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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 13-030-9010
JOHN J. MADDEN MENTAL HEALTH CENTER

Case Summary: The HRA did not substantiate the complaint that the facility did not follow Code requirements when a recipient 1) did not receive a psychiatric evaluation upon admission, 2) did not give consent for the psychotropic medications she was administered, 3) had her phone use restricted for no adequate reason, 4) was prevented from contacting an advocacy agency, and 5) was discharged to the streets without discharge planning.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at John J. Madden Mental Health Center (Madden). It was alleged that the facility did not follow Code requirements when a recipient 1) did not receive a psychiatric evaluation upon admission, 2) did not give consent for the psychotropic medications she was administered, 3) had her phone use restricted for no adequate reason, 4) was prevented from contacting an advocacy agency, and 5) was discharged to the streets without discharge planning. If substantiated, these would be violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

Madden Mental Health Center is a 151-bed, Illinois Department of Human Services (DHS) facility located in Hines, Illinois.

To review these complaints, the HRA conducted a site visit and interviewed the Medical Director, the Acting Director of Nursing, the Quality Manager, and the Director of Social Work. Hospital policies were reviewed as well as the recipient's clinical record with written consent.

COMPLAINT SUMMARY

The complaint indicates that a recipient, with a lifelong diagnosis of schizophrenia, lost her insurance and thus was not able to be treated at her usual hospital. She was then transferred to Madden where she was admitted as a voluntary recipient for treatment of her self- reported suicidal/homicidal thoughts. The complaint indicates that the recipient was asked by the nurse manager what medications she was taking, however she was not evaluated by a psychiatrist and

did not consent to psychotropic medication. The complaint indicates that one day the recipient called the Illinois Office of the Inspector General (OIG) to report her concerns and a nurse approached her and asked if she had called the helpline. Allegedly, the recipient was told to hang up the phone because her physician wanted to speak with her but when she did, the recipient was told that the physician was not there. When the recipient wanted to call the OIG back, she was reportedly told by Madden staff that she could not use the phone. A short while after this call two security officers were called to the main desk and at this time the recipient was allegedly told she was discharged. The staff gave the recipient 1 bus ticket with no referral or discharge planning as per the complaint. She is not a resident of the Chicago area.

FINDINGS

The record contains the recipient's Comprehensive Psychiatric Evaluation completed in the Intake Department on 1/08/13 at 6:30 a.m. It states, "Patient is a poor historian, with poor motivation for interview and provided inconsistent, unreliable information. She reported that she has a history of depressive, bipolar and schizophrenia for more than 10 years and long substance abuse. She also has history of psychiatric treatment for depression, psychosis and substance use at … hospital and private hospital many times. She was on risperdal, buspar, ativan. She did not take her medication recently, reported family member loss and mother is sick, she has been stressed and relapsed with alcohol and drug abuse. She reported that her depression has been getting worse in the last few days with depressive mood, crying spells, poor concentration and poor appetite. She reported hearing? voices telling her to kill herself. She also has suicidal thoughts at times. She denied current suicidal or homicidal ideation at hospital setting." The recipient's diagnosis is listed as Mood Disorder NOS (not otherwise specified), and Polysubstance dependence. The record also contains a Social Assessment and Psychiatric Nursing Assessment completed the same day. The Social Assessment states, "This is a 40 years old female, with long history of psychiatric treatment since age 13 with substance abuse problems, unemployed, has history of working as a manager for fast food restaurant, mother of 6 children who live with her mother in IL. She does not think she has poly substance abuse problems, or needs to go to any outpatient or residential treatment, has a history of sexual abuse in her childhood, during the interview she reported that she was in [state mental health facility] couple times in the past and she was linked to [a community agency] and did not follow up, denied any substance abuse problems, verbal, well oriented, denied any suicidal/homicidal ideations or plan, organized thought process, she stated that she came here couple days ago to go to funeral of a family member and started drinking and using drugs, poor insight and judgment."

The record contains the written Consent for Medication signed by the recipient. It indicates that on 1/08/13 she received information regarding the risks, benefits and side effects of the following psychotropic medications: Lorazepam, Buspar, Cogentin, Trazadone, and Seroquel. The Medication Administration Record is included in the record and it shows that the recipient gave informed consent for her medication.

The record does not show that the recipient was restricted in her phone use.

The record contains the recipient's Discharge/Transfer Summary, completed and signed by the recipient on 1/11/13. It states, "Client declines inpatient at South Suburban. Referred

there and to [a community agency] for outpatient." Contact information is given for both programs. On 1/10/11 Psychiatric Progress Notes indicate that the recipient is unwilling to enter inpatient treatment due to conflicts with employment and again on 1/11 the Psychiatric Progress Notes state that commitments to work prevent the recipient from seeking inpatient treatment.

Progress Notes (1/11/13) indicate that the recipient was very upset by the fact that the facility was not providing transportation for her to return home: "Pt is psychiatrically calm but is upset about not being able to get fare for Amtrak to [home]…." Also, "….She is apparently very upset that we didn't pay $50 Amtrak fare to get to [her home]." The record shows that the recipient had a brother in the Chicago area and the facility provided a Metra ticket for her to travel to his house and then return to her home on her own. A final discharge note was entered on 1/11/13 which states, "Client involved [the Medical Director] now endorses travel plans already made. Client has $48 in her fund money which she could use to purchase travel to [home]."

FACILITY REPRESENTATIVES' RESPONSE

Facility staff were interviewed about the complaints. They indicated that the recipient was admitted into the "Intensive Stabilization Unit" (ISU) of the Intake Department on 1/08/13. This unit focuses specifically on substance abuse issues in addition to mental health issues. The recipients in this unit are only there for 72 hours and the recipient was voluntarily admitted there on 1/08/13. The policy for the Intake Unit is that all new admittees are given a psychiatric evaluation within 24 hours and as the record shows, this was done in this case. At this time the recipient was also interviewed about her psychotropic medication, and she signed informed consent for all her medications after being given information about them from her psychiatrist.

The recipients on the ISU are able to use the Intake Department phones at any time and would not be prohibited from calling the OIG or anyone. Signs for the Illinois Guardianship and Advocacy are displayed on the unit along with other advocacy group information. The only way calls would be restricted is on the order of a physician and if that happened, a Restriction of Rights Notice would be issued. The staff did not remember that the recipient was ever limited in her phone use and they noted that it was not mentioned in the progress notes.

The staff indicated that the recipient's need for aftercare substance abuse treatment was identified at admission. The facility has partnerships with programs in the recipient's area and she was recommended for these programs and given contact information for them. The recipient was unwilling to take part in the inpatient treatment and was then given information for outpatient treatment, which she indicated might conflict with her employment. Staff indicated that it was not clear from the recipient's report whether or not she was employed as she gave conflicting information about this. The recipient was given a discharge plan, which she signed, on the day she was discharged from the facility.

Staff were interviewed about the recipient's transportation home. The staff indicated that the recipient had $48 of her personal money with which to buy a train ticket home. They stated that when patients have their own money the facility generally does not provide train fare.

Because the recipient had a brother in the Chicago area, the facility provided a Metra ticket for her to take the train to his home, and then she was responsible for transportation from there.

STATUTES

The Mental Health Code states that when a person is first presented for admission to a mental health facility, the facility must provide or arrange for a comprehensive physical examination, mental examination, and social examination of that person within 72 working hours. The examinations and social investigation must be used to determine whether some program other than hospitalization will meet the needs of the person, with preference given to care or treatment that will enable the person to return to his or her own home or community. (405 ILCS 5/3-205.5). Additionally, within three days of admission, a treatment plan must be prepared for each recipient of services and entered into the clinical record. The plan must include an assessment of the recipient's treatment needs, a description of the services recommended for treatment, the goals of each type of service, an anticipated timetable for the accomplishment of the goals, and a designation of the qualified professional responsible for the implementation of the plan. The plan must be reviewed and updated as the clinical condition warrants, but not less than every 30 days (5/3-209).

The Mental Health Code guarantees all recipients adequate and humane care in the least restrictive environment. As a means to this end, it outlines how recipients are to be informed of their proposed treatments and provides for their participation in this process to the extent possible:

"(a-5) If the services include the administration of…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. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment. …. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only (i) pursuant to the provisions of Section 2- 107 [unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available, or upon a court order]…." (405 ILCS 5/2-102).

The Mental Health Code mandates that recipients shall be permitted unimpeded, private and uncensored communications with persons of their choice by mail, telephone and visitation. Correspondence must be conveniently received and mailed and reasonable times and places for the use of telephones and for visits may be established by the facility. Communication may be reasonably restricted only in order to protect the recipient or others from harm, harassment or intimidation. When communication is restricted, the recipient must be advised that he has the right to require the facility to notify the affected parties of the restriction and when the restriction is no longer in effect (5/2-103).

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).

FACILITY POLICY

Madden provided the policy and procedure for Intake Screening Requirements (#1500 Assessment and Treatment Planning). It indicates that while the recipient is in the Intake process, he/she will be given a psychiatric assessment to determine the need for hospitalization, and the psychiatrist will write the appropriate orders for recipients who have been evaluated, and recommend other dispositions if hospitalization is not required. If the recipient is transferred, the psychiatrist will approve the ambulance order to another hospital.

Madden provided the policy and procedure for Medication Counseling-Informed Consent (#1700 Medication). It indicates that written consent will be obtained for every psychotropic medication being recommended to the recipient, whether or not an order for the medication is

subsequently written. Information given to the recipient in order to obtain consent includes the name of the medication and its dosage, its purpose, whether the medication requires periodic tests/procedures to ensure its safety, side effects associated with the medication's use, diagnosis and risks from not taking the medication, alternative treatments, the right to refuse medication, general information about the reduction of psychotropic medication, and possible food-drug interactions which may occur.

Madden provided policy and procedure for Patient Phone Use (#200 Patient Rights Specific). It indicates that patients will be permitted unimpeded, private and uncensored telephone use with persons of their choice. Patient phones for personal use are reasonably accessible during the hours of 7:00 a.m. and 10:00 p.m. Patients are allowed to use business telephones to place and receive calls to and from attorneys, advocates, or probation officers with minimal limitations as to the number, length, and time of calls if the use of the patient telephone is not feasible. Any restriction of phone use must be in compliance with the Mental Health Code and documented in the patient's clinical record. A patient with a phone restriction is not restricted from making or receiving calls to or from his/her attorney or legal advocate.

Madden provided policy and procedure for Discharge and Aftercare Planning (#1500 Assessment and Treatment Planning). It indicates that Discharge Panning begins at admission and it includes unit staff, community agency/aftercare staff, the patient, and other significant individuals and agencies, all of which is documented in the clinical record. The policy indicates that a written Notice of Discharge is provided to all patients, without exceptions, at least 7 days prior to the intended date of discharge, including those patients discharged by court order. When it is not possible to give 7 days notice, the Treatment Coordinator must give the notice to the patient with as much notice as possible. The Madden Patient and Family Handbook indicates that Madden staff will assist patients in finding aftercare help once they are discharged and will make an appointment with that person before the patient leaves the facility.

CONCLUSION

The record provides the recipient's psychiatric evaluation, completed the day she was admitted into Intake, as well as consents for the medication she received while she was a patient at Madden. There is no evidence that the recipient had her phone rights restricted and she was able to call family, friends and advocacy agencies, whose contact information is provided. The recipient's discharge planning is noted in the progress notes and the psychiatrist's recommendations are formalized and signed off on by the recipient. The HRA does not substantiate the complaint that the facility did not follow Code requirements when a recipient 1) did not receive a psychiatric evaluation upon admission, 2) did not give consent for the psychotropic medications she was administered, 3) had her phone use restricted for no adequate reason, 4) was prevented from contacting an advocacy agency, and 5) was discharged to the streets without discharge planning.