FOR IMMEDIATE RELEASE

North Suburban Human Rights Authority
Report of Findings
Elgin Mental Health Center
HRA #09-100-9013

Case Summary: The HRA concluded that the loss of privilege for 24 hours appeared justified based on the number and type of the incidents that day. Some electronic equipment is restricted in certain areas for safety reasons; the allegation that the consumer was unjustly unit restricted for using a CD player in the dining room was unsubstantiated. The HRA's public record on this case is recorded below; the provider's response immediately follows the report.

The North Suburban Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Elgin Mental Health Center (EMHC), Forensic Treatment Program, Unit K. In October 2008, the HRA notified EMHC of its intent to conduct an investigation, pursuant to the Guardianship and Advocacy Act (20 ILCS 3955). The complaint accepted for investigation was that a consumer received an unjust unit restriction for using a portable audio player in the dining room and for swearing at a staff member after being awaken up at 4:00 a.m. for a 7:00 a.m. appointment. The rights of consumers receiving services at EMHC are protected by the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102 and 5/2-104).

To pursue this investigation the HRA reviewed, with written authority, a portion of the clinical record (July and August 2008) of the consumer whose rights were alleged to have been violated. An on-site visit was conducted in January 2009, at which time the allegations were discussed with the consumer's Case Worker (via telephone) and a Case Worker on the unit familiar with the consumer identified in the allegation. The consumer was also interviewed via telephone.

Background

Consumers receiving services at EMHC's Forensic Treatment Program have been remanded by Illinois County Courts to the Illinois Department of Human Services (DHS) under statutes finding them Unfit to Stand Trial (UST) and Not Guilty by Reason of Insanity (NGRI). Placement evaluations determine the most appropriate inpatient or outpatient setting for forensic treatment based on a number of factors including age, gender, mental health diagnosis, and security need. Unless a person is specifically ordered to receive services in an outpatient setting, court ordered referrals under state forensic statutes call for placement in a secure inpatient setting. The Forensic Treatment Program has 315 beds.

Findings

The clinical record reveals data on a male consumer admitted to the Program in July 2007. He was adjudicated NGRI for his crime. According to the clinical record, on July 28th, progress notes showed that the consumer was woken up at 5:00 a.m. because he had an off-site

appointment. The note states he was woken at that time so he could shower and eat early. The note states that he became belligerent. A few hours later, the consumer had to wait for his medication; it was documented that he gave the RN an attitude and threw a medication cup through the window. When told that he should have taken this medication earlier and not display an attitude, the consumer got "even more abusive, mumbling expletives, saying it took 30 fucking minutes to get meds." When the consumer returned from the off-site appointment, an RN documented (about noon) that he was counseled about the a.m. incident - the consumer wanted to know which incident. The RN documented that the consumer was made aware that if an incident happened again, the staff may put him on restriction or he would lose privileges without waiting for the treatment team.

Progress notes showed that at about 2:30 p.m., the consumer's Social Worker met with the consumer to discuss his 24-loss of privileges for verbal abuse of staff that morning. It was documented that at first the consumer was upset, but later he understood that he should not use abusive language.

At the site visit, the Social Worker explained that each morning the unit conducts morning meetings with as many unit staff as possible. At this time, the staff/treatment team discusses issues that may have recently arisen and reviews other matters. It is during this time that a privilege restriction would be imposed. The Social Worker explained that someone might propose a privilege restriction, and the team then decides if the restriction fits the crime. The Worker stated that restrictions are not automatic, and often there is a debate amongst staff about what restriction might be best.

Once the team decides that a privilege restriction is necessary, the consumer's Social Worker and sometimes others from the team will meet with the consumer to inform him of the decision. At this time, staff members will get input from the consumer regarding the incident. At times, the consumer is asked what restriction they believe should be imposed. The Clinical Team, depending on the patient's input, can change the severity of the restriction. Keeping in mind, this is just for a privilege restriction, meaning that the consumer would lose the privilege of going off-unit for non-programming activities - even on a privilege restriction, the consumer is able to leave the unit for treatment programming. If a consumer made a dangerous breach of unit rules, the nurse on duty or the administrator on duty can impose an immediate restriction.

The Social Worker stated that he did recall the incident about the consumer being belligerent after being woken early being discussed at the morning meeting, and he recalled that some staff present felt that his reaction to be awoken at those hours was somewhat warranted. However, he could not recall if a privilege restriction had been decided. The HRA then spoke to the consumer's Social Worker (via telephone) and he explained that at the morning meeting it was decided that the consumer would receive a 24-hour unit restriction for the verbal abuse of staff as a result of being woken up. He stated that he was not able to discuss this with the consumer until later that day because the consumer was off-grounds.

The shower times are:

Mon-Fri	Weekend
5:00-5:50AM	5:00-5:50AM
12:00-2:45PM	8:00AM-2:45PM
5:30-10:00PM	5:30-10:00PM

Regarding the allegation that the consumer was unit-restricted for using his CD radio in the dining room, the Social Worker stated that these devices are not allowed in the dining room

for safety reasons. He stated that often there are only one or two staff members dispensing the meal trays, and each consumer must be able to hear the instructions given by staff during this time. He did say that the consumer was restricted for this, but the incident occurred on another unit (he was transferred to this unit on July 11, 2008) and he had no further knowledge of the restriction details. It is noted that on August 18, 2008, the consumer received an Audiological Evaluation. The evaluation documented that the consumer was encouraged to reduce the volume on his portable CD player, as he reportedly listens to it 8-16 hours a day.

The Center's Off-Unit Supervision of Forensic Patients policy states (in part) that the Center is a medium security program and specific procedures must be in place when escorting consumers without grounds pass privileges off the unit and within the fenced perimeter of the FTP complex. The policy indicates four levels of supervision needed whenever a consumer is taken off the unit, but not off grounds. The four levels include: 0 means two staff must provide an escort; 1 means one staff to one consumer; 5 indicates one staff member to five consumers; 10 means one staff member to ten consumers; P means that the consumer has a Pass for unsupervised on-grounds privileges. The policy states that prior to leaving the unit, the consumer shall be screened to determine 1) if they present an unauthorized absence risk; 2) if their clinical condition is appropriate as it relates to being in the areas; 3) if they are considered a behavior management problem; 4) if they have complied with the facility program and/or unit rules and regulations. The policy states that a review of the consumer's status is to be completed on a weekly basis. In this particular case, the consumer's restriction was for 24-hours; the consumer confirmed that the restriction did not go beyond the 24-hour. The chart did not denote that the restriction was lifted.

The Center's Rights to Personal Property states that its purpose is that consumers in the Forensic Program be permitted to receive, possess and use personal property except where specific restrictions are necessary as determined by the Program's rules and regulations. Staff are to respect the rights of consumers to have/own personal property and to have adequate and reasonable access to this property. The FTP's Patient/Family/Significant Other Information Booklet states that consumer's may own and possess personal computers and associated peripheral devices (MP3 players and CDs) but they are subject to certain restrictions for safety.

Conclusion

Pursuant to Section 5/2-102 of the Mental Health and Developmental Disabilities Code, "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 5/2-104 states that "Every recipient who resides in a mental health or developmental disabilities facility shall be permitted to receive, possess and use personal property and shall be provided with a reasonable amount of storage space therefor, except in the circumstances and under the conditions provided in this Section."

The consumer's Social Worker stated that the restriction was imposed at the morning meeting for verbal abuse. A note in the chart says that if an incident happens again the consumer may be placed on restriction without consulting with the full team (11:50AM note). Although the charting is unclear it may be that the morning team meeting agreed to impose the restriction if another incident happened and that the restriction was ultimately imposed because the second incident [throwing the cup etc] occurred. The HRA concludes that the loss of privilege for 24 hours appears justified based on the number and type of the incidents that day. The allegation is unsubstantiated. Some electronic equipment is restricted in certain areas for safety reasons; the

allegation that the consumer was unjustly unit restricted for using a CD player in the dining room is unsubstantiated.

The HRA suggests that when a decision is made to impose a restriction, documentation should be clear as to which incidents are involved.

Comment

The HRA noted that the chart often documented that the consumer was verbally abusive. Abuse, as defined in the Mental Health and Developmental Disabilities Code, means "any physical injury, sexual abuse, or mental injury inflicted on a recipient of services other than by accidental means." The Department of Human Services (Policy Directive) says that verbal abuse is "the use of words by an employee toward or about and in the presence of any individual(s) which a reasonably prudent person would believe to, or the employee knows will for that particular individual, intimidate, demean, curse, harass, cause emotional anguish or distress, threaten harm or knowingly precipitate in maladaptive behavior by that individual, whether or not there is a psychological injury." The Center's Code of Ethics states that employees must be understanding of patients' limitations, lack of skills, lack of social propriety, or lack of progress.

The words "verbally abusive" imply that the staff member has been intimidated, demeaned or the words have caused emotional anguish or distress to that staff member. Like all other aspects of a consumer's behavior, documentation should simply say exactly what the staff member has heard and/or observed.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

Pat Quinn, *Governor*

Illinois Department of Human Services

Carol L. Adams, Ph.D., *Secretary*

Division of Mental Health - Region 2
Elgin Mental Health Center ■ Singer Mental Health Center

RECOVERY IS OUR VISION
Recovery is a Personal Journey of Hope, Healing, Growth, Choice, and Change

April 7, 2009

Mr. Dan Haligas - Chairperson
North Suburban Regional Human Rights Authority
9511 Harrison Street, W-300
Des Plaines, IL 60016-1565

Re: HRA #09-100-9013

Dear Mr. Haligas:

Thank you for your always thorough investigation. Per your finding, the allegations were not substantiated.

As for your comment, we agree that all consumer restrictions should be clearly documented and that progress notes should clearly state what the staff member has "heard and/or observed". We have re-educated our staff concerning this issue.

I would request that this response be attached to the report and be included with any public release of your Report of Findings.

Respectfully,

Tajudeen Ibrahim, BA
Acting Hospital Administrator

TI/JP/aw

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