

Investigation of the Care and Treatment Provided to Juan Gonzalez

By Presbyterian Medical
Center Emergency Room
July 3-5, 1986

NYS Commission on



QUALITY
OF CARE

for the Mentally Disabled

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PREFACE

The Commission on Quality of Care initiated this investigation to review the adequacy and appropriateness of the psychiatric treatment afforded to Juan Gonzalez in the few days immediately preceding the events on the Staten Island Ferry that left two persons dead and several others wounded. The Commission participated in interviews of staff at Presbyterian Hospital, conducted jointly with staff from the Department of Health and the New York City Department of Mental Health, Mental Retardation and Alcoholism Services. The Commission concurs with the findings contained in the reports issued by those agencies.

As the State agency charged by law to ensure that the quality of care provided to mentally disabled persons is "of a uniformly high standard" (Mental Hygiene Law §45.07, subd. (a)), the emphasis of the Commission's investigation is on determining whether policies and practices regarding care delivered in psychiatric emergency rooms need modification to meet this legislative expectation and to reduce the likelihood of a recurrence of such a tragedy. In offering the recommendations contained in this report, the Commission is cognizant that, given the nature of mental illness and the practical realities of

available treatment options, the elimination of all risks is not reasonably possible.

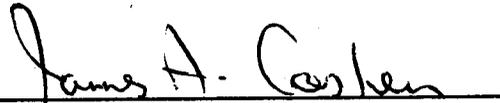
The findings, conclusions and recommendations of this report represent the unanimous opinion of the Commission.



Clarence J. Sundram
Chairman



Irene L. Platt
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Synopsis of Events

On July 3, at approximately 10:00 AM, Mr. Gonzalez began threatening passersby outside the Fort Washington Armory Men's Shelter and saying, "Jesus wants me to kill." The acting director of the shelter called the New York City police who removed Gonzalez to Columbia Presbyterian Medical Center Psychiatric Emergency Room in handcuffs.

He was seen by a third year resident who was on the first week of her psychiatric rotation. The resident was informed that the shelter did not have much of a history of Gonzalez as he had had a brief stay there. The patient was speaking in both English and Spanish and a police officer assisted with translation.

No diagnosis was made at admission. Upon a mental status exam, patient was noted to be animated with pressured speech, though content clear but bizarre, evidencing hallucinations and delusions. He was grandiose, verbally threatening but denied suicidal or homicidal thoughts, denied alcohol or drug intake.

Over the course of July 3 and 4, the patient was seen by several third and fourth year resident physicians and treated with Thorazine and Haldol. On several occasions, he repeated the messages from God to kill.

On July 4, at 5:45 PM, after initially refusing, patient signed a consent form for a voluntary inpatient psychiatric admission because God told him to. However, a problem developed in finding an available bed. Although Presbyterian Hospital had a vacant bed in its psychiatric unit, that bed was being reserved

for an admission planned for July 7. Seven voluntary hospitals had been called earlier by Presbyterian Hospital, but none had a bed available. No State or municipal hospitals were contacted.

On July 5, at 6:30 AM, a night nurse coordinator noted that the patient's speech was pressured and that he still had religious preoccupation. The patient did not want to be in the hospital. Two hours later, he was seen by fourth year resident who found no evidence of psychosis. The patient denied messages from God, saying they stopped last night. He denied command hallucinations to kill or suicidal thoughts. He expressed a willingness to go for outpatient treatment. He was discharged about an hour later after filling a prescription for Thorazine and receiving a piece of paper with the name of a social worker to contact at the shelter.

His whereabouts are unknown from the time of his discharge until his arrest on July 7 after allegedly killing two persons and wounding several others aboard the Staten Island Ferry.

Findings

- (1) MR. GONZALEZ' CARE IN PRESBYTERIAN HOSPITAL'S PSYCHIATRIC EMERGENCY ROOM (PER) DID NOT MEET PROFESSIONAL STANDARDS.
 - o No physical examination was performed on Mr. Gonzalez and no medical history was obtained. No drug screening was done.
 - o No diagnosis was ever made.

- o No clinical impression was recorded until the discharge note.
- o Psychotropic medications were administered to the patient by a security guard rather than a nurse, on occasion.
- o Record keeping was inadequate on several occasions, particularly for events the morning of July 4, 1986. Between the hours of 5:00 AM and 6:35 AM, Mr. Gonzalez was medicated four times, yet there were no descriptions of mental status during this time and only scanty notes concerning patient's behavior/demeanor.
- o The patient's record contained no treatment plan.

(2) THERE WAS INADEQUATE SUPERVISION OF RESIDENT PHYSICIANS IN THE PSYCHIATRIC EMERGENCY ROOM DURING MR. GONZALEZ' STAY.

- o There is no documented evidence that the attending physician reviewed the work of a third year resident who had less than a week's experience in the PER. This resident treated Mr. Gonzalez for approximately the first 24 hours of his stay at PER.
- o The residents treating Mr. Gonzalez did not consult their supervisor (attending physician or the director of PER) for direction, particularly when they could not find a vacant bed in the hospitals they called and when discharging the patient.
- o Inadequacies in PER care (as noted above) were not detected and corrected by supervising physicians.

(3) RESIDENT PHYSICIANS AND HOSPITAL ADMINISTRATORS WERE UNFAMILIAR WITH OR FAILED TO ACT IN ACCORDANCE WITH CRITICAL DOH AND HOSPITAL POLICIES AND PROTOCOLS. THE HOSPITAL POLICY ITSELF WAS INCONSISTENT WITH STATE AND FEDERAL LAW IN SOME RESPECTS.

- o The fourth year resident failed to canvass municipal hospitals when looking for a bed late in the afternoon of July 4. The resident recorded she called seven voluntary hospitals and none had an open psychiatric bed. There her search ended, despite a policy manual directive that undomiciled patients "usually can only be admitted to a municipal or state hospital." In any event, no contact was made with municipal or state hospitals which would have been able to admit Mr. Gonzalez nor, apparently, was any consideration given to admitting the patient to Presbyterian Hospital which had a vacant bed which was not planned to be used until July 7.
- o The policy manual directive cited above appears to violate state laws and policies as well as federal laws barring discrimination against indigent and handicapped persons.
- o DOH interpretations of public health regulations do not allow keeping a patient in an emergency room for more than 24 hours except in an emergency (10 NYCRR §401.2; DOH Memoranda 81-72, 82-54). However, the director of PER indicated that approximately four patients or more per

week are kept more than 24 hours and, apparently, this practice has become commonplace.

(4) INTERPRETERS FLUENT IN SPANISH WERE NOT USED CONSISTENTLY IN FACILITATING COMMUNICATION BETWEEN THE PATIENT AND PHYSICIANS DESPITE THE AVAILABILITY OF A LANGUAGE BANK FOR THIS PURPOSE.

- o When admitting Mr. Gonzalez, the resident physician used the services of the policeman escorting the patient to interpret his speech. On a second occasion, a security guard was used as a translator. The services of a translator were not used during the critical discharge interview. When questioned later, the discharging physician stated that her final interview with the patient took approximately 20 minutes and that he spoke heavily-accented English haltingly.
- o The Presbyterian Hospital ER policy and procedures manual includes mention of the availability of a Language Bank which uses staff and volunteers to act as interpreters. PER staff indicated that one has to be very careful in using untrained interpreters in working with mentally disturbed patients because they have a natural tendency to "clean up the language." It is also essential that the interpreter be able to identify pressured speech and other speech characteristics common to emotionally disturbed people.

- (5) THE STAFFING IN PER DID NOT AFFORD ANY CONTINUITY OF OBSERVATION FOR PATIENTS NOR FOR APPROPRIATE ATTENTION TO PATIENT NEEDS.
- o There are no nurses assigned exclusively to PER on evenings, nights and holidays. The only persons continually observing and listening to patients throughout these hours are the security guards. Hence, as noted earlier, notes were sketchy and reflected, generally, periods of the patient's agitation, the administration of medications, and admitting and discharging notes. For acutely ill psychiatric patients, more consistent recording of observations of trained professional staff is necessary.
 - o There is also a need for attention to the patients' physical needs and comfort, particularly in view of the fact that several patients each week spend more than 24 hours in PER.
- (6) THE DISCHARGING PHYSICIAN FAILED TO MAKE ADEQUATE EFFORT TO ENSURE THAT THE PATIENT WAS LINKED WITH OUTPATIENT CARE.
- o At the time of discharge, the patient was given a prescription for a major tranquilizer (which he filled) and a piece of paper with the name of the shelter social worker on it. The shelter social worker was supposed to link Mr. Gonzalez with outpatient services.

The discharging physician did not call the shelter to advise them the patient was being discharged and to inform

them of her reliance on the social worker to make the outpatient connection.

The case record indicates that while she gave the patient the name of the shelter social worker, she (the physician) recorded she was giving him the name of the social worker at the Council for Problems in Living, the provider of a full range of outpatient services.

Conclusions

1. Assessing the potential for violence by patients and predicting the likelihood of such violence are among the most difficult tasks expected of mental health professionals. Generally, such assessments and predictions are not done with any reasonable scientific certainty but rely heavily on the skills of the particular professional involved, honed by training and experience. The reliability of such professional judgments is also heavily dependent on accurate information about a patient's past history, which is often the best -- although not an infallible -- guide to future behavior.

The difficulty of this challenge suggests that responsibility for making these judgments about patients, particularly in psychiatric emergency rooms and admissions wards where professional contact with patients is brief, should rest with well trained and experienced clinicians. However, it is not a general practice to assign more senior staff with such training and experience to the entry points of the mental health system.

4. A body of professional opinion has identified substantial difficulties in diagnosing and treating bilingual and bicultural psychiatric patients without a staff with similar characteristics. These difficulties exist particularly where English is a second language, learned in adulthood and spoken with difficulty. The reluctance of a patient to use a language with which he is uncomfortable may lead to problems with verbalizing thoughts and feelings, stilted patterns of speech or simply a reluctance to talk very much. Important material needed for an accurate psychiatric diagnosis may be lost because of linguistic difficulties or a misreading of verbal cues by staff unfamiliar with the speech patterns of bilingual or bicultural patients.

According to a study by the Office of Mental Health in 1981, of all patients treated in municipal hospital emergency rooms, 21.8 percent were Hispanic, as were 16.2 percent of patients treated in voluntary hospitals. The Governor's Select Commission on the Future of the State-Local Mental Health System identified a need to improve the quality of mental health services available to minorities, particularly by increasing the number of minority professionals and providers.

In this case, a Hispanic patient, who spoke heavily accented English haltingly, was brought to the psychiatric emergency room of a hospital which, like many others, had no Spanish-speaking professional staff on duty. A police officer and a security guard served as translators on occasion. But, during the

20-minute interview with a resident prior to the decision to discharge him, no translator was present. It is difficult to determine with any degree of certainty what role language difficulty played in evaluation of the patient's condition as sufficiently improved to warrant his discharge a scant 17 hours after he had been determined to require inpatient hospitalization.

5. There is a need for closer monitoring of the conditions of care in psychiatric emergency rooms which, because of overcrowding in other parts of the mental health system, are increasingly being called upon to retain patients beyond the 24 hour limit set by the Department of Health. The longer lengths of stay make it imperative that the policies and treatment practices of psychiatric emergency rooms be reviewed to ensure their compliance with the mental hygiene law and policies. It is also necessary that such facilities be able to meet patients' needs for safety and comfort.

Recommendations

This investigation suggests a need to reexamine the types of staff and the role of staff who man the gateways into the mental health system. Accordingly, the Commission recommends the following:

- (1) Presbyterian Hospital and other facilities with psychiatric emergency rooms should reexamine the formal responsibility of their senior clinicians in monitoring

More typically, junior staff and residents are assigned such responsibilities, under supervision which varies in immediacy and intensity.

In this case, the responsibility for assessing the danger posed by a patient evidencing command hallucinations to kill others fell largely on the shoulders of third year residents at the very start of their psychiatric residency, with scarcely a week of experience, and fourth year residents with relatively brief experience. There was little supervision offered by more senior attending physicians, and the residents did not seek such assistance as might have been available. There was no regular staff of experienced psychiatric nurses in the emergency room over this holiday weekend to regularly observe and monitor the patient's behavior. The assessment of the patient by a more experienced nurse on the day of discharge was discounted by a resident.

2. Although not a factor in this case, obtaining timely access to relevant information on the psychiatric history of a patient from other mental health providers is frequently difficult. It is often difficult to determine if the patient has a history of psychiatric treatment at other mental health facilities, particularly in metropolitan areas where a multitude of such programs exist and patients move among their catchment areas. Proper concerns about the confidentiality of clinical information, as well as the time-consuming response of bureaucratic organizations, impede the prompt communication of

clinical information, often resulting in decisions on admission or referral of patients in psychiatric emergency rooms being made without a complete history of the patient. There is considerable pressure to make such decisions quickly because the demand for space in psychiatric emergency rooms and admission wards often exceeds the supply.

3. If a patient is deemed not to require inpatient psychiatric hospitalization, or is not susceptible to involuntary civil commitment even though such patient may benefit from inpatient treatment, the responsibility for negotiating entry into an outpatient program is generally left to the patient, usually with the assistance of a referral. Frequently, mentally ill patients do not make this transition successfully on their own and fail to enter into or remain in outpatient treatment.

A system of case management that would assist patients in need in making this connection is available to chronic mentally ill patients in the Community Support Service program but is not available to patients like Mr. Gonzalez who do not have a substantial history of inpatient treatment.

In this case, the patient was given a prescription for Thorazine and a slip of paper with the name of a social worker at the shelter, who was supposed to assist Mr. Gonzalez to enter an outpatient program. However, no attempt was made to ensure that the patient returned to the shelter nor was the shelter itself informed of the reliance that was being placed on its staff.

and supervising more junior staff who have decision-making responsibility. The Commission would suggest that consideration be given to adopting a policy requiring a senior staff physician to approve any recommendation not to admit a patient who has been brought to a psychiatric emergency room by police officers, or who is believed to need inpatient psychiatric care but is not willing to accept it voluntarily and who is believed not to meet the requirements for involuntary commitment.

- (2) The Office of Mental Health, and municipal and voluntary hospitals in New York City, should jointly explore the possibility of creating information sharing mechanisms that would facilitate the prompt transmission of relevant patient information to facilities within the mental hygiene system to promote better decision making regarding patient care.
- (3) The Office of Mental Health should consider adopting a policy applicable to all psychiatric facilities requiring the creation of a case management system to assist patients in making linkages with other facets of the mental health and social support systems as needed. Recognizing the difficulty of the creation of such systems, as well as the substantial costs entailed therein, we suggest that priority be given to providing case management to those patients who need it most --

patients for whom it is believed that inpatient hospitalization would be beneficial, but who refuse such hospitalization and who are not subject to involuntary commitment.

- (4) Mental hygiene facilities must make it a high priority to increase the recruitment and training of minority professionals, particularly bilingual and bicultural professionals in areas where such patients require mental health services. To meet the great need for such professionals, strong efforts need to be made at the college and university level to enroll members of minority groups in programs leading to degrees in the mental health professions. The Commission endorses recommendations made by the Governor's Advisory Committee on Hispanic Affairs in this regard.
- (5) As an interim measure, psychiatric hospitals which serve significant minority populations who speak languages other than English should make significant efforts to train translators to work with psychiatric patients.
- (6) The Department of Health, which certifies emergency rooms, should ensure that psychiatric emergency rooms comply with the requirements of the Mental Hygiene Law in such areas as the use of seclusion and restraints, for example. In its role as the certifying agency for psychiatric wards of general hospitals, the Office of

Mental Health should review as well the hospitals' policies and procedures applicable to psychiatric emergency rooms, to ensure that such policies and practices comply with the Mental Hygiene Law.

If the practice of retaining patients in psychiatric emergency rooms beyond 24 hours is permitted to continue, it is imperative that provision be made to enable these facilities to meet patients' other human needs -- for mobility, reasonable privacy, safety and comfort.