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Egyptian Regional Human Rights Authority
Report of Findings
Chester Mental Health Center
Case #12-110-9005

The Egyptian Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning Chester Mental Health Center:

1. A recipient has been inappropriately restricted from attending off-unit activities.
2. The recipient was not provided with a Restriction of Rights Notice when the restriction was implemented.

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

Chester Mental Health Center is a secure, inpatient mental health facility operated by the Illinois Department of Human Services. The facility has 240 beds. Approximately half of service recipients receive forensic services upon court referral after having been found either unfit to stand trial or not guilty by reason of insanity. The remaining service recipients have been civilly committed.

To investigate the allegations, an HRA team interviewed a service recipient and facility staff, examined a recipient's record, with consent, and reviewed pertinent facility policies and procedures.

FINDINGS

Interviews

According to an interview, a recipient was restricted from participating in off-unit activities in September 2011 without an adequate reason and with no restriction of rights notice. He stated that as of November 2011, the restriction was lifted. The recipient stated that he has been at the facility since May of 2010 and has previous admissions both at Chester and at another state-operated mental health facility.

Staff reported to the HRA that there is a facility "level system" in place that guides recipient access to the facility as well as the process for increasing and decreasing access. Restriction notices are used when access is denied or decreased. Staff indicated that facility access changes due to recipient needs, safety issues and behavioral risks. The treatment team evaluates a recipient's level status.

Record Review

The HRA reviewed the recipient's treatment plan, dated 11-01-11, which states that the recipient was found unfit to stand trial on 04-09-10 and was admitted to the facility on 05-03-10. The recipient has a history of four admissions to the facility and a total of eight admissions to Illinois Department of Human Services facilities. The recipient's Axis I diagnoses include Schizoaffective Disorder, Bipolar Type and Polysubstance Dependence, in remission. The recipient is on court-enforced medication (Haloperidol Decanoate) for psychosis. According to the treatment plan, the recipient continues to have delusions related to Jesus Christ, satellites and cameras. The treatment plan includes goals to address fitness restoration, aggression, psychotic symptoms, weight issues, high cholesterol, and physical pain. The plan states that the recipient has required restraints on 9 different occasions; all but one restraint episode occurred in 2010 and the most recent occurred on 09-05-11. The recipient was placed in seclusion on 3 occasions in 2010. In August 2011, the physician discontinued Olanzapine and was awaiting approval to begin a different medication, Risperidone Consta; however, due to 2 incidents of verbal aggression and one incident of physical aggression the Olanzapine was reinstated. At the time of the treatment plan review, the recipient was not on a unit restriction, but his history of volatile behavior was noted. The recipient was documented as being present at the treatment plan meeting, and he signed his treatment plan.

A restriction of rights notice, dated 09-19-11, states that the recipient was restricted to the unit because he was "…extremely unpredictable due to clinical instability - threatens to harm others if off the unit." The restriction notice documents that the restriction time period is from 09-19-11 through 10-19-11, with weekly reviews. The notice was signed by a social worker and does not indicate that the recipient wanted anyone notified of the restriction.

Accompanying progress notes from 09-19-11 begin with a nurse's note stating that the recipient was not sleeping during the early morning shift and had not slept the prior evening. A therapist note at 9 a.m. states that the recipient was placed on unit restriction "…due to his continued clinical deterioration and unpredictable behavior." Later that day, sutures were removed from the recipient's right ear. Progress notes stated that the recipient repeatedly refused some medication and his refusals were honored; however, court-ordered medication appeared to be given. A nursing note on 09-26-11 stated that the recipient approached the nurse's station "ranting and raving over hurting, and 'those damn satellites.'" He was given Ibuprofen. A physician's note later in the day stated that the recipient was restricted from making a phone call referencing threatening statements, agitation, accusatory statements by the recipient, loudness and screaming "non-stop for 2 nights." Other documentation indicated that the recipient was not specifically restricted from phone use; instead, he was informed that recipients cannot make in-house calls from the patient phones when he attempted to call the facility administration.

Behavior data reports were reviewed. A report dated 09-18-2011 at 10:30 a.m. checks off certain recipient behaviors observed by staff, including the following: noncompliance with directions, manipulating/bullying, verbal threats, bizarre behavior/delusions, hallucinations, and denial of mental illness. Narrative statements included in the report reported that the recipient was volatile on the unit and displayed violence when angry and when someone disagreed with or challenged him. Another documented statement indicated that his medication had been discontinued.

Further documentation states that the recipient "…has been steadily deteriorating since his daily shots were d/c [discontinued]. Rec [recipient] is becoming more grandiose in his beliefs that JC (Jesus Christ] is in him and he is becoming God-like. If any attempt is made to question or reason with Rec or even to get him to leave other patients or staff alone instead of forcing his beliefs and invading their personal space he becomes angry and is on the verge of violence."

A behavior data report dated 10-6-2011 at 17:00 documented verbal threats and included a narrative statement reporting that the recipient "…believes JC is telling him things about a recipient at [another facility]…He has been more aggressive and his thoughts with JC are more aggravating to him. Everyday he becomes more aggressive and his delusions are much worse." And, a data report dated 12-09-11 at 19:20 indicates the presence of the following behaviors: physical aggression, verbal threats, and loudness; an accompanying narrative statement indicated that the recipient "almost came to blows with [another recipient] over a card game. He was yelling and extremely angry, blaming the God Damn satellites!"

Chester Mental Health Center Information Reports were also reviewed; these reports document behavioral incidents. Reports from seven different employees document an incident that occurred on 09-05-11 in which restraints were applied after he struck a peer in the face and threatened to kill staff. One report from an incident that occurred on 09-11-11 at 18:15 documented that the recipient became upset and started yelling at a peer who sat at his table in the dining room. When attempts to calm him were unsuccessful he was escorted to back to the unit; on his way out of the dining room, he threw food at the peer. The recipient was placed on a dining room restriction. Two reports from a 09-26-11 incident that occurred at 10:00 indicated that the recipient became upset after unsuccessfully trying to make an in-house phone call to the facility director. Although the recipient could use the patient phone for external phone calls, the report stated that "…patients are not allowed to call within the hospital." When attempts to calm the recipient were unsuccessful, the recipient was given court-enforced medication. In a follow-up contact with the facility human rights chair, the HRA learned that recipients should be able to make internal calls from patient phones unless the phones are turned off during treatment. The chair examined the time frame of the 09-26-11 incident and reported that the phones would have been on and the recipient should have been able to make an in-house phone call unless he was restricted; however, the chair could not find documentation of a rights restriction notice.

Policy Review

The facility's Level System Procedure states that the level system is a means to reinforce appropriate behaviors and manage maladaptive behaviors that pose risks. The level system review is part of each recipient's treatment planning process. Having a restrictive level does not automatically preclude participation in groups or classes as per the policy. The most restrictive level is Red in which recipients are confined to the unit except for church, the dining room, the gym, cook-outs, Birthday parties, and the commissary one time per week. The next level is Yellow in which recipients are still primarily restricted to the unit but can take part in more off-unit activities. Green is the highest level and with the greatest access to off-unit activities. The policy explains the movement through the levels if no behaviors occur within specified periods of time. Each unit maintains level system documentation indicating each patient's respective level, anticipated date for progressing, the reason for placing on a more restrictive level, and restrictions to any groups or classes. The process for placing a recipient on a more restrictive

level due to behaviors is described. Staff who observe a behavior will evaluate it in terms of whether the behavior is considered physical aggression, property destruction, predatory sexual behavior or self-injury, and, if so, a level change will occur; recipients are informed of level changes. The type of behavior exhibited will determine whether restrictions from attending groups or classes are warranted. The procedure also outlines special situations in which a level may be changed, such as the presence of psychosis or cognitive deficits that impact a recipient's awareness and orientation, the severity or frequency of a given behavior, or based on clinical judgment.

MANDATES

The Mental Health and Developmental Disabilities Code (405 ILCS 5/ 2-102) guarantees that "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…. 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." Furthermore, the Code states in Section 2-201, "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:… the recipient…."

CONCLUSIONS

According to the complaints, a recipient was inappropriately placed on a unit restriction with no restriction of rights notice.

Documentation indicated that the recipient had multiple behavioral issues and a deterioration in his condition the day prior to the unit restriction. It was stated that the behaviors may have been related to a medication issue; however, the HRA notes that the recipient was experiencing medical and pain issues as well.

Facility policy on the level system allows for unit restrictions due to psychosis, cognitive deficits or based on clinical judgment. Documentation of the recipient's condition seems to support the unit restriction as per policy; a restriction of rights notice was part of the recipient's file.

The Mental Health Code does not specifically state that access to facility grounds is a guaranteed right although the Code does guarantee services in the least restrictive setting. If a guaranteed right is restricted, a restriction of rights is to be provided.

The HRA did find that the recipient's behaviors appeared to have led to a telephone restriction on 09-26-11 when the recipient was restricted from making an in-house phone call from the patient phones when the phones were to be available for patient use; however, there was no restriction notice issued.

Based on the documented evidence, the HRA finds no violations of the Mental Health Code

or facility policy pertaining to the 09-19-11 change in the recipient's facility access level. The HRA does find a violation of the Code's restriction notice provisions when, on 09-26-11, the recipient was restricted from making an in-house call and no restriction notice was provided. The HRA notes that the facility did issue a restriction notice for the level status change that occurred on 09-19-11. Based on its findings, the HRA issues the following recommendation:

1. **When telephone communication is restricted during times in which the patient phones are to be in use, issue a restriction notice in accordance with the Mental Health and Developmental Disabilities Code.**

Comment

With regard to the 09-26-11, documentation stated that "patients are not allowed to call within the hospital." Follow-up contact with the Chair indicated that patients can make in-house calls unless the phone is turned off during treatment. The HRA offers the following suggestion:

1. Ensure that staff and recipients know that patients can use the patient phones for in-house calls when the phones are available for use.