FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY - NORTHWEST REGION

REPORT 09-080-9008
ROCK RIVER ACADEMY AND RESIDENTIAL CENTER

Case Summary: Substantiated violations were found only on guardian inclusion sides of the complaints. The facility responded with staff training and policy development. The HRA's findings and the facility's response are recorded below.

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving complaints of possible rights violations at the Rock River Academy and Residential Center in Rockford. It was alleged that the residential side of the facility has not provided a resident with adequate individual treatment planning and monitoring and has not consistently communicated with the resident's guardian for treatment planning and monitoring. Substantiated findings would violate rights protected under the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Licensing Standards for Child Care Institutions (89 Ill. Admin. Code 404).

Rock River provides a therapeutic day school and a residential treatment center for youths with behavioral and emotional problems. The facility is a subsidiary of Psychiatric Solutions, Inc., a behavioral health management firm headquartered in Franklin, Tennessee that has programs in thirty-one states. Other Illinois locations include Riveredge Hospital in Forest Park, Streamwood Behavioral Health Systems in Streamwood and Lincoln Prairie Behavioral Health Center in Springfield.

We toured the Rock River site and discussed these complaints with program administrators. Relevant policies were reviewed as were sections of a resident's file with guardian authorization.

COMPLAINT SUMMARY

The complaint states that in general, there is no therapeutic component at the residential center. A young resident is said to sleep-in and skip school without consequence, and although the situation is improving, she is not given support for her homework and her treatment plan lacks goals, objectives or at least a statement of what the facility will do. The treatment plan was reportedly developed in July without the guardian's presence and was not sent to the guardian until September. It is also stated that there is little to no communication from the center about treatment planning, medications and any progress or updates; the guardian has to call for

information but even then staff members are vague. The resident is allegedly left unmonitored, and in one instance she was able to run away and was found later by the police in a park bathroom with two male strangers.

FINDINGS

Administrators explained that their therapeutic day school opened in November 2007. The program has forty students, mostly coming from within the local school district. The residential side opened in April 2008, and there are currently thirty-two females between thirteen and seventeen years of age who live there. Three of them attend outside local high schools or "mainstream" schools, including the resident in this review. The residential program is licensed to serve up to fifty-nine youngsters between ten and twenty-one years of age who have any psychiatric diagnoses and IQs of sixty-five or greater, but have no conduct disorders as primary diagnoses and no mental retardation; most of the residents come with traumatic histories. Four "suites" make up the living area in what was described as a highly structured environment where residents act as a community with a strengths-based approach. They are supported with scheduled educational, trauma and expressive therapies, three therapists, three registered nurses, two licensed practical nurses, two discharge planners or case managers, a clinical psychologist and a psychiatrist. One therapist is assigned to each suite and is responsible for developing programs, writing treatment plans and conducting group and individual therapies. Staffings are held on a monthly basis for the purpose of treatment planning and review. Participants, or team members, include residents, guardians, the psychologist, a therapist and a discharge planner. Any team member can call for plan modification. Discharge planners have the most contact with guardians and families and are responsible for notifying them whenever a staffing is scheduled. Email notifications seem to be preferred but they can notify by phone or regular mail if needed; there is no established rule on how far in advance notices are to be made. Treatment plans are always copied and provided to participants. Copies are also placed on the suites for staff reference. Regarding psychotropic medication use, the psychiatrist meets with residents initially for full evaluations and then once per week thereafter, perhaps more if required, and is also available to talk to guardians. Informed consent for medications is obtained from residents and their guardians. Guardians are asked to sign consent forms if they are present at the time a medication is proposed, otherwise, verbal consent is reached and consent forms are sent to the guardians for signing.

In response to the complaints specifically, we were informed that this resident was fully assessed during her first week of treatment beginning in early July 2008. The resident's assessment phase included interactions with her primary therapist and with nursing and medical staff. Her individual treatment plan was formulated from those assessments, and plan reviews have taken place on a monthly basis since. The initial plan cited goals to increasing a positive family relationship through therapies where the resident could verbalize her needs. In addition, the plan set up weekly individual and group therapies, which have been carried out as plan-directed throughout the rest of the year, sometimes more frequently, although family therapies were not accomplished after the guardian refused to have them. Along with individual therapies, the psychiatrist has provided ongoing assessment and monitoring, and there has been consistent contact with the resident's guardian as the record should demonstrate.

We were also told during our interviews that the resident came to the facility post-adoption and that she is not a ward of the state, which is a unique situation for the program. Administrators said there may have been problems keeping the guardian notified at first but that the staff have adjusted appropriately. One administrator said that the resident's guardian prefers to communicate via email. They were provided with an old or incorrect address at first but have since been given a valid one. It is believed that the guardian has attended every treatment team meeting although she does not return the resulting treatment plan reviews and revisions that are sent to her for signing. Administrators said that the guardian refuses to sign a release for the facility to communicate with the resident's school, which prevents continuity. They cannot match their treatment plan with her education plan or receive important updates, developments and general information from the school. In addition, the school cannot alert them whenever the resident is truant. To their knowledge the resident has eloped from school two times. In one instance she was discovered in a public bathroom with an adult male, and it was the police who informed them and returned her. On the issue of skipping school they explained that this was a problem for a while when school started. They have no authority to physically force residents to get on a school bus as requested by this resident's guardian. They use a therapeutic approach as individually planned. For example, the resident finds comfort in pacing and listening to music as an effective coping strategy, so the staff will encourage her to do that in addition to other incentives that might engage her. Residents can also earn "suite money", which is a reward system that allows them to write checks for outings based on what has been earned. Money would not be earned for skipping school. The administrators reported to us that the resident has come a long way; they see her benefitting from the program, she is following her treatment plan and is attending school consistently.

During our tour of the suites we were able to observe the staff interacting with residents. The staff members appeared to have good rapport with them, and they were appropriate and professional; all of them were well engaged with the residents. The residents seemed comfortable with the environment and aware of suite rules. Several of them responded to us quite positively and without expressed fear or concern. The suites were very clean.

We reviewed this resident's file for support of what was relayed to us. We asked to see previous emails demonstrating guardian invitations or notices but were informed that the facility has changed email systems and cannot retrieve archives. The resident's initial treatment plan from July listed mental/emotional health, family, social/recreational, educational, life skills and case management as goal categories. There was at least one objective along with interventions and reinforcements for each goal to start services off. They included controlling impulsive behaviors like elopement and increasing positive family relationships and participation in school. The plan directed staff to reinforce through encouragement and earned privileges, and it called for weekly individual and group therapies. An accompanying behavior plan cited elopement as a potentially high risk, which was to be addressed by alerting appropriate staff and getting support group or individual therapy sessions on the move if trigger behaviors are observed. According to the treatment plan participation page the guardian was not present at the team meeting or at least there was no guardian signature. A corresponding physician's note from the same day stated that the physician met with the staff and client but did not mention the guardian. The next plan that was provided to us had been reviewed in September. There were notable revisions to existing goals and objectives as well as the addition of a completing homework goal. There, staff were

instructed to help the resident record her assignments and to plan ahead in order to complete them. The behavior plan was unchanged. Troubling about the September plan is that its participants' page seems to be a nearly identical copy from July---July's signatures are attached and there are no signatures from September. Again, the guardian is not listed although a corresponding physician's note showed that the guardian was present and interacted with the team. The physician wrote that the guardian expressed concerns about homework, prompting the plan's revisions and additions. We were informed that October's original plan was lost so we were unable to review it, except that the physician noted once again about the team having met with the resident and her guardian in October to discuss progress. A treatment staffing report for November listed school attendance and homework completion as continued needs, and progress was highlighted from various service areas. As before, the physician's notes referenced guardian presence and involvement. Therapeutic service narratives from the same timeframe indicated that multiple face-to-face counseling and general case management sessions with the resident have taken place, many of them referencing contact with the guardian to discuss treatment planning, progress, developments and various situations. There were several notations about helping the resident make phone calls to her mother, encouraging her to complete her homework and exploring how to deal with anxieties whenever she felt like running away. Community support notes, similar to daily progress notes, provided much of the same. Per the documentation, there seemed to be constant activities in place. There were numerous instances when staff would meet with the resident individually to discuss coping skills at times when she was agitated, when her "buttons were pushed", and when she felt like leaving. Early on, there were several notes stating that the resident attempted to elope or had eloped during outdoor activities. In each case staff escorted her back to the building. The notes reflected how the staff provided attention and encouragement, almost on a daily basis, in the areas identified as goal categories in her treatment plan. There is an abundance of notes stating how staff persons checked with the resident on whether she had or was completing homework.

The medication consent documentation provided to us was scant. The guardian's consent for Stratera was obtained verbally on September 30th and then in writing on October 7th, and information about the drug's risks, benefits and side effects were attached. However, the resident's first treatment plan from July listed Abilify, Cymbolta and Tenex as being prescribed, and the revised September treatment plan listed the same but added Lithobid. There was no evidence of guardian consent for these medications in the record, physician's notes and medication monitoring sheets that were included.

CONCLUSION

Rock River policy (TX-14) states that treatment plans are to be developed based on assessment of fundamental needs by a multidisciplinary team. Plans must identify problems to be addressed during the course of treatment and identify long-term goals. Goals are to be realistic, relevant and measurable and have short-term objectives (pg. 1). For each objective, the name and discipline of the staff responsible for evaluating and documenting progress towards accomplishment of each goal should be entered. The treatment team is to review the plan with the resident no less than quarterly. A policy on guardians/families (1800.23 and TX-18) states that their involvement in treatment begins at admission, and, they are invited to participate in master treatment planning sessions and review. Regarding medications, the program's policy

(MM-01) requires guardian consent in writing. Except for emergencies, consent is obtained prior to administering psychotropics. A nurse may complete drug education for residents and guardians, and there is to be a completed consent sheet for each psychotropic ordered.

According to the Mental Health Code,

> *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….* (405 ILCS 5/2-102).
>
> *If the services include the administration of electroconvulsive therapy or psychotropic medication, the physician or…designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment…. The physician or…designee shall provide to the recipient's substitute decision maker, if any, the same written information that is required to be presented to the recipient in writing.* (405 ILCS 5/2-102 a-5).

The Illinois Administrative Code for child care institutions adds that a plan for services shall be made in writing, reviewed at least every six months, and shall be signed by all parities involved. The plan shall describe services, how needs will be met and establish a timeframe for termination of services (89 Ill. Admin. Code 404.25). In addition, there must be written guardian consent for the use of psychoactive drugs (89 Ill. Admin. Code 404.27).

In this case there is evidence by personnel statements and record documentation that the facility has provided individual treatment planning and monitoring to meet the resident's needs, which were based on multidisciplinary assessments and guardian input. The therapeutic component is there, so that part of the complaint is <u>not substantiated</u>. Although there is evidence of the guardian being at every treatment team meeting for September and after, the facility cannot demonstrate proof that they invited her, made attempts to invite her or provided an opportunity for her input before that when the first treatment plan was developed in July. And, without an established system of timely guardian notification and documentation about treatment plan meetings, there is no way to tell if this guardian was properly informed by the facility about the subsequent meetings or if she found out incidentally during visits or phone calls to the facility. The treatment plans provided to us, and apparently to the guardian if they are part of the record, include measureable goals and objectives but there is no documented status, progress or data collection to demonstrate how and if the resident is attaining them, at least through September, which is in conflict with program policy. There are staffing summary reports for November and after to show how many times she attended activities and group or individual therapies, but even those contain only general statements about her involvement. In addition, the plans do not list the specific staff who are responsible for evaluating and documenting the resident's progress toward accomplishment. Finally, prescribing medications is part of treatment planning. Guardian informed consent is required by regulations, in writing by the

Administrative Code and program policy, but there was no written consent provided or proof that it was attempted until the end of September and just for one medication although there were four others being administered beforehand. Communication with the guardian about treatment planning and monitoring has not always been consistent, and that part of the complaint is substantiated.

RECOMMENDATIONS

1. Treatment planning staff must document their efforts to notify guardians about treatment planning and reviewing to demonstrate compliance with inclusion requirements.

2. Instruct all appropriate staff to document goal/objective status on treatment plans as well as the names of those responsible for evaluating progress.

3. Complete appropriate signatures and dates for each treatment plan.

4. Instruct all appropriate staff to secure written informed consent from guardians for psychotropic medication orders and to document receipt every time.

5. Develop a procedure specific to private guardian contact and psychotropic medication consent matters.

SUGGESTIONS

1. Note on treatment plan meeting/participant pages whether guardians/family attend or were invited to attend, regardless of whether they choose to sign.

2. Continue efforts to work with the guardian in obtaining a release in order to communicate with the resident's school.

3. To reduce communication snags and benefit the program and guardians alike, consider having witnesses to consents and other agreements and designate a primary contact person.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

Rock River
Academy & Residential Center

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May 9, 2009

Erin Wade, PhD., Acting Chairperson
Human Rights Authority
Illinois Guardianship and Advocacy Commission
4302 N. Main St., Suite #108
Rockford, Illinois 61103-5202

Re: #09-080-9008

Dear Mr. Wade:

Thank you for the opportunity to address the complaint stating in general, there is no therapeutic component at the residential center. I am pleased that the team of professionals from the Guardianship and Advocacy Commission found ample evidence of multidisciplinary assessment and treatment beginning with the resident's admission July 2008, in addition to compliance with the Mental Health Code:

> *A recipient of service 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 (405 ILCS 5/2-102).*

Initial treatment plans are designed to provide individualized treatment based on the residents needs, multidisciplinary assessments, resident and guardian input. As noted during the onsite visit and in subsequent documentation RockRiver Residential Treatment Center exceeds The Administrative Code for child care institutions by reviewing the residents treatment plan every 30 days in addition to a quarterly opposed to at least every six months.

Although medications that the resident came to the facility on were continued following her admission, we recognize the importance of documented evidence of compliance with code 405 ILCS 5/2-102 a-5. The following actions have been implemented in response to recommendations received on April 27, 2009:

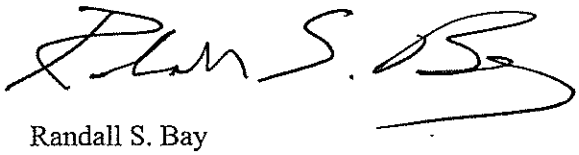
- The attending physician will continue to review medication recommendations with the guardian prior to initiation of any new psychotropic drug; nursing staff will follow up with the guardian for consent prior to initiating medication administration.
- A copy of the signed consent including a copy of documentation provided to the guardian of risks and benefits pertaining to the specific drug will be placed in the resident's record.
- The facilities medication consent policy MM-01 has been revised adding a provision for sending guardian consents via facsimile or certified mail to ensure receipt.
- Guardian notification of upcoming treatment staffing will be documented by the therapist in the clinical record at the time of contact.

- Review of treatment plan requirements including documentation of responsible individuals as well as evidence of status updates in relation to treatment, has been completed.
- Therapists have additionally been instructed to document participants involved in treatment planning. Participants will continue to be encouraged to provide evidence of participation by signature.

As suggested the treatment team at RockRiver Resident Treatment Center will continue to encourage the guardian to authorize communication with the resident's home school as a means to providing continuity of treatment for the resident.

Should this complaint be posted on the Commission's Web Site and/or forwarded to any regulatory agency, it is requested that this response additionally be posted for public view.

Respectfully,



Randall S. Bay
C.E.O.