents/Data

- The Grand Jury followed a uniform approach in requesting data so that comparisons could be made among providers of similar services. Data was obtained from various agencies involved in delivering crisis services to youth. The Jury also sought data from various other providers to measure efficacy, impact, and scope of service.

- San Mateo Medical Center provided data on the number of youth visits and visitors to its Psychiatric Emergency Services (PES) facility over a three-year period. It also provided data related to where patients went after leaving PES, data on admissions to hospitals, and patient insurance information. See Table 1 for some of this this data.

- Mills-Peninsula Medical Center tracks the number of youth visits, but it does not track the number of individual visitors. Since some individual youth visit a psychiatric emergency facility multiple times in a given year, the number of visits is greater than the number of youth. The San Mateo Medical Center tracks both statistics.

- First responders decide where to take a youth—to Mills-Peninsula or to SMMC—based on whether the incident is north or south of Highway 92. The Grand Jury believed it was reasonable to assume that the populations north and south of Highway 92 were homogeneous. The Grand Jury first calculated, for each year, the ratio of youth-to-visits for the San Mateo Medical Center. Then those ratios were used to estimate the youth-to-visits ratio for Mills-Peninsula. The average youth-to-visits ratio for the four years was 79%. Thus, the Grand Jury estimated that the number of individual youth visiting Mills-Peninsula in 2015 was 387.

Site Tours

- Psychiatric Emergency Services at San Mateo Medical Center, San Mateo
- Psychiatric Emergency Services at Mills-Peninsula Medical Center, Burlingame
- Adolescent Psychiatric In-patient Unit at Mills-Peninsula Medical Center, San Mateo
- EMQ FamiliesFirst, Campbell
- American Medical Response, Burlingame
- Office of Public Safety Communications, Redwood City

Interviews

Reports issued by the Civil Grand Jury do not identify individuals interviewed. Penal Code Section 929 requires that reports of the Grand Jury not contain the name of any person or facts leading to the identity of any person who provides information to the Civil Grand Jury.

In conducting this investigation, the Grand Jury interviewed 21 individuals from Behavioral Health and Recovery Services, American Medical Response, StarVista, San Mateo County Sheriff's Office, EMQ FamiliesFirst in Santa Clara County, National Alliance on Mental Illness, members of the public, San Mateo County Office of Education, San Mateo Union High School, Youth Services Bureau, San Mateo Medical Center, Mills- Peninsula Medical Center, Office of Public Safety Communications, Redwood City Police Department, Canyon Oaks Residential Treatment Center.

APPENDIX A SMART CAR DATA MODIFIER

Behavioral Health and Recovery Services (BHRS) provided the following explanation of how it determines SMART response availability.

After April 2014 (when the second SMART car was added), BHRS did a technical analysis to determine when a SMART car is unable to respond. They used a month's worth of data,[33] applying a filter and a modifier applied against this data. A time filter was used to determine the number of calls the SMART car could potentially respond to, based on calls made during 7:00 a.m.-9:00 p.m. shifts when the SMART cars are on duty. The modifier, based on a compare/contrast of three different datasets (listed below), provides a standardized tool to determine the number of calls a SMART car could not have been expected to respond to because of the following reasons:

- They are dealing with other patients.
- They cannot handle the patient because he/she is suicidal, and/or could hurt others, in which case an advanced life support (ALS) ambulance needs to be called instead.
- There was a mechanical problem with the car.
- Someone did not show up for work for a shift on a 911 ALS ambulance; the ambulance contractor then used the SMART paramedic to fill in for that missing worker. Therefore, the SMART car was not able to offer its services.
- The vehicle was in an accident and needed to be serviced.

Using the time filter and the modifier showed that about 65% of all calls were calls that the Smart car could not respond to. Due to the complexity of determining what calls the SMART car could or could not have responded to on a quarterly basis, this same modifier is applied against each quarter's data.

Three Datasets

1. Public Safety Dispatch Out-of-Service report on SMART car. The data is from the Computer Aided Dispatch (CAD) System.

2. Public Safety Communications Dispatch. This dataset includes all 911 calls in San Mateo County; the dataset includes Smart car responses both as the initial unit responding and whether or not they were the final unit responding.

3. A dataset created by the EMS Agency and used by SMART car team members to record detailed patient records for each call.

[33] The validity of using this modifier depends in part on whether or not a single month's data is truly representative of all other months.

APPENDIX B CURRICULUM—CRISIS INTERVENTION TEAM TRAINING[34]

I. Introduction to course
  A. Objectives
    1. Increase ability of officer to recognize an individual with mental illness.
    2. Increase empathy of officer for the individual with mental illness.
    3. Provide additional techniques for de-escalating a tense situation (e.g., nonphysical interventions) and increase proficiency in non-violent crisis intervention techniques.
    4. Decrease officer anxiety in dealing with the individual with mental illness.
    5. Increase basic knowledge and understanding of various presentations of mental illness (as well as with the Developmentally Disabled, persons with Traumatic Brain Injury, and Alzheimer's disease or Dementia).
    6 Increase understanding of how a person with mental illness will respond to different approaches.
    7. Increase ability to recognize "dual diagnosis" situations.
    8. Increase knowledge of available community resources regarding dealing with a person with mental illness.
  B. Class introductions.

II. Major Mental Disorders (Psychoses, Bipolar Disorder, Depressive Disorders, and Personality Disorders)
  A. Definitions
  B. Causes
  C. Prevalence
  D. Symptoms
    1. Delusions
    2. Hallucinations
    3. Disorganized Speech
    4. Grossly Disorganized or Catatonic Behavior
    5. Negative Symptoms
    6. Depression
    7. Schizophrenia
  E. Behaviors
  F. Treatments
    8. Medications
    9. Mental Health Support
  G. Mood Disorders
    1. Major depression and dysthymia
    2. Medications and treatment
    3. Suicidality
    4. Medications
  H. Bipolar Disorder
    1. Manic episode characteristics
    2. Bipolar I vs. Bipolar II

[34] Information supplied by BHRS and Sheriff's Office.

3. Epidemiology
4. Treatment
5. Medications

I. Symptoms Domains in Mania and Mixed Mania
1. Manic mood and behavior
2. Psychotic symptoms
3. Dysphoric or Negative Mood/Behavior

J. Personality Disorders
1. Overview
2. Etiology
3. Epidemiology

K. Description of Types
1. Borderline
2. Narcissistic
3. Histrionic
4. Antisocial

III. Dual Diagnosis

A. Drugs of Abuse
1. Alcohol
2. Marijuana
3. Cocaine
4. Speed, Methamphetamine
5. PCP. Hallucinogens
6. Prescription Drugs

B. Mechanisms of Actions of Drugs of Abuse

C. Actions on Behavior

D. Distinguishing Which Drug(s) the Person is on
Management of the Person UI

IV. Developmental Disabilities

A. Definition of terms
1. Appearance
2. Communication
3. Behavior
4. Response

B. Prevalence

C. Contrasts DD system with that of mental illness (MI) system-of-care

E. Causes

F. Contrast mental retardation with MI

G. Specifics on Cerebral Palsy given

H. Autism contrasted with ADD/ADHD

I. People first language in communication stressed

V. Writing Better 5150s

A. The Lanterman-Petris-Short Act (LPS) of 1969

B. Who has 5150 authority
C. Criteria for 72-hour hold
    1. Danger to self
    2. Danger to others
    3. Gravely disabled
D. Field Assessment for the peace officer
E. Documentation on the 5150 form

VI. Community Resources

VII. National Alliance on Mental Illness (NAMI) Informational Session

VIII. Introduction to Crisis Management
A. Liaison with the county mental health dept.
B. Reviewing all 5150 reports
C. Mental Health Courts
D. Documentation of crimes committed by mentally disordered individuals
C. Multi-disciplinary monthly meetings

VIX. Active Listening and Suicide Assessment
A. What is active listening?
    1. A communication skill involving both the speaker and the receiver
B. Why is it important to listen?
C. Active Listening techniques
    1. Encouraging
    2. Restating
    3. Reflecting
    4. Summarizing
D. Suicide Assessment and Intervention
    1. Objectives
        a. What is suicide?
        b. Risk factors
E. Causes of suicide
    1. Stress
    2. Depression
    3. Divorce
    4. Child Custody Problems
    5. Life Problems
    6. Age
    7. Debt
    8. Health Problems
    9. Going Back to Jail
    10. Loss of a Love F. Cultural Components

X. Suicide by Cop (SBC)
A. Definitions

1. Terminology
2. Incident dynamics
3. Demographics

B. Statistics

C. Incident dynamics
1. Fleeing felons
2. Opportunists
3. Prior suicidal intent with SBC plan

D. Effects on involved parties
1. One peace officer, family, department
2. Decedent's family, friends
3. Community

E. Prevention

F. Officer Safety

XI. Crisis Intervention

A. Psychological & Physiological Response to Crisis
1. Definition of Crisis
2. Characteristics of Crisis
3. Stages of Crisis

B. Verbal/non-verbal Intervention
1. Rapid Access
2. Precipitating Stress
3. Support
4. Learning
5. Active Approach
6. Focus

C. Communication Techniques
1. Qualities of a CIT Officer
2. Facilitative Listening
3. Things to Assume and to Avoid
4. Limit Setting

D. Nonverbal Behaviors E. Pre-Death Behaviors F. Effective Communication Strategies

XII. Police Stress and Health

A. Nature of Stress
1. Characteristics
2. Etiology
3. Symptoms

B. PTSD
1. Characteristics
2. Symptoms
3. Treatment
a. Medications
b. Psychotherapies

C. Other Considerations
    1. Risk to Emergency Response Personnel
D. Health Promotion
E. Peer Support
F. Critical Incident Stress Management
    1. Defusing
    2. Stress debriefing

XIII. Review, Questions, and Wrap-up

Issued: June 7, 2016

APPROVED BY
BOARD OF SUPERVISORS

SEP 06 2016

CLERK OF BOARD
BY Sarkhanni P. DEPUTY

COUNTY OF SAN MATEO
Inter-Departmental Correspondence
County Manager's Office

Date: August 4, 2016
Board Meeting Date: September 6, 2016
Special Notice / Hearing: None
Vote Required: Majority

To: Honorable Board of Supervisors

From: John L. Maltbie, County Manager

Subject: Board of Supervisors' Response to the 2015-2016 Civil Grand Jury Report, "Teens in Mental Health Crisis: From 911 to the Emergency Room Door"

RECOMMENDATION:
Approve the Board of Supervisors' response to the 2015-2016 Grand Jury Report, "Teens in Mental Health Crisis: From 911 to the Emergency Room Door."

BACKGROUND:
On June 7, 2016, the 2015-2016 San Mateo County Civil Grand Jury issued a report titled "Teens in Mental Health Crisis: From 911 to the Emergency Room Door." The Board of Supervisors is required to submit comments on the findings and recommendations pertaining to the matters over which it has some decision making authority within 90 days. The Board's response to the report is due to the Honorable Joseph C. Scott no later than September 6, 2016.

DISCUSSION:
The Grand Jury made eight findings and six recommendations in its report. The Board responses follow each finding and the five recommendations that the Grand Jury requested that the Board respond to within 90 days.

FINDINGS

Finding 1:
Only about 20% of all law enforcement officers in San Mateo County are CIT-trained. There are significant barriers to enrolling officers.

Response:
Wholly disagree. All San Mateo County law enforcement officers are provided with eight hours of Crisis Intervention Team (CIT) training in the basic police academy.

Finding 2:
Beyond the training itself, CIT is an important forum where all who deal with children in crisis—EMTs, SMART staff, schools, police—can learn from each other.

Response:
Agree.

Finding 3:
The SMART car program is unique and highly effective at managing mental health emergencies in a sensitive manner, keeping adults and adolescents out of emergency rooms whenever possible.

Response:
Agree.

Finding 4:
SMART can provide temporary post-crisis services, sometimes including in-person follow-up. BHRS provides on-going case-management services only to children who qualify for Medi-Cal.

Response:
Partially disagree. Although the San Mateo County Mental Health Assessment and Referral Team (SMART) has on occasion provided post-crisis services, it is not a primary function of the team. In addition to providing on-going case management to children, Behavioral Health and Recovery Services (BHRS) does provide services to uninsured/indigent children and youth.

Finding 5:
Behavioral Health and Recovery Services provides adult residents with crisis-stabilization services, in-home follow-up, and a specialized mental health respite center as an alternative to Psychiatric Emergency Services hospitalization. No such programs exist for teens, even though 90% are discharged from the hospital within 24 hours.

Response:
Partially disagree. Transitional youth aged17 and older are eligible for all of the services listed in the above finding. BHRS has a youth case management team that makes contact with youth in Psychiatric Emergency Services (PES) and helps to coordinate post discharge services. Full Service Partnerships are field-based and can provide in-home support services.

Star Vista operates Your House South which provides a "time-out" for youth and their family, and an opportunity to work on the family's situation in a safe and supportive environment.

Finding 6:
Data collection by the County on SMART program response rates and PES adolescent admissions at Mills-Peninsula Medical Center is not comprehensive or consistent.

Response:
Wholly disagree. SMART captures response call data, which includes the percentage of time, the date and time of day that SMART responds to a call initiated by a law enforcement officer for assistance. That data is available and reviewed on a regular basis. PES encounters at Mills-Peninsula is also available. For 2015, there were 503 PES admissions of which 201 were during the school day.

Finding 7:
Schools and other public agencies are often reluctant to use the 911-dispatch system because of the detrimental effects on adolescents when first responders arrive on the scene with lights and sirens activated.

Response:
Partially disagree. While the reports may identify anecdotal evidence in support of the finding, it cannot be validated whether, in general, school officials are reluctant to use 911 for the reasons cited in the report. In contrast, BHRS' data indicates for calendar year 2015, there were 952 PES admissions to SMMC and Mills-Peninsula Medical Center. Of the total PES admissions, 475 occurred during school days.

SMART/Advanced Life Support (ALS) responded to 46% of the school day calls for assistance. Additionally, in the Fall of this year, BHRS in partnership with the County Office of Education will be making available to all schools a standardized suicide prevention protocol. Included will be information to help school official's access emergency response services that minimize the impact on the student in crisis and the school environment including materials from the existing BHRS "Guidelines for Calling 911" that prepares the caller for communicating to dispatch during a mental health emergency. In addition, unless there is a potential for violence or violent intruder(s), law enforcement officers usually do NOT respond with lights and sirens activated. Further pre-emergency protocols can be negotiated and agreed to as part of a school's "Big 5" Emergency Plan. For more information on the Big 5, please visit: http://www.smcoe.org/learning-and-leadership/safe-and-supportive-schools/the-big-five.html.

Finding 8:
The County's Office of Public Safety Communications does not have a systematic outreach program to the public and to County entities that deal with adolescents on the best way to call 911 when a no-lights no-sirens response is appropriate.

Response:
Wholly disagree. Public Safety Communications (PSC) works with each of its customer agencies and participates in public outreach campaigns. Furthermore, PSC participates in the County's Civics 101 Academy. PSC develops common ways to contact emergency services that cover a broad range of categories. Singling out individual methods for reporting emergencies would undermine PSC's ability to provide such services to all persons that are in need of emergency or other assistance.
This does not mean, however, that PSC does not have a detailed response plan when such an emergency is brought to a dispatcher's attention. Lastly, the method of response by PSC customers (e.g., Law, Fire/EMS) is policy driven and is not based solely on the recommendation of the dispatcher.

RECOMMENDATIONS

Recommendation 2:
Planners for CIT training—the Sheriff's Office and Behavioral Health and Recovery Services—should amend the curriculum to include techniques for dealing with situations unique to schools and other public agencies working in the area of youth mental health.

Response:
The recommendation has been implemented. The most recent training session was held in early August 2016. The CIT course originally had a ninety-minute block of instruction titled, "Youth Resources," where County mental health professionals provided information regarding not only the resources available to youth with mental illness, but also techniques in effectively interacting with youth who have mental illness. BHRS expanded this block to include specific therapists and school officials that have established relationships to improve school-based responses to crisis situations, providing instruction to the students about what to expect when responding to an on-campus situation, and what interventions can be employed for the circumstance most likely occurring. Officials involved with ongoing planning and training of the "Big 5" Program also participated to share the existing agreed to protocols for response to the top five crisis scenarios.

The Sheriff's Office expanded the current CIT curriculum to include an experienced CIT trained, School Resource Officer (SRO) who provided a block of instruction specific to dealing with school-age youth who have mental illness. The SRO instructed the students on the best practices in interacting with school officials and parents, and the mitigation of potentially volatile situations specific to youth. The SRO also highlighted more youth resources and the laws that relate to juveniles.

BHRS currently provides Youth Mental Health First Aid training to schools and other public agencies. This training increases school personnel and staff's knowledge and awareness in understanding and recognizing emotional and mental health stressors in youth and increases their capabilities in effectively intervening when necessary. Over the past two years, more than 1,000 staff in schools and other agencies have received this training.

BHRS, through the Coalition for Safe Schools and Communities, establishes mental health collaboratives with schools and districts to support and plan for their specific mental health needs. To date, 42% of the County's school districts are actively engaged in a collaborative representing 44% of all schools in the County.

The Sheriff's Office will also extend invitations for upcoming trainings to school officials and other personnel from public agencies that deal with children in crisis to attend the "Youth Resources" block of instruction and the "School Resources Officer" portion of instruction. The CIT course can accommodate between 10-15 additional students for those blocks of instruction.

Recommendation 3:
Behavioral Health and Recovery Services should extend as soon as possible the two-car SMART program by at least one hour so that the high-volume time between 3:00 p.m. and 8:00 p.m. is fully staffed by both SMART cars.

Response:
The recommendation has been implemented. SMART and BHRS staff periodically review data to ascertain if there are changes to the peak times for services and therefore a change to the operating hours. The data to support moving the hours of operation as identified in this recommendation are related to trends occurring in 2012 and 2013. Based on the most current data, however, SMART is now being deployed from 8 a.m. to 10 p.m.

Recommendation 4:
The Board of Supervisors should direct the County's Health System to institute an improved system of data collection and analysis regarding SMART response rates and adolescent PES admissions at Mills-Peninsula Medical Center, with such collection to start no later than October 1, 2016.

Response:
The recommendation requires further analysis. The current system to collect SMART response data provides sufficient information to determine the effectiveness of SMART, patterns of demand, geographic breakdown of where calls are generated from, and demographic data. There is a need to improve data collection related to calls for assistance that emanate from school campuses.

BHRS will work with the County Office of Education and Emergency Medical Services to evaluate ways data can be collected. This evaluation will be completed by January 31, 2017.

Recommendation 5:
The Board of Supervisors and Behavioral Health and Recovery Services should use the data obtained as a result of R4 to determine by the beginning of the 2017-2018 school year whether to expand the non-emergency aspects of the SMART program significantly and/or augment it with other services such as a respite center and in-home services regardless of insurance status.

Response:
The recommendation will not be implemented because it is not warranted. SMART does not provide non-emergency services. All requests for SMART are initiated by a law enforcement officer requesting assistance with a situation that may, but not always, result in transporting an individual to psychiatric emergency services. BHRS provides services to children who have Medi-Cal coverage and those who are indigent and not yet covered.

As provided in the Federal Mental Health Parity and Addiction Equity Act of 2008, health insurance plans are required to treat mental health and substance use disorder benefits on equal footing as medical and surgical benefits. Therefore, residential services and in-home services to the privately insured should be provided by their insurer.

Recommendation 6:
The Board of Supervisors should direct the County's Office of Public Safety Communications to devise a comprehensive plan to educate and collaborate with County entities and the public on the best way to call for help in a psychiatric emergency. The plan should be completed by year-end 2016.

Response:
The recommendation will not be implemented because it is not reasonable. As previously stated, PSC staff cannot develop individual approaches to specified emergency calls for assistance. The variety of calls are so vast that each call must be triaged in a very similar manner so that all calls can be dispatched in a timely manner. Creating such a response would overwhelm the dispatch center and slow the process to an untenable rate of response. It should be noted, however, that when such calls are triaged through the emergency medical dispatch program, there are specific instructions for ensuring that the response is accurate and timely, and that appropriate resources are allotted. BHRS has developed a comprehensive marketing program for County residents on how to plan and prepare for making a 911 call for a mental health emergency.

An overview of the program with downloadable brochures and wallet cards can be found on the Health System web site at www.smchealth.org/mh911.

Acceptance of the report contributes to the Shared Vision 2025 outcome of a Collaborative Community by ensuring that all Grand Jury findings and recommendations are thoroughly reviewed by the appropriate County departments and that, when appropriate, process improvements are made to improve the quality and efficiency of services provided to the public and other agencies.

FISCAL IMPACT:
There is no Net County Cost associated with accepting this report.

COUNTY OF SAN MATEO
OFFICE OF THE SHERIFF

CARLOS G. BOLANOS
SHERIFF

TRISHA L. SANCHEZ
UNDERSHERIFF

TOM GALLAGHER
ASSISTANT SHERIFF

400 COUNTY CENTER ▫ REDWOOD CITY ▫ CALIFORNIA 94063-1662 ▫ TELEPHONE (650) 599-1664 ▫ www.smcsheriff.com

ADDRESS ALL COMMUNICATIONS TO THE SHERIFF

July 27, 2016

Honorable Joseph C. Scott
Judge of the Superior Court
Hall of Justice and Records
400 County Center, 8th Floor
Redwood City, CA 94063-1655

RE: Grand Jury Report: Teens in Mental Health Crisis: From 911 to the Emergency Room Door

Honorable Judge Scott,

In response to the Crisis Intervention Training (CIT) related findings and recommendations listed on page 15 of the Grand Jury Report, the Sheriff's Office is providing you with the following update:

Finding #1

Only about 20% of law enforcement officers in San Mateo County are CIT-trained. There are significant barriers to enrolling officers.

The respondent does not agree with the finding. All San Mateo County law enforcement officers are provided with 8 hours of CIT training in the basic police academy. In addition, the respondent is aware that approximately 459 law enforcement officers out of 1,064 have completed 40 hours of advanced training for CIT.

Finding #2

Beyond the training itself, CIT is an important forum where all who deal with children in crisis; Emergency Medical Technicians (EMTs), the San Mateo County Assessment and Referral Team (SMART), schools, police can all learn from each other.

The respondent agrees with the finding.

Finding #3

The SMART car program is unique and highly effective at managing mental health emergencies in a sensitive manner, keeping adults and adolescents out of emergency rooms whenever possible.

The respondent agrees with the finding.

Finding #4

SMART can provide temporary post-crisis services, sometimes including in-person follow-up. BHRS provides on-going case-management services only to children who qualify for Medi-Cal.

The respondent agrees with the finding in that SMART, on occasion, provides post-crisis services, though its primary function is for immediate response to occurring crises.

Finding #5

Behavioral Health and Recovery Services provides adult residents with crisis-stabilization services, in-home follow-up, and a specialized mental health respite center as an alternative to Psychiatric Emergency Services hospitalization. No such programs exist for teens, even though 90% are discharged from the hospital within 24 hours.

The respondent does not agree with the finding. The Sheriff's Office is aware that Behavioral Health and Recovery Services offers the same services listed above for transitional youths, 17 years of age and older. Additionally, BHRS has a youth case management team that helps coordinate post-PES discharge services for youths. BHRS also partners with Star Vista which operates Your House South, a youth residence which provides a respite for youths from their homes, and provides opportunities for the families to work on their situation in a safe and supportive environment. For further details, please contact BHRS staff.

Finding #6

Data collection by the County on SMART program response rates and PES adolescent admissions at Mills-Peninsula Medical Center is not comprehensive or consistent.

The respondent cannot offer an opinion on data collection and response rates by BHRS and Public Health, respectively.

Finding #7

Schools and other public agencies are often reluctant to use the 911- dispatch system because of the detrimental effects on adolescents when first responders arrive on the scene with lights and sirens activated.

The respondent does not agree with the finding. The respondent cannot provide data related to the willingness or reluctance of schools and other public agencies to utilize the 911 dispatch system. In addition, unless there is a potential for violence or violent

intruder(s), law enforcement officers usually do NOT respond with lights and siren activated.

Finding #8

The County's Office of Public Safety Communications does not have a systematic outreach program to the public and to County entities that deal with adolescents on the best way to call 911 when a no-lights no-sirens response is appropriate.

The respondent cannot offer an opinion on the policies or protocols of The County's Office of Public Safety Communications.

Recommendation #1

The Grand Jury recommends that the Sheriff's Office should devise a plan by year-end 2016 to expand CIT training to include school representatives and those from other public agencies that deal with children in crisis. Additional CIT training sessions should be added if necessary so that law enforcement agencies can continue to encourage attendance by their officers. The plan should: (a) include ways to encourage those in leadership positions at police departments, schools, and other public agencies to attend; and (b) include refresher courses.

Response: Crisis Intervention Training has been offered on a semi-annual basis to all San Mateo County law enforcement personnel and first responders since 2005. CIT has historically been open to non-emergency personnel on a selective basis, due to the course being geared toward first responders. School representatives have not historically attended CIT due to the course being directed toward first responders.

In 2015 and 2016, the Sheriff's Office added a third and fourth CIT course to the calendar year, making it a quarterly training. There are four CIT courses already scheduled for 2017. These additional classes were added based on the increased demand for CIT in conjunction with the realization of this training's importance and relevance to law enforcement and first responder work.

Law Enforcement leadership have regularly attended CIT since its conception, but the majority of students have been officers and deputies, as they more regularly interact with the public.

The Sheriff's Office will research the implementation of an annual, on-line, CIT overview and refresher courses that will be offered to not only CIT graduates, but also law enforcement leadership, county school officials, and other public agencies working in the area of youth mental illness. The accessibility of this on-line CIT course will be ideal for leadership, and those whose intensive schedules may not allow them to attend the 40-hour course. Other courses can be offered to school representatives and personnel from public agencies that deal exclusively with youth, and be designed to specifically address the topic of youth mental health.

Recommendation #2

The Grand Jury recommends that planners for CIT training—the Sheriff's Office and Behavioral Health and Recovery Services—should amend the curriculum to include techniques for dealing with situations unique to schools and other public agencies working in the area of youth mental health.

> **Response: The Sheriff's Office CIT course currently has a ninety-minute block of instruction titled, "Youth Resources," where county mental health professionals provide information regarding not only the resources available to youths with mental illness, but also techniques in effectively interacting with youths who have mental illness.**
>
> **The Sheriff's Office will work to expand the current CIT curriculum to include an experienced CIT trained, School Resource Officer (SRO) who can provide a block of instruction specific to dealing with school-age youths who have mental illness. The SRO will instruct the students on the best practices in interacting with school officials and parents, and the mitigation of potentially volatile situations specific to youths. The SRO will also highlight more youth resources and the laws that relate to juveniles.**
>
> **The Sheriff's Office will also extend invitations to school officials and other personnel from public agencies that deal with children in crisis to attend the "Youth Resources" block of instruction and the soon-to-be developed, "School Resource Officer" portion of instruction. The CIT course can accommodate between 10 - 15 additional students for those blocks of instruction.**

In closing, the Sheriff's Office thanks the Grand Jury for its diligence and investment in strengthening the practices of law enforcement as it relates to youths with mental illness. The Sheriff's Office strives to accommodate the Grand Jury's findings and recommendations and continues to improve the interactions between the community and law enforcement.

Sincerely,

Carlos G. Bolanos
Sheriff

cc: County Manager
Board of Supervisors