FOR IMMEDIATE RELEASE

North Suburban Regional Human Rights Authority
Report of Findings
HRA #10-100-9018
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.

In April 2010, the North Suburban Regional Human Rights Authority (HRA) opened this investigation regarding Elgin Mental Health Center, Forensic Treatment Program, Unit L. A complaint was received that alleged that a recipient received an unjust unit restriction and that a room search was conducted without the recipient's knowledge. If found substantiated, the allegation would be a violation of the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102).

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.

To pursue this investigation the HRA reviewed, with written authority, progress note documentation for the incident in question. On-site visits were conducted in May and June 2010, at which time the allegations were discussed with a Registered Nurse (RN) and the staff member that conducted the room search/security check. The recipient whose rights were alleged to have been violated was interviewed via telephone and in person.

Findings

According to the recipient, he had food items (granola bars, individually wrapped butter) in his room which he has had in his room for about two months. He stated that the food was in a zip-lock plastic bag and the bag was in a drawer, thus the bag could not have been seen during a routine security check. And, since the bag was not in plain sight, this means that staff members conducted a room search which means that he should have been allowed to be present during the search. Also, he stated that unit restrictions are imposed for safety reasons and he did not believe that food is a safety matter. The recipient acknowledged to the HRA that he knew he was not to have food items in his room.

Progress notes showed that during "security checks", a staff member found a gallon size plastic bag filled with food (almond butter, granola bars, and honey sticks) in the recipient's room. The staff member documented that she removed the bag, labeled it with his name and notified the

caseworker. The next entry is by an RN who documented that the recipient was informed that he has a 24-hour loss of privileges due to the contraband (food) found in his room during security checks. The RN documented that the recipient acknowledged that he was not to have the food in his room and he seemed to accept the restriction. It was documented that he was calm, quiet and did not appear to be in disdain about the incident.

In discussing the matter with the RN, he stated at the beginning of each shift, an assigned staff member conducts a unit security check. The RN provided the HRA with the security checklist document, which shows what staff members are to be observant of during the check. He stated that the staff is looking at the following: windows to ensure that the screens remain intact, lights to ensure all are working, electrical outlets to ensure that there are no signs of tampering, etc. He stated that during these checks should the staff member observe something else unsafe, they are to take the necessary steps to ensure safety. He stated that absolutely no food, perishable or not, is permitted on the unit. The rule is for health reasons; the concern being the food might attract bugs or other pests. He stated that during the routine check in question, the staff member noted the bag of food in a drawer; he described the drawer as a plastic bin with clear drawer fronts.

The staff member that conducted the security check stated that the drawer to the bin was open and the bag was in plain sight. She stated that during the routine security checks if something of concern is observed, the necessary steps must be taken. She stated that had the drawer been closed and she saw the bag, she would have locked the door, reported the suspected contraband to unit management and a room search would have occurred. She stated that recipients are told when a room search is being conducted so that they have the option of observing the search. She stated that during the routine security checks, staff members are not to touch any personal possessions and they do not open any drawers/doors, closets, etc. It was also stated that the recipient's items were not disposed of, but instead placed in a "commodity box" to which the recipient would have access.

The HRA and the recipient went to his room to see the container. The container is a one-drawer plastic bin, which sat on the floor and was about 12 inches in height. At the time of our visit, a plant was sitting on the top of the bin, which somewhat obscured the drawer front. When asked, the recipient stated that the plant was not on the bin at the time of the inspection.

The Center's Off-Unit Supervision of Forensic Patients policy states (in part) that prior to leaving the unit, the recipient 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 recipients status is to be completed on a weekly basis.

Conclusion

Pursuant to the Mental Health and Developmental Disabilities Code, Section 2-102, "a recipient of services shall be provided with adequate and humane care and services in the least restrictive environment…" Contraband was found in the recipient's room; as a consequence he received a unit restriction. The allegation that the recipient received an unjust unit restriction is unsubstantiated.

Although there are two versions as to what transpired with the room search/security check; the findings do not support the claim that a room search was conducted without the recipient's knowledge; the allegation is 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

Michelle R.B. Saddler, 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

August 23, 2010

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

Re: HRA 10-100-9018

Dear Mr. Haligas:

Thank you for your thorough investigation. I am glad that this rights allegation was unsubstantiated. The staff 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,

Paul N. Brock, M.P.A., M.H.A.
Hospital Administrator

PNB/JP/aw

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