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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case #16-090-9018
Tazwood Mental Health Center

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of possible rights violations involving services at Tazwood Mental Health Center. The allegations were as follows:

1. Inappropriate discharge.
2. Inadequate treatment, including lack of communication with other providers regarding patient care.

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) and Community Mental Health Provider Regulations (59 Il Admin Code 132).

The facility services Tazwell and Woodford Counties and has approximately 1,000 recipients at any given time. There are 60 employees including support staff, direct service staff, case managers, and therapists. They offer programs such as out-patient substance abuse services, outpatient therapy, community case management, some residential services, and psychiatric services.

Complaint Statement

The allegations state that a recipient of mental health services at Tazwood was admitted to a hospital for psychiatric services and while there, was discharged from services at Tazwood. On December 30th, the recipient had an appointment with a physician at Tazwood who said she had to stay substance free and they scheduled another appointment. Another counselor said that the recipient had to receive 5 different areas of treatment or she could get services elsewhere. The recipient decided to stay with Tazwood. On January 15th, the recipient had an appointment with her primary care physician who sent her to the emergency room for a psychiatric review and was admitted into the psychiatric unit. On January 19th, the recipient was called and told that she needs intensive case management which is not offered by Tazwood. The recipient was told to link up with another community mental health service. It was stated that if the recipient got to a

more stable spot, she can come back. The recipient spoke with Tazwood staff and was told that the physician at Tazwood said that she needed to go elsewhere to receive services but the recipient thought that she only had to remain substance free. Allegedly, the facility did not provide any referrals other than the one community mental health center and there was no communication with that center from Tazwood. The other facility declined the recipient for mental health treatment but accepted her for substance abuse treatment and the recipient was told that she had to receive the substance treatment before the mental health treatment. Tazwood reportedly knew this but still told the patient that she should go to the facility for treatment. Additionally, Tazwood allegedly would not communicate with the hospital psychiatric unit or the community mental health center about the treatment that the recipient was receiving at Tazwood.

Interview with staff (5/5/2016)

Staff began the interview by stating that the individual has been hospitalized several times before. The patient is diagnosed with borderline personality disorder, with a chemical dependency and is actively using substances. She was told that it is not acceptable to use cocaine and marijuana but she had no commitment to remaining substance free. The patient had mental health needs but was using a splintered approach to her treatment; using two different agencies for services. She was told by staff that it would be in her best interest to attend one agency for all her services. Every week the patient was in crisis and she was told that she needed intense care and a higher level of services than Tazwood could offer. When she initially began services with Tazwood in March 2015, she was staying at a skilled nursing facility, and she was attending Tazwood for group therapy and individual therapy. She was discharged from the skilled nursing facility and hospitalized because she had cut her neck. She did not return to the nursing facility but did return to Tazwood for group and outpatient therapy.

Staff explained that the patient was discharged because staff did not believe they could meet her needs and keep the patient safe. They stated that she was better at an inpatient facility, nursing home, or group home. The recipient had an appointment with the facility psychiatrist on December 30th which was described as a brief assessment to figure things out. The appointment was one week after a hospital stay at a psychiatric unit. After that, the patient was receiving services at Tazwood, then returned to the psychiatric unit and then was discharged by Tazwood during her last stay at the unit. Staff said that she was at an inpatient unit which was a safe environment. Because of the patient's severity, the hospital psychiatric unit wanted to send the patient to a state operated mental health facility. The hospital psychiatric unit was supposed to find a place for the recipient and Tazwood also spoke with another community mental health provider who was aware of the transition. The community mental health provider thought that the patient needed more stabilization before she was admitted as a patient but Tazwood explained they could not provide those services so the community mental health provider still agreed to accept the patient.

Staff stated they spoke with the patient about her level of care and future services. The patient called twice while she was at the psychiatric facility; they explained the situation to her again and she was upset. She asked if she was being discharged and Tazwood said yes and they recommended that she contact the community mental health center for treatment. Staff said that there was a lot of contact with the recipient and the community mental health center. She also

received a letter while she was in the hospital. While she was admitted at the hospital, Tazwood received a call from the facility and had a detailed discussion.

Staff said that from March to August, they felt that the level of care the patient was receiving was adequate because she was staying at the skilled nursing facility. Tazwood was not aware that the patient was discharged from the skilled nursing facility and that she was hospitalized until it was discovered around November/December. Staff said that the idea that the patient needed more integrated care was introduced during the December 30th psychiatry appointment when she was assessed. The decision to discharge when she was admitted to the psychiatric unit the last time was because she was in the safest environment and she would be linked with services quickly.

Staff said that she was told more than once that she just needed to remain substance free. When asked about the 5 levels of treatment referenced in the complaint, staff assumed that this was referring to substance treatment, therapy, community support and specialist services, and psychiatry care. Staff explained that they tend to discharge face-to-face for therapy and they called because the patient was admitted to the facility. Staff explained that in psychiatry, patients drop out of treatment without notice and they do not have contact with them, so letters are sent when the patients are discharged. If there is an attempt to contact them and they do not return contact, then they will be discharged. This is a general practice and the letters include referrals for other services. If a patient is completing treatment, they start the discharge process a couple sessions before treatment is actually completed and then make referrals for any other needed services. If it is determined that they are unable to meet the patient's needs when they come to the facility, then they provide them with a referral, for example, if they have a primary diagnosis of Autism. Staff said that they have policy and procedures and a discharge contract that outlines all the reasons for discharge. Discharge protocol depends on where the client is and if he/she is in an inpatient setting; if in an inpatient setting, the protocol does not apply because he/she is already with another provider. Staff said that the letter that the individual was sent did have referrals but referrals are mostly sent if they are not receiving another form of care.

The psychiatrist from Tazwood spoke with the community mental health provider staff and they discussed treatment and discharge. They faxed records to them and they had a meeting regarding the individual. They also spoke with a social worker from the hospital psychiatric unit about the individual's care. Staff said that they also faxed records and the recipient signed a release for disclosing the records. They said that if they have knowledge that a patient has been admitted to the hospital, they will talk to the patient but usually they discover the individual's discharge and they request records so that they know what led to the discharge. Staff said that the allegation that substance abuse treatment needed to happen before the mental health treatment was not accurate. They stated that the patient told the community mental health provider that Tazwood would only offer mental health treatment with no substance abuse treatment. The community mental health provider will only offer substance abuse treatment with no mental health treatment. Staff said that she was accepted for mental health services at the community mental health provider.

Findings (Including record review, mandates, and conclusion)

Complaint #1 - Inappropriate discharge.

The HRA first reviewed the discharge letter that was sent to [individual involved in

complaint] and it stated that "the purpose of this correspondence is to inform you that you are being discharged from Outpatient Mental Health Services at Tazwood Center for Wellness effective today. As of today's date, any valid releases in your chart will remain valid until their expiration date unless you revoke them in writing. As a result of services being ceased, please refer to the below referral list for available resources for Outpatient Mental Health Services. If a Tazwood Center for Wellness psychiatrist was prescribing medications for you, I recommend that you follow up with another psychiatrist or your primary care physician. I am aware that you are currently an inpatient at [hospital]. And as we discussed your transfer of mental health services to [community mental health facility] on 1/19/16, it was due to a level of care needed that Tazwood cannot provide to you. You are recommended to continue with psychiatrist, individual therapy, group, case management and substance abuse services at [community mental health facility] as these services are beneficial to your improved functioning. In the event of an emergency, please be aware that Emergency Response Services (ERS) are available at (309) 671-8084 twenty-four hours a day. Please also be aware that inpatient behavioral health services can be accessed through Emergency Department at [hospital], or an evaluation from your nearest Emergency Department." Additional lists with four referrals were included with the letter to the individual involved in the complaint. This letter was dated on January 20th, 2016.

The HRA reviewed the discharge summary for the individual involved in the complaint. The discharge summary was dated on January 21st, 2016 and included that the individual had poor progress while in treatment, and as services were increased, functioning declined significantly. The individual was discharged from their care due to needing a different level of care. The discharge summary also stated that she was referred to another outpatient mental health services facility. This facility would be more able to address the individual's needs and improve her stability. To go along with the discharge summary, the progress summary located on the discharge summary states, "poor progress while in treatment. [Individual] attended several therapy and group sessions while living at [living facility]. [Individual] was discharged from their services due to needing a different level of care. [Individual] increased services with Tazwood and declined significantly in functioning. [Individual] has been hospitalized several times in the last year."

Also in part of the progress notes, it states, "the following letter was mailed today to [individual involved in complaint]. A copy of the letter is in [individual's] closed chart. This letter is being sent to inform you that Tazwood Center for Wellness is not able to meet your needs. Please be advised that you are not welcome to return to Tazwood Center for Wellness. Please be aware that if you attempt to come on Tazwood Center for Wellness premises, including the parking lot, we will consider this trespassing and will contact the police. We wish you the best with your future pursuits." This letter was dated April 4th, 2016.

The HRA then reviewed the transfers/discharges criteria of Tazwood Mental Health Center. According to the procedure, "transfers/discharges of individuals from Tazwood are based on the individual's right of choice, on the assessment that individual needs have been addressed as fully as possible and there is no further benefit to be gained by remaining engaged in service, on the assessment that Tazwood cannot provide the necessary level of treatment to meet the individual's needs, or due to the individual's failure to comply with treatment. In the event of clearly intentional noncompliance with treatment or program rules or potentially injurious behaviors to others, discharge from the program may be immediate. Discharge from Tazwood is accomplished with the use of the Discharge Summary (Appendix), indicating the individual's diagnosis, services received, progress, reason for discharge, and recommendations."

Lastly, the HRA reviewed Tazwood Mental Health Facility Rights of Clients. This states that the client has "the Right not to be denied, suspended or terminated from services or have services reduced for exercising any" of their rights.

According to the Community Mental Health Provider Regulations, "Service termination criteria shall include: A) Determination that the client's acute symptomatology has improved and improvement can be maintained; B) Determination that the client's level of role functioning has significantly deteriorated to a degree where referral or transfer to a more intensive mental health treatment is indicated." And also from the Community Mental Health Provider Regulations, "C) Documentation in the client's clinical record that the client terminated participation in the program." (59 Il Admin Code 132.150). The regulations also read "c) When discharging a client from services, the provider shall ensure continuity and coordination of services as provided in the client's ITP….2) Documents in the client's record the referrals to other human service providers and follow-up efforts to link the clients to services." (59 Il Admin Code 132.145). The Mental Health and Developmental Disabilities Code states that: "A recipient of services shall be provided with adequate and humane care and services…pursuant to an individual services plan." (405 ILCS 5/2-102a). Adequate and humane care and services are defined as those "…reasonably calculated to prevent further decline in the clinical condition of a recipient of services so that he or she does not present an imminent danger to self or others." (405 ILCS 5/1-101.2).

Complaint #1 – Conclusion

Since the individual involved in the complaint needed a different level of care, Tazwood Mental Health Center provided the individual involved in the complaint a discharge and referral elsewhere in order for that individual to receive needed care, per the Community Mental Health Provider Regulations and Tazwood Mental Health Center Transfers/Discharges procedure. Because the facility policy regarding discharge process matches the Community Mental Health Provider Regulations and these policies were followed correctly, the HRA finds this complaint **unsubstantiated.** The HRA offers the following **suggestions:**

- Although the HRA found no regulations against the actions taken by the facility, the HRA believes that the discharge appeared sudden and thinks that it could have been handled with advance notice to the patient with direct contact after discharge from the hospital. Providing services in this manner, rather than a discharge while the resident is admitted into another facility, may advance the coordination of care for the patient.

Complaint #2 - Inadequate treatment, including lack of communication with other providers regarding patient care.

The HRA first began by reviewing communication that Tazwood Mental Health Facility made with another hospital regarding the patient's care. The following was recorded in the patient's progress notes. It is dated that on March 25th, 2015, the individual involved in the complaint gave Tazwood Mental Health Facility signed consent to collaborate with their healthcare provider. The progress note stated as follows: "Staff met with client today to complete the comprehensive mental health assessment. Staff gathered information including presenting concerns, history of symptoms, history of treatment, psychosocial history, and assessed current level of functioning. Brief Summary of Presenting Concerns: [Individual] is seeking services to comply with parole and work on her mental health needs. She has been in mental health services

since the age of 12. She spent 4 years in residential care from age 13-17. She was not transitioned well and struggled with psychosis, mood and personality issues for the last ten years. She has been arrested and served two years for possession of a controlled substance. She was released on parole in September of 2014 and required to engage in therapy services. [Individual] denied active psychosis, suicidal or homicidal ideations. Client Response: [Individual] appears to understand she has needs to be addressed but struggle with anxious moods and engagement at times. Recommended Services: individual therapy and CSG [Community Services Group]. Plan: return to complete CMHA [community mental health agency]. Client reported that he/she has a primary healthcare provider. This staff discussed with the client the importance of having a primary healthcare provider and following throughout with primary healthcare provider recommendations. This staff also discussed the benefits of Tazwood Center for Wellness staff collaborating with the primary healthcare provider and encouraged the client to sign consent from in order for this collaboration to occur. Client signed a consent form allowing Tazwood staff to collaborate with his/her healthcare provider." Yes, was checked. "It was recommended to the client that he/she meet with staff to assist him/her in obtaining and/or accessing primary healthcare services." Client declined this service according to the progress notes.

On December 17th, 2015, Tazwood Mental Health Facility spoke with another community mental health center regarding the patient to request records for the individual involved in the complaint's records. They also discussed the individual's current progress, current risk, and goals. The progress note for that date reads as follows, "Called [staff member] from the [community mental health center] to request records for [individuals] crisis admissions. Left a VM for her to call back. [Staff member] called me this afternoon and we discussed [patients] current progress. We spoke about [individuals] current risk of self-harming thoughts and touched base on her goals and plans to work towards her goals. Informed [staff member] about all the services [individual] preferred to receive at Tazwood. Also mentioned that she will be referred to [doctor] and for that we would require all her crisis admission records. Requested [staff member] to fax me all records on crisis services received by [individual] from [community mental health center]. [Staff member] stated that their psychiatrist had provided services while [individual] was admitted to the crisis center and she would fax me the reports."

On January 15th, 2016, Tazwood spoke with that same community mental health center about the individual's level of care and the individual's needs. The progress notes reads as follows, "spoke with [counselor] at [community mental health center] regarding care. [Individual] reported to counselor at [community mental health center] that she was going to overdose on her blood thinners by saving them up. It was also discussed with [community mental health center] her level of care and her needs. [Community mental health center] informed me that [individual] is allowed to seek MH services at [community mental health center] but told them Tazwood would not allow her to do so. Tazwood therapist informed [community mental health center] that she reported the opposite about them. [Community mental health center] will work with Tazwood therapist directly to link [individual] back to them for MH and continued SA to better target her needs within the next few weeks. [Staff member] is contact [counselor] at [community mental health center] [phone number]. Return phone call from [staff member] 3:00pm-Mental health team requested records to assess her needs. They will meet on 1/18/16 to coordinate care. Therapist will call [staff member] on 1/20/16 at 12:00 to discuss [individual's] care and transfer via phone. Records were faxed to [community mental health center] 1/15/16 with release."

On January 19th, Tazwood spoke with that same community mental health center again,

about the individual's level of care. The progress notes state that Tazwood "received a call from [community mental health center staff] [phone number] regarding [individuals] level of care. She indicated that therapy should continue with Tazwood due to [individuals] needs but [community mental health center] would take over psychiatrist. They indicated eventually she will be transferred to their level of care but not specific date was found. VM was transferred to [clinical director]."

Also on January 19th, 2016, the progress notes state that Tazwood staff "left a VM for hospital to call back regarding [individual's] level of care and being admitted to PHP [Partial Hospitalization Program] upon discharge due to recurrent hospitalizations. Return call from [staff member] indicating progress with [individual] and needs. He agreed to PHP and then link to [community mental health center]. Tazwood therapist will call [individual] while she is in hospital to notify her of changes to better stabilize her before discharge. She is in need of care with one facility until she can stabilize."

On January 22nd, 2016, the progress notes read that "this staff contacted [staff member], recovery specialist at [community mental health center], per the request of the [individual]. This staff informed [recovery specialist] that this staff had just spoken with [individual] and that she stated that [community mental health center] staff had not been informed that she was being discharged from mental health services at Tazwood. This staff stated that this staff was calling to inform her of this per [individual] request. [Recovery specialist] stated that she was not aware of this but did know that Tazwood and [community mental health center] psychiatrist has spoken. This staff stated that this staff was aware of that and that the hospital and [community mental health center] psychiatrist have been contacted to help coordinate care for her transfer of services to [community mental health center]. [Recovery specialist] asked if she could ask her supervisor if she needed any more information. This staff stated yes. [Recovery specialist] returned to the phone and stated that her supervisor wants this staff to contact [staff member] as she is over their intensive mental health services. This staff stated that this could do so; however, this staff has been limited to information about this case and is aware that Tazwood staff have already been in communication with her and [community mental health center] psychiatrist as well as hospital staff to coordinate transfer of her care. She stated that she would inform [community mental health center staff member] to contact me if needed."

The HRA reviewed the policy and procedure for Coordination of Care/Continuity for Tazwood Mental Health Center. According to the policy, number three on procedures states that "Tazwood Center maintains relationships with local hospitals, the state operated facility, subsidized housing complexes, other supervised residential facilities, and other mental health centers, local physicians, clinic, and dentists in order to help individuals engage in other needed services."

Under the policy and procedures of Tazwood Mental Health Center for Exchange of Information, "Tazwood Center, within its capacity and in accordance with all applicable laws and regulations, facilitates the appropriate care and exchange of clinical information when individuals are admitted, referred, transferred or discharged….1) Information regarding individuals served by more than one program or service of Tazwood Center is shared by those programs by providing copies of progress notes, medication charts, psychiatric assessments and reviews, comprehensive or other assessments, or other pertinent information from the individual file. 2) Pertinent and appropriate information from individual Tazwood Center files (discharged or open to Tazwood Center) is made available to other providers of care to these individuals pursuant to all applicable laws and regulations. 3) Information released to Tazwood Center from

other providers regarding individuals applying for admission to Tazwood Services is instrumental in determining individual need and appropriateness of service."

Also, "Information regarding individuals served by more than one program or service of Tazwood Center is shared by those programs by providing copies of progress notes, medication charts, psychiatric assessments and reviews, comprehensive or other assessments, or other pertinent information from the individual file."

Under the Coordination of Care/Continuity, the Policy reads "Tazwood Center coordinates care and services among health professionals and settings in an effort to provide smooth transitions from one level of care to the next. Services are coordinated to ensure continuity of care as well as appropriateness of service to individual needs at any particular time, and Tazwood Center acknowledges that treatment needs may change for an individual over time." The procedures consist of, "1) Tazwood Center offers a continuum of resources/services to individuals, ranging from crisis services, residential care, substance abuse services, case management, and outpatient mental health. 2) Tazwood Center employs policies and procedures regarding the movement of individuals throughout its programs and services. 3) Tazwood Center maintains relationships with local hospitals; the state operated facility, subsidized housing complexes, other supervised residential facilities, and other mental health centers, local physicians, clinic, and dentists in order to help individuals engage in other needed services. 4) Tazwood staff provides recovery focused services that address psychological and community resources for individuals served."

The Community Mental Health Provider Regulations read "1) Communicate, consistent with the requirements of Section 132.142, relevant treatment and service information prior to or at the time that the client is transferred to a receiving program of the provider or is terminated from service and referred to a program operated by another service provider, if the client, or parent or guardian, as appropriate, provides written authorization; and 2) Document in the client's record the referrals to other human service providers and follow-up efforts to link the clients to services." (59 Il Admin Code 132.145)

Complaint #2 – Conclusion

As referenced above, Tazwood Mental Health Center has provided evidence of communications with another community mental health center and a hospital regarding the individual's care and issues regarding discharge and transfer. There were faxes sent with information regarding the patient involved in the complaint, such as progress reports and notes from employees at Tazwood Mental Health Center, and there have also been phone calls discussing the patient involved in the complaint as well. Communicating with other facilities regarding their patients is something that Tazwood Mental Health Facility must follow according to their own rules and regulations and the Community Mental Health Provider Regulations as well. After reviewing the procedures and regulations that Tazwood Mental Health Facility follows and reviewing the regulations according to the Community Mental Health Provider Regulations, the HRA finds this complaint **unsubstantiated**.