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Egyptian Regional Human Rights Authority
Report of Findings
Case #12-110-9014
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 allegations concerning Chester Mental Health Center:

1. **A facility aide interacts inappropriately with a recipient by picking fights and making inappropriate statements.**

2. **A recipient was restrained without adequate reason.**

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.) and regulations regarding abuse reporting (59 Ill. Admin. Code 50).

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

To investigate the allegations, an HRA team met with and interviewed the recipient and facility staff, reviewed the recipient's record, with written consent, and examined relevant policies and mandates.

COMPLAINT STATEMENT

According to the complaint, a particular security therapy aide (STA) repeatedly picks on the recipient and makes inappropriate, derogatory statements directed at the recipient. The STA's behaviors and comments reportedly incite the recipient and he has lashed back physically. The complaint also stated that the recipient was inappropriately held down by staff.

FINDINGS

Interviews

In a November 2011 interview with the recipient, the HRA was informed that a particular STA has come into his room stating, "Here is my bitch, [recipient's name]." The recipient stated that the remark and other remarks by the same STA have upset the recipient and have caused him to lash out at the STA. The recipient stated that the STA repeatedly tries to pick fights with him

and there are ongoing conflicts with the specific STA. The recipient stated that he is currently on the green pass level, which is the highest level of facility access for individuals who are not exhibiting behaviors. He also stated that he routinely goes to his treatment plan review (TPR) meetings. He stated that has been at the facility since May 2009 when he was involuntarily admitted to Chester from another state-operated facility. The recipient reported that he has spoken to his therapist about his desire to transfer to another facility. He also reported that he was inappropriately restrained about six months to a year ago after striking the STA; the recipient stated he was held down, kicked and struck during the incident. When asked if he had reported the incident to the Office of Inspector General (OIG), the recipient stated that he could not remember reporting his concerns or speaking with the OIG. In a follow-up visit to the facility, the HRA learned that the recipient had been transferred back to the less restrictive state-operated facility from which he came; the date of his transfer was 01-09-12.

The HRA team spoke with the chair of the facility's internal human rights committee who reported that the recipient's complaints were reported and reviewed by the facility's internal human rights committee and forwarded to the OIG in October 2011 as a verbal abuse allegation. The chair along with the unit director searched for incident reports documenting the recipient's restraint episodes and only found one in the past year dated, 05-06-11.

Record Review

With written recipient consent, the HRA team examined record documents pertinent to the complaints, including two past treatment plans, an incident report, complaints filed by the recipient, and the facility's response.

The recipient's 11-15-11 treatment plan provides the recipient's history and background which references an involuntary admission to Chester in May 2009 after aggressive behaviors toward staff and peers at another state-operated facility. The aggressive incidents appeared to have been triggered by auditory hallucinations and delusions. Prior to his admission to Chester, the recipient had 17 admissions to psychiatric facilities beginning in 1998; 10 admissions were to another state-operated facility while 7 admission have been to Chester Mental Health Center. The recipient also has a history with correctional facilities and served sentences for felonies that include the aggravated discharge of a firearm and aggravated battery of a corrections officer. He has been incarcerated 9 times; 4 of those times he was at a psychiatric correctional facility.

In the discussion portion of the TPR, it is documented that the recipient has been on green pass level and has not displayed aggressive behaviors during the review period. His cooperation, medication compliance and activity participation were all noted. Also documented was his unpredictable aggression arising from psychosis, delusions and auditory hallucinations which are often related to paranoia and feelings of persecution. His primary diagnoses include, Schizoaffective Disorder, Bipolar Type; Anti-Social Personality Disorder; Hypothyroidism; Asthma; and Dyslipidemia. He takes the following medications: Haloperidol syrup 15mg twice per day; Benztropine 1mg twice per day; Lithium 900 mg in the a.m. and 600 mg at night; Clonazepine 1mg twice per day; Propranalol 30 mg twice per day; and a PRN (as needed medication) of Haloperidol injections of 5 mg and Clonazepam 1mg.

Treatment goals on the 11-15-11 TPR are as follows:

- Medication compliance;
- Decrease aggression;
- Reduce symptoms of psychosis;
- Reduce symptoms of mood disorder;
- Stabilize thyroid levels;
- Decrease respiratory distress;
- Lower cholesterol level;
- Control water intoxication;
- Participate in activities;
- Pursue educational/vocational services by enrolling in rehabilitation program;
- Develop positive life skills via meetings with psychologist and reviewing aggression, transfer, and dealing with difficult situations.

A specific behavior plan was included in the TPR in which the recipient is to learn non-aggressive means of pursuing issues of concern, particularly when he believes someone is talking about or persecuting him, by talking with staff about the issues, walking away from the situation and focusing on his goal to transfer.

In the TPR section which describes the extent to which the recipient is benefitting from treatment, it is documented that the recipient has been on green pass level since 09-09-11, not displayed aggression since 09-01-11, has had zero behavioral reports, is medication complaint and participates in activities. The section also reports that the recipient continues to have chronic psychosis. There is no TPR documentation related to conflicts with a particular STA.

A TPR dated 12-13-11 documents continued progress and the recommendation for a transfer from Chester Mental Health Center to a less restrictive setting. This TPR does not document conflicts with an STA.

The HRA requested copies of incident reports for the past year and received only one with regard to an incident that occurred on 05-06-11. The HRA was informed that if there were additional incident reports, they were sent with him to the receiving facility to which he was transferred. The 05-06-11 incident documents that an incident occurred at around 7:25 a.m. in the dayroom hall involving the recipient and five others, all STAs; there was one documented witness who was also an STA. The specific STA referenced in this HRA case documented that the recipient came around the corner and hit the STA in the face "…for no apparent reason. He was placed in a [physical hold] from 7:25 a.m. - 7:30 a.m. and placed in restraints at 7:30 a.m. He is in the process of a medication adjustment at this time." In the antecedent section of the report, the incident is described as a "spontaneous attack" and the STA documented that he was injured in the left side of his face. All other STA accounts document the same. Two of the reports indicated that the recipient remained combative after a physical hold necessitating the need for restraint application.

The HRA examined two complaint forms completed by the recipient. One form is dated 10-23-11 and states that at 7 a.m. on 10-23-11, the identified STA "…yelld [sic] where is [recipient's name]. He's my Bitch." The recipient noted that that there were no witnesses to the incident.

In a separate complaint form dated 11-18-11, the recipient documented "Verbal abuse in [sic] which may lead to interfeance [sic] of my behavior because of the other patients and how the [sic] may take it." The form stated that it happens frequently and includes name calling; on this form another individual is named and it is unclear if the named individual is a staff person or a recipient.

The facility completed a complaint processing form with regard to the 10-23-11 complaint which documented that the "Patient alleges that he was yelled and cursed at by staff [name of staff person]." The form further stated the following:

> [The recipient] stated that he heard [the staff person] call him a bitch when he was out on the stem. He has heard a lot of people talking about him and calling him names. He said that because he is from the South everyone talks about him and wants sex from him. He gets upset because he's not homosexual. [the staff person] has no idea what [the recipient] is talking about. He has never call [sic] [the recipient] a name or yelled at him. [The staff person] said that he is paranoid and has delusions. [The recipient] spends much of his time in his room; most of the time has good behavior.

Another staff person was interviewed and reported that the staff person in question "…uses appropriate language with all patients under his care." A reviewer, who is identified as a unit manager, signed the form, identified that the complaint was determined to be "invalid," and stated that "This will be ongoing with [the recipient.]" A written response, dated 11-01-11, was sent to the recipient which summarized the complaint, indicated that the human rights committee found the complaint invalid, and provided contact information for the Guardianship and Advocacy Commission.

Policy Review

Chester Mental Health Center maintains a Code of Conduct policy last revised on 03-19-09 stating that "All patients, employees and visitors shall be treated with dignity, respect and courtesy….Chester Mental Health Center has zero tolerance for intimidating and disruptive behavior. These behaviors include but are not limited to: Harrassment (verbal or physical conduct that denigrates or shows hostility or aversion toward an individual…Improper Language - this includes vulgar, profane or loud/disruptive language….All DHS employees are required to expose without fear or favor, illegal or unethical conduct of others….All DHS employees who are victims of, witnesses of, or who become aware of any incident of Code of Conduct violations must report it immediately to his/her immediate supervisor and write an incident report….The supervisor will forward the report to the Hospital Administrator."

The facility maintains a policy and procedure regarding allegations of abuse which was last revised on 11-22-10. The policy defines mental abuse as "The use of demeaning, intimidating or threatening words, signs, gestures or other actions by an employee about an individual and in the presence of an individual or individuals that results in emotional distress or maladaptive behavior, or could have resulted in emotional distress or maladaptive behavior, for any individual present." The policy directs employees who become aware of an incident to immediately report it the on-duty supervisor who then must contact the Department of Human Services' Office of Inspector General within four hours. The facility administrator is also to be

notified. A separate policy (last reviewed 02-21-09) describes the reporting of incidents to external agencies states that both OIG and the Illinois Department of Public Health are to be notified of abuse allegations.

The facility's complaint form (last revised 01-2000) allows recipients to document incident specifics and witnesses; the form is then forwarded to the internal human rights committee and quality assurance committee.

The DHS rights statement includes the right to humane care and services in the least restrictive environment, the use of restraints only to protect self or others from physical harm or as part of a medical/surgical procedure, and the right to notify individuals if rights are restricted.

The DHS restraint and seclusion policy for state-operated mental health facilities was reviewed and states that "…restraint or seclusion be limited to emergencies in which there is an imminent risk of an individual harming himself or herself, other patients or staff." The policy goes on to address variables to be considered in the use of restraint (e.g. health risks), procedures for restraint application, physician orders and order renewals, the discontinuation of the restraint use and the debriefing process, associated rights, nursing monitoring protocol and approved restraint devices.

Chester Mental Health Center also has its own procedure related to the use of restraint and seclusion "…as a measure to prevent an individual from causing physical harm to himself or others…" and references the DHS policy. The Chester procedure provides additional details specific to monitoring restraint use, physician orders, nursing checks, restraint release and performance improvement. The performance improvement section of the procedure requires supervisory review of each restraint order, the collection of data related to the restraint application and the tracking of restraint use for statistical reporting and review by performance improvement groups.

MANDATES

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) states 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." Section 5/2-112 requires that "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect." Section 5/2-108 describes restraint application and states that "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 the staff." Furthermore, an order must be written for restraint application after observing the recipient and determining that there is a clinical need. The Code stipulates timelines for use, the documentation of the events leading up to the restraint application, guidelines for monitoring and releasing the recipient, required training for staff who administer, and notification requirements.

Regulations that govern abuse and neglect reporting (59 Ill. Admin. Code 50) define mental abuse as follows: "The use of demeaning, intimidating or threatening words, signs, gestures or other actions by an employee about an individual and in the presence of an individual or individuals that results in emotional distress or maladaptive behavior, or could have resulted in emotional distress or maladaptive behavior, for any individual present." Abuse allegations, including allegations of mental abuse, along with any related incident details are to be reported to the OIG within four hours of initial discovery (59 Ill. Admin. Code 50.20).

CONCLUSIONS

Complaint #1: A facility aide interacts inappropriately with a recipient by picking fights and making inappropriate statements.

The HRA found no evidence that confirmed or denied the allegation that a specific STA had made a demeaning statement to the recipient. The recipient had filed one written complaint regarding the STA with the facility's internal human rights committee which was similar to the complaint reviewed by the HRA. The internal human rights committee found the complaint invalid and related it to the recipient's clinical condition. There was no TPR documentation related to the particular STA or the manner in which the STA interacted with the recipient. Instead, there were multiple TPR statements regarding the recipient's progress and eventual transfer to a less restrictive placement. There was no indication regarding recent fights or conflicts with any staff or peers. The only other documentation related to the STA was an incident report in which the specific STA was struck by the recipient as per other STA reports and there was no indication of an antecedent to the recipient's aggression. The facility does maintain protocol for staff conduct, reporting abuse and filing complaints. The facility abuse reporting policy appears to be consistent with Office of Inspector General requirements. **Due to the lack of evidence, the HRA does not substantiate the allegation that a facility aide interacts inappropriately with a recipient by picking fights and making inappropriate statements.**

The HRA suggests that the facility periodically monitor staff to recipient interactions, ensure that staff can easily report inappropriate interactions that are observed or reported by recipients and document and address any recipient conflicts with staff via the TPRs.

Complaint #2: A recipient was restrained without adequate reason.

The complaint concerned an incident that occurred approximately six months to a year from the time the complaint was filed with the HRA. The recipient's TPR documents an incident of aggression on 09-01-11 but it is unclear if a restraint was involved. **Documentation was found for a restraint incident on 05-06-11 in which a restraint was applied after the recipient struck staff and remained combative; thus, it appears that the Mental Health Code standard for restraint application "…to prevent a recipient from causing physical harm to himself or physical abuse to others" has been met. Therefore, the complaint is not substantiated.** The DHS and Chester restraint policies and procedures appear consistent with Mental Health Code requirements.

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