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Egyptian Regional Human Rights Authority
Report of Findings
10-110-9044
Chester Mental Health Center
September 28, 2010

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 239 male recipients. The specific allegation is as follows:

> Recipients' rights to adequate care and services have been compromised due to the closing of a unit specifically designed to accommodate their disabilities.

Statutes

If substantiated the allegation would be a violation of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/1-101.2 and 405 ILCS 5/2-102 (a)).

Section 5/1-101.2 states," 'Adequate and humane care and services' means services reasonably calculated to result in a significant improvement of the condition of a recipient of services confined in an inpatient mental health facility so that he or she may be released or services reasonably calculated to prevent further decline in the clinical condition of a recipient of services so that he or she does not present an imminent danger to self of others."

Section 5/2-102 (a) 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."

Complaint Information

According to the complaint, Unit D-3 was developed for elderly recipients with special needs to have a calmer and quieter setting where their needs were met by qualified staff. Individuals in the established criteria were transferred to Unit D-3 from other units where aggression occurred daily; thus, providing a safer environment. However, Unit D-3 was closed, and the recipients needing the specialized care were transferred to other facilities or returned to the more dangerous units where they had resided prior to the opening of D-3.

Investigation Information

To investigate the allegation, the HRA Investigation Team, consisting of two members and the HRA Coordinator (Coordinator) conducted a site visit at the facility. During the visit, the Team spoke with two Representatives of the facility's Human Rights Committee (Representative A and Representative B) and three recipients (Recipient A, Recipient B, and Recipient C).

I.. Interviews with Facility Staff:

Representative A:

When the Team spoke with Representative A regarding the allegation, he stated that unit D-3 was closed in October 2008 due to the state's budgetary issues and a decrease in recipient population. He stated that several of the recipients who resided on the unit had met the criteria established in their individual Treatment Plan Reviews (TPRs) to receive services in a less restrictive setting; therefore, a transfer was implemented. He stated that remaining recipients were transferred to other units within the facility. Representative A provided a list of the recipients who resided on the Unit D-3 at the time of closure.

Representative B:

According to Representative B, the recipient population has decreased from approximately 300 male recipients to less than 250. Due to the decrease in the number of recipients and the State budgetary crisis a decision was made by administrators at the facility to close the unit. Representative B stated that some of the recipients who were eligible to receive services in a less restrictive setting were transferred. The remaining individuals were moved to other units within the facililty. Representative B informed the Team that any individual who has significant medical issues will be sent to the facility infirmary where medical staff can provide adequate care and services.

B. Review of List of Recipients:

The Authority reviewed the list of recipients who were housed on unit D-3 at the time of the October 2008 closure. Documentation indicated that seventeen recipients resided on the unit. Seven of the recipients were transferred to less restrictive settings and ten were transferred to other units at the facility.

C: Interviews with Recipients:

During a site visit at the facility, the Team requested to speak with recipients who remained at the facility after the closing of Unit D-3. Three of the ten recipients who were listed as being transferred to other units agreed to speak with the HRA Team.

Recipient A:

Recipient A stated that he has been a recipient at the facility for fourteen years. He informed the Team that he didn't know the reason for Unit D-3 being closed; however, he was pleased with his transfer to another unit. He stated that there were several recipients with incontinence problems causing Unit D-3 to have an adverse smell on occasion. Recipient A stated that he had not experienced any problems with the transfer.

Recipient B:

According to Recipient B, he could not recall if he had been on Unit D-3, but remembered that he had been transferred from one unit to another. He stated that he was probably housed on Unit D-3 for a period of time because he had experienced some problems with not wanting to eat. He did not express any problems associated with a move to his present unit.

Recipient C:

Although Recipient C was listed as residing on Unit D-3 when it was closed, the recipient denied being on the Unit at any time during his stay at the facility.

Summary

According to the complaint Unit D-3 was developed for elderly recipients with special needs, and the closure of the unit presented problems for the individuals who were transferred to other units. When the Team spoke with two Representatives, both stated that the unit was closed due to the decrease in recipient population and the State's budgetary problems. One of the Representatives stated that if a recipient has significant medical issues the recipient will be housed in the facility's infirmary in order that medical staff may provide appropriate care. A list of the recipients who were transferred to other units was provided to HRA. When the Team interviewed three of the recipients, two informed the Team that they had experienced any problems with transfer, and the third recipient denied being on the unit at the time of closure.

Conclusion

Based on the information obtained, the allegation that the recipient's right to adequate care and services were compromised due to closing of the unit specifically designed to accommodate their disabilities is unsubstantiated. No recommendations are issued.

Suggestion

The following suggestion is offered:

The facility should include a statement in the infirmary policy to demonstrate that the services provided to those individuals with specialized needs who were previously housed on Unit D-3 will be provided in the infirmary.