FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
09-110-9047
Jefferson County Comprehensive Services, Inc.
November 9, 2009

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Jefferson County Comprehensive Services, Inc., a community agency that provides comprehensive services for individuals in Jefferson and Hamilton counties. The agency provides the following: services for seniors, mental health services, rehabilitation/workshop programming and substance abuse services. This report is regarding services within the mental health division of the agency. The mental health services division provides assessment, counseling (individual, group and family), sexual abuse treatment, crisis intervention, case management, psychiatric/psychological evaluation, and Community Integrated Living Arrangements. The specific allegation is as follows:

> Jefferson County Comprehensive Services, Inc. has refused to provide services to an individual.

Statutes

If substantiated, the allegation would be a violation of the Illinois Administrative Code (59 Ill Admin Code, 132.145 (f) and 132.150 (a-2).

Section 132.145 (f) states, "When discharging a client from services, the provider shall ensure that continuity and coordination of services as provided in the client's ITP. The provider shall: 1) Communicate, consistent with the requirement of Section 132.142, relevant treatment and service information prior to or at the time that the client is transferred to a receiving program of the provider or is terminated from services and referred to a program operated by another service provider, if the client or parent or guardian, as appropriate, proved written authorization; and 2) Document in the client's record the referral to other human service providers and follow-up efforts to link the clients to services."

Section 132.150 (a-2) states, "Service termination criteria shall include: A) Determination that the client's acute symptomatology has improved and improvement can be maintained; b) Determination that the client's level of role functioning has significantly deteriorated to a degree where referral or transfer to a more intensive mental health treatment is indicated; or C) Documentation in the client's clinical record that the client terminated participation in the program."

Investigation Information

To investigate the allegation, the HRA Investigation Team, consisting of one member and the HRA Coordinator (Coordinator), conducted a site visit to the facility. During the visit, the Team spoke with the Agency Director (Director) and the Director of Mental Health Services (MH Director). The Coordinator spoke via telephone with the client whose rights were alleged to have been violated. With the client's written authorization, the HRA requested, received and reviewed information from the client's clinical chart. Policies pertinent to the allegation were also reviewed.

I…Interviews:

A…Client

The client informed the Coordinator that he had an appointment at Jefferson County Comprehensive Services for individual counseling services. However, he was unable to keep the scheduled time because he became ill and required treatment at an area emergency room at the same time the appointment was scheduled. He stated that after the missed appointment he received a letter stating that he could not return for counseling services. He informed the Coordinator that shortly after receiving the letter, the MH Director called him and told him to disregard the letter and instructed him to call to arrange for another appointment. The client stated that when he called his counselor to arrange for a counseling session, he was informed that he could no longer receive services at the agency. The client stated that he considers the agency's refusal to allow him to return for counseling as retaliation for his wife being named by Social Security as payee for a client at the facility. He stated that his wife replaced the agency as payee.

B…Agency Director (Director)

According to the Director, the client has received services intermittently in the Psychosocial Program, individual counseling and substance abuse programs. The Director stated that the client was most recently involved in individual counseling; however, he consistently failed to show up for scheduled appointments.

The Director informed the Team that a letter is sent to clients upon admission to mental health services notifying them of the importance of attending all recommended services. According to the Director, clients are informed that missing two doctor appointments, therapy sessions or case management could result in a referral to another agency and closure of a client's case at the facility.

C… MH Director

According to the MH Director, the client received services at the agency from May 2007 until August 2007. When he discontinued services at Jefferson County Comprehensive Services, he commenced services at another agency. However, when the physician that was treating the client left the area in 2008, the client returned to the agency in crisis. The MH Director stated

that the crisis situation was addressed, and he was scheduled for weekly counseling sessions. She stated that the sessions were scheduled for the same day of the week at the same hour of the day, and a telephone call was made to remind the client of each forthcoming session. The MH Director informed the Team that when the call was made, the client would state that he would attend the session. However, he consistently failed to come to the agency for the scheduled sessions.

The MH Director stated that due to the client's failure to attend the sessions, the facility psychiatrist stated that he did not believe there was a therapeutic alliance with the client and a referral to another agency was recommended. The MH Director stated that the client was informed that due to his lack of participation in therapy sessions, the sessions would be discontinued; however, he would continue to have access to crisis intervention. The MH Director informed the Team that the client has a pattern of going from agency to agency to receive mental health services.

According to the MH Director, clients are informed of the grievance procedure during the admission process, and the client, who rights were alleged to have been violated, did not choose to follow the process.

II…Clinical Chart Review

A…Consumer Service Plan (Plan)

According to the Plan for the period of 12/29/08 to 06/29/09, the 44-year-old male had problems with depression and coping with problems in his life at various times. His ability to stand up for himself and his computer skills were listed as a strengths. Documentation indicated that the recipient's need for treatment and some friends were listed as problem areas.

Problem Area I was listed as follows: "[NAME] reports that he is having trouble with depression as evidenced by his report that he feels sad, has trouble coping and states that he has anger problems due to feeling depressed." The Long Term Goal to address the problem was for the client to develop healthy cognitive patterns and beliefs about self. Alleviation of depression would be evidenced by his report of feeling better, improved mood, enjoying life and activities and feeling calmer. The short term objective was for the client to identify cognitive self-talk that supports depression and to replace the negative self talk with realistic and positive self-talk. The action plan to assist the client in achieving the goals was listed as individual therapy for one hour four times per month to address and reinforce positive cognitive messages.

According to the Plan, the client could benefit from coordination of services between agency staff, providers from other agencies, and his family members/significant others. A goal for the client to receive client centered consultation services to promote planning and integration of services to best meet his needs was included in the plan.

Problem Area II was listed as, "[NAME] needs assistance at times to access necessary services that help him to maintain his functioning level, as evidenced by staff observation and [NAME] report." The plan included a goal for the client to receive mental health case

management services, which would include but not be limited to referral linkage services, planning, assessments, home visits/outreach, monitoring, advocacy and support. The client's ability to continue to function at his present level and his reporting that he is receiving an array of services that contribute to his well being is listed as evidence of goal attainment.

The recipient's diagnoses were listed as the following: AXIS 1: Bipolar Disorder mixed; AXIS II: Personality Disorder NOS (Not Otherwise Specified); AXIS III: Diabetes, Hypertension, Obesity, Asthma, allergic to Mellaril and Prozac and AXIS IV: Home living situation.

The Plan documented that the side effects of the client's medication had been reviewed, and he had been informed of his client rights.

B.. Statement of Rights (Statement)

The record indicated that the client was presented with a Statement upon admission to the agency's programming. According to documentation, the agency was committed to ensure that each client receives professional services directed toward his/her needs in a manner that protects the dignity and feeling of self-worth of each client.

Clients are informed that they retain all rights, benefits and privileges guaranteed by Chapter 2 of the Mental Health and Developmental Disabilities Code. Clients were also informed of the right to be free from neglect or physical, emotional or sexual abuse.

According to the Statement, an individual's ethnic background, personal or social creed, sexual orientation, racial membership, sex, religion or age will not affect services to a client. Services will not be refused due to lack of or limited personal financial resources. No physical barriers will preclude treatment.

Documentation in the Statement assures clients of confidentiality of information in accordance with the Mental Health and Developmental Disabilities Confidentiality Act and the Health Insurance Portability and Accountability Act. Clients are informed that they have a right to review and approve any information being sent to another provider giving services, and a signed release of information is required before any information can be sent. Information regarding HIV/AIDS status, testing, and test results is confidential and is not included in a client's treatment record.

Clients are informed of the case manager who is assigned to assist them in obtaining services throughout their treatment, the right to participate in the development and updating of an individualized treatment plan and the right to have any family member/significant others to participate in any staffing. Clients are advised that they have a right to know the name and professional credentials of anyone working with them, the right to be advised of the positive effects and possible complication of any medication prescribed by agency physicians, the right to refuse to participate in or be interviewed for any research purposes, and the right to terminate treatment at any time. They are advised that denial, suspension or termination of services will not be implemented due to exercising any of their rights.

The grievance procedure is outlined in the Statement. Clients are advised to discuss their concerns with their assigned case manager as the first step to attempt to resolve their problems. If after talking with the case manager, the issues have not been satisfied, the concerns should be presented in writing to the Program Coordinator. Within five working days, a written response will be provided. If the matter is not resolved to satisfaction, clients are informed that they may present a written appeal to the Executive Director, who will provide a written response within five working days. If the problem still exists, clients may request that the matter be reviewed by members of the agency's Board of Directors through the Executive Director. Clients are also provided with the address and telephone numbers of the following agencies: The Illinois Guardianship and Advocacy Commission, the Department of Human Services, the Office of Mental Health, and Equip for Equality.

Clients are informed of the agency's expectations. Those expectations were listed as: 1) to provide accurate information; 2) to comply with treatment plans and agency rules. 3) to pay for services, whether directly, through insurance, or third party payments; and 4) To respect the confidentiality of other consumers. Clients are advised of the opportunity to provide input into evaluating agency services for the purpose of improving the quality of services throughout their treatment, at case closure and three months following closure.

C. Letter to Client:

The Authority reviewed a letter that was sent to the client when he was admitted for services at the agency, and the HRA was informed that it is facility policy to send to all clients after being admitted to mental health services.

The letter states, "You have requested and been referred to our agency psychiatrist for services. We prefer to provide the best clinical services possible. It is important that you attend all recommended services. You will be part of developing your treatment plan. If you have concerns or believe your plans should change then request to review the plan and discuss changes. If there are barriers to your attendance and participation in treatment it is important that you speak with your case manager or therapist. Area resources for affordable mental health treatment are limited. We ask that you attend scheduled sessions. Failure to attend all scheduled sessions will be reviewed by your team. Two missed doctor appointments can result in referral to an outside source. Two missed therapy or case management sessions can also result in referral to another agency and closure of your case."

D. Progress Notes

According to an 11/03/08 Progress Note, the client came to the agency in crisis and requested to speak with a therapist. Documentation indicated that the client met with the therapist and determined that the client was emotionally stable enough to leave the office. The client vocalized that he would call the office or the crisis line if needed prior to his upcoming appointment with his primary therapist.

Documentation in an 11/10/08 Progress Note completed by the MH Director indicated that the client called to complain that he was having difficulty arranging an appointment with an area physician. The record indicated that the MH Director explained that there was a shortage of psychiatrists in the area; therefore, it was difficult to obtain an appointment. The MH Director advised the client to remain with the psychiatrist that was presently treating him until he was able to be seen by another psychiatrist. The client also expressed a desire to return to the Psychosocial Rehabilitation (PSR) Program. He explained to the MH Director that his past problem was due to the leader of the PSR Program. The MH Director agreed to speak with others at the agency in a staffing session to discuss the client's return to the PSR Program.

The client's therapist documented on 12/29/08 that he had seen the client three times since his return to the agency. He documented that the client's mental status was normal and he did not report any intent to harm anyone. The Therapist recorded that he would see the client again the next month per the client's request.

According to a 02/03/09 Progress Note at 2:15 PM, the client repeatedly called the agency to request payment of $70, which he perceived was owed to another client that his wife was presently acting as Social Security payee. He was directed to leave a voice mail message for a staff member who was involved in programming. The record indicated that the client left a voicemail message; however, he promptly called back, hung up and called back several more times. Documentation indicated that the client stated that he was coming to the facility and bringing documentation with him from Social Security and the Attorney General's office. An additional Progress Note completed by the MH Director on 02/03/09 at 2:45 PM indicated that the client, a family member and a teenage male came to the agency office. The record indicated that they presented in a very loud and demanding way at the counter and were asked to have a seat in the lobby until the client's therapist was available. According to the documentation, the client came back to the counter, slammed down a checkbook and began speaking to the receptionist in a threatening manner. The MH Director recorded that she spoke with the client and stated that she would be happy to speak with him if he could come into her office; however, he continued to threaten and his tone of voice became louder. According to the record, a young child in the waiting room became frightened and began to cry. The MH Director documented that she continued to request that the client come into her office and speak in a calm manner versus threatening others. However, he opted to slam his fist into the counter and walk outside, leaving his family in the office.

Documentation in a 02/20/09 Progress Note indicated that a staffing was conducted regarding the client. The record indicated that the recipient had consistently missed his therapy and doctor's appointments. He had become loud, threatening and very inappropriate when he was present at the agency. Additionally, other clients had complained about his behaviors, and that he was interfering with their services. The MH Director documented that a referral for services had been made to another community agency. The MH Director recorded that the client's therapy sessions would end at the facility due to the above factors when he commenced services at the referred agency.

A Therapist recorded that the client called him on 03/09/09 to speak with him about his frustration because the agency would not give him money that belonged to his roommate for

whom the agency acted as payee. The Therapist documented that he informed the client that the agency could not give money to him without his roommate's consent. The Therapist recorded that he reminded the client that he had missed counseling appointments, but he could return to the agency to discuss his issues of concern. According to the Therapist's recordings, the client replied in an angry manner that he "would rather not do that". Documentation indicated that the Therapist let the client know that the crisis line was available if needed.

A Progress Note dated 08/29/09 indicated that the client went to an area emergency room with suicidal ideations. When a crisis worker from the agency went to the emergency room to assess the client's mental status, documentation indicated that the client had "calmed down". When the assessment was completed, the client agreed to the following: to take all prescribed medication, utilize his support systems, to return to the emergency room if the symptoms worsen, to follow up with the physician who treated his psychiatric condition, to refrain from taking illegal drugs and alcohol, to get plenty of rest and to call the agency crisis line if needed. The record indicated that the crisis worker recommended follow up counseling at the agency; however, the client refused the services.

The HRA did not observe any documentation in the Progress Notes that indicated the client had followed the agency's grievance policy to resolve his issues of concern.

History of Attendance:

According to an attendance form, the client was sent for intake and mental health assessment purposes on 05/24/08, individual therapy on 06/05/07, individual therapy/treatment plan development on 06/19/07, individual therapy on 07/24/07, an undated mental health assessment on 11/04/08, individual therapy on 12/29/08, and psychiatric evaluation on 01/02/09.

Documentation indicated that the client failed to keep appointments on 12/12/08 (Psychiatric appointment), 01/26/09 (Individual Therapy), 02/20/09 (Individual Therapy) and 02/23/09 (Individual Therapy). The record indicated that when the client called a facility therapist on 03/09/09, the therapist informed the client that even though he had missed scheduled therapy sessions he could return to the agency to discuss his issues of concern. Additional documentation indicated that on 08/28/09 the client was seen by a facility staff during a crisis situation.

Closing Summary and Aftercare Plan

Documentation indicated that the client received services from 05/24/07 until the case was closed for therapy sessions on 09/25/09. The record indicated that the client was a 44-year-old male who reports depression and problems with coping in his daily life. The client reported that he wanted services to assist him in coping better and controlling his anger. Documentation indicated that at the time of closing his remaining needs were to become serious about treatment and to attend scheduled sessions in order to work toward recovery. The record indicated that the goals were not accomplished due to the client's poor attendance and lack of commitment to recovery. The record indicated that the client was made aware that he could call the agency for assistance as needed.

III…Policies

Admission Criteria for Mental Health Division Outpatient Program (Admission Policy)

The Procedure is listed as follows: "1. Applicants are set up for a mental health assessment appointment with a case manager as they make initial contact with the Mental Health Center. Scheduling is according to first available appointment or by consumer choice, if otherwise. Callers expressing suicidal ideation or who appear to be severely depressed are given priority scheduling, as are hospital discharges requiring immediate linkage. Applicants shall be interviewed by the Case Manager (or other mental health professional) for completion of an intake interview and mental health assessment. a) During this intake interview, eligibility for services will be evaluated, based on assessment of level of care required, problem areas, strengths, abilities, needs, preferences and personal goals for treatment. Availability of possible funding sources is also assessed at this time with a determination made as to eligibility for coverage through Medicaid, insurance, contract services or other payer source. b) An interim service agreement (preliminary treatment plan) is completed with input from the consumer or his/her family, when appropriate. c) The client is asked to co-sign the plan. Persons aged 12 or older may sign the plan for themselves. If the client is younger than 12, parent or guardian signature is required."

According to the Admission Policy, one or more of the following criteria must be met before an individual is accepted for outpatient counseling: 1) The person must request services or be referred for services.2) The primary problem must be related to a mental health issue. 3) The client has a Global Assessment of Functioning (GAF) score that indicates some difficulty in social, occupation or school functioning. 4) The applicant is not a danger to self or others and does not require a more intensive level of services. 5) The applicant can not be better served by another program. 6) The applicant is deemed capable of making changes to enhance level of functioning as a result of short-term outpatient treatment. 7) The applicant is in need of case management/support services or medication monitoring to maintain present level of functioning. 8) The applicant is able to speak English, sign language or work through a translator. 9) The applicant is legally eligible for services.

According to the Policy, the Case Manager or other mental health professional who completed the intake assessment shall present the results at a treatment team staffing. A determination will be made regarding the appropriateness of mental health outpatient programming, other agency services that might benefit the applicant and/or the applicant's family, other treatment options, and other community resources that might be of benefit to the applicant and/or the applicant's family. If the applicant is accepted for treatment, the case is assigned to the appropriate counselor. If the applicant is assessed as being ineligible for services, explanations are given and recommendations/referrals made for alternative services. With the applicant's consent, the referral source is also notified.

The exclusionary criteria for services are listed as follows: 1) The individual presents acute symptoms or deterioration in functioning to the degree that the criteria for inpatient

psychiatric is met. 2) The individual is a risk to self or others. 3) The individual is experiencing acute psychotic symptoms. 4) The individual has the means to pay for services but refuses to pay or provide adequate information to allow the Center to utilize the individual's third-party payee. (Refusal to cooperate is not due to the individual's mental illness.) 5) The individual is not a resident of Jefferson or Hamilton County and is unwilling to pay fees. 6) The individual does not exhibit a mental illness diagnosis. 7) The individual is not willing to participate in the Mental Health Evaluation (MHA) or Treatment Planning process and/or is not willing to participate in treatment by consistently attending scheduled sessions. (Refusal to cooperate is not due to the individual's mental health issues.) 7) The individual threatens staff. 8) The individual presents acutely intoxicated. 9) The individual has medical complications that require stabilization prior to the individual being able to participate in treatment. 10) The individual is not willing to provide adequate information about themselves or their history in order that an accurate and clear diagnosis may be made.

Readmission Criteria (Mental Health Division Outpatient Program):

According to the readmission criteria, consumers are informed that they may return to the agency if they feel the need for further services. At that time, they will be assessed for admission to the program in the same manner as the previous assessment when they initially contact the agency.

Summary

According to documentation, the client had received services at the agency prior the emergency call associated with the most recent admission. The record indicated that he was receiving treatment at another agency when he called for crisis intervention on 11/03/08. When he was accepted for services, a treatment plan was developed with his input and counseling sessions with a therapist were scheduled for the same time on the same day of the week. Documentation indicated that agency staff called the client to remind him of his appointment, and he would always state that he would attend the counseling session. According to documentation, the client failed to keep an appointment with the facility psychiatrist on 12/12/08 and therapy appointments on 01/26/09, 02/20/09, and 02/23/09. Documentation also indicated that on 02/03/09 the client repeatedly called the agency and spoke to staff in a threatening manner. After making the calls, he came to the agency, demanded money that he perceived the agency owed an individual that his wife was acting as payee and lives with the couple. During the visit, he became very loud, pounded on the counter where the receptionist was located and threatened staff. According to the documentation, the client's behaviors frightened a small child in the waiting room causing the child to cry. When the client called the Therapist on 03/09/09 to speak with him regarding his frustration because the agency refused to give him money that belonged to his roommate, the Therapist informed him that he could return to the agency to speak with him about his frustrations; however, the client refused to return for the counseling session.

According to facility policy, clients who are at risk to self or others and those who are not willing to participate in treatment by consistently attending scheduled sessions can be terminated. However, clients will not be excluded from crisis treatment, and a referral will be

made to another agency in order that a client may be provided services. Additionally, the facility policy allows for clients to apply for re-admission to agency programming. Documentation indicated that the client was seen by an agency crisis worker on 08/29/09 at an area emergency room. When the crisis worker recommended that he return to the agency for follow up counseling, he refused the services. The record indicated that the client was informed at the time of closure for therapy sessions on 09/25/09 that he could contact the agency as needed for services.

Conclusion

During the course of the investigation, the Authority found some of the recordings in the client's difficult to follow; however, the HRA does not determine the client's rights were restricted. Based on documentation obtained, the client was not formally discharged from mental health services until 09/25/09, after he refused to attend counseling sessions. The record indicated that the client was informed that crisis intervention services were always available to him. Therefore, the allegation that the Jefferson County Comprehensive Services, Inc. has refused to provide services to an individual is unsubstantiated. No recommendations are issued.

Comments and Suggestions.

During the case review, it was noted in 12/29/08 progress notes that the therapist spoke with the client on three occasions; however, the HRA was only able to determine by the documentation that the therapist spoke with the client twice. The record also indicated that during a staffing on 02/20/09, a decision was made to refer the client to another agency for mental health services. However, the record indicated that the client was scheduled to attend a counseling session with the therapist on 02/23/09, three days after the staffing was conducted. The HRA suggests the following:

1. Facility staff should assure that there is consistent documentation pertinent to services provided to clients.

2. Staff should provide clear and concise recordings in Progress Notes pertinent to a client's attendance or failure to attend programming/therapy sessions, as well as an explanation for any changes in a client's status while receiving services at the facility.