



SAN LUIS OBISPO COUNTY HEALTH AGENCY

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Jeff Hamm
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DATE: July 29, 2009
TO: Geoff O'Quest, Administrative Analyst
FROM: Jeff Hamm, Health Agency Director
Karen Baylor, Ph.D., MFT, Behavioral Health Administrator
SUBJECT: Response to Grand Jury Report

This is provided as the required response to the Grand Jury's Report; "A Psychotic Episode: Drug Induced?" The Grand Jury report contains six findings and three recommendations.

The Grand Jury Report begins with a summary section in which a middle-aged man complained to the Grand Jury that he was mistreated and possibly endangered when placed on an involuntary 72-hour hold. A member from the Grand Jury contacted Dr. Baylor last fall and told me that the Grand Jury was required to inspect any involuntary detention facilities in the county and that their visit was just a routine visit. Now that the report has been released, it is clear that the investigation was in response to a specific complaint and not just a routine matter. The Grand Jury's covert approach to their investigation of the Psychiatric Health Facility was neither necessary nor indicated. The Grand Jury should be honest and forthright in their investigations in the same manner as they require the subjects of their investigations to be honest and forthright.

Finding 1: The complainant was admitted to the San Luis Obispo County Psychiatric Health Facility at 1:13A.M. on a Saturday morning in October 2007 acting irrationally. He was released about 9AM that same morning, was coherent and functioning well enough to be safely taken home by a friend.

Response: The Department agrees with the finding.

Finding 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.

Response: The Department agrees with the finding.

Finding 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.

Response: The Department disagrees wholly with the finding. The patient was brought to the Psychiatric Health Facility by local law enforcement. The patient was incoherent and could barely talk. The patient record does not indicate that within minutes after his admission he informed staff that he had been using a prescribed pain medication patch.

Finding 4: This patient was not taken to a hospital emergency room.

Response: The Department agrees with this finding.

Finding 5: The Health Facility routinely allows video records showing the behavior of isolated 5150 patients to be erased after 30 days.

Response: The Department disagrees partially with this finding. The Psychiatric Health Facility has a Digital Video Recorder that runs continuously for thirty days. The cameras are motion sensitive and will pre-record six frames and post-record three frames when activated by motion. The information is not erased but is recorded over approximately every thirty days.

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

Response: The department agrees with this finding. Prior to the Grand Jury Report, the Department did discontinue the contract with the previous laboratory and has a new contract with another laboratory service. The new laboratory service is local and has quicker response times. In this situation, a drug reaction would not have shown up on a toxicology screen. The results of the toxicology screen would not have been relevant in this case.

Recommendation 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.

Response: The recommendation will not be implemented because it is not warranted. The Department has a current policy that in cases where there is evidence of a drug overdose, the patient is taken to the emergency department. In this particular case, there was no evidence of a drug overdose.

Recommendation 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.

Response: The recommendation will not be implemented because it is not warranted or is not reasonable. Several months ago, the Department implemented a procedure where the Nursing Supervisor and the Patient's Rights Advocate review the DVR on all seclusions. This review will identify if procedures were properly followed and will identify any improvements or training issues for the staff. The Patient's Rights Advocate will identify any seclusions where procedures were not followed and a copy of that event will be kept for two years. In order to comply fully with this recommendation, staff would have to burn a CD every time there is a seclusion. This would require additional staff time, storage and resources.

Recommendation 3: Mental Health officials must assure that speedy toxicology screens are available when needed, with a stated policy that requires such action.

Response: The recommendation has already been implemented. In May of 2009, the Department ended the contract with the previous laboratory and entered into a new contract with a different laboratory service. The new laboratory does have a faster turn around time with results.