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METRO EAST REGIONAL HUMAN RIGHTS AUTHORITY

REPORT OF FINDINGS

HRA CASE # 13-070-9030

ALTON MENTAL HEALTH CENTER

OCTOBER 10, 2013

INTRODUCTION

The Alton Regional Human Rights Authority (HRA) has completed its investigation of complaints at Alton Mental Health Center (Center), a state-operated facility (SOF) that has 125 inpatient beds in Alton. The allegation being investigated is that the Center may have violated a consumer's rights when it did not provide adequate and humane care treatment in the least restrictive environment pursuant to a treatment plan when reducing an individual's privileges. If substantiated, the allegations would be a violation of the Mental Health and Developmental Disabilities Code.

Specifically, the allegation states that a consumer was attempting to speak to a peer through a windowed door when a staff member interrupted and implied that the two persons should not speak to one another. The consumer was puzzled by the staff member's determination and continued speaking to her friend. Later the staff determined that the consumer's privileges would be decreased.

METHODOLOGY

To pursue the investigation, an HRA team visited the Center and interviewed the consumer and the unit staff member. The HRA reviewed the consumer's record, with consent.

FINDINGS

The consumer stated that the Center violated her rights when staff rescinded privileges and reduced her level of freedom. The consumer said that action reflects poorly on her attempts to progress to a less restrictive environment.

The consumer explained that on April 10, 2013 a staff member not assigned to her care, observed her speaking to a male resident from a different unit which is not against rules. The staff person's entry into her record portrayed the incident as though she had misbehaved by speaking with the male consumer. Furthermore, when the staff implied that she should not continue her conversation, the consumer responded that she "wasn't breaking any rules" and the staff reported in the record that the consumer could not be redirected. Immediately after that discussion, the consumer spoke to another staff who witnessed the incident and that staff member concurred that the consumer had not done anything wrong.

The next day, the team reduced the consumer's privileges and they were not reinstated for several months. The consumer told her team that a staff member who had witnessed the event told her she had not done anything wrong; however, the team did not ask that staff member what had happened. The consumer concluded that the loss of pass level makes it look like she is not cooperating with treatment, while her ambition is to comply with treatment and work toward discharge.

DOCUMENTATION

Progress Notes:

> 04/10/13 @ 1955: Behavior Note: upon this writer returning from lunch it was noted that [the consumer] and peer were in the main hallway on their passes. Peer was half way up main hall and [the consumer] was standing right before knuckle on c-unit talking to males that were in C hallway waiting on staff for rehabilitation. This writer tried to redirect [the consumer]. She stated 'I'm not doing anything wrong.' Continued talking to c-unit male through door. This writer informed her that this would be brought to team's attention.
>
> 04/11/13: 9:30: Privileges level - unsupervised building privilege. Team based on behavior noted in above note reduced pass from supervised grounds pass to unsupervised building pass without hall pass time. Team met with [the consumer] and she indicated she was not breaking rules. [The consumer] became tearful and stated it was bull crap. [The consumer] noted she felt it was petty. [The consumer] mentions another staff who would have differing information about the matter which would exonerate her in terms of what was noted. [A staff member] indicates she will investigate the matter. Staff spoke with [the consumer] and she indicated she could calm herself.
>
> 04/24/13: Psychiatric Note...she was upset about her pass being pulled. It was pointed out that her tendency to argue and be defensive when redirected by staff has been on point problem which she fully agreed. She agreed that she would work on her attitude.

The HRA did not find documented evidence that the party identified by the consumer as a witness was interviewed.

Individual Treatment Plan established 11/14/12:

> Short term goal # 1: [The consumer] will be able to have at least four months of appropriate behavior to be considered by the team for increased privileges in four consecutive reviews.
>
> Interventions/rationale/frequency [09/22/12: Treatment team will meet

with patient at least monthly to assess clinical and behavioral status and evaluate appropriateness for increase of privileges.

Staff will monitor patient on a 24 hour basis for any signs of symptoms or behaviors interfering in safety of patient and others or interfering in his ability to perform daily activities....

Social Worker will meet with the patient one time weekly to provide education on the privileging process....

...Short term goal # 3: [The consumer] will be able to list two ways to continue stability in the hospital and in the community....

Interventions/Rational/Frequency....staff will provide 24 hour supervision and monitoring for exacerbation of symptoms or behaviors related to illness that may place patient or others at risk of harm. If observed exhibiting bizarre or dangerous behaviors or if he [sic] is verbalizing paranoia or delusions, staff will provide supportive reality-oriented interactions, assure patient of his [sic] safety, and provide for the safety of patient and others in least restrictive means possible....

The HRA notes that plan review did not reveal a goal stating that consumer should not argue or be defensive when redirected by staff.

Psychiatric review of Progress:

For the period 04/03/13 - 05-02-13....Since her last monthly psychiatric review 04/03/13 there has been no significant change in her psychiatric condition. She continues to report a fair control of psychosis and dysphoria. On 04/10/13 she was seen being with another patient in the main hallway while using the UBP [unsupervised building pass]. She was standing right before the knuckle area on C-unit hallway talking to male patients that were in their C unit hallway while waiting on their staff to go to rehabilitation. She was redirected away from the area, but she stated that she was not doing anything wrong. She continued talking to C unit male patients through the glass door. On 04/11/13 her privilege level was reduced from SGP [supervised grounds pass] to UBP [unsupervised building pass] due to her not following the rules related to the use of UBP and inability to follow redirection.

Psychiatric review of Progress: for the period 05/02/13 - 05-30-13: since her last monthly [treatment] review on 05/02/13 there has been no significant change in her psychiatric condition. She continues to report a fair control of psychosis and dysphoria [sic]. On 05/17/13 she stated to the staff 'I forgive you for lying on me,' Referring to the staff documenting an incident that occurred on 04/10/13. The staff told her that the facts

were placed into the chart. There has been no episode [sic] of severe agitation or physical aggression. She has not required any use of emergency medications or restraint. She usually cooperates with unit routines. She is self-sufficient...she participates in unit therapeutic programs...She was initially approved for supervised on-grounds privilege 01/07/2010. It was suspended again on 02/19/13 due to violation of unit rules and failure to be redirected. It was reinstated on 03/22/13 but pulled again on 04/11/13....

MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CODE

The following rights are guaranteed under these Sections:

(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient...[405 ILCS 5/2-102].

ALTON MENTAL HEALTH CENTER POLICY

Any privilege may be suspended by the treating psychiatrist for an indefinite period of time in response to changes in the patient's clinical condition. Such changes may include deterioration clinically to the point that the patient poses a threat of harm to himself or others, or that the patient has stopped meeting designated treatment goals necessary to sustain the privilege (i.e., is not attending programming that was necessary to maintain progress in treatment that allowed for the specified privilege level) or that his/her presence in activities off the unit will be disruptive to other patients in attendance. At no time should privileges be suspended as a punishment for behaviors unrelated to safety, interference with treatment of other patients or progress in treatment directly related to sustaining privileges as written in the treatment plan. Lowering of privilege levels should not be communicated in a threatening manner and any discussion with the patient should be done privately, explaining the reason for the change and the expected behavior for reinstatement of the previous level. For example, the privilege level for a patient who chooses not to shower may be modified because his presence in the small vending area when he/she is disheveled and malodorous is disruptive to other patients. When the treating psychiatrist is not available, a privilege may be temporarily suspended by the Unit RN or CNM until the patient's treatment team, under the direction of the treating psychiatrist, meets to review the reason for the suspension. Suspensions of privilege levels are not considered restrictions and DO NOT require that a Restriction of

> Rights be issued.... Temporary suspensions occurring over weekends or holidays will be reviewed daily by the lead unit RN who will decide after consultation with staff whether the suspension should continue. Temporary suspensions will be documented by the unit RN in the form of a progress note which includes the justification/reason for the suspension, and on the Privilege Record. Treatment team reviews of suspended privileges will be documented in a progress note and will also be included in the patient's weekly/monthly treatment review.

CONCLUSION

The Alton Mental Health Center policy states "any privilege may be suspended for an indefinite period of time in response to changes in the patient's clinical condition, including deterioration to the point that the patient poses a threat of harm to himself or others, or that the patient has stopped meeting designated treatment goals necessary to sustain the privilege (i.e., is not attending programming that was necessary to maintain progress in treatment that allowed for the specified privilege level) or that his/her presence in activities off the unit will be disruptive to other patients...At no time should privileges be suspended as a punishment for behaviors unrelated to safety, interference with treatment of other patients or progress in treatment directly related to sustaining privileges as written in the treatment plan."

The consumer's treatment plan states that "if observed exhibiting bizarre or dangerous behaviors or if he [sic] is verbalizing paranoia or delusions, staff will provide supportive reality-oriented interactions, assure patient of his [sic] safety, and provide for the safety of patient and others in least restrictive means possible..."

A psychiatric note implied that the consumer's tendency to argue and be defensive when redirected by staff has been on point problem which she fully agreed as per a psychiatric note.

Progress notes stated that another staff member could exonerate the consumer; however, there was no evidence that the staff member was interviewed.

While the consumer's plan addressed bizarre and dangerous behaviors, the HRA did not find documentation in the treatment plan that addressed argumentative behavior or expectations for redirection.

Based on the documentation and the Center's policy, the allegation that the Center violated the consumer's rights when it did not provide adequate and humane care treatment in the least restrictive environment pursuant to a treatment plan when reducing an individual's privileges is substantiated.

RECOMMENDATIONS

The HRA recommends that the Center:

1. Consistent with the Mental Health Code requirements governing treatment planning, convene the treatment team to discuss the specific plan goals and expectations, if still appropriate, return privilege level. When pass privileges are rescinded, clearly identify what behavioral goals/objectives/expectations the consumer must meet to regain privileges versus simply listing a time frame.

2. Adhere to the policy that states privileges may be suspended in response to changes in the patient's clinical condition, to the point that the patient poses a threat of harm to himself or others, or that the patient has stopped meeting designated treatment goals necessary to sustain the privilege.

3. When there is an incident that impacts a consumer's treatment, privileges and/or restrictions and there is a dispute over the circumstances of the incident, thoroughly review the incident and interview any witnesses.

SUGGESTION

The HRA suggests that the Center review its policy that states any privilege may be suspended for an indefinite period of time in response to changes in the patient's clinical condition, including deterioration to the point that the patient poses a threat of harm to himself or others, or that the patient has stopped meeting designated treatment goals.

Consider implementing a finite period for privilege suspension when the offending consumer is not a safety threat and they continue to work on treatment goals. (For example, a one day suspension for chewing gum)