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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 10-030-9004
Chicago Read Mental Health Center

Case Summary: The HRA substantiated the complaint that the facility discharged the recipient in violation of the Mental Health Code.

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at the Chicago Read Mental Health Center (Read). It was alleged that the facility discharged a recipient in violation of the Mental Health Code. If substantiated, these allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.) and program policies.

Chicago Read Mental Health Center is a 215-bed Illinois Department of Human Services (DHS) facility located in Chicago. To review these complaints, the HRA conducted a site visit and interviewed the Quality Manager, the Social Work Unit Supervisor, the Director of Social Work, and a Social Worker. Relevant hospital policies were reviewed, and records were obtained with the consent of the adult recipient.

COMPLAINT SUMMARY

The complaint alleges that on 9/03/09 a recipient was discharged from Read because he objected to his discharge and facility staff then had him arrested for an incident that occurred the day before his staffing. This denied the recipient his right to a discharge hearing and to be referred for appropriate services to address his mental health needs.

The complaint states that on 8/26/09 the recipient was taken to Read from a hospital emergency room because he was having suicidal thoughts. At the recipient's admission his father spoke with the staff social worker and informed her that the recipient had attempted suicide in the past and he thought he was a danger to himself and others. The complaint alleges that throughout his hospital stay the recipient repeatedly verbalized suicidal ideation, primarily related to his anxiety over becoming homeless and the news of his mother's cancer. The complaint alleges that on or about 9/01/09 the recipient was experiencing an anxiety attack and

wanted to speak with his psychiatrist, who was in his social worker's office, to request an administration of Ativan. The recipient allegedly was crying and requesting his psychiatrist when he pushed past a nurse (who was blocking the doorway with her arms) into his social worker's office. The recipient's psychiatrist then ordered Ativan for the recipient and he left. The security staff was not called and the recipient was not placed in restraints or restrained medically or isolated from his peers. He continued with his normal activities.

According to the complaint, on 9/03/09 the recipient was called into a room with his treatment team and a doctor whom he did not know. He was told that there was no reason medically or psychologically to keep him in residential treatment. At this time he was given a Notice of Discharge to which the recipient immediately objected, although staff told him he could take time to think about it. At the same time, the facility told the recipient they notified the police and reported that the recipient had previously been violent and they wished to file charges against him for assault. The police were waiting at the facility and removed the recipient, taking him to the police station where he was charged. In the meantime the police officer placing the recipient in handcuffs told the recipient that the facility must have wanted to get rid of him because they did not ordinarily press charges against unruly residents, thus the recipient believed the facility used his arrest as a means to discharge him because they realized he would object to his discharge.

The complaint further states that approximately six hours after the police arrested the recipient he was released on bond. He was released without any medication or belongings. He then borrowed someone's phone and called his father stating that he had nowhere to go and had not been given any of his personal effects. His father then took him to his home to make arrangements for some kind of placement. In his father's home the recipient located a key to the father's gun safe and removed a gun. His father heard the click of the gun in his son's hand attempting to commit suicide and realized that he had selected one of the guns that was not loaded. The recipient was then taken to a hospital that referred him to a mental health facility.

The complaint indicates that the father returned to the facility several days after the incident to pick up his son's belongings and asked security staff about what happened on the day of his son's arrest. They stated that they did not remember an event and did not think that an incident report had been completed.

FINDINGS

The clinical record facesheet indicates the recipient was admitted to Read on 8/26/09. The Comprehensive Psychiatric Evaluation completed on Intake the same day states, "39 yr old white male comes with h/o [history of] depression and anxiety. Says he has been depressed for about 2 yrs. Says he attempted suicide by taking an OD of Tylenol (100 tabs) also 3 Motrin when he found out he had Hepatitis C. He was admitted and released from [hospital]. He stayed in NH [nursing home] for about 3 months where he was seen by psychiatrist, who placed him on Xanax, Haldol and Cogentin. Says he mainly takes Xanax for anxiety. He denies any hallucinations. He also denies any suicide ideas at present. Has had 5-6 admissions since April, 2009." The chief complaint sections states, "I feel depressed. My girlfriend left me after being with me for 13 years. I also lost money in stock market." In the past personal history section it

states, "Single, no children. Owned an ad agency but says business went down due to recession. At present is unemployed." The evaluation listed an Axis I diagnosis as Major Depression-Recent episode with anxiety, Axis III diagnosis as Degenerative Disease of the Spine, Axis IV as homeless and unemployed, and Axis V GAF (Global Assessment of Functioning) 25.

A Self Injurious Behavior Risk Assessment document is included in the record which indicates that the recipient is at "Very little/no risk" for suicide or self injury. However, the checklist did not indicate the recipient's method of prior suicide attempts, did not indicate the recipient's chronic back pain, recent loss or other life stressors, and that the recipient had a history of drug abuse.

The Social Assessment, completed on 9/01/09 states, "39 yr old single white male who has a Hx [history] dating back a few months. Pt. presents with a strong personality disorder and appears to have a prescription drug abuse problem although he denies this. He presents as demanding and manipulative and is insisting on being provided housing during this admission or he will kill himself. Pt. has a poor relationship with his family and they report he is not welcome at home due to his addiction and threatening behavior." In the Reason for Referral section it states, "Brought to ER by mother after patient exhibited severe anxiety, threatened SI [suicide], was agitated and threatening to mother and refused to return to his nursing home."

Nursing Notes entered on 8/29/09 state, "Engaged in 1:1 session to verbalize feelings and concerns. Claimed feeling depressed 'I feel depressed because my mom was diagnosed with lung cancer yesterday and I feel like shit because I'm homeless'. Verbalized feeling frustrated about present life situation. Denies to self harm. Took prn [as needed] medication. Denies to auditory and visual hallucinations. Continue to monitor behavior and maintain unpredictable behavior." On 8/30/09 a psychiatry note was entered stating, "Pt. reported 'mother has cancer, feel very anxious, want to leave and visit his mother. Pt. agitated…..order Ativan 2 mg PRN.'" A psychiatry note was entered the following day stating, "Talked to pt. discussed with social worker that mother has lung cancer. I have [increased] anxiety, do not want take psych meds because of my Hep C. Need continue Klonopin for anxiety. Not suicidal irritable, anxiety, demanding….agreed to go to rehab program." On 9/01/09 a nursing note entry states, "Lorazepam 2 mg IM [intramuscular] given per request. Patient complained of feeling very anxious. Demanding for his medication. 'I'm worried about my mother, she is in the hospital.' Refuse PO [oral] claimed doesn't work. Continue to observe. Assess effect of medication."

On 9/01/09 a social work note was entered into the progress notes. It states, "Met with pt. x 5 to complete initial assessment, develop tx [treatment] goals/aftercare plan. Spoke with pt.'s father. Pt. readily meets with writer and requests housing. He reports he was staying in a nursing home despite not having active funding but had only been there a few weeks and then he left. Pt. reports 'hating' the nursing home and refused to return. He is requesting housing in the Des Plaines area. This writer explained he did not meet the requirements for a referral to a nursing home and was unfunded which greatly limited his housing options. Pt. repeatedly threatened throughout 1:1 session that he would kill himself if he was discharged to a shelter. Pt. was offered a referral for substance abuse tx including housing but refused stating he did not have a SA [substance abuse] problem. On Monday 8/31/09 he agreed to a SA tx referral stating he 'use to have' an addiction to pain medication. This writer provided pt. with over 20 possible

housing options for SA tx including…but pt. has refused all referrals for various reasons because they are no in the Des Plains [sic]. Pt.'s father reports he cannot return home to live with them due to his drug problem and threatening behavior. Pt. sabotaging treatment process by refusing referrals, demanding unrealistic referrals, and not being honest about his illness. Signed a 5 day. Threatening suicide to get his needs met. Uncooperative with aftercare planning. Continue attempts to assist pt. with aftercare referrals, continue 1:1." A psychiatry note made on the same day states, "Pt. agreed to take Celexa for anxiety depression. He agreed to be cooperative and work on his discharge, try to find a place. He withdraweled [sic] 5 day request…."

The recipient's Master Treatment Plan was included in the record. It identified 5 Goals and Objectives:

"1. Patient will attend AT [Active Treatment] (groups assigned. Participate in activities and discussions, gain insight into Mood disorders, substance abuse, learn to manage, cope with and minimize symptoms of illness).

2. Patient will take medicine, will not hurt self, attend groups, do his ADL's, personal care.

3. Patient will have a stable mood free from episodes of depression/ SI for 5 days.

4. Pt. will be able to discuss discharge from hospital without threatening suicidal ideations by 9/3.

5. Patient will accept a referral for housing (shelter, recovery Home) and participate in any intake interviews as needed."

Nursing notes entered on 9/01/09 at 8:00 p.m. state, "1:1 with pt. to discuss appropriate behavior for the milieu and the unit policies. Pt. grabbed telephone from behind the desk and refused to follow staff direction when asked to use one of the two patient phones. Said that his social worker said he could use the staff phone. When staff said the pt. phone was available for him to use he threw the phone at the wall and said, "You're all a bunch of cunts…." On 9/02/09 a psychiatry entry states, "…Pt. was demanding to get a place to stay. Threatened, 'if you discharge me with no place to stay I will kill myself.' Irritated, agitated, non-cooperative, manipulative…" Later the same day an entry indicates, "….Pt. upset and agitated my mother sick I have no place to stay if they discharge me I'll kill myself and refused to be discharged. If you give me thorazine I'll hit you in your face you're giving thorazine to everybody." A nursing note entered at 8:00 p.m. states, ….Pt. verbally abusive very entitled and demanding. Pt. insists on getting Lorazepam IM states, 'I can have whatever I want.' Discussed that he could not be discharged and Lorazepam IM. He says he's not going anywhere because he isn't going to a lousy shelter…."

An Activity Therapy progress note dated 9/01/09 states, "Pt. to be discharged on 9/2- Stable, appropriate behavior/self conduct- has attended some groups No overt behaviors/symptoms present that need inpatient treatment- lazy, not responsible for his behavior, unmotivated- wants to be taken care of. 9/2 discharge cancelled- 9/3 discharge to jail."

On 9/03/09 (no time given) a social worker note entered in the record states, "Pt. attempted to and (illegible) in coming around the Nursing Station without permission. This writer asked patient what he needed and patient called me 'Black Cunt' and pushed me into the

wall. Patient was out of control and was threatening another social worker and doctor. This is the second time patient has without permission came behind the nursing station. Patient does what he wants and refuses to follow the rules." A nursing note entry made at "1050" (presumably a.m.) states, "pt. on F.O. [frequent observation] for unpredictable behavior. Assessed and verbal redirections done by staff to pt. during ADL [activities of daily living] time. Pt. reported still feeling depressed and not sleeping good. Pt. ate good at breakfast time, 100% of food served. Pt. encouraged to cooperate with safety (illegible) Pt. still reports suicidal ideation, denies suicidal plan. Pt. remained very unpredictable and still having difficulty discharge plan. Pt. easily gets agitated and angry…." A nursing note made at 11:45 states that "Pt. was discharged to …police as ordered today with all his belongings @ 11:00 escorted by security staff to the lobby."

On 9/03/09 a psychiatry note was entered into the record at 11:00 a.m. It states, "Staffing with pt. treatment team medical director…discussed with pt. about his discharge notice. Pt. has had no psychotic or manic symptoms, sleep and appetite have fine [sic]… [illegible] energy and concentration. No suicidal behavior. He made threat as 'suicidal if you discharge me' which was his manipulative behavior. He showed non-cooperative with treatment plan poor motivation to make change interrupted unit treatment. He also pushed staff and was arrested by police."

The Notice of Discharge is signed 9/03/09 and describes the reason for discharge as "no longer meet medical necessity criteria for continued hospitalization." The objection to the discharge is signed by the recipient on the same day. The recipient was discharged at 11:00 a.m. with none of his belongings at the request of the arresting police.

The clinical record contains the Discharge Summary which offers the following reason for discharge: "Staffing meeting discussed with the patient and reviewed the patient case. A discharge notice was issued to the patient. Based on his clinical manifestation and based on staff observation, the patient no longer meets the criteria for inpatient psychiatric treatment. Recommend the patient continue outpatient treatment". The statement of the recipient's Condition on Discharge states, "mental status exam showed the patient had normal weight. His grooming and dressing was fair. His attitude was manipulative. He was uncooperative and hostile at time (sic) toward staff. He was alert and oriented with normal psychomotor activity. At time (sic) he was angry and agitated. His speech was fully organized, articulate. He had stable mood most times and he could be irritable, angry at times. He had full range affect. He reported suicidal ideations when discussed with the patient about discharge notice. The treatment team agreed that the patient's suicidal threats were just one of his manipulative behaviors to be uncooperative with treatment. There was no evidence of mania or psychotic symptoms during inpatient treatment at …. The patient had fair concentration and memory. He also had good daily function and good activity level. At this point the patient is stable." The discharge diagnoses were as follows: Axis I Anxiety Disorder, NOS, Axis II Personality Disorder (with Antisocial and Narcissistic Features), Axis III Hepatitis C, Axis IV Unemployed, and Axis V GAF 65-70. The referral for services section states: "Jail".

Hospital Representatives' Statements

Hospital representatives were interviewed regarding the complaint. They stated that from the time the recipient was admitted to the facility he made it very clear that he needed housing, not treatment. He met with his social worker daily (sometimes more than daily because he was very demanding) regarding housing and discharge and it appeared to staff that he sabotaged any effort to place him anywhere but in the area of Des Plaines, IL, and because he lacked funding, this was very difficult to do. The recipient rejected numerous options for placement and staff realized throughout his course of treatment that all of his episodes of suicidality centered around discussions of discharge or periods in which he was not getting his way. The recipient interacted actively on the unit and staff never saw the depressive symptoms which would suggest that he could become suicidal; every day he was becoming more agitated but not depressed. Staff stated, "He was never psychotic, he just had a personality disorder. We discharged him because he was manipulative but he was not psychotic."

Staff reported that the event for which the recipient was arrested occurred on 9/03/09. At this time he was insisting on getting into the social worker's office and when told he could not, he pushed the nurse against the wall to prevent her obstruction (she states she was not injured). Staff were asked about the timing of the police notification and they stated that the unit supervisor was immediately notified as well as the police. Staff reported that the treatment team was then called together to make a decision about placing charges against the recipient. They stated that this would always be a team decision and that the police would be notified only if the event was very serious. Staff stated that when the police were called they could not predict what they would do- at times they came to the facility and questioned staff, at times they just took a report, and at this time they came to the facility and issued an arrest. For this incident the police decided to arrest the recipient because the staff involved wanted to press charges.

Hospital representatives stated that they then called the recipient into the treatment team meeting. They informed him that he no longer met the criteria for inpatient placement. They issued his Notice of Discharge to which he immediately objected. At this time they also told him that the police had been called. The police were waiting outside the door of the meeting room and they then took the recipient into custody. The facility staff stated that they would have been in the process of setting the hearing date for his objection to discharge, however the fact that he was arrested made that unnecessary. Police told the staff that the recipient could not take any belongings with him to jail, and this is why he was left without his personal effects when he was released from police custody. The recipient's father then came back to the facility to pick up his belongings the following day.

After the HRA met with hospital representatives we requested and received a copy of the Incident Report for the above complaint. It indicates that the event that resulted in the arrest of the recipient occurred on 9/02/09 and was reported to security on 9/03/09.

STATUTORY BASIS

The Mental Health Code states that the facility director shall give written notice of discharge to the recipient, his attorney and guardian, if any, and that this notice shall include the reason for discharge. Whenever possible, this notice should be given at least 7 days prior to the date of the intended discharge. Also, the Code allows for the recipient to object to this discharge,

and upon receipt of an objection the facility director shall schedule a hearing to be held within 7 days at the facility and that no discharge shall proceed pending a hearing on the recipient's objection. At the hearing the department has the burden of proving that the recipient meets the standard for discharge under the Mental Health Code and its Administrative Act (405 ILCS 5/3-903 and 20 ILCS 1705/15).

The Mental Health and Developmental Disabilities Administrative Act mandates that before persons are released from a state operated facility the facility director must determine and state in writing whether the person is not currently in need of hospitalization and:

(a) is able to live in the community; or

(b) requires further oversight and supervisory care for which arrangements have been made with responsible relatives or supervised residential program approved by the department; or

(c) requires further personal care or general oversight as defined by the Nursing Home care Act, ….; or

(d) requires community mental health services for which arrangements have been made with a community mental health provider in accordance with criteria, standards, and procedures promulgated by rule.

It states, "Such determination shall be made in writing and shall become part of the facility record of such absolutely or conditionally discharged person. When the determination indicates that the condition of the person to be granted an absolute discharge or a conditional discharge is described under subparagraph c) or (d) of this section, the name and address of the continuing care facility or home to which such person is to be released shall be entered in the facility record." Also, the Act states, "Insofar as desirable in the interests of the former recipient, the facility, program, or home in which the discharged person is to be placed shall be located in or near the community in which the person resided prior to hospitalization or in the community in which the person's family or nearest of kin presently reside" (20 ILCS 1705/15).

The American Counseling Association Code of Ethics Section A.11a. states, "Counselors do not abandon or neglect clients in counseling. Counselors assist in making appropriate arrangements for the continuation of treatment, when necessary, during interruptions such as vacations, illness, and following termination." Also, if counselors determine they are unable to assist their clients, "Counselors are knowledgeable about….clinically appropriate referral resources and suggest these alternatives" (A.11b.).

FACILITY POLICY

Chicago Read Mental Health Center provided agency policy and procedure for Discharge (PC-09-10-25.00) and Objection to Discharge (PC-09-10-50.00). Both policies comply with the Mental Health Code standards and administrative rules. Hospital staff reported that the facility does not have policy specific to the discharge of recipients to the county jail.

CONCLUSION

The Mental Health Code guarantees recipients the right to object to their notice of discharge and to be given a hearing at the facility within 7 days of their written objection, and that no discharge shall proceed pending this hearing. Additionally, best practices mandate that persons with mental illness are discharged from a facility with a plan for continued care. The discharge planning sessions, held throughout the treatment episode, culminate in the notice of discharge and a final discharge planning session which ideally addresses not just the type and location of ongoing services, but also family involvement, medication needs, and other post-treatment concerns. In this case the final discharge process was complicated by the fact that at the same time as the discharge, the recipient was told that he could be arrested. Since the incident for which he was being arrested occurred the previous day, the arrest gave to the recipient the appearance of a planned manipulation on the part of hospital representatives, who wanted him released but knew that he would object.

The clinical record further obfuscates the events surrounding this recipient's discharge. Staff reported at the site visit that the aggression event involving the unit nurse occurred on 9/03/09, the same day that the recipient was given his discharge notice. They stated that the recipient was brought into the treatment team meeting and given his notice and then told that the police were called. The progress notes also suggest that the event occurred on the 3rd. The Incident Report, however, states that the event took place on the 2nd and was reported to security on the 3rd. An Activity Therapy note also indicated that the discharge was scheduled for the 2nd and then it was cancelled and the recipient was discharged on the 3rd "to jail". There is no mention of the aggression incident in the progress notes written on the 2nd. Additionally, the record does not indicate that the recipient received any consequence for his aggression, and in fact he was allowed to be in the milieu and continue his regular activities, leaving us to wonder how violent he could have been to be arrested a day after his alleged offense. Finally, the discharge summary indicates that the recipient is "stable" and it recommends "outpatient treatment". The recommendation for referral however, is "jail". If the recipient had been stable, then certainly an event serious enough to be arrested for would suggest he is in need of further evaluation and treatment, and a referral for treatment would seem to be appropriate. In any event it is impossible to discern from the record both the sequence of events and their degree of severity, and given that a crime was alleged to have been committed, these details are clinically relevant to the recipient's follow-up care and his right to object to his discharge and to have a discharge hearing. The HRA substantiates the complaint that the facility discharged the recipient in violation of the Mental Health Code.

RECOMMENDATIONS

1. Develop policy to address the discharge of a recipient to jail and review this policy with staff, so that the recipient right to object is honored and recommendations are made for continued care upon discharge.