ARIZONA
INDEPENDENT OVERSIGHT COMMITTEE

Department of Health Services (DHS)
Arizona State Hospital Independent Oversight Committee (IOC)
Public Meeting Minutes
Thursday, January 16, 2025 – 6:00pm

Call to Order

Meeting called to order by Committee Chair, Laurie Goldstein. The meeting was virtual, no physical address.

Welcome and Introductions

- Laurie Goldstein (Chair)
- Charles Goldstein, MD
- Melissa Farling
- Jane Jepson
- Kim Scherek
- Alyce Klein
- Kay Kunes
- Barbara Honiberg

Absent:
- Alyce Klein
- Dee Putty
- Janina Rotaru

Public in Attendance: Patsy Adams, Sey In

Other IOCs – Crystal Fox

Arizona Department of Administration (ADOA): Larry Allen

DDD: None

AHCCCS: Fredreaka Graham

ASH Administration: Michael Sheldon, Trevor Cooke & Terra Morgan

IOC: DHS/ASH IOC Meeting - 2025/01/16 17:51 MST - Transcript

Attendees

+1 480-***-**66, +1 602-***-**31, +1 602-***-**37, barbara honiberg, Chuck Goldstein, crystal Fox, Fredreaka Graham, Jane Jepson, Laurie Goldstein, Lawrence Allen, Lawrence Allen's Presentation, Melissa Farling, Michael Sheldon, Michelle Rademacher, Patsy Adams, Sey In, Terra Morgan, Trevor Cooke

Transcript

Laurie Goldstein: Welcome everyone to the Arizona State Hospital Independent Oversight Committee meeting. January the 16, 2025 and it is 6:02pm and we have met quorum. We have Chuck, Barb, Melissa and we expect Janina and myself so far and with that is there any welcome and does anyone have any conflict of interest that they need to disclose to any of the committee members?

Laurie Goldstein: Hearing none, let's go ahead and begin. Has everyone had a chance to review the meeting minutes? I know they're a little tedious since they're AI, but they were sent out by Larry what about a week ago?

Lawrence Allen: Yes.

Laurie Goldstein: And okay, sorry K. I see Terra on.

+1 480-*-**66:** I did and…

+1 480-*-**66:** I did review them.

Laurie Goldstein: Okay. So, do we have a motion to pass either as is or…

Laurie Goldstein: with edits?

+1 480-*-**66:** All right.

Melissa Farling: I motion to approve the minutes as is…

+1 602-*-**37:** I second it.

Melissa Farling: unless someone wants discussion.

Laurie Goldstein: Okay, Barb second.

Laurie Goldstein: All in favor? I. Anyone opposed? So the meeting minutes passed last month. So first let's start with an update from ADOA.

Lawrence Allen: Good evening. The only update I have for the committee tonight would be that we were able to hire an ombudsman for the state hospital. I am not sure on the start date yet. might be next week.

+1 602-*-**31:** Larry, I just have a quick question.

+1 602-*-**31:** Will we be given this person's name and a way to contact that person? Will we be getting that information as a patient?

Lawrence Allen: No. I believe that's going to be more of an admin position that's going to be working more with Michael and Trevor and their teams on projects that are going on within the hospital. so, there's going to be more to come on this, but as it stands now, I don't believe we'll have more of a solid update for you next month once the person gets on the ground but at least we got some positive momentum there.

Laurie Goldstein: So maybe we can ask and we can take a vote on it. Could we request that we get a kind of a job role and description? Because I think when it first was brought up, most people felt that it was going to be like the person that the patients would contact. And if that's not the case, we wonder what their role will be? How will it differ from the patient advocate,…

Laurie Goldstein: the ombudsman Terra Morgan who is now at ASH and acts as the patient ombudsman.

Lawrence Allen: Yeah, no problem. I'd be happy to secure the job description of this individual and how they're going to work within the hospital.

Chuck Goldstein: I'd like to point out that the very dictionary definition of an ombudsman is somebody…

Chuck Goldstein: who hears and investigates complaints from private citizens against governmental officials or administrators or employees of a company against the administration of that company. It doesn't seem that the word ombudsman as you're describing it, Larry, applies to the person that's going to be taking this job. Maybe some other name would be given to him because he's certainly not going to be an ombudsman in the dictionary sense of that word if he's not investigating and facilitating complaints from the people involved which in this case are the people who are in the forensic and civil units of this Arizona State Hospital and the administration. So I'm not sure the word ombudsman actually applies.

00:05:00

Chuck Goldstein: So please clarify.

Lawrence Allen: I don't have the job description. I have never seen it. So, I'm just letting the committee know that the ombudsman has been hired. Now, I'm not too sure on the job description and what it's going to entail, but I was told that or at least what I remember from the last meeting that it's not going to be patient contact. But I might be wrong. I could certainly get the job description and get that back out to the committee. so, you'll have an idea of what to expect from this individual.

Laurie Goldstein: Do we need to take a vote on that, Larry, or you're just going to send us the job description and we'll Okay,…

Lawrence Allen: No, I can send that to you. I'll send it to everybody.

Laurie Goldstein: Thank you.

Lawrence Allen: You're welcome.

Laurie Goldstein: Okay, updates from other IOC's. Crystal, I see you're on. Do you have anything from the DDOC?

crystal Fox: Let me think.

crystal Fox: Not really. I can't think of anything. at least at this point.

Laurie Goldstein: Okay. Thank you.

Laurie Goldstein: Always good to have you on.

crystal Fox: Thank you.

Laurie Goldstein: Any other IOC members on that would like to give an Review of action items. All of them follow up on previous discussions. the only one and something else popped in my head, but I didn't write it down and it's gone. But one thing was based on some patient visits I know that Alice and Barb did maybe a month and a half of anguish, maybe more. They were going to write up a document because they didn't want to discuss the complaints in detail. They did at a high level. And at this point, we don't have that document. I know Barb said that she has that information that she'll share in executive session today, but other than that, trying to think if there was anything else. Any other committee members can you think of anything else that was ongoing that we left?

+1 602-*-**31:** I think we were discussing risk assessments, but we've gotten updates from the hospital on that. I don't know if we should discuss it here or not or if we need to.

Laurie Goldstein: I think if I recall, Mike Sheldon sent out, didn't you send us what the risk assessment, which was reasonable on, you have to be med compliant, you have to be participating in your therapy, kind of basics. before they will invest in a risk assessment since they have limited resources. It didn't make sense to the team to just every time someone asked for a risk assessment to get it if even the clinical team wasn't going to recommend that the person progress. But Mike, did I capture that right? Yeah, you did.

Michael Sheldon: did send you all that document. if I didn't, I apologize and I'll get it over to you ASAP.

+1 602-*-**31:** I didn't get a copy.

Michael Sheldon: I did send it, I'm not imagining this.

Laurie Goldstein: But Kay can't get email.

Michael Sheldon: Okay.

Laurie Goldstein: So, I think we need to get Kay copies of the meeting minutes and then anything that we send out

Michael Sheldon: Yeah, that's our fault.

Michael Sheldon: We'll make sure Trevor or Tara gets the minutes and that document.

Laurie Goldstein: Okay. Mike,...

Laurie Goldstein: Do you have any other updates from the hospital administration?

Michael Sheldon: Happy new year everybody. So the only real updates I have is that we're still actively in recruitment for some pretty high level positions including our chief medical officer and our director of human resources at the hospital. So those positions are posted and if anyone on the IOC is interested in seeing it, at the end of December, the hospital posted its 2024 fiscal year annual report to the department's website. it's up there for your review and download if you want to take a look at it.

00:10:00

Michael Sheldon: It's got some pretty interesting stuff in there showing a lot of the improvements that we're making and the numbers that we're seeing. So, very proud of what we've been accomplishing and that report I think does a good job of showing where we've been, and where we're going. That's all I have. Yeah. Yeah.

Laurie Goldstein: request. Yeah.

Michael Sheldon: And so we did add a section at the end with some recent notable achievements and some potential options for moving forward that would benefit the hospital and the citizens of the state. Yep.

Laurie Goldstein: Thank As far as patient visits, some of the things that have come up since the last meeting, one was a safety concern by a patient and when they wanted to come to my response, I think what Chuck was on with me is that they first have to voice that concern to the clinical team or the unit or the

Laurie Goldstein: unit PM. So, the hospital has the opportunity to hear the complaint and re and react to the complaint, the safety concern before really escalating to us. I don't know what the rest of the team members feel, but I thought that it's hard if someone comes straight to the OC without at least letting someone in administration or the team know that they felt unsafe. And I think that they went back and did that. And from what I've heard that they were moved to alleviate that safety concern. Any questions on that?

Melissa Farling: Yeah, Lori from I'm going to answer the question, but I presume the safety concern it didn't have anything to do I suppose with staff or...

Melissa Farling: anyone that they might end up telling. So that was not a conflict, right? Yeah.

Laurie Goldstein: Right. It was another patient.

Laurie Goldstein: There were Yeah.

Melissa Farling: Thank you.

Laurie Goldstein: And I see whether you're getting if the patient is in fear or has safety concerns and they're concerned from the staff, then it would be hard to say to that staff. I don't know, Mike, what's the procedure for that? Did they call Terra?

Michael Sheldon: Yeah, they can always reach out to Terra. they can file a complaint stating they like to be moved off to a different unit. and then we'll take that under consideration. Tara will go meet with the individual. and then we'll engage from that perspective. so there are avenues for that individual to state their concern without speaking directly to somebody on that unit or the staff member in question.

Laurie Goldstein: Okay, thank you. The other one was a little bit unusual. We have Jane here now and hopefully Janina will be on shortly. But in this other situation, there was a concern because of a safety protocol and procedure to make sure that the hospital remains a safe environment and that it's drug-free. And because of that, there were some inspections and some searches and some of the patients felt that their rights were being violated. Again, I think the details of which are if the hospital or staff have reason to believe that someone is bringing drugs or weapons or whatever that could be harmful to the patient or other patients or the environment that I think as an entity they have to follow certain procedures like they would in any hospital. And I think that's as much as I can say without revealing too much. but I think that Mike,...

00:15:00

Laurie Goldstein: if you do want to add anything.

Michael Sheldon: No. I think you stated it perfectly, if we have a reason or a suspicion to believe that we have some elicit activity going on, we have a responsibility to interject and ensure the safety and security of the overall facility. and when we do searches of the kind that you're speaking about, it is only done under the order of a doctor asking to have it done. So it's not something that we take lightly. We do have police policies and protocols in place to make sure that a specific chain of command is followed. so we are checking the boxes appropriately in matters like

Laurie Goldstein: Okay, thank you for other than that, anything else from the committee before we go into some overview of incident and accidents

+1 602-*-**31:** Am I able to distribute that to the patient?

Michael Sheldon: Yeah.

Michael Sheldon: No, you can definitely distribute it, K. and I. So Trevor, Tara, can you do me a favor and print out 10 copies of it and just kind of distribute it across the forensic campus so K doesn't need to go to Kinko or anything like that?

Terra Morgan: I will do it.

+1 602-*-**31:** All right. Thank you.

Laurie Goldstein: Thank you, Okay, let me First thing I was going to talk about and I'm looking at my other monitor, so in the assault perpetrators, we had again just one patient that was pretty assaultive. They had seven incidents and after that we had three that had three in three instances and then we had four that had two and then about six that had one. So it's what we have seen. I think the numbers of assaults by a particular patient seem to have gone down if I recall correctly the patients or patients since I don't know the names that had some I think cognitive decline and cognitive issues have now been moved to a more appropriate setting.

Laurie Goldstein: Is that correct Mike? Yeah. Thank you.

Michael Sheldon: Yeah. and…

Michael Sheldon: That was not recent. Those specific individuals that you're referring to actually discharged about 15 or 16 months ago, but we have seen a noticeable downward trend for assaults for seclusion restraints across the facility. and that is also mentioned in the annual report that I spoke of a few minutes ago.

Laurie Goldstein: One quick question. So, I know that not all the counties, Maricopa in particular, send a lot of their patients to restore competency to the hospital. Some of them keep them in jails and do their own program. But when you have patients that are there for restoration or if they're non-restorable and dangerous, do those patients tend to have highly assaulted behavior?

Michael Sheldon: It depends. Sometimes the individuals who are sent to us for restoration services almost always come in from outlying counties where in Arizona most of the counties do restoration services in their county jails. They have psychiatrists to do that work. so we typically get restoration patients from the outlying more rural areas of the state. Santa Cruz, Graham, counties like that, Mojave. so when they do come to us, they're restoration cases, they're typically not hyper assaultive, but they are quite sick when they come in because they have not been properly treated for their mental illness prior to coming to us.

Michael Sheldon: The individuals that have been deemed nonrestorable those folks typically come to us under a civil commitment order and yes those individuals tend to be more active on that front. It can be because of a number of reasons. Typically if someone is deemed non-restorable it's because of something outside of a psychiatric issue. It's neurocognitive disorder, it's dementia, traumatic brain injury, things like that.

00:20:00

Michael Sheldon: So yeah, they do have a tendency to be a little bit more on the higher end of the aggression scale.

Laurie Goldstein: Do you have the luxury of putting them in a place that separates them from the regular civil patients or…

Laurie Goldstein: the regular forensic patients? Or do you have to intermingle? Okay.

Michael Sheldon: Unfortunately, we're in a situation right now where we don't have the luxury of olating patient groups like that. we're pretty much operating at capacity. So anybody that we get, we just try to make sure we have a bed available to put them in, introducing somebody like that to the general mills is and most often is detrimental to the care for the rest of the population that we treat.

Chuck Goldstein: Mike, how many of your population are the people, who are found or that you're holding to be better restore competency? How many?

Michael Sheldon: yeah so Dr. Goldstein members, I believe there are three current patients in the forensic hospital who are here specifically under rule 11 for restoration services. and typically our restoration cases stay with us for about 90 to 120 days before we restore them and send them back to the county for trial. the individuals I can't give you an exact number for the folks that are under title 36 civil and…

Michael Sheldon: have a incompetent stand trial background I would say right now it's probably about a handful that we

Chuck Goldstein: That's…what I would expect. And to answer your question, Lord, these people that are not competent to stand trial are not competent because they fail at one of two points of law. I guess you would call it or competencies and one is that they understand the charges against them and the other that they are felt by the judge to be able to assist in their own defense, work with their defense attorney. So if they fail at either one of those two, that makes them incompetent to stand trial.

Chuck Goldstein: because that's a legal point. It does not go to the character of the person. So, I would not expect these people to be either more dangerous or less dangerous than the general population. No, that they're not usually any more violent than you would expect from the general population.

Laurie Goldstein: But what about the classification of people that are non restorable can't stand trial and they're deemed dangerous. they go through that other I'm talking about those people…

Chuck Goldstein: That's yeah,…

Laurie Goldstein: if okay we'll start with a few incidents and…

Chuck Goldstein: That's a different case because those people are already judged to be dangerous. So, you would expect them to be violent, Thank you.

Laurie Goldstein: accidents that looked a bit unusual one was ash 2024 4 3946 and it was an assault on sexual staff conduct which is unprofessional, immoral or abusive to patients or staff or visitors. The way that was written, I thought it was staff and sexual abuse, but reading through it, I think it was one patient that was acting inappropriately with another patient and let me see because in here they're talking and the patient saying they didn't hit him but inappropriately touched another patient.

Laurie Goldstein: Wasn't really clear...

Laurie Goldstein: why it was 3946.

Michael Sheldon: What number was this,...

Michael Sheldon: Lori? I'm sorry.

Laurie Goldstein: It seemed like it was between two patients.

Michael Sheldon: That may have been

Laurie Goldstein: So, I don't know why there was an unprofessional, immoral, abusive to patients that tagged on to the description.

Trevor Cooke: Yeah, Lori,...

Trevor Cooke: I just reviewed. I think that whoever submitted the IR selected something in error and my team did not correct it, but you are absolutely correct. It did not involve a staff member between two patients.

00:25:00

Laurie Goldstein: Okay.

Trevor Cooke: So, I will get that corrected now. I appreciate you bringing it to our attention.

Laurie Goldstein: Thank you.

Laurie Goldstein: Because I was looking and it just seemed like there were two patients in that staff. The next one was 3947. And this one had to do with a patient that was saying certain things and being very confronted.

Laurie Goldstein: They were confronting staff and when the RN asked a person to stop and to de escalate and they're trying to then that the patient was told that they were going to be root or threatening staff and at that point then the patient started punching that same person and a radio went flying but the note were saying that when telling a patient that they're going to be roou for behavior make sure that they're not in range to be assaulted.

Laurie Goldstein: I would think by that point you'd call a code and it did seem like they called a code gray, but it seems like that was after they started escalating and started to get physical.

Michael Sheldon: Yeah. members, as we've discussed several times in this venue and others, our initial action is verbal de escalation. We want to make sure we do that. some individuals in this situation may have called a code earlier than what happened in this specific case. It all comes down to the relationship

the staff member has with the patient. Some of them have really really good rapport and they know how to talk the patient down. others much. so it's a very kind of fine line they

Laurie Goldstein: The next one was 3978 and that was a medical alert. And what this one a patient was found in the bathroom having had a medical alert and then they were sent out. a question just for making sure that if they are just now starting to have seizures and if that's not something that can be addressed, what's the protocol? So there's a fine line between letting them have their privacy in the restroom and then there's the other side of and then finding them having seizures on the floor in the restroom.

Laurie Goldstein: How do you balance that once someone's had a seizure or has had seizures?

Michael Sheldon: So it's very similar to the folks that we would determine as being high fall risks. So if someone falls repeatedly or has a well documented ongoing history of seizures, we may put them on a one on one to ensure their safety to make sure someone is within reach to potentially catch them if they start to fall or to assist them if they begin to seize. I don't believe that this individual has that history though. we'll send them across the street. They may do a neurological workup on them, see if there's anything that we need to be concerned about. see if it's medication related, whatever it may be.and then we'll reassess their risk and then decide how to proceed from that review.

Jane Jepson: Yeah, I have a follow-up question. Michael, I'm just curious. So, is that what you did in this case? Did you refer this individual for a neurological workup as part of the aftercare?

Michael Sheldon: On the top of my head I can't answer that question right now. I haven't gone through all the notes to see what happened with this. it would not necessarily be us referring for neurological assessment. It would be the physician at Valley Wise u making that referral if he or she feels is necessary based on the patient's condition. I haven't had a chance to review all the notes to see what this individual went for.

00:30:00

Jane Jepson: Okay.

Trevor Cooke: I can jump in here. Yes, this patient was referred for neurological consultation and that has already taken place.

Michael Sheldon: Thank you.

Laurie Goldstein: morally abusive to patients, staff or visitors. So in this situation a code gray was called and the patient was put in a physical hold with multiple staff in a seclusion room with the patient and the patient continued to spit toward staff. Then they got a spit mask. I didn't know you guys had those and placed them over the patient's face, but a BHT later identified was holding the patient and began an exchange of words with the patient and they appeared that BHT was pretty upset with having gotten spit upon and having a struggle. So they were responding in an inappropriate manner towards the patient in an escalated tone which then caused the The patient they were in a back and forth in an aggressive manner and the other person whoever is writing this recognized that BHT was upset and offered to just step in

and take over and asked them to kind of move out. So that was good that this person writing saw that this was not a healthy interaction with the staff towards the patient.

Laurie Goldstein: It was escalating and it was a shift commander maybe.

Michael Sheldon: Yeah, that's the security officer…

Michael Sheldon: who wrote the incident report. The individual in question is no longer with the hospital.

Laurie Goldstein: Yeah, that's what I was going to say.

Laurie Goldstein: I know we've been frustrated before when we saw staff acting in ways we didn't think was therapeutic,…

Laurie Goldstein: But at the bottom line after this went to review, it said following an investigation, it was determined that BHT is designed to not return. and it was made in alignment with their hospital policies and procedures. my question was this a traveling nurse or registry? not nurse tech. Okay. And that…

Michael Sheldon: Yes. Yep.

Laurie Goldstein: Why was it so easy to say that this person can't come back? I just wonder. I assume it's harder if an employee is acting in that manner, but I was glad to see that it was immediately acted upon. too bad Alice wasn't here. She'd be very happy. So, okay, let me see This one, next one is 4028 and it was an attempted suicide. So, for this, it's on December 12th. And the suicide the patient was voicing concerns about harming themselves and that they wanted to die. And then the patient grabbed the phone cord and quickly wrapped it around their neck, not tight. And when that happened, a code gray was called. The patient was put into a restraint chair, taken back to the seclusion room. In the medical notes, it said that the patient was admitted to the state hospital while still under one-on-one staff at a previous site facility due to self harm. and She's on CO and LOS and had been during the above incident with the phone cord. In addition, the patient has to have a sterile room, no objects smaller than their fist, wear a jumpsuit, only finger foods with no utensils, and they have a behavioral health plan with privileges and rewards. It's been effective in cases like this. So I know line of sight means I have to see them and cos is what again. Okay.

Trevor Cooke: It depends on the type of COS LOS they're on. but in this case for DTO or DTS behaviors, it's three feet. That's correct.

Michael Sheldon: And then just for clarification so the committee knows our phone cords are only 12 in long. So this was not a situation…

00:35:00

Laurie Goldstein: Okay.

Michael Sheldon: where the person could wrap it around their neck multiple times. It's a ligature resistant phone. So it was more of not a suicide attempt versus kind of making the Say it again Trevor.

Trevor Cooke: a suicide gesture is more.

Michael Sheldon: There you go. Yeah. Exactly. Nope.

Trevor Cooke: We just don't have the ability to code that way yet. But one day.

Laurie Goldstein: And so the next one 4036 was the same. patient ID again, it was attempted suicide. I'm trying to look at times. One of them had time, but it was a day later and the same patient was in the day room by the phone when they appeared. They were on the phone and then they used the phone and used the phone to start banging the head upon the phone.

Laurie Goldstein: And it was the same one that was trying to harm themselves with the phone cord. At that time a medical alert was called and the patient was sent to the hospital one on one. so if I go down to the nursing notes, it said someone noticed the cord was wrapped around her neck after they removed the phone cord and in a BPH. they placed her. It's all in code here. and they appear to pass out.

Laurie Goldstein: So, a medical code was called and the medical Yeah.

Michael Sheldon: BP B.

Michael Sheldon: Yeah, BPH is a brief physical hold.

Laurie Goldstein: Then they appeared to pass out.

Laurie Goldstein: cold medical on call doc was on the unit within a minute and they took the vitals BP 120 over 116 oxygen 97% they called 911 and they sent the patient to the hospital. But what was interesting is they said that the patient was using to bang their head on the phone and then in the notes it said they were wrapping the cord but while this was happening the patient also tried to hurt themselves with the phone cord.

Laurie Goldstein: So in this case, what do you do if the patient continues even if they're on COS and LOS?

Laurie Goldstein: Do they have to stay away from the phone or something? I mean, I don't know what to do.

Michael Sheldon: So we definitely don't want to do anything that would prohibit the patient from contacting friends,…

Michael Sheldon: family, guardians, legal counsel, whatever it may be. but with someone like that who's doing things like this, if it's DTS behavior like this it would be most likely obviously assuring their immediate medical wellness, which is why I think they went to Valley wise in this case. but it may be something if it doesn't elevate to where it is right now, that would be a situation where we would look at potentially restraining the individual to make sure they can't self harm or do any kind of physical self-injurious behavior. and we want to make sure that we do that only and when needed. That's kind of like that last resort that we want to go to.

Laurie Goldstein: The last one that stood out to me was 4228 and this was patient refusing redirection, self- abuse, self-injury, significant physical changes in a patient and other significant irregular events. So the first thing it says is an urgent KUB ordered incident involving code gray and sent to the Valley wise emergency room.

Laurie Goldstein: So, I had no idea what Kub means.

Michael Sheldon: Trevor, Dr. Ghosting.

Michael Sheldon: I don't know that either.

Trevor Cooke: It's abdominal pain. They were sending her out to have things checked in her abdomen. And you'll see why as you read through the rest of the IR.

00:40:00

Laurie Goldstein: Yeah, I thought that's...

Trevor Cooke: I don't know

Chuck Goldstein: Is this an X-ray,...

Trevor Cooke: what the acronym stands for.

Laurie Goldstein: what I thought too. No, this is a patient and...

Chuck Goldstein: L? Okay,...

Michael Sheldon: Okay.

Laurie Goldstein: The first thing says urgent KUB orders.

Trevor Cooke: Yeah, it's great.

Laurie Goldstein: .

Chuck Goldstein: That's an abdominal X-ray.

Laurie Goldstein: So, the patient as you read down, I just didn't know what KUB the patient as you read down, they complained of 10 out of 10 on a pain scale in their abdominal. and they described it as deep shooting and stabbing. They had already had some medication from the nurse. The Tylenol provider was notified and they were referred to an order for an urgent KUB. They went to the appointment for that urgent KUB and came back and it was reported that they didn't find anything. So the patient was asking what now?

Laurie Goldstein: because the patient still had 10 out of 10 and they were trying to walk them through what was going to happen at that point I don't know whether it was atypical or not but the hero staff witnessed the patient breaking off the right temple of their glasses long piece that goes over the ear at the hinge swallowing it and the screw connecting to the temple to the rim was found to not have been swallowed but the was discarded out of their reach. They were escorted and they were still complaining 10 out of 10 and the provider was called back. So there's orders now for a behavior plan, sterile room, jumpsuit, nothing smaller than fist. And they tried to view everything prior to being transported to Valley Wise. So on this, what happens? I mean, again, this is not my domain, but if someone's breaking their glasses and swallowing, you want them to be able to see, but how do you mitigate that so they don't self harm? Can they do goggles maybe?

Trevor Cooke: So, I don't know if we have goggles or not. I think the hope is that one to one can intervene as quickly as possible. which is what our staff are trained to do. Unfortunately, this particular patient was rather fast and so even though they were only 3 feet away, this patient was able to do that. but there are things again such as a sterile room, being in a jumpsuit. if needed, they could be put in mitts or have a helmet on. different things to that nature.

+1 602-*-**37:** goggles for scuba that have a prescription and…

+1 602-*-**37:** I imagine those are a lot more expensive than prescription glasses. I don't know what other alternatives there are.

Laurie Goldstein: I don't know.

Laurie Goldstein: Are there any questions about the committee or any comments over any of the instances that I brought up?

Chuck Goldstein: Don't.

Laurie Goldstein: Okay, here's

+1 602-*-**37:** I'm just a little stumped following the piece. What's it called?

+1 602-*-**37:** You just I the arm of the glasses. It's got a different name. How does one swallow that? Was it swallowed entirely?

Laurie Goldstein: I do know and I mean Chuck can speak to this too. People that want to swallow, you'll turn your back and Crystal has worked as a site nurse. They can swallow a spoon faster than you can. Right, Crystal? I think J.

Laurie Goldstein:

crystal Fox: Yes, I've had people swallow their dentures.

crystal Fox: I've had sweet people swallow a lock. I've had people swallow just things that you'd never think possible.

+1 602-*-**37:** No, thank you.

crystal Fox: And they are fast. They are extremely fast.

Laurie Goldstein: Yeah, Jane, you had your hand up.

Jane Jepson: I did, I'm just curious.

Jane Jepson: So for the outcomes once the incident occurs and then there's intervention that takes place then in every case that we discussed was that individual brought back to the hospital with kind of the interventions that you described were there any of these cases that resulted in a removal from a transfer from the hospital.

00:45:00

Trevor Cooke: So in these particular incidents, these patients all returned fairly quickly.

Jane Jepson: Okay, thank you.

Trevor Cooke: As far as some of the interventions that we discussed implemented upon their return from Valley Wise, the answer would be You're awesome.

Laurie Goldstein: more than one had mailed off correspondence to Larry at the IOC to pass on to the committee. There is a concern and there were grievances and complaints filed with allegation that reducing patients' work in the therapeutic work program to save money is unethical, unacceptable. and they're talking about the therapeutic work program is anticipated to undergo changes that will include setting standards and expectations. Once those changes are in place, the amount of work hours that the participants are able to utilize per week will be revisited.

Laurie Goldstein: So, Mike, as far as the work program, is it the provider not going to provide enough hours or is it going to be, based on if patients are adhering to plans or what's the reason patients are getting their work hours reduced?

Michael Sheldon: the program. so it is a matter of funding. so we do pay the patients minimum wage to work in that program. So the provider in this case is actually the state hospital. so we want to look at this program to make sure that we're maximizing our funds, and that the hospital as well as the patient are truly benefiting from the program. So, the patients are learning skills that are going to help them once they discharge from the hospital.

Michael Sheldon: and it's meaningful and appropriate and is in alignment with their treatment goals. therapeutic work program just so we're kind of on the same page is not it is an earned privilege. so I just want to make sure everybody understands that we're not violating anybody's rights in this situation. we're

under no obligation to provide this program. It's entirely based on funding and based on the appropriateness and necessity to help the patients.

Michael Sheldon: so that being said, yesterday, Trevor's team did host a focus group with, nine or 10 forensic patients to get their feedback and input about how the program, could possibly be transformed in the future, looking for things like criteria to be put into the program, what types of opportunities should be in that program, and kind of rules around it. The last time this group met, I think I made a comment along the lines of we really want to make it appear to be a real world kind of job scenario, right? Where the patients need to be on good behavior to participate in this program to earn the right to be in that program and if the patients do not participate in treatment are aggressive assaultive then they should be fired from the program just like any of us would be in the real world. so that's where we're heading with this. Hopefully I'll have in the next week and a half or so some tangible recommendations that come out of that focus group. and then I'll sit down with the rehab team and we will go from there.

Laurie Goldstein: and they're in supported employment. If they're symptomatic or if they're for whatever reason under stress, certain behaviors come out or whatever, usually their coaches will help and if they're having racing thoughts or whatever their issue and they need to leave work, they're pretty accommodating with that. Is that I mean I know it's a fine line between willfully acting out or is this a sign of you having symptoms of your mental illness? So are they going to adjust for that like they do in the supported employment in the outside

00:50:00

Laurie Goldstein: Okay.

Michael Sheldon: Yes, Lori.

Michael Sheldon: So, it's not so much if someone is responding to internal stimuli symptomatic of their mental illness, that individual, first of all, most likely would not be participating in the work program at that point in time. but they will obviously take that into consideration. if it's a result of a stressor from their psychosis versus a behavioral outburst, then they will take that into consideration.

Laurie Goldstein: Thank you. Anything else from the committee before now?

Laurie Goldstein: We also have an executive session, but the way it goes is that this is still the main session. If you have anything else to discuss before going to public comment, we will adjourn and go to executive session. And I'll put Larry sent that out, but if you need the executive session, I'll put it in the chat. We go to executive session to discuss the items that Barb and Alice wanted to discuss from some of their patient visits and then we adjourn out of that come back to this meeting and adjourn. Okay.

+1 602-*-**31:** Do you have the phone number and…

Laurie Goldstein: Yes. Yes.

+1 602-*-**31:** the extension? What is that? Yes. Okay.

Laurie Goldstein: So it's dial 1 470 268 2393 and the pin is 248 057 653 lb.

+1 602-*-**31:** I think it's 470-2682393.

+1 602-*-**31:** P is 248057653 pound. Okay.

Laurie Goldstein: pound. Yes.

Laurie Goldstein: Okay. Jane

Jane Jepson: One final question in just processing the information that was shared with us regarding the incidents.

Jane Jepson: Once for those patients that had the more aggressive intervention in terms of being put into a suit and having the one interaction. Could you give us an idea of what is the average length of time that is appropriate and then are there changes in medication or what's the strategy then to reintegrate that person back into the normal population with the normal kind of conditions of residency.

Michael Sheldon: Hey Jane. So, it's entirely dependent on the individual and the behaviors that they're exhibiting. typically if somebody goes into a jumpsuit, that is not something where they're in it for, 5 hours or whatever. it could be weeks as long until our medical staff is confident that the person can be that we should attempt to kind of reintegrate them. and that's not a great word to use because they're still within the general population of the hospital. They're around other patients. They're just in specific clothing. so it is very dependent on their behaviors.

Michael Sheldon: and the interactions that they have with the staff and with other patients. and your question about medication changes that is constant and continuous for all patients, not just individuals in this situation. We're always reassessing if the medications are appropriate to address the psychosis of our folks. So, we're always looking at potential medication changes that may be necessary to help these folks out.

Jane Jepson: Thank you.

00:55:00

Laurie Goldstein: Anything else from the committee before we go to public comment and then executive session and then back to public Crystal.

crystal Fox: So I didn't know if this was public or if it's part of the committee, but kind of back to the non-restorable individuals that would have been forensic had they been able to go through the process. I'm not sure that there isn't more than that. unless there's been a lot of discharges over the last few years. If you go way back to some of our longtime patients. but the other thing I kind of wanted to mention about the non-restorable individuals that are on the civil side, I never saw a difference in their dangerousness and stuff so much, but what there is a difference is the length of stay and the ability to discharge.

crystal Fox: So that's my concern is if we continue to accept people that are in that criminal realm onto the civil side, it's going to be a forensic hospital all the way around. It's going to be the forensic side and then it's going to be the nonrestorable side. It's not going to have civil beds just because it's so difficult to discharge unless we can get those secure PEFs or some kind of a different setup for them. So, maybe I don't know if somebody could go back in those charts and actually get a solid number of how many people are at the hospital that went through the criminal system first and then were just non-restorable. I mean, I'm even thinking back to the individuals that were there and are my age, like 60s.

Michael Sheldon: No.

crystal Fox: So yeah.

Laurie Goldstein: So two comments. First, Crystal is an IOC member, so we can speak and…

crystal Fox: Okay. Yeah. So, it…

Laurie Goldstein: She can Number two that Crystal is a psych nurse and she was at Arizona State Hospital working there for 30 years. She no longer works here. She works at another facility. So when she refers back to when she actually worked there for a long time,

crystal Fox: it was a long time ago and my numbers could be off, but again, I'd be interested if and again, I can't really make a motion or anything, but if the committee would consider and I know you might be able to answer me about getting that number that might have gone through the criminal system first or are still in the hospital.

crystal Fox: And then also considering the fact that those individuals' length of stay and ability to discharge could in the future if this is the way the courts are going to do it could become just a forensic hospital with no civil beds and I know that would take a while but that's a fear of mine.

Chuck Goldstein: correctly. He asked Mike Michael to estimate how many people were in that category you're talking about non-restorable and on the civil side. I'm not sure whether they came through title 13 or title 36 but they're non-restorable and they're kind of like inhabiting the Arizona state hospital they're living there and I thought you told him Michael that that was about 15 to 20 patients

Michael Sheldon: that. Yeah,…

Michael Sheldon: That's probably a close estimate, Dr. Goldstein. That's not something that we readily track because they're under a civil commitment order. So we don't have a designation in our health record that would say this kind of designation as an encounter to stand trial in the past. and I think what Crystal said is very important. There are other states in the country that are actually getting sued right now because of situations like this where they've had to sacrifice civil beds to take on the incompetent stand trial non-reusable population.

Michael Sheldon: So there's a very kind of small slice of resources and everyone is pulling to try to get a little bit of it. And if for one population to grow, another one organically needs to, it's a zero sum game, I guess, is what I'm trying to say.

Laurie Goldstein: prosecutors and the judicial system and they really want a place for people to stay for a long period of time. They should utilize and fund another building. I mean, it's not right. We have the fewest number of civil beds in the country. We don't need to be filling them up with people that we know will stay there probably for the rest of their life and take away those scarce few. We have one bed per 100,000 and you should have 50 to 60 per 100,000. So, we don't need to lose any more beds.

01:00:00

Chuck Goldstein: I was under the impression that this had been discussed and…

Laurie Goldstein: Better.

Chuck Goldstein: that there was some movement to move these nonrestorable patients to other facilities. Is that incorrect? .

Michael Sheldon: I guess it depends on their medical status. So if we can no longer provide care for them

Laurie Goldstein: So I think the takeaway is that we should try to advocate

Michael Sheldon: because of increased medical needs then they may be transferred to a skilled nursing facility for ongoing care. but even those beds are really limited. They got to get qualified for all techs. which everyone knows is very difficult to do. So yeah, we do have limited options. but it's very difficult to do that.

Laurie Goldstein: at the legislature and at the governor's office because I understand there's a problem: the county prosecutors want a place to send people that they have deemed nonrestorable, dangerous and…

Laurie Goldstein: in some instances I think they've just let them out but now they want them to go somewhere but again we need a better solution Jane

Jane Jepson: Yeah, I want to tag team a little bit with Crystal's thoughts…

Jane Jepson: because I heard her say, is it appropriate to make a motion? And I'm wondering if we have a p is the information that we received right now on the number of patients that fit this criteria.

Jane Jepson: Do we need a motion to make sure that we get a precise count and then to understand of that count how many ultimately get transferred to a skilled nursing facility and…

Jane Jepson: under what conditions they are transferred.

crystal Fox: So the problem with Jane is that once they become nonrestorable they change it to title 36.

crystal Fox: So what Mr. Sheldon was saying is it's hard to track it. So, I know of patients that were probably admitted in the 1990s to 2000s that I don't know if they could adequately track. I know that they've done a really violent crime and they likely went through the criminal justice system. but they've been title 36 for so long now. I don't know how much of that history is in the chart. I could be wrong. I don't know if somebody else wants to answer that, but I do think right now there's two conflicting bills. One of them is from I think the state or somebody else that they're going to allow ash to be basically the dumping ground. I don't want to say dumping ground because all the patients deserve care in a hospital. but they're going to use ash for this. And then there's another bill out there that says that the two can't be mixed. So, there's two conflicting bills right now that it's going to be interesting to see how that plays out. If you get them where they can't be m What do you think? This is my question. What do you think about opening the top floor of Ironwood for non-restorable individuals?

Laurie Goldstein: What? Yeah.

Laurie Goldstein: Want the Yeah.

Michael Sheldon: That's still the civil campus.

crystal Fox: So you still couldn't mix them.

Michael Sheldon: So, right.

Laurie Goldstein: And the other thing, Crystal, the whole reason for the separation of populations for the ESPRFs is that it's a whole different ball game when you have a hospital, whether it's the Arizona State Hospital or Valley Wise or any hospital where you have some patient that is acting out, you have a show of force. If you are in a residential setting, whether it's a birth or whether it's a secure birth, which means it has a nice gated area, you don't. You don't have that kind of staff. You have one or two behavioral texts. You have no real security. If they're dangerous and violent in a hospital, the hospital can react. If they're in a residential setting and they're assaulting people all the time, I don't see how that works.

01:05:00

Laurie Goldstein: So, I think the providers don't want to provide people that just need time where they can't leave while they get their medications take effect and their therapy takes effect so they can step down to a non secure versus people that might have to live out their life and may act out. Thanks. any other comments on that?

Jane Jepson: good reminder.

Laurie Goldstein: So remember, go down to the legislature when their bills are being heard. It's important. And So any other discussion before we go to an open public forum, public comment? And remember for

public comment we're not the treatment team. So we're not addressing your specific treatment. If you want to bring up an issue, whether it's unit safety or lack of particular treatment that you feel that you should be getting, things like that as a group, but not your specific treatment. That's the right forum to bring it up.

Laurie Goldstein: And also, it's not a form to discuss that you don't like your doctor or your nurse, those kinds of specific details. And with that, are we going to open for public comment? Do we have anyone from the public that'd like to make a comment? quiet tonight. So, anyone that isn't part of the IOC, if you'd like to say anything or any patients that are on, this is the opportunity to talk during public comment, remembering we cannot respond just listen. Hearing none, I guess we can go to our executive session. We will see you in a few minutes and executive session. Thank you everyone.

+1 602-*-**37:** Thanks Laurie. Bye-bye.

Laurie Goldstein: Thanks for joining our IOC. Thanks.

02:00:00

Laurie Goldstein: We're trickling in. Barb and Kim.

Lawrence Allen: Yes.

Laurie Goldstein: and hopefully Barb and…

+1 480-*-**66:** here.

Laurie Goldstein: Kim also, but we have a quorum so we could welcome her back to the Arizona State Hospital IOC Meeting. . Hi, Kim. We just are coming out of executive session and we do have a few things to vote on. One we have a motion to get some followup on what are the approved noise cancelling headphones and blue light glasses for patients that have had some of that type of equipment confiscated. So, we do want that. Do I have The motion? We want a list of noise cancelling headphones and…

Chuck Goldstein: What is the motion?

Laurie Goldstein: blue light glasses that are approved and that list provided to us and to the patients.

+1 480-*-**66:** I second the motion. I

Laurie Goldstein: Okay. All in favor?

Jane Jepson: I and…

Jane Jepson: May I make a recommendation,…

Laurie Goldstein: What? Yeah, sure.

Jane Jepson: Could because I know this is an issue that's been aging for a couple of months.

Jane Jepson: Could we say that within 14 days? Can we add that to our motion that we'll get that list within 14?

Laurie Goldstein: Can we put a time restriction?

Lawrence Allen: on the response.

Laurie Goldstein: Yes. Okay.

Lawrence Allen: I'm sorry. yeah, the time restriction is 21 days.

Chuck Goldstein: Very good.

Lawrence Allen: So you should have a response back before your next meeting.

Laurie Goldstein: All in favor?

Jane Jepson: Hi.

Chuck Goldstein: right.

Laurie Goldstein: I Motion passes. The second one, we wanted the hospital to provide their policy and their process for non-indigent patients that may owe money for prepaid medications or services.

Laurie Goldstein: What is that process and has that been explained to the patients? And can we see those processes? That's a mess of a motion.

Chuck Goldstein: Yeah. …

Chuck Goldstein: The motion more concisely is we make a motion that the hospital provide us with their process for recovering funds from patients that have the means to have funds and…

Chuck Goldstein: and exactly what that entails and how they go about informing the patients that they are doing this. Right. Not that I remember.

Laurie Goldstein: Do we have a second?

+1 602-*-**31:** Second.

Laurie Goldstein: All in favor? So, that motion passes. Do we have any other motions from the executive session that we'd like to propose?

barbara honiberg: I thought there was one more like it was towards it was with one the second to the last or…

Chuck Goldstein: Yeah, I thought so too, but Remember?

Melissa Farling: The complimentary.

barbara honiberg: the last patient …

02:05:00

Laurie Goldstein: Was there a desire to understand…

barbara honiberg: no, I think that's an alternative to me…

Laurie Goldstein: what complimentary services or alternate alternative medicines are acceptable on the campus. Okay.

barbara honiberg: if I would phrase that as a motion.

barbara honiberg: I think it would clarify things that we get information on what complementary and alternative methods are available which if any can be done or…

+1 602-*-**31:** All right.

barbara honiberg: have or can be

Jane Jepson: I second the motion. I

barbara honiberg: at Ash. That was my motion.

barbara honiberg: I Okay,…

Chuck Goldstein: Wow.

Melissa Farling: Thank you everyone.

Laurie Goldstein: And with that,…

Laurie Goldstein: I think we're about to call for adjournment.

+1 602-*-**31:** Motion to adjurnn. Thank you too,…

Laurie Goldstein: Do I have a second?

barbara honiberg: second. Bye.

Laurie Goldstein: All in favor? I. Thank you guys for all your hard work.

+1 602-*-**31:** Lori. Byebye.

barbara honiberg: Thank you.

Laurie Goldstein: Okay.

barbara honiberg: Thank you. Byebye.

Lawrence Allen: Thank you everybody.

Laurie Goldstein:

Laurie Goldstein: Take care. Bye. Bye.

Meeting ended after 02:06:46 👋

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