FOR IMMEDIATE RELEASE

Peoria Regional Human Rights Authority
Report of Findings
Case #10-090-9011
Human Service Center

The Peoria Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning the Human Service Center:

1. The Center relied on input from another mental health program in determining the recipient's needs and medications rather than on objective assessments and input from the service recipient.

2. The Center psychiatrist abruptly ended a medication prescription without involving the service recipient.

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.) and regulations that govern community mental health services (59 Ill. Admin. Code 132).

The Human Service Center, located in Peoria, offers a variety of outpatient services to approximately 1600 individuals primarily residing in Peoria County. Available outpatient services include psychiatric, supportive employment, crisis and substance abuse services.

To investigate the allegations, an HRA team met with and interviewed a Center administrator and a Center psychiatrist, reviewed pertinent Center policies and, with consent, examined the record of a service recipient.

COMPLAINT STATEMENT

According to the complaint, a service recipient was referred to the Center from another mental health provider. A Center caseworker reportedly contacted the recipient by phone and acknowledged contact with the referring provider allegedly without a release. The complaint states that the caseworker accepted the referring provider's assessments and diagnoses of depression, anxiety, paranoia and delusions as well as the referring provider's statement that the recipient "went off her meds." The complaint states that the caseworker had a personal relationship with a caseworker at the referring agency. After contact with the Center psychiatrist began, the recipient attempted to renew her prescriptions but she was reportedly told that the psychiatrist discontinued one medication (Mirtazapine, an antidepressant). The medication was allegedly dropped without any discussion with the recipient.

FINDINGS

Interviews

The Center administrator provided an overview of Center services. Of the 1600 individuals receiving outpatient services, approximately 99% also receive psychiatric services. There are five levels of outpatient services and the level identifies the frequency with which the Center has contact with a service recipient. Services begin after a recipient contacts the Assessment and Admission Unit; referrals come to the Center as walk-ins, referrals from other agencies or through a crisis service. With telephone inquiries, screenings are conducted to verify county of residence as well as eligibility; state criteria currently prioritizes services primarily for individuals considered to have a serious mental illness. Two levels of assessments are conducted; one by the assessment unit and the other by the specific program to which the individual has applied. When there is no available capacity within a particular program, another program called, Start Now, allows individuals to attend group sessions; however, if someone is extremely symptomatic, staff can refer an individual to the hospital or for medical or psychiatric care. Even with the Start Now Program, assessments are still completed. Referrals from another agency are directed to the assessment unit and there is an attempt made to obtain recipient information from the provider; this is usually done by Center nursing staff and only with a release. The administrator stated that if the Center cannot access prior provider information, then the Center may not be able to serve the recipient as the recipient's treatment history is important. Upon receipt of prior provider information, staff evaluate the information and then present it to the recipient for verification. According to the administrator, a prior provider is viewed as one resource or perspective just as the client presents another perspective; however, an independent assessment by the Center is still needed.

The administrator stated that treatment planning is a part of the ongoing assessment process with the first assessment representing a snapshot of the recipient's needs. Assessment information is reviewed and the treatment team works toward an accurate assessment and a treatment plan that will meet recipient needs. Listening to the recipient is integral to the treatment planning process although a treatment plan may be massaged a bit to meet funding requirements. The treatment plan is developed by the treatment team and the physician signs it; the plan is reviewed every six months. Both computerized and hard copies of the treatment plan are developed; the Center reports that it is working toward concurrent documentation with the client reviewing what is documented at the time staff are actually writing a documented entry. The recipient signs the treatment plan.

The psychiatrist reported that the recipient cannot prescribe his/her own medications. For the recipient in this case, the psychiatrist stated that she was psychotic and delusional; she wanted to be prescribed an antidepressant but he felt that she needed an antipsychotic. According to the psychiatrist, the recipient needed Center services as part of her funding mechanism but she still needed to comply with treatment. The psychiatrist stated that he discussed medication and risks with the recipient who was concerned about weight gain with the medication. The psychiatrist stated that the recipient signed a consent form for treatment but the Center does not secure written consent forms for medications. He also indicated that he had been seeing the recipient when she received services from the prior provider had met with the recipient and staff from the prior provider at a joint meeting and had completed a psychiatric evaluation specific to the recipient. The psychiatrist stated that he had seen the recipient since

2007. He reported that she had been on an antidepressant but he wanted to add Seroquel (an antipsychotic); the recipient wanted to discontinue the Seroquel because of weight gain. He initially continued the antidepressant but then wanted to discontinue the antidepressant in favor of the antipsychotic; he quit prescribing a specific antidepressant in December of 2008 and the recipient quit taking the Seroquel. He last saw the recipient in May 2009 at which time she was to follow-up in 2 to 3 months; however, she did not return even after his office attempted to schedule an appointment. The psychiatrist stated that he is still willing to see her. When she did not return for psychiatric appointments, he could no longer prescribe medications for her. Her case was closed in August 2009. At the time she was seeing the psychiatrist, she was also being seen by a caseworker approximately once every three months.

Record Review

With recipient consent, the HRA team examined the record of the service recipient in this case. The record indicated that the recipient initially received services from the Center in July 2002. In January 2008, her client status changed to a "medication only" client; staff reported that this status does not require a treatment plan although in follow-up contact with Center administration, the HRA was informed that physician progress notes constitute the treatment plan activity for recipients receiving "medication only." She met with a recovery specialist case manager from February 2008 to February 2009. Assessments were completed in 2007. The recipient's case was closed in August 2009.

The HRA examined a release of information allowing the prior provider to release recipient written and verbal information to the Center's psychiatrist and a second release allowing the Center's psychiatrist to release written and verbal recipient information to the prior provider. Both releases are signed by the recipient and dated 06-10-08; the releases included witness signatures, no consequences for consent refusals and expiration dates of 06-10-09. The HRA found no evidence that the recipient had revoked the releases prior to the expiration dates.

A treatment plan review completed in May 2007 indicated that the caseworker had not had contact with the recipient for some time although she had seen the Center psychiatrist in December 2007; however, continued contact with a counselor employed by the prior provider was also noted, including a note that the recipient was content with continued contact with the counselor for the prior provider. Because of her lack of follow-up with the Center caseworker, her status changed to "medication only."

The recipient's most recent formal treatment plan was dated 01-31-08. The plan listed the recipient's diagnoses as Major Depressive Disorder with paranoia, Generalized Anxiety Disorder and Paranoid Personality Disorder. Medical information was included as well as socio-economic data. The plan did not list medications. The physician and supervisory staff signed the plan; however, on the signature line for the recipient, there was a note that the recipient refused to meet with staff.

Physician progress notes were reviewed. In a note dated 03-16-09, the psychiatrist stated that the recipient met to discuss services of the prior provider, that the funding agency wants her to consider more intensive treatment and her dissatisfaction with the prior provider. With regard to medication, the notes stated that "Patient has not taken the Seroquel as prescribed because she

was afraid of heart disease as it runs very strongly in her family." Her diagnoses were listed and were consistent with diagnoses listed in the 01-31-08 treatment plan. The notes concluded with a plan stating the following: "Patient was recommended to discontinue her Mirtazapine and take the Seroquel instead which she took under advisement. Risks and benefits were discussed. Patient is capable of administering her own medication. Follow-up will be made by the patient in one month to six weeks." Physician progress notes dated 04-15-09 indicated that the recipient was attempting to apply for services with another agency after complaining about the prior provider. Also, the recipient indicated to the physician that she was not taking the Seroquel as it disagreed with her. The plan for the recipient as of 04-15-09 was to prescribe Sertraline (or Zoloft, an antidepressant) and Clonazepam (an anti-anxiety medication) and follow-up with her in one month. The notes stated that risks and benefits were discussed with the patient and that the "Patient is to discontinue her Seroquel." And, progress notes dated 05-27-09 indicated that the recipient had been meeting with a therapist at another agency but she also wanted to continue psychiatric services at the Center. She voiced concern about weight gain and inquired about a weight loss drug that the physician indicated reluctance toward. The medications of Sertraline and Clonazapam continued to be prescribed.

Finally, the HRA examined a July 20, 2009 letter from the recipient to a Human Service Center caseworker indicating that the physician refused to treat the recipient for depression and refused to prescribe antidepressants; as such, she indicated that she would be seeking another physician. The letter also referenced the prior provider adding a diagnosis other than depression, questioned why the new diagnosis was never discussed with her, and stated that the prior provider does not have the final say.

Policy Review

The HRA concluded its review by examining pertinent policies. The agency maintains a policy specific to the involvement of clients, families and others in which recipients "…are encouraged to express their views, make choices, and partner completely through the treatment planning process." The accompanying procedure requires the documentation of recipient participation in treatment planning and in the development of goals and objections. Recipients are asked to sign the treatment plan and the agency is to provide each recipient with a copy of his/her plan and offer the recipient any needed explanations for the plan's content. If a recipient refuses to sign the plan, the refusal is to be documented. A reminder at the bottom of the policy indicates that written consent is required before involving individuals other than the recipient/guardian in treatment planning. The agency's policy section on ethics, rights and responsibilities reinforces client involvement in treatment decisions and problem resolutions as well as the involvement of others in treatment planning with client consent.

A policy on initial assessment indicates that assessments are done for new clients to determine needs and services as well as treatment preferences. The various types of assessments are described and time frames are listed depending on the type of service being considered. Included in the assessment process is the evaluation of presenting issues as well as an evaluation of treatment history. The policy does not indicate that prior providers will be contacted as part of the assessment process. The policy concludes by indicating that an integrated assessment is completed prior to the development of the initial treatment plan which is to be completed in 30 days of enrollment. A continuation of the integrated assessment is also to be completed prior to

the development of the treatment plan if the patient is engaged in treatment; if the patient is not engaged, the continuation of assessment is completed after the treatment plan is developed. A policy on reassessment indicates that clients are reassessed as needed based on responsiveness to treatment or any changes in the client's status.

Medication policies were also reviewed. The agency maintains a policy on self-administration of medications which indicates that clients receive training, reviews and assessments related to medications that include a discussion of medication frequency, dose, and side effects. The policy states that "…this is discussed at each visit with the client to the psychiatrist or Advanced Practice Nurse." A policy on client education and training describes the various components of client education such as techniques to manage symptoms, safety practices and "…safe and effective use of medications, including benefits and risks…." And, a policy on monitoring medication side effects states that "Each patient in the outpatient and residential mental health programs, who is prescribed psychotropic medications by an [Center] physician, is scheduled to see the psychiatrist or Advanced Practice Nurse at least every 3 months and more often if indicated." The monitoring is to include a review of the client's perceptions of the medication, medical information and client responsiveness to the medication. The HRA also examined the agency's self-administration medication screening tool which would document a recipient's medication and doses. The tool also allows for the evaluation of the recipient's understanding of the reason for the medication, ability to comply with medication self-administration and knowledge of the medication and prescription directions. The tool concludes with a determination as to whether or not the client can self- administer medication. The staff person completing the tool and the client sign and date the tool.

The HRA team examined policies related to confidentiality. General confidentiality guidelines stress that the Center is not to disclose client identity or other information without written consent. The policy goes so far as to ensure that confidential information is not left on desks, that computer terminals be shielded from view, that confidential discussions occur in secure areas, that paper documents are secured and that electronic data is only accessible with a password. A policy on releasing confidential information describes the required contents of release forms as well as who is authorized to release confidential information. A separate policy describes information that can be released without consent such as for medical emergencies, threats of harm, law enforcement investigations or child abuse reports.

Finally, the client rights policy and statement were reviewed. The policy recognizes the personal beliefs and preferences of the individual, indicates that a rights statement is to be provided to each recipient at intake and then posted at all agency facilities, includes a provision for filing complaints and states that no individual will be denied services for exercising his/her rights. The accompanying procedure states that clients will be informed of confidentiality practices, the grievance procedure, the right to informed consent, the right to refuse treatment and a contact person who is responsible for their care. The procedure further states that new staff are to receive training on professional conduct, staff relationships with clients, client rights and client confidentiality. The Client Rights statement provided to recipients includes provisions on confidentiality, active recipient participation, the right to consent to treatment, the right to refuse treatment, and the right to be informed of treatment risks, benefits and side effects.

MANDATES

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) guarantees the right to "…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….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….If the services include the administration of electroconvulsive therapy or psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated. …." Section 5/2-107 states that "The recipient…shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication."

The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/5) specifies that records and communications can only be disclosed with written consent.

Regulations that govern community mental health centers (59 Ill. Admin. Code 132) require in Section 132.145 that a provider is to "…directly provide [a] mental health assessment, ITP development review, [and] modification...." This section also states that "Prior to the initiation of mental health services, the provider shall obtain written or oral consent from the client…, as applicable." A separate section specific to evaluation and planning (59 Ill. Admin. Code 132.148) indicates the following:

> *Mental health assessment is a formal process of gathering information regarding a client's mental and physical status and presenting problems through face-to-face, video conference or telephone contact with the client and collaterals, resulting in the identification of the client's mental health service needs and recommendations for service delivery….The provider shall complete a mental health assessment report within 30 days after the first face-to-face contact…..A written mental health assessment shall be a compilation of the following…Extent, nature, and severity of presenting problems…Client preferences relating to services and desired treatment outcomes….Previous and current psychotropic medications….A psychological evaluation, if recommended, shall: Be conducted within 90 days after completion of the ITP…Be conducted face-to-face or video conference with the client; and Result in a written report that includes a formulation of problems, tentative diagnosis and recommendations for treatment or services*

Section 132.100 address clinical records and requires a client's clinical record to contain certain items, including "Documentation of consent for or refusal of mental health services…A single consolidated ITP…."

CONCLUSIONS

Complaint #1: The Center relied on input from another mental health program in determining the recipient's needs and medications rather than on objective assessments and input from the service recipient.

The HRA does not substantiate this complaint. The HRA found evidence that the Human Service Center conducted its own evaluation of the recipient as required in community mental health regulations and the agency's own policies. Pursuant to the Confidentiality Act and the agency's confidentiality requirements, the HRA found evidence that the recipient in this case signed consents allowing for the exchange of information with the prior provider. The HRA also found in the physician progress notes that the physician documented recipient preferences; recipient preferences are a mandated part of treatment planning as per the Mental Health Code, community mental health regulations and agency policy.

At the same time, the HRA would like to note that, initially, the provider indicated that treatment plans are not required for recipients who only see the physician for medication but later reported that the physician progress notes serve as the treatment plan. The HRA did not find in the regulations that recipients who only utilize physician services are not entitled to a treatment plan. While the physician progress notes were thorough enough in this case, the HRA suggests that there be a formal policy statement related to the use of physician progress notes as the treatment plan for a recipient who only sees the physician or that the agency develop a treatment plan specific to physician services.

Complaint #2: The Center psychiatrist abruptly ended a medication prescription without involving the service recipient.

The HRA does not substantiate this complaint. Physician progress notes documented discussion with the client about the use of antidepressants versus antipsychotics and discussions about medication risks, benefits and side effects. The physician attempted to prescribe an antipsychotic which the recipient repeatedly refused and the medication was subsequently discontinued. An antidepressant was prescribed consistent with the recipient's interest in receiving an antidepressant although the specific antidepressant prescribed appeared to be different from the antidepressant that the recipient had previously been taking as referenced in the HRA complaint. However, there was no documentation regarding the recipient's preference for one antidepressant over another. The recipient was also prescribed an anti-anxiety medication.

Of note, the Mental Health Code requires the provision of written information on medication benefits and side effects; the HRA did not see evidence of this. Also, the agency indicated that it does not require written consent for medication. While the Mental Health Code does not specifically state that written consent is required and regulations make general reference to written consent for mental health treatment, the HRA believes that written consent affirms recipient participation and preferences. Based on its findings, the HRA suggests the following:

1. Ensure that written medication information is provided consistent with Mental Health Code requirements.

2. Consider securing written medication consents from service recipients.

The HRA acknowledges the full cooperation of the Human Service Center during the course of its investigation.