

A PSYCHOTIC EPISODE: DRUG INDUCED?

LESSONS FROM ONE CASE

SUMMARY

A middle-aged man complained to the Grand Jury that he was mistreated and possibly endangered when placed on an involuntary 72-hour hold and locked in an isolation room at the Psychiatric Health Facility in San Luis Obispo. To encourage our investigation, the complainant released his medical records. Inpatient staff notations when he was admitted say that he was behaving in a threatening manner. The staff also noted that he had a strong pain medication administered by a patch. The patient's behavior was observed every fifteen minutes and assessed more thoroughly every two hours. The staff recorded that he was active and acting "bizarre" throughout much of the night. At 5:30 AM, he was deemed still unable to respond appropriately to facility rules, but by 8:30 he was released from isolation room and, soon after, was cleared to go home.

The patient alleged that the staff's response to his acknowledged use of a dangerous pain medication could have been life-threatening. And he felt abused when staff refused to take him to the bathroom though he waved his arms and shouted in the direction of the observation camera. Ultimately, records show, he fouled himself.

Grand Jury members generally lack the qualifications to determine what is or is not appropriate medical treatment. We tried to address whether Mental Health Department policies on taking patients to a hospital emergency room were appropriately applied in this case. That assessment was difficult because the facility utilizes a video system that destroys the tapes after only one month.

METHOD

Interviews were conducted with San Luis Obispo police officers and San Luis Obispo County Mental Health officials; also, the Grand Jury reviewed the complainant's medical records and

county mental health policies. Also reviewed were a police video recording of the officer's arrival at the complainant's home, and a recording of comments during the ride to the psychiatric health facility.

NARRATIVE

The events at issue began with a call to San Luis Obispo police from a neighbor who sought police help when the complainant reportedly waved a baseball bat while running down the street in the middle of the night and threatening others. When two officers arrived in separate cars, they reported observing him hitting "something" in his yard with the bat. A police video, including a vocal record of the incident including his transport in the police car, shows the complainant quickly dropping the bat when he saw the officers and quietly submitting to being handcuffed and placed in a patrol car. He was, however, unable to give the officers any explanation for his behavior. During his ride to the county psychiatric health facility, he indicated he had been there previously while responding incoherently to most questions and emitting a high pitched whistling sound most of the ride.

Before turning the man over to the inpatient staff, the transporting officer filled out a "5150 hold," a document which enables a psychiatric health facility to place a patient in detention for up to 72 hours for evaluation and treatment. On that document the officer declared the man in custody a danger to himself and gravely disabled. He "was incoherent. He could barely talk. He could not answer questions. He kept laughing and whistling," the officer wrote.

The complainant was admitted on the 5150 hold by a registered nurse at 1:13 AM Saturday Oct. 12, 2007. It was noted at the time that the patient was combative and uncommunicative.

A "Nutrition Screen and Pharmacy Information Sheet" filled out at the time of admission noted that the complainant "routinely" used a pain medication patch for his chronic arthritis. It had been "removed" the day before.

After admission, facility staff ordered a "regular" toxicology screen, a urine test that might have identified a drug reaction. Inpatient officials say it may take a business day or more to receive

the results from such a test. There was an alternate place on the form for ordering an “emergency” tox screen. That was left blank.

The San Luis Obispo County Mental Health Service policy and procedure manual provides that “any person brought to the PHF (Psychiatric Health Facility) for admission due to a mental disorder after having ingested alcohol and/or more medications than directed, whether prescription or over the counter, or any person suspected of having ingested any of these substances, is to be sent to an Emergency Department immediately for a medical evaluation and any necessary treatment.”

If the patient had been transferred to a nearby hospital emergency room, the results of a tox screen might have been available quickly if judged necessary.

Testimony to the Grand Jury indicated that both police officials and mental health officials consider a decision to take mental patients for evaluation by emergency room physicians to be excessively time-consuming. Police officers may be kept from returning to patrol for hours before a noncompliant patient can be thoroughly medically evaluated.

In this case, at 2:15 AM, a psychologist was called in to conduct a “seclusion/safety” evaluation at the request of an on-call psychiatrist. The psychologist noted the patient was “alert” but unable to discuss his “specific location” and exhibited “ritualistic and grandiose thought processes.” The evaluator recommended continued seclusion.

While still in isolation at 2:27 AM, the patient accepted a medication used to treat anxiety. At some point during the night he was allowed to go to the bathroom. Later, there are indications on the hospital records that he defecated on himself. At 5:20 AM he was allowed to shower and his underwear was sent to the laundry.

By mid-morning, the inpatient staff had contacted the patient’s wife who was out of town on business. She told the staff that her husband had not previously experienced a psychotic episode. The Psychiatric Facility’s staff concluded that he was no longer a danger to himself or others and released him to a family friend.

The video record of the patient's time in isolation is unavailable. The motion-activated cameras used in the room, according to the facility, "pre-record back six frames and with the cessation of movement, post record for three seconds. With this set up, the cameras have the capacity to record up to 30 days. After 30 days, the information is said to "fall off." In other words, it is erased and is not retrievable. As a result, it is impossible for members of the Grand Jury to properly evaluate the patient's treatment while he was held in an isolation room equipped with a blanket, a mattress and a camera.

A mobile private Mental Health Crisis Unit is under contract to provide mental health evaluation and patient counseling services to the county. That unit is often called out by emergency room staff when hospital patients are acting out. Police officers in the City of San Luis Obispo and other jurisdictions are regularly offered optional training on when to place subjects under a 5150 hold. Different mental health officials disagreed about how frequently the crisis unit is or should be called out during incidents occurring in the city of San Luis Obispo. The staff of the crisis unit is made up of counselors not medical doctors. Officials from that unit, and police department specialists in mental health issues, say that deciding when a psychotic individual is suffering from a medical problem such as a drug reaction and when that individual is actually mentally ill is one of the more difficult issues they face. Some suggest certain symptoms help in making that judgment. Others suggest even those markers are unreliable. Given the experienced staff at the Psychiatric Health Facility, it is unclear what calling in the crisis unit would have contributed in this case.

CONCLUSION

Our complainant apparently suffered a serious psychotic episode as a result of an overdose of a dangerous prescribed pain medication. Transported by police to a local psychiatric health facility, he was evaluated, isolated and observed through the night. The next morning he was released to go home. He asserts that his treatment by the psychiatric health facility was abusive, degrading and could have placed his life in danger. The Grand Jury has no evidence to support that conclusion beyond the known problems with some pain medication patches and the facility record indicating he was allowed to defecate on himself. Mental Health Facility policy declares

that mental patients who have “ingested alcohol and/or more medications than directed” should be sent to an emergency room. . In this case, the Mental Health facility staff members, in their professional opinion, did not feel the patient met the requirements for transport to an emergency room for a medical clearance. After careful and extensive review, the Grand Jury wonders if this patient could have benefited from a medical evaluation and possible treatment at an emergency room. At the very least, the Grand Jury would recommend a careful review and clarification of the use of this protocol. The Grand Jury also recommends that the facility retain video records of patients kept in isolation on a 5150 hold be retained for two years and that officials at the facility make sure they have access to timely results of toxicology tests.

FINDINGS

1. The complainant was admitted to the San Luis Obispo County Psychiatric Health Facility at 1:13 AM on a Saturday morning in October 2007 acting irrationally. He was released about 9 AM that same morning, was coherent and functioning well enough to be safely taken home by a friend.
2. The San Luis Obispo County Psychiatric Health Facility has in place a policy prescribing that mental patients who have “ingested alcohol and/or more medications than directed, or any person suspected of having ingested any of these substances” should be sent to an emergency room.
3. The patient in this case communicated to the health facility staff minutes after his admission that he’d been using a prescribed pain medication patch hours before he was determined to be a danger to himself or others.
4. This patient was not taken to a hospital emergency room.
5. The Health Facility routinely allows video records showing the behavior of isolated 5150 patients to be erased after 30 days.

6. Mental health department officials say that it takes them too long under current conditions to receive results of a toxicology screen.

RECOMMENDATIONS

1. The County Psychiatric Health Facility should review how its policy of taking possible drug overdose patients to the emergency room is implemented. The results of that review should be reported to the Board of Supervisors within three months to assure patient protection.
2. The Psychiatric Health Facility should retain for at least two years the video records of 5150 patients' isolation room behavior, as a way both of assuring appropriate treatment of patients and of protecting the county in the case of legal action.
3. Mental Health officials must assure that speedy toxicology screens are available when needed, with a stated policy that requires such action.

REQUIRED RESPONSES

Responses to Findings 1 – 6 and Recommendations 1 – 3 are required of the Department of Mental Health Services and the San Luis Obispo County Board of Supervisors.

The responses from the Department of Mental Health Services shall be submitted to the Presiding Judge at the San Luis Obispo Superior court by August 20, 2009. Please provide a copy of all responses to the Grand Jury as well.

The responses from the San Luis County Board of Supervisors shall be submitted to the Presiding Judge at the San Luis Obispo Superior court by September 19, 2009. Please provide a copy of all responses to the Grand Jury as well.

The mailing addresses for delivery are:

Presiding Judge	Grand Jury
Presiding Judge Martin Tangeman Superior Court of California 1035 Palm, Room 385 San Luis Obispo, CA 93408	San Luis Obispo County Grand Jury P.O. Box 4910 San Luis Obispo, CA 93403