FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
TINLEY PARK MENTAL HEALTH CENTER— 09-040-9013
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary— The Authority made four corrective recommendations regarding two of the allegations, and the service provider accepted all of them. The public record on this case is recorded below; the provider did not request that its response be included as part of the public record.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA) has completed its investigation into allegations concerning Tinley Park Mental Health Center, a state-operated facility. The complaint alleged the following: 1) a recipient was not provided with a comprehensive psychiatric examination within the Code's requirements, 2) the recipient's designated support person was not allowed to participate in treatment planning, and, 3) the recipient's right to visitation with persons of his choice was unjustly denied. If substantiated, these allegations would violate the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.), the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/5 [a]) and the Illinois Administrative Code for state-operated facilities (59 Ill. Admin. Code 112).

METHODOLOGY

To pursue the investigation, the complaint was discussed with the Attending Psychiatrist, the Clinical Nurse Manager and a social worker. The recipient's record was reviewed with his written consent. Relevant facility policies were reviewed. Additionally, Tinley provided the HRA with the Unit Visitor's Log that was not part of the record reviewed.

The adult recipient in this case maintains his legal rights.

COMPLAINT STATEMENT

The complaint stated that the recipient was not seen by the psychiatrist until three days after his admission to the facility. The recipient gave written consent for his girlfriend to participate in treatment planning, but she was not included. He was not allowed visits with his 17-year old girlfriend because visitors must be 18 years or older. The recipient requested that special consideration be made regarding visitation with his girlfriend, but the psychiatrist never responded to his inquiry.

FINDINGS

According to the record, the 23-year old recipient was transferred to Tinley from a local hospital's emergency room because of suicidal ideations. He was diagnosed with Bipolar Affective Disorder upon his admission to the facility on May 20th, 2009. A Comprehensive Psychiatric Evaluation and Physical Examination Report including a Medical History Report were completed during the intake process. The recipient signed on the admission day the following: 1) A Voluntary Application, 2) The Rights Of Individuals Receiving Mental Health And Developmental Disabilities Services, and, 3) An authorization form to obtain information from his parents and disclose information to his girlfriend. (The release was valid for only one day and the specific information authorized for sharing was not checked on the form).

The Comprehensive Inpatient Psychiatric Evaluation, the Social Assessment and progress notes, completed on May 21st, 2009, documented that the recipient denied having thoughts of suicidal or homicidal ideations. He had lived with his parents prior to hospitalization, and their relationship was problematic. He refused to give consent for his parents' involvement in his treatment planning. The recipient had criminal charges pending for assaulting his 17 year old girlfriend but claimed that they were hitting each other with plastic bottles. On that next day the 72-hour treatment staffing was held. The recipient signed the treatment plan approved by the psychiatrist. His plan included goal objectives concerning his primary diagnosis of affective disturbance, but there were no indications of his involvement in the plan's development or that a copy of the plan was offered.

In regard to the complaint concerning the recipient's right to designate a support person in treatment planning, the social worker explained that recipients are verbally informed that the assessment process is ongoing, and a treatment plan will be developed. Recipients are encouraged to include appropriate persons in the process so that they can identify goals and move toward discharge. The Attending Psychiatrist and the social worker said that they were unaware that the recipient wanted his girlfriend to be involved in treatment planning. The psychiatrist further explained that the recipient's girlfriend was 15 or 16 years old, although he first reported that she was 17 years old. If requested, she would not have been allowed to participate in treatment planning because he had charges pending for physically bashing her. He also said that a person must be 18 years or older to participate in a treatment staffing

According to the social worker, the recipient's parents were very involved in treatment decisions, although he vacillated daily about their involvement. He talked to the recipient's mother by phone several times when the recipient was present in the room. The family reportedly disagreed about discharge plans. The recipient did not want to return home but changed his mind. He called the recipient's girlfriend during the assessment process because she was the center of contention within the recipient's family but never talked to her. On questioning, the staff person said that he did not document the call because it was not "productive," but the HRA noticed that discussions with the recipient's mother were also not recorded. The social worker reportedly did not notice that the release for disclosing or obtaining information previously mentioned was valid only for May 20th, 2009.

On questioning concerning whether the recipient participated in the treatment staffing, the social worker was not sure because he did not attend the meeting. The staff person reportedly signed the plan's signature page as though he had participated in the meeting because he wrote the plan.

In regard to the complaint concerning the recipient's right to communication that includes visitation, there was no documentation regarding visitation or restriction notices or names of family/friends that the recipient wished to have as visitors found in the record. The Unit Visitor's Log indicated that the recipient's parents were his only visitors. The HRA was informed that Tinley's Central Intake Department is responsible for gathering the names of persons approved by the recipient for visitation during his stay at the facility. According to the staff, the recipient did not request visits with his girlfriend. The psychiatrist added that she would not have been allowed to visit because of her age. The Clinical Nurse Manager explained that visits are arranged for children under 18 years old but this does not apply to a patient's girlfriend. The treatment team reportedly reviews all requests individually involving visitors under the age of 18. The social worker stated that visitation is rarely restricted, and if this occurs, it is usually related to contraband issues.

According to Tinley's "Assessment of Patient Needs" policy, each patient presenting to the facility for services shall receive a comprehensive, multi-disciplinary assessment that indentifies their individual needs. The assessment information is integrated into a Master Treatment Plan that addresses the patient's individual needs and goals. The Admitting Psychiatrist is responsible for developing the initial treatment plan. A medical history and physical assessment must be done, which includes a pain screening within 24 hours of admission. The unit psychiatrist must interview the recipient and complete a psychiatric evaluation within 72 hours. A social investigation and the Master Treatment Plan must be completed within the 72 hours timeframe.

Tinley's "Treatment Planning Policy" states that each patient shall be given the opportunity to participate fully in the treatment planning process. This includes all aspects of the process such as assessments, the formulation of written plans and the ongoing revision of both. Each clinician and treatment team member must respect and facilitate this right. There must be evidence of the patient's involvement, not merely review, in the formulation of all treatment plans. This means that each patient should attend their treatment staffings and be given time for input in their plans' formulation. The plan form includes space for signatures, refusals and the patient's comments. The patient's family or significant others will be informed about the treatment planning process and can attend [the meetings] with the patient's consent. The plan also provides space for documenting family attendance and involvement.

The facility's consumer's rights statement #13 repeats that consumers shall be given the opportunity for ongoing participation in the treatment plan's development and that a copy of their plans will be provided. It also states that consumers have the right to designate a support person such as a family member to participate in the treatment planning and review process. The consumer's written consent is required.

According to the facility's consumer's rights statement #16, consumers are entitled to communication by mail, telephone and visitation except when there is a safety concern.

The facility's "Visiting Policy" states that recipients will be asked to provide a list of persons of choice that they wish to have visits with upon their admission to the facility. It states that individuals who knowingly bring contraband items to the unit will be restricted from visiting until the treatment team makes a determination regarding the therapeutic value of future visits. Also, individuals who are determined to have a counter-therapeutic effect on the recipient will be restricted. A restriction of rights notice will be given if the restriction is against the recipient's will, and the facility's security department will also be notified. Special arrangements can made through the Unit Administrator for children under the age of 18.

CONCLUSION

The Illinois Administrative Code (59, Section 112.30) requires that,

> Each person admitted to the Department in accordance with the Code [405 ILCS 5] shall have a thorough physical examination on admission.… Persons with mental illness shall be examined within 24 hours in accordance with the Mental Health Standards…. The examination shall include an evaluation of the recipient's condition, including … diagnoses, plan of medical treatment, recommendations for care, including personal care needs, treatment orders … and any other required examinations….

According to Section 5/2-102 (a) of the Code,

> …. The [individual services] 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. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided.

Section 5/2-103 (c) of the Code states that,

> Unimpeded, private and uncensored communication by mail, telephone and visitation may be reasonably restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction shall be given to all recipients upon admission.

Section 5/2-201 of the Code states, whenever any rights of a recipient of services are restricted, the recipient shall be promptly given notice of the restriction.

Section 5/3-205.5 of the Code requires the facility to provide or arrange for a comprehensive physical, psychiatric evaluation and a social investigation within 72 hours of a recipient's admission, excluding Saturdays, Sundays and holidays.

The complaint that a recipient was not provided with a comprehensive psychiatric examination within the Code's requirements is unsubstantiated. Supportive documentation indicated that the facility completed the comprehensive physical examination, the intake psychiatric evaluation and the medical history report within 24 hours in accordance with the Illinois Administrative Code (59, Section 112.30) even though the Code's Section 5/3-205.5 allows 72 hours. The comprehensive inpatient psychiatric evaluation and the social investigation were completed on the second day of admission. No violations of the Section or policy were found.

The complaint that the recipient's designated support person was not allowed to participate in treatment planning is unsubstantiated. Although the HRA does not discredit the complaint, there was no valid written consent as required by the Mental Health and Developmental Disabilities Confidentiality Act Section 110/5 (a) for sharing or disclosing the recipient's personal health information found in the record. The recipient's treatment staffing was held on May 22nd, 2009, but his signed authorization was only valid for May 20th, 2009, and the specific information authorized for sharing or obtaining was not checked on the form. Although the social worker said that recipients are encouraged to designate support persons of choice to participate in treatment planning, the psychiatrist said that they must be at least 18 years old to participate. The Authority must caution the facility because there is no age requirement under Section 5/2-102 (a) or Tinley's Treatment Planning Policy or consumer's rights statement #13. In fact, the Code states that plans are formulated and reviewed with participation from *any other individual designated in writing by the recipient*, and, that the facility shall advise recipients of the option. A notice must be given under Section 5/2-201 if this right is restricted in any way.

In regard to treatment planning, the Authority found no evidence of the recipient's involvement in the formulation of his plan. The boxes on the signature page which asks "Did the recipient participate in the development of his treatment plan and he was offered a copy of the document" were not checked. This violates Section 5/2-102 (a) and Tinley's policy. And, the facility's consumer's rights statement #13 only in regard to a copy of the plan being provided.

The complaint that the recipient's right to visitation with persons of his choice was denied is unsubstantiated. There was no documentation that the recipient requested visits with his girlfriend or notices of restrictions found in the record. Tinley's policy states that visitors must be at least 18 years but includes provisions for children and a notice when visitation is restriction. There is no age requirement under Section 5/2-103 (c) that restricts visitation to persons 18 years or older and if a recipient's guarantee right is restricted again Section 5/2-201 applies. Although the Authority found no evidence to support the complaint, the facility violates

its policy because the record lacked a list of persons of choice that the recipient wanted to visit him. There was no written statement that he refused to provide a visitors list.

RECOMMENDATIONS

1. Tinley shall follow the Mental Health Code and its Treatment Planning Policy that allows recipients to participate in the formulation and review of their treatment plans to the extent feasible. Recipients should be invited to participate in their staffings unless it is clinically contraindicated to do so.

2. Be sure to check the boxes on the signature page indicating whether the recipient participated in developing his or her treatment plan and a copy of the plan was offered.

3. Tinley shall follow its Visitation Policy and ask recipients to provide a list of visitors of their choice.

4. Train appropriate staff on these requirements and provide the HRA with documentation.

SUGGESTIONS

1. Discuss recipient's right to designate a support person of choice in treatment planning with the appropriate staff members.

2. Document in recipients' records the advisement of the right to designate support persons in treatment planning and whenever they are designated.

3. Best practice dictates that all contacts with recipient's family members or significant others should be documented.

4. The facility should revise its Visitation Policy to conform to Section 5/2-103 (c) of the Code.

COMMENT

The social worker reported that he talked to the recipient's mother several times although the discussions were not documented in the record. There was no written authorization to contact his parents after May 21st, 2009 found in the record. The Mental Health and Developmental Disabilities Confidentiality Act Section 110/2 define communication as "any … in connection with providing mental health … services to a recipient." We suggest that the facility follow Section 110/5 (a) of the Act stating that,

> Records and communications may be disclosed to someone other than those persons entitled listed in Section 4 of this Act only with the written consent of those persons who are entitled to inspect and copy a recipient record pursuant to Section 4 of this Act.