Need for a State Based Quarantine Facility:

Report to the Joint Standing Committee on Criminal Justice and Public Safety

in response to P.L. 2007 C. 359 (LD 1290)

March, 2008

Background

This report has been prepared in response to P.L. 2007, c. 359, which effected certain changes in Title 22, Ch. 250 pertaining to the authority of the courts to order persons subject to involuntary commitment transported to health facilities for care and treatment. The legislation arose from L.D. 1290, an initiative by the Department to enhance the enforcement of its public health measures. The case which precipitated the legislation was the "Portland TB case" in which a transient adult male with pulmonary TB escaped immediate apprehension due to technical problems in the execution of the civil arrest warrant. The Legislature subsequently ordered the Department to coordinate a study of potential secure facilities in which to house and treat significant public health cases, and to report its findings and recommendations to the Joint Steering Committee on Criminal Justice and Public Safety by January 31, 2008. This report summarizes the issues and complexities of assuring isolation and treatment for a noncompliant person who presents a public health threat.

The "Portland TB Case"

The practice of isolation and quarantine to prevent the transmission of tuberculosis (TB) or other infectious disease entities varies considerably from state to state. Recent cases nationally and within the State of Maine have dramatically revealed the unevenness of these practices and the controversies surrounding the laws and interpretation of laws intended to protect the public from infectious patients. They also point to the need to find a secure placement for those who are noncompliant with a prescribed treatment regiment.

A recent noncompliant case of TB in Maine is illustrative of the many complex issues confronting the public health community when attempting to deal with such a scenario. In November 2005, a homeless man from another state who had previously been incompletely treated for TB arrived in Maine and lived at a homeless shelter in Portland. The man had multiple incarcerations at the county jail between December and June of 2006. In June, he was found to have single drug resistant tuberculosis and was subsequently admitted to the hospital. This drug resistance developed because the patient had received intermittent treatment (loss to follow up), prior to moving to Maine, allowing drug resistance to develop. More than 100 persons were exposed to TB at the shelter and at the county jail and transmission to six homeless men was demonstrated.

The patient remained hospitalized for two months, as a team of public health professionals worked with the hospital discharge team to try and identify an environment where the patient would feel comfortable and where a secure enough environment would be in place to ensure completion of a minimum six-month course of therapy. However, despite public health efforts to work closely with the patient to educate him on his disease and to work with him to ensure that the necessary antibiotics were administered appropriately, the patient declared that he would not participate in treatment after leaving the hospital. Because this patient represented a public health threat if left untreated, with further development of drug resistant TB of great concern, a court order compelling treatment was obtained and the patient was ordered by the court to be admitted to a non-secure long term care facility to complete therapy. After eight days, the

patient eloped from the facility. An arrest warrant was issued on September 21, and after three days the patient was arrested and temporarily housed at the county jail.

The District Court subsequently ordered the patient to complete treatment in a secure setting, and because such a setting was not available in Maine, the patient was transferred to the Lemuel Shattuck Hospital Tuberculosis Treatment Unit in Boston, Massachusetts on September 27th, where he completed treatment in March 2007.

Such a case, as well as the recently publicized case of TB of the traveling Atlanta lawyer suggest that public health and the community it serves would benefit from having specific standards and best practices defined to address the complex issues involved in individual isolation of contagious persons. LD 1290, introduced in the 2006 legislative session, "An Act To Enhance Enforcement of Public Health Measures" addressed the issue of timely arrest warrants for individuals who violate court orders for involuntary treatment, and granted the Department a realistic mechanism to arrest and detain public health cases for short-term placement. The Criminal Law Advisory Committee tasked the Maine CDC to authorize the issuance of an arrest warrant by the Superior Court in the event of a violation of a public health measure or prescribed care order. The bill also requires DHHS, in consultation with the Department of Public Safety, the Maine Emergency Management Agency, the Office of the Attorney General, the Criminal Law Advisory Commission and the Maine Sheriff's Association, to evaluate present procedures for placing persons in violation of public health orders into custody and to review the feasibility of establishing an in state or out of state secure residential treatment facility for persons determined to pose imminent significant public health risks.

When we were faced with our noncompliant homeless TB case in August 2006, hundreds of hours were expended by the TB program coordinator, the TB medical director, Maine Public Health Nursing, the Maine CDC administration, the Maine DHHS administration, local government, hospital officials and the State Attorney General's office, who all came together to try and find the least restrictive environment for ensuring completion of drug therapy. Maine does not have a secure setting outside of a psychiatric or a correctional facility. As our Maine case demonstrated, the Commissioner was unwilling to use a state psychiatric facility for placement of a person who potentially posed a public health threat. The Maine Sheriff's Association has made it clear that they would not support placement of such a person within a correctional facility. Because a correctional facility is not the optimal place for someone who is infectious but who does not require the specialized care of the hospital environment, and because in Maine we are legally not able to utilize correctional facilities for such a purpose as noted below, jails would only pose a short-term answer until a secure facility for a patient is identified.

Sec.11.22 MRSA §807, sub ¶, as enacted by PL 1989, c 487, §11, reads:

For purposes of carrying out this chapter, the Department may designate facilities <u>and</u> private homes for the confinement and treatment of infected persons posing a public health threat. The Department may designate any such facility in any hospital or other public or private institution, other than a jail or correctional facility. Designated institutions must have necessary clinic, hospital or confinement facilities as may be required by the Department. The Department may enter into arrangement for the conduct of these facilities with public officials or persons, associations or corporations in charge of or maintaining and operating these institutions.

Further, our public health emergency preparedness plan should include a component for treating persons whose behavior presents a public health risk. Sec – 22 MRSA§§ defines the behavior of an infected person who poses a public health threat as:

(1) The infected person engages in behavior that has been demonstrated epidemiologically to create a significant risk of transmission of a communicable disease;
(2) The infected person's past behavior indicates a serious and present danger that the infected person will engage in behavior that creates a significant risk of transmission of a communicable disease to another;
(3) The infected person fails or refuses to comply with any part of either a cease and desist order to a court order issued to the infected person to prevent transmission of a communicable disease to another.

In addition to the issues posed by individual noncompliant persons, during the pendency of an extreme public health emergency, it will also be critical to identify a cohort of available secure facilities to treat uncooperative infected patients. Ideally, most patients will cooperate and not require law enforcement supervision. The 2006 TB noncompliant case was eventually aborted because Massachusetts has a 12-bed TB hospital, which accepted the patient. However, if the next public health threat was SARS, avian influenza or some other potential infectious disease event, we might not be so fortunate.

At the very least, Maine needs to identify a list of viable secure placement options, and decide which options will be utilized in the event of an bio-emergency or noncompliant individual subject to involuntary treatment orders.

However, several complex issues need to be considered in the context of designating a secure setting for treatment.

- **Assuring Equity of Case Management**

  Two simultaneous cases illustrate the vast differences in applying public health law. In the case of Andrew Speaker of Georgia, a well-to-do professional, all possible measures to convince him to voluntarily accept the medical advice of his doctors were brought to bear including involving family members and providing transportation to the nation's premier hospital for treating drug-resistant TB. In the case of Robert Daniels of Arizona, an indigent Phoenix man, he was booked and incarcerated in the local jail, had 24 hour surveillance with the lights on, had his personal property such as a radio taken away, was denied showers, was not given permission to talk with friends or the press, and was essentially in lock down for 12 months. Although both men were nonadherent to infection control measures, one person intentionally eluded travel restrictions while the other had an unclear understanding of the risk he was placing other persons by not wearing a mask. Why was the isolation and treatment measures taken for these patients thought to have XDR-TB so different with one patient incarcerated with a criminal status?

- **Defining infectiousness**

  The Speaker case raises the issue on what grounds is a person with tuberculosis a threat to the community? Although TB isolation laws often refer to "infectious TB", some TB programs have applied quarantine laws to patients with sputum smear negative TB who during treatment becomes nonadherent. The decision to isolate Speaker was based less on his degree of infectiousness and more on the strain of TB he was infected with. What is the risk to other individuals? Our Maine case had been treated on an inpatient basis for 13 weeks; was considered to be noninfectious at the time of discharge from the hospital setting to a LTCF; but concerns regarding relapsing into an infectious MDR TB case prompted subsequent court action.

- **Defining Noncompliance**

  With regard to determining noncompliance; nonadherence or noncompliance, a psychiatric assessment would have to be done to determine whether a person is competent to make health care decisions and if found to be incompetent, than a psychiatric facility would be a more appropriate facility for placement. That said, if elderly individuals, who are impaired neurologically (ie dementia) represented a public health threat, how would competency be assessed when more than one or two cases were involved?

- **Protecting the public health – Enforcement concerns**

  The police powers of public health officials are defined in statutes that give that power to state officials. What measures can be taken in the face of private providers who are unwilling to work with public health practitioners, who fail to implement directly observed therapy or fulfill reporting, discharge planning, and treatment plan requirements? At the same time if measures taken to protect the public health are too draconian as to drive infectious patients "underground" to avoid government action, there could be significant societal implications.

- **Ensuring individual rights and due process**

  The need to isolate contagious individuals is a judicial process that guarantees equal protection under the law and safeguards including the right to an adequate written notice detailing the grounds for quarantine, the right to a hearing before an impartial decision maker, the right to appeal, and the right to a least restrictive confinement. The TB control health order must state the individual assessment of the person's situation or behavior that justifies the order including the measures attempted and their lack of success.

- **A regional approach to community patients across state lines**

  In the Northeast, one model that has taken on the scope of a regional isolation TB unit is the TB Treatment Center at the Shattuck Hospital in Boston. The Shattuck is a closed facility that has a multidisciplinary team with interpreters and providers sensitive to cultural differences. The unit is able to address complex treatment problems in addition to behavioral and adherence issues. The facility

was used by Maine for our 2006 homeless TB case for a period of seven months because Maine does not have an adequate facility to quarantine a noncompliant patient. Limitations of this model include the fact that citizens of other states have to be voluntarily committed to the Shattuck; (and voluntary agreement is not something that all noncompliant persons necessarily provide) the facility has a limited number (n=12) of beds available; the facility decides which patients to accept, which is not necessarily based on another states' needs for placement; the facility is not inexpensive; and other states are able to assume the legal liability associated with another states' resident.

- **Financial considerations: who pays?**

  Is this period of resource restricted TB prevention and control, prolonged isolation in a hospital or other restricted environment raises the question of who pays for the costs associated with enforced isolation, The costs of home isolation are usually borne by the patient in the form of lost income. Patients with insurance may not have hospital charges paid for beyond their immediate infectious period. Is the state the payer of last resort? And is so, which agency within the State would pay? (Mental Health? Public Health? Medicaid?)

The field of TB isolation and quarantine is a complex balance of protecting the public's right to be free of exposure to dangerous pathogens and the individual's right to have their freedom and person protected from unwarranted incursions and restrictions by the state. Our 2006 TB case reintroduced the debate regarding collective welfare and civil liberties. As a practical matter, what we really need is a place to use on those rare occasions when we have to involuntarily isolate the patient who presents with the occasional noncompliant public health risk; who is found to be of sound mind, but who just refuses treatment or ignores pubic health recommendations. Based on what we have seen to date in Maine, such a scenario is most likely to occur amongst the homeless persons or persons from another country who do not understand or wish to comply with Maine law. Setting aside more than a few beds for this purpose would not be practical, hence creative solutions are needed.

Given these many challenges, Maine DHHS staff have identified the following potential options for placement. The following list and table outlines the possible options along with pros and cons of each option. Further deliberation and discussion for each individual threat is required within DHHS to make a decision as to which option might best serve Maine's needs. However, we believe this list with delineated pros and cons will serve as a good template for a discussion and decision-making when we are faced with the next applicable public health threat. For each type of threat, it is possible a different solution is most appropriate.

Options Placement Non-Compliant Public Health Threats

1. **County jails**

   Pros:

   Secure setting
   Medical staff on site

   Cons:

   Illegal per Maine Statute: 22 MRSA Section 807
   Limited infection control (negative pressure rooms)
   Extensive staff training needed
   Conflicts with mission of correctional facilities

2. **Nursing homes**

   Pros:

   Already in existence throughout State
   Staffing familiar with medical treatment

   Cons:

   Need to determine who provides security
   Licensing issues restricting patient rights
   Negatively impacts other residents who see another resident receiving special privileges
   Negative pressure rooms not available

3. **State Mental Health Facility (Riverview; Doreatha Dix)**

   Pros:

   Already in existence
   Secure setting; with no extra security needed
   Staff familiar with medical and psychological issues/concern/needs of patients

   Cons:

   Licensing issues restricting patient rights
   Shortage of mental health beds/facilities
   Beds not available on short notice
   Current laws preclude psychiatric admissions for other purposes

4. **Crisis House**

   Pros:

   Already exists in State Mental Health system
   Well accepted by patients

Cons:

Licensing issues
Restricting patient rights
Lack of security
Non medical staff unfamiliar with transmission infectious diseases
Negative pressure isolation rooms not available

5. RFP to Community Agencies

Pros:

Potential for imaginative solutions
Possible regional approach

Cons:

Never before tried
No funding available at this point in time for RFP

6. Renting an RV

Pros:

Would only have to pay as needed
Optimal approach for homeless; patients with lack family support

Cons:

Need to determine medical/nursing and security staffing
Need to determine where the RV would be located

7. Vacant State Property

Pros:

Already in existence
? Cost effective

Cons:

Need to determine staffing
What condition/physical shape are these empty buildings in?
Who owns this property, and who needs to give consent to such usage?
Security Concerns

8. Own Home

Pros:

Already in existence
PHN's could provide therapy

Cons:

Need to determine security staffing
Not applicable to high risk populations: homeless; inmates

9. Home Quarantine

Pros:

Public Health Nurses could provide therapy
Security potentially not as big an issue

Cons:

Not applicable to high risk populations: homeless

10. Regional Approach, working with other New England States

Pros:

Shattuck Hospital, Boston already in existence

Cons:

Shattuck Hospital only accepts TB patients
Limited capacity (n=12 beds)
Legal issues surrounding care provided by one state for another state's resident
May not work in widespread outbreak, as beds are insufficient and state of ownership would need limited beds for their own residents
Costly

Options Placement Non-Compliant Public Health Threat

Potential Options	Staffers	Security 24 x 7	Infection Control (neg pressure)	Availability	Licensing	Cultural Issues	Language Access	Comments
County Jails	Medical Staff on site	Yes	Only some facilities	Throughout State	N/A	Likely	Likely	Prohibited by 22 MRSA Section 807 Resistance of jail administrators as would be seen as a conflict of missions
Nursing Homes	Medical Staff on site	No	Unlikely	Throughout State	Concerns with restricting patient rights. Current regulations prohibit	Unlikely	Possible	Negatively Impacts other residents who see another resident receiving special attention/privileges

Potential Options	Staffers	Security 24 x 7	Infection Control (neg pressure)	Availability	Licensing	Cultural Issues	Language Access	Comments
State Mental Health Facility	Medical staff on site-familiar with psychological issues of patients	Yes	Unlikely	Throughout state but shortage of beds. Beds are not available on short notice	?	Likely	Likely	Laws governing psychiatric admissions preclude use for other purposes
Crisis House	Non-medical staff-unfamiliar with transmission of infectious disease	No	No	Exists within state mental health system	Licensing issues	Possible	Possible	Staffing well accepted by mental health patients
RFP Community Agencies	Perhaps	No	No	?	?	Possible	Possible	Could be a creative solution for regional approach

Potential Options	Staffers	Security 24 x 7	Infection Control (neg pressure)	Availability	Licensing	Cultural Issues	Language Access	Comments
Rent RV	Who provides staffing?	Who provides security?	N/A Patient could live alone	Rent on a "prn" basis/hospice type approach	N/A	Unlikely	Possible	Would be useful for homeless patients; patients whose family does not want to risk further infection (ie young children in household) "Not in my neighborhood"
Vacant State Property	Who would staff?	Who would provide security?	N/A as patient could live alone	Already in existence- Not clear where	N/A	Unlikely	Possible	Where is vacant property? What physical shape are these empty buildings in? Who owns? Who needs to provide consent for use?
Own Home	Utilize PHN for DOT	Who would provide security?	N/A as patient lives alone or with already exposed family members	Already in existence hospice type approach	N/A	Likely	Likely	Will not be applicable to homeless; inmates

Potential Options	Staffers	Security 24 x 7	Infection Control (neg pressure)	Availability	Licensing	Cultural Issues	Language Access	Comments
Home quarantine ankle bracelet	Utilize PHN for DOT	Unnecessary	N/A as patient lives alone or lives with already exposed family member	Already in existence; hospice type approach	N/A	Likely	Likely	Not useful for homeless; inmates
Hospitals	Medical staff on site	Who provides security?	Yes	Hospital throughout Maine	?	Likely	Likely	Expensive place to provide out patient care plus would still require hiring a 24 hour guard
Rural isolated facility/island location	Who would staff?	Security still necessary despite nowhere to escape to! Socially reprehensible	Unnecessary	?	N/A	Unlikely	Unlikely	Creative solution but may not be workable. Civil libertarians would have a field day!

Potential Options	Staffers	Security 24 x 7	Infection Control (neg pressure)	Availability	Licensing	Cultural Issues	Language Access	Comments
Regional Approach, New England	Medical staff on site	Yes	Yes	Limited capacity; and final decision to accept patient rests with admitting State and facility	N/A	Likely	Likely	Current capacity of 12 beds in Boston's Shattuck Hospital would not be adequate for New England's needs. Concerns regarding legal liability
Other?								