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Egyptian Regional Human Rights Authority
Report of Findings
08-110-9010
Chester Mental Health Center
March 26, 2008

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Chester Mental Health Center, a state-operated mental health facility located in Chester. The facility, which is the most restrictive mental health center in the state, provides services for approximately 300 male residents. The specific allegations are as follows:

1. Chester Mental Health Center has failed to provide a safe environment for a recipient.
2. A recipient has not been allowed to review his clinical chart.

Statutes

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/2-102 and 405 ILCS 5/2-112) and the Mental Health and Developmental Disabilities Confidentiality Act (Act) (740 ILCS 110/4 a and 110/4 d).

Section 5/2-102 of the Code 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…"

Section 5/2-112 of the Code states, "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect."

Section 110/4 (a) of the Act states, "(a) The following persons shall be entitled, upon request to inspect and copy a recipient's record or any part thereof: 1) the parent or guardian of a recipient who is under 12 years of age or older. 2) the recipient if he is 12 years of age or older. 3) the parent or guardian of a recipient who is at least 12 but under 18 years, if the recipient is informed and does not object or if the therapist does not find that there are compelling reasons for denying the access. The parent or guardian who is denied access by either the recipient or therapist may petition a court for access to the record. Nothing in this paragraph is intended to prohibit a parent or guardian of a recipient who is at least 12 but under 18 years from requesting and receiving the following information: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed, including medication, if any. 4) the guardian of a recipient who is 18 years or older. 5) an attorney or guardian ad litem who represents a minor 12 years of age or older in a judicial or administrative proceeding, provided

that the court or administrative hearing officer has entered an order granting the attorney this right. 6) an agent appointed under a recipient's power of attorney for health care or for property".

Section 110/4 d states, "Whenever access or modification is requested, the request and any action taken thereon shall be noted in the recipient's record."

Complaint Information….Allegation 1

According to the complaint, Security Therapy Aides (STAs) at Chester Mental Health Center failed to intervene when a recipient (Recipient B) became aggressive towards another recipient (Recipient A). As a result of the STAs' failure to take the appropriate action, Recipient A sustained an injury to his foot and wrist when Recipient B hit him.

Investigation Information…Allegation 1

Allegation 1: Chester Mental Health Center has failed to provide a safe environment for a recipient. To investigate the allegation, the HRA Investigation Team (Team), consisting of two members and the HRA Coordinator (Coordinator), conducted a site visit at the facility. During the visit, the Team spoke with the Chairman of the facility's Human Rights Committee (Chairman), two recipients and an STA. The Team attempted to interview another recipient; however, he refused to speak with them. With the recipient's written authorization, the Team reviewed Recipient A's clinical chart.

Interviews:

Chairman:

When the Team spoke with the Chairman regarding the allegation, he stated that that the matter had not been brought before the facility's Human Rights Committee. Nor was he made aware of any information pertinent to the allegation by any other means.

Recipient A:

The Team spoke with the recipient whose rights were alleged to have been violated. Recipient A stated that while taking his medication, Recipient B "came out of nowhere, ran toward him and began to hit him. According to Recipient A, Recipient B stepped onto his right foot, hit him on the cheekbone three times, and injured his left foot. Recipient A stated that the act was unprovoked, and he "didn't do anything bad to him". Recipient A stated that the STAs that were present did nothing to intervene on his behalf when the August 30, 2007 incident occurred. Recipient A provided the name of the recipient who hit him, another recipient who was

a witness to the incident, and the name of one of the STAs who was present at the time of the incident.

Recipient B:

Recipient B acknowledged that he had hit Recipient A. However, he could not remember the date of the incident, where the incident had occurred, or what staff members were present. He informed the Team that he was concerned about another problem and took his frustration out on Recipient A. He stated that when he hit Recipient A, the STAs were there to "tackle" him in order to stop his aggressive actions. He informed that Team that his medications have been reviewed and changes made since the episode, and as a result of the medication adjustment his behaviors have improved. He stated that he had not been in "a fight" since October 2007.

Recipient C:

When the Team requested to speak with Recipient C, who was named as a witness to the August 30, 2007 incident, the recipient declined the interview.

Security Therapy Aide

The Team spoke with an STA who was reported to have been present when the alleged episode occurred. The STA informed the Team that Recipient B had hit numerous recipients. He related that Recipient B's actions appear to be more to aggravate than to harm others. However, he has caused injuries to some recipients, as well as to staff members. The STA stated that he did not recall the specific incident pertinent to the alleged attack on Recipient A.

The STA stated that when Recipient B begins to annoy others, he would re-direct him and request that he go to his room. He informed the Team that the recipient usually complies to the request and, as a result, the behavior subsides. He informed the Team he believes that Recipient B's behaviors have improved, possibly due to changes made in his medications.

The STA informed the Team that he and the other STAs that he works with always strive to protect recipients from harm.

Record Review

The Authority reviewed Recipient A's clinical chart, with his written authorization,

Treatment Plan Reviews (TPR):

According to a 09/12/07 TPR, the recipient was admitted to Chester Mental Health Center from another state-operated mental health facility on 02/23/04. His legal status is

recorded as NGRI (Not Guilty By Reason of Insanity), and his Theim date, anticipated time of release, is listed as 12/08/09.

Documentation in the recipient's TPR indicated that the recipient has an extensive history of self-injurious behaviors, as well as behaviors of threatening harm to others. According to the record, the recipient had threatened a peer and had continued to keep an argument going with the peer instead of "letting it go". According to recordings in the TPR, the recipient had also written threatening letters to the President of the United States and had made inappropriate calls to America's Most Wanted Hotline.

Additional documentation in the 09/12/07 TPR indicated that the recipient had been doing well with his goals and objectives until recently when he began to have problems with a peer and his Coordinating Therapist. According to the record, the recipient wrote a note to the peer calling him an inappropriate name. Documentation indicated that the recipient also verbally threatened the peer and his Coordinating Therapist.

In the recipient's 10/10/07 TPR, documentation indicated that a different Coordinating Therapist was assigned to the recipient's treatment when he had moved to another unit. The Therapist documented in a September 2007 letter that the recipient threatened the lives of a peer and his Therapist. The Therapist recorded that the recipient always seems to have a problem with a peer or a staff member and that he overreacts to situations and has little insight in what he has done wrong.

The recipient's Psychiatrist reported that some of the recipient's symptoms and inappropriate behaviors had improved. He recorded that the recipient had stated that he "did not mean any harm", and no longer has thoughts of harming others.

Additional Information

The HRA observed no documentation in the recipient's chart indicating that he sustained injuries from the August 30, 2007 incident. Additionally, the Team did not observe any incident reports pertinent to the August event. When the Team spoke with the recipient, there were no observable injuries.

Summary

It is alleged that facility staff failed to protect a recipient from being harmed by another recipient. The recipient, (Recipient A), whose rights were alleged to have been violated indicated that staff failed to intervene when Recipient B hit him. Recipient B conceded that he hit Recipient A. Recipient B stated that the STAs present at the time of the August 2007 incident immediately pulled him away from Recipient A. Recipient A named Recipient C as a witness; however, Recipient C refused to speak with the Team. When the Team spoke with a STA who was reported to be present, the STA stated that he could not remember the particular incident, but acknowledged that Recipient B has problems with hitting others. The STA stated that when any

recipient becomes aggressive, he and the other STAs on the unit always address the situation in a timely manner in order to protect the recipient and others from harm. Documentation in Recipient A's clinical chart indicated that during the time period of the incident, Recipient A was exhibiting threatening behaviors toward another recipient, a staff member, and individuals outside the facility. There were however, no documented references to the recipient sustaining injuries himself from the August 30th incident.

Conclusion

Based on the information that was obtained during the course of the investigation, the Authority is unable to substantiate that staff failed to intervene to protect the recipient. Therefore, the allegation is unsubstantiated. No recommendations are issued.

Allegation 2: A recipient has not been allowed to review his clinical chart. To investigate the allegation, the Team spoke with the recipient whose rights were alleged to have been violated and the Chairman. The Team reviewed the recipient's clinical chart, with his written authorization. Additionally, HRA reviewed the facility's Patient Handbook.

Interviews:

Recipient:

According to the recipient, he was recently moved from Unit E to Unit C at the facility. He stated that he had also lived on Unit F3 before that unit was closed. He informed the Team that he did not have any difficulties reviewing his record while on Unit F and Unit E. However, when he requested to look at his chart after moving to C, his Social Worker informed him that he would have to get the approval of his treatment team at his next TPR before he could review his chart.

Chairman:

When the Team spoke with the Chairman about the complaint, he conferred with the Unit E Manager. The Chairman stated that the Unit Manager informed him that the recipient had been allowed to review his records; however, there had been some problems regarding the length of time that he wanted to spend in the reviewing his chart. The Chairman stated that, according to the Unit Manager's report, the recipient wanted to spend hours going through his records.

Clinical Chart Review

Upon review of the recipient's clinical chart, the Team did not observe any documentation that indicated that the recipient had requested to review his chart or that the review had occurred.

Patient Handbook (Handbook) Review

HRA reviewed the facility's Handbook that is given to recipients when they are admitted to the facility. In the Introduction Section of the Handbook, each recipient is made aware of the names and job titles of the staff member that are a part of the recipient's treatment team. The times set aside for meals, the medication administration, library and barber service hours are also listed in the Introduction Section. Information about the facility's description, mission, vision and values is documented in the Handbook, Information about the Unit where the recipient is assigned, mail delivery, phone calls, and visits are provided. A list of services available and the cost of those services is included. Additionally, documentation in the Handbook informs recipients of their rights and responsibilities while they are hospitalized at the facility.

In the Patient's Rights Section of the Handbook recipients are informed that it is the policy that discrimination in treatment based on race, color, national origin, religion or handicapping condition is strictly prohibited. Recipients are informed that the facility forbids the releasing of any information about the recipient, except under certain specific circumstances, without the recipient's written consent. This includes information to relatives unless the relative is a recipient's legal guardian. Rights are listed as follows: humane services in the least restrictive environment; communication; property; money; banking; payment for work that benefits the facility (except personal housekeeping and daily personal hygiene chores), the right to refuse services; restraint use only to protect the recipient or others; seclusion use only to protect the recipient or others; a recipient's written consent prior to any unusual, hazardous or experimental services; and informed consent to be obtained before any medical or dental services are provided, except in emergencies.

Recipients are informed that any time their rights are restricted in order to protect them or others from harm, harassment or intimidation, a restriction of rights notice will be provided to the recipient and to anyone of his choice.

Documentation in the Handbook indicated that at the beginning of the recipient's hospitalization, he would be asked to make a choice of emergency methods to be used in the event that his behaviors created a danger for himself or others. The choices included emergency medication, restraints, or seclusion. Documented indicated that the recipient's choice of emergency treatment should be recorded, in the order of the recipient's choice, in the recipient's TPR

Recipients are informed of the complaint process that encourages recipients to speak with staff on the unit to try to resolve the problem. According to the documentation, if the issue of concern is not resolved, the recipient should make a written complaint to the facility's Human Rights Committee. Recipients are also informed of their right to seek assistance outside the agency by contacting the Guardianship and Advocacy Commission or Equip for Equality. In the event that a recipient believes that he has been neglected or abused, he is informed that he may

call of the Office of Inspector General. Telephone numbers and addresses of the outside agencies are listed in the Handbook.

The HRA did not discover any documentation in the Handbook to inform recipients of their right to review their clinical charts.

Summary

According to the recipient, staff on Unit C had denied him the right to review his clinical chart. Conversely, the Unit Manager on Unit C stated that the recipient was allowed to review his chart. However, the amount of time that the recipient wanted to spend in reviewing the chart created a staffing issue. When the Team reviewed the recipient's clinical chart, the Team did not observe any documentation that indicated that the recipient had requested to review his chart or that a review had taken place. When the HRA reviewed the facility's Handbook, the handbook did not contain any information to make recipients aware of their right, per the Mental Health and Developmental Disabilities Confidentiality Act, to review information in their clinical charts.

Conclusion

HRA did not observe any documentation in the recipient's clinical chart pertinent to the request or receipt of the chart for review per 110/4 d of the Act. Therefore, the allegation that the recipient was not allowed to review his clinical chart is substantiated and the following recommendations are issued.

Recommendations

1. The facility should adhere to the Mental Health and Developmental Disabilities Act's allowance for a recipient to review and obtain copies of information from his clinical chart.

2. Whenever a recipient requests to review his clinical chart and when the review is completed, documentation in the recipient's clinical chart should reflect the request and the review.

Suggestion

HRA suggests the following:

1. Recipients should be informed in the Patient Handbook of the Act's allowance pertinent to record review, and the procedure that is necessary to obtain the record for the review should be outlined.