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Egyptian Regional Human Rights Authority
Report of Findings
Case #17-110-9008
Choate Mental Health and Developmental Center
June 6, 2018

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 (Choate):

1. **Recipients were inappropriately admitted to the mental health unit.**
2. **A recipient was inappropriately denied admission**

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

Choate provides services to both persons with mental illness and persons with developmental disabilities. According to the Illinois Department of Human Services' (DHS) website Choate provides 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 unit census at the time of the complaint was approximately 147 which was 27 over their budgeted census of 120. The mental health unit has a budgeted census of 40 and at the time of the complaint the census was 40.

To investigate the allegation, an HRA team met with representatives of Choate, examined the recipients' records with written consent and reviewed pertinent policies and mandates related to admission.

COMPLAINT STATEMENT

According to the complaint, recipients 1 and 3 were admitted to the mental health unit when they only had a developmental disabilities diagnosis. Recipient 2 was inappropriately denied admission to the developmental disabilities unit due to him arriving with a detain and evaluate order for *mental health* treatment not developmental disabilities placement; however, he was sent to another state operated developmental center.

FINDINGS

Interviews:

Complainant: The complainant told the HRA that recipient 1 who has a diagnosis of moderate intellectual disabilities, seizures and attention deficit disorder, was placed on the mental health unit after having significant maladaptive behaviors that resulted in a detain and evaluate (D&E) order being issued by a judge. It was explained that the recipient had recently had a medication change and had aggressive behaviors towards staff at his work when he was asked to do things, when his break was over, during file drills, etc. He had also had 3 episodes at home of aggressive behavior towards staff. The recipient also had a history of busting out windows when on medication previously. On December 2, 2016, the recipient was on the bus and when the driver asked him to move seats, the recipient tried to punch staff and was spitting at staff. The police were called and he became aggressive towards the police and was taken to jail. The police referred him to Choate. Staff from the home went to see the recipient at Choate but Choate staff refused to let them see the recipient. Choate then sent him to the local emergency room and from there he was sent to another hospital out of town due to "some type of neuroleptic issue" which they believed to be a reaction to his psychotropic medications. The complainant was not sure of the events that occurred after this, but said that the recipient was returned to Choate from the out of town hospital.

Guardian for recipient 2: The guardian told the HRA that this recipient had some significant behaviors in the weeks leading up to the D&E Order being issued. He had multiple trips to the emergency department at the community hospital, the police had been called daily and he would spit at and fight the police officers; he had punched walls, and tried to break windows and televisions. The community support team / crisis intervention had been involved and he was on 1:1 supervision at home. The community hospital refused to admit him after 2 weeks of ongoing maladaptive behaviors and medical reasons for those behaviors had been ruled out, therefore there was nothing further the hospital could do. The team had scheduled a telephone conference on the Monday before the D&E Order was issued. The conference was to be between the community support team, the case coordination agency, and a representative from the department of human services to discuss placement of this recipient. The home had completed admission paperwork for a state operated developmental center to send to Springfield to the department representative who was supposed to be on the telephone conference to review and assist with placement, but that person was not on the telephone conference. Therefore, the admission could not be completed. That following Friday the recipient attacked a peer in his home and was taken to jail. A local attorney talked to the jail staff and a D&E Order was issued by a judge. The Sheriff took the recipient to Choate and after a few hours the Sheriff transported him to the next closest facility after Choate deflected him.

Guardian for recipient 3: The guardian explained to the HRA that she was concerned with this recipient's placement on the mental health unit due to the recipient having an IQ of 70 and a diagnosis of mild mental retardation. The recipient has had several past placements in facilities for persons with developmental disabilities. The guardian said that her mental illness has always been a secondary diagnosis not a primary one and the guardian believed that her placement on the mental health unit was a detriment to her progress because she tends to adapt to her environment behaviorally and on that unit, the recipient feels like she always needs to be on guard and defensive and therefore, she reacts by being aggressive towards others as a self-protection mechanism.

Director and Administrator: The HRA met with the Director and Administrator to discuss the allegations involving recipient 1. They explained that he had maladaptive behaviors at his home and the police were called. The Judge signed a detain and evaluate (D&E) Order for mental health treatment and he was brought to Choate by the police. The Psychiatrist evaluated him and determined he met criteria for admission due to risk of harm to self and others. The Petition and Certificate for involuntary admission were completed. The recipient was there for 2 weeks before his court date regarding his admission and he was discharged from court. Staff on the mental health unit of Choate were working on discharging him prior to his court date but he attacked staff and refused to leave because there was a girl on the unit that he liked. The HRA questioned them about the reason for transfer to the hospitals. It was explained that after being given anti-psychotic medications, he presented with a fever and the physician was concerned about neuroleptic malignant syndrome (NMS). He was taken to the local hospital and then transferred to another hospital out of town. After approximately one week, his medications were stabilized and he was returned to Choate with a diagnosis of a viral infection. When the HRA inquired as to why the recipient was admitted to the mental health (MH) unit rather than the developmental disabilities (DD) unit, they stated that it was not possible to admit someone to the DD unit on a D&E Order because it specifically orders an evaluation at a *mental health facility* and the only option is to stabilize them on the MH unit and then transfer to the DD unit or back home. The HRA asked if the facility has a policy specific to D&E Orders but they do not. Upon a subsequent visit to the facility, the Director and Administrator told the HRA that they were mistaken in that statement and said that they could admit someone to a developmental unit on a D&E Order. When asked about a patient who only has a developmental diagnosis being admitted to the mental health unit, they responded that they may have not had a prior diagnosis of mental health but then are evaluated and found to have a mental health diagnosis later, so it is possible in some instances for a person with developmental disabilities to be admitted to the mental health unit. They further explained that most of their admissions to the DD unit come from the local community case coordination agency. If a person is brought in on a D&E Order and does not meet admission criteria, then the jail has to take them back or they must return home. The HRA also asked if recipient 1 was denied visitors during his stay. They said his mother visited him while he was at Choate, but they were not sure if he had any visitors from his CILA home and were unaware of anyone being denied a visit with the recipient.

During a second visit to the facility, the HRA interviewed the Director, Administrator and Facility Director regarding recipients 2 and 3. Recipient 2 arrived at Choate with a D&E Order. The typical process is that the recipient is taken to the security office and is evaluated by a qualified examiner which can be a Psychiatrist, Social Worker, etc., usually a person is evaluated by 2 or 3 professionals, depending on who is working at the time of arrival. Recipient 2 arrived at 4:25 p.m. with no prior notice. Security called both units and neither the DD nor the MH unit was expecting an admission. The D&E Order stated that the recipient was to be taken to "Choate *Mental Health Hospital*, which is the nearest appropriate *mental health facility*" and should be examined to see if he was subject to involuntary admission. Two psychiatrists and the hospital administrator went to security and the psychiatrists completed the evaluation. There was no doubt that he had "severe mental retardation" and his primary presenting problem was behaviorally related. The recipient had been admitted to Choate Developmental Center in 2004 and the CILA home had contacted Choate a week prior to this incident to discuss this recipient's

current issues and was asking for advice on what else could be done as he was "acting out at home." They had been working with the community support team/crisis intervention, the case coordination agency and the community hospital. At that time, Choate advised the home staff to continue working with those entities. The recipient's past admission and the contact from the CILA home left no doubt that his diagnosis and primary presenting problem was developmental disabilities and behavioral issues relating to that. However, Choate Developmental Center had no beds available at that time and therefore the next closest facility was contacted. That facility had an opening and the police officer/Sheriff who brought him to Choate transported him to that facility which was approximately an hour and a half away. Choate contends that the CILA home could have reached out to the community support team or case coordination agency for crisis beds but said that the community support team may not have been aware that the D&E Order was done for this recipient. The state's attorney from the county this recipient resided contacted the hospital administrator and told the administrator that he wrote the Order for D&E based on direction from a local attorney. The administrator advised the state's attorney that this local attorney would not know if there were beds available at Choate and in the future, Orders should not name Choate specifically, but rather should be written ordering the person to "the nearest DHS (department of human services) facility that could meet his needs to determine appropriateness for state operated developmental center placement." The administration also informed the HRA that if a person has felony charges, Choate cannot admit them and releases have to be signed before they can even talk to the attorneys and others involved in his placement and/or care. In those cases, the recipient either has to sign voluntary or have the charges dropped against them in order for Choate to admit him to their facility.

The administration was also interviewed regarding Recipient 3 being placed on the mental health unit instead of the dual diagnosis unit when the location for those services changed. Originally, the cottages were used for persons who are dually diagnosed with both mental illness and developmental disabilities. The cottages had to be closed due to structural requirements and those patients were moved to a unit that was formerly a mental health unit and the patients with mental illness were combined into one unit instead of two. This recipient was moved to the mental health unit when the cottages closed rather than being placed with her peers from the cottages on the dually diagnosed unit. The administration informed the HRA that at the cottages this recipient attacked a peer and was transferred to another state operated mental health forensic unit until December when she themed out. At that time, she was referred to Choate mental health unit due to no civil beds being available at the other facility. That facility stated that this recipient still needed mental health treatment so she was transferred to Choate as they believed that mental illness was her primary condition at that time. She was later transferred to the cottage program for individuals with dual diagnosis where she resided until the cottages had to close. When the cottages closed, those individuals were moved to a new unit for persons with dual diagnoses and this recipient was moved to the mental health only unit. The recipient's guardian was not in agreement with placement on the mental health unit at Choate and requested a utilization review (UR) hearing in writing, which administration stated should have been done within 7 days but she was admitted in December and the hearing was not until February. The UR team consisted of the quality assurance employee who is the UR chair, a nurse, the medical director of the mental health unit, the medical director of the developmental disabilities units, the clinical director of the developmental disabilities units and the quality manager of the developmental disabilities unit. The committee determined that the individual was appropriately

placed because she had no adaptive deficits and public health stated that she was not appropriately placed on the developmental disabilities units because she did not meet criteria for active treatment. The guardian filed an appeal with the Department of Human Services Secretary and at the time of our interview that appeal was still pending. The HRA asked for clarification on the differences between the dually diagnosed unit and the mental health unit. It was explained that there is a more intensified program on the mental health unit. On that unit patients see the Psychiatrist frequently as needed such as daily or weekly. On the dually diagnosed unit, patients may only see a Psychiatrist monthly. The dually diagnosed unit focuses more on managing behaviors such as relaxation techniques, dialectical behavior therapy, telling staff when something is bothering them, coping skills, symptom management type treatment and it also focuses on activities of daily living deficits. The goal is to discharge those individuals to the community. This recipient was on 1:1 supervision at the time of our interview for aggressive behaviors against 3 peers on the mental health unit. She had spit at and pushed a chair against female peers. The State's Attorney held the charges for that time so she could remain at Choate to continue treatment. Prior to that behavior, she was on staff escort for medications, programs and meals; at the time of the interview, her level of supervision had increased to 1:1. On the dually diagnosed unit, there are more restrictions on PRN (as needed) medication than on the mental health unit. The team felt that the mental health unit was a more appropriate placement for this recipient due to her "continued need for psychiatric stabilization." In the past they have been able to transfer patients from the mental health unit to the other units at Choate once they are stable which was also the plan for this recipient.

Judge: The HRA met with a local Judge who has signed D&E Orders for Choate to get some clarification on the process and intention of D&E Orders. The Judge explained that typically if a recipient is in a CILA home or other community placement and becomes behaviorally unstable or out of control, he or she is taken to the emergency department to evaluate for medical issues and the involuntary commitment process is followed if a community mental health agency deems that is the least restrictive environment for that person at that time. On rare occasions, the emergency department and other community resources have been exhausted or refuse service and then in the crisis situation, a D&E Petition is completed. If it is regular business hours, a Petitioner has to appear in court and the Judge decides if an Order for D&E is appropriate. If it is a weekend or evening, a person could get the State's Attorney involved and the attorney would call the Judge and summarize the situation and an Order could be issued. This Judge was interviewed in July and said that he has issued less than 5 D&E Orders since January. When a D&E Order is issued, the recipient is to be taken to the nearest facility which is Choate for this Judge's area. The Sheriff or Police Officer takes the recipient to the facility, gives the order to the staff and then that officer's responsibility is done. The officer is not required to stay with the individual during the evaluation or transport him or her anywhere else. The receiving facility is required to take the recipient for 24 hours regardless of whether or not they have a permanent bed available to determine whether or not admission to a mental health or developmental disabilities facility is appropriate. If the receiving facility refuses to detain and evaluate the individual for 24 hours, a Rule to Show Cause Order could be issued requiring staff to appear in Court and explain why the individual was turned away. If deemed a necessary and appropriate placement, then the process for an involuntary commitment (for a mental health hospital) or judicial admission (for a developmental disabilities facility) is followed. This involves a Petition

being completed as well as two certificates by different physicians certifying the individual is in need of inpatient treatment.

Since Choate is a unique facility due to having both mental health units and developmental disabilities units, the HRA questioned if the D&E Orders signed for Choate specifies which unit the individual should be taken to. The Judge responded by saying that the Petition and Order should cite the Mental Health and Developmental Disabilities code regulations that are specific to either developmental disabilities or mental illness depending on that individual's needs and this should determine whether he or she is taken to the developmental center or mental health hospital. The HRA discussed some possible confusion with the wording on the copy of the Order that was obtained and reviewed for recipient 1 which stated *"it is necessary that the evaluation be done at a mental health facility"* and continued by stating that the recipient *"shall be taken by a peace officer to Choate Mental Health Hospital which is the nearest mental health facility, and be examined to see if the respondent is a person subject to involuntary admission."* The Petition for this recipient cited 405 ILCS 5/3-704 and stated that he needed to be admitted to *"the nearest mental health center, which is Choate Mental Health Hospital…"* These regulations and wording lead Choate staff to believe that the Court was ordering the recipient to the mental health units rather than the developmental disabilities units and if they did not follow that order could possibly be held in contempt of court. The Judge clarified that their orders are not meant to specify one unit at Choate over the other just that the individual should be taken to Choate Mental Health and Developmental Center since it is the nearest facility. He agreed that the specific wording of just Choate Mental Health could cause some confusion and he agreed to speak with the Assistant State's Attorney and have the forms revised to include the full name of the facility and to reflect the correct statutes for either mental health or developmental center to avoid any possible confusion in the future.

Chart Reviews:
Recipient 1

Detain and Evaluate Order (D&E): The D&E Order for recipient 1 was signed by the Judge and filed December 2, 2016. The Order stated "*3. That an evaluation is needed in order to determine whether the respondent is subject to an involuntary admission. 4. 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. 5. The facts show that an emergency exists such that immediate hospitalization is necessary…It is so ordered that [recipient] shall be taken by a peace officer to Choate Mental Health Hospital, which is the nearest mental health facility, and be examined to see if the respondent is a person subject to involuntary admission."*

Petition for Involuntary in-patient Admission: This document was completed for recipient 1 and signed by a social worker at Choate. The inpatient certificate was completed and signed by another social worker at Choate and the second certificate was completed and signed by the evaluating Psychiatrist at Choate. The Petition listed initiation reasons by checking the boxes next to the following reasons:

- *inpatient admission by court order (405 ILCS 5/3-700)* [specific for mentally ill population]

- *Emergency admission of the developmentally disabled (405 ILCS 5/4-400)* [specific for developmentally disabled population]
- *a person with mental illness who: because of his or her illness is reasonably expected, unless treated on an inpatient basis, to engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed*
- *a person with mental illness who: refuses treatment or is not adhering adequately to prescribed treatment; because of the nature of his or her illness is unable to understand his or her need for treatment and if not treated on an inpatient basis is reasonably expected based on his or her behavioral history to suffer mental or emotional deterioration and is reasonably expected, after such deterioration, to meet the criteria of either paragraph one or paragraph two above;*
- *an individual who: is developmentally disabled and unless treated on an in-patient basis is reasonably expected to inflict serious physical harm upon himself or herself or others in the near future and/or*
- *in need of immediate hospitalization for the prevention of such harm*

The handwritten basis for the Petition states that the recipient *"is a 33 year old Caucasian male with an intellectual disability…has been violent including throwing a chair, swinging a fire extinguisher, throwing rocks at people, spitting and making a homicidal threat…would benefit from psychiatric hospitalization due to his threat to harm others and inability to control rage."* This was signed by the social worker at 3:10 p.m. and indicated that a copy of the Petition and Rights of Admittee were given to the recipient.

Inpatient Certificates: The first certificate for recipient 1 was signed by the Psychiatrist evaluating the recipient at 3:15 p.m. the handwritten basis for the certificate stated that the recipient *"has been exhibiting dangerous behaviors like [illegible] and attempting to hurt people. He was recently [illegible] spitting on his face…says he was not taking psychotropic medication as prescribed …he is also developmentally disabled and unless hospitalized on an inpatient basis is expected to inflict serious physical harm. He also recently threw a chair at staff and said 'I will kill you. I know where the knives are.'"*

The second certificate for recipient 1 was signed by another social worker at Choate at 3:35 p.m. stated that *"A review of information provided at the time of evaluation indicates a history of aggressive behaviors including episodes of biting, throwing items, spitting and making threats to kill others. Per [Psychiatrist] [Recipient] is diagnosed with ADHD, Additionally, [Recipient] is diagnosed with Moderate Intellectual Disability which impairs cognitive functioning."* She checked the box indicating that the individual is subject to involuntary inpatient admission and is in need of immediate hospitalization.

The comprehensive psychiatric evaluation completed by the psychiatrist at Choate noted that the Qualified Intellectual Disabilities Professional from the recipient's CILA home stated that he has never had a psychiatric history and no history of psychiatric hospitalization, suicide attempts or homicide attempts. He had previously been diagnosed with ADHD and seizures. He had been taking psychotropic medications of Depakote ER and Lamictal for seizures and Celexa for impulse control. The evaluation noted that the patient was awake, alert and oriented to person

only, not place or time. His articulation problems made it difficult for the psychiatrist to discern his language and answers and only responded to questions "with the fewest number of words; often times nodding his head yes or no." He had stopped taking his psychotropic medication for seizures in the community. The psychiatrist observed no evidence of perceptual disturbances, active hallucinations or responding to internal stimuli. Although the recipient "did state he may be having some paranoia as he says that when he becomes very angry he feels like he is under the control of an outside force." The evaluation stated that his "overall level of intelligence is intellectual disabled, mild to moderate mental retardation, based on his insight, judgment, vocabulary, sentence complexity, capacity to abstract, level of education, current and previous jobs held and general fund of knowledge." The diagnostic impression was Primary: ADHD-per history; psychosis NOS; Gender Identity Disorder. Secondary rule out Intellectual disability NOS. Medical: Seizure Disorder; Seasonal allergies. The treatment plan was to admit to a psychiatric inpatient unit at Choate; start medical and psychotropic medications; provide supportive psychotherapy and psychoeducation; continue to monitor for potential adverse side effects from medications; facilitate family meeting with QIDP and family members; adjust medications so that his potential for violence is brought down to low risk and address his mood swings, anger, poor impulse control and low levels of frustration tolerance; and prescribe antipsychotic medication to address his paranoia and delusions. It was noted that the case was discussed with two social workers and the facility administrator.

Social Work Progress Note dated 12/13/16 documented a meeting following the recipient's return from the community medical hospital. His mother attended the meeting and stated that the recipient "has never had psychosis before in his life." The treatment plan was to "monitor [recipient] a little longer (perhaps a week) and will return to [CILA Home] as soon as deemed stabilized."

The Progress note signed by the psychiatrist 12/13/16 documented that the plan was to increase his Depakote by 250 mg and repeat the level check in 6 days. It was also documented that they "Will not re-challenge with Risperdal as there is no evidence of psychosis". It was also noted that they would continue Adderall for ADHD and monitor for breakthrough psychosis or agitation. And also they would monitor for improvement in his mood, affect and frustration tolerance.

Recipient 2

The Order for Emergency Admission or D&E Order for recipient 2 was worded similar to the one signed for recipient 1 from another county. The main difference was that this Order cited the mental health and developmental disabilities code specific for developmental disabilities (405 ILCS 5/4-405) whereas the other county for recipient 1 did not list specific regulations in their order but had cited 5/3-704 in their Petition which is specific to the mental illness population rather than developmental disabilities. This Order stated that the recipient *"shall be immediately detained and taken by a peace officer to Choate Mental Health Hospital, which is the nearest*

appropriate mental health facility, and be examined to see if the Respondent is a person subject to involuntary admission pursuant the Mental Health and Developmental Disabilities Code."

The Petition for Emergency Admission for recipient 2 also cited the Mental Health Code regulations specific for persons with developmental disabilities just as the Order had cited. A copy of the Incident report was attached to show that an emergency exists which warranted the emergency admission and evaluation. The Assistant Chief of Police for that county had signed the Petition. No certificates were available for inspection by the HRA as those would have been completed at the receiving facility. The police incident report which was attached stated that they were dispatched to the CILA Home on 3/8/17 at approximately 11:00 a.m. It was noted that this was the seventh call in reference to this recipient since February 28th to which the police had responded. The Assistant Chief of Police had responded personally to three of the seven calls. The first of the three calls was on 2/28/17. The recipient was being physically held by staff after having punched and kicked holes in the cabinets. The second was on 3/5/17. The recipient was in his room beating on the walls. He was secured and transported to the hospital by ambulance that day. The third incident was the 3/8/17 which is the focus of this investigation. Around 11:00 a.m. police had responded due to this recipient striking another resident. He had been sent home from day training because of his behavioral issues. The recipient began hitting walls, cabinets and filing cabinets once he was inside the home. The recipient began swinging at a peer in the home and the peer was placed in a room to protect him from the recipient. The recipient was again transported to the hospital for his hands to be checked from striking the walls. He was evaluated and released from the hospital. Once released from the hospital, the officer transported him to the jail.

Admission/Triage Record from Choate: The triage record documented that recipient 2 was evaluated at 5:38 p.m. by the hospital administrator and a Psychiatrist. The interview statement documented that the recipient *has "severe mental retardation as he was at Choate Mental Health DD unit in the past…he is yelling, [illegible] and shouting. He is trying to kick the chair. It is our recommendation that [recipient] be transported to the nearest developmental disability facility with an open bed. Per state of Illinois statutes an individual with severe mental retardation cannot be admitted to a state mental health facility."* The triage record documented that the non-admission was approved by the Psychiatrist and the next closest developmental center was listed as the place to send him to. Choate also provided the HRA with a list of the census for the developmental center units on March 8, 2017. There were 147 civil patients and they have 120 budgeted beds; there were 32 forensic patients and they are budgeted for 30 beds. So on this date Choate Developmental Center was 29 patients above their targeted census.

Recipient 3

Recipient 3 has a long history of both a developmental disability and mental illness. The *primary* diagnosis changed between the two depending on the timeframe of the records reviewed. The full scale IQ scores varied from mid-60s to 70, also depending on the document and timeframe. The first school records in the chart dated back to 1995 and documented that the recipient was enrolled in special education classes with an IQ of 68. Community mental health records dated 10/10/96 listed her diagnoses as Axis I: Bipolar Disorder, Manic, Oppositional Defiant Disorder, and Adjustment Disorder with depressed mood and Axis II: Mild Mental

Retardation with a current GAF (Global Assessment of Functioning) listed as 40. A community medical center in 1997 listed her diagnoses as bipolar disorder, manic type and borderline personality disorder, documented her IQ to be 65 and also noted that she had 20 private hospitalizations in the past year for "acting out" and making homicidal and self-injurious behavior (SIB) threats. It was also documented that as a senior in high school, she had a 1st-3rd grade ability level in her classes. The first state operated placement was in a mental health hospital in 1997 when she was 18 years old. The diagnoses listed in the initial treatment plan are Axis I: Adjustment Disorder with Mixed Disturbances of Emotion and Conduct, Parent/child relational problem and to rule out oppositional defiant disorder and mood disorder. Axis II: Borderline Intellectual functioning, Rule out Mild Mental Retardation. That psychiatric evaluation in September, 1997 changed her diagnosis to Axis I: None and Axis II: Mild Mental Retardation. In December 1997 while at a state operated mental health (SOMH) facility, she was decertified from having a mental illness diagnosis and needed to be transferred to a developmental center and was transferred to a state operated developmental center (SODC). An ICAP evaluation dated 1/22/98 when the recipient was 18 years old listed her primary diagnosis as "mental retardation –moderate" and listed an additional diagnosis of "mental illness" with an overall age equivalent of 5 years 6 months. From this SODC she was discharged to a community CILA home in July of 2001 but in December, 2001 she was transferred back to a SODC due to maladaptive/aggressive behaviors. In June, 2006 she was transferred to another SODC and discharged in October, 2006 to a county jail. The discharge summary by the psychiatrist at the SODC stated that there was no evidence to justify her previous diagnosis of Schizoaffective Disorder or Bipolar disorder. Instead, this psychiatrist was of the opinion that her behavior was accounted for by a personality disorder with borderline antisocial features and that she likely had symptoms of Post-Traumatic Stress Disorder. The following is the rest of her history of diagnoses:

- In July, 2009 she was transferred to Choate Developmental Center from the jail with an admitting diagnoses as "Axis I: Bipolar disorder with depressed and agitated types 296.50 Axis II: (PRIMARY) Mild mental retardation."
- She was seen in August, 2009 by a consulting facility psychiatrist for evaluation of diagnosis and medications. This psychiatrist recommended changing her Axis I diagnosis to Bipolar Disorder, Mixed.
- Another facility psychiatrist re-evaluated the recipient in August, 2013 and discontinued her Axis I diagnosis of Bipolar Disorder and was given an Axis II diagnosis of Borderline and Anti-Social Personality Disorder.
- In October, 2014 she again had legal charges filed against her for aggravated battery against a peer in her cottage home at Choate and was transferred to a SOMH forensic unit and returned to Choate Developmental Center a month later as Unfit to Stand Trial (UST) as a judicial admission on a court order. The discharge summary listed her diagnosis as Axis I None; Axis II: Borderline Intellectual Functioning, Borderline and Anti-Social Personality Disorder.
- The discharge summary dated 11/8/14 from the forensic hospital back to Choate cottage housing listed diagnosis of Axis I: Bipolar Disorder, NOS and Borderline Intellectual Functioning. Axis II: None
- In August, 2015 she was again transferred to a SOMH forensic unit due to being found fit to stand trial and not guilty by reason of insanity and ordered to treatment in a secure

DHS setting. Her discharge diagnoses were Axis I: None Axis II: Borderline Intellectual Functioning, Borderline Personality and Anti-Social Personality Disorder.

- In December, 2016 she was transferred back to Choate but was admitted on the Mental Health unit this time. Her discharge diagnoses were Primary: Borderline Intellectual Disability and Unspecified Mood Disorder.
- The summary index from Choate for the 12/27/16 to 3/15/17 admission listed her Primary diagnosis as Schizoaffective Disorder, Bipolar subtype F25.0 and secondary diagnosis as Antisocial Personality Disorder and Borderline Intellectual Functioning.

Ongoing Diagnoses Form for Choate documented the following:

- 10/20/10 Axis I: Bipolar disorder with depressed and agitated times and Axis II: (PRIMARY) Mild Mental Retardation
- 6/1/11 Axis I: Bipolar disorder with depressed and agitated times and Axis II: (PRIMARY) Mild Mental Retardation
- 6/20/12 Axis I: Bipolar disorder with depressed and agitated times and Axis II: (PRIMARY) Mild Mental Retardation
- 7/8/13 Axis I: Bipolar disorder and Axis II: (PRIMARY) Mental retardation, mild
- 8/7/14 Axis I: Bipolar and Axis II: (PRIMARY) Mental retardation, mild
- 9/26/14 Delete: Axis I previous diagnosis and Axis II: (PRIMARY) Mild mental retardation. Add: Axis I None and Axis II: Borderline intellectual functioning; Borderline and anti-social personality
- 9/29/14 Add Axis I: none; Axis II: (PRIMARY) Borderline intellectual functioning; Borderline and anti-social personality disorder
- 11/18/14 Axis I: None; Axis II: Borderline intellectual disability; Borderline personality disorder; Antisocial disorder
- 12/27/16 to 3/15/17 PRIMARY: Schizoaffective disorder; Bipolar SECONDARY Antisocial personality disorder; Borderline intellectual functioning.

Psychiatric Evaluation Report to Court: The evaluation dated 8/26/16 and completed by a psychiatrist at the forensic SOMH Facility stated the history of her diagnoses and noted that according the most recent (at that time) evaluation done at Choate her IQ score of 70 combined with her level of adaptive functioning would indicate a diagnosis of Borderline Intellectual Functioning. The diagnostic formulation of this psychiatrist stated that the recipient "had below average intellectual functions and a history of mood swings, irritability, anger outbursts, agitation, physical aggression, frequent suicidality since childhood with repeated self-harm behaviors and psychiatric hospitalizations, with somewhat response to the treatment with mood stabilizer Valproic acid and antipsychotic medications in the past. The presentations and disease course of [recipient] mental illness are consistent with the diagnosis of Bipolar Disorder, not otherwise specified."

Request for Clinical Review: The forensic SOMH facility requested a clinical review in November, 2016 due to the thiem date approaching for the criminal charges. The basis for the request was listed as "has a history of explosive, aggressive outbursts, which are out of proportion to any precipitating stressors. She will achieve her thiem date on 12/24/16 and [is] in need of supported living placement." Behavioral issues were described as "When frustrated she resorts to excessive screaming, verbally abuse language, and threatens to use physically

aggressing on others. On numerous occasions, she has stealthy attack other patients and run to her room to avoid repercussion. She will then hide in her room crying excessive with persistent daily worry about other peer's retaliation. She shows signs of hypervigilance as indicated by constantly feeling on edge, difficulty interacting with her peers and irritability. She has reported she can only relax while she is in her locked room."[sic] Attempted interventions were listed as cognitive behavioral therapy that focused on her learning healthy coping skills for anxiety, tension, frustration and anger. Her barriers to discharge were listed as being "institutionalized with no desires to become independent or self-sufficient. This is due to her being cared for in state facilities throughout most of her life…most recent measured IQ score of 70 combined with her level of adaptive functioning, would indicate a diagnosis of Borderline Intellectual Functioning. Due to cognitive deficits she responds to distress by having a temper tantrum."

December 6, 2016 Clinical Review Team Recommendations: This clinical review was requested by the forensic SOMH facility when recipient 3's thiem date from legal charges was about to expire to assist with placement and treatment. The following recommendations were made:

- "If DDD (division of developmental disabilities) is not able to take her, or if they can't take her in the next few weeks, you should strongly consider asking her to sign a voluntary. If she does not do that, please consider commitment proceedings.
- Please consider whether changes can be made to her treatment-especially her behavior plan-to assist her in getting more control of her aggression.
- Consider motivational enhancement techniques, if you believe that part of the reason more progress has not been made involves motivation…
- Please consider a possible change in her behavior plan if you believe she has 'maxed out' the amount of improvement she has made…
- With respect to medication: if, as you believe, she would be best served in a facility for ID/DD, please adjust medications in a manner that she gets adequate medication coverage without PRNs, as DD/ID facilities cannot take her with PRNs. If she needs more medication, please maximize the medication she's taking."

In March, 2017 she was discharged from the mental health unit and readmitted due to her legal charges being dropped. The guardian requested that she be moved to the unit for developmental disabilities at that time. A clinical specialist and a psychologist met with her to make a determination on where she was best suited. A utilization review was held 3/28/17. The psychiatrist at Choate cited justification for his diagnosis of schizoaffective disorder that had been ruled out by two other treating psychiatrists previously. Another psychiatrist at Choate cited historical documentation supporting a diagnosis of mild intellectual disability rather than borderline intellectual functioning. An independent examination was also conducted. On May 31, 2017 the guardian was notified that the Department of Human Services and the independent consulting psychiatrist determined that a developmental disabilities setting was more appropriate for the recipient. She was transferred to the dual diagnosis unit with her peers from the previous cottage housing in June, 2017 with a Primary Diagnosis listed as Borderline Intellectual Functioning and Secondary listed as Borderline personality Disorder, Antisocial Personality disorder and Bipolar Disorder.

Policy Review

Choate Mental Health administration told the HRA that in regard to D&E Orders, they follow the Mental Health Code (405 ILCS 5/3-607). When feasible, the individual is evaluated upon arrival to determine if they are in need of inpatient hospitalization. Choate has no specific policy for D&E admissions therefore the general admissions policy was reviewed. The Developmental Center Admission Policy SOPP.0455 states that:

"All admissions shall be considered temporary given the ultimate goal for each individual of placement in the most independent living situation that meets his/her individual needs. Admission to the Clyde L. Choate Developmental Center is without regard to religion, ethnic origin, color, sex and degree of disability or the individual's ability to pay. Persons shall not be admitted to Clyde L. Choate Developmental Center solely on the basis of their inclusion in a particular diagnostic category, identification of sub average intelligence test score, or consideration of a past history of residential placement. Population Size: Individuals shall not be admitted in numbers that exceed the capacity of the center to provide basic care, services and programs. Pre-admission Evaluations: It is the responsibility of the Clyde L. Choate Developmental Center staff to ensure that admission is permitted only to individuals whose needs are optimally met by the programs provided at the center and that individuals whose needs cannot be met are not admitted…The center shall admit only those individuals who have been appropriately evaluated and for whom residential services can be supported by the evaluation process. A pre-admission process shall be completed by the IDT for every admission/transfer to Clyde L. Choate Developmental Center to ensure: 1) The individual's strengths, abilities, preferences and needs are fully reviewed and the individual's immediate and urgent needs are identified, documented and addressed. 2) All community services which could benefit the individual and meet his/her needs have been proposed, explored and recommended regardless of the immediate availability of such services. 3) Recommendations to admit the individual are based on a conclusion that residence within the center would be in the best interest of the individual and that all other alternatives to the center are inappropriate. 4) If admission is recommended even though it does not optimally meet the individual's needs, this should be noted as part of the evaluation and a plan developed to secure a more appropriate placement. 5) If admission is not recommended a) the individual is informed in writing as to the reasons admission is not recommended. b) Recommendations for alternative services and appropriate referral resources are provided."

Admission Criteria for individuals admitted to Choate Developmental Center are listed as:

1. *Function at the mild, moderate, severe or profound level of retardation as determined by Intellectual assessments and adaptive behavior scales. In cases where there is a disparity between the levels, the overall functioning level of the individual shall be considered. 2. Require further skill development in order to live in an alternative residential setting. 3. Be at least 18 years of age"*

Admission Exclusionary Criteria for individuals are listed as:

"1. Are younger than 18 years of age. 2. The individual does not present with a primary diagnosis of developmental disability. 3. The individual would not benefit from active treatment."

This same policy states that the Unit Director is responsible for completing appropriate admission forms with consultation from the Center Director, or designee as needed and that admissions *"shall comply with the Mental Health and Developmental Disabilities code and shall be as follows: administrative, judicial, etc..."*

The Mental Health Services Admission Procedure policy states that the Mental Health Center 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."*

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."*

Section 5/3-607 of the Mental Health and Developmental Disabilities Code outlines the procedure for temporary detention and examination for the mentally ill and states that when *"any court has reasonable grounds to believe that a person appearing before it is subject to involuntary admission on an inpatient basis and in need of immediate hospitalization to protect such person or others from physical harm, the court may enter an order for the temporary detention and examination of such person. The order shall set forth in detail the facts which are the basis for its conclusion. The court may order a peace officer to take the person into custody and transport him to a mental health facility. The person may be detained for examination for no more than 24 hours to determine whether or not she or he is subject to involuntary admission and in need of immediate hospitalization. If a petition and certificate are executed within the 24 hours, the person may be admitted provided that the certificate states that the person is both subject to involuntary admission and in need of immediate hospitalization. If the certificate states that the person is subject to involuntary admission but not in need of immediate hospitalization, the person may remain in his or her place of residence pending a hearing on the petition unless he or she voluntarily agrees to inpatient treatment. The provisions of this Article shall apply to all petitions and certificates executed pursuant to this section. If no petition or certificate is executed, the person shall be released"*

Section 5/3-704 describes the admission process for persons with mental illness and states *"…If, however, the court finds that it is necessary in order to complete the examination the court may order that the person be admitted to a mental health facility pending examination and may order a peace officer or other person to transport the person there. The examination shall be conducted at a local mental health facility or hospital or, if possible, in the respondent's own place of residence. No person may be detained for examination under this Section for more than 24 hours. The person shall be released upon completion of the examination unless the physician, qualified examiner or clinical psychologist executes a certificate stating that the person is subject to involuntary admission on an inpatient basis and in need of immediate hospitalization to protect such person or others from physical harm. Upon admission under this Section treatment may be given pursuant to Section 3-608…"*

Section 5/4-201 addresses instances when a person is dually diagnosed with an intellectual disability and mental illness and states: *"A person with an intellectual disability 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…*

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

Section 5/4-300 of the Code addresses administrative and temporary admission of persons with developmental disabilities and states that *"No person may be administratively admitted to any facility…unless an adequate diagnostic evaluation of his current condition has been conducted to determine his suitability for admission. Prior to an administrative admission, the person may be admitted to a facility for not more than 14 days for such evaluation. The evaluation shall include current psychological, physical, neurological, social, educational or vocational and developmental evaluations. It shall be conducted under the supervision of qualified professionals including at least one physician and either one clinical psychologist or one clinical social worker…"*

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.*

Section 5/4-402 of the Code describes the process for emergency admission and states that:

> *(a) 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.*
>
> *(b) The certificate shall contain the examiner's observations, other factual information relied upon, and a statement as to whether the respondent was advised of his rights under Section 4-503. If no certificate is executed, the respondent shall be released immediately.*

Section 5/4-403 outlines the procedures after a Petition is received and states "*Upon receipt of a petition and certificate prepared pursuant to this Article, a peace officer shall take a respondent into custody and transport him to a developmental disabilities facility."*

Section 5/4-404 provides that "*A peace officer may take a person into custody and transport him to a facility when, as a result of his personal observation, the peace officer has reasonable grounds to believe that the person meets the standard for emergency admission. Upon arrival at the facility, the peace officer shall complete a petition for emergency admission."*

Section 5/4-405 of the Mental Health and Developmental Disabilities Code outlines the procedure for detention and examination for the intellectually disabled and states *"When, as a result of personal observation and testimony in open court, any court has reasonable grounds to believe that a person appearing before it meets the standard for emergency admission, the court may enter an order for the temporary detention and examination of such person. The order shall set forth in detail the facts which are the basis for the court's conclusion. The court may order a peace officer to take the person into custody and transport him to a facility. The person may be detained for examination for no more than 24 hours. If a petition and certificate, as provided in this Article, are executed within the 24 hours, the person may be admitted and the provisions of this Article shall apply. If no petition or certificate is executed, the person shall be released"*

CONCLUSION

The complaint alleged that recipient 1 who only had a diagnosis of developmental disabilities was inappropriately placed on the mental health unit for treatment upon being brought to Choate by police with a detain and evaluate order (D&E). When the HRA interviewed facility administration as to why the recipient was admitted to the mental health (MH) unit rather than the developmental disabilities (DD) unit, they stated that it was not possible to admit someone to the DD unit on a D&E Order because it specifically orders an evaluation at a *mental health facility* and they would be in violation of a court order if they admitted to a developmental unit. Therefore, the only option was to stabilize him on the MH unit and then transfer to the DD unit or back home. However, the Judge refuted this statement and said that the intention of the order is to transport the individual to the facility in general and not to one unit or the other and the specific unit should be determined by Choate staff upon evaluation. The D&E Order reviewed did specifically state that the recipient shall be taken by a peace officer to *"Choate Mental Health Hospital, which is the nearest mental health facility, and be examined to see if the respondent is a person subject to involuntary admission."* The petition for admission was then reviewed for clarification. The statutes referenced on the Petition for Involuntary/Judicial Admission were not specific to mental illness (MI) OR developmental disabilities (DD) but rather one referenced DD regulations and the other referenced MI regulations. Therefore, it was unclear if the intention of the petitioner was to have the recipient admitted by emergency basis to the mental health unit or developmental center. The diagnostic impression from the initial psychiatric evaluation was that the recipient's primary diagnoses were ADHD-per history; psychosis NOS and gender identity disorder. The addition of psychosis NOS seemed to be based on the recipient telling the psychiatrist that when he becomes very angry he feels like he is under the control of an outside force and the psychiatrist interpreted this as paranoia. It was documented that the mother said in a treatment meeting that the recipient had never had psychosis in his life. Also, the QIDP did not list a diagnosis of psychosis in his past medical information. The Mental Health Code (405 ILCS 5/4-201) prohibits a person with an intellectual disability from residing in a mental health facility unless they are evaluated and also determined to have a mental illness diagnosis. Since the recipient had no history of mental illness prior to this admission, the HRA contends that he could have been admitted to a developmental center on an emergency basis for stabilization and then returned to his community CILA home and the allegation is **substantiated**. The following **recommendations** are made:

1. **The HRA recommends that social workers and other staff who complete Petitions and/or Certificates for involuntary or judicial admission be retrained on the mental health code statutes and which ones are specific for recipients with intellectual disabilities and which ones are specific for recipients with mental illness and ensure that Petitions and Certificates are completed accurately.**

2. **There seemed to be confusion relating to the how the D&E Orders are worded and administration was initially under the impression that if the Order states "mental health facility" they have to admit the patient to a mental health unit and cannot admit to the developmental center or they would be in violation of a court order. The Judge, when interviewed, stated that the intention of their orders are just to the facility in general not to one unit or the other and that determination should be made by Choate staff upon evaluation. The Judge also agreed to speak with the**

state's attorney's office and have the forms revised to eliminate confusion in the future. Administration should clarify the facility's procedures for admissions based on D&E Orders with social workers, psychiatrists and any other pertinent staff and ensure they are aware that admissions as a result of D&E Orders can be to either the mental health unit or the developmental center depending on the specific circumstances/diagnoses to prevent possible inappropriate admissions in the future.

The HRA also offers the following suggestion:

1. The HRA suggests that administration consider developing a policy specific to emergency admissions so that proper procedures are clear even though the admission criteria would be the same as outlined in the general admission policies.

The complaint also alleged that recipient 2 was denied admission to Choate Developmental Center when he arrived by police transport with a D&E Order. The reason given was that a person with a diagnosis of developmental disabilities could not be placed on the mental health unit for treatment and also that a person could not be placed on a developmental center unit with a D&E Order, only the mental health unit. However, the recipient was transferred to another state operated developmental center. When discussing this allegation with the administration at Choate, the HRA was informed that the reason for denying admission was because his primary presenting problem at the time was behaviorally related to his developmental disabilities and at the time of his arrival, Choate Developmental Center was over census. Since he had no mental illness diagnosis, he could not be admitted to the mental health unit, therefore he was transported to the next closest facility with an available bed. Since there was no policy for emergency admissions, the HRA reviewed the general admissions policy which states that "*Individuals shall not be admitted in numbers that exceed the capacity of the center to provide basic care, services and programs."* The Mental Health Code is not specific in its D&E Order regulations as to whether or not Choate is required to hold a person for evaluation upon receipt of such Order regardless of bed availability, although the Judge stated that they *are* required to hold the person at the nearest facility for the initial evaluation and then if deemed appropriate for admission transfer the recipient to a facility that has a bed available if they do not. Since Choate was over census at the time of arrival and no specific Code requirements for this were available, this allegation is unsubstantiated. The HRA offers the following suggestions:

1. The HRA suggests that the administration discuss D&E Order requirements with the local State's Attorney, Judge and/or DHS legal department to determine if they may be in contempt of court in the future by not holding someone on a D&E Order for evaluation even if they're over census. Staff should then be retrained on procedures as necessary.

2. According to the Judge, the peace officer's only responsibility regarding D&E Orders is to transport the patient to the nearest facility, which is Choate and then his/her duties are fulfilled. In this case, the sheriff was required to transport the recipient approximately an hour and a half to the next nearest facility when Choate deflected due to being over census. The HRA suggests that proper procedures be reviewed with DHS and the local police departments to determine if the facility is required to provide transportation in future instances as the Mental Health Code is not specific and just requires a peace

officer to "transport to a developmental disabilities facility."

Finally, the complaint alleged that recipient 3 was inappropriately admitted/transferred to the mental health unit of Choate rather than a developmental disabilities/dually diagnosed unit when her living unit was closed. The guardian contends that mental illness has always been a secondary diagnosis not a primary one and that the recipient has more maladaptive behaviors when placed in a setting where she feels threatened as she lashes out at others as a protective mechanism. The historical chart documentation showed that her diagnosis has fluctuated between an intellectual disability, personality disorder and Bipolar Disorder and also Schizoaffective Disorder has been added and dropped as well. In October, 2006 a psychiatrist at the SODC stated that there was no evidence to justify her previous diagnosis of Schizoaffective Disorder or Bipolar disorder and up until 2016 her primary diagnosis was still listed as an intellectual disability or Borderline Intellectual Functioning. Bipolar Disorder had been added to and dropped from her diagnosis several times between 2009 and 2017. On May 31, 2017 the guardian was notified that the Department of Human Services and the independent consulting psychiatrist determined that a developmental disabilities setting was more appropriate for the recipient. She was transferred to the dual diagnosis unit with her peers from the previous cottage housing in June, 2017 with a Primary Diagnosis listed as Borderline Intellectual Functioning and Secondary listed as Borderline personality Disorder, Antisocial Personality disorder and Bipolar Disorder.

The admission criteria for individuals admitted to Choate Developmental Center includes: *"1. Function at the mild, moderate, severe or profound level of retardation as determined by Intellectual assessments and adaptive behavior scales….2. Require further skill development in order to live in an alternative residential setting…"* Admission Exclusionary Criteria for individuals includes: *"2. The individual does not present with a primary diagnosis of developmental disability. 3. The individual would not benefit from active treatment…"*

Admission criteria for the mental health unit at Choate states that they 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…"* The policy also requires that acceptance of an individual for admission 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 Mental Health Code allows for placement of individuals with dual diagnosis in a mental health facility providing that the individual 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. Choate administration stated that at the time of her admission to the mental health unit, the recipient was on 1:1 supervision due to aggressive behaviors in the cottages against peers. Prior to that behavior, she was on staff escort for medications, programs and meals. Therefore, due to her "continued need for psychiatric stabilization" at that time, they felt that a more intensified program offered on the mental health unit was a more appropriate placement. Although the utilization review requested in March resulted in the recipient being transferred back to the dual diagnosis unit in June, this could have allowed for time for the

recipient to stabilize. The HRA also considered the guardian's opinion that the recipient's behaviors were intensified in the mental health setting, however, the chart documentation also showed aggressive behaviors when in the previous cottage setting. The issue of the complaint was whether or not the recipient was inappropriately placed on the mental health unit. Considering maladaptive behaviors at the time of admission requiring increased supervision levels and provisions under the Mental Health Code allowing individuals with dual diagnosis to be placed in a mental health facility if certain requirements are met, the HRA concluded that given the circumstances and the recipient's history of both mental illness and developmental disabilities, the placement could be considered appropriate. Therefore, the allegation is unsubstantiated. The HRA offers the following suggestion:

1. This recipient has a long history of both mental illness and developmental disabilities diagnoses that have been constantly changed based on the evaluator's opinion. The HRA suggests that for future placements, the facility take into consideration the Clinical Review Team's findings that a developmental center placement was the most appropriate setting. The treatment team should consider the possibility that maladaptive behaviors could also be a result of her developmental disability and consider revising behavioral intervention plans when possible before considering placement in a mental health facility or unit for stabilization.

The HRA acknowledges the full cooperation of the facility and would like to recognize and thank the Union County State's Attorney's Office for providing staff training on Detain and Evaluate Orders and completion of Petitions and Certificates for admission.

RESPONSE

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

Bruce Rauner, Governor • James T. Dimas, Secretary

CHOATE MENTAL HEALTH AND DEVELOPMENTAL CENTER
1000 NORTH MAIN, ANNA, IL 62906

February 26, 2018

Mr. Paul Jones
Egyptian Regional Human Rights Authority
#7 Cottage Drive
Anna, IL 62906-1669

RE: HRA Case # 17-110-9008

Dear Mr. Jones,

Please see the attached response to your recommendations regarding this case.

Sincerely,

Linda Parsons, Hospital Administrator

cc: Bryant Davis

100 South Grand Avenue, East • Springfield, Illinois 62762
401 South Clinton Street • Chicago, Illinois 60607

HRA Case # 17-110-9008

February 26, 2018

Finding/Recommendations/Suggestions	Response
1). The HRA recommends that social workers and other staff who complete Petitions and/or Certificates for involuntary or judicial admission be retrained on the mental health code statutes and which ones are specific for recipients with intellectual disabilities and which ones are specific for recipients with mental illness and ensure that Petitions and Certificates are completed accurately.	The facility will review training needs related to Petitions and/or Certificates for Involuntary/Judicial admissions. If training needs are identified, training will be tailored to the identified need.
2). There seemed to be confusion relating to how the D&E Orders are worded and administration was initially under the impression that if the Order states "mental health facility" they have to admit the patient to a mental health unit and cannot admit to the developmental center or they would be in violation of a court order. The Judge, when interviewed, stated that the intention of their orders are just to the facility in general not to one unit or the other and that determination should be made by Choate staff upon evaluation. The Judge also agreed to speak with the state's attorney's office and have the forms revised to eliminate confusion in the future. Administration should clarify the facilities procedures for admissions based on D&E Orders with social workers, psychiatrists and any other pertinent staff and ensure they are aware that admissions as a result of D&E Orders can be to either the mental health unit or the developmental center depending on the specific circumstances/diagnoses to prevent possible inappropriate admissions in the future.	The facility will review training needs related to D&E Orders. If training needs are identified, training will be tailored to the identified need.

Bruce Rauner, Governor • James T. Dimas, Secretary

CHOATE MENTAL HEALTH AND DEVELOPMENTAL CENTER
1000 NORTH MAIN, ANNA, IL 62906

April 13, 2018

Mr. Paul Jones,
Egyptian Regional Human Rights Authority
#7 Cottage Drive
Anna, IL 62906-1669

RE: HRA Case # 17-110-9008

Dear Mr. Jones,

This letter is in response to your request of training records. Please see the attached copies of training records regarding completion of petitions for admissions and D&E assessments.

Sincerely,

Linda Parsons

Linda Parsons, Hospital Administrator

cc: Bryant Davis