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Egyptian Regional Human Rights Authority
Centerstone
Report of Findings
Case #21-110-9012
March 23, 2022

The Egyptian Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission voted to pursue an investigation of Centerstone after receiving the following complaints of possible rights violations:

Complaints:

1. **Inadequate treatment**

If the allegations are substantiated, they would violate protections under The Mental Health and Developmental Disabilities Code (405 Ill. Comp. Stat. Ann. 5/2-102), the Mental Health Community Service Act (59 Ill. Admin Code 132.30) and The Code of Federal Regulations (42 CFR 485.914).

Complaint Summary: The compliant states the individual was attending a 10-day inpatient crisis stabilization unit at the facility. Allegedly, the individual was discharged prior to the completion of the 10-day program due to the individual's behaviors which the individual denies.

Investigation:

The HRA proceeded with the investigation after having received proper consent. To pursue the matter, the HRA met with staff and the program representatives were interviewed. Relevant practices, policies and sections of the consumer's record were reviewed.

Interviews:

Centerstone is a not-for-profit Community Mental Health Center (CMHC). The types of services Centerstone provides includes residential programs, inpatient treatment, outpatient treatment, and counseling. Staff stated that Centerstone has a Crisis Stabilization Unit (CSU) which provides inpatient mental health care. The CSU provides a lower level of care than a psychiatric facility. Patients can stay up to 10 days at the CSU. Patients in the CSU work on coping and life skills. Furthermore, the patients speak with a psychiatrist and receive medication while at the CSU. Patients can be refereed to the CSU from Centerstone's Mobile Crisis Unit (MCU). Additionally, patients can be referred to the CSU after attending an inpatient psychiatric stay to help the patient transition back to the community. The individual was in the CSU in Cartersville, IL for a stay of up to 10 days.

Staff stated verbal aggression, physical aggression, refusal to participate two or more times and medication refusal are all criteria for early discharge. Patients must be willing to participate. If a patient wants discharged, they can be, but staff ensure the patient is safe and stable before they leave. If a patient chooses to be discharged, then a crisis resource developer provides follow up services. Staff stated upon discharge they take inventory of all belongings including medication and a discharge summary is provided to the patient. Staff stated they assist the patient in finding transportation and have paid for public transportation for patients in the

past utilizing petty cash. Furthermore, if a patient is deemed a danger to themselves or others upon discharge then the police may be called.

Patients in the CSU self-administer medication. Staff lock the medication and give access to the patient when it is time to administer. Staff advised that the individual has been admitted to the CSU twice and has ongoing treatment with a counselor at Centerstone. In November 2021, the individual was admitted into the CSU after being referred by the Mobile Crisis Unit (MCU). Initially the individual was cooperative, motivated for treatment, and would take her medication. Staff kept the medication locked up until it was time for the individual to take her medication. One day staff asked the individual what medication she was taking, solely to ensure she was taking the correct medication, and the individual became upset, started cussing and threw the medication bottle against the wall. The individual refused medications at least 3 times. Staff reminded the individual that she could be discharged early if she continued to refuse her medication. Staff advised that the individual refused to take Xanax and Zofran, claiming it made her tired. Staff stated they documented anytime the individual refused medication. Staff stated they contacted the manager of the CSU, at home, and advised her of the situation. The manager directed staff to discharge the individual if the behaviors continued.

Staff advised that the individual contacted her daughter and while one the phone, the individual was mocking staff. Additionally, the individual was making verbal threats towards staff. Staff contacted the MCU to meet with the individual and speak with her about her behavior. The individual was cooperative with MCU staff and denied behaviors with CSU staff. MCU staff recommended the individual be discharged but the individual refused to leave until a supervisor told her to leave. Staff advised there was not a supervisor on staff since it was a weekend. However, the manager of CSU had already advised to discharge the individual if the behaviors continued. The police were contacted since the individual was refusing to leave. However, once the individual's daughter arrived, the individual became cooperative and left with her daughter.

Policy Review:

Centerstone's website states "this 8-bed facility provides a short-term stay (up to 5 days) for individuals needing additional stabilization services following a behavioral health crisis. Guests must consent to receive services because the CSU is a voluntary facility. The CSU provides step-down services for individuals discharging from psychiatric facilities who need additional support prior to returning home. While at the CSU, guests receive individual counseling, a complete mental health assessment, case management services and connection to local resources…"

The HRA reviewed the CSU's house rules which was signed by the individual and witnessed by staff. The house rules stated "…Lack of participation in the treatment program or dismissal of safety procedures could result in discharge form the CSU. Any acts of theft will be investigated and if found could result in discharge from CSU. The threat of violence, acts of violence-including verbal abuse or aggression, are prohibited and could result in immediate discharge. Physical gestures or acts as well as verbal suggestions or threats of a sexual nature are prohibited and could result in immediate discharge from the CSU. Behaviors that could cause physical or emotional harm to others could result in discharge from the CSU…".

The HRA received a copy of the CSU's non-compliance with treatment practice update that is dated 2/3/2020 which states "Consistent with the Crisis goal of continuous quality improvement, a review of current Non-Compliance with Treatment procedures has been completed. Current Practice: All clients must be compliant with treatment, including taking medication as prescribed and participating in intervention while staying at the unit. 2) Refusal of medication must be documented on the medication sheet…If a client refused crisis intervention services, it could result in being discharged from the unit. 2 declines for intervention initiates the conversation with client about participating in services and the consequence of not participating. 3 declines is when the Recovery specialist should consult with supervisors to see if discharge is warranted."

The HRA reviewed the CSU's "Threatening Behaviors of Property Destruction" policy which stated "…The threat of violence, acts of violence – including verbal abuse or aggression, are prohibited and could result in immediate discharge. Physical gestures of acts, as well as verbal suggestions or threats are prohibited and could result in immediate discharge. Behaviors that could cause physical or emotional harm to other could result in immediate discharge…"

Progress Notes Review:

The HRA reviewed progress notes for the individual. The note dated 11/18/2020 stated "Mitigated a crisis with [individual] as [staff] called her and let it ring only once or twice before hanging up. [Individual] became frustrated and started cussing and throwing papers around in her room. Worked with staff to stabilize [individual] and intervene, successfully de-escalating the situation…".

On 11/19/2020 the note stated "…. She said things are going well at the CSU. The staff are helping her to apply for housing and SSI, and more. She said her big stressor is being homeless and dealing with medical issues…".

On 11/20/2020 the note stated "This writer offered for client to participate in a group activity. Client refused." Furthermore, another note stated "This writer offered client a session along with a phone number for a case manger that could potentially help allocating resources. Client refused." Another note stated "client denied wanting to participate in session. 'maybe in a little bit', Writer asked again, but client denied session again."

Individual Notes Review

The HRA reviewed "individual notes" for the individual. The note dated 11/4/2020 stated "Client expressed that when she left the CSU she was still homeless. Client stated that she remained sober and recently applied for disability but has no income at this time… Client stated that she is exhausted because she's sought help in every way she knows how, and that she needs somebody to hear her voice. Client expressed that she doesn't understand how Centerstone just received a 2.2-million-dollar grant but can't help somebody get housing."

The note dated 11/15/2020 stated "Client actively participated in session. Client's daily goal was stay awake and organize my things, prepare for tomorrow, and take a shower."

On 11/16/2020 the note stated "This nurse met with client to discuss medications, effectiveness, and any side effects, moods, sleep, appetite, and any thoughts of SI/HI (self-injury/homicidal ideation) client was open and responded appropriately. Client reports that she is unsure of the effectiveness of her meds. She reports that she didn't want to take her alprazolam this morning because it made her so sleepy last night. She stated that when she takes Topamax, it makes her itch and break out in a rash. Client declined to take her Zofran this morning stating that she does not feel nauseous and that it makes her tired as well. Client denies any other side effects from any other medications at this time. She described her mood as tired and stated that she has slept most of the time she been here at the CSU. Client says her appetite has been poor recently. She denies any thoughts of SI/HI (self-injury/homicidal ideation) at this time." Furthermore, another note dated 11/16/2020 stated "[Individual] verbally indicated frustration and agitated 'I just am so confused'. I don't know what to do. I can't think. I need to take my Xanax' This writer utilizes verbal de-escalation techniques, including validation and redirection. [Individual] was receptive and decided not to take medication…".

The note dated 11/17/2020 stated "This writer provided [Individual] with access to morning medications. [Individual] reported feeling nauseous and wanted to take her Zofran and return to bed. [Individual] took AM medications as prescribed in my presence…[Individual] declined to take AM dose of Xanax 'I'm not anxious, it makes me tired.'."

On 11/18/2020 the individual note stated "Client was open and responded appropriately. She discussed history of trauma and her current medications. Client reports that Zoloft works well for her and she does not feel

depressed. Client reports feeling very overwhelmed due to not having a safe place to go upon discharge from the CSU. Client reports getting adequate sleep while here at the CSU, but only 2-3 hours outside of here due to felling unsafe. Client reports that taking 2 mg of Prazosin has been effective for her sleep."

On 11/20/2020 the note stated "Client was open and responded appropriately. Client reports that her medications are effective. She declined taking her morning dose of Xanax stating that it makes her sleepy. She denied any other side effects. She says that her mood is okay today and that she slept okay last night. Client reports having a fair appetite. She denies any SI/HI at this time."

The Individual note on 11/21/2020 stated "This writer provided client with access to morning medications. When client was provided access, client became upset that staff asked what pills she grabbed from her box and took. This writer then tried to de-escalate client and prompted her that if she continued to curse, refuse treatment (2 documented refusals in chart already, not counting the refusals with other staff), and threaten staff that she could be discharged… client began to yell and exclaimed, that 'this is for my fucking PMS there's a sheet in there!' Staff told client that they just had to make sure which medication it was for documentation purposes. Client stated 'do you really wanna start this shit with me? I'm not the one to fucking mess with.' Client stated, 'I've been documenting everything you fuckers do, why didn't I get my clipboard at 10:15am yesterday?' Client stated, 'I want to talk to a supervisor.' Client stated that she has been participating in sessions and followed all the rules. Client then left the med office and yelled, 'didn't do my journal either'." Furthermore, the note stated, "client will D/C (discharge) if they continue to behave in an aggressive manner and refuse treatment."

Another note dated 11/21/2020 stated "After conferring with management, this writer approached client with fellow staff to communicate to client that if there were any other threatening behaviors, name calling, or lack of participation going further that we could immediately discharge. When client continued behaving in this manner, mocking staff and stating that she did none of the preceding behaviors that lead to this point staff began D/C process." Furthermore, another note stated "This writer completed D/C (discharge) process due to client continuing to curse, be dishonest about prior behaviors including being verbally aggressive towards staff, and refusal to participate in treatment. Client was non-compliant throughout the process and was escorted out by the police.

Records Review:

The HRA reviewed a re-assessment done on the indiduval on 11/21/2020 which stated "…writer was informed from CSU employee the following information: [individual] was amplifying threating behaviors, mocking /being rude towards staff, and threw her pill bottles. Writer was informed from [staff] that the police were involved to escort [individual] out of the CSU, and that she was not allowed back to the CSU after discharge. [Individual] reported the following information to writer: 'I had a bad day yesterday, and I didn't participate in the volleyball icebreaker game' …Writer consulted with [staff] at the CSU regarding writer's disposition after the mental health assessment. Writer and [staff] agreed that [individual] was appropriate for discharge from services at the CSU."

Conclusions

Complaint 1. Inadequate treatment

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

treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan."

The Mental Health Community Service Act (59 Ill. Admin Code 132.30) states "To assure that a client's rights are protected and that all services provided to clients comply with the law, all providers under this Part shall ensure that: a) A client's rights shall be protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code [405 ILCS 5]…3) The right to be free from abuse, neglect and exploitation. 4) The right to be provided mental health services in the least restrictive setting…"

The Code of Federal Regulations (42 CFR 485.914) states "…If a client refuses the services of a CMHC, or is discharged from a CMHC due to noncompliance with the treatment plan, the CMHC must forward to the primary health care provider (if any) a copy of— (i) The CMHC discharge summary. (ii) The client's clinical record, if requested…".

The individual was admitted into the Crisis Stabilization Unit (CSU) of the facility. Patients admitted into the CSU can stay up to 10 days. The CSU program is voluntary, and patients must be willing to participate in the program. The individual reviewed and signed a copy of the house rules which stated "…The threat of violence, acts of violence-including verbal abuse or aggression, are prohibited and could result in immediate discharge." The individual became aggressive and was threating staff. Additionally, the individual threw her medication bottle against the wall when asked what medications she was taking. Furthermore, the CSU's non-compliance with treatment policy stated, "All clients must be compliant with treatment, including taking medication as prescribed and participating in intervention while staying at the unit." The individual refused medication on more than one occasion and refused to participate in treatment. The individual was advised she may be discharged if she continued refusing medication, treatment, and threatening staff. The individual did not change her behavior and continued to be non-complaint with treatment. As a result, the individual was discharged from the program. The HRA found no regulations stating that an individual participating in this program could not be discharged for not following the agreed rules.

Based on the findings above as documented in the individual's record, the Egyptian Human Rights Authority concludes that the consumer's rights were not violated. Therefore, the complaint of inadequate treatment is **unsubstantiated.**

This was a situation where the individual was voluntary and did not follow the rules that she was requested to follow to receive treatment. This does not mean that the individual did not need treatment, and her actions and behaviors indicated that more treatment was needed than the facility could provide. The HRA is disappointed that the facility did not transfer her to another facility or make more of an effort to help this patient with any discharge instructions or referrals. The HRA **strongly suggests** Centerstone consider referring patients, who become aggressive, to other programs to get further help. Additionally, the CMS regulations state that the patient's primary health provider must receive a copy of the discharge summary and clinical record, if requested. The HRA saw no evidence that this occurred. If it did not, the HRA **strongly suggests** the facility start the practice to be in compliance with 42 CFR 485.914