FOR IMMEDIATE RELEASE

East Central Human Rights Authority
Report of Findings
The Pavilion
HRA # 16-060-9017

INTRODUCTION

The East Central Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, opened an investigation after receiving complaints of possible rights violations in the care provided to an inpatient recipient at The Pavilion Behavioral Health System. The allegations are as follows:

1. The facility failed to accommodate a recipient's Post-Traumatic Stress Disorder (PTSD).
2. The facility failed to provide adequate care in the provision of case management contacts and services, as well as psychiatric contacts.
3. The recipient was inappropriately threatened with court for signing a 5-day notice of discharge.

If substantiated, the allegations would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

The Pavilion has approximately 69 beds, and 27 for inpatient adults. The average length of stay is approximately 9 days for adults. Per its website, The Pavilion offers comprehensive care to youth, adults, and their families. The Pavilion offers distinct, highly structured inpatient and partial hospitalization programs for the treatment of alcohol, drug, and psychiatric problems. A patient arriving at The Pavilion receives a professional intake assessment, directed by a physician. After the patient's needs are assessed, a treatment plan is recommended. Therapeutic programming includes individual, group and family therapy, activity and recreational therapy, psycho educational groups and medical intervention.

To investigate the allegations, these matters were discussed with staff involved in this patient's care. Relevant policies were reviewed as was the Mental Health and Developmental Disabilities Code.

COMPLAINT SUMMARY

The complaints state that a recipient suffers from PTSD after a past history of being sexually assaulted, and has stated that the facility has a lot of men employed. The recipient has asked the facility if male employees could knock before entering her room and the recipient states that the hospital refused. She also has a male psychiatrist, and she asked the facility if she

could be transferred to a female psychiatrist and the recipient stated again that the hospital refused.

According to the complaint, the facility also fatled to provide adequate care when it came to case management contacts and services. The recipient reportedly was only able to meet with her case manager once in the week of March 15, 2016. The treatment was allegedly not very helpful for the recipient, and the recipient identified outpatient and alternative inpatient services, but neither the case manager nor psychiatrist would meet and discuss these plans that the recipient formulated.

Lastly, the recipient signed a 5-day notice for discharge, and the psychiatrist automatically stated that she would be taken to court. The recipient felt that she was being threatened.

FINDINGS

The Clinical Summary states that the recipient was referred by a crisis team at a hospital due to a serious suicide attempt that consisted of a drug overdose. The recipient was then found by law enforcement in a cemetery, and then was transferred to the hospital. The crisis reports state that she has been feeling overwhelmed after leaving her job, and she feels that she does not know how to parent her son. The recipient's admission order dated 3/8/2016 shows that she has a diagnosis of a Mood Disorder NOS (not otherwise specified).

ALLEGATION #1: The facility failed to accommodate a recipient's Post-Traumatic Stress Disorder

Record Review:

The primary treatment concern listed for this recipient is the recipient's suicidality. The Master Treatment Plan Goal is for the recipient to be able to utilize healthy coping skills to manage her depressive symptoms so that she does not consider overdosing and suffocating herself.

In the Psychosocial Assessment document dated 3/9/2016, in the section that assesses for sexual abuse the recipient admitted to being molested/raped twice in her life. The recipient has developed Post-Traumatic Stress Disorder (PTSD) due to the trauma that the recipient has experienced.

In a psychiatric evaluation dated 3/9/2016, the recipient stated that she denies any feelings of anxiety, but she did admit to having flashbacks and nightmares related to her history of sexual abuse. The psychiatric evaluation also provided a treatment plan showing suicidality and Depression as the chief diagnoses for the recipient's stay. The recipient was admitted under suicide and self-harm precautions, and was to receive individual case management and participate in group activities. For the recipient's depression the recipient reported that she recently started on Viibryd, and would therefore continue with the medication at I 0mg orally daily.

In a patient progress note dated 3/10/2016, the recipient stated that she had feelings of being violated when she was asked to remove her clothes to be put into gowns.

In a patient progress note dated 3/15/2016, the recipient stated that there are many men who work here, and that she feels uncomfortable even though no male staff have been inappropriate towards her.

The HRA team found out that the recipient did not report that she had PTSD upon admission, or in the nursing assessment at admission but sexual assault was mentioned during psychosocial and psychiatric evaluations completed the day after admission. Also, the recipient came forward in therapy a couple of days later and admitted to her sexual assault which led to PTSD and she brought up her discomfort with removing her clothing on 03-10-16. There did not appear to be any subsequent changes to the recipient's diagnosis, treatment plan or treatment approaches after the recipient disclosed the history of sexual assault. The HRA did not find evidence that the recipient requested a female physician.

The Nurse, Social Worker, Recreational Therapist, and Physician all participated in the Interdisciplinary Master Treatment Plan. The recipient signed the treatment plan stating that it was explained to her in a language that she understood, but the boxes that state if the recipient participated or not are both left blank. The treatment plan does not contain any reference to the recipient having any PTSD, her reports of past sexual assaults as stated in the evaluations completed after admission or her statements of discomfort with male staff and disrobing as per progress note documentation.

Interviews:

The HRA team consJStmg of the HRA member coordinator, and three volunteers interviewed a facility agent on 4/23/2016. According to the staff interviews, changes in treatment are determined by the physician/psychiatrist i£'when new information or diagnoses are identified.

Regarding any issues of male providers, there is a very strict protocol for all staff to knock on doors before entering any recipient's room. When recipients are sleeping staff are to check in the room from the door using flashlights. The facility staff member interviewed stated that the facility would have tried to accommodate the recipient's request for a female physician.

The HRA contacted the facility on 7/11/2016, and asked about the focus of treatment and how PTSD works into treatment. The facility stated that they triage for crisis and safety first and then use a trauma informed model of treatment with PTSD issues integrated within. Family

involvement woul<l be parl of the treatment approach. And, the patient's psychiatric diagnosis and suicide threats would be primarily targeted.

ALLEGATION #2: Failed to provide adequate care in the provision of case management contacts and services, as well as psychiatric contacts.

Record Review:

In a nursing note dated 3/09/16, it states that the recipient 1s refusing to attend programmine and is remaining in her room during group time.

In a social services note dated 3/09/2016, it states that the Case manager (CM) met with the family to discuss the recipient's hospitalization. The recipient's family seemed frustrated and agitated due to trying to get the recipient discharged, and sent to a different facility. The CM contacted the admissions coordinator at the other facility so that the family could play an active role in participating in conversations between both facilities. Both facilities explained how the process of hospitalization worked. The recipient would be cleared to transfer to the other facility for long tenn placement once she reaches psychiatric stabilization. The CM then took the family to a meeting with the recipient to discuss the information that they had just gathered from both facilities.

In a social services note dated 3/12/2016, it states that the CM met with the recipient to discuss the recipient's call to the other facility for a prescreening interview. The recipient had presented herself as calm with good eye contact, but a flat affect and guarded body posture. The CM took the recipient to a phone and helped the recipient in making the call to the other longer tenn facility. After the phone call, the other longer term facility did not feel it was a "good fit" for their program. The CM assured the recipient that the CM would call to verify at a later date.

In a social services note dated 3/14/2016, the Social Worker (SW) spoke with the recipient's father on the phone to inform him that the recipient would not be getting discharged that day. The recipient's father stated that the longer term facility recommended another residential facility in a different state. The SW assured the recipient's father that since the recipient had a serious suicide attempt, that the facility had not scheduled a discharge date and had time to coordinate the aftercare plans.

In a social services note dated 3/15/2016, the CM spoke with the admissions department of the residential facility to discuss discharging the recipient from the facility to be admitted to the residential facility. The residential facility required a screening of the recipient over the phone, and that was set for the next day. The residential facility had a waiting list of about 4-5 weeks.

Iu a Sot:ial Service Note dated 3/17/2016, the CM spoke with a staff member of a tlurd facility for this recipient. The staff member confinned that they are expecting the recipient to arrive at their facility for daily intensive outpatient treatment.

In the discharge smmnary dated 3/18/2016, it states that the recipient's CM worked with the recipient's family who initially was reluctant to support the recipient's inpatient treatment. However, due to the severity of the recipient's suicide attempt she remained in the inpatient treatment program where she received treatment in group therapy fonn, and received individual case management.

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The HRA was told that treatment is detennined at admission by a comprehensive assessment. The facility looks at current functionality and what treatment they may already be receiving. They look at medical acuities, trauma history, and many other different risk factors. Examples of some of the questions consist of: does the recipient have a psychiatrist, are there any issues of abuse, how safe is the recipient, what is the suicide risk, is there a plan, etc.

In the same interview conducted on 4/23/2016, the facility stated that the record shows that the recipient refused to meet with the case manager one time, but did appear to meet regularly with the case manager.

Lastly, in the site visit interview on 4/23/2016, the facility stated that there were in fact some links to other providers to continue services the recipient needed. The SW would pass such information along to a recipient's CM, and the facility would assist in setting up the intake process; however, it might occur at a later date.

ALLEGATION #3: Was inappropriately threatened with court for signing a 5-day notice of discharge.

Record Review:

According to a social services note on 3/15/20 I6, the recipient's father stated that he was told that the psychiatrist at the facility filed a petition with the court to keep the recipient hospitalized in a state psychiatric unit. According to the notes, the CM clarified with the recipient's father that the recipient signed a "Request for Discharge" form. The CM explained that this form is a legal document staring that the recipient feels like she is ready to be discharged from the hospital. The doctor has 5 business days to observe the recipient to decide if it is necessary to file with the courts to keep the recipient in the hospital longer. The CM let the recipient's father know that the psychiatrist has not yet filed any paperwork with the court.

According to a different social service note on 3/15/2016, the recipient seemed upset about the possibility of being taken to court. The SW explained to the recipient the request for

disdiatge]Jtucess aud the concerns about any recipient who would have such a serious suicide attempt and then be so focused on being discharged from the hospital.

Per the record the recipient did not file any complaints related to the allegations.

The "request for discharge" from was completed on 3-14-2016, and the recipient was discharged on 3/18/2016.

Interviews:

The facility states that the recipient was not threatened with court, as she was admitted to the facility as an involuntary recipient; however, she signed a voluntary admission request at admission. She then later signed a request for discharge. The facility states that there was no intention of taking her to court, and she was discharged a couple of days later.

Policies:

The "Interdisciplinary Treatment Planning Process" provides for the interdisciplinary treatment team to communicate, collaborate, and develop an individualized therapeutic plan of care with each recipient. "Each patient shall contribute to their comprehensive individualized treatment plan, based on an inventory of the patient's problems, strengths, deficits and obtained directly from the initial Assessment and Psychiatric Evaluation and ongoing assessment of the patients' presenting problems.

All patients are to have an Initial Treatment Plan initiated within 8 hours of admission by the unit nurse. The Master Treatment Plan will be completed within 72 hours of admission by the treatment team and approved by the treating physician. The plan will be updated by the team at least weekly, but also as needed, as directed by the patient, or upon a change in level of care. Patients and their families will contribute to the master plan, approve where appropriate, and be given a list of treatment goals and objectives in language that they can understand."

According to the "Privacy" policy the facility is to provide patients and their possessions with personal privacy and to assure that staff are aware of patients' needs and attend to them in a timely manner.

"All patients can expect to receive care in a manner that fosters comfort, dignity, and respect of privacy. Locked storage of some personal items will be provided to patients as appropriate for each individual patient.

This policy allows the recipients of care at the facility to:

A. Individual meetings and interviews will be held in the patients' rooms, conference rooms or staff offices out of hearing range of other patients.

B. The ouler door to the patient's room may be closed when the patient is receiving medical treatments, or being assisted with hygiene or toileting.

C. Patients will be appropriately draped, dressed or shielded/covered when receiving medical treatments, physical exams or basic hygiene care.

D. Only those directly involved in the patient's care should be in attendance."

The Patient Bill of Rights states: "As a client at The Pavilion, you are entitled to be infonnerl of yonr rights prior to evaluation services as a client and of all rules and regulations governing your conduct as a client in this facility as outlined in the Mental Health Code and Developmental Disabilities Confidentiality Act and Chapter 2 of the Mental Health and Developmental Disabilities Code and tl1e Health Insurance Portability and Accountability Act of 1996. These rights include, but are not limited to the following:

I. As a general rule, you lose none of your rights, benefits, or privileges simply because you are a recipient of mental health or developmental disabilities services. For example, you do not lose your right to vote. However, persons admitted to mental health facilities will be disqualified from receiving firearm owner's identification cards, and will lose such cards possessed prior to admission.

2. You have the right to request discharge by requesting and signing a Request for Discharge form, available from your case manager. In the case of a minor, the request may be made by their parent/legal guardian. You then have the right to be discharged within 5 business (court) days, unless your physician believes it is not in your best interest to be discharged and files an affidavit with the court for your continued hospitalization on an involuntary basis.

3. You have the right to receive proper care and mental health services in the least restrictive enviromnent appropriate to your needs.

4. You have the right to be treated with dignity and respect in the provision of all services. You have the right not to be mentally or physically abused, neglected, and/or exploited by anyone, including staff, volunteers, other patients, visitors or family members.

5. You have the right to continuity of care. You will be informed if it is necessary for you to be discharged or transferred to another facility, and you will be prepared for such a discharge or transfer.

6. You and/or your guardian have the right to voice opinions, recommendations and grievances (up to and including the Chief Executive Officer) in relation to policies and services offered by the facility, without fear of restraint, interference, coercion, discrimination or reprisal. The Chief Executive Officer's decision shall be the final

a<lmiuislialive <let:isiou. You have the right to contact the public payer in the case of grievance and be informed of the public payer's process for reviewing grievances.

7. If your rights are restricted, the facility must notify you and it will be documented in your record. Documentation will include a plan with measurable objectives for restoring your rights that is signed by you or your parents or guardian. You, along with your parents or guardian, will receive a copy of the plan. If requested by you, a copy will be provided to one or both of the agencies listed in #30. You have the right to be offered assistance in contacting your parent or guardian if you are under 18, or other family member or person of your choice. At your request the following agencies may also be contacted: Department of Children and Family Services, Department of Human Services, Department of Corrections or The Public Payer.

8. You have the right to assistance in contacting the Guardianship and Advocacy Cmmnission at 2125 South First St., Champaign, IL, 61920,217-278-5577, and Equip for Equality Inc.,! West Old State Capitol Plaza, Suite 816, Springfield, IL 62701 217-544-0464.

9. Residential Treatment Center infonnation: To report a complaint or grievance call 217-373-1930. The resident and/or guardian is provided a copy of the RTC handbook that outlines how grievances are handled at the provider level, how a record of such grievances is kept, and how the response to those grievances shall be maintained by the provider.

10. We want to assure that your rights are upheld. If you have a complaint or grievance, please call The Pavilion Patient Advocacy Line at 217-373-1744 and the patient advocate will assist you."

Statute:

According to the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/2-102): *(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided.*

"Adequate and humane care and services" means services reasonably calculated to result in a sign(ficant improvement of the condition of a recipient of services confined in an inpatient mental health.facility so tha or she may be released. (405 ILCS 5/1-101.2).

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Under Chapte@Krticlyffl, arly person 16 years of age and older may be accepted as a voluntary recipient if determined clinically suitable, with capacity to consent to the admission. The application shall state in bold-faced type that the recipient may be discharged at the earliest appropriate time, not to exceed 5 days, excluding weekends and holidays, after giving written notice. No physician, qualified examiner or clinical psychologist may state to anyone that involuntary admission would result if a voluntary application is not signed, unless prepared to execute a certificate and advises that the person is entitled to a hearing and counsel. A voluntary recipient shall be discharged at the earliest appropriate time, not to exceed 5, excluding weekends and holidays, after giving treahnent staff written notice unless he withdraws or within that time a petition and 2 certificates are filed in court (405 ILCS 5/3-400; 401; 402 and 403).

CONCLUSION

Based on the available information obtained in the policies, interviews, and the statute, the HRA concludes that the bill of rights is in compliance with the requirements of the Mental Health and Developmental Disability Code. The "Patient Dill of Rights" documents tights protections, the 5-day notice discharge process, the right to proper care in the least restrictive setting, the right to dignity, the right to continuity of care, the right to file grievances as well as the grievance process, and the right to contact the Guardianship and Advocacy Commission. The HRA concludes that "Interdisciplinary Treatment Planning Process" policy is in compliance with the Mental Health and Developmental Disabilities Code. The "Interdisciplinary Treatment Planning Process" documents that all recipients are to have a treatment plan initiated within 8 hours of admission and a master treatment plan within 72 hours, and approved by the treating physician. The master treatment plan includes: substantiated diagnosis, patient assets, patient stressors, problem list, discharge criteria, preliminary discharge plan, estimated length of stay, patient and family involvement and approval, names/signatures/and dates of team members who are participating in the plan development, physician approval (signature), behavioral rating scale example and data, staff duties, goal sheet, master treatment plan update, nursing treatment plans, treatment plan addendum. The HRA concludes that the "privacy" policy is in compliance with the Mental Health and Developmental Disabilities Code. This policy is to provide recipients and their possessions with personal privacy and to assure that staff are aware of the recipient's needs and attend to them in a timely manner. All recipients can expect to receive care in a comfortable setting with dignity, and respect to their privacy. Although the HRA recognizes that the recipient's crisis and suicide needs were priority treatment issues at admission, the records reviewed show that the facility did not specifically address the recipient's sexual abuse trauma and PTSD after she brought these concerns forward. The treatment plan does not show specific

treatment methods or even reference to the recipient's PTSD related concerns (e.g. hi.story of sexual assault, concerns with disrobing, concerns with male staff) as reported in evaluations and progress notes. According to staff it is the facility's practice for all staff to knock on recipient doors before entering and there was no evidence that a female physician was specifically requested by the recipient. There is evidence of case management and social work contacts with both the recipient and family members regarding services and discharge plarming arrangements, including pursuing alternate placement arrangements. There is no evidence in that the recipient was told that she was going to court in a threatening manner by any staff member. The record shows that the recipient did receive an inpatient certificate that is filled out according to the Code, and a petition for involuntary admission also appears to be filled out according to the Code.

Therefore, regarding the three allegations:

1. Due to the lack of treatment plan documentation regarding the recipient's reported PTSD related concerns, the complaint that the facility failed to accommodate a recipient's Post-Traumatic Stress Disorder is **SUBSTANTIATED**
2. Failed to provide adequate care in the provision of case management contacts and services, as well as psychiatric contacts. **UNSUBSTANTIATED**
3. Was inappropriately threatened with court for signing a 5-day notice of discharge.
   UNSUBSTANTIATED

RECOMMENDATIONS:

1. To ensure adequate care with recipient participation as guaranteed by the Mental Health Code (405 ILCS 5/2-102), address and document a recipient's concerns that come up during her treatment in the treatment plan.

SUGGESTIONS:

1. Put in the privacy policy for staff to knock on recipient's doors before entering room.
2. Consider how staff address 5-day notices of discharge to ensure that recipients do not perceive them as threats.
3. Change the language in the Bill of Rights, item 2, from "affidavit" to petition.

RESPONSE

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