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Egyptian Regional Human Rights Authority
Report of Findings
11-110-9006
Chester Mental Health Center
November 16, 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 approximately 230 male recipients. The specific allegation is as follows:

> A recipient at Chester Mental Health Center was inappropriately placed in restraints.

Statutes

If substantiated, the allegation would be a violation of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/2-102 (a), 405 ILCS 5/2-108 and 405 ILCS 5/2-201).

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."

Section 5/2-109 states, "Restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be utilized. In no event shall restraint be utilized to punish or discipline a recipient, nor is restraint to be used as a convenience for staff."

Section 5/2-201 states, "Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to (1) the recipient and, if the recipient is a minor or under guardianship, his parent or guardian; (2) a person designated under subsection (b) of Section 2-100 upon commencement of services or at any later time to receive such notice; (3) the facility director; (4) the Guardianship and Advocacy Commission, or the agency designated

in 'An Act in relation to the protection and advocacy of rights of persons with developmental disabilities and amending the Acts therein names', approved September 20, 1984, if either is so designated; and (5) the recipient's substitute decision maker, if any. The professional shall be responsible for promptly recording such restriction or use of restraints or seclusion and the reason therefor in the recipient's record."

Investigation Information

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 recipient whose rights were alleged to have been violated. The Team also spoke with a Representative (Representative) from the facility's Human Rights Committee. With the recipient's written authorization, his clinical chart was reviewed and copies of pertinent information were provided to the Authority. The facility's Policy and Program/Policy Directive pertinent to restraints were reviewed.

I...Interviews:

A...Recipient:

According to the recipient, he was incarcerated for more than a year in a county jail before he was transferred to another state-operated hospital. The recipient stated that he was transferred from the less restrictive facility to Chester Mental Health Center in June 2010 with a legal status of NGRI (Not Guilty by Reason of Insanity).

The recipient informed the Team that in July 2010, he was inappropriately placed in restraints. He stated that when another recipient attacked him he attempted to defend himself. However, STAs (Security Therapy Aides) blamed him for the incident, and he was placed in restraints. The recipient stated that the other recipient was not placed in restraints and did not experience any type of adverse consequences for his actions.

The recipient stated that this was his initial placement in restraints, and he has not been placed in restraints since the July incident. He stated that he is on the Yellow Level, the mid level of participation in the facility's level system that addresses a recipient's access to the facility and need for supervision.

B: Representative:

According to the Representative, restraints are only applied when a recipient is a danger to self or others and in accordance with the Code's requirements. The Representative stated that the facility has a written restraint policy and also follows program directives which mirror the Code's requirements.

II: Record Review:

A: TPRs

Documentation in a 07/20/10 TPR indicated that the 30-year-old recipient was transferred to Chester Mental Health Center on 06/01/2010 from a less restrictive state-operated mental health facility. The recipient's legal status was listed as NGRI, and his theim date (date of anticipated discharge) recorded as 05/27/2012. The record indicated that the recipient was transferred because he was considered a dangerous risk to others and would benefit from the structure of a maximum security setting in order to successfully manage his aggression and impulsive behaviors.

The recipient's diagnoses were listed as follows: AXIS I: Bipolar I Disorder, Manic with Psychotic Features; AXIS II: Anti-Social Personality Disorder; AXIS III: None; AXIS IV: NGRI on 11/04/09, Theim date 05/27/2012.

According to the 07/20/10 TPR the recipient's medications were listed as: 1) Risperidone 2 mg in AM, 4 mg at bedtime for psychosis and mood disorder; and 2) Oxcarbazepine 600mg every AM, 900mg every PM for mood stabilization.

Documentation indicated that the recipient was informed of the circumstances under which the law permits the use of emergency forced medication, restraint or seclusion. Should any of these circumstances arise, the recipient listed the following forms of intervention in order of preference: 1) seclusion 2) emergency medications and 3) none.

The recipient's 07/20/10 TPR contained a goal to reduce his psychotic symptoms and impulsive behaviors. Treatment interventions included the following: 1) The psychiatrist will prescribe medication and report the effects on the patient; 2) Nursing staff will administer medication and encourage and monitor compliance; 3) The psychiatrist, nurses and STAs will report if the recipient complains of side effects or is observed to be experiencing side effects; 4) The psychiatrist and nurses will work with the recipient for him to understand the need to continue taking the medications.

The same treatment interventions were listed to assist the recipient with the problem of aggression. In addition, STA staff members were to inform the recipient of the limits on his behaviors and that violent behaviors would not be tolerated. All staff members were to report any instances of verbal or physical aggression, and property destruction. Nursing staff and STAs were to ensure that the recipient's preferences for emergency interventions are followed. While the recipient is participating in on-unit and off-unit activities, the activity staff members were to observe, monitor and report the targeted behaviors, level of participation and progress toward the goal.

According to the record, STAs stated that during the reporting period the recipient continued to test the limits of module rules and had tried to start altercations with other recipients. However, the psychiatrist reported that the recipient's physically aggressive behaviors were controlled. An RN conveyed that the recipient had experienced instances of agitation, but he had requested and received medication for the agitation, and had required restraints on one occasion.

Documentation in the Extent to Which Benefitting From Treatment Section of the 07/20/10 TPR indicated that on two occasions the recipient had been sexually inappropriate with a female staff member at the transferring facility. He was found inside the nursing station and another unauthorized area at the facility. He was transferred due to his unpredictable behaviors and his escape risk. The record indicated that he was considered an unauthorized absence risk due to working his way out of handcuffs while returning from court to the transferring facility. Documentation indicated that although the recipient's behavior had started to improve as he adjusted at Chester Mental Health Center, he had recently received 10 BDRs (Behavior Data Reports) for horse playing, verbal aggression and failure to follow module rules. When the 07/20/10 TPR meeting was conducted, the record indicated that the recipient was not displaying any verbal or physical aggression, had denied any thoughts of self-injurious behaviors and had stated a willingness to comply with the treatment team's recommendation.

Documentation in the Extent to Which Benefitting From Treatment Section of the 08/17/10 TPR indicated that the recipient had received several BDR reports for behaviors such as trading his Nintendo DS with a peer and making inappropriate comments to staff members. However, he had not displayed any verbal or physical aggression, denied any thoughts of self-injurious behavior and stated a willingness to comply with treatment.

B...Restraint Records:

Documentation in a 07/03/10 Order for Physical Hold indicated that the recipient was very argumentative and threatening toward staff and a resident, and he had attempted to hit a staff member. The record indicated that the recipient was placed in a physical hold at 7:10 PM and was released at 7:15 PM. A RN and facility physician verified personal examination of the recipient at 7:15 PM by signing the Order. Both medical professionals documented that the hold did not pose an undue risk to the individual physical or medical condition.

According to the record, the recipient was provided with a Restriction Notice (Notice) for the 07/03/10 Physical Hold. Documentation indicated that the Notice was delivered to the recipient in person, and he did not wish anyone notified of the hold.

An Order for Restraint was issued at 7:15 PM after the recipient refused to "calm down while in the hold". The record indicated that two attempts of empathic listening, distraction and verbal support failed prior to the restraint application. The release criteria were listed as follows: 1) The recipient must be calm, quiet and cooperative with reviews; 2) He must deny any thought of self harm or harm to others; and 3) He must not pull on restraints. The established criteria

must be exhibited for a period of 60 minutes before release. An RN examined the recipient at 7:15 PM, and a physician examined him at 7:25 PM. Both medical staff members determined that the restraints did not pose an undue risk to the recipient.

When the recipient failed to meet the established release criteria at the expiration of the initial Order at 11:15 PM on 07/03/10, a second order was issued. Documentation indicated that an RN and a physician examined the recipient at 11:15 PM and determined that the restraint application did not pose a risk to the recipient.

Documentation in Restraint Flowsheets (Flowsheets) indicated that post application a body search was completed. The following were determined: 1) The restraints were properly applied; 2) The room environment was appropriate; 3) The recipient was wearing proper clothing for the restraint; and he was properly positioned. Documentation indicated that he was informed of the reason for the restraint, the criteria for release, and provided with a Notice pertinent to the restraint.

Recordings in the Flowsheets indicated that the recipient was continually observed, and his behaviors/conditions recorded in fifteen minute increments during the entire restraint episode. Documentation indicated that the recipient was examined by a RN on an hourly basis. During the evaluations his circulation was checked, limbs released, vital signs taken and his physical and mental status evaluated. He was offered fluids and toileting on an hourly basis. Documentation indicated that he met the criteria for release at 3:15 AM on 07/04/10.

The record indicated that the recipient was provided with a Notice for the 8 hour restraint. The reason for the restriction was listed as the recipient had attacked staff. Documentation indicated the recipient's preferred intervention was not used due to his refusal to calm himself and for the safety of all. According to the documentation, the Notice was delivered to the recipient in person, and he expressed that he did not want anyone notified of the restraint.

Documentation indicated that an RN conducted a Post-Episode Debriefing with the recipient at 3:15 AM on 07/04/10. According to the record, the recipient was able to identify the stressors occurring prior to the restraint and was able to understand the causes and consequences of the aggressive behaviors. He stated that he felt that staff could help him to remain in control, and he was aware that he could request help from staff prior to escalation of his anxiety. Documentation indicated that the recipient was encouraged to discuss his feelings related to the restraint and to identify methods to control his aggressive behaviors. Documentation indicated that the recipient had never been in restraints prior to this incident. It was determined that a physical injury had not occurred during the event and his physical well-being and privacy needs were addressed while he was in restraints.

C...Progress Note

Documentation in an RN's 7:15 PM Progress Note on 07/03/10 indicated that the recipient had a verbal altercation with another recipient. When staff attempted to calm and redirect the recipient, he became hostile and attempted to strike a staff member. The RN recorded that due to these actions and for the safety of all the recipient was placed in full leather restraints. The RN documented that after the restraints were applied, his condition was stable, circulation good and no injuries were noted. The record indicated that a facility physician was notified, a Notice was given to the recipient, and a urinal was placed at his bedside.

A physician recorded at 7:15 PM on 07/03/10 that the recipient had been verbally threatening toward peers and had attempted to strike staff. He was placed in a five minute physical hold and transferred to full leather restraints for the safety of all.

A STA recorded at 11:15 PM on 07/03/10 that the recipient was talking "very bizarre and demanding release". The STA documented that the recipient had failed to meet the release criteria; therefore, the restraint application would continue. A physician recorded at 1:15 PM that due to the recipient's continued unstable and unpredictable condition a second restraint Order was issued for the safety of all.

An RN documented at 3:15 AM on 07/10/10 that the recipient took responsibility for his actions and stated that he would not engage in any type of physical attack on others; therefore, he was released from the restraints.

The HRA's review of the recipient's clinical records did not reveal that the recipient had required any additional restraint applications.

III...Facility Policy and Program/Policy Directive

A...Use of Restraint and Seclusion (Containment) in Mental Health Facilities Policy (Policy)

The Policy Statement is listed as follows, "Chester Mental Health Center uses restraint and seclusion only as a therapeutic measure to prevent an individual from causing physical harm to himself or others and follows the Department of Human Services Program Directive 02.02.06.030"

B: Illinois Department of Human Services Program Directive 02.02.06.030 (Directive).

The Policy Statement in the Directive is as follows, "It is the policy of the Department of Human Services, Mental Health (DHS/MH) that the use of restraint or seclusion be limited to emergencies in which there is an imminent risk to an individual harming himself or herself, other

patients, or staff. This directive is the primary directive for the use of restraint and seclusion in mental health facilities. It is consistent with the requirements of the Mental Health and Developmental Disabilities Code. It supersedes any previous DHS or mental health facility procedure. For clinical and administrative reasons the DHS may have chosen in this directive to exceed MHDD Code or Joint Commission on Accreditation of Health Care Organization (JCAHO) requirements; therefore, this directive takes precedence.

Neither restraint nor seclusion may ever be used to punish or discipline an individual or as a convenience to staff. The least restrictive intervention that is safe and effective for a given individual will be used. It is the role of leadership to help create a physical, social, and cultural environment in which the approach to restraint and seclusion protects the individual's health and safety; preserves his or her dignity, rights, and well-being; and minimizes the risks to staff and others. Limiting restraint and seclusion use to clinically-appropriate and alternative strategies is the role of all staff. An approach to restraint and seclusion utilization that focuses on reduction while striving to assure the safety of the individual, other patients, and staff requires planning, thoughtful education, and continuous efforts at performance improvement.

The circumstances that result in the use of restraint or seclusion are complex. Consequently, the strategies for reducing and eliminating restraint and seclusion use must be multi-faceted and incorporate multiple points of view, including those of patients, consumers, and staff at all levels of the organization. It is the position of DHS/MH that the goal of reduced restraint and seclusion utilization be approached through a broad range of strategies for enhancing positive behaviors, preventing destructive behaviors, and limiting the circumstances that may necessitate the use of restraint or seclusion. These include, but are not limited to:

1. the use of nonphysical interventions as preferred interventions for both patients and staff;
2. the implementation of staff training based upon a nationally-recognized training program in conflict de-escalation and prevention;
3. the inclusion of the consumer perspective on the restraint and seclusion experience and perceived opportunities for reducing utilization; and
4. effective assessment and treatment."

Summary

According to the recipient, he was placed in restraints without a valid reason for the application. He informed the Team that he had never been placed in restraints; therefore, the 07/03/10 incident was very stressful. Documentation throughout the recipient's chart indicated that the recipient was involved in a verbal altercation with a peer, and when a staff member attempted to calm him the recipient struck at the staff member. The record indicated that the recipient was placed in a physical hold, and then transferred to restraints due to the level of his aggressive behaviors.

Conclusion

The Code, facility Policy, and DHS/MH Directive allow for restraint use as a therapeutic measure to prevent an individual from causing physical harm to self or others; therefore, the allegation that the recipient was inappropriately placed in restraints is unsubstantiated. No recommendations are issued.

Suggestion

Although documentation indicated that the recipient's level of aggression required the restraint application, the Authority suggests that the facility make every effort to consider recipients' preferences when emergency interventions are required. If a recipient only indicates two preferences, remind him that he can designate an additional, third preference.