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Egyptian Regional Human Rights Authority
Report of Findings
Case #12-110-9011
Chester Mental Health Center

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

A recipient is dissatisfied with his therapist and his request to change therapists has been denied.

If found substantiated, the allegation would represent a violation of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

To investigate the allegations, an HRA team met with and interviewed a service recipient and facility representatives, reviewed a recipient's record, with consent, and examined pertinent agency policies and relevant statutes.

Chester Mental Health Center is a secure, inpatient mental health facility operated by the Illinois Department of Human Services. The facility has 240 beds.

COMPLAINT STATEMENT

According to the complaint, a recipient has had the same therapist for three years and the therapist does not act on the recipient's behalf and does not like the recipient. A request for a different therapist has been attempted but refused. The complaint further stated that during the treatment plan review meetings, the therapist is particularly negative while other facility staff report more positive information about the recipient.

FINDINGS

Interviews
In interviews with the service recipient, the HRA team learned that the recipient and therapist have had disagreements over therapeutic approaches. The recipient verified that he has seen the therapist weekly for the past three years and the therapist is negative toward the recipient during therapy sessions. In addition, the recipient stated that the therapist is particularly negative

toward the recipient and his progress during treatment planning reviews (TPRs) while other treatment team members are positive regarding the recipient and his progress.

The HRA team spoke to the chair of the facility's human rights committee regarding the situation. The chair reported that the recipient's current therapist has expertise on subject matter related to the recipient's risk factors. According to the chair, the recipient's sexually acting out behaviors make his situation more stringent. Furthermore, the only other therapist available to the recipient is a female therapist who is unwilling to provide therapy due to the recipient's sexually acting out behaviors. In follow-up contact with the internal human rights committee chair, the HRA learned that there is no policy that outlines the process for a patient to request a different therapist. It was reported that the patient would usually report a request to the treatment team which would then go to the unit director with oversight of the unit in question. The unit director would consider the request and determine if there is a valid reason for changing therapists. If the reason for the request is considered valid, the unit director would assign a different therapist. If the reason for the request is not considered to be valid, then the unit director would not change the therapist. Cases are considered and resolved on an individual basis and if the unit director is unsure about the request, he/she can consult with the clinical director and then the hospital administrator to make a determination.

Record Review

With recipient consent, the HRA team examined the record of a recipient. The dates of sessions with the therapist for the past six months are listed as follows: 10-06-11; 10-21-11; 11-17-11; 11-21-11; 12-16-11; 01-09-12; 01-27-12; and, 02-03-12.

Progress notes related to the complaint state:

10-06-11 - Therapy Progress Note - "This afternoon I met with [the recipient] in my office for approximately thirty minutes. We discuss his progress in attaining his therapy goals. His progress remains rather poor. We went over some materials in the literature on personality traits which are related to [the recipient's] clinical profile. One of the items, 'gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations.' [The recipient] became verbally hostile and stated he is not admitted to this facility because of any wrong doing. He stated that the treatment team 'wants to keep me here because you don't like me…its personal and I ain't personal.' I brought up the idea of 'blaming others' for his current situation - and encouraged him to monitor his own actions and assess how his own actions result in his continued admission. [The recipient] was unable to discuss these clinical issues in a rational manner. He directed verbally hostile statements to me - some of which alluded to his ability to inflict harm on others."

10-18-11 - Therapy Progress Note by a different therapist - "[The recipient] refused to meet with this therapist for the purpose of discussion about Involuntary Commitment Hearing on 10-19-11. Therapist referred to treatment team and the clinical chart for current information. [The recipient] continues to meet the criteria for Involuntary Commitment."

10-19-11 - Court Note - "[The recipient] was found subject to Involuntary Commitment for a period not to exceed 180 days."

10-21-11 - Therapist Progress Note - "This afternoon I met with [the recipient] for approximately thirty minutes. We discussed his court hearing for Involuntary Commitment. [The recipient] stated they keep bringing up his past - referring to sex offender status. He stated 'I got cured…if they keep reminding me…it might turn things around.' I asked if he meant that he may experience a period of decompensation - he refused to comment. He later stated 'you guys know I ain't got no problem…that's what pisses me off.' He stated the judge agrees to commit him because 'you bribe him.' Mr. Hughes stated that historically the mental health centers have 'been letting me out in the winter time and picking me up in the summer…not allowing me to get no sun…make it so I'm not a black man…I'm this red…this hue.' [The recipient] indicated that over the years [elected officials] have made sure that he has been 'locked up.' He stated that the only law he ' ever broke was stealing candy when I was a little kid.' [The recipient] became hostile when I asked him to attempt to provide a more reasoned explanation for his long term admission. I encouraged him to think about what a more rational explanation would sound like - and for him to be ready to provide that next week."

02-13-12 - Therapist Progress Note - "This afternoon I met with [the recipient] in my office for approximately thirty minutes. It had come to my attention through report of a previous coordinating therapist that [the recipient] had stated it is better to harm a person's family member than to actually harm the person. I asked [the recipient] about this statement today and he became quite defensive. He stated 'if I did say something like that it's because when my father died…I had been telling you people that I wanted to see him in his last days.' He also stated that he felt pressure while he was on Unit E and he mentioned feeling a lot of anger toward [a name is listed but with no relationship identified.] I encouraged [the recipient] to consider how these kinds of statements make others feel. [The recipient] was unable to engage in a meaningful discussion regarding how his maladaptive statements and behaviors negatively impact others."

09-27-11 Treatment Plan:
Two treatment plans were reviewed; one was dated 09-27-11 and the other, more current plan, was dated 01-17-12.

The treatment plan dated 09-27-11 documents the recipient's reason for admission and history. The recipient was admitted to Chester on 02-29-08 as involuntary from a correctional center upon reaching his projected parole date. The recipient has a history of state-operated psychiatric hospitalizations dating back to 1977. He also was sent back to the correctional facility at one point after "…intimidating and stalking female staff." His criminal past includes serving sentences for indecent liberties to a minor, home invasion, attempted murder, and burglary. He then served more than 13 years in a correctional facility psychiatric center after shooting a public official's family member and raping the family member's girlfriend. According to the treatment plan, the recipient has "…a history of threatening his psychiatrists and threatening family members."

The discussion portion of the 09-27-11 treatment plan stated that the recipient was moved to a unit that houses recipients with aggressive behaviors; the move was partially due to repeated incidents of exposing himself to female staff. At the same time, the recipient is described as being "verbally hostile, stating he has reached his treatment goals," little to no acknowledgement of his past criminal or violent behaviors and the resulting impact, and little insight on

"maladaptive sexual and aggressive behaviors…." His primary diagnoses are listed as follows: Schizoaffective Disorder, Bipolar Type, Antisocial Personality Disorder, Hypertension and Non-Insulin Dependent Diabetes Mellitus and he takes Risperidon 4 mg Bid for psychosis and Divalproex ER 1500 mg for mood lability.

The 09-27-11 treatment plan lists the following **goals**:

- Adaptive social function without inappropriate sexual behaviors for 6 consecutive months;
- Adaptive function with reduced/eliminated psychiatric symptoms for 6 consecutive months;
- Lowered blood pressure;
- Weight loss within ideal body weight;
- Social function free of physical aggression for 12 consecutive months;
- Reduced pain and discomfort from spurring of the spine;
- Reduced cholesterol and/or triglycerides; and,
- Stabilized blood sugar and prevention of hyperglycemic/hypoglycemic incidents.

Corresponding **objectives** include the following:

- Improved insight into maladaptive sexual behaviors and impact for 6 consecutive months;
- Improved insight into medication compliance and impact on transferring out of facility for 6 consecutive months;
- Medication understanding and compliance by 12-2011;
- Compliance with lab and blood pressure monitoring by 12-2011;
- Understanding of nutrition, exercise and weight loss and maintenance by 12-2011;
- Cooperation "…in meetings with the coordinating therapist (as well as in other therapeutic activities) addressing his need to develop adaptive social skills;
- Refrain from engaging in aggressive behaviors;
- Improved insight into how his maladaptive behaviors have a negative/harmful impact on others;
- Completed cognitive behavioral homework assignments designed to assist him in addressing 1. Cognitive distortions. 2. Regard for the welfare of others. 3. Inability to take responsibility for his own behaviors;"
- Decreased pain/discomfort by 12-2011;
- Understanding of symptoms of hypo/hyperglycemia by 12-2011; and,
- Understanding of diabetes care.

Prescribed treatment plan **interventions** include:

- Weekly therapist meetings with recipient regarding non-aggressive behaviors, impact of maladaptive behaviors, sense of empathy, insight into psychiatric condition and social interactive skills;
- Aide reminders of more appropriate behavioral alternatives for inappropriate sexual behaviors;
- Medication administration, education and monitoring;
- Nursing monitoring and education on diabetes, blood pressure, diet;

- Attendance at 5 gym or exercise sessions per week;
- Goal directed behaviors such as computer skills, educational activities, and pro-social behaviors; and documentation of aggressive incidents.

Progress notes are documented as follows: insight remains limited; on 08-03-11 disrobed in front of female staff; medication insight limited; no PRNs, restraints or seclusion; no medication refusals; faulty cognition and delusions continue; labs are normal; no complaints of symptoms; regular diet; weight above ideal weight range; meeting goal of gym/exercise 5 times per week; on 08-07-11 aggressive toward peer and violent speech; 75% attendance in a rehabilitation class; stable accuchecks; refuses diabetic diet; and, refuses diabetic education information.

In the extent to which the recipient is benefitting from treatment section of the treatment plan, it is documented that the recipient received PRN medications for agitation on 02-03-11 and 02-09-11; took his shirt off in front of female staff on 02-27-11; exposed himself again to female staff on 07-27-11 and on 08-03-11; was aggressive to peers on 03-06-11, 03-17-11, 04-22-11, 06-05-11, and 08-07-11; made inappropriate sexual statements and gestures to female staff on 06-01-11; and was threatening to staff on 06-03-11.

Under the criteria for separation, the 09-27-11 treatment plan indicates that a transfer will be submitted when the recipient's "behavior, sexual inappropriateness and psychosis has been brought under sufficient control….He will also demonstrate a consistent ability to function without engaging in physically aggressive behavior…[and] will also demonstration significant progress in the following areas: addressing cognitive distortions, discontinue minimizing seriousness of his maladaptive behavior; developing empathy for others (especially victims); managing his emotions (especially anger); and taking responsibility for his actions." The criteria for involuntary admission includes state-operated mental health facility and correctional facility history dating back to 2009 that documents incidents that involve choking peers; fixating on female staff; aggressive gestures toward a psychiatrist; sexual statements to female staff and peers; verbal aggression at treatment team meetings; fracturing the orbital bone of a peer; attempting to start a fire through an outlet, etc. The recipient did attend his 09-27-11 treatment planning meeting but his specific input regarding treatment goals or preferences is not listed.

01-17-12 Treatment Plan:
In the 01-17-12 treatment plan, the updated discussion section documented a PRN medication on 12-22-11 due to agitation, threats to staff on 01-06-12 and 01-07-12 and anger and profanity toward his therapist on 01-30-12. Diagnoses and medications remain the same as the 09-27-11 treatment plan. Goals, objectives and interventions remain exactly the same as the 09-27-11 treatment plan with a few date changes. Progress notes are also very similar with the following exceptions: an updated lab level is noted, the recipient reportedly had no PRNs, restraints or seclusions; his tardive dyskinesia rate changed slightly; therapist statements regarding current delusions were noted; he lost a few pounds; medication compliance continues; verbally hostile statements toward staff were noted on 01-06-12 and 01-07-12; his attendance in a prior class was noted to be 100% and in a new class is at 83%; and, an updated accucheck score is listed. The "extent to which benefitting from treatment section" is exactly the same as the 09-27-11 plan as are the sections regarding the criteria for separation and the criteria for involuntary admission.

There was no specific documentation of recipient preferences or input in treatment plan development.

Utilization Reviews:
The HRA examined two utilization review forms, one dated 11-10-11 and the other dated 02-09-12. Documentation on each form is exactly identical with regard to discharge barriers, recommendations from the previous review, progress made and changes to recommendations with a few exceptions. On both forms, the stated barriers include behaviors that pose a risk of harm to self and others, including maladaptive sexual behaviors and aggression toward peers, and thought disorder manifested by delusional statements. Under progress, each form states that the recipient does not take responsibility for his behaviors, his insight is poor and he needs to improve social functioning by addressing cognitive distortions, refrain from minimizing serious behaviors, developing empathy, managing emotions and taking responsibility for his actions. The 11-10-11 form cites behavioral issues on 06-16-11 and 07-27-11, exposing self to female staff on 08-03-11, making sexual statements to female staff on 06-01-11, aggression toward a peer on 07-31-11 and aggressive gestures on 11-01-11. The 02-09-12 form cited aggression toward a peer on 11-29-12, verbal threats to staff on 01-06-12 and 01-07-12 and staring at a female nurse on 02-03-12. A handwritten statement on 11-10-11 form made note of a "psycho pharm review." And a handwritten note on the 02-09-12 form states "monitor response to insight-oriented and empathy training. Communicate barriers to transfer with patient and ways he can demonstrate that he can reduce such." It appears that a medication review was conducted on 12-21-11 in which the treating psychiatrist reviewed current medication, response to medication, lab results, behavioral incidents, medication history, and diagnoses. Handwritten notes on the medication review raises questions concerning the effectiveness of long term medication use, the use of various protocols, the possibility of decreasing one medication and the possible addition of a medication to tone down sexual preoccupation.

Rehabilitation Notes:
Recent rehabilitation progress reports from 02-11-12 document the recipient's appropriate personal care, interpersonal relationships, social behaviors (no incidents of verbal or physical aggression), work readiness, and limited symptoms of mental illness interfering with learning, with a brief mention of anxiety.

Other:
The HRA found no documentation that the recipient had filed a complaint with the facility regarding his therapist. There was also no record documentation that the recipient requested a change in therapists.

Policy/Practice Review
Although there is no specific policy related to requesting a change in therapists, the facility does maintain a grievance policy and procedure that involves a written complaint form or verbal reports being filed with the facility's internal human rights committee. The committee chair meets with recipients and involved staff and the committee typically provides a written response to reported concerns.

Illinois Department of Human Services (DHS) Website Review

The DHS website identifies and emphasizes strategies to help in the recovery of mental illness described as "Evidence-Based Practices State-of-the-Art Strategies to Help Recover from Mental Illnesses." According to the website, "The work of the Division of Mental Health is guided by the vision that all persons with mental illnesses can recover and participate fully in a life in the community. In order to more effectively provide support for consumers of mental health services, the Division of Mental Health promotes the use of Evidence-Based Practices, or EBPs, by its many affiliatated agencies. Evidence-Based Practices are state-of-the-art techniques that research by organizations such as the Federal Substance Abuse and Mental Health Services Administration has shown to be effective. A person working with mental health professionals and following a course of treatment based upon EBPs can expect to make significant progress toward their treatment goals. Evidence-Based Practices combine research-based information, clinical expertise, and the consumer's own needs and values to work toward recovery. They are approaches that are known to work when properly put into use. The Illinois Department of Human Services' Division of Mental Health strives to make EBPs available throughout the state by providing training and technical assistance to staff who work for the many mental health agencies that are affiliated with the Division." Examples of various strategies include Illness Management and Recovery, Medication Algorithms, Wellness Recovery Action Plans, and Cognitive Therapy.

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. The plan shall be formulated and periodically reviewed with the participation of the recipient …. 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."

CONCLUSION

The complaint states that a service recipient has requested a change in therapists because his current therapist reportedly does not act in the recipient's behalf, does not like the recipient and is negative about the recipient during treatment review meetings. Furthermore, the recipient's request for a change in therapists was reportedly denied.

First, there was no record documentation related to the recipient's request for and subsequent denial of a change in therapists. When the HRA team inquired about the possibility of changing therapists, it was informed that the current therapist has particular expertise in the recipient's risk area and the only other available therapist that could serve the recipient is female; a female therapist is not recommended for clinical reasons.

Second, the complaint contends that the therapist does not like the recipient, does not work on his behalf and is negative toward the recipient at treatment review meetings. The treatment plan stated that the therapist is to meet with the recipient on a weekly basis. However, it appears from the record that weekly therapy contact has not been made. It also appears from the therapist

progress notes that there is conflict during therapy session particularly when the therapist brings up particular subject matters. The treatment plan lists general goals and objectives related to gaining insight, developing empathy and exhibiting social adaptive function without specific measures or evaluation criteria. The therapy progress notes provide somewhat more information about approaches used such as going over literature on personality traits and discussing a past statement the recipient made to a prior therapist about hurting family. It appears that much of the TPR progress documentation is specific to behavioral and verbal incidents which continue to occur; the HRA notes that bringing up these incidents may be perceived as being negative by the recipient. The HRA also notes that the rehabilitation staff brought forth very positive statements about the recipient's participation in the rehabilitation classes which appear to be a strength for the recipient and a part of the recipient's treatment where progress is noted and symptoms subside, at least temporarily. There is no documentation in either treatment plan regarding the recipient's views or input into his treatment plan.

Finally, the utilization reviews remain constant with the exception of some handwritten notes related to a medication review and monitoring the recipient's response to treatment, including progress in the areas of communication barriers, empathy, etc. The medication review brought up additional questions which do not yet seem to be addressed in the treatment plan and there have been no TPR statements, to date, regarding monitoring the recipient's response to treatment. There have been no changes to the content of the treatment plan in the past six months in spite of the lack of progress.

Because there is no documentation of a recipient's request for and denial of a therapist change and because there is a clinical concern about changing therapists due to the current therapist's experience and the only available alternate therapist is female, the HRA does not substantiate a rights violation related to the request for and denial of a therapist change. The HRA acknowledges that the therapist's focus on the past and current behavioral/verbal incidents could be perceived as negative by the recipient. The HRA takes this opportunity to offer the following suggestions:

1. Review the treatment planning process with regard to this recipient, building on his strengths when possible, and consider positive reinforcement where appropriate.

2. Consider the use of measureable objectives and evaluation criteria to better track progress and the need for revision and to facilitate objective progress reviews in which the data provides the progress results rather than relying on staff progress statements that could be perceived as biased, negative and/or subjective.

3. Incorporate DHS recommended evidenced based strategies, including the recovery model, where appropriate. Provide relevant staff training and even recipient education on these strategies.

4. Ensure and document recipient input into the development of treatment goals and objectives.

5. Provide therapy sessions at the frequency stated in treatment plans.

6. Review the possible availability of another male therapist.

The HRA acknowledges the full cooperation of the facility and its staff during the course of its investigation.