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Egyptian Regional Human Rights Authority
Report of Findings
Case #13-110-9010
Choate Mental Health and Developmental Center

The Egyptian Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegation concerning Choate Mental Health and Developmental Center:

> **A recipient was inappropriately admitted to the mental health unit at Choate when he may have been better served on the developmental disability unit.**

If found substantiated, the allegation represents a violation of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

Choate Mental Health and Developmental Center provides services to both persons with mental illness and persons with developmental disabilities. According to the Illinois Department of Human Services' (DHS) website Choate services to persons with developmental disabilities include, psychiatric, psychological, medical, social educational, vocational, rehabilitation, recreational, speech, language, hearing, pharmacy, dental, dietary and other services. The developmental disabilities units consist of 5 civil units and one forensic unit. The website indicates that of the individuals receiving developmental disability services at Choate, 15% have a profound intellectual disability, 11% have a severe intellectual disability, 27% have a moderate intellectual disability and 43% have a mild intellectual disability. In addition, 67% have a secondary mental illness, 75% have a behavior program and 65% receive psychotropic medications.

The mental health program at Choate is one of 9 state-operated psychiatric hospitals providing inpatient mental health treatment; a screening process is completed to ensure that hospitalization is needed or if there are more appropriate treatment alternatives. According to an Illinois Department of Human Services, Office of the Inspector General (OIG) report published on the DHS website, the mental health side of Choate served 39 unduplicated individuals in fiscal year 2012 (July 1, 2011 to June 30, 2012) and the mental health side had a census of 69 individuals on June 30, 2012. The OIG report indicated that the developmental disability side of Choate served 193 unduplicated individuals in fiscal year 2012 with a census of 165 individuals on June 30, 2012.

To investigate the allegations, an HRA team met with representatives of Choate, examined a recipient's record with written consent, and reviewed pertinent policies and mandates related to admission.

COMPLAINT STATEMENT

According to the complaint, a recipient was inappropriately admitted to the wrong unit at Choate. The complaint states that the recipient was admitted to a mental health unit but may have been better served on a developmental disability unit.

FINDINGS

Interviews with Choate Representatives

An HRA team met with representatives of the facility who reported that individuals with dual diagnoses must be screened by an area pre-admission screening agency prior to admission to a developmental disability (DD) unit. Screening and admission to a facility mental health unit may be quicker as long as the individual meets admission criteria. If being admitted from the maximum, secure state mental health facility, an individual will usually be first admitted to a mental health unit as a "step-down" and then, if the individual has a developmental disability, be transferred to a DD unit. Individuals with a dual mental health and developmental disability diagnosis are often difficult to transfer to other state-operated facilities or to the community as per facility representatives. If the recipient with a developmental disability also has an Axis 1 (a major mental health clinical condition) and is a harm to self and others, the facility may admit to the mental health side, at least temporarily, especially if the individual is aggressive and needs emergency medication administration. According to the facility representatives, the recipient involved in this HRA case was admitted to Choate by a petition and certificate on 08-18-12; he was admitted to the mental health unit due to his level of dangerousness to self and others which is the mental health unit's primary requirement for admission. Once he was stable and no longer met criteria for a continued stay on the mental health unit, an attempt was made to transfer him to the developmental disability unit but there was a delay in his acceptance there. He was involuntarily committed on 09-05-12 and sent to the secure state-operated facility on the same day as the commitment and as recommended by the Department of Human Services forensics network.

Record Review - Choate

According to a community hospital emergency room assessment, a recipient arrived at the emergency room on 08-17-12 at around 4 pm due to being violent and attacking staff. The hospital sought in-patient admission at 20 different facilities but was turned down. A crisis team was called in "due to inability to be placed in facility with dual diagnosis." Choate agreed to admission and the recipient was transferred on 08-18-12.

Supporting documentation included a petition for involuntary emergency admission that was completed by a crisis worker from a mental health center on 08-17-12 at 7:45 pm. The recipient had been residing at a community integrated living arrangement (CILA). According to the petition, the recipient, who had a diagnosis of Major Depressive Disorder and Intermittent

Explosive Disorder was verbally threatening suicide, had destroyed property, had physically struck a staff person and had run out into the street twice. He was described as having explosive and impulsive behaviors and impaired sleep; he also voiced the need for medication. The petition recommended immediate hospitalization as a person with mental illness due to placing himself and others at risk of physical harm. A certificate was completed at the hospital emergency room on 08-18-12 at 8 a.m. again recommending inpatient hospitalization as a person with mental illness at risk of physical harm to self or others; the certificate stated that the recipient left the emergency room 4 times, walked into the middle of the street, had been combative with staff and lacked judgment and insight. A second certificate was completed at 4:15 pm at Choate recommending hospitalization due to the recipient's mental illness and risk of harm to self. The recipient received emergency medication on 08-18-12 after he threw chairs in the day room.

An initial pre-screening form completed by Choate staff at 10:34 pm on 08-17-12 stated that the recipient had diagnoses of Major Depression and Intermittent Explosive Disorder with Mild Cognitive impairment. He was described as being a danger to himself due to walking out into the street and making suicidal statements as well as a danger to others; the report stated that he hit staff with a belt. It appeared that community hospitalization was attempted at numerous hospitals with each deflecting on the grounds that the recipient needed a more structured setting; at least one hospital was full. It appeared that the prescreening agency made contact with DHS representatives and eventually Choate accepted the recipient for admission. A Choate diagnosis form documented a final diagnosis on 08-23-13 which included an Axis 1 diagnosis of Intermittent Explosive Disorder and an Axis II diagnosis of mild cognitive impairment. An initial treatment plan was developed on 08-18-12 and included a goal for self safety "…through unit milieu and treatment procedures including orientation to unit and safety measures" with objectives being to report and reduce thoughts of self harm and harm to others. Treatment staff were to encourage the recipient to seek assistance for symptom management and medication side effects and to orient the recipient to comfort/relaxation techniques to reduce anxiety and stress. Nursing staff were to administer and monitor medication and to discuss a personal safety plan with the recipient to help him identify triggers and stressors. The psychiatrist was to prescribe antipsychotic medication. Several therapeutic groups were identified for the recipient's participation including a peer support group, health living group, an orientation group, a relaxation group and a goal setting group. Medical issues were also identified and addressed in the treatment plan. The treatment plan documented that the recipient had only been at the CILA for persons with developmental disabilities for 30 days before exhibiting behaviors and he had legal charges pending. Another goal was added on 08-21-12 to control his impulsive behaviors including aggression and elopement so that he could return to a less restrictive living arrangement. A personal safety plan indicated triggers, cues and interventions.

The recipient's social history completed on 08-23-12 by Choate stated that the recipient received special education services throughout school. He was described as being "very slow - very difficult to get answers - perseverates." The assessment stated that "when in an environment he is comfortable and he is noted to be pleasant and sociable." While residing at the CILA, he participated in a supported employment job. The history indicated that his thought processing was "very slow," he was unable to make good decisions, he engaged in self-injurious behaviors when frustrated, he had poor impulse control and he "continues to have difficulty adjusting."

An ICAP (Inventory for Client and Agency Planning) assessment completed in April 2012 documented the recipient's functioning skills in different domains including motor skills, social/communication, personal living, community living and broad independence; the recipient's age equivalent, in months, was 63 or 5.25 years. Prior social work and psychological assessments documented the recipient's mild cognitive impairment with IQ scores ranging from the 40s to the 50s. More recent assessments included mental health diagnoses of Major Depressive Disorder and Intermittent Explosive Disorder.

A psychiatry note stated that the recipient did not seem to understand why he was hospitalized but later the recipient indicated that he needed help with anger. Contact was made with the CILA staff who indicated significant mood swings that resulted in behaviors that put him and others at risk of harm. Medication adjustments were to be considered. A psychiatric evaluation completed on 08-19-12 described his self-injurious behaviors and aggression to others. It also documented his limited functioning concluding that the "patient is in need of psychiatric hospitalization and will be referred for further continuation of treatment care to the inpatient psychiatrist." The patient was to be observed for agitation and given psychotropic medication. A psychiatry note dated 08-28-12 indicated that medication adjustments were being made and behavioral interventions were being pursued.

On 08-31-12, Choate completed a request for transfer form to a state-operated maximum secure mental health facility which indicated that the mental health unit and facility medical director approved the transfer. The transfer request stated that the recipient had been admitted as an emergency with a petition and certificate but had not been civilly committed. The rationale for transfer to the maximum secure facility was that the recipient had struck peers four times leaving one recipient with significant bruising requiring further examination to rule out head trauma. In addition, he verbally threatened the psychiatrist. He required restraints twice. He attempted to elbow staff in the eye during restraint application and he attacked two elderly recipients. It was also reported that he was verbally threatening to peers. Attempted interventions were listed and included the involvement of a Support Service Team through the DHS, Division of Developmental Disability Services and medication adjustments. The proposed benefits of a transfer to the maximum secure facility were listed as follows: to protect vulnerable peers, to provide greater security for his elopement risk, and to increase structure due to "extremely compromised judgment and impulse control." The criteria for his return required 2 months of stable behavior which was defined as no restraints, emergency medication administrations or elopement attempts.

A discharge summary stated that the recipient was discharged on 09-05-12 to the maximum secure facility. The summary stated that the recipient had not tolerated hospitalization at Choate from a community CILA very well and "His limited understanding of the reasons for his confinement continue to cause him frustration and have seemed to generate significant behavioral dysregulation. During his hospital stay, [the recipient] has required 7 PRNs and has 2 episodes of restraint for significant acts of deliberate aggression. [The recipient's] admission of approximately 1 month's duration in the [CILA] also demonstrated significant behavioral and mood dysregulation. Impulse control problems predominate, as well as significantly decreased frustration tolerance when limits are set and [the recipient] is not able to obtain the immediate

goal he seeks. It is believed that this is due to [the recipient's] overall level of functioning. His current full scale IQ is determined to be 56, previous documentation at 21 years old indicated a full scale of 43 within the moderate MR rage….He has been during his stay at Choate significantly verbally aggressive and belligerent and has difficulty responding to redirection. His level of aggression is considered to be quite dangerous for our environment, as it appears to be quite premeditated. This is evidenced by the recent active aggression resulting in injury to a frail female peer, where [the recipient] wrapped 2 belts around each hand and postured flexing his muscles prior to attacking the peer. In terms of medication adjustment, it was felt by the treatment team that some of his frustration may be due to his limited ability to express himself. He is currently on 3 antiepileptic agents and discussion with a provider who had treated [the recipient] for a period of over 3 years duration indicated that no combination of agents had proved to be effective in attenuating his aggressive and impulsive behaviors." His prognosis is described as "poor. This patient's limited cognitive range has chronically been a barrier to improved understanding of the need for behavioral regulation and control." Placement and follow-up are listed and stated that the "Patient will be transferred to [maximum state-operated mental health facility] for a higher level of care and intervention." His diagnoses at discharge included an Axis I diagnosis of Intermittent Explosive Disorder and an Axis II diagnosis of mild cognitive impairment.

An order for involuntary admission to a state-operated facility for 90 days was signed and filed by the courts on 09-05-12. There did not appear to be any updated petitions or certificates beyond the dates of 08-17-12 when the initial petition was completed and 08-18-12 when the most recent certificate was completed.

On 11-07-12, one new certificate was completed by the maximum secure mental health facility and stated that the recipient was a person with mental illness who was a danger to self and others and was in need of immediate hospitalization. The certificate stated that since the recipient's admission to the maximum secure facility, had had several incidents of aggressive behaviors that led to restraint use and emergency medications. The recipient was described as having a low frustration level resulting in his being easily agitated. The clinical recommendation was for a structured inpatient treatment facility and involuntary commitment.

Record Review - Maximum, Secure Mental Health Facility

Records at the maximum secure state-operated facility were also reviewed. Initial paperwork stated that the recipient was admitted due to physical aggression toward staff and peers and he had diagnoses of Intermittent Explosive disorder and a mild cognitive impairment. An initial psychiatric nursing assessment completed on 09-05-12 stated that the recipient had communication problems due to slow cognition and speech. A psychiatric evaluation also completed on 09-05-12 stated that "At the present time patient presents with no psychotic, manic, depressive, or anxiety symptoms. However, he has poor impulse control and poor insight and judgment about his behaviors." His cognitive impairment is described and his diagnoses included the following: "Personality Change due to unspecified encephalopathy, Mild Mental Retardation…Mental illness; history of psychiatric hospitalization; poor impulse control." His prognosis was listed as being "poor due to subnormal intellectual functioning and poor impulse control." The recipient signed a consent for medication, including psychotropic medication. A patient education evaluation form completed on 10-09-12 stated that the patient had a "poor

understanding" and that the patient had a cognitive impairment and was "just laughing while I talked to him…." Treatment plans documented incidents of aggression as well as the recipient's cognitive needs. According to a 01-16-13 treatment plan, the recipient's criteria for separation included the following: "(1) He must demonstrate a sincere desire for transfer to a less secure facility; (2) He must exhibit compliance with prescribed medications and other treatment modalities as required; and (3) He must demonstrate effective management of aggressive behaviors." The plan stated that the recipient is appropriately placed at the maximum secure mental health facility. A treatment plan dated 05-07-13 documented one incident of aggression with a peer and progress in other areas, including medication compliance. The criteria for separation was the same as the January 2013 treatment plan and he was listed as being appropriately placed. Reference was made to his intellectual functioning with regard to educating the recipient on medication and medical needs.

On 06-04-13, the recipient's psychologist completed a review and indicated that "the setting in which services are being provided is appropriate to [the recipient's] current requirements."

Policy Review

Policies pertinent to the allegations were also reviewed. An "Admission and Intake Procedure" specific to mental health services at Choate states that admission will be offered regardless of physical or mental disabilities and the facility "…shall admit individuals who exhibit an acute exacerbation of psychiatric symptoms and who, without treatment there is the reasonable expectation they are at risk of harming his/herself or others; or are placing his/herself in way of physical harm; or due to refusal of treatment, it is a reasonable expectation their mental status and function will continue to deteriorate without intensive, psychiatric inpatient treatment. Acceptance of an individual for admission shall be made if the admission examination concludes that: the treatment services required by the individual are appropriate to the intensity and restriction of care provided by the hospital; the treatment services required can be appropriately provided by the Hospital; and, the alternatives for less intensive or restrictive treatment services are not available in the community or have been unsuccessful." For an involuntary admission, the psychiatrist/physician is to admit the individual and a physician's exam is to be completed within 12 hours unless there is a question regarding medical stability or special needs and then the physician's exam is to be completed within 2 hours. The policy then directs the completion of various forms.

A Choate Mental Health services policy entitled, "Completion of Second Certification of Emergency Admission" quotes sections of the Mental Health and Developmental Disabilities Code specific to emergency admission by certification and directs facility staff to review petitions and certificates as soon as possible and determine if admission criteria have been met. A staff psychiatrist is to complete a second certificate within 24 hours excluding Saturdays, Sundays and holidays if he/she believes, upon exam, the individual meets the criteria for involuntary admission. If a psychiatrist is unable to determine that the individual meets involuntary admission criteria, he/she is to confer with administrative staff. If the recipient had been prescreened by a community mental health clinic, a second opinion by another psychiatrist is to be secured but if no prescreening was done and no behavior meeting admission criteria is observed, the individual can be triaged to a community mental health center for further examination and treatment. "In situations where examiners disagree or in cases where the

psychiatrist may be uncertain as to whether or not the individual meets the criteria for Admission, the Medical Director shall be notified. The Medical Director or his/her designee shall examine the individual and determine if the second certificate should be issued or if the individual should be released."

According to a policy entitled, "Admission Status, Continuation of Voluntary or Involuntary Commitment" with regard to mental health admission, treatment teams are to conduct weekly reviews to monitor the expiration of involuntary commitments. "The responsible case manager shall have the patient scheduled for assessment by the Treatment Team to determine if he/she is suitable for discharge and/or if continued involuntary commitment shall be pursued….Petition and Certificates shall be promptly executed in accordance with the Mental Health Code."

The "Admission, Extension of Stay, Discharge Criteria - Mental Health Services" establishes criteria to be used to evaluate the clinical need and appropriateness of admission, continued inpatient care and discharge. For psychiatric admission, all of the following criteria "must be present 100% of the time:" a person with a mental illness who because of his/her behavior places him/herself at risk of harm to self or others; a person with mental illness who because of the mental illness "…is unable to understand his or her need for treatment and who, if not treated, is reasonably expected to suffer or continue to suffer mental deterioration or emotional deterioration, or both, to the point that the person is reasonably expected to engage in dangerous conduct….; the patient requires observation and/or evaluation available only in a state-operated facility; and, …Due to the mental disorder, the patient is impaired to the degree that he/she manifests major disability in social, familial, educational, and/or occupational functioning which cannot be managed in a less intensive and less restrictive setting and/or is reasonably expected to engage in dangerous conduct." Secondary criteria are also listed and include such items as the lack of a social support to facilitate outpatient treatment, lack of access to outpatient treatment, failed outpatient treatment, safety concerns, a severe mood disorder, the use of high dose or intensive medication, etc. With regard to extensions of stay for adult psychiatric admission, the policy states that the following criteria are used to determine the need for a continued stay for adults, ages 21 to 65: the recipient continues to pose a risk of imminent danger to self/others; or, the patient has had adverse reactions to medications/treatment requiring resolve; or, the patient requires 24 hour observation in a structured environment; or, a less restrictive setting is not available. Secondary criteria for continued stay includes the development of new psychotic symptoms, regressed functioning, and acute disturbances in mood, behavior and/or thinking. In determining discharge the policy requires that all of the following criteria be met: the patient's inpatient treatment goals have been substantially met "unless transfer to another hospital setting is the chosen course of action; follow-up and aftercare plans have been formulated; and, releasing or transferring the patient to a program offering a less intensive and less restrictive level of care does not pose a threat of imminent danger to self or others."

The procedures for admission to a developmental disabilities unit include: functioning at a mild, moderate, severe or profound level of intellectual disability; the need for skills development to live in a residential setting; and be at least age 18 or older. Exclusionary criteria for admission to a developmental disability unit includes being younger than age 18, not having a primary developmental disability diagnosis; and an inability to benefit from active treatment. Admissions to Choate's developmental disabilities division requires pre-admission evaluations,

contact with the DHS, the involvement of the Center Director or designee, a review by an interdisciplinary team consisting of a physician, nurse, psychologist, social worker, personal services coordinator and unit director "…to ensure the individual is 1) eligible for services based on the strengths, abilities, needs and preferences of the persons service, 2) that the individual's immediate and urgent needs have been identified, and 3) the center is able to provide services in accord with the individual's identified needs. A recommendation regarding acceptance is made to the Center Director who is responsible for the final admission decision."

MANDATES

The Mental Health and Developmental Disabilities Code (405 ILCS 5/1-106) defines a developmental disability as "a disability which is attributable to: (a) an intellectual disability, cerebral palsy, epilepsy or autism; or (b) any other condition which results in impairment similar to that caused by an intellectual disability and which requires services similar to those required by intellectually disabled persons. Such disability must originate before the age of 18 years, be expected to continue indefinitely, and constitute a substantial handicap." The Code (405 ILCS 5/1-119) defines a person subject to involuntary inpatient admission as:

> *(1) A person with mental illness who because of his or her illness is reasonably expected, unless treated on an inpatient basis, to engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed;*
>
> *(2) A person with mental illness who because of his or her illness is unable to provide for his or her basic physical needs so as to guard himself or herself from serious harm without the assistance of family or others, unless treated on an inpatient basis; or*
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> *(3) A person with mental illness who:*
>
> *(i) refuses treatment or is not adhering adequately to prescribed treatment;*
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> *(ii) because of the nature of his or her illness, is unable to understand his or her need for treatment; and*
>
> *(iii) if not treated on an inpatient basis, is reasonably expected, based on his or her behavioral history, to suffer mental or emotional deterioration and is reasonably expected, after such deterioration, to meet the criteria of either paragraph (1) or paragraph (2) of this Section.*
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> *In determining whether a person meets the criteria specified in paragraph (1), (2), or (3), the court may consider evidence of the person's repeated past pattern of specific behavior and actions related to the person's illness.*

The 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."

With regard to involuntary, emergency admission, the Code (405 ILCS 5/3-600) states that "A

person 18 years of age or older who is subject to involuntary admission on an inpatient basis and in need of immediate hospitalization may be admitted to a mental health facility…." The emergency admission begins with a petition detailing the rationale for emergency inpatient admission "including the signs and symptoms of a mental illness and a description of any acts, threats, or other behavior or pattern of behavior supporting the assertion and the time and place of their occurrence." Section 5/3-602 requires the petition to be accompanied by a certificate completed by a physician, qualified examiner or psychiatrist, who personally examined the individual not more than 72 hours before admission, indicating that the individual is subject to inpatient involuntary and immediate hospitalization. The certificate is to document the examiner's clinical observation, facts that contributed to a diagnosis and a statement of rights advisement. Section 5/3-604 stipulates that "No person detained for examination under this Article on the basis of a petition alone may be held for more than 24 hours unless within that period a certificate is furnished to or by the mental health facility. If no certificate is furnished, the respondent shall be released forthwith." Section 5/3-607 allows for court ordered temporary detention and examination based on personal observation in court that an individual is subject to involuntary, immediate inpatient admission to protect him/herself or others from physical harm. The court order must detail facts for its decision and may order an peace officer to take the individual to a mental health facility where the individual can be detained for up to 24 hours to determine the need for involuntary and immediate hospitalization. A petition and certificate must be completed within 24 hours for involuntary admission. Section 5/3-610 governs an examination by a psychiatrist at the admitting facility and states the following:

> *As soon as possible but not later than 24 hours, excluding Saturdays, Sundays and holidays, after admission of a respondent pursuant to this Article, the respondent shall be examined by a psychiatrist. The psychiatrist may be a member of the staff of the facility but shall not be the person who executed the first certificate. If a certificate has already been completed by a psychiatrist following the respondent's admission, the respondent shall be examined by another psychiatrist or by a physician, clinical psychologist, or qualified examiner. If, as a result of this second examination, a certificate is executed, the certificate shall be promptly filed with the court. If the certificate states that the respondent is subject to involuntary admission but not in need of immediate hospitalization, the respondent may remain in his or her place of residence pending a hearing on the petition unless he or she voluntarily agrees to inpatient treatment. If the respondent is not examined or if the psychiatrist, physician, clinical psychologist, or qualified examiner does not execute a certificate pursuant to Section 3-602, the respondent shall be released forthwith.*

Subsequent to admission and within 24 hours (excluding the weekend and holidays), the facility is to file 2 copies of the petition, first certificate, proof of service of the petition, and a rights statement in the county court after which the court is to hold a hearing within 5 days excluding the weekends and holidays with notice going to the individual, responsible relatives and other entitled to receive a petition copy (405 ILCS 5/3-611).

The Code makes a general statement with regard to transfers between DHS facilities in Section 5/2-908 which states that "The facility director of any Department facility may transfer a recipient to another Department facility if he determines the transfer to be clinically advisable

and consistent with the treatment needs of the recipient."

Transfer procedures for persons with mental illness are described in Section 5/3-910 which state:

> *Whenever a recipient who has been in a Department facility for more than 7 days is to be transferred to another facility under Section 3-908, the facility director of the facility shall give written notice at least 14 days before the transfer to the recipient, his attorney, guardian, if any, and responsible relative…..The notice shall include the reasons for transfer, a statement of the right to object and the address and phone number of the Guardianship and Advocacy Commission. If the recipient requests, the facility director shall assist him in contacting the Commission…..A recipient may object to his transfer or his attorney, guardian, or responsible relative may object on his behalf. In the case of a minor, his attorney, the person who executed the application for admission, or the minor himself if he is 12 years of age or older, may object to the transfer. Prior to transfer or within 14 days after an emergency transfer, a written objection shall be submitted to the facility director of the facility where the recipient is located. Upon receipt of an objection, the facility director shall promptly schedule a hearing to be held within 7 days pursuant to Section 3-207. The hearing shall be held at the transferring facility except that when an emergency transfer has taken place the hearing may be held at the receiving facility. Except in an emergency, no transfer shall proceed pending hearing on an objection.*
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> *(d) At the hearing the Department shall have the burden of proving that the standard for transfer under Section 3-908 is met. If the transfer is to a facility which is substantially more physically restrictive than the transferring facility, the Department shall also prove that the transfer is reasonably required for the safety of the recipient or others. If the utilization review committee finds that the Department has sustained its burden and the decision to transfer is based upon substantial evidence, it shall recommend that the transfer proceed. If it does not so find, it shall recommend that the recipient not be transferred.*

With regard to admissions and transfers for persons with cognitive needs, the Code states in Section 5/4-201 that:

> *(a) An intellectually disabled person shall not reside in a Department mental health facility unless the person is evaluated and is determined to be a person with mental illness and the facility director determines that appropriate treatment and habilitation are available and will be provided to such person on the unit. In all such cases the Department mental health facility director shall certify in writing within 30 days of the completion of the evaluation and every 30 days thereafter, that the person has been appropriately evaluated, that services specified in the treatment and habilitation plan are being provided, that the setting in which services are being provided is appropriate to the person's needs, and that provision of such services fully complies with all applicable federal statutes and regulations concerning the provision of services to persons with a developmental disability. Those regulations shall include, but not be limited to the regulations which govern the provision of services to persons with a developmental*

disability in facilities certified under the Social Security Act [FN1] for federal financial participation, whether or not the facility or portion thereof in which the recipient has been placed is presently certified under the Social Security Act or would be eligible for such certification under applicable federal regulations. The certifications shall be filed in the recipient's record and with the office of the Secretary of the Department. A copy of the certification shall be given to the person, an attorney or advocate who is representing the person and the person's guardian.

(b) Any person admitted to a Department mental health facility who is reasonably suspected of being mildly or moderately intellectually disabled, including those who also have a mental illness, shall be evaluated by a multidisciplinary team which includes a qualified intellectual disabilities professional designated by the Department facility director. The evaluation shall be consistent with Section 4-300 of Article III [FN2] in this Chapter, and shall include: (1) a written assessment of whether the person needs a habilitation plan and, if so, (2) a written habilitation plan consistent with Section 4-309, and (3) a written determination whether the admitting facility is capable of providing the specified habilitation services. This evaluation shall occur within a reasonable period of time, but in no case shall that period exceed 14 days after admission. In all events, a treatment plan shall be prepared for the person within 3 days of admission, and reviewed and updated every 30 days, consistent with Section 3-209 of this Code.

(c) Any person admitted to a Department mental health facility with an admitting diagnosis of a severe or profound intellectual disability shall be transferred to an appropriate facility or unit for persons with a developmental disability within 72 hours of admission unless transfer is contraindicated by the person's medical condition documented by appropriate medical personnel. Any person diagnosed as severely or profoundly intellectually disabled while in a Department mental health facility shall be transferred to an appropriate facility or unit for persons with a developmental disability within 72 hours of such diagnosis unless transfer is contraindicated by the person's medical condition documented by appropriate medical personnel.

(d) The Secretary of the Department shall designate a qualified intellectual disabilities professional in each of its mental health facilities who has responsibility for insuring compliance with the provisions of Sections 4-201 and 4-201.1.

Furthermore, the Code addresses treatment objections of persons with cognitive impairments in Section 5/4-201.1 as follows:

(a) A person residing in a Department mental health facility who is evaluated as being mildly or moderately intellectually disabled, an attorney or advocate representing the person, or a guardian of such person may object to the Department facility director's certification required in Section 4-201, the treatment and habilitation plan, or appropriateness of setting, and obtain an administrative decision requiring revision of a treatment or habilitation plan or change of setting, by utilization review as provided in Sections 3-207 and 4-209 of this Code. As part of this utilization review, the Committee shall include as one of its members a qualified intellectual disabilities professional.

(b) The mental health facility director shall give written notice to each person evaluated as being mildly or moderately intellectually disabled, the person's attorney and guardian, if any, or in the case of a minor, to his or her attorney, to the parent, guardian or person in loco parentis and to the minor if 12 years of age or older, of the person's right to request a review of the facility director's initial or subsequent determination that such person is appropriately placed or is receiving appropriate services. The notice shall also provide the address and phone number of the Legal Advocacy Service of the Guardianship and Advocacy Commission, which the person or guardian can contact for legal assistance. If requested, the facility director shall assist the person or guardian in contacting the Legal Advocacy Service. This notice shall be given within 24 hours of Department's evaluation that the person is mildly or moderately intellectually disabled.

(c) Any recipient of services who successfully challenges a final decision of the Secretary of the Department (or his or her designee) reviewing an objection to the certification required under Section 4-201, the treatment and habilitation plan, or the appropriateness of the setting shall be entitled to recover reasonable attorney's fees incurred in that challenge, unless the Department's position was substantially justified.

The Code makes provisions for informing individuals of their rights when a petition has been completed and prior to an examination for certification and requires in Section 5/4-210 that "the person conducting this examination shall inform the person being examined in a simple comprehensible manner: that he is entitled to consult with a relative, friend, or attorney before the examination and that an attorney will be appointed for him if he desires; that he will be evaluated to determine if he meets the standard for judicial or emergency admission; that he does not have to talk to the examiner; and that any statement made by him may be disclosed at a court hearing on the issue of whether he meets the standard for judicial admission. If the respondent is not so informed, the examiner shall not be permitted to testify at any subsequent court hearing concerning the respondent's admission."

Section 5/4-400 of the Code describes the admission process for persons with developmental disabilities and cognitive impairments and states that:

(a) A person 18 years of age or older may be admitted on an emergency basis to a facility under this Article if the facility director of the facility determines: (1) that he is intellectually disabled; (2) that he is reasonably expected to inflict serious physical harm upon himself or another in the near future; and (3) that immediate admission is necessary to prevent such harm.

(b) Persons with a developmental disability under 18 years of age and persons with a developmental disability 18 years of age or over who are under guardianship or who are seeking admission on their own behalf may be admitted for emergency care under Section 4-311.

A person with a developmental disability cannot be held for more than 24 hours pending admission unless a clinical psychologist, clinical social work or physician conducts and examination and a certificate indicating the need for emergency admission with the certificate

detailing the examiner's observations, facts and a statement that the individual has been informed of his/her rights (405 ILCS 5/4-402). Just as with mental health recipients, a court can detain an individual for examination via a court order if the court determines that the individual meets the criteria for emergency admission after which a peace officer can take the individual to a facility for examination that must be completed within 24 hours and a petition and certificate (405 ILCS 5/4-405). Section 5/4-407 requires that within 24 hours excluding weekends and holidays, the facility director is to file the petition and certificate along with proof of service that the petition and rights information had been provided to the recipient/respondent. Furthermore the respondent is to be evaluated and the evaluation is to be filed with the court within 7 days of admission after which a hearing it to be send. With regard to transfers between facilities for persons with developmental disabilities, Section 5/4-707 states that "The facility director of any Department facility may transfer a client to another Department facility if he determines that the transfer is appropriate and consistent with the habilitation needs of the client. An appropriate facility which is close to the client's place of residence shall be preferred unless the client requests otherwise or unless compelling reasons exist for preferring another facility." According to Section 5/4-709, when a recipient has been in a state-operated facility for more than 7 days and is being transferred to another facility, the director is to provide notice of transfer, the reasons for transfer and the right to object to the recipient attorney and specified individuals except in an emergency when there is risk of health and safety and then notice must be provided within 48 hours subsequent to the transfer along with documentation of the reason for the emergency transfer. Recipients and representatives can object to a transfer prior to the transfer or within 14 days subsequent to the transfer; the objection should be in writing to the facility director who must schedule a hearing within 7 days. "Except in an emergency, no transfer shall proceed pending hearing on an objection." The state-operated facility must prove that the standard for transfer has been met at the hearing and if the transfer is to a more restrictive facility, the facility must prove that such a transfer is required to protect the safety of the recipient or others. If the burden of proof is met, the recipient is transferred; if not the recipient cannot be transferred.

The HRA also examined the conditions of the Nathan versus Levitt Consent Decree from 1975 which pertains to the admission of persons with cognitive impairments to state-operated facilities as well as timely and adequate evaluations and treatment. The conditions of the Decree include the following: adequate evaluations and treatment planning for persons with a dual diagnosis of mental illness and cognitive impairment; the transfer and placement of individuals with severe and profound cognitive impairments as well as mental illness in a developmental disability center within 30 days of the date of identification; the transfer and placement of individuals with mild to moderate cognitive impairments as well as a mental illness in the least restrictive placement possible, including community settings; treatment planning by a team comprised by professionals from both developmental disability and mental health services; and, training of mental health staff on treatment issues related to cognitive impairments.

CONCLUSION

According to the complaint, a recipient was inappropriately admitted to a mental health unit at Choate rather than to a developmental disability unit where he might have been better served

The recipient's record revealed that he was initially taken from a CILA to a community hospital due to aggression and suicidal behaviors. Because the community hospital did not have a behavioral health unit, placement for a longer term acute stay was sought. After numerous attempts to admit the recipient to a community hospital behavioral health unit failed, admission to Choate was pursued. A petition for emergency, involuntary mental health admission was completed on 08-17-13 while the recipient was at the hospital emergency room. An initial certificate was completed by a crisis worker on 08-17-13; a second certificate was completed on 08-18-13 by a Choate psychiatrist. Choate admitted the recipient to a mental health unit on 08-18-12 noting both mental health and developmental disability diagnoses. While at Choate, his treatment primarily consisted of medication adjustments and behavioral interventions. Still, he continued to exhibit behaviors, such as striking peers and causing injuries, including injuries to two elderly recipients, threatening peers and staff, and attempting to elbow staff in the eye; he was restrained twice, given PRN psychotropic medications seven times and received support team consultation. Choate recommended transfer to a more restrictive mental health facility using the behaviors, peer injuries and threats as the supporting rationale. The recipient was transferred to the more restrictive mental health facility for 90 days on 09-05-12 after a court order was filed on the same day. It did not appear that there were updated petitions and certificates for the 09-05-12 court order.

Choate's policies indicate that individuals can be admitted for mental health services due to psychiatric symptoms and for risk of harm to self and others. A second certificate is to be completed within 24 hours by a staff psychiatrist (excluding weekends and holidays) to confirm the need for involuntary admission. Treatment teams are to monitor the continuation of involuntary commitment and petitions/certificates are to be compliant with Mental Health Code requirements. In order for a recipient to remain at the facility for mental health services, Choate policy dictates that he/she must meet certain criteria related to a mental illness, including dangerous conduct and risk of self-harm. To admit an individual to a developmental disabilities unit, a recipient must have an intellectual disability, be at least age 18 and need skills development. Exclusionary criteria for admission to a developmental disability unit include not having a primary diagnosis of a developmental disability and an inability to benefit from active treatment. Pre-admission evaluations, contact with DHS, the involvement of the Center Director and a review by an interdisciplinary team are all required for admission to a developmental disabilities unit.

The Mental Health Code defines both a developmental disabilities and an individual subject to involuntary mental health admission. For an individual to be considered for involuntary mental health admission, he must have a mental illness and be expected to harm himself or others along with other criteria. The Code also describes the process to be used for involuntary admission which begins with a petition, includes the completion of two certificates by qualified individuals and within a certain time frame (24 hours) and then the filing of the petition and certificates within 24 hours after which a hearing is to be held within 5 days. Allowances are made for weekends and holidays.

The Code dictates that transfers between state-operated facilities can occur if "clinically advisable and consistent with the treatment needs of the recipient." Once a recipient has been at a facility for more than 7 days, a written transfer notice is to be given to the recipient at least 14

days before the transfer except in an emergency when justification for an emergency transfer is to occur. Notification is to include information about the right to object. With regard to recipients with cognitive impairments, the Code states that "An intellectually disabled person shall not reside in a Department mental health facility unless the person is evaluated and is determined to be a person with a mental illness and the facility director determines that appropriate treatment and habilitation are available and will be provided to such person on the unit." The recipient with cognitive impairments is to be evaluated every 30 days regarding appropriate services in a mental health setting. Notice of the evaluation is to be provided to the recipient.

The Nathan versus Levitt Consent Decree requires that individuals with a dual diagnosis be placed within the least restrictive setting, have adequate evaluations and treatment planning and have access to staff who have training related to a dual diagnosis.

Based on the available evidence, it appeared that the recipient was considered to have mental health needs in addition to his cognitive needs; the suicidal behaviors and aggression appear to meet the Code's criteria for involuntary admission to a mental health facility. The HRA does not substantiate the complaint that the recipient was inappropriately admitted to a mental health unit versus a developmental disability unit. However, the HRA does have concerns about the process used for involuntary admission in that it appears that Code timelines were not followed with regard to filing the petitions/certificates with the court. In addition, the HRA did not find evidence of notification to the recipient of his transfer to another state-operated facility that would include his right to object to such a transfer. Finally, while the HRA did find documentation that justified the recipient's transfer to a more restrictive setting, it questions why the recipient could not have been transferred in-house to a developmental disability unit or the forensic unit at Choate. **The HRA finds rights violations related to the facility's continued admission status and subsequent transfer process for the recipient in this case and recommends the following:**

1. **Follow Mental Health Code requirements for filing petitions and certificates with the court within the Code required timelines.**
2. **Follow Mental Health Code requirements for notifying recipients of transfers and include information about the right to object.**

The HRA also offers the following suggestions:

1. Before considering the transfer of a recipient with a dual diagnosis to a more restrictive mental health facility, consider whether or not the recipient could be served by Choate's developmental disability services or forensic program.

2. Given the unique offerings of Choate and its experience serving both recipients with mental illness and developmental disabilities, consider developing services for persons with a dual diagnosis.

3. Review the process for admission to a Choate developmental disabilities unit. The multi-layered approval process involving several different individuals and entities can create

delays to needed care and treatment.

RESPONSE

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

Pat Quinn, *Governor*

Michelle R.B. Saddler, *Secretary*

CLYDE L. CHOATE DEVELOPMENTAL CENTER
1000 NORTH MAIN ! ANNA, IL 62906

July 11, 2014

Regional Human Rights Authority
#7 Cottage Drive
Anna, Il. 62906

ATTENTION: Human Rights Coordinator

RE: Response HRA Case #13-110-9010

The Authority's report sets out the facts in the above case involving a recipient who was inappropriately admitted to the mental health unit at Choate when he may have been better served on the developmental disability unit. The HRA did not substantiate the complaint that the recipient was inappropriately admitted to a mental health unit versus a developmental disability unit. While the HRA found documentation that justified the recipient's transfer to a more restrictive mental health setting, it questioned why the recipient could not have been transferred in-house to a developmental disability unit or the forensic unit at Choate.

The HRA reported having found rights violations related to the facility's continued admission status and subsequent transfer process for the recipient in this case regarding:

1. Filing petitions and certificates with the court within the Code required timelines. Upon our review of individual's record, a petition and certificate was noted to have been completed by Union County Counseling and given to Choate upon admission of the individual on 08/18/12, which was a Saturday. According to the Mental Health Code requirements, a second certificate was completed by Choate staff that same day, within the 24 hour requirement. The petition and certificates were then filed with the court on Monday, 08/20/14. I am enclosing copies of these documents.

2. Notifying recipients of transfers and include information about the right to object. Staff have been reminded of the need to notify guardians of transfers, including the right to appeal and information on how to appeal per facility policy.

Sincerely,

Interim Assist. Facility Director ~~of~~ Residential Services

cc: , Deputy Director of SODC Operations
, Director of Division of Developmental Disabilities, DHS

1000 North Main Street - Anna, Illinois 62906 618/833-5161 Voice 618/833-4052 TT
Fax 618/833-8613 Developmental Services
Fax 618/833-4191 Administration
Fax 618/833-1415 Human Resources/Payroll
Fax 618/833-7641 Business Office
Fax 618/833-2428 Chief Engineer

Pat Quinn, *Governor*

Michelle R.B. Saddler, *Secretary*

CLYDE L. CHOATE DEVELOPMENTAL CENTER
1000 NORTH MAIN ¦ ANNA, IL 62906

January 29, 2014

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FEB 10 2014
...SHIP & ...MISSION ...AL OFFICE

Regional Human Rights Authority
#7 Cottage Drive
Anna, Il. 62906

ATTENTION: Human Rights Coordinator

RE: Response HRA Case #13-110-9010

The Authority's report sets out the facts in the above case involving a recipient who was inappropriately admitted to the mental health unit at Choate when he may have been better served on the developmental disability unit. The HRA did not substantiate the complaint that the recipient was inappropriately admitted to a mental health unit versus a developmental disability unit. While the HRA found documentation that justified the recipient's transfer to a more restrictive mental health setting, it questioned why the recipient could not have been transferred in-house to a developmental disability unit or the forensic unit at Choate. Although this individual was never a resident of the Developmental Center, we are working with the developmental disability center's social workers in regards to the problems identified in this case, and the Developmental Center has undertaken the following:

1. Working with the records department to set up some type of system to address the Code requirements for filing petitions and certificates with the court within the Code required timelines.

2. Staffs have been reminded of the need to notify guardians of transfers, including the right to appeal and information on how to appeal per facility policy.

As far as HRA suggestions, the current MI director and I are working closely in regards to the transfer of recipients from MI to DD when clinically or legally indicated. The process for admission is developed by the Division and Legal teams to ensure compliance with the Mental Health Code. Persons can not be transferred to the Forensic Unit unless they have been found unfit to stand trial in a court of law or not guilty by reason of insanity. The Division has recently approved the development of a Dual Diagnosis Unit for the Choate facility. We are in the process of developing that program.

Sincerely,

, Center Director
Choate Developmental Center

Cc: Deputy Director of SODC Operations
Director of Division of Developmental Disabilities, DHS