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Egyptian Regional Human Rights Authority
Report of Findings
23-110-9007
Chester Mental Health Center
May 30, 2024

The Egyptian Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegation concerning Chester Mental Health Center:

A recipient is not being served in the least restrictive environment.

If found substantiated, the allegation represents violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5 et al.) and facility policies. Chester Mental Health Center is a state-operated mental health facility serving approximately 280 recipients; it is considered the most secure and restrictive state-operated mental health facility in the state.

The complaint alleges that a recipient has been on the transfer list for over two years without being transferred despite the recipient having no behavioral issues, restraints or emergency medication use.

I. Interviews:

A. Recipient: The recipient stated he has met his transfer criteria and has been on the list to transfer for over two years, but other recipients continue to be transferred ahead of him. He has been trying to be patient but wants a less restrictive placement. He is a voluntary patient and has no court order keeping him at the facility. The recipient's family has moved away so he has no preference of the region to which he is transferred. The recipient stated he has had no restraints and has not required the use of emergency medication. He is compliant with taking his psychotropic medications.

B. Forensic Coordinator: The coordinator explained that they are one of two sex offender evaluators in the Department of Mental Health. The recipient is considered a higher risk sex offender due to refusing sex offender treatment and being in denial he did anything wrong. Representatives of the Department of Mental Health and the State Medical Director have been involved in the placement of this recipient. The Forensic Director and the Medical Director agree with the higher risk assessment. One facility that has sex offender treatment is their first choice of placement, but that facility says the recipient needs more work at Chester before they will accept him. Another facility stated they cannot accept him due to being a high-risk offender and that facility is considered a minimum secure facility. The coordinator had sent two other facilities packets too, but they never responded. The recipient needs protective factors in place which the unit social worker should have been working on with the recipient. The coordinator has given the unit social worker modules for the recipient to work through and has given them ideas on how to build supports such as income, housing, follow up care etc. The preferred receiving facility requested that the team put protective factors in place to help him with placement such as Social Security Disability benefits and public aid benefits. If those protective factors are completed before transfer, it helps the coordinator facilitate a quicker transfer. Ideally, they would like to transfer the recipient to a less secure state operated facility and then into the community. The Medical Director does not recommend placing this recipient straight into the community due to high risk factors of reoffending. Typically, the receiving facilities will just tell the coordinator they can take one person over another, but they do not send denial letters. It also depends on if the receiving facility has a male or female bed availability, a

developmental disabilities facility or a forensic unit, whether the person can be in a co-ed dorm, whether the person can have a roommate, etc. The receiving facilities can interview a person and then say they do not think they are a suitable fit or the patient can say they do not want a roommate and the placement will fall through. The coordinator is unaware if the DHS facilities have guidelines for acceptance, but referred the HRA to a statewide medical director who might know. The coordinator checks weekly on availability at other facilities. The treatment team is all in agreement that the one facility with sex offender treatment is the most appropriate setting for this recipient.

C. Medical Director: The HRA reached out to the statewide medical director via email to inquire if the Department of Human Services (DHS) facilities have acceptance criteria or other guidelines to follow when deciding whether or not to accept placement or transfer of recipients. After looking into this specific recipient's case, the director informed the HRA that the recipient's treatment team had been given ideas on how to adjust his treatment plan to minimize risk factors which had not been accomplished yet. The director did not offer any further insight regarding state facilities guidelines for acceptance.

D. Social Worker 1: This social worker stated that the Forensic Coordinator had completed a sex offender assessment on the recipient which assessed him as a high risk for reoffending, but he was on the transfer list for a year and a half before that assessment was completed. Some Department of Human Services (DHS) facilities had stated they had no bed availability, one who had bed availability stated they were keeping the open bed for emergency placements and would not accept the recipient for admission. The recipient is compliant with medications and has not had any restraints, psychosis or emergency medication use. However, the recipient refuses to discuss his past crimes to show he is receiving treatment to address the sex offender issue, so for that reason, he was assessed as a higher risk to reoffend. The recipient had spoken to an attorney, and it was recommended that he request a 5-day request for discharge since he did not currently meet the criteria for involuntary commitment and the recipient would have to be discharged. The recipient signed the 5-day request for discharge but rescinded it before the 5 days expired. The social worker is not sure why he rescinded it, but the recipient said he was fearful he had no other place to go. The sex offender status is his only barrier to discharge currently.

E. Social Worker 2: This social worker stated the recipient had requested to be taken off the transfer list because they were told by the Forensic Coordinator he needs to discuss his prior sex offender history and triggers in order to be stepped down to another facility. This social worker has been the recipient's therapist for approximately 8 months and was told to add things to his treatment plan (TPR) that the social worker did not think needed to be added. The social worker felt he had met the criteria to transfer, but then the Forensic Coordinator wanted the criteria to change to include discussing the modules for sex offenders. The recipient refused and the social worker did not want to include that in his TPR when he did not agree to it because that would keep him from meeting step down criteria. The previous therapist put the recipient on the transfer list. The barrier for transfer to a less secure facility is the recipient's prior history and lack of cooperation with treatment. This social worker has worked with the recipient to see if he wants to transfer, he said he did but not if it means discussing his sex offense. The social worker was trying to build rapport and did not want to push those discussions right away. The recipient chose to be removed from the transfer list rather than address those issues. The Unit Director offered to talk to the recipient in a small group about triggers and he thought about it but decided he did not want to discuss it. The social worker explained that it was a barrier to transfer, and the recipient still said, "no I absolutely don't want to transfer then." The social worker has received the same response for 2 months. The social worker is hopeful that in time, he will be willing to address those issues. The treatment team is of the opinion that he would reoffend in a less restrictive environment because he is not willing to address the problem. He is compliant and pleasant and there have been no reports of inappropriate behaviors while at Chester. The recipient has been at Chester for approximately 20 months. They have not pursued SSI/SSD benefits because that is typically not done until they recipient is going to be on the transfer list since it is such a lengthy process. Since he requested to be removed form the list they have not pursued obtaining benefits.

F. Director of Social Work: The Director explained that the recipient's treatment plan is client centered and he does not want to discuss his history of sex offense and relationship building. The treatment team explained to him that it is a barrier to his transfer, but he still does not want to work on it. That is his only barrier currently, but he refuses to address social issues and attend groups to address the underlying issues. He has had no maladaptive behaviors while at Chester. The Director believes that all social workers offer the treatment they have available to him, he is just not interested. The treatment team has discussed having him work through the modules provided by the Forensic Coordinator, but he refuses to work on them. The Director asked if he would participate in group therapies for empathy, cognitive behavioral therapy, substance abuse etc. which he considered it but eventually refused. The Director does Utilization Reviews. This recipient's review is every 3 or 6 months. The Director audits the files with the Unit Directors and they usually complete 3 per unit per month.

II. Clinical Chart Review:

A. Sex Offender Evaluation: The evaluation documented that the recipient was being evaluated for the appropriateness to transfer to a less secure Illinois Department of Human Services (DHS) facility. The dates the recipient was interviewed are listed as 10/29/21, 12/28/22 and 3/9/22. The date of the report is listed as 3/9/22 There is no signature date so it's unclear if the date should have been 3/9/23 due to the 12/28/22 date also being listed. It was noted that if the recipient transfers and continues to do well with increased privileging, then an updated sex offender evaluation will need to be completed before transitioning to the community or group living facility. The recipient was admitted to Chester as an involuntary commitment from a prison. The staff at that prison determined that the recipient met criteria for involuntary commitment to DHS and the court agreed that the recipient was "suffering from a diagnosed mental illness and had multiple high-risk factors, including homelessness and is a registered sex offender…the combination of diagnosed mental disorders including paraphilia, schizoaffective disorder and antisocial personality disorder along with having an intellectual disability, these mental disorders are acquired or congenital conditions that predispose [recipient] to commit further acts of sexual violence. In particular, the combination of a personality disorder with paraphilia and psychopathy personality characteristics have been associated with a particularly high risk for sexual recidivism." The evaluation noted that the recipient reported stopping attendance at outpatient substance abuse treatment because he "got tired of the difficulties of having people try to figure me out." The recipient reported that the current medication regimen helps regulate his symptoms and now, when he becomes agitated, he uses alone time or talking with his therapist as a coping skill. The recipient admitted to alcohol addiction in the past "to get away from his problems." He stated that he was under the influence when he committed the crimes. The recipient was assigned the following diagnoses: schizoaffective disorder; other Specified Paraphilic Disorder; Antisocial Personality Disorder; Mild Intellectual Disability (by history); and Moderate Intellectual Disability (current Chester MHC). The most recent Full Scale IQ score was listed as 50 from an assessment done in 2020. The most recent (2020) assessment also listed the General Adaptive Composite (GAC) score as 62. The recipient's medical file from the Department of Corrections indicates that the recipient is in the *"severely to moderately mentally retarded range."* The current risk assessment showed a score of 6 on the STATIC 99R and the STATIC 2002R, meaning he is "well above average risk category … this score places him at a relative risk at 3.62 times that of the 'average' sexual offender." Some factors contributing to this score include lack of an emotionally intimate relationship with an adult, lack of compliance with sex offender specific treatment and minimization of the severity or harm brought to the victims in combination with his mental illness and intellectual disability diagnosis; no family supports, no stable housing plan, and lack of feasible plan for aftercare. Historical factors that raised the recipient's risk level include previous violence, history of sexual abuse (victim), young age at first violent incident, relationship instability, history of substance use problems, major mental illness, early maladjustment, personality disorder, history of rules/law violations, and prior supervision failure. Clinical factors that contribute to risk includes potential impulsivity. Future risk management items include exposure to destabilizers, no family support and stress. Because of the aforementioned factors, the recipient was determined to be a high risk for relapse. It was also noted that since being at Chester, there have been no known rule violations or behavior reports. The treatment team at Chester recommended him for a review for transfer. During the interview, the recipient "denied the sex offenses ever

occurred and displayed some agitation when more details of his sex offenses were asked … No remorse was expressed during this interview. He did inquire as to when his transfer date would be and to which facility." While incarcerated with the Department of Corrections, there were incidences of assaultive behavior when not consistently taking prescribed psychotropic medications. Since being at Chester, there have not been any incidents of assaultive behaviors. The criminal history dating back to 1981, 1982 and 1991 include unlawful restraint (received 3 years served 1 year), rape and deviant sexual assault (received 15 years, served 8 years) and attempted criminal sexual assault (received 20 years and was transferred to Chester Mental Health 19 years into sentence). According to his clinical file, it was noted that the recipient has never participated in sex offender treatment. The recipient denied that he was offered sex offender treatment during his hospitalization or incarcerations. Clinical records indicate the treatment has been offered and the recipient has declined to participate. The evaluator's opinion was that "there is a high probability that [recipient] would reoffend again if the opportunity became available." The recommendations for the treatment team included a review of the treatment plan and corresponding diagnoses for the purpose of identifying crucial objectives and evidence-based interventions and a conservative pursuit of progressive liberties for proper monitoring of behavioral compliance to determine if he would maintain taking prescribed medications more independently. A third recommendation is to establish a feasible housing plan that would include educating the recipient on residency restrictions and loitering since he is a registered sex offender. Another recommendation is to provide the recipient with special education services to help him obtain his GED. Finally, the recipient was recommended to a provision of thorough substance abuse education due to his history of substance abuse and his own comments of utilizing substances as negative coping mechanisms for stress when in the community; and that after using substances, he had more thoughts of sexual re-offense.

B. Treatment Plan Reviews (TPRs): History: The initial treatment plan from 2020 stated the recipient was admitted as an emergency admission from a detention facility. The treatment team at the detention facility determined that the recipient needed further psychiatric treatment on an inpatient basis due to the severity of his mental illness and high risk of sexual offense recidivism. In 1981 the recipient was charged with rape and unlawful restraint. He was found not guilty of rape but served 3 years for unlawful restraint. In 1982 while on parole, he was charged with rape, deviant sexual assault, unlawful restraint, and aggravated kidnapping. He pled guilty to rape and deviant sexual assault and was sentenced to 15 years in the Illinois Department of Corrections (IDOC). While on parole in 1991, the recipient was charged with attempted criminal sexual assault, aggravated kidnapping, and unlawful restraint. He pled guilty to attempted criminal sexual assault and was sentenced to 20 years in IDOC. While in IDOC, the recipient received disciplinary tickets for sexual misconduct. In 2001 he was transferred to a more secure IDOC facility and designated as a sexually violent person. While there, the recipient refused to participate in sex offender treatment. In February 2020 the Court found that the recipient "is not a sexually violent person."

The May 2023 TPR stated the recipient follows module rules and engages appropriately with staff and peers. He attends activities on and off the unit without difficulty. There have been no reports of any sexual inappropriate behaviors. He reports that his medications are helping him, and he believes there are no adjustments needed. He takes medications as prescribed and has had no refusals. There have been no side effects noted. He is doing well overall and continues to express a desire to transfer to a less secure environment. The Social worker noted on the TPR that the recipient "… remains on the transfer list and expresses a desire to leave Chester MHC. He has been on the transfer list since August 2020 … [Recipient] has met with therapist to discuss any negative thought of maladaptive behaviors, which he has continued to deny this reporting period … He maintains a good rapport with staff. He has not received any BDR's [behavioral reports] this reporting period and had no episodes of restraints. [Recipient] continues to remain free from verbal/physical aggression … remains at his clinical baseline … continues to take his medications as prescribed and he follows unit rules. He engages appropriately with peers and staff. He remains on the transfer list and continues to meet the criteria for transfer to a lesser secure facility. He has been on the transfer list for nearly 3 years; however, he has continued to decline any services or discussion surrounding his index crime and the risk involved of reoffending in a lesser secure environment." The extent to which benefitting from treatment section of the TPR documented that the recipient has had no behavior issues since admission in 2020. He was

recommended for transfer in August 2020. He follows rules and routine and gets along with his peers and staff. It was noted that the recipient understands the ongoing requirement of his sex offender registration. He declines discussion of his past convictions but is cooperative with ongoing mental health treatment. The recipient recognizes that he has not been in the community and will need assistance for any placement in the community. The criteria for separation section states that the recipient has met all criteria and is awaiting transfer. It was noted that he was informed of his right to a utilization review and declined.

The November 2023 TPR documented that the recipient attended and remains at his clinical baseline. He had no new questions or complaints. He stated if he was ever to reconsider transferring, he would let the Treatment Team know. He continues to refuse transfer at this time. It was noted there had been no behavioral issues and the recipient is still medication compliant. The recipient continues to seek out his therapist and engage in discussion about his current well-being. The criteria for separation section states that the recipient has met all criteria and was awaiting transfer for almost 3 years before he asked to be removed from the transfer list as he no longer expresses a desire to transfer to a lesser secure facility at this time. It was noted that he was informed of his right to a utilization review and declined.

C: Utilization Reviews: The HRA reviewed a utilization review completed in May 2023. It was documented that there have been no changes and the recipient remained on the transfer list and had since August 2020. It was noted that the recipient was at his baseline, takes medication as prescribed with no refusals, has had no restraints since admission and expresses a desire to transfer, however he refuses to discuss his criminal history or triggers. The recommendation is listed as "… on transfer list. Team needs to continue to discuss transfer barriers." Staff present is listed as three social workers, a unit director, the chief of social work and the medical director.

The November 2023 utilization review lists the changes to transfer/discharge barrier as "[recipient] refuses to transfer." It was noted that the recipient still was at baseline, taking medication as prescribed with no refusals and had no restraints. It was documented that the recipient "no longer expresses a desire to transfer from Chester MHC and states that if he was to change his mind, he would let his therapist know." There was no reason listed as to why the desire to transfer had changed. The recommendation was to "continue to work on engagement." The signatures indicate the participants were the facility director, the director of nursing, chief social worker, and quality manager.

Facility Policies

RI.01.01.02.01 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."*

IM.03.01.01.03 Treatment Plan policy requires that the facility *"shall ensure that each individual is receiving active treatment to address problem areas which precipitated hospitalization. Treatment planning is an ongoing process in which problems, 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 reviews, progress notes and other documentation…*
Treatment Plan Participation and Treatment Oversight:

Each person attending the treatment plan review will sign in with signature and title on the Treatment Plan/Review Attendance Record (CMHC-811f). Additionally, the Treating Psychiatrist will be listed as the person responsible for ensuring prescribed treatment is appropriate and occurs as specified. This will be validated by the Treating Psychiatrists signing the Treatment Plan. 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:

A. Treatment plan meetings happen within all the required time frames.
B. All discipline input is gathered and utilized for treatment plan reviews.

C. 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.
D. The treatment plan reflects current treatment...".

Utilization Review Policy CC .06.00.00.01 states that *"The facility will oversee a review process to ensure that the patient is receiving proper care and that any barriers to discharge/transfer are being addressed… II. The Utilization Review Committee has established the following number of days considered acceptable as a length of stay based upon legal status: Civil Patients LOS [length of stay] > 9 months; UST [unfit to stand trial] Patients LOS > 5 months; NGRI/UST-G2/UST Extended LOS > 12 months. III. The Utilization Review (UR) Committee will meet monthly to review any patient whose length of stay exceeds the number of days established by the Committee."*

Statutes

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) states *"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 Code (405 ILCS 5/2-107) provides that *"(a) An adult recipient of services … must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient… 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."*

The Code (405 ILCS 5/3-209) requires that *"Within three days of admission under this Chapter, a treatment plan shall be prepared for each recipient of service and entered into his or her record. The plan shall include an assessment of the recipient's treatment needs, a description of the services recommended for treatment, the goals of each type of element of service, an anticipated timetable for the accomplishment of the goals, and a designation of the qualified professional responsible for the implementation of the plan. The plan shall include a written assessment of whether or not the recipient is in need of psychotropic medications. The plan shall be reviewed and updated as the clinical condition warrants, but not less than every 30 days."*

With regard to transfers between state-operated facilities, the Code (405 ILCS 5/3-908) states *"The facility director of any Department facility may transfer a recipient to another Department facility if he determines the transfer to be clinically advisable and consistent with the treatment needs of the recipient…"* The Code (405 ILCS 5/3-900) provides that *"Any recipient hospitalized or admitted to alternative treatment or care and custody under Article VIII of this Chapter [405 ILCS 5/3-800 et seq.] may at any time petition the court for transfer to a different facility or program of alternative treatment, to care and custody, or to the care and custody of a different person. His attorney, guardian, custodian, or responsible relative may file such a petition on his behalf... Recipients may petition for transfer to a program of alternative treatment, or to care and custody ... Recipients in Department facilities may petition for transfer to a private mental health facility, a*

United States Veterans Administration facility, a program of alternative treatment, or to care and custody. Admission to a United States Veterans Administration facility shall be governed by Article X of this Chapter 3 [405 ILCS 5/3-1000 et seq.]. No transfers between Department facilities or between units of the same facility may be ordered under this Section. An order for hospitalization shall not be entered under this Section if the original order did not authorize hospitalization unless a hearing is held pursuant to Article VIII of this Chapter. An order of transfer entered under this Section does not eliminate any obligations under the federal Emergency Medical Transport and Active Labor Act (EMTALA) of the transferring facility toward the receiving facility. Before implementing an order of transfer, the transferring facility shall notify the receiving facility of the recipient and obtain medical clearance for the recipient."

Conclusion

The allegation is that the recipient is not being served in the least restrictive environment. The recipient has had no behavioral issues since admission in 2020, is compliant with taking medication and is documented as being "at his baseline." However, after being on the transfer list for 3 years, the recipient requested to be removed from the transfer list. Per the social workers interviewed, the reason for the refusal of transfer was because the recipient was recently told that he would have to discuss his criminal history and complete modules for sex offender treatment to be accepted in a less secure DHS facility. This was due to the recipient being assessed as a high-risk sex offender. The forensic coordinator stated that the receiving DHS facilities where packets had been sent, wanted to see that the recipient was compliant with sex offender treatment before accepting him in a less secure DHS facility. The recipient did not want to discuss his history and disagreed with this new criterion for transfer, and therefore decided to be removed from the transfer list rather than complete the treatment. Utilization reviews were held but no specific recommendations were made. Instead, there were broad recommendations listed such as "continue to work on engagement" without stating how the team would work on engagement or defining engagement. Another UR recommended "team needs to continue to discuss transfer barriers" without listing what the barriers were or how they planned to work on those barriers. Further, the HRA found no documentation that any less restrictive placements were explored except less secure DHS operated facilities. The treatment team, including the forensic coordinator and Chester's medical director, agreed that the specific DHS facility that offered sex offender treatment was the most appropriate DHS placement for the recipient. However, when that facility did not accept the recipient for placement, there was no documentation showing that meetings were held to discuss alternative community placements, inpatient or otherwise, where the recipient could receive sex offender treatment. The Mental Health and Developmental Disabilities Code does not require step down from Chester Mental Health Center to another DHS state operated facility, and there was no court order remanding this recipient to a DHS facility. It was documented several times in the recipient's records that he had met criteria and was on the transfer list, was at his baseline, continued to be compliant with medication, had no maladaptive behaviors, sexual or otherwise, and had no restraint episodes. Further, the Court decided in 2020 that he was no longer considered a sexually violent person. The Code also provides the right to refuse generally accepted mental health treatment (405 ILCS 5/2-107). The HRA finds that the recipient's right to treatment in the least restrictive environment was violated and this allegation is **substantiated.** The HRA makes the following **recommendations:**

1. **The facility policy (CC .06.00.00.01) requires that utilization reviews occur every 6 months until discharged for patients who are refractory to treatment. The recipient has been at the facility for approximately 3 ½ years with no barriers to transfer other than refusing to discuss his past crimes. The HRA contends this could be accomplished in a less secure environment. The URs held in 2023 listed recommendations that were broad without specific or measurable criteria to address this barrier to transfer. The statewide medical director also stated that the treatment team had been given ideas on how to adjust the recipient's treatment plan to minimize risk factors which had not been accomplished yet. The UR committee should ensure that proper recommendations are given to the treatment team to provide guidance on how to specifically address this transfer/discharge barrier. Please provide the HRA with evidence this is now being addressed by**

providing an updated UR and/or treatment plan showing how this will be addressed for this patient.

2. **The Mental Health and Developmental Disabilities Code has no requirement that recipients must be stepped down to another DHS facility when discharging from Chester. Considering the documentation that the recipient has not had any maladaptive behaviors, is medication compliant, and has not required restraints since admission in 2020, the step-down concern may not be warranted. Also, placement in another less restrictive DHS facility has been unsuccessful after 3 years on the waiting list. Chester should explore alternative community placement for this recipient to uphold his right to treatment in the least restrictive setting as required by the Code (405 ILCS 5/2-102.)**

The HRA **strongly suggests** the following:

1. The Code (405 ILCS 5/3-908) provides that *"The facility director of any Department facility may transfer a recipient to another Department facility if he determines the transfer to be clinically advisable and consistent with the treatment needs of the recipient."* The HRA suggests that this be considered as an option since the treatment team was all in agreement that treatment could occur in a less restrictive environment.

2. Chester should ensure that the recipient understands his right to request a transfer to an alternative treatment as provided in the Code (405 ILCS 5/3-900).