FOR IMMEDIATE RELEASE

North Suburban Regional Human Rights Authority
Report of Findings
HRA #10-100-9005
Elgin Mental Health Center

Case Summary: the HRA did not substantiate the allegations presented. The HRA's public record on this case is recorded below; the provider's response immediately follows the report.

Preface

In August 2009, the North Suburban Regional Human Rights Authority (HRA) opened this investigation regarding Elgin Mental Health Center, Forensic Treatment Program, Unit Pinel. A complaint was received alleging that a recipient was advised that all excess paper in his room would be removed for safety reasons; staff not only removed the papers but also clothing and toiletries. It was also alleged that the personal items in the storage area are not secure and that the recipient does not have access to the items.

If found substantiated, the allegation would be a violation of the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102).

Milieu

Recipients 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.

Investigative Methodology

To pursue this investigation, an on-site visit was conducted at which time the allegations were discussed with the recipient's Psychiatrist, the unit's Manager and the recipient's Case Worker. The recipient whose rights were alleged to have been violated was interviewed in person. The HRA reviewed, with written authority, clinical documentation pertaining to the allegations.

Investigative Findings

The recipient was admitted to the Forensic Treatment Program on 12/5/2000. The recipient told the HRA that his room received a safety inspection in the middle of June 2009. The recipient was advised after that inspection that he would have about two weeks to clean out his room, which meant storing the items that were on the floor. The recipient said that he was working

on putting things in duffle bags to store in his room and he was trying to get rid of some items. According to the recipient, on July 6th staff told him that he had only one more day to clear out his room and if it was not cleared out, they would do it for him. The recipient reported that staff left a large cart outside his room and gave him boxes for his things. He reported that he had filled two boxes and multiple duffle bags, but he was not quite ready to move things out. The recipient stated that on July 7th he had not yet put anything in the cart and staff came (his Caseworker, two RN's, and his Psychiatrist) and they started filling up the cart with his things. He said that they were grabbing things at random and that he could not keep up, and did not know what they were taking. He was allowed to keep specific items that he requested. He stated that he has been obtaining things in preparation for his possible discharge, and freely admits that he had a "lot of stuff" in his room. The recipient stated that he was given a Restriction of Rights Notice.

The recipient went on to say that on July 10th staff members brought up two bins from storage and said that they were going to inventory his things with him. He said that some things in the bins were "folded up" and "crumpled". He said that he left after the first bin because they were "shuffling his papers and mixing them up." When he has asked to have specific items released from storage, they do find the item for him but insist that he must send a similar item back into storage so as not to accumulate additional items in his room. He said that he wants to go through the bins in preparation for possible discharge, but has been told that he cannot do this until his discharge date is certain.

The recipient contacted the HRA shortly after the removal of the excessive items to say that he was left without adequate exercise clothing. Upon request, the Center provided the HRA with an inventory of clothes that were in his closet. This included 1 belt, 1 pair of blue jeans, 2 pairs of shorts, 2 hats, 1 winter coat, 1 sweater (zip front), 1 tie, 24 shirts (button down and Polo), 2 pairs of tennis shoes, 2 pairs of flip flops, 6 pairs of canvas shoes, 8 pairs of underwear, 17 pairs of tube socks, and17 T-Shirts.

In discussing this matter with Center personnel, it was explained that the Safety Officer found that the amount of possessions in the recipient's room posed a fire risk (boxes filled with items and paper stacked on the floor). It was stated that on June 24th the recipient was informed that his room was out of order and he needed to box up the excessive items by July 6th. Center personnel stated that he was provided with boxes and a time frame to clean up the room. When he had not complied by July 7th they moved the items from his room.

It was stated that there are specific rules as to how much recipients are allowed to have in their rooms. They are, in general, allowed to have seven of each item of clothing, [shirts, pants, socks, shoes etc]. The only furnishings allowed in the room are the supplied bed, bed-stand, chair, closet and hamper for dirty laundry. Center personnel stated that this recipient had far in excess of the allotted amount and was encroaching into his roommate's space, and not just in paper products. The problems that he has had in maintaining his room have been an ongoing difficulty and have been incorporated into his treatment plan to find a corrective action. Regarding the assertion that the recipient does not have access to the stored items, Center personnel stated that the recipient simply has to ask staff to retrieve a specific item from storage and that the item(s) will be retrieved. However, staff will not bring up a bin from storage and allow the recipient to sort through the bin. It was stated that this has been attempted in the past and the recipient has been unable to discard any significant amount and that the rest of the bin contents end up back in the room.

The HRA toured the recipient's room and there were still items in numerous boxes spread out around the foot of his bed. He has additional items stored under the bed. The HRA toured the area in the basement where the items are stored. There is locked access to the area and the key can only be obtained by security personnel. The items are stored on shelving units in boxes and plastic bins, each labeled with the owners and unit name. One wall of shelving storage held items that had

been previously stored from this recipient's room. The bins that were filled on July 7th were many; the HRA inspected the contents of several of the bins. The items seem to have been neatly packed in the bins (coffee cup, papers, clothes); the cloths were folded and all of the containers and their contents seemed clean and intact.

The recipient's Treatment Plan dated August 24, 2009, documented that the Safety Officer did a review of the recipient living quarters and the recipient's living area were found to be one of several that were deemed to be in possession of too many items of personal property. On June 25, the recipient was informed by the treatment team and unit manger that he was in possession of excessive personal property and that his property needed to be sorted through and in storage by July 7. It was documented that on July 7, the recipient had not completed the task required and the treatment team went to the room- with the recipient present- and removed his excessive property and put it into storage. It was noted that the recipient was upset and anxious but eventually he cooperated with the treatment team. The chart contained a physician's order to restrict personal property due to a safety hazard.

The Center's *Personal Property Retained on the Unit* policy states that patients are permitted to receive, possess and use personal property except where specific restrictions are necessary to protect a patient or others from harm. The facility shall have the authority to decide what property may be brought into and/or stored at the facility. A reasonable amount of storage space shall be provided for the storage of personal possessions on the unit, this will be dependent on the physical space/area of the individual unit and allowing for an equitable distribution of storage capacity for each patient. An orderly environment shall be maintained for the benefit of all patients on the unit. There shall be limits upon the amount of property which may be kept by patients in their living space; these limits must take into account safety and hygienic standards or the needs of others. Every effort shall be made by unit staff to have excess property stored by relatives/friends. Patients shall be counseled regarding the necessity to dispose of items inappropriate for the hospital environment. After reasonable efforts to have excess property disposed of by alternate means have failed, excess property (other than clothing) may be placed in the Trust Fund personal property storage area. Under no circumstances shall the facility compromise the safety, hygienic standards or the needs of other patients by allowing excess personal property on the treatment units. The policy goes on to state that each patient shall be provided with a basic amount of personal storage space which shall include a wardrobe and a bedside stand. Limits placed upon patients regarding the amount of property which they may keep in their own living space shall be based upon safety and hygienic standards and the needs of others patients.

The *Patient/Family/Significant Other Information Booklet* states that due to the limited storage space on the unit, the patient can take to the unit only those items that can be stored in the bedroom locker and night stand. The Booklet states that the units are limited in the amount of available space for keeping clothes. It is suggested that the patient bring no more clothing than he/she will need. The booklet suggests no more than seven changes of clothing.

Investigative Conclusion

Pursuant to the Mental Health Code, Section 2-104, "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 professional responsible for overseeing the implementation of a recipient's services plan may…restrict the right to property when necessary to protect such recipient or others from harm." The Code's Section 2-201 adds that a notice shall be provided to the recipient and entered into his record whenever a right is restricted.

Excess items were removed for safety reasons, which included clothing and toiletries, and a restriction notice was provided; personal items in the storage area are secure and the recipient does have access to the stored items. The HRA observed the room to still contain many personal possessions that were stacked in piles on the floor; the inventory taken after the survey indicated that he had many clothing items. Based on the information received, the allegations of a rights violation are unsubstantiated.

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*

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

Illinois Department of Human Services

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

October 16, 2009

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

Re: HRA #10-100-9005

Dear Mr. Haligas:

Thank you for your as always thorough investigation. I am glad that this rights allegation was unsubstantiated. The staff here at Elgin Mental Health Center make every effort to resolve consumer issues in a fair and reasonable manner.

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

Sincerely,

Tajudeen Ibrahim, BA
Acting Hospital Administrator

TI/JP/aw

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