

State of Connecticut
GENERAL ASSEMBLY



CVH WHITING TASK FORCE

MEETING SUMMARY

Co-chairwoman Linda Schwartz convened the meeting.

Ms. Schwartz noted that the task force would send a note to the chairs of the Public Health Committee requesting clarification about the preliminary report requirements. This item will be included for discussion on the next meeting agenda.

Dr. Charles Dike and Dr. Vinneth Carvalho of the Department of Mental Health and Addiction Services (DMHAS), Connecticut Valley Hospital (CVH) presented:



Connecticut Valley
Hospital Presentation.p

CVH is a large hospital with 18 inpatient units comprised of two campuses, the Middletown and Hartford campuses.

Ms. Schwartz asked if the specialists attending to the patients at CVH are employed through the Yale contract with DHMAS, or whether they're employed solely through DHMAS.

Dr. Dike answered that most of the individuals and specialists providing services on the ground are state employees, such as dentists, nephrologists or therapists. However, not all specialties are present and if a patient requires a specialty such as gastroenterology then they must be referred to outpatient services.

Ms. Schwartz asked about patient capacity at CVH divisions such as young adults or traumatic brain injury.

Dr. Carvalho answered that the bed capacity for the young adult division is 17, and the traumatic brain injury unit has a bed capacity of nine.

Ms. Schwartz asked if any veterans go to CVH with traumatic brain injury.

Dr. Carvalho answered that there have been veterans in the past, although doesn't believe there are any current veteran patients.

Mr. Lawlor asked if 100% of the patients are inpatient, or whether CVH has outpatient responsibilities.

Dr. Carvalho answered that there are 10 outpatient beds.

Dr. Dike stated that CVH is an inpatient hospital and the largest inpatient state facility. He noted that River Valley Services is on the grounds and it is outpatient, but is considered a separate division of DHMAS. What separates CVS from most other hospitals is that it is the last stop for people that have significant difficulties. Dr. Dike added that he is often called to Emergency Rooms (ER) when someone presents with crippling illness.

Ms. Alisberg asked what the CVH position is if a patient no longer meets commitment standards. An example would be if a patient's legal status is reviewed during the monthly treatment team meetings and it is decided that they're neither gravely disabled nor dangerous to self or others but are not willing to convert and become voluntary.

Dr. Dike stated that ideally, CVH should go back to the probate court and inform them that a certain patient no longer meets the standards, but sometimes even if a patient doesn't meet the standards it might be difficult for them in the community. This is where safe discharging becomes the question. He added that most difficulty is presented around the area of grave disability because an individual is not gravely disabled if they have the resources to keep them safe in the community, but even if they're no longer dangerous, if they don't have those resources then they may not be safe.

Ms. Alisberg asked if the unwillingness of a patient to sign a voluntary essentially mean that they're gravely disabled because they're not taking into account the CVH desire to give them a safe discharge plan.

Dr. Dike answered that that is a separate determination. Questions posed include whether a particular individual can take care of their needs on their own, whether they can provide food, heat, and navigate the outside systems on their own. If this individual is impaired by their illness in a manner that makes it difficult for them to keep safe, then releasing them could become dangerous.

Dr. Rodis stated that he got the sense that CVH is always juggling trying to make rooms for other patients, and asked whether the hospital is always at capacity.

Dr. Carvalho answered that they are generally at full capacity.

Dr. Rodis asked how many of the 360 patients end up at CVH voluntarily.

Dr. Carvalho answered that the majority of patients are voluntary. Last year only four patients came in through a Physician Emergency Certificate (PEC).

Mr. Lawlor asked how often a patient transitions from a hospital such as Dutcher to CVH.

Dr. Dike stated that transitions are not too rare. He added that he views Dutcher services as almost equivalent to the general psychiatry division at CVH. If there is pressure from Dutcher for beds and we need to create room for transitioning patients, then we may move them to general psychiatry. If we know that a patient has traumatic brain injury and that is the

reason they were sent to Dutcher, then we move them to the TBI division but the goal is to always have a discharge plan. Dr. Dikes stated that transitions can also happen where CVH patients are transitioned to Whiting Forensic Hospital if an individual is too aggressive.

Mr. Lawlor asked whether CVH staff is consulted on cases of competency. If a case of minor criminal charges is presented, is there a point of discussion by those making placement decisions where they ponder whether they can transfer a patient to an inpatient bed at CVH.

Dr. Dike answered that they are not consulted. Generally the process is for an individual to be seen by the Office of Court Evaluations, which then represent their findings to the court and then the court makes the determination whether the individual is competent or not and where they should be placed based on the least restriction, and whether inpatient or outpatient.

Mr. Lawlor asked about the options a police officer has if they encounter someone that they can arrest due to their behavior.

Dr. Dike answered that police officers have the ability to bring individuals to the ER if they determine that an individual is experiencing psychiatric distress. After examining the individual, the ER doctors may decide that they do not meet admittance standards and discharge them, they may decide that the individual should be observed but not admitted, or they may decide that they need to be admitted. The PEC can last for 15 days, but usually individuals get better and are discharged within that time. The patients can also request to be discharged and the hospital would inform the probate court judge who would then determine whether that individual meets the hospital standards of admittance. If they don't get better and cannot be discharged within the 15 day timeframe, then the hospital goes to court for civil commitment.

Mr. Acker asked for clarification to an earlier point and whether Dr. Dike's comments mean that there are potentially patients at CVH that are well enough to be discharged but cannot be because of a lack of resources in the community.

Dr. Dike stated that often the needs of CVH patients go way beyond those a regular hospital patient may need to be discharged. There are too many variables that enhance the cost of the ability to discharge them as they would need staff to watch them in the community to make sure they're safe.

Mr. Lawlor stated that the task force has had presentations from the Whiting and Dutcher hospitals with regards to the racial breakdown of staff. He noted that the concentration of people of color seemed to be among the relatively lower level positions. He asked whether CVH also falls in that category.

Dr. Carvalho stated that CVH has a diverse workforce and can provide the task force with specific data in the future. She added that 40% of the workforce is made up of minority groups, and 61% of the workforce is female. She also added that both, the Chief Executive Officer and the Chief Medical Officer at CVH are black.

Ms. Schwartz asked if staff has debriefing resources if issues that they don't understand arise, whether these issues are related to their personal feelings or related to the patients.

Dr. Carvalho answered that available resources include the Employee Assistance Program (EPA), and part of crisis resolutions always include debriefings.

Ms. Schwartz commented that some of the occurrences that precipitated the creation of the task force suggest that some of the staff is scared of the things they are asked to do and feel that they are being placed in a negative situation. She added that the people who perform the type of work needed at the DMHAS hospitals must have special personalities because the work they do is very special and wondered if there is any support for them as they try to navigate difficult situations.

Dr. Carvalho stated that every allegation or issue is taken very seriously and they try their best to investigate situations and provide support to staff.

Dr. Dike added that if a staff member feels threatened and they present that fear to the treatment team, then that would be an indication that the team needs to work on a treatment plan that would keep the staff safe, the patient and everyone else who may be around the patient. There are patients that may present a danger to themselves and to staff and identifying this risk would help in creating an objective treatment plan.

Ms. Alisberg commented that perhaps more frequently the problem lies with the staff and not the patients. It is important to avoid blaming patients for everything that happens in these environments. The reason the task force was created is because of inappropriate behavior by staff that are charged with taking care of the patients, so the patients should not be judged and labeled as always dangerous or at fault.

Ms. Schwartz clarified that it wasn't her intention to infer that the patients are at fault, but rather to ask the doctors presenting whether they have ever thought to have, or currently have any programs to educate the staff that is tasked with such a weighed responsibility.

Dr. Dike stated that in addition to EPA, they also try to identify other options so that they can do better. He added that both the staff and the patients are important and both should feel safe.

Dr. Rodis asked for clarity on reporting situations of abuse and an example of the incident form that is completed by employees for reporting. He stated that abuse tends to be underreported, and while he appreciates the fact that even a visitor just walking by can report abuse if they witness it, they are not likely to do that. He added that peers are also unlikely to report their peers.

Dr. Dike said they would make the form available to the task force.

Mr. Acker asked about the recovery rate of patients.

Dr. Dike answered that recovery is a broad term. Recovery may include participation in the community, how an individual would engage, live and learn and achieve their own goals. Many people are at different levels of recovery because their goals are different. If one patient's goal is to decrease restraints and they achieve that goal, then that patient is in recovery, although all other patients are in recovery with their own goals. He added that as long as individuals are empowered to take charge of their own treatment and care, then the staff will work with them towards moving to the next process.

Ms. Schwartz asked about the number of patients discharged to the community.

Dr. Carvalho answered that it depends on the hospital divisions. She noted that the addiction services division discharges patients more frequently.

Ms. Schwartz thanked Dr. Dike and Dr. Carvalho and noted that they brought many things to the task force's attention, and that the task force would contact them in writing should they have any additional questions.

Ms. Schwartz proceeded to the Dutcher and Whiting Forensic Hospital Steering Committee Meetings discussion portion of the agenda.

Ms. Alisberg stated that the task force has been invited by the Dutcher Steering Committee to attend one of their meetings which take place on Fridays, so the task force should pick a date to attend and figure out which members will go. She added that it might be overwhelming for all members to go at once as there may be more members than patients present.

Ms. Schwartz commented that she is not comfortable splitting up the members as all listen with different ears and it will be important that they all hear the same things at the same time. She also added that since the task force has lost quorum for a vote, she is not comfortable making a decision at this point and the meeting subject can be added to the next agenda.

Ms. Schwartz proceeded to the discussion on Legislative Report Timeline.

Task force staff suggested that the preliminary report is due on January 1, 2020, and the final report in January 2021. The co-chairs of the task force can write to the co-chairs of the Public Health Committee to ask for reporting extensions if one is needed.

Ms. Schwartz noted that the next meeting date cannot be chosen now because many task force members are not present at the meeting. She suggested that the task force staff send an email to members asking their availabilities to attend meetings for the months of October and November. The final meeting date chosen will be communicated to members through email.