FOR IMMEDIATE RELEASE

East Central Human Rights Authority
Report of Findings
Case 11-060-9009
Veterans Administration Illiana Health Care System

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving complaints of possible rights violations within the inpatient mental health program at the Veterans Administration's Illiana Health Care System in Danville. The following allegations were made:

Complaints:

1. A patient was not allowed to make unimpeded private phone calls.
2. The provider restricted the patient's access to third party advocacy.
3. The hospital inappropriately pursued involuntary admission to the behavioral health unit.

Substantiated findings would violate standards under the Veterans Administration (VA) Guidelines (1103.3 and 1160.01) and recipient rights as protected by the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Per its website regarding mental health services, it states, "Inpatient Mental Health Services are available. Inpatient psychiatry is a 29 bed, locked unit with 24-hour monitoring and nursing supervision. The unit provides a safe environment for veterans in crisis. Veterans hospitalized on this unit are assigned a treatment team which consists of a psychiatrist, psychologist, social worker, and nurse. Treatment plans are tailored to meet each veteran's needs. Group and individual therapies are available to all inpatients.

The Illiana system provides comprehensive inpatient and community based health services to veterans throughout a wide region of central Illinois and western Indiana."

To pursue the matter the HRA visited the facility where program representatives were interviewed. Relevant policies were reviewed as were sections of a patient's record with written authorization.

INVESTIGATIVE INFORMATION

Interviews

The HRA met with the administrator, physicians, social work staff, nursing and other professionals.

Staff stated the VA provides many services to veterans and at this particular VA program, the building maintains 29 inpatient mental health beds in an acute locked ward. The average, length of stay is 7-10 days. The age range of the patients served is approximately 19-86.

Regarding the patient in this case, he was an involuntarily admission from another hospital. His admitting diagnosis was Bipolar Disorder. Because he is a veteran, the police would bring the veteran to the VA or a social worker would contact the VA from the community hospital. The staff would authorize to keep the veteran at the community hospital, until they would receive authorization from the judge to amend the order so that the patient can be admitted to the VA.

Regarding the admission process, the staff explained that they request information to be transferred to the VA to present to the court to see if the VA facility could provide services. In certain circumstances when preparing for court they examine medication compliance. They check to see if the patient has an authorized representative or if the person has a power of attorney (POA) or a guardian. They follow advance directives and patient preferences. They would not release information if the guardian did not sign the release. Staff would follow the Illinois Mental Health and Developmental Disabilities Code, the Illinois Mental Health and Developmental Disabilities Confidentiality Act, and the Health Insurance Portability and Accountability Act (HIPAA). The VA focus is access to customer centered care. There are standard evaluations that would be completed such as physician, nursing, social work, and psychiatric evaluations, screening for depression, and post traumatic stress disorder (PTSD).

The HRA asked about the telephone policy on this unit and how the facility guarantees private telephone communication. Staff explained that there are two portable phones. Long distance is not provided generally, but it would be in certain emergencies. The treatment team may determine to limit phone calls because of the number of residents who have to share the phones. Staff stated that they ask that residents to use the phones in close proximity to the nursing station because there are issues of safety. Patients can still sit far enough from the nurse's station that nurses would not hear the phone conversations.

Incoming calls are forwarded to one of the two portable phones that are made available to the patients. Staff do not confirm that a patient with whom the caller is requesting to speak is on the unit, but first ask the patient if he or she wants to take the phone call. The staff request that phone conversations be limited to 10-15 minutes due to other patients needing to use the phone. These phones are also available for the patients to make calls out on, except for long distance calls. For those calls, the social workers will provide phone cards. Conversations are not monitored, but if the user becomes agitated or starts using loud, inappropriate or threatening language they are asked to terminate the call. This concern is referred to the treatment team. If an outside person requests no phone calls from an inpatient, this is also directed to the treatment team.

When asked what the policy is about displaying rights, staff explained that patients and their families are informed of the policies and patient rights within 12 hours of admission to the facility. The HRA asked what types of training are provided to staff regarding patient rights.

Staff stated that all employees receive orientation on veteran centered care and reporting rights violations, and all employees have reviews on veteran centered care and patients rights.

Regarding grievances, a patient can take them to any of the team members, who will refer those complaints to the patient advocate, or the patient can speak directly to the patient advocate; those complaints are relayed to an administrator. Leadership works with the patient on what can they do to make things better. Third party advocacy contact information is posted and also given to patients at admission. When asked what would happen if someone would be abusive to a patient, the response was they would call the police and report it to the central office in Anne Arbor, Michigan.

The HRA asked what quality assurance the VA uses. Staff explained there is a focused review by the treatment team, patient reviews, Joint Commission standards for health care facilities, and the Office of Inspector General (OIG). They have reviewers from the central Veterans Administration office in Battle Creek, Michigan in which two external physicians educate staff about integrated opportunities for improvement. One of the psychologists assists in staff training across the VA. Staff explained that they keep apprised of treatment ideas/evidenced based treatment such as: talent management systems, mental health and suicide prevention training, infection control, continuing education units, and vital continuing education video conferencing.

The HRA was provided a tour of the behavioral health unit. It was observed in the tour that, on average, there are 4 male patients per room when full, except for five private rooms used for women. Attached to the behavioral health unit was a very well kept and enclosed floral garden where patients could spend time outside independently. Rights and third party advocacy contact information were posted in the unit where patients could easily access them.

Records Reviews

The HRA reviewed the court records of the veteran's involuntary commitment, including the petition, the certificate and order from the county court that had committed the veteran to receive services. The petition was dated 8/11/10 and was filed on 8/12/10. It listed family members to be contacted for notice of the hearing, and statements of a security officer. A certificate was signed by the psychiatrist on 8/12/10. The order for treatment on 8/20/10 stated the veteran could receive treatment in either a Department of Human Services Mental Health Center or be hospitalized with the Veterans Administration.

Per the psychiatry notes, the patient had been originally admitted to a different hospital on 8/11/2010 and was transferred to the VA. On 8/20/2010 psychiatry notes document that the physician from another hospital, who was treating the patient, had contacted the VA to see if the patient could receive his treatment there. It was documented that the patient had been taking his medications and was agreeable to being treated at the Veteran's Administration. The patient was accepted for admission to the VA behavioral health unit. The ambulatory care/nursing note states that the patient arrived via emergency medical services from the hospital.

The HRA reviewed the documentation and notes in the record that would apply to the three complaints. Nursing notes documented the patient's behavior upon arrival: "…The patient

is restless and talking in a rambling hyper speech pattern. The patient is touching and moving everything. The patient is very aggressive, questions everything staff tells him. The patient wanders around the waiting room. The patient is very uncooperative and doesn't answer the nurse's questions…."

Nursing notes stated: "The patient is delusional (persecutory) and he believes that the FBI thinks he is a spy." It was documented that unit orientation was completed. The rights and responsibilities information were provided and reviewed with the patient. The patient information handout was given and reviewed with the patient. The prohibited items list was reviewed with the patient and/or family. The patient was informed of the medical center's philosophy concerning the use of restraint and the patient was asked if there was permission to notify a family member in the event of restraint use. The veteran was provided with information on the national crisis hotline number and the VA pocket card suicide risk questions.

It was documented that the patient was pacing the floor, awakening other veterans. The patient appeared agitated at all times and was creating conflicts with other veterans for no apparent reason. It further documents the patient was constantly banging on the nursing station door, swearing at and threatening the nursing staff. He was redirected when he made several attempts to sexually harass staff and other patients. He was continually verbally aggressive with staff and other patients, and sometimes threatening violence to staff and other patients. The patient was noncompliant with unit rules regarding 10 minute time limits on phone usage. He was noncompliant about returning his items to a locked box for safety (credit card and sharpened pencil).

In the notes it was documented that another city's police department, from the city the patient was previously hospitalized in, called the unit. The officer explained to staff that the patient had contacted the police department about missing items he had while at the other hospital. The police sergeant stated to staff that the items the patient was looking for were released to the patient at his discharge and that the patient was responsible for those items. The patient, on various dates during his hospitalization, accused staff and other patients of taking his commitment papers, his divorce decree, his CIA "papers" and his Yahtzee game. He was allowed to contact the VA police and make appropriate complaints. Per the record the VA police did investigate his complaints.

On 8/26/10 his physician ordered that outgoing calls for the individual be restricted. His rights to make outgoing calls were restored on 9/3/10. His physician ordered again that outgoing phone calls were restricted on 9/4/10. On 9/29/10 his physician and his treatment team removed his phone restrictions to making outgoing calls. During the time of the restriction on making outgoing calls there was no evidence of the veteran receiving a notice of such restriction. There was no evidence that the VA had advised the individual that he had the right to have affected parties noticed of the restriction, and notified again when the restrictions were no longer in effect. There is much evidence that staff did assist the veteran in making calls on his behalf during this time. Notes document on 9/6/10 VA police were again notified that this veteran received an unwanted touch on his arm by another veteran. The record shows that the patient advocate met with the veteran individually about his complaint. In the record it is documented

that staff redirected the veteran as needed using a calm approach and short concise explanations. Supervisors admonished staff to avoid any power struggles.

In the notes it is documented that the veteran demanded that staff call on his behalf or the patient himself had contacted the following entities from 8/21/10 to 9/21/10:

- The police 17 times
- China 3 times (the social worker assisted veteran who had to use his phone card to these make calls)
- The patient advocate 7 times
- His attorney 7 times
- The public defender 2 times
- the VA attorney 1 time
- the Director of Nursing (DON) 2 times
- the CIA 2 times
- FBI, 6 calls were documented, including the FBI staff calling the VA asking that the patient not call the FBI. On 9/8/10 the social worker assisted the veteran in talking with an FBI representative who explained this to him.
- OIG 1time
- The White House 6 times
- There were several calls documented that were made to other advocacy groups including the Joint Commission because the patient believed his medication orders were written improperly.

One of the examples in the record of the individual interacting with staff regarding the use of the phone and accessing third party advocates was on 9/8/10. The notes documented that: "The patient attends treatment team meeting. He is demanding to speak to the patient advocate. He is pounding on the window and threatening to have all staff fired if he does not see him immediately. The patient advocate was notified and relayed at this time the patient advocate will not be visiting the veteran. The patient demanded to make a phone call to his attorney he wants to know who's in charge of making orders and he wants to talk to the patient advocate. He made numerous commands to talk to his doctor, his psychologist, and again the physician. The patient demanded to call the VA police because he wanted to make a complaint of neglect. The VA police came down and met with the patient. He had a discussion with the VA police." He did later meet with the patient advocate.

Social worker notes document on the same date: "That she assisted the veteran to make phone calls to the following agencies: the FBI, both offices in Springfield and in Chicago, his wife in China, Equip for Equality Attorney, Veteran Security, and Guardianship and Advocacy Commissions. The veteran was allowed by the social worker to speak to a federal agent at the Chicago office. The agent indicated he has known the veteran for the past five years. He reported that the veteran is not assisting the agency at this time, nor does the FBI believe the veteran may assist them in any official business in the future. The agent requested that VA staff encourage the veteran not to contact FBI offices. The veteran's mood remains elevated. His insight and judgment are poor despite multiple efforts by the social worker to assist the veteran handling personal affairs…. "

"The veteran is limited to contacting his attorney without using a telephone card, because of his telephone use. The social worker will remain available and assist the veteran when clinically appropriate."

Another conflict was documented "The patient refused to relinquish the phone and claimed he was waiting to talk to the CIA. That they would call him back and that the nurse had violated his rights when she asked the patient to surrender the phone. The patient believed that he was associated with government agencies including CIA and FBI. He believed staff and the VA police are withholding his rights as a US citizen. He demands to make contact with the patient advocate, the VA police, CIA, and the FBI."

On 09/10/10, it was documented: "The patient would not surrender the phone after it was handed to him. He made repeated calls to Springfield and Chicago offices of the FBI and White House. The patient became more perturbed as his calls were put on hold or switched to an answering machine by operators. He finally handed it back to the worker as he spit on the floor in frustration. He believes he has important information about the Chinese to disseminate and became increasingly unreasonable as our meeting went on. The patient made comments that he could kill everyone in the ward. He had no insight into his illness and is wrapped up in a frenzy of grandiose delusions."

On 09/16/10 notes document: "The patient requested to speak with all treatment team regarding violation of federal law at earliest opportunity due to the fact he will be filing grievances against them. The treatment team was notified this morning. The patient was at the office door requesting to speak with social worker, patient advocate or worker supervisor this a.m. The patient requested to speak with the VA attorney, the social worker was contacted regarding this matter. He spoke with a nurse manager and she stated that she had notified the Chief of the patient's request and to have social worker notify the VA attorney. The patient wanted the Director notified and if the Director did not respond he would file a grievance with OIG. He wanted the social worker notified again immediately."

More notes later in the day document that the patient believes that he was associated with several different government agencies including the CIA, FBI, Pentagon, and etc., that the patient wanted to speak with the patient advocate immediately and that he would file a grievance if she didn't respond immediately because it would be a violation of his rights. The patient also wanted to call the police and his attorney. The nurse manager explained to him that nursing staff can only call and not make people come to the unit.

It is documented in the record by the social worker that she assisted the veteran in placing a phone call to the public defender's office and his attorney at Equip for Equality. The veteran was able to leave a voice recording at each office. He also demanded to discuss his belief that the facility is violating his rights and that there was a conspiracy between this facility and the FBI to violate his rights. The veteran continues to be demanding, hostile, degrading and grandiose. A hearing regarding court ordered medication was scheduled for 09/20/2010.

The treatment planning team notes that the patient's perceptions are badly flawed as related to the psychosis and mania. Social work notes state: "The patient was assisted in

contacting Equip for Equality. Equip for Equality asked this worker about the patient, regarding privacy and the patient's restricted phone rights. The social worker informed the attorney that the veteran would be able to have private phone conversations in his room, provided another patient was not occupying the room. The patient's did not wish to move from the conference room. The social worker had to be present with him as patients cannot be left alone in the conference room. The attorney requested that the patient complete a release of information to allow the attorney to see the patient's mental health records for his current admission. The social worker discussed with the veteran the release of information…."

On 10/7/10 the patient received discharge instructions that were reviewed with the patient before leaving the hospital. The patient may receive post discharge phone calls. Medications were discussed and provided to the patient as well as instructions and side effects. The patient was then given 12 future appointments.

Policy Reviews

The HRA reviewed the following policies:

- *Department of Veterans Affairs VHA HANDBOOK 1160.0, Uniform Mental Health Services in VA Medical Centers and Clinics Washington, DC 20420 (September 11, 2008)*
- *Veterans Health Administration Guide, 1103.3, Mental Health Program Guidelines, For the New Veterans Health Administration,* (June 3, 1999)
- *Memo: Commitment Paperwork for Patients in Mental Health Service, Mental Health Service Policy Statement # 2* (10/2011)
- *Memo: Mental Health Admissions-Mental Health Service Policy #9 (*11/2008*)*
- *Patient Centered Comprehensive Interdisciplinary Treatment Plan - Mental Health Service Policy #38 (*10/2011*)*
- *Bar Code Medication Administration (*09/2010)
- *Illinois Department of Human Services, Rights of individuals receiving Mental Health and Developmental Disabilities Services (*08/2010*)*
- *Rights for Veterans Admitted to Ward 103-7* (No Date)
- *Inpatient Information Packet, Ward 103-7* (No Date)
- *Our Commitment* (12/06)

Per the *Veterans Health Administration (VHA) Guide, 1103.3, Mental Health Program Guidelines, For the New Veterans Health Administration,* (June 3, 1999) in Section 2, Guidelines for providing Mental Health Services, item a. Principles for Organizing Mental Health Care, states: "…In developing an efficient structure for the delivery and monitoring of quality mental health care in VHA, organizational structures need to:
(1) Promote inter-professional collaboration in leadership, planning, and the monitoring of mental health program performance**.**
(2) Provide for a cost-effective**,** seamless continuum of mental health treatment programs.
(3) Support a continuity of care to meet both the primary care and specialty mental health care needs of patients while mindful of the patient's involvement in treatment decisions.
(4) Acknowledge the need for discipline specific involvement in the recruitment and evaluation of the practice of mental health professionals, including the oversight of training and research activities.

(5) Include contributions from patients and patient advocate groups in planning and evaluating mental health care delivery."

In the General Psychiatric Hospital Unit section (19) it states: "(a) General Psychiatric Wards offer thorough, comprehensive, psychiatric evaluation, diagnosis, and treatment in a highly structured hospital environment for new patients requiring hospital-level structure, as well as for patients experiencing recurrence of illness that cannot be assessed, or treated, at a lesser level of care. (b) The primary objective is to provide an intensive care setting with a shift to a less intensive level of care as soon as clinically appropriate. All or parts of such units should be securable in order to accommodate involuntary patients and patients who are temporarily out of control or at risk of harming themselves or others…."

Per the *Department of Veterans Affairs VHA Handbook 1160.0, Uniform Mental Health Services in VA Medical Centers and Clinics Washington, DC 20420 (September 11, 2008)* it states in section 11. regarding inpatient care: "Inpatient care must be available to all veterans who require hospital admissions for a mental disorder, either in the VA medical center where they are treated, a nearby facility, or by contract, sharing agreement, or non-VA fee-basis referral to a community facility to the extent that the veteran is eligible.
b. Secured (locked) inpatient mental health units must be available for these veterans when symptoms or conditions require them. Secured inpatient units in VA medical centers must be prepared when it is feasible to accept involuntary hospitalizations resulting from civil commitments for veterans for whom VHA provides health care services.
(1) Requirements for facilities to accept involuntary hospitalizations resulting from civil commitments do not apply when another agency of Federal, State, or local government has the duty to give the care or services in an institution of such government.
(2) Facilities must consult regional counsel, as needed, to ensure that local policies are consistent with Federal, State, and other applicable laws….
c. Inpatient units must promote a positive therapeutic and least restrictive environment and strive to be restraint- free…..
h. Acute inpatient psychiatry units need to be staffed at a level that ensures that all patients are safe in the environment of care…."

Per the *Commitment Paperwork for Patients in Mental Health Service, Mental Health Service Policy Statement # 2* (10/2011) in Section II, the policy states "Generally, this medical center accepts only fully committed patients in which case no paperwork for the court is needed from our treatment teams except for patients thought to need recommitment. However, a patient may arrive at the medical center with a court order for examination. Also, during a voluntary patient's stay (medical or psychiatric), it may be against medical advice (AMA), but requires hospitalization due to being dangerousness to self or others."

Part C of procedures explains: "…If the patient is deemed committable the necessary paperwork (a petition, one certificate, proof of service of the petition and statement of rights minimum) has to be submitted to the court within 24 hours of admission (excluding weekends and holidays); a psychiatrist must complete a certificate within this same time frame, this will be filed with the court as soon as possible if filed separately."

Part D states: "The petition will be completed by any person 18 years of age or older who has knowledge of the patient's symptoms and/or behaviors requiring involuntary psychiatric inpatient treatment. A certificate is to be completed by a physician, clinical psychologist or a Qualified Examiner as defined in the Illinois Mental Health & Disabilities Code, 405 ILCS 5/1-103 & 1-122. Illinois law does not require a physician to complete a Petition, but one Certificate must be completed by a Psychiatrist. The Chief of Mental Health Service will assign appropriate staff to complete the necessary paperwork as needed.

Part E of the document states:" Within 12 hours from involuntary admission a treatment team member or clinical staff will advise the patient of his/her rights and will indicate so by signing the forms. The patient is to receive a copy of forms MHDD-5 'Rights of Admittee', 79-MHDD-1 'Rights of Recipient' and Petition…."

Included in the record was the State of Illinois-Department of Human Services *Rights of Individuals Receiving Mental Health Services (8-10).* It listed rights information, including rights concerning emergency medical services and the addresses and phone numbers of regional offices of the Illinois Guardianship and Advocacy Commission.

Under the section of restrictions of rights, persons notified, it states: "If your rights are restricted, the facility must notify:

- your parent or guardian, if you are under age 18;
- you and the person of your choice
- the Guardianship and Advocacy Commission if you say you want the Commission to be contacted.

If communications were restricted with a specific person, you may have that person notified if you so desire."

The patient's file contained the above-referenced document, but it was not completed by staff for the individual and there was no information as to who he wanted notified with the document.

The HRA reviewed the *Rights for Veterans Admitted to Ward 103-7 (No date)* pamphlet, it stated: "You will be treated with the team, compassion, and respect as an individual. Your privacy will be protected you will receive care in a safe environment. We will seek to honor your personal and religious beliefs…."

"… Treatment will respect your personal freedoms. You are entitled to adequate and humane care and services in the least restrictive environment and to an individual service plan…."

"… You have the right to communicate with other people in private, without obstruction, or censorship by staff at the facility. This right includes mail, telephone calls and visits. There are limits to these rights. Communication by these means may be reasonably restricted by the treatment team, but only to protect you or others from harm, harassment or intimidation…."

"… You are encouraged and expected to seek help from your treatment team or a patient advocate if you have problems or complaints. You will be given understandable information about the complaint process. You make a complaint verbally or in writing, without fear of retaliation. If your rights are restricted, the facility must notify you and the person of your choice, the Guardianship and Advocacy Commission, and if communications were restricted with a specific person, you may have that person notified if you so desire…."

The HRA reviewed the *Patient Rights* on the VA Website. Per the VA Website it stated that "You will be treated with dignity, compassion, and respect as an individual. Your privacy will be protected. You will receive care in a safe environment. We will seek to honor your personal and religious values."

"Treatment will respect your personal freedoms...."

"As an inpatient or nursing home resident, you have the right to communicate freely and privately...You will have access to public telephones…."

"You may consult with the Medical Center's Ethics Consultation Service and/or other staff knowledgeable about healthcare ethics…."

"If you or the Medical Center believes that you have been neglected, abused or exploited, you will receive help…."

The website explained how to contact a patient and provided the address, directions, parking locations, visiting hours and the means to locate to locate the inpatient unit or the unit's phone number. It further stated: "If you want to talk to somebody in the ward all you do is ask…they will check if that person wants to talk to you."

The HRA reviewed the *Inpatient Information Packet, Ward 103-7* (No Date). In section 7, it states: "Privilege times begin at 8:30 - 9:30 AM, and 1:00 - 2 PM, for either 30 minutes or one hour the pending on how your psychiatrist orders them. You are required to stay on hospital grounds, smoke in approved areas, and do not bring back any open food or drinks. You may use your own personal cell phone during your privilege time."

Section 8 states: "There is a portable phone available for your use on the ward. You will have to call collect or use a phone card to use this phone for long distance calls, if you are unable to make long-distance calls by these methods, please ask your social worker to assist you. We ask that you limit phone calls to 10 minutes, so all patients will have equal access to the phones."

The HRA reviewed a document titled *Our Commitment* (12/06). It states: "… Our goal is to provide exceptional healthcare to our veterans that improve your health and well-being. As part of our commitment, we seek accreditation from the Joint Commission. The Joint Commission does unscheduled inspections to make sure we comply with standards that they set for quality care, patient safety and the safety of the environment.

The Joint Commission's Patient Safety Goal #13a states: 'Define and communicate the means for patients and their families to report concerns about safety and encourage them to do.'

If you feel that we cannot meet this goal, we want you to let us know by telling any member of your care team or by calling the Patient Advocate office or the close call program, or complete the close call form."

The document listed third party contact information including the Joint Commission's contact information.

SUMMARY

Complaints:

1. A patient was not allowed to make unimpeded private phone calls.
2. The provider restricted the patient's access to third party advocacy.
3. The hospital inappropriately pursued involuntary admission to the behavioral health unit.

The *Department of Veterans Affairs VHA Handbook 1160.0,* in section 11.(2) for inpatient care states: "Facilities must consult regional counsel, as needed, to ensure that local policies are consistent with Federal, State, and other applicable laws…."

The Mental Health Code in the section 5/2-100(a), states: "No recipient of services shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the receipt of such services." Section 5/2-200(a) of the Code, regarding the notice of rights, states: "Upon commencement of services, or as soon thereafter as the condition of the recipient permits…. shall be informed orally and in writing of the rights guaranteed by this Chapter which are relevant to the nature of the recipient's services program. Every facility shall also post conspicuously in public areas a summary of the rights which are relevant to the services delivered by that facility." Per the record, rights were discussed with the patient and he was given a copy of his rights. The HRA observed rights posted in the facility where patients could read them and obtain third party advocacy information.

Regarding the first complaint that a patient was not being allowed unimpeded private phone calls, per the Code in Section 5/2-103 regarding mail, telephone and visits it states: "Except as provided in this Section, a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation…."

Regarding the physician order restricting the individual's telephone usage, in part (c) of this section it states that: "Unimpeded, private and uncensored communication by mail, telephone, and visitation may be reasonably restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction shall be given to all recipients upon admission. When communications are restricted, the facility shall advise the recipient that he has the right to require the facility to notify the affected parties of the restriction, and to notify such affected party when the restrictions are no longer in effect. However, all letters addressed by a recipient to the Governor, members of the General Assembly, Attorney General, judges, state's attorneys, Guardianship and Advocacy Commission…."

The Code in Section 2-201 states: "Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefore to:

(1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian;

(2) a person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice;

(3) the facility director;

(4) the Guardianship and Advocacy Commission…; and

(5) the recipient's substitute decision maker, if any.

The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefore in the recipient's record…."

Included in the record was the State of Illinois Department of Human Services' *Rights of Individuals Receiving Mental Health Services (8-10)* document, but it was not completed by staff for the individual and there was no information as to who he wanted notified. The only documentation that the individual's rights were restricted were located in the physician's orders which were not included in the original documents provided by the VA.

Section 2-202 of the Code states: "The facility director of each service provider shall adopt in writing such policies and procedures as are necessary to implement this Chapter. Such policies and procedures may amplify or expand, but shall not restrict or limit, the rights guaranteed to recipients by this Chapter."

Per the VA practices, patients are encouraged to make calls in close proximity to the nurse's station, but could occasionally use the cordless phone in the patient's room to make a private phone call from time to time. Local calls are free. Patients can use a phone card or call collect to make long distance calls unless they were provided assistance by the social worker. When the social worker assisted the patient, the long distance calls were free.

Per the record the social worker assisted the patient in making phone calls to the FBI and other entities to help provide insight to the patient. It was also documented that the social worker assisted the patient in making phone calls to third party advocacy groups and legal resources to find representation for the patient's pending court date. The policy of making two portable phones available for use on the ward, a phone card to use the phone for long-distance calls and/or the social worker to assisting the patient for long distance calls when the patient is out of resources, per the Code, is an appropriate policy. To limit phone calls to 10 minutes, so all patients will have equal access to the phones appears to be reasonable and still guarantees telephone communication as per the Code.

In this case the patient had his telephone rights restricted and there is evidence that this was necessary to protect the patient or others from harm, harassment or intimidation. The problem was that a completed notice of such restriction was not given to the patient. The patient has the right to require the facility to notify the affected parties of the restriction, and to notify such affected party when the restrictions are no longer in effect. There was no evidence that the patient had the opportunity to have this notice provided to others on his behalf. The VA did

ensure that the patient did have contact with third party advocacy groups including Guardianship and Advocacy Commission, but missed this vital procedural step when restricting the patient's phone rights. Based on the evidence, the complaint that **a patient was not allowed to make unimpeded private phone calls is a <u>substantiated as a rights violation</u> with regard to Mental Health Code notice requirements when phone calls are restricted.**

The HRA makes the following recommendation:

1. **Complete rights restriction notices and issue them to anyone designated (405 ILCS 5/2-201) whenever telephone communication or any right under the Code is restricted and be sure that all rights related policies may amplify or expand but not restrict or limit these rights (405 ILCS 5/2-202).**

Per the second complaint, the HRA reviewed the record of the patient to see if the provider restricted the patient's access to third party advocacy. The record shows that this patient requested and was allowed to contact third party advocacy sources approximately 48 times. The complaints made about lost and stolen property were appropriately referred to the police at the VA and other outside police departments to investigate. There may have been some times when he could not connect to a particular resource as quickly as he would have liked, but there was no evidence that staff were withholding his right to contact anyone to advocate on his behalf. The record shows that quite a few staff members made every attempt to assist the veteran in accessing third party resources including representation for his court appearances. Pursuant to the Mental Health Code procedures concerning rights of recipients of services it states: "A recipient …. upon commencement of services shall be informed of the right to designate, a person or agency to receive notice, under Section 2-201 or to direct that no information about the recipient be disclosed to any person or agency.

(c) Upon commencement of services, or as soon thereafter as the condition of the recipient permits, the facility shall ask the adult recipient or minor recipient admitted pursuant to Section 3-502 whether the recipient wants the facility to contact the recipient's spouse, parents, guardian, close relatives, friends, attorney, advocate from the Guardianship and Advocacy Commission or the agency designated by the Governor…."

The Code further states that "The facility shall by phone or by mail contact at least two of those people designated by the recipient and shall inform them of the recipient's location. If the recipient so requests, the facility shall also inform them of how to contact the recipient." In this case rights information on contacting these third party agencies was given to the resident and posted in the ward. He was provided access to third party advocates including the Guardianship and Advocacy Commission. He was allowed to call the police, China, the FBI and CIA with the assistance of his social worker. The record shows his complaints were investigated. He was also provided assistance to make multiple phone calls to locate representation for his court date regarding medication. This is consistent with the *Veterans Health Administration (VHA) Mental Health Program Guidelines,* "…In developing an efficient structure for the delivery and monitoring of quality mental health care in VHA, organizational structures need to Include contributions from patients and patient advocate groups in planning and evaluating mental health care delivery." Based on the evidence, the complaint **the provider restricted the patient's access to third party advocacy is <u>unsubstantiated.</u>**

The HRA does take this opportunity to offer the following suggestion:

1. The HRA strongly encourages the VA to advise patients of there rights upon commencement of services or as soon as the patient's condition permits as required by the Mental Health and Developmental Disabilities Code.

The third complaint alleges the hospital inappropriately pursued involuntary admission to the behavioral health unit. The record documents that the patient was taken into custody and held at a local hospital after going to the FBI office and demanding to be shot. The physician at that hospital contacted the VA to receive the patient after he had been committed by the court system of that community. Per the record, the VA was merely the location where the recipient was transferred to obtain mental health treatment. The Mental Health Code, in Section 5/3-1000, which addresses "(a) … the admission, transfer and discharge procedures for the mentally ill for the Veterans Administration Facilities," states: "A person may be admitted pursuant to any of the provisions of this Chapter to a mental health facility of the United States government when the facility determines that services for the person are available and that the person is eligible to receive them. A person so admitted is subject to the rules and regulations of the Veterans Administration or other agency of the United States government which operates the facility in which such treatment is provided…."

In part (c) of that section it states: "A person employed by the Veterans Administration as a physician may perform the functions of a physician under this Act insofar as relates to a person who is or is proposed to be admitted to a Veterans Administration facility." Section 5/3-1001 states: "The courts of this State retain jurisdiction over persons admitted under this Article for purposes of enforcing the provisions of this Act per the Code…." Section 5/3-1003 states: "The Veterans Administration may transfer any recipient admitted to it under this Article...." The hospital did obtain a court order for the patient to take medication. The VA did not pursue admission to the behavioral health unit. The patient was judicially committed which was sought by the admitting hospital in another city after his episode at the FBI office. The order for treatment stated that he could receive treatment in either a Department of Human Services Mental Health Center or be hospitalized with the Veterans Administration, even though the VA did not seek the order.

Per the *Department of Veterans Affairs VHA Handbook 1160.0,* Section 11: "(2) Facilities must consult regional counsel, as needed, to ensure that local policies are consistent with Federal, State, and other applicable laws. c. Inpatient units must promote a positive therapeutic and least restrictive environment and strive to be restraint- free…." **There was no evidence the hospital inappropriately pursued involuntary admission to the behavioral health unit. The transfer appears to meet Mental Health Code and VA requirements. This complaint is <u>unsubstantiated</u>.**

The HRA appreciates the cooperation of the Veterans Administration Illiana Health Care System during the course of this investigation.

RESPONSE

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

STATE OF ILLINOIS
Pat Quinn
Governor

GUARDIANSHIP & ADVOCACY COMMISSION
Dr. Mary L. Milano, Director

HUMAN RIGHTS AUTHORITY
LEGAL ADVOCACY SERVICE
OFFICE OF STATE GUARDIAN

REGIONAL HUMAN RIGHTS AUTHORITY

HRA CASE NO. 11-060-9009

SERVICE PROVIDER: VA Illiana Healthcare

Pursuant to Section 23 of the Guardianship and Advocacy Act (20 ILCS 3955/1 *et seq.*), we have received the Human Rights Authority report of findings.

IMPORTANT NOTE

Human Rights Authority reports may be made a part of the public record. Reports voted public, along with any response you have provided and indicated you wish to be included in a public document will be posted on the Illinois Guardianship and Advocacy Commission Web Site. (Due to technical requirements, your response may be in a verbatim retyped format.) Reports are also provided to complainants and may be forwarded to regulatory agencies for their review.

We ask that the following action be taken:

✓ We request that our response to any recommendation/s, plus any comments and/or objections be included as part of the public record.

____ We do not wish to include our response in the public record.

____ No response is included.

Emma Metcalf, MSN, RN
NAME

Director
TITLE

4/24/13
DATE

EAST CENTRAL REGIONAL OFFICE
✦ 2125 South First Street ✦ Champaign, IL 61820
✦ Telephone (217) 278-5577 ✦ Fax (217) 278-5588
✦ Statewide Toll Free Intake (866) 274-8023 ✦ Statewide TTY (866) 333-3362

DEPARTMENT OF VETERANS AFFAIRS
Illiana Health Care System
1900 East Main Street
Danville IL 61832-5198

APR 24 2013

In Reply Refer To:
550/00

•Thomas Larison Phillip
Chairperson, Regional Human Rights Authority
East Central Regional Office
2125 South First Street
Champaign, IL 61820

RE: Human Rights Authority Case #11-060-9009

Dear Mr. Thomas Larison Phillip:

The following information is a response regarding the report findings and recommendations for Human Rights Authority Case #11-060-9009.

HRA recommendation: Complete rights restriction notices and issue them to anyone designated (405 ILCS 5/2-501) whenever telephone communication or any right under the Code is restricted and be sure that all rights related policies may amplify or expand but not restrict or limit these rights (405 ILCS 5/2-202).

VA Illiana Health Care System, Danville, IL, concurs with the above recommendation and as a result has implemented the following:

1. All Veterans in the inpatient mental health unit who are placed on right restrictions will be notified of such restrictions utilizing form IL462-2004M (R-6-10) (MHDD-4) Notice Regarding Restriction Rights of Individuals (see enclosed) as reference in the State of Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5).

2. The Chief of Mental Health in conjunction with the Chief Nurse Acute & Ambulatory Care/Mental Health will be responsible for implementation, staff education, and monitoring compliance with the above. Target date for completion is May 20, 2013.

HRA suggestion: The HRA strongly encourages the VA to advise patients of their rights upon commencement of services or as soon as the patient's condition permits as required by the Mental Health and Developmental Disabilities Code.

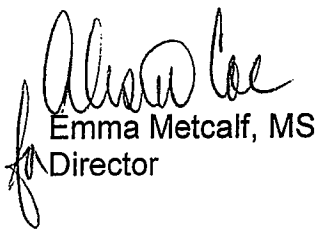
Thomas Larison Phillip

VA Illiana Health Care System, Danville, IL, also concurs with the recommendation that we advise patients of their rights upon commencement of services or as soon as the patient's condition permits as required by the Mental Health and Developmental Disabilities Code. We will be taking appropriate action to remind the responsible staff of this requirement.

We request that our response to this recommendation, plus any comments be included as part of the public record. Enclosed is a signed released pursuant to Section 23 of the Guardianship and Advocacy Act (20 ILCS 3955/1 *et seq.*).

Please contact Angelia Montgomery, Risk Manager, at (217) 554-5094 or angelia.montgomery@va.gov, if you require further information regarding this case.

Sincerely,



Emma Metcalf, MSN, RN
Director

Enclosures

Notice Regarding Restricted Rights of Individuals

Reference: 405ILCS 5/2-102, 2-103, 2-104, 2-107, 2-108, 2-109, 2-200, and 22-201

Name:_____ I.D.:_____ Unit:_____ Facility:_____

PART I (Physical Hold/Restraint/Seclusion/Emergency Medication Restrictions)

On _____ @_____
Date Time

Individual was: ☐ placed in physical hold ☐ placed in restraint ☐ placed in seclusion ☐ administered emergency medication

Reason(s) for the identified restrictions(s):

In accordance with the Mental Health and Developmental Disabilities code, the individual designated his or her preference for emergency intervention if circumstances arise as indicated below (check one):

☐ The individual indicated "No Preference" for emergency intervention(s)

☐ The individual preference was utilized (see Treatment Plan)

☐ The individual preference was **NOT** utilized for the following reason(s):

PART II (Other Restrictions)

From: _____ to: _____
Date and Time Date and Time

Had a restriction placed on certain rights (checked and explained below):

☐ To refuse medical services - x-ray ☐ To refuse medical services - laboratory specimens ☐ To retain personal property

☐ To refuse other medical services ☐ To refuse search of person or living area ☐ Other: _____

☐ To manage personal hygiene ☐ To refuse dental services

☐ To be allowed communication via: ☐ Telephone ☐ Mail ☐ Visitation ☐ Other: _____

Reason(s) for the identified restrictions(s) include:

PART III (Applies to Parts I and II)

A copy of this notice was given to the individual in: ☐ English ☐ Spanish ☐ Other: _____

☐ Individual wished no one be notified of this Notice **(Exception: Guardian must always be notified)**

☐ Individual wished Guardian and/or Designee notified as idicated below:

Guardian: _____ Address: _____

Designee: _____ Address: _____

I certify that I have completed this form. Copies of this notice are given to the individual, mailed to all indicated individuals, and placed in his or her medical record.

Date/Time: _____ Signature: _____

Title: _____

NOTICE REGARDING RESTRICTED RIGHTS OF INDIVIDUAL

Notice Regarding Restricted Rights of Individuals

Reference: 405ILCS 5/2-102, 2-103, 2-104, 2-107, 2-108, 2-109, 2-200, and 22-201

NOTICE REGARDING RESTRICTED RIGHTS OF INDIVIDUAL

Additional Notice to Individual

If your right to mail a letter or package, have visitors, or use the telephone is restricted, you have the right to have the facility notify the affected parties.

When the restriction is over, you also have the right to have facility notify the affected parties.

You may tell the staff member giving you this NOTICE REGARDING RESTRICTED RIGHTS OF INDIVIDUAL or your caseworker if you would like the facility to notify the affected parties.

If you need assistance regarding this Notice, ask your caseworker or another staff member for help.

Information about the health care services you receive at a mental health or developmental disabilities facility is protected by privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) at 45 CFR 160 and 164. Your peronally identifiable health information will only be used and/or released in accordance with HIPPA and the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110).