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Egyptian Regional Human Rights Authority
Chester Mental Health
Report of Findings
Case #22-110-9015

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

Complaints:

1. **Inadequate treatment including inadequate treatment planning**

If the allegations are substantiated, they would violate protections under The Mental Health and Disabilities Code (405 Ill. Comp. Stat. Ann. 5/2-102 and 405 ILCS 5/2-107).

Complaint Summary: The complaint alleges the facility filed a petition for involuntary medication when the individual was not aggressive or a threat to himself or others. Allegedly, the individual was not aware of the criteria for discharge.

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:

The HRA interviewed the individual's social worker. The social worker stated the individual was paranoid and guarded. The individual believed he had many wives. The social worker stated the individual was verbally aggressive. The individual made threats towards staff when they attempted to redirect him from eating out of the trash. The individual denied the incident when meeting with the team. The social worker advised Chester filed a petition for court enforced medications due to the individual's delusions and refusal of psychotropic medication that would help him attain fitness. The social worker stated the individual was started on medication in January 2022 and passed the fitness test on 3/2/22.

Policy Review:

The HRA reviewed Chester's "Use of Psychotropic Medication" policy which states "Prior to prescribing psychotropic medication in non-emergency situations, the treating physician shall ascertain and document whether the individual is capable of giving informed consent. This documentation shall be included in the consent form as a statement regarding recipient's capacity to make a reasoned decision about the proposed

treatment. The basic standard for decisional capacity shall include knowing that one is being offered treatment by a doctor in a hospital setting with the understanding that this treatment may be helpful and may have side effect. Prior to administration of medication, the nurse must have the completed consent form CMHC-535 consent to Psychotropic Medication in the patient's clinical file and must give the patient medication information sheets about the medication, noting the medication prescribed, and review appropriate information with the patient … Regarding refusal of medication: Emergency medication to prevent an individual from causing serious and imminent physical harm to self or others and no less restrictive alternative is available. The physician and RN initiating the use of emergency medication shall give the patient, guardian, or substitute decision maker, if any, notice of alternate services available and the risks of such alternate services, as well as the possible consequences to the patient of refusal of such services … emergency medication shall not be administered for a period in excess of seventy-two hours, unless a Petition for the Administration of Authorized Involuntary Treatment has been completed. A notice regarding restricting rights of individuals shall be completed for emergency medication administration. All refusals of psychotropic medication shall be documented on the Psychotropic Medication Refusal form CMHC-748 and in the progress notes by the nurse … the nursing supervisor shall give CMHC-748 to the patient's treating psychiatrist for review. The treating psychiatrist shall determine if the patient meets the criteria for court enforced involuntary medication. Issues regarding psychotropic medication refusals shall be discussed with or by the treatment team during the unit morning report …".

The HRA reviewed Chester's "Guidelines for the Treatment of Patients with Severe Maladaptive Behaviors" that states "Treatment prescribed in a patient's treatment plan addressing the goal of managing or extinguishing maladaptive behaviors and promoting adaptive replacement behaviors will be identified in the treatment plan as a Behavior Intervention Plan. It will include the following: Definition of the target behavior; a hypothesis on the function of the behavior; Identifying a goal and objectives for the patient to achieve; including the replacement of the behavior with a more adaptive one, interventions should include the method of implementation, strategy, support, teaching methods, motivation and reward is used, frequency, and circumstances under which the plan will be implemented; a condition of discontinuation; all interventions attempted; data collection in order to monitor response to treatment …The patient will be offered alternative ways to cope with situations that result in the unwanted or maladaptive behavior. These skills may be taught in individual or group therapies, rehabilitation classes or activity therapies….".

A review of the "Patient Rights" policy states "a patient shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual treatment plan … Individuals and the individual's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or ECT (Electro-Convulsive Therapy) … Individuals shall not be subject to treatment by unusual, hazardous, or experimental therapies without the individual's consent. Such treatment shall follow applicable federal or State statues or regulations….".

The HRA reviewed Chester's "Treatment plan" policy that states "Treatment planning is an ongoing process in which problem goals, objectives, and interventions are identified and monitored. The multi-disciplinary treatment planning process is to be documented upon admission and throughout a patient's stay via assessments, treatment plan, treatment plan review, progress notes and other documentation. Treatment Plan Development: within 8 hours the admitting nurse and physician identify problems, goals, objectives, interventions, and discharge recommendations for the patient, based upon the initial assessments, the pre-placement evaluation, and referral documents from previous placement. The nurse completes the admission treatment plan within 8 hours. A copy of the patient's initial core schedule of groups and activities is given to the patient by the nurse during intake, after the admission treatment plan is completed… The treatment plan coordinator develops the multi-disciplinary treatment plan for a 72-hour review based upon the nursing, psychiatric, and social services assessments, and recommendations from the team, and in collaboration with the patient. This 72-hour treatment plan must be entered into the record within 2 working days of the meeting. Treatment plan reviews 21 days: The treatment plan is to be completed 21 days after the deployment of the 72 hours treatment plan along with the

treatment plan review and filed in the chart within 7 working days… Monthly: a treatment plan review is to be completed using a minimum of every 30 days beginning at the 21-day review and filed in the chart within 7 working days… Each person attending the treatment plan review will sign in with signature and title on the treatment plan/review attendance record… It is the responsibility of all disciplines to participate in the development of a multidisciplinary treatment plan. It is the responsibility of the primary therapist to serve as the coordinator of the treatment plan, ensuring the following: treatment plan meetings happen within all the required time frames. All discipline input is gathered and utilized for treatment plan reviews. The plan is comprehensive and individualized based upon the assessment of the individual's clinical needs, strengths and limitations and is written in behaviorally defined and measurable terms. The treatment plan reflects current treatment. The patient is given a daily schedule of assigned groups and activities based on the interventions assigned in the treatment plan… If the patient has a guardian, the therapist will notify the guardian of all scheduled meetings and this will be documented in a progress note, and a copy of the treatment plan will be mailed to the guardian. Individuals are encouraged to involve their family or support system to participate in treatment planning…".

Records Review:

The HRA reviewed a "Psychological evaluation" of the individual dated 12/11/2021. The evaluation states "[Individual] was referred for psychological evaluation on 12/7/21 by CMHC (Chester Mental Health Center) due to suspected malingering. He was tried and found guilty, but then found Unfit to be Sentenced. [Individual] is not prescribed medication at CMHC. Despite this, he is compliant with rules and direction overall. Given CMHC concerns, an evaluation was conducted to evaluate for malingering…. His mental status exam was significant for delusional and disorganized thought but not hallucinations. He was found to be hyperverbal and grandiose with impaired cognition, comprehension, judgment, insight, and attention/concentration. He also was found unable to assist counsel in his defense/unit for trial sentencing at this time. Primary diagnoses were delusional disorder and r/o (rule out) schizophrenia. Secondary diagnoses included substance use disorders. He was refusing neuroleptic medication at admission. His comprehensive social work assessment reported [Individual] was found guilty of multiple paranoid delusions and schizotypal personality. [Individual] has contradictions in his history consistent with malingering, including presenting as hyperverbal and grandiose with impaired cognition, comprehension, judgement, insight, and attention/concentration on his IPE [Independent Psychological Evaluation] despite having nearly average intellect and intact comprehension and attention/concentration during the current evaluation…".

The HRA reviewed the individual's treatment plan dated 10/19/21 that states "[Individual] attended his TPR (treatment plan review). Since admission he has had no behavioral issues or aggression. He appears to have delusional and grandiose thoughts. He states he has multiple wives and hundreds of children. He is religiously preoccupied and stated he does not need medication because 'Allah' is the only drug he needs. He has taken the fitness test multiple times since his admission and has not passed. [Individual] continues to state he does not have felony charges, and that he has been charged with a minor misdemeanor offense. It is unclear at this time if he is attempting to avoid returning to court. A referral for psychological testing has been made… Problem #1: Psychosis and Aggression… [Individual] is adamant that he is not mentally ill and does not need medication, His thoughts appear grandiose and delusional. No aggression or agitation since admission. He does present as passive aggressive, especially when discussion [sic] his charges…Problem #2 Unfit to Be Sentenced…[Individual] appears to have a poor understanding of the severity of his charges. He reports he has been charged with 'minor traffic violation'…Problem #3 Substance Abuse/Drug Abuse. [Individual] minimizes past drug use. Will not engage in discussion. Problem #4 History of suicidal ideations and self-injurious behavior…Problem #5 History of Previous Hospitalizations, Numerous Arrests. Will not engage at this time…Criteria for separation: In order to be recommended for return to [jail] for a fitness hearing, [Individual] should meet the criteria for Fitness including the following: A) be able to communicate with counsel and assist in his own defense; B) be able to appreciate his presence in relation to time, place, and things; C) be able to understand that he is in a court of justice charged with a criminal offense; D) show an understanding of his charges and their consequences, as well as court procedures, and the roles of the judge, jury, prosecutor, and

defense attorney; E) have sufficient memory to relate the circumstance of the alleged criminal offense; and F) and not demonstrate any aggressive behavior. Discharge plan: [Individual] has been convicted and is waiting sentencing. He is facing prison time and is currently on parole…".

The treatment plan for the individual dated 12/14/21 states "…On 11/17 [Individual] became agitated and began to scream 'I'll fucking kill all of you!' He then went to his room and screamed 'I'm going to my room to kill Satan.' Staff reported it appeared he was talking to someone who was not present. When the team discussed then [sic] incident with his [sic] he denied. Does not like to follow rules. He believes he is the son of God and can do whatever he pleases. He doesn't like to listen to staff."

The HRA reviewed the "Petition for Administration of Enforced Medication" for the individual dated 1/6/2022 that states "[Individual] is a 36-year-old male who was found Unfit to Stand Sentencing in [county] on charges of Aggravated DUI… He has had 3 prior psych hospitalizations for suicidal ideations at [facility]. He denies taking any psych medications, but per records, he used to be on Zoloft, Buspar, Thorazine, and Remeron, when he was at [correctional center]. He has been anxious, irritable, agitated, angry, threatening to kill staff, impulsive, delusional, he believes that he has five thousand children and takes care of them. He does not know their addresses or where abouts. He has been paranoid, suspicious, and hostile. He easily becomes agitated; he goes to garbage cans and dig into them and find things. He has difficulty to redirect, also has difficulty to follow rules and regulations of the unit. He refuses to take medications to improve/control his mood problems or psychosis…".

The HRA reviewed "Patient's Complaint Form" for the individual on 2/11/22 and 2/12/22. The complaint on 2/11/12 states "I [Individual] was forced to take a medication. I do not agree by it being excessive force and without my consent…told by nurse and staff that I have to take medication or receive a shot to further degrade me…". The complaint on 2/12/22 states "Against my consent I am being forced to take psychotropic drugs that are making me suffer and violates my religious practices… I am not a harm to myself or anyone else in this family. The nurses are telling me if I don't take medication, I'll be forced into a needle injection…".

The HRA asked for records however staff stated "there was no petition for involuntary commitment or medication over objection in the chart. There was also no voluntary reaffirmation of commitment in the chart also."

Progress Notes:

The HRA reviewed a progress note for the individual dated 9/29/21 which states "Therapist note: this therapist met with [Individual] to complete his social assessment. He presented as agitated and asked why he was here and when he would be leaving. This therapist attempted to explain his reason for admission and treatment…When asked about his history to obtain information for the social assessment he reported he was offended by the questions and that he is not mentally ill… During his IPE with the psychiatrist, he was offered medication and refused. [Individual] presents as delusional, paranoid, and easily agitated. This therapist will follow up Friday to complete his 3-day TPR (treatment plan).

On 10/1/21 the note states "Therapist note: The treatment team met with [Individual] to hold his 3-day TPR… became agitated when the psychiatrist asked him questions. He reported he does not take medication and that his medication is 'Allah'. He made several grandiose and delusional statements. He reported he owns a business and is a famous rapper, writer, and dancer. He denied self-harm and harm towards others. He denied any past mental health treatment. The records show three past admissions to [hospital]. He denied. He denied experiencing any hallucinations or paranoia. He reported several times that he should not be here at CMHC. [Individual] declined to authorize release of information. He refused to sign the attendance sheet."

On 10/4/21 the note states "Patient refused his new admission labs. Report sheet updated." Another note on 10/4/21 states "Pt (patient) stays to himself, voices no complaints, eating and sleeping well, no behaviors.

Currently not on any medications." There are notes from 10/8/21 to 10/14/21 all of which indicate the individual refused lab work and tests including a Tuberculosis (TB) test "despite education and encouragement".

The progress note dated 2/8/22 states "Therapist note: During [Individual's] TPR today he requested some of his records for an upcoming hearing he has for court enforced medication. I had him sign a release of information and he requested all progress notes and psychiatrist notes. [Individual] reported his family is in the process of hiring him an attorney. He also indicates he wanted copies from the court on his hearing... This therapist provided him with the phone number to [county] court."

On 2/11/22 the note states "Patient would prefer to refuse Invega medication. He states he received information on this drug, agreed to take this AM and request copy of court enforced papers. Supervisor notified."

Progress Notes/Fitness Assessments:

The HRA reviewed fitness assessment progress notes for the individual. The assessment on 10/15/21 states "[Individual] has been free of physical aggression since his admission. He refuses to consent to medication. He appears delusional….". The assessment indicates the individual was not a danger to self or others.

The note on 10/25/21 states "[Individual] has been free of physical aggression since admission. He does show agitation when discussing charges and medication options. He refused to take medication and reports 'Allah' is his medication." The assessment indicates the individual was not a danger to self or others.

The assessment on 11/22/21 states "On 11/17/21 [Individual] was disruptive to his living unit. He began chanting [sic] and screaming at peers 'I'll fucking kill all of you'… no other behavior problems noted since admission. He has been offered medication, but refuses." The assessment indicates the individual is not a danger to self but is a danger to others.

Another assessment was done on 1/18/22 which states "On 1/6/22 [Individual] showed an increase in agitation and became verbally threatening towards staff, made statements to 'kill' when meeting with the treatment team. He made delusional statements. He refuses medication." The assessment indicates the individual is a danger to others but not self.

Conclusions

Complaint 1. Inadequate treatment including inadequate treatment planning

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 and Developmental Disabilities Code (405 ILCS 5/2-107) states "(a) An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse

generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available. The facility director shall inform a recipient, guardian, or substitute decision maker, if any, who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services. (b) Psychotropic medication or electroconvulsive therapy may be administered under this Section for up to 24 hours only if the circumstances leading up to the need for emergency treatment are set forth in writing in the recipient's record."

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107.1) states "Psychotropic medication and electroconvulsive therapy may be administered to the recipient if and only if it has been determined by clear and convincing evidence that all of the following factors are present. In determining whether a person meets the criteria specified in the following paragraphs (A) through (G), the court may consider evidence of the person's history of serious violence, repeated past pattern of specific behavior, actions related to the person's illness, or past outcomes of various treatment options. (A) That the recipient has a serious mental illness or developmental disability. (B) That because of said mental illness or developmental disability, the recipient currently exhibits any one of the following: (i) deterioration of his or her ability to function, as compared to the recipient's ability to function prior to the current onset of symptoms of the mental illness or disability for which treatment is presently sought, (ii) suffering, or (iii) threatening behavior. (C) That the illness or disability has existed for a period marked by the continuing presence of the symptoms set forth in item (B) of this subdivision (4) or the repeated episodic occurrence of these symptoms. (D) That the benefits of the treatment outweigh the harm. (E) That the recipient lacks the capacity to make a reasoned decision about the treatment. (F) That other less restrictive services have been explored and found inappropriate…"

The complaint alleges the facility filed a petition for involuntary medication when the individual was not aggressive or a threat to himself or others. The records indicate the individual did not display behavioral issues and was not physically aggressive. However, on November 17th, 2021, and January 6, 2022, the individual did threaten peers and staff. The individual threatened to kill staff. It is documented that the individual was a danger to others during his fitness test on 11/7/21 and 1/18/22. Staff stated the individual was delusional and refused to consent to any medication. On 1/6/22 a petition for involuntary medicine administration was filed with the court which was granted. The complaint alleges the individual was not aware of the criteria for discharge. However, the individual's treatment plan indicates the criteria for discharge. It is noted in a progress note that the individual refused to sign his 3-day treatment plan. The treatment plan and progress notes indicate the individual attended and participated in the treatment plan meetings. Therefore, the HRA finds the complaint of inadequate treatment including inadequate treatment planning **unsubstantiated.**

Staff was not able to locate the "petition for involuntary commitment or medication over objection" or the "voluntary reaffirmation of commitment" in the individual's chart. The HRA **strongly suggests** that Chester Administration ensure the chart is complete and accurate. The HRA **strongly suggests** Chester Mental Health Center ensure during treatment meetings that individuals understand their separation criteria. The HRA was not provided signature pages for any treatment plan meetings. It is documented the individual was present and participated in his treatment plan meetings, but it is not documented if the individual signed the treatment plans. The HRA **strongly suggests** Chester Mental Health Center ensure it is documented showing who attended and participated in the treatment plan meetings buy obtaining signatures. If the patient and/or guardian refuse to sign that should be documented.