FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
Case #12-110-9028
Chester Mental Health Center

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

1. **Recipients are not being served in the least restrictive environment and referrals to less restrictive state facilities are denied.**

2. **Language barriers are not adequately addressed.**

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code. Chester Mental Health Center is a state-operated mental health facility serving approximately 240 recipients; it is considered the most secure and restrictive state-operated mental health facility in the state.

To investigate the allegations, a Human Rights Authority team reviewed two client records, with consent, met with facility administration and examined facility policies.

COMPLAINT STATEMENT

According to the complaint, recipients are supposed to return to the state-operated facility or catchment area from which they came; however, some referring state-operated facilities are notorious for refusing to accept recipients back even though the recipients have experienced improvements in their conditions. An example of a recipient was given; the recipient had met his treatment plan, was ready to be discharged but the referring state-operated facility refused even though the recipient had been at Chester for approximately 27 years. In addition, the complaint contends that language barriers are not adequately addressed for recipients who speak a foreign language. An example was given of a recipient from a Middle Eastern country whose primary mode of communication is a foreign language. A physician at the facility can provide some assistance with language interpretation but it is difficult to assist the individual with regard to placement and his court charges. A tele-interpreter is used. The language barrier may contribute to the recipient's paranoia associated with his mental health needs.

FINDINGS

Interviews

The HRA received releases from two individuals; one individual had been seeking a transfer to a less restrictive placement since 2009 and the other was a non-English speaking individual whose preferred language is Urdu. The HRA team was unable to interview the individual whose long-term stay was reported to be an example of a violation of his right to placement in the least restrictive placement; shortly after the Authority opened the case, he was moved to the less restrictive placement in his catchment area. The facility offered to make arrangements to interview the individual with the language barrier; however, it was thought that a meeting would further the recipient's paranoia issues. The HRA team did observe the recipient through the window of his bedroom sleeping in the middle of the afternoon. Unit staff reported that he spends a great deal of time in his room and in bed.

The social worker who serves the individual with the language barrier expressed concern about the recipient's participation in his defense for criminal charges in another county. A language telephone line is currently being used; however, the telephone interpreter for the recipient's dialect is not from the United States and has difficulty communicating with the recipient over our country's legal system. Also, language interpretation is difficult over a telephone. A facility physician provides some assistance but he is not a certified interpreter. The social worker indicated that she is not sure to what extent the recipient understands his charges, treatment plan or situation due to language barriers and possible cognitive delays resulting from post traumatic stress disorder and a history of malnutrition. The social worker believes that the recipient might be better served if he returned to the state-operated facility in his catchment area where he might have linkage to family and other individuals from his Middle Eastern heritage who could assist with interpretation.

In follow-up contact with the social worker who works with the recipient in this case, the HRA learned that while the facility uses the teleinterpreter service, he can speak some English and has indicated that he has not wanted to use the teleinterpreter service lately. His physician, who can speak the same language but is not a certified interpreter is still utilized. When asked about the use of language cards or other prompts, the social worker stated that he understands English well enough without any type of prompts. When asked about interpreting forms and information in the recipient's language, the social worker reported that the facility is trying to do this but the recipient confirmed through the physician that he does not read any language and has limited intellectual capacity most likely from a history of malnourishment. The social worker reported that when the recipient returns to court, the court will provide the interpreter as long as Chester lets the court know one is needed.

The HRA team also interviewed representatives of the facility's administration, the facility medical director and the clinical director, regarding the issues of language interpretation and transfers to less restrictive state-operated placements.

According to the medical and clinical directors, the facility has revised its language interpretation policy in the past two months. The facility primarily uses telephone interpretation and the quality of the interpreter services is monitored. The patient handbook addresses this service. The need for interpretation is established at intake; a language poster is used on which the recipient can point to the language he primarily uses. The language barrier is then flagged in the recipient's medical record through documentation and forms. A member of the recipient's

treatment team is identified as the liaison for accessing interpreter services; most often, the liaison is the recipient's social worker, psychologist or unit director. Family is involved whenever possible; however, the facility tries not to use them as interpreters as it is sometimes contraindicated in terms of treatment issues. The telephone interpreter line is used for intake, nursing and during treatment plan meetings. The facility reports no problems in using the telephone interpreter service.

For the recipient identified with a language barrier in this case, the line has been used with no reported complaints. The clinical and medical directors reported that it is difficult to fully assess whether the recipient's needs are related to his language, his mental health issues or a possible developmental disability. A process is being developed to indicate interpreter needs when a recipient is being sent to court. Also, a new interpreter phone number is expected to come through next week. With regard to the provision of any forms to the recipient, it was explained that the content of forms is explained verbally to the recipient.

The medical and clinical directors then described the process of transferring recipients to less restrictive state-operated facilities. It was explained that a transfer begins with a recommendation by the recipient's treatment team. The hospital located within the recipient's catchment area is contacted and a video conference meeting is held between the hospital and the recipient. The receiving hospital will also review the recipient's records. In most cases, referrals are accepted. However, any concerns are addressed through a utilization review and the Illinois Department of Human Services' central office which may mediate concerns. At times, an external assessment of an individual might be sought. A recipient can be sent to another state-operated facility outside of the recipient's catchment area.

According to the medical and clinical directors, the patient is involved in the transfer process through treatment plan review meetings. Patients are kept informed of a transfer status at treatment team meetings.

A transfer waiting list is sent to central office. The utilization review team meets monthly and consists of the medical director, clinical director, hospital administrator, director of nursing, and quality assurance manager.

Record Review Regarding Transfers to Least Restrictive Setting

The HRA examined the record of a recipient who was alleged to have not been receiving services in the least restrictive environment.

The recipient's treatment plan of 10-13-11 described his legal status as "Involuntary Criminal (Expiration Date 11/27/2027)." He was considered to be legally competent and had been transferred to Chester from another state-operated facility in 2007 "…after he assaulted a female staff member, striking her over 30 times resulting in significant injury." The recipient has a history of state-operated mental health placement dating back to 1981. An admission in 2007 was a result of a Class X Felony of Attempted First Degree Murder and battery charge in which he was found Unfit to Stand Trial (UST). The recipient is described as being 6'11" tall and weighing 367 pounds. He has a history of participation in special education and community developmental disability services.

In the discussion section of the treatment plan, the plan indicated that the recipient has not been "in trouble" and asked about transfer. "He was commended for his patience and encouraged to maintain his appropriate, cooperative behavior…[The recipient] has been recommended for transfer to [another state-operated facility] since 2/17/09." The plan also noted his regular contact with family.

The recipient's diagnoses included the following: Schizophrenia, Undifferentiated Type, Mild Mental Retardation, chronic mental health problems, history of noncompliance and some physical issues, including Hypertension, Noninsulin Dependent Diabetes, Dyslipidemia and Chronic Constipation. He takes medication for Psychosis, mood lability, Dyslipidemia, Diabetes, High Blood Pressure and Constipation. He had been compliant with medication and exhibited no behavior problems. The plan stated that he is awaiting transfer to a different state-operated facility than the one in his catchment area "but they do not want him because of violence towards a therapist there."

Under the treatment goals and related progress section of the treatment plan, the HRA noted the following comments: "Taking medication. No issues of aggression, no restraints or seclusion. Patient awaiting transfer," "attends weekly anger management group sessions," " is recommended for transfer pending administrative review," "has shown good progress attending 30 off-unit activities again with active participation away from the unit with no instances of aggression noted," "attends activity therapy group regularly," "he is currently on the green level [highest level of facility access]."

In the treatment plan section entitled, "Extent to which benefitting from Treatment," the plan stated that the recipient was responding to treatment, compliant, demonstrated no psychotic symptoms, desired to be transferred, was able to describe the events that led to placement at Chester, had not been verbally or physically aggressive, had a pleasant mood and had not been agitated. "[The recipient] has been recommended for transfer, pending administrative review, since 2/17/09. The treatment team discussed the possibility of another video conference with [state-operated facility in catchment area] or the possibility of yet another supplemental report. During the 7/28/10 reporting period [the psychiatrist] wrote the supplemental transfer recommendation. Transfer remains pending. Utilization Review Committee reported [the recipient's] transfer is being reviewed by Springfield." The "Criteria for Separation" section of the treatment plan stated much the same documenting that the recipient's "…behaviors are under sufficient control to make to [sic] possible for him to function appropriately at a less secure forensic hospital setting." The team concluded the treatment plan meeting by indicating that the recipient was still Unfit to Stand Trial and still in need of inpatient mental health treatment.

Earlier treatment plans dated 09-15-11 and 08-18-11 also noted transfer recommendations and the recipient's desire to be transferred. A more recent treatment plan dated 12-08-11 indicated that the recipient had gone to court where they had discussed the incident at the prior state-operated facility; the recipient's mother was present at the hearing. Treatment plans of 01-05-12, 01-31-12, and 02-29-12 all continued to recommend transfer and state that Springfield is reviewing the request. The recipient's 03-29-12 treatment plan stated that a teleconference meeting took place with the prior state-operated facility and the recipient's prior behavioral

incident was discussed; Chester staff reported that "…no similar behavior has occurred at Chester MHC…[and the recipient's] behavior has been more than appropriate for over three years." The recipient's 04-27-12 treatment plan indicated that he was "…first on the transfer list…" to the prior state-operated facility.

The HRA examined the "Transfer Recommendation Update" which was last updated on 06-30-10 stating that the recipient "…conducted himself appropriately. Participated in therapy related interviews and activities. Displayed no inappropriate sexual behavior. Very cooperative and compliant with treatment including medication. Displayed no signs of aggression, did not require any restraints, seclusion or PRNs in recent months….He has met all the criteria for transfer. He is quite prepared for such new adjustment. He is appropriate for transfer."

The HRA reviewed Utilization Review Forms dating back to 07-21-11. The form dated 07-21-11 referenced that he had been recommended for transfer on 02-17-09, that he continued to be cooperative and that he had no incidents of aggression. The possibility of transferring the recipient to a state-operated developmental disability facility was noted. The utilization review form dated 01-19-12 acknowledged the recipient's continued patience and cooperation in spite of a 3 year wait for a transfer. A note on the form stated the following: "Reported to central office regarding transfer barriers. [Physician] will continue to report pt. ready for transfer to [the less restrictive state-operated facility] to central office monthly." A similar note is documented on the utilization review form dated 04-19-12. The review form noted that utilization committee members include the facility director, medical director, nursing director, clinical director, chief social worker, administrative assistant, quality manager, and assistant hospital administrator. Also, it is documented that unit staff participated in reviews but it is not clear if the recipient participated.

Record Review Regarding Language Barrier

With regard to the complaints concerning inadequate language interpretation, the HRA examined the record of a recipient with a language barrier.

A treatment plan dated 11-09-11 indicated that the 28 year old recipient was found Unfit to Stand Trial on 05-05-09 for a residential burglary. He was initially admitted to another state-operated facility in 2009 but was transferred to Chester in November 2011 when he became more agitated and threatening. The discussion notes stated that it was difficult for the recipient to follow English and a physician who can speak the recipient's dialect was used for interpretation. It was noted that "During the entire meeting he appeared paranoid and anxious. Also during the meeting he appeared to mumble to himself. He appears to have no understanding of his transfer." The recipient's rights were explained to him "…and he appeared to understand them." Treatment goals included: restore fitness, reduce psychotic symptoms, and reduce aggression. The plan noted that the recipient had been cooperative since his transfer to the facility. The "Criteria for Separation" section of the plan stated that the recipient would be returned to county court when he is able communicate with counsel and assist with his defense, understand his relation to time, place and things, understand his criminal charges and the court process, remember the circumstances related to his charges and demonstrate a reduction of aggression.

The recipient's most recent treatment plan, dated 06-07-12, stated that the recipient "was present and cooperative during his meeting with his treatment team. Today the use of an interpreter was used from Tele-interpreters in the Dari language. He remains confused about his status, so the UST process was again explained to him. The interpreter stated that a lot of [the recipient's] responses were difficult to interpret because he spoke extremely fast and had trouble focusing and answering questions. He would jump topics and he did say 'I have a mental problem….sometimes I can't think.'" When referencing his needs with regard to fitness, the plan states that the recipient "…lacks appropriate knowledge about the court system despite education with an interpreter." In the "Response to Medication" section, the treatment plan referenced difficulties in explaining the fitness situation due to limited language and cognitive ability. "He was instructed that learning English would significantly improve the likelihood of achieving fitness. The patient spends most of his time sleeping during the day and is restless at night….Patient agreed to start attending gym and classes to relieve boredom and improve English….He was informed that his public defender would be speaking with him with an interpreter and that there would be a court hearing at the end of his period of extended UST in October." The plan noted that the recipient was verbally informed of his rights. In goal progress notes, documentation indicated that the recipient's level of participation in activities was low, he had been more paranoid, he was quiet on the unit and he declined to indicate emergency treatment preferences. One progress noted stated that he appeared to be confused and communication was difficult. It was also noted that it was difficult to assess him due to his language. Documentation indicated contact from family friends and their phone numbers were listed. Also, a brother was reported to be in a correctional facility.

The HRA examined progress notes dating back to his admission. On 12-22-11, it was noted that the recipient attended his treatment planning meeting. "He was very nervous and struggled to answer questions we asked about his situation and his charges. He was frustrated by the language difficulties and by his fear of the unknown in his circumstances. He was so nervous that he needed to rush out to the restroom….He does not read English and speaks it very poorly so he does not have a clear idea of his circumstances. Even when having it explained to him in Urdu by [a physician who speaks his dialect], he remains vague. He appears to have some cognitive limitations." A note from 01-05-12 stated that the recipient "…appears sad and anxious most the time. He does not socialize with others. He is isolative. He does not have behavioral problems and is able to follow routine well." On 03-25-12, notes stated that "Much of the time he is difficult to communicate with, even when using [facility physician] as an interpreter. He appears confused and anxious. He does know what he was arrested for but has no understanding of his legal situation. He has no family contact and when asked where he will go if released, has no home." A note on 04-13-12 indicated that he attended his treatment plan meeting and it was recommended that he learn English to which he agreed. According to a therapist note dated 04-27-12, the therapist spoke to the recipient "…using TeleInterpreter services in the language Urdu. He spoke of the restraint episode last week, exhibiting a lot of paranoia. He says he feels people are trying to hurt him. He was explained why he is here and how we're answering to the Judge. He still does not understand this. He again is trying to bargain to get out of here. He asked how much money does he need to pay to be released. He did say his native language is 'Pushto' but also speaks English and Urdu well. As the interview was attempting to be terminated, he escalated and was upset about being here. The call was then ended to avoid any further anger." And, a note on 06-07-12 documented the recipient's

participation in the treatment plan meeting using the language line and an interpreter who spoke Dari. "The interpreter describes the patient as jumping from one topic to another, sometimes giving an answer to a different question from the one asked and at other times just babbling on unintelligibly. He was informed that his PD [public defender] would be speaking with him with an interpreter and that there would be a court hearing at the end of his period of extended UST in October."

The HRA examined nursing reassessment summaries. A summary dated 1-20-11 stated that the recipient does not understand English well. A summary dated 12-01-11 noted the recipient's language barrier and indicated that the nurse attempted to provide information on weight issues but the recipient did not seem to understand. A more recent summary dated 05-12-12 documented the continued language barrier and the recipient's refusal to get out of bed, eat breakfast or take showers. The recipient has not yet noted any emergency treatment preferences. When the recipient had an incident on 04-18-12, physical restraints were used. Also, an order was given for the recipient to be locked out of his room from 8:30 to 11 a.m.

Policy Review

The HRA examined policies pertinent to the allegations beginning with a review of policies related to recipient transfers to less restrictive placements. A policy entitled, "Transfer Recommendation of Behavior Management Patients," indicates that the Mental Health and Developmental Disabilities Code requires service provision in the least restrictive setting and treatment team evaluations regarding placement in a maximum secure facility must be ongoing. The process for transfer to a less restrictive placement begins with a recommendation by the treatment team after which the psychiatrist prepares a transfer recommendation that documents the reason for and clinical condition at the time of admission to Chester. The transfer recommendation report outlines the treatment provided, treatment outcomes, positive changes that warrant the transfer, psychiatric concerns and treatment recommendations for the receiving facility. The treatment team meets with the recipient about the transfer recommendations and the therapist assists the recipient in preparing for the transfer. "Progress notes from that time on should address the said issues [and the] recipient's ability to cope with the upcoming changes that correlate to his transfer." A transfer notice is given to the recipient at least 14 days prior to a transfer unless there is an emergency and then the transfer notice is to be provided within 48 hours after transfer; the reason for an emergency transfer is to be documented in the recipient record and include the date in which notice is given. A recipient's attorney, guardian or responsible relative is also to be noticed. The recipient, attorney, guardian, or responsible relative can object to a transfer proposal after which a hearing is to be held within seven days. The right to request a hearing is briefly mentioned at the end of the policy.

A policy entitled, "Discharge Summary" requires the completion of a discharge summary within 30 days of discharge along with specific forms that detail continuity of care information such as medication, medical condition, psychiatric diagnoses at discharge as well as treatment course, instructions and post-discharge recommendations.

The facility maintains two policies related to communication assistance: one for non-English speaking patients and one for persons who are deaf or hearing impaired. The policy for non-English speaking patients reiterates the right to adequate services pursuant to an individualized

treatment plan. "No patient shall be excluded from the treatment process. An inability to communicate by oral or written English will not be a barrier to receiving such treatment." The policy states that communication assistance is to be provided through interpreters "…if the absence of interpreter services affect patient care. Interpreters will be used during admission…during the intake process, during assessment or evaluation procedures, and during interviews or examinations. In addition, interpreters are will [sic] be used during therapy when care and treatment information is being conveyed; during discussion regarding discharge or transfer; patient objections to such planning; when informing a patient of his rights, or restrictions thereof; and/or when a patient is being evaluated for involuntary admission or certification. Whenever medical or psychiatric information are [sic] being discussed with a patient, it is imperative that appropriate interpreting services are used, especially of [sic] Limited English Proficiency affects delivery of services." Examples of interpreter resources include facility staff from the facility language bank, telephone interpreter services and contractual interpreter services via an approved contract. Family members are not to be used during the admission, assessment, discharge or transfer process or when sharing rights information unless requested by the recipient and approved by the treatment team, the family member is the legal guardian, the family member is not part of the admission process, and the family member is over the age of 18. A recipient can use his own interpreter but Chester can also provide its own interpreter at the same time noting that there may be issues of competency, confidentiality or conflict of interest. Certain staff are trained to arrange for interpretive services and the use of interpreter services during admission is to be documented in the medical records. Critical documents and the patient handbook are to be interpreted into the patient's primary language "as soon as feasible." The facility's quality manager is to audit the adequacy of interpreter services semi-annually. A separate policy addresses communication assistance for persons who are deaf/deaf blind or hard of hearing through the provision of sign language interpreters.

The facility also has developed a "Resource Guide for Services for Patients with Limited English Proficiency" which was last updated 04-10-12. The guide provides more specifics about using interpreter services including the specific means of contacting interpreters. The DHS (Department of Human Services) interpreter bank available Mondays through Fridays, 8:30 a.m. to 5 p.m. includes the language of Urdu. The guide lists 34 agencies that provide interpreter services through an outreach project. The guide includes a description of an interpreter monitoring process as well as staff guidelines related to interpreter services. Staff guidelines include the posting of notices that advise recipients of the availability of interpreters, the provision of standardized picture and phrase sheets for staff, and using the interpreter service in a confidential setting. The guide describes the grievance process and outlines best practices, including cultural assessments, a cultural appropriate treatment plan, providing books and newspapers in a recipient's preferred language and providing culturally sensitive discharge/after care services. According to the guide, an interpreter should be called during admission, for assessments, to explain legal rights and status, for discharge planning and when the recipient requests one. Included in the guide are 2006 standards from the U.S. Office of Mental Health (OMH) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO). The OMH standards identify the preferred method of providing interpreter services through a bilingual staff person or a face to face interpreter "…in a timely manner during all hours of operation." The OMH also states that organizations should provide language assistance in a patient's environment; additional suggestions include language identification cards, the posting

of signs in the preferred language and the provision of patient materials in the preferred language. The JCAHO standards address interpreter services but are much more vague that OMH requirements.

A review of the patient handbook found reference to the transfer process as well as language assistance but no information about the utilization review process.

MANDATES

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) guarantees the right to "…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….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….If the recipient is unable to communicate effectively in English, the facility shall make reasonable efforts to provide services to the recipient in a language that the recipient understands."

Section 5/3-204 of the Code requires that "Whenever a statement or explanation is required to be given to a recipient under this Chapter and the recipient does not read or understand English, such statement or explanation shall be provided to him in a language he understands. Such statement or explanation shall be communicated in sign language for any hearing impaired person for whom sign language is a primary mode of communication. When a statement or explanation is provided in a language other then English, or through the use of sign language, that fact and the name of the persons by whom it was provided shall be noted in the recipient's record. This Section does not apply to copies of petitions and court orders."

The Illinois Administrative Code (59 Ill. Admin. Code 111.25) also addresses state-operated services with respect to recipients who are non-English speaking:

> *All individuals in Department facilities shall be provided with adequate and humane care and services pursuant to an individualized service (treatment or habilitation) plan in accordance with Sections 2-102(a), 3-209 and 4-309 of the Code [405 ILCS 5/2-102(a), 3-209 and 4-309]. In accordance with Sections 2-102(a), 3-204, 3-205 and 4-305 of the Code [405 ILCS 5/2-102(a), 3-204, 3-205 and 4-305] no individual shall, on the basis of an inability to communicate in the English language, be denied the benefits of, or be subjected to discrimination by, a Department facility. …*
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> *b) Service provision*
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> *1) Prior to admission or during the admission process, intake staff shall determine whether a person presenting for admission is a non-English or limited-English speaker and, if so, the person's native language. Intake staff shall document interpreter services required on the intake and treatment summaries. The provision of the interpreter services shall be defined as a part of active treatment.*

2) Interpreter services in the individual's native language shall be available in accordance with Sections 3-204, 3-205, and 4-205 of the Code [405 ILCS 5/3-204, 3-205, and 4-205] for the treatment or habilitation staff to provide services to non-English or limited-English speaking individuals. Staff shall document in the individual's clinical record that an interpreter was used to provide information.

3) Each facility shall maintain a list of interpreters employed by or under contract to the facility and what language(s) they speak. In addition, each facility shall maintain a list of community interpreter resources. The facility director shall be responsible for distributing the list to the appropriate staff and updating it at least annually.

4) Facilities shall provide interpreters during admission, when denying admission, during intake, or specifically during all assessments or evaluations while the individual is being interviewed or tested by a psychologist, psychiatrist or physician. Additionally, interpreters are to be used during therapy, when care and treatment information is being conveyed, when information is being conveyed regarding the individual's discharge, transfer, objection to discharge or transfer, or the individual's rights, when the individual is being examined for involuntary admission or certification at the request of the individual's family or guardian, or whenever necessary to provide effective treatment or habilitative services to the individual.

5) Qualified staff who speak the individual's native language may be used as interpreters or the facility may contract for the services of interpreters. The facility shall pay for the cost of the interpreters. Family members of the individual shall not be used as interpreters. Family members may inform the individual that an interpreter has been contacted and the expected time of arrival. The family may participate in the intake and treatment process with the interpreter provided by the facility.

c) Facility plan

Facilities shall establish a written implementation, monitoring and evaluation plan for interpreter services to non-English and limited-English speaking individuals. This plan, which shall be a part of the facility quality assessment and improvement program, shall include but not be limited to the following areas:

1) Designation of personnel within the facility responsible for implementing the plan, monitoring the provision of interpreter services and conducting an annual evaluation of services provided;

2) Establishing a list of interpreters on the facility's staff or on contract from the community, the languages they speak and their availability. In

addition, insure that postings that advise individuals and their families of the availability of interpreters, the procedures for obtaining interpreters, and the telephone number to call to file a complaint are posted in conspicuous places in the facility;

3) Defining an effective process to implement the Department's procedures for identifying the individual's level of functioning in English and his or her native language and accurately recording this information in the individual's clinical record and the Department's data systems and based on new assessments or information updating them as indicated; and

4) Training facility staff in the unique aspects of providing services to individuals who are non-English or limited English-speaking and in procedures to assist the individual in submitting the complaint form.

With regard to transfers/discharges, mandates reference a utilization review process using a utilization review committee. Utilization review committees and hearings are addressed in the Mental Health Code Section 5/3-207 which requires a utilization review committee at each state-operated facility comprised of multidisciplinary staff with the recipient being represented by a person of his choice. Results of a hearing are to be submitted to the facility director and recipient/objector within 3 days and within 7 days the facility director provides the recipient or objector with his acceptance or rejection of the committee recommendations. If dissatisfied, the recipient or objector can request a review by the Department of Human Services Secretary.

Section 5/3-908 states that "The facility director of any Department facility may transfer a recipient to another Department facility if he determines the transfer to be clinically advisable and consistent with the treatment needs of the recipient." The transfer process is described in Section 5/3-901; the process begins with a written notice 14 days in advance of a transfer although a transfer can occur immediately for medical or safety emergencies after with a notice is provided within 48 hours after transfer. A recipient can object to a transfer and a hearing by the utilization review committee is to be held within 7 days after a written objection to transfer is submitted to the facility director.

Illinois Department of Human Services' regulations (59 Ill. Admin. Code 112) also address the process of transfer and utilization reviews. Section 112.10 states the following:

> *Utilization review hearings shall be conducted in accordance with Sections 3-207, 3-405, 3-903, 3-910, 4-209, 4-312, 4-704 and 4-709 of the Code. When a person who is evaluated as being mildly or moderately mentally retarded, resides in a Department mental health facility and objects to the facility director's certification of the treatment and habilitation plan or the appropriateness of the setting, a utilization review hearing shall be conducted in accordance with Section 112.20(g)....*

The same section of the Administrative Code states that recipients attempting but denied state-operated facility admission are to receive notice of the denial. Recipients who have been in a state-operated facility for more than 7 days are to receive notice 14 days prior to any transfer

unless there is an emergency which requires notice within 48 hours after transfer. Recipients can object to transfer as well.

Section 112.10 of the Administrative Code further addresses the utilization review committee:

> *Each Department facility director shall recommend individuals to serve on a utilization review committee(s) in accordance with Sections 3-207 and 4-209 of the Code to hear requests for review and objections received under the Code. The recommendations shall be sent to the Secretary or his or her designee for approval or denial.*
>
> *1) The committee shall consist of at least three and not more than seven members, who shall represent at least two different professional clinical disciplines, trained and equipped to deal with the recipient's clinical and treatment needs (for persons with mental illness) or habilitation needs (for persons with developmental disabilities) or both types of needs for those persons with dual diagnosis in accordance with Section 112.20(g)(3). Clinical disciplines include psychiatry, psychology, medicine, nursing, social work, or the other disciplines that qualify a person to be a qualified mental retardation professional, as defined in Section 112.20(d).*
>
> *A) The committee membership may be permanent or rotating, at the facility director's discretion and must be approved by the Secretary; or*
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> *B) The facility director shall not recommend himself/herself or designee, or any staff member involved in the decision to admit, transfer or discharge the recipient to be a committee member or to participate in the committee's decision on any request for review or objection.*
>
> *2) The facility director, or at the facility director's discretion, the committee, shall appoint, from the committee's membership, a chairperson who shall have the duties and responsibilities as set forth in subsection (g)(2)(A) of this Section.*

A utilization review hearing to consider transfer objections is to be held within 7 days of a hearing request. The recipient or objector can be represented by anyone of his/her choosing. Also, "Unless waived by the recipient or his or her attorney, the recipient or the objector (if not the recipient) has the right to be present at the hearing as well as responsible relatives and other interested persons designated by the recipient. [59 Ill. Admin. Code 112.10]"

Section 112.10 also addresses the standards for transfer from a mental health facility as follows:

> *A) All transfers occurring more than seven days after admission*

The facility director may transfer a recipient if the transfer is clinically advisable and consistent with the recipient's treatment needs as defined by the recipient's individual treatment plan. (See Section 3-908 of the Code.)

B) Emergency transfers

A recipient may be transferred as soon as the transfer can be arranged when the health of the recipient or the physical safety of the recipient or others is imminently imperiled and appropriate care is not available at the facility where the recipient is located. (See Section 3-910(b) of the Code.) If an emergency transfer cannot be effected within 48 hours after the decision to transfer, the transfer shall proceed only as a non-emergency transfer with prior written notice of the right to object as provided in Section 3-910 of the Code and subsection (c)(2).

C) Transfer to a more restrictive facility

A recipient may be transferred if the transfer is clinically advisable and consistent with the recipient's treatment needs as defined by the recipient's individual treatment plan and is required for the safety of the recipient or others. (See Sections 3-908 and 3-910(d) of the Code.) …

As to the utilization review committee's recommendations, the Administrative Code (59 Ill. Admin. Code 112.10) requires:

1) Within three working days after the conclusion of the utilization review hearing, the committee shall submit to the facility director its written findings of fact, conclusions and recommendations. The committee shall not consider or decide questions of law.

2) Findings of fact, conclusions and recommendations shall be separately stated and so labeled. Findings of fact shall be based exclusively on the evidence and on matters officially noticed. The Department has the burden of proof in all utilization review hearings.

A) Findings of fact

To conclude that the Department has sustained its burden of proof, the committee must find that the Department has established the facts by substantial evidence. Substantial evidence is such evidence as a reasonable person can accept as adequate to support a conclusion (i.e., consists of more than a scintilla of evidence but somewhat less than a preponderance).

B) Conclusions and recommendations

i) If the committee finds that the Department has established the facts by substantial evidence, it shall make its written conclusion that the decision was based on substantial evidence and shall recommend that the decision be upheld.

ii) The committee shall recommend that the decision be overturned if it concludes that the Department has not sustained its burden of proof.

C) Manner of service of the committee's recommendations

A copy of the committee's recommendations, with its factual findings and conclusions, shall be given to the recipient and objector at the time the recommendations are submitted to the facility director. Service may be made either personally or by certified first class mail.

j) Facility director decision

The facility director shall review the committee hearing record to determine if the evidence supports the committee's findings of fact, conclusions and recommendations. The facility director shall not consider or decide issues of law nor participate in reviewing the committee's recommendations in those instances in which the facility director made the original decision which was appealed. In such circumstances, the facility director shall appoint a designee to review the committee's findings, conclusions and recommendations.

The facility director will either accept or object to the committee's recommendation and then provide notice of his/her decision to the recipient/objector and representatives. Included in the notice will be the right to submit a written for a review by the Department of Human Services (DHS) Secretary within 7 days. The Administrative Code (59 Ill. Admin. Code 112.10) addresses the Secretary's role:

4) The Secretary's authority

The Secretary shall, in reviewing any facility director's decision, have the authority, if he or she deems it necessary to reach a decision as to any question of fact or law based on the complete record:

A) To dismiss a request for review as moot or not ready for adjudication;

B) To approve or disapprove the facility director's decision in whole or in part;

C) To reverse and remand the facility director's decision in whole or in part and, in such case, to state the questions requiring further

hearing or proceedings and to give such other instructions as deemed proper;

D) To remand the committee for the purpose of taking additional evidence when from the state of the record of the hearing, it shall appear that such is necessary to resolve the issues raised at the hearing.

5) Manner of service of decision
The Secretary's decision shall be served on the recipient and objector and their attorneys or representatives, either by personal delivery or by certified first class mail, addressed to the recipient and objector at his or her last known address no later than 30 days after the person has submitted the request for the review.

6) Final administrative decision
The Secretary's decision shall constitute the Department's final administrative decision and no application for rehearing will be entertained. The decision is then reviewable in accordance with the Administrative Review Law.

CONCLUSIONS

Complaint #1: Recipients are not being served in the least restrictive environment and referrals to less restrictive state facilities are denied.

According to the complaint, a recipient was not being served in the least restrictive environment. The record demonstrates that a transfer to a less restrictive state-operated facility placement had been recommended by Chester dating back to 2009 and that Chester staff maintained this recommendation until he was eventually transferred in 2012. According to documentation, the recipient was physically aggressive to staff at the facility where he was seeking transfer and the facility may have been reluctant to take him back. Utilization reviews were conducted and the recommendation for transfer was repeatedly made. The reviews did not indicate any specific reasons for the transfer delays. There was reference on the review forms that the issue was being presented to "central office" and there was consideration of a transfer to a state-operated facility that serves persons with developmental disabilities; however, the results of these efforts were not documented on the utilization forms nor was there documentation in the treatment plans as to follow-up on transfer recommendations. Also of note, it was unclear if the utilization review forms were simply representing reviews or if a hearing had been pursued given the length of time the recipient was awaiting transfer. And, the option of pursuing the transfer with the DHS Secretary never seemed to be pursued either unless this was what was meant by contact with "central office." The composite of the utilization review committee appears inconsistent with administrative code requirements. And, it is unclear as to the role the recipient played in any utilization process.

The Mental Health and Developmental Disabilities Code guarantees the right to services in the least restrictive environment pursuant to an individualized treatment plan with input from the recipient. Both the Mental Health Code and the Administrative Code provide a utilization review and hearing process to address conflicts or disputes associated with admissions, transfers and discharges. The DHS Secretary can review decisions made by the facility's utilization review committee and facility director. And, the committee is to be comprised of individuals who are not charged with making admission, transfer and discharge decisions. The recipient also is to be a part of the utilization process.

While the HRA commends the facility for its efforts to clearly document the recipient's progress and its recommendation for transfer, the HRA still contends that he was not being served in the least restrictive setting and substantiates the complaint. The HRA recommends the following:

1. **To ensure that recipients are being served in the least restrictive environment, follow through on transfer recommendations.**

2. **When transfers are denied or delayed pursue available options, including utilization reviews, utilization hearings and referrals to the DHS Secretary.**

3. **Assist recipients in accessing the available options when necessary. Ensure recipient participation in the utilization review process. Document the recipient's participation.**

4. **Document attempts to address transfer delays and the outcomes of those attempts on utilization review forms and treatment plans.**

5. **Revise the transfer policy to include provisions for utilization reviews, utilization hearings, facility director reviews and reviews by the DHS Secretary.**

The HRA also suggests the following:

1. Review the composite of the utilization review committee to ensure compliance with requirements.

2. Consider further policy development regarding the transfer and utilization review process.

3. Pursue external assessments when there are conflicts over transferring a recipient.

4. With treatment team and recipient/guardian involvement, consider transfers to other catchment areas when recipient transfers are delayed or denied.

5. Provide recipients experiencing delayed/denied transfers with contact information for external advocacy resources.

6. Revise the patient handbook to address the utilization review process.

Complaint #2: Language barriers are not adequately addressed.

The complaint stated that a non-English speaking recipient was not being adequately accommodated with regard to his language preference.

The HRA found evidence that the recipient's language barrier was known and documented at admission and in his treatment plan. A facility physician provided some communication assistance although he is not a certified interpreter. Documentation indicated that communication assistance through a telephone interpretation service was obtained for treatment planning and to explain the recipient's status with regard to a court hearing. The recipient's social worker indicated that language cards and materials in the recipient's language have not been provided but the recipient was not able to read and could understand some English and he would receive an interpreter when he returned to court. The treatment team recommended a class for the recipient to learn English. The facility maintains a plan for addressing language needs last updated in April 2012.

The Mental Health and Administrative Codes make provisions for providing interpreter services, materials and information in a recipient's preferred language and a facility plan for addressing language needs.

Based on the evidence, the HRA does not substantiate the complaint but does offer the following several suggestions.

The HRA noted that the treatment plan and progress notes for the recipient indicate his lack of participation in activities, self- isolating behaviors and frustration over language difficulties. In addition, the HRA's own observation of the recipient found him to be asleep in his room in the middle of the afternoon. The HRA cannot say that the recipient's isolating behaviors and frustrations are solely the result of language barriers; however, the barrier could certainly be a contributing factor as documented by facility. The HRA suggests the following:

1. Continue to pursue approaches for addressing communication barriers and increasing the recipient's interactions.

2. Ensure that that the interpreter service will be available for the recipient's next court hearing.

3. Continue efforts to seek out family contact for the recipient.

4. When appropriate, consider a transfer back to the recipient's catchment area where he may be closer to family and persons who speak the same language.

5. Continue to ensure that the required Administrative and Mental Health Code information is provided in the recipient's preferred language.

6. Ensure that medication and treatment information is provided in the recipient's preferred language so that informed consent can be secured.

7. Ensure that the practice of locking the recipient out of his room is addressed in the treatment plan with recipient input.

The HRA commends the facility for its cooperation and assistance during its investigation.