FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
Case #13-110-9038
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 with a developmental disability received inadequate treatment planning.

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

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, 67% have secondary mental illnesses. The mental health program at Choate provides inpatient mental health treatment; a screening process is completed to ensure that hospitalization is needed or if there are more appropriate treatment alternatives.

To investigate the allegation, 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 with a developmental disability was admitted to the mental health unit at Choate and alleges that required treatment and habilitation services were not provided and required certifications were not completed every 30 days.

FINDINGS

<u>Interview with the Administrator of the Mental Health Unit:</u> An HRA team met with the administrator who reported that normally, individuals with dual diagnoses are screened by an

area pre-admission screening agency prior to admission to a developmental disability (DD) unit. Screening and admission to the facility's mental health unit may be quicker as long as the individual meets admission criteria. However, the administrator shared that individuals with a dual diagnoses of mental illness and a developmental disability are often difficult to transfer to other state-operated facilities or to the community so they try to deflect if at all possible, but will admit a person with a dual diagnosis if his mental illness is the primary concern and he is considered to be a harm to himself or others, especially if the individual is aggressive and needs emergency medication administration. In this case, the recipient was first admitted on an Order for Detention and Evaluation by the Court on 4/24/13. Then, on 4/25/13 he signed a voluntary application for admission which was reaffirmed according to mandated timeframes. The Qualified Intellectual Disabilities Professional (QIDP) and Chief Clinical Psychiatrist determine if it is appropriate for an individual to stay on the mental health unit and they conduct a review every 30 days (not monthly). In July, it was determined that this recipient was ready to transfer to a DD facility. The treatment team decided that transferring him to Choate's DD unit was the most practical approach because he could stay in the area and he could easily be transferred back to the Mental Health unit if there was a "flare up" in his psychiatric needs. However, the DD unit at Choate was temporarily prohibited from taking new admissions at that time, but they anticipated a bed would be available soon. After an additional 30 days, they still were unable to transfer the recipient to the DD unit at Choate; therefore they sought out placement at other DD facilities in the state. By that time, the treatment team had determined that the recipient's psychiatric symptoms were manageable enough that it was more feasible for him to be placed in another DD center with minimal need for a sudden transfer back to a psychiatric hospital. Approximately 1 month later, on 8/15/13, another placement was found and he was transferred to that facility. The administrator said that during the month while he was waiting for an available bed, he continued to attend and participate in programming. The administrator advised the HRA that a Joint Commission complaint had also been filed regarding this same individual and Choate's response to the findings of that investigation was provided to the HRA for review. Finally, the administrator provided the HRA with a copy of the email sent to her from the Joint Commission which stated that based on review of the facility's response to this incident, the Joint Commission "will take no further action at this time, the incident is now closed."

Response to Joint Commission Inquiry: The response explained that the recipient was admitted with a primary diagnosis of "Schizoaffective Disorder and Intermittent Explosive Disorder and a secondary diagnosis of Mild Mental Retardation." A Utilization Review meeting with the treatment team within 21 days of admission resulted in the treatment team recommending that the patient's appropriate discharge setting be to a DD Center once his psychiatric symptoms were manageable. The response also stated that in June, 2013 the treatment team decided that the acuteness of his mental health issues was diminishing and began seeking transfer to a state operated DD center "as their assessment determined that he was not appropriate for community placement at that time." The Complaint section of the response said that "required 30 day certifications have not occurred. Choate is in violation of 405 ILCS 5/4-201 (2012)." The Mental Health and Developmental Disabilities Code requires that a QIDP complete a monthly review on all dual diagnosed patients certifying that the setting in which services are being provided is appropriate to the patient's needs. The response also stated "It was discovered that our facility's individual 'Monthly Review Certification' form (MR69F) was not completed by the QIDP and placed in the chart every month for this patient as policy dictates

(PSY.002). However, the monthly report was completed each month and submitted to DHS summarizing all dual diagnosed patients currently admitted, if they were certified that month to still need services, and what their current readiness for discharge was." The conclusion section stated that "although the patient was being tracked, monitored and reported on monthly to DHS for certification of the appropriateness of placement to meet his identified treatment needs, the individual patient 'Monthly Review Certification' form (MR69F) was not completed and placed in the chart per policy." The Follow-up Actions are listed as follows:

1. The "Evaluation and Treatment for persons who are both Mentally Ill and Intellectually Disabled" (PSY.002) was revised to prescribe that the Clinical Directors/QIDPs (rather than clinical psychologists) were to complete the "Admission Information" (form MR69A) within 72 hours of admission and forward to the Chief Psychologist as well as the Hospital Administrators office.

2. The policy also added that subsequent 14 day evaluation and certification forms (MR69C) and the monthly review certification (MR69F) will be copied to the hospital administrators office also for monitoring and sustainability of compliance.

3. The QIDPs were all re-trained on 8/12/13 on the policy "Evaluation and Treatment for persons who are both Mentally Ill and Intellectually Disabled" (PSY.002)

4. An ongoing tracking log (CMHDC XX) was added to the policy (PSY.002) that will be completed/maintained by the Hospital Administrators office to ensure timely completion of the "Admission Information" referral form (MR69A) within 72 hours of admission; the "Multidisciplinary Evaluation" form (MR69C) within 14 days of admission and the "Monthly Review Certification form (MR69F).

5. The Administrative Assistant to the Hospital Administrator was trained on this revised policy (PSY.002) and new tracking log on 8/12/13.

Policy Review

Policy PSY.002 was reviewed by the HRA to ensure that the above listed changes had been incorporated and found the following stated in this policy.

> *"The clinical psychology staff and Clinical Directors are designated by the Hospital Administrator as QIDPs under the direction of the Chief Psychologist/QIDP Coordinator. Using the form entitled '**Admission Information for Persons Who Are Mentally Ill and Intellectually Disabled' (MR69A),** Clinical Directors will notify the QIDP Coordinator and the Hospital Administrator of any admission who is intellectually disabled by the time of the patient's 72 hour treatment planning meeting. The form will be filed in the assessments section of the patient's medical record after review by the QIDP coordinator."*

"A. The multidisciplinary evaluation shall be documented by the QIDP on the form entitled 'Multidisciplinary Evaluation for Persons Who Are Mentally Ill and Intellectually Disabled' (MR69C) within 14 days of admission. <u>A copy shall be sent to the Hospital Administrator</u> and the original shall be filed in the assessments section of the patient's medical record.

B. On the form entitled 'Monthly Review Certification' (MR69F) the QIDP <u>and Hospital Administrator</u> shall certify within 30 days of the completion of the [form MR60C] and every 30 days thereafter that 1) The patient has been appropriately evaluated; 2) The services specified in the treatment plan are being provided; 3) The setting in which the services are being provided is appropriate to the patient's needs; and 4) The provision of such services fully complies with all applicable federal statutes and regulations concerning the provision of services to persons with a developmental disability. 5) If any of the above statements are not valid at the time of a monthly certification, this will be noted in the appropriate area on the form and a written explanation will be attached. The Monthly Review Certification (MR69F) shall be filed in the admission section of the patient's medical record.

C. If the multidisciplinary treatment team determines that an intellectually disabled patient is NOT in further need of psychiatric services on an inpatient setting: 1) The QIDP will notify the QIDP Coordinator of this determination, including treatment team recommendations regarding appropriate placement or services, in a timely manner. In turn, the QIDP Coordinator will notify the Hospital Administrator in a timely manner. 2) If discharge to a community setting is recommended, the treatment team will pursue appropriate placements and services so that discharge may occur. The QIDP Coordinator will assist with difficult placements by contacting appropriate SODC [state operated developmental centers] operations staff involved with community placements. 3) If transfer of the patient to a SODC is recommended, the QIDP Coordinator will notify appropriate SODC operations staff at a local and departmental level. If transfer does not occur within a reasonable amount of time, the treatment team may pursue filing a petition for judicial admission to a SODC, as provided in the Mental Health and [Developmental] Disabilities Code…

E. <u>Monthly Report:</u> A monthly report shall be prepared by the 10th of each month by the QIDP Coordinator and sent to the location/individual designated by the Department of Human Services Office of Mental health to keep such records. The report shall include: 1) Initials of patients admitted to, residing at, or discharged from Choate MHC during that month with a primary or secondary diagnosis of mental retardation; 2) Date and unit of admission; 3) Legal admission status; 4)Psychiatric diagnosis; 5) Date and location of transfer or discharge; 6) Whether there is a legal guardian; 7) Whether the hospital administrator determined that appropriate treatment and habilitation are available and being provided and 8) Whether the patient or guardian has requested a utilization review and, if so, the outcome of the review.

> *F. Hospital Administrator Tracking Log: The Administrative Assistant to the Hospital Administrator shall track for the completion of the 72 hour 'admission information referral', the 14 day 'multidisciplinary evaluation' and the 30 day 'recertifications.' This will be tracked on the 'Hospital Administrator's Tracking Log for MI/DD Certification', CMHDC705."*

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.*

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.

Choate Forms pertinent to the investigation were also reviewed. On the Admission Information (form MR69A), it states at the top of the page "To be completed by the 72 hour treatment planning meeting." The Multidisciplinary Evaluation (form MR69C) states at the top of the page "to be completed within 14 days of admission." The Monthly Review Certification (form MR69F) lists the patient's name, identification number, date of admission and unit at the top and along with the following statement "signatures on the lines below validate that 1) A review has been conducted on the date documented 2) The patient has been appropriately evaluated; 3) Services as specified in the treatment plan are being provided; 4) The setting in which services are being provided is appropriate to the patient's needs and 5) The provision of services fully complies with all applicable federal statutes and regulations concerning the provision of services to persons with developmental disability." The form includes signature lines for the QIDP and Hospital Administrator to sign, date and check if the statement listed on the form is not valid.

The Training Program Attendance Form dated 8/12/13 shows that the Hospital Administrator conducted a training on "MI/DD [Mental Illness/Developmental Disabilities] Evaluation/tx [treatment]/Certification" and signatures of attendance included two Clinical Directors and the Chief Psychologist. A second Training Program Attendance Form indicated that the

Administrative Assistant was trained on "Hospital Administrative Tracking Log for MI/DD Cert. [certification]" on 8/12/13.

The MI/ID [Intellectual Disabilities] Report for Division of Mental Health Choate MHS – July 2013 was reviewed and this recipient's initials were listed on the form. The Admit Type was listed as "Detain & Evaluate" The unit is listed as "LTC" [lower treatment complex of the mental health unit]. The Axis I diagnosis is listed as "Schizoaffective Dis. [disorder]; Intermittent Explosive Disorder." The Axis II diagnosis is listed as "Mild MR [Mental Retardation]; Borderline Personality Disorder" The box marked "Facility Director Cert." has a "Yes" in it. The box marked "UR [utilization review] request" is marked with "No" and "Readiness for Discharge" is marked with "No."

Record Review - Choate

A Court Order for Detention and Evaluation dated 4/24/13 and signed by the Judge was in the recipient's chart which stated that "reasonable grounds exist" to believe that the recipient "may be a person subject to involuntary admission…that an evaluation is needed in order to determine whether the respondent is subject to an involuntary admission; that such an evaluation cannot be properly performed at the respondent's residence and it is necessary that the evaluation be done at a mental health facility; the facts show that an emergency exists such that immediate hospitalization is necessary." The respondent was ordered to "Choate Mental Health Hospital… [to] be examined to see if the respondent is a person subject to involuntary admission."

An Application for Voluntary Admission dated 4/25/13 was signed by the recipient stating that he was seeking admission. The attached assessment of capacity for voluntary admission status stated that this was "per individual's request" and had the "yes" box checked for the following: "1) Does the individual know he is requesting to be admitted to the hospital? 2) Does the individual understand what his options are? 3) Can the individual express his choice and 4) Is the individual able to understand the consequences of his choice?" The assessment section was completed by a medical doctor and there is a check mark next to the box which states "All questions were answered yes. In my professional judgment, the individual is able to give informed consent for admission. Application for Voluntary Admission was completed."

A Notice of Change in Status was sent to the court on 4/26/13 which stated that the recipient was "changed to voluntary status."

Reaffirmations of Voluntary Status dated 5/24/13 (for 30 days) and 7/24/13 (For 60 days) were in his chart and signed by the recipient.

The Comprehensive Psychiatric Evaluation dated 4/25/13 lists the diagnoses as Axis I Schizoaffective Disorder, Bipolar Type; Axis II is deferred; Axis III Chronic Obstructive Pulmonary Disease (COPD), Asthma, Gastroesophageal Reflux Disease (GERD), Hypothyroidism, Urinary Incontinence, and PICA [WebMD defines as "persistent eating of substances with no nutrition such as dirt or paint"]; Axis IV Chronic Mental Illness; Axis V GAF 30 [global assessment of functioning-scale 0-100]. He is listed as a moderate risk for violence, "can easily be redirected occasionally, sometimes very impulsive." His Elopement risk is also

moderate "has a history of elopement in the past." His prognosis is listed as "short-term prognosis is fair. Long-term prognosis is guarded. Relapse due to chronicity of illness, tends to refuse medication, and has Mild MR Illness."

The recipient's initial treatment plan dated 4/26/13 states that his estimated length of stay or anticipated discharge date as "30-60 days" and the discharge criteria is listed as "ability to maintain behavioral controls x2 weeks and locating a placement for [recipient]." It also stated that it was unlikely the recipient will be able to return to the CILA he was in. Other CILA placements would need to be explored. His admitting diagnoses are listed as Axis I Schizoaffective Disorder, Intermittent Explosive Disorder; Axis II Mild MR, Borderline Personality; Axis III Obesity; GERD; COPD; PICA; Hyperlipidemia; Urinary Incontinence; Axis IV None; and Axis V Current GAF [none listed].

The 72 Hour Progress Note dated 4/29/13 stated that the recipient was on "frequent observation" but discussed with the treatment team that he felt that this is no longer indicated. The recipient reported that he became out of control because he did not like the 1:1 who had been assigned to him after he swallowed batteries in his CILA home. The recipient reported that he felt that he was in control of his moods and behaviors and did not feel that he required a 1:1 staff ratio. The recipient also indicated he was not interested in returning to his CILA home. His psychotropic medications prescribed were listed as Valproic Acid syrup and Olanzapine. The facility had completed x-rays which showed that he did not swallow the batteries that he reported he had as there was nothing visualized in the x-ray. The recipient stated that he had no desire to swallow non-food items while at Choate and that he would follow unit rules without difficulty. The recipient reported he was in good spirits and the Psychiatrist concurred that "his mood appears as he reports" and signed the progress note.

A 5/1/13 10 day psychiatry note stated that the recipient "got his schedule for group programs". The note also indicated that his Olanzapine was given BID (twice daily) and the recipient complained of sleepiness so it had been "adjusted to evening." The recipient requested to change this medication to Fluphenazine as it worked better for him in the past. The psychiatrist agreed to give 6.25 IM [intramuscular] every 14 days and noted "for placement possibly DD."

On 5/2/13 the recipient's "level" pass had increased which allowed him to participate in courtyard and other treatment programs. This level pass note indicated he was not an imminent risk of harm to self or others; he had required no special procedures for at least 48 hours, had no acute medical problems, was not at moderate or high risk for elopement and had not had any episodes of unmanageable behaviors for the past 48 hours. This form was signed by the social worker and listed several treatment team members who were present including two psychiatrists.

A 5/3/13 Social Service Progress Note stated that the recipient has had "no behaviors such as aggression or SIB [self-injurious behavior] since admission." It was also noted that the recipient "attends 100% of scheduled programs he is active and appropriate in programs." In the discharge planning section, it was noted that the CILA home had been contacted and declined to accept him back. They believed he was "too unstable/unpredictable to remain at the group home." A readmission meeting was scheduled for 6 days later.

The 5/17/13 Social Service Progress Note said the recipient "has been keeping busy in groups and listening to music to help him cope with stress…has had no incidents of Pica, self-harm or aggression toward others. Interacts appropriately with peers and staff most of the time. He will get mad at staff if his wants/needs are not met immediately. However he has not made any threats to harm the staff that he is mad at…is attending programs. He is noted to be active and appropriate. [Name] would like to return to [previous community day training workshop]" Under discharge planning, nothing is listed regarding discharge, only a note that he has family with whom he keeps in touch.

A 5/24/13 Psychiatrist note stated that the plan was "preparing and looking for placement." The recipient "has been doing fairly well, stable…going to programs, doing ADLs" [activities of daily living].

The 5/24/13 Social Service Progress Note said that the recipient "is not regularly attending programs. He will go to all programs one day then refuse for a few days. The [community sheltered workshop] reported they would not take [recipient] back due to his elopement, aggression and threats to harm himself and others." In the discharge planning section it was noted that the recipient "has been recommended for transfer to the DD division of Choate."

The 6/18/13 Social Service Progress Note also said that the recipient had been referred to DD services, however that reporting period he had to be sent to the hospital and was then placed on 1:1 observation due to swallowing two batteries. It was reiterated that he was not regularly attending programs; he will go to all programs one day and then refuse for a few days.

On 6/21/13 a Social Service Transfer of Care Note was prepared. The note listed the recipient's family member and noted that she had been notified of his upcoming transfer and voiced no concerns about it.

A 7/1/13 Social Services Progress Note indicated that the recipient "has been recommended for transfer to the DD division."

The Individual Problem Plan listed problem #1 as "poor impulse control with aggression and self-injury." Interventions included enrollment in the following programs: "The World Around You Group 7 x weekly to provide [recipient] with opportunities to relate to current events…Relaxation Group 7 x weekly in order to provide [recipient] the opportunity to learn effective coping and de-stressing methods that he will be able to utilize during periods when he is feeling overwhelmed by symptom exacerbation or high stress. Goal Setting Group 7 x weekly to encourage [recipient] to set simple daily goals related to daily wants or needs including self-care, social interactions and coping skills related to working towards success upon discharge. Self-Management Group 6 x weekly technicians will assist [recipient] in techniques of relaxation and self-soothing approaches to difficult and emotional situations…Healthy Eating Group 1 x weekly will provide information to [recipient] on basic nutritional concepts and meal preparation skills…Medication Education Group 1 x weekly will provide [recipient] with a better understanding of appropriate uses and cautions regarding his prescribed psychoactive meds…Healthy Living Group 1 x weekly will assist [recipient] learn healthy lifestyle components which include education on the importance of good sleep and appetite patterns,

medication compliance, follow-up with health issues, nutrition, importance of physical activities, knowledge regarding avoidance of overuse of alcohol, nicotine and etc. in order to maintain a positive mental health status…Effective Communication Group 1 x weekly to educate [recipient] about various communication methods…Let's Talk Group Wednesdays at 3:15 p.m., to foster appropriate social interaction, expression of concerns and problem-solving in a supportive atmosphere." Two other classes were also used and then discontinued approximately one month later: "B.E.S.T. to provide [recipient] opportunities to engage in productive, simulated work experience and focus on assigned tasks and divert aggressive and self-injurious behavior and W.R.A.P to assist [recipient] in developing a wellness recovery action plan to help him more effectively manage his poor impulse control, self-injurious behaviors and aggression." There was no explanation as to why those two programs were discontinued.

Several "group participation progress notes" dated 5/1/13 through 8/10/13 were reviewed which documented progress made in the above listed group sessions. On 5/1/13 it was noted that the recipient "is in Let's Talk Group, Effective Communication and Self-management groups. He can identify that 'talking things out' helps him manage his reactions to his feelings." On 5/24/13 it was noted in the monthly treatment plan review that the recipient "goes to staff to talk about what he is feeling, he listens to music and will ask for extra medication when he is feeling like hurting himself or someone else. However, he continues to have difficulty managing his emotions without assistance from staff or medication." The class attendance sheets were also reviewed which showed regular attendance and active participation with an occasional refusal to attend.

STATUTES

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) guarantees the right to *"adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan."*

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…."* 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 a 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.

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.

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.*

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 <u>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</u> 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) <u>The mental health facility director shall give written notice to each person evaluated as being mildly or moderately intellectually disabled</u>, 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, <u>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.</u> 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. <u>This notice shall be given within 24 hours of Department's evaluation that the person is mildly or moderately intellectually disabled.</u>

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.

Per the Code (405 ILCS 5/4-402) *"No person may be detained at a facility for more than 24 hours pending admission under this Article unless within that time a clinical psychologist, clinical social worker, or physician examines the respondent and certifies that he meets the standard for emergency admission."*

Just as with mental health recipients, <u>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</u> 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)

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 with a developmental disability was receiving inappropriate treatment on the mental health unit at Choate.

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. In this case, the recipient was court ordered for detention and evaluation and then he signed a voluntary application the next day. Treatment teams are to monitor the appropriateness of the setting and ensure that the recipient is being served in the least restrictive environment and is receiving appropriate treatment planning.

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 includes: 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 Code dictates that transfers between state-operated facilities can occur if "clinically advisable and consistent with the treatment needs of the recipient." 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."** A 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 that 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 HRA found several documentations in the recipient’s chart indicating that he was enrolled in active treatment and was actively participating for the most part, with an occasional refusal to attend classes. As early as May, 2013, there was documentation that the facility was recommending the recipient be discharged to a DD facility

and they began searching for placement. The most practical placement would have been to Choate's DD unit, but that could not be accomplished due to lack of bed availability. As soon as it was realized that this status would continue, Choate staff sought out placement in another DD facility once the threat of his mental illness symptoms "flaring up" had passed. Although it was found that the "Monthly Review Certification" (form MR69F) was not completed and placed in the chart per policy, as per Choate's response to the Joint Commission's inquiry, the HRA was satisfied that this oversight has been addressed by the facility. Therefore, the HRA finds that no rights violations occurred relating to the facility's treatment planning of this recipient. The HRA offers the following suggestions:

1. 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.