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Egyptian Regional Human Rights Authority
Report of Findings
Case #18-110-9010
Choate Mental Health and Developmental Center
November 20, 2019

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):

A recipient was inappropriately denied admission

If found substantiated, the allegation represents 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 the following services to persons with developmental disabilities: psychiatric, psychological, medical, social, educational, vocational, rehabilitation, recreational, speech, language, hearing, pharmacy, dental, dietary and others.

To investigate the allegation, an HRA team met with representatives of Choate, a community service coordinating agency and a community counseling agency. The HRA also examined the recipient's records with written consent and reviewed pertinent policies and mandates related to admission.

COMPLAINT STATEMENT

According to the allegations, the recipient was denied admission during a crisis episode because he did not meet criteria for the mental health unit, and the developmental disabilities unit only accepts admissions Monday through Friday, during daytime business hours.

FINDINGS

Interviews:

Crisis Worker/QMHP (qualified mental health professional): This community mental health crisis worker stated that the recipient had a crisis episode which began on Tuesday, January 9th and her agency was involved through the following Saturday the 13th. The recipient was a resident at a CILA (Community Integrated Living Arrangement) home and is diagnosed with moderate intellectual disabilities with an overall IQ of 61. On that Tuesday, he had grabbed 2 staff person's buttocks and made a statement that he was going to rape them. The nurse took

him to the emergency department (ED) at the local hospital. Initially another crisis agency responded but they referred the recipient to this agency since he was under the age of 21 and he had to be screened by a CARES (crisis and referral entry system) and SASS (screening assessment support services) provider for funding purposes. Initially the caseworker responded and attempted placement at a community psychiatric unit at a local hospital because the recipient's treating psychiatrist has unit privileges. However, the psychiatrist denied admission stating that the recipient needed long term care placement rather than acute care. At that time the recipient was calm and compliant and, since no placement could be found, he was returned to his CILA home. The CILA home nurse spoke with the crisis worker and stated that the recipient needed to have a medication review and clear diagnosis because his community psychiatrist had changed his medication monthly since September 2016 and had recently taken him off Seroquel prior to this crisis episode. This agency offered to have its psychiatrist review his medication and scheduled an appointment for 1:00 on Thursday the 11th. The recipient's community psychiatrist told the CILA home staff not to attend the appointment and worked the recipient into his schedule at 1:00 that same Thursday. The recipient went into crisis Wednesday night before the appointment and was taken back to the hospital. His community psychiatrist ordered Haldol and Ativan 3-5 times per day and the recipient was returned to the CILA home but was very sedated. Friday morning the recipient hit staff and pulled fire alarms at the CILA home. The police responded and called an ambulance to transport him to the hospital. The crisis worker who was working on placement tried again to place him on the psychiatric unit at a local hospital where the recipient's community treating psychiatrist had privileges, but again the treating psychiatrist denied admission stating he could not meet his needs and he needed a long-term care placement. However, the psychiatrist did not complete any referral paperwork for admission to a long-term care facility. The crisis worker left at 11:30 p.m. on Friday because a hospital in the Chicago area had agreed to accept him but not until after 7:30 a.m. on Saturday when admissions staff returned. The crisis worker returned to the hospital at 7:30 a.m. on Saturday but the Chicago hospital declined admission. The crisis worker continued searching for placement without success and Choate was contacted. The worker spoke with the mental health unit nurse on call and was informed he did not meet criteria for admission due to his diagnosis of developmental disabilities. The Administrator on Duty (AOD) for the developmental disabilities unit was also contacted and the crisis worker informed him that 16 community placements and the mental health unit of Choate had all denied admission. The AOD spoke with the Director and was informed that they could not admit him until regular business hours the following Tuesday because Monday was a holiday. The AOD thought that the recipient met criteria for a "crisis bed" placement in the Springfield area but did not have any information on admission to those. Another crisis worker took over at 1:30 p.m. and had difficulty finding placement as well. One hospital said he did not meet criteria for an involuntary admission and because he was so sedated from the medication, they refused to take him as a voluntary patient because they were afraid he would change his mind upon arrival. At 9:30 p.m. Saturday, the ED Physician said the recipient had to be discharged from the hospital because he was showing no signs of psychiatric symptoms and had no medical reason to stay there. The crisis worker agreed that he no longer met criteria for involuntary admission and had no reason to stay at the hospital ED. The CILA home owner was upset and wanted him to stay at the hospital until Choate could accept him the following Tuesday because the CILA home had low staffing levels and the recipient had a history of unpredictability. However, CILA home staff picked him up around 11:00 p.m. Saturday night. A crisis worker followed up with the CILA home on Sunday evening around

5:30 and was told that the recipient had not been aggressive but was isolating himself to his room. The home was informed that the crisis agency would keep his case open for 3 months and he would remain eligible for outpatient mental health services if needed but the CILA home owner did not feel that mental health counseling would help due to his developmental disabilities. The crisis worker agreed that Choate would be a better placement for medications to be reviewed and stabilization to occur. The plan was to continue attempting placement at Choate that following Tuesday during business hours. The crisis worker was also concerned about the frequent medication changes that the community psychiatrist had implemented (at least 14 between September 2016 and January 2018) and thought that the recent removal of Seroquel might have been the cause of this behavioral crisis

Second Crisis Worker: This crisis worker was involved in the recipient's crisis episode in January and was interviewed in March 2018. The worker informed the HRA that on Tuesday, January 9th the recipient had a crisis episode and was taken to the emergency department (ED) at the local hospital. The hospital's contracted crisis worker assessed him and initially he met criteria for a psychiatric admission, but she and the other crisis workers had great difficulty in finding placement due to his dual diagnosis of developmental disabilities and mental illness. The crisis worker believed his primary problem at the time of initial assessment was behavioral due to his intellectual disability. However, crisis workers are required to give a diagnosis of their first impression and the worker documented schizophrenia as the presenting problem because she believed he was experiencing auditory and visual hallucinations. The worker explained that it was very rare for them to assess and place an individual whose primary presenting problem is behavioral due to intellectual disabilities; most of their clients have mental illnesses which is typically the cause of the crisis episodes. As such, the facilities they typically refer individuals to are mental health facilities for children. This caused another barrier with placement because those facilities would not admit anyone over the age of 17. SASS providers typically only deal with children so the facilities they were familiar with is who they called. Another community mental health provider typically assesses adults and are more familiar with adult facilities, but they could not because of his age he had to go through SASS for funding reasons. In the meantime, the recipient was cleared medically by the hospital and since placement could not be found, he was released back to the CILA home, but he returned to the hospital the next evening following another crisis episode. On Saturday, January 13th after unsuccessfully attempting placement at several psychiatric hospitals the crisis worker contacted Choate. Initially the crisis worker spoke to a nurse who stated that the recipient did not meet criteria for placement on the mental health (MH) unit, but he agreed to review policies for afterhours admissions to the developmental disabilities (DD) unit. The AOD returned a call to the crisis worker and the worker gave the AOD a list of all the hospitals who had denied the recipient's admission. The crisis worker also voiced concerns over the recipient returning to his CILA home due to his aggression. The AOD contacted the Director of the facility and then returned a call to the crisis worker stating that they could only admit individuals during regular business hours and since Monday was a holiday, he could not be admitted until the following Tuesday. When asked for any suggestions on placement of the recipient until that Tuesday, the AOD advised the crisis worker to keep him in the hospital ED or call the police. However, she felt these were unrealistic options because the hospital had cleared the recipient and the recipient had not been aggressive towards hospital staff so there was no reason to involve the police. Someone at the facility, the worker could not remember if it was the nurse or AOD, had mentioned 3 "crisis bed" homes in

the Springfield area for individuals with developmental disabilities but that person stated they were usually full, he might not meet criteria and they were not aware of the process for admission to one of those crisis bed homes. By this time the recipient had calmed and was no longer aggressive, so the hospital cleared him medically. The recipient was returned to his CILA home with the plan to monitor closely until he could be admitted the following Tuesday to Choate for medication review and stabilization.

Administration: When asked about admission to the residential unit at Choate, the HRA was informed that the community case coordination agency is the "gatekeeper" and all admissions must go through them and the Department of Human Services (DHS), which is why admissions can only occur during regular business hours. There are no emergency admissions because it is considered a residential placement unlike the mental health unit which is considered more of an acute stabilization unit. The mental health unit nurse received the initial pre-screen call for placement, but since the recipient lived in a CILA home, the nurse knew he had an intellectual disability and therefore the CILA home would need to work with the case coordination agency for placement to Choate residential. The crisis worker also spoke with the AOD for the residential unit who reached out to the Director for direction. The Director informed him that the recipient would need to be referred to the case coordination agency for admission because Choate DD unit does not do direct admissions. It would be Tuesday before the Director could contact the case coordination agency to help facilitate admission. The Director stated that she did reach out that Tuesday but could not reach anyone. She had trouble reaching anyone that entire week and played "phone tag" with them. At the end of the week she discovered that the workers at the case coordination agency were out due to bad weather. The Director also informed the HRA that the case coordination agency has on call services on the weekend for emergencies and they can pursue State Operated Developmental Center (SODC) admission to a facility like Choate via application, but admissions also must go through Springfield for statewide SODC placement. Springfield then contacts Choate for admission. When asked about crisis beds for individuals with developmental disabilities, the HRA was informed that there are some community crisis beds in the Springfield and Chicago area but no SODCs have crisis beds, there are only the community provider owned stabilization beds.

Administrator on Duty (AOD): The AOD advised the HRA that AODs rotate shifts Monday at 4:30 to the following Monday and there are currently 4 staff that rotate shifts. AOD duties include fielding calls within the units, peer to peer aggression, and taking residents to the hospital for X-rays or any injuries that might occur. They also notify the Director of anything that comes up during business hours requiring additional attention and complete reports that outline the series of events that may have occurred. He stated that when he took the call for admission for the recipient, he contacted the Director because he has no admissions authority. He was unaware of any crisis beds at Choate and did not recall mentioning crisis beds to the crisis worker with whom he spoke. He stated that the Choate DD unit does not typically admit on the weekends; even jails are asked to bring recipients between 8 a.m. and 4:30 p.m. during the week.

Case Coordination Caseworker and Director: The HRA met with the caseworker and Director of the community coordination agency to further clarify what role they play in Choate admissions and to discuss any specific information they have on the recipient's crisis episode. It was

confirmed that they do have a 24-hour crisis line for emergencies, however they have no authorization to admit to Choate unless the admission is approved by the DHS committee. Their crisis line is available solely to provide advice, give options, offer contact information etc. They are aware of stabilization beds in the Springfield area but those have a waiting list and there is typically no immediate placement there either. The only option for individuals with developmental disabilities who are in a behavioral crisis is for community psychiatrists to get involved. The psychiatrist will provide a psychiatric diagnosis and treat but the only placement options are to return the individual to the CILA home and pursue short term stabilization or judicial admission to a SODC. For placement in a short-term stabilization home, a referral is made to another crisis prevention agency who will observe and evaluate the individual. They take referrals on Monday mornings but often make recommendations and conduct staff trainings before referring the individual to a stabilization home and they are only placed there if the agency feels they can stabilize the individual and return him/her to a CILA home. The CILA home must agree to take individuals back before they can be placed in the stabilization home and even then, there is a waiting list before they can be placed.

This recipient was admitted to the CILA home as an emergency placement on September 27, 2016 and had been stable until January 2018. When asked if the recipient was diagnosed with only developmental disabilities or was dually diagnosed with mental illness the caseworker informed the HRA that according to his CILA home, he had a diagnosis of schizophrenia, bipolar disorder and intermittent explosive disorder. In February 2016 a psychiatrist he saw in jail diagnosed him with antisocial personality and disruptive behavior. In July 2016 a psychiatrist diagnosed him with schizophrenia, ADHD, depression and bipolar disorder. The following was the recount of this crisis episode according to the caseworker: The recipient had been on Vyvanse medication which was removed due to his age prior to this behavioral crisis. He had gained 16-20 pounds in a month and was not able to follow his routine. He was also overstimulated and experiencing hallucinations. His psychiatrist said to take him to the hospital ED. While there, the recipient hallucinated, was speaking in different languages and thought he was a dog. The CILA home nurse contacted the caseworker on January 9th and advised that he threatened to rape staff and was being taken to the ED. He had been placed back on the Vyvanse medication a few days before this episode due to the weight gain and other issues he had since it was discontinued. He had a follow up appointment scheduled with his psychiatrist but went into crisis and was told to go to the ED to obtain placement clearance for a psychiatric unit of a community hospital. However, he was denied admission to that unit an hour before he was to be released because he became oriented again, but the following day he relapsed. His psychiatrist saw him on January 11th and took him off Buspar and Vyvanse medications and started him on Haldol and Ativan. He went home from this appointment and declined mentally. On January 12th the caseworker checked on him and he was not calm, had "jumped staff" and pulled fire alarms. The psychiatrist advised staff to contact 911 and pursue psychiatric admission. He was denied admission to the psychiatric unit again due to being "too acute and too violent." On January 13th the caseworker called the CILA home and was informed he was still at the hospital ED and that a facility in Chicago had denied placement and so had Choate. The AOD at Choate had told the community crisis worker to contact another crisis prevention agency for assistance and had mentioned he could possibly be placed at Choate the following Tuesday. The caseworker confirmed that the residential side of Choate must have authorization from DHS in Springfield to admit individuals and that only occurs during regular business hours. The ED

physician had said that the recipient needed to be discharged as there was no medical reason to hold him and he went home around 11:00 pm. to await placement at Choate which was supposed to occur the following Tuesday. On January 26th the recipient was still at the CILA home and punched staff in the face and asked to go to the hospital ED. 911 was called and he was taken to jail. The community crisis prevention agency became involved on January 30th. On February 1st he was in court and the judge released him back to his CILA home. The recipient declined significantly. He would not eat or get out of bed, was incontinent, when he did eat he "dumped food into his mouth," and he drank a dozen eggs that staff had placed in a bowl to scramble. There were at least 2-3 conference calls held between this case coordination agency, the CILA home, DHS and other consultants regarding appropriate placement and SODC availability. The crisis prevention agency was also seeing him and trying to help stabilize him in his home until a placement could be secured. On March 6th he was finally admitted to Choate, but the caseworker was unsure to which unit he was admitted.

The Director and caseworker from the case coordination agency both explained how there is no recourse for DD Crisis treatment on weekends unless a recipient is already established with the community crisis prevention agency. It they are not, the only available options are to take the recipient to the hospital EDs, jail or the CILA homes must use their resources to try to manage the recipient through the weekend. The Director explained that the last few years it has become harder to admit individuals to a SODC. Community mental health agencies will not see an individual if they have a developmental disability and they tell families and guardians to contact the case coordination agency. However, the case coordination agency does not do mental health screenings for psychotic episodes as they are not qualified to do so. Their screenings are only for long term care for those not already in services that need services.

Chart Review:

The Pre-Screening Assessment for Psychiatric Hospitalization dated 1/9/18 was completed by the crisis worker and documented that the recipient *"grabbed multiple staff members on the butt stating that he was going to rape them. Experiencing auditory/visual hallucinations…talks to the wall as if someone/something is there…. narrative diagnosis schizophrenia."* It was also documented that he was a risk of harm to self or others and there were 7 current medications listed. The initial time of service was 7:40 p.m. until 10:15 p.m. The crisis plan was to follow up with mental health services and to keep an appointment with a psychiatrist at the crisis agency for his mental needs. It was noted that the client *"gave minimum feedback due to his moderate intellectual disability."* This same form dated 1/10/18 completed by a second crisis worker documented the recipient was referred for *"aggressive behaviors, harm to others…decreased ability in self-care…client had become verbally aggressive with staff at the facility he lives at. He then tried to disturb his neighbors by knocking on the doors and pulling the fire alarm. He was also having auditory hallucinations…became sexually aggressive towards a female staff member…talking to no one."* The recommendation was to return home and see his doctor on 1/11/18 to seek hospitalization and have a medication adjustment. There were 3 medications listed. The next form dated 1/12/18 was completed by the QMHP and documented *"physical aggression, auditory visual hallucinations, risk of harm to self or others, decreased ability in self-care, increase in stressful environment, evidence of co-existing psychiatric disorder…became physically aggressive with staff, inappropriately touching staff in private*

area, pulled fire alarm twice, very aggressive police called to home he was transported to [hospital]" The recommendation was for hospitalization and it was documented that all involved wanted the recipient to be hospitalized to seek treatment for anger and physical aggression. There were 8 medications listed. The same form dated 1/13/18 was completed by a fourth crisis worker and documented that the recipient was exhibiting "physical aggression, auditory, visual hallucinations ... laughs inappropriately and talks to self." His medical information listed diagnoses as ADHD, Oppositional Defiant Disorder, Autism, Bipolar Disorder, Schizophrenia, intermittent explosive disorder and mild intellectual disability. It was documented that he was a risk of harm to self or others, had decreased ability in self-care, increase in stressful environment, evidence of co-existing medical illness, and substance use disorder or psychiatric disorder. The Crisis plan documented that he was having auditory and visual hallucinations and became physically aggressive with staff. It was also listed that the resident inappropriately touched staff "in private area," pulled the fire alarm twice and was very aggressive. The police were called to the home and the client was transported to a hospital ED. The recommendation noted that the worker observed and sat with the client until a hospital could be confirmed. Multiple hospitals were contacted that denied the client and the worker awaited further instruction from the QMHP. The medications listed on the assessment were Haldol and Ativan. Upon second screening, the client showed no signs of aggressive behavior and cooperated with the staff and crisis worker. The recommendations listed were to follow up with mental health services and a psychiatrist and continue to receive services from his CILA home. It was noted that he had been referred to Choate and the CILA home was to follow up on Tuesday, January 16th regarding services.

Initial Pre-Screening Information Form was completed by the QMRP on Saturday, 1/13/18. This form documented at 10:20 a.m. that 16 hospitals had declined the resident. This was the third time he had been "in crisis" that week. The latest crisis incident was described as "hitting staff in the face, threats to rape them, hitting walls and doors and grabbing female staffs butts." The recipient was removed from the CILA home by law enforcement and it was documented that he was "calm at present." His diagnoses were listed on this form as ADHD and Schizophrenia. The worker had documented that he was "On a ton of meds" and has only escalated. The plan was that if he declines further, they will have to send him back to the group home because no placement had been secured. He was described as "laughing inappropriately, doesn't know what raping someone really means, doesn't know what else to do, doesn't feel like he meets criteria. [for admission to Choate]." The worker documented at 10:45 that she had spoken to two AOD's at Choate and one stated that they "followed our DD Placement policy." The other was going to contact the supervisor at the counseling agency. Other forms completed this day indicated that the plan following that conversation was to send the recipient back to the CILA home until he could be admitted into Choate the following Tuesday during regular business hours because Monday was also a holiday.

Policy Review

The Developmental Center Admission Policy SOPP.0455 states that:

"All admissions to Clyde L. Choate Developmental Center 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. Admission Status: Admission to the center shall be available on the basis of need. The type of admission, level of services, and/or determination of legal competence shall be separate from the determination of the individual's need for 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/transition 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."

The Pre-admission process is described as:

"1. Pre-admission evaluations concerning individuals seeking admission shall be coordinated through the DHS Deputy Directors office and the Clyde L. Choate Developmental Center Director, or designee…3. Once pre-admission evaluations have been reviewed and approved by the DHS Deputy Directors office, the pre-admission information is reviewed by an Interdisciplinary Team consisting of a physician, nurse, psychologist, social worker, personal services coordinator and unit director to ensure the individual is 1)eligible for services based on the strengths, abilities, needs and preferences of the persons served, 2) that the individuals immediate and urgent needs have been identified and 3) the center is able to provide services in accord with the individuals identified needs. A recommendation regarding acceptance is made to the Center Director. 4. Following the completion of a Pre-admission Evaluation, and acceptance of an individual to Clyde L. Choate Developmental Center, admission to the Center should occur as soon as possible..."

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 HRA requested additional admissions policies that might specifically address judicial or emergency admissions. The Director informed the HRA that there is not a policy, but the facility follows the Mental Health Code. The Director also provided the HRA with a copy of the online training materials used regarding emergency admissions. The training materials included a page which states that a person with developmental disabilities may be admitted as an emergency admission if the person is 1) developmentally disabled 2) reasonably expected to inflict serious physical harm upon self or another in the near future and 3) immediate admission is necessary to prevent such harm.

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 5/4-201 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 disability 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 year 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.* (see below)

Section 5/4-311 of the Code states that *"(a) A person with a developmental disability may be temporarily admitted to a facility for respite care intended for the benefit of the parent or guardian, or in the event of a crisis, care where immediate temporary residential services are necessary, upon application by a person empowered to make application for administrative admission, if the facility director determines that the individual is suitable for temporary admission. The application shall describe the person's developmental disability and shall conform with the provisions of paragraph (a) of Section 4-301..."*

Section 5/4-401 of the Code provides that *"A petition for emergency admission may be submitted to the facility director of a facility by any interested person 18 years of age or older. The petition shall include a detailed statement of the basis for the assertion that the respondent meets the*

criteria of Section 4-400 including a description of any act or significant threat supporting the assertion; the name and address of the spouse, parent, guardian, and close relative or, if none, any known friend of the respondent; a statement of the petitioner's relationship to the respondent and interest in the matter; the name, address and phone number of any witness by which the facts asserted may be proved. The petition may be prepared by the facility director of a facility."

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 1-107 defines *"Developmental disability facility" as "a facility or section thereof which is licensed or operated by or under contract with the State or a political subdivision thereof and which admits persons with a developmental disability for residential and habilitation services."*

Section 5/4-404 provides that "*A peace officer may take a person into custody and transport him to a facility when, because 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 a recipient was inappropriately denied admission to the facility. The issue was that this recipient had been in crisis for about a week and in and out of the community hospital at least 3 times during that time. The community crisis counseling agency had great difficulty finding him placement. After he was refused by at least 16 hospitals, the case worker tried placement at Choate on a Saturday and was told that admission could only occur during regular business hours, and the following Monday was also a holiday, therefore the recipient

could not be admitted until Tuesday. The recipient was returned to the CILA home and eventually administered more medication by his community psychiatrist which sedated him until placement could be secured in a more appropriate setting. Choate's admission policy for the developmental disabilities (DD) unit did not address emergency or judicial admissions only regular residential admissions. The Director informed the HRA that there was no formal policy for judicial or emergency admissions but stated that they follow the Mental Health Code guidelines and provided the HRA with a copy of the training materials used which listed emergency admission as one type. However, the case coordination agency, as well as Choate Administration, advised the HRA that admissions to the DD unit are considered a residential placement and not crisis stabilization, therefore, admissions must be approved by the DHS. The case coordination agency informed the HRA that in crisis situations involving recipients with developmental disabilities, there are not many options after hours, especially if the crisis prevention agency is not already involved in their treatment. There are a few short-term stabilization beds near the Springfield area, but there is usually a waiting list for those and the referral must come from the crisis prevention agency. The crisis prevention agency only takes new referrals on Mondays, according to the case coordination agency. The only option after hours and on weekends is to return the individual to their CILA or family home until a more appropriate placement can be obtained. The Mental Health Code does have provisions for crisis placement for individuals with developmental disabilities through judicial, emergency or temporary admission to a state operated facility. The Code (405 ILCS 5/4-400) states that "*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."* The recipient in this case is diagnosed with a developmental disability. He had made threats of harm towards staff at his CILA home, had touched staff inappropriately and had repeated episodes of maladaptive behaviors which required emergency department visits. The recipient's care givers and crisis workers had concerns over recent medication changes that could have prompted the maladaptive behaviors and discussed this with Choate staff. The crisis workers agreed that he met criteria for admission and medication stabilization, but the recipient was unable to access to community resources and placement at Choate was denied because it was a weekend. Section 5/4-311 of the Code provides for admission due to a recipient in the community being in crisis without regard to business hours, holidays or weekends. Section 5/4-401 of the Code provides that *"A petition for emergency admission may be submitted to the facility director of a facility by any interested person 18 years of age or older."* The Code also allows for a peace officer to take a respondent into custody and transport him to a developmental disabilities facility either following a petition and certificate completion (Section 5/4-403) or because of the officer's personal observation and having reasonable grounds to believe that the person meets the standard for emergency admission. Upon arrival at the facility, the peace officer can complete a petition for emergency admission. (Section 5/4-404). Since the Mental Health Code has provisions that allow emergency admissions, but Choate's admission policy does not address emergency admissions and only accepts admissions to the DD unit during regular business hours, after approval from the DHS, this allegation is **substantiated**. The following **recommendations** are made:

1. **Choate's admission policy should be revised to align with the provisions and requirements under the Mental Health Code that allow for emergency placement (405 ILCS 5/4-311; 5/4-400; 5/4-401; 5/4-403; 5/4-404)**

2. **Staff should be trained on the revised policy and requirements under the Mental Health Code.**

The HRA also offers the following suggestions:

1. Consider developing formal agreements with community hospitals and crisis agencies to ensure a continuum of service provision.

2. Work with the DHS/DMH to develop a plan for patient stabilization in crisis situations when the state operated facilities are at maximum census.

3. Cease in providing advice to "contact police" regarding individuals in crisis. A jail is not an appropriate setting for an individual experiencing symptoms of mental illness or one with developmental disabilities in a behavioral crisis and should not be criminalized. Additionally, cease in providing the advice that an individual with symptoms of mental illness should be detained in an emergency room. Again, this is not an appropriate setting for an individual with symptoms associated with mental illness and detaining an individual without following the commitment process and the associated mandated timelines would be out of compliance with the Code. The HRA is deeply concerned that this guidance was offered by staff at Choate.

4. Consult with DHS and the PAS agency regarding the establishment of protocol for making referrals to the crisis stabilization beds as an alternative if Choate admission is denied subsequent to repeated denials from hospitals, including accessing PAS agencies to facilitate crisis referrals regardless of PAS business hours, holidays, weekends or PAS protocol for non-emergencies.