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Egyptian Regional Human Rights Authority
Report of Findings
13-110-9007
Chester Mental Health Center

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Chester Mental Health Center, a state-operated mental health facility located in Chester. The facility provides services for approximately 240 recipients serving both forensics and civil commitments. The specific allegations are as follows:

1. A recipient's discharge plan will inappropriately send him to another state operated facility than the one in his catchment area.

2. A staff person verbally attacked a recipient after he voiced a complaint about her in a treatment planning meeting and Security Therapy Aides speak to recipients in a derogative manner.

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2).

Statutes

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) states "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent possible….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." (405 ILCS 5/3-908) states "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 Administrative Code (59 IL ADC 112.10) Section 112.10 (h)(3)(A) states: For all transfers occurring more than seven days after admission to a mental health facility, "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.

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-112) states "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect." The Code (405 ILCS 5/2-100) also states "No recipient of services shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the receipt of such services. A person with a known or suspected mental illness or developmental disability shall not be denied mental health or developmental services because of age, sex, race, religious belief, ethnic origin, marital status, physical or mental disability or criminal record unrelated to present dangerousness."

Investigation Information for Allegation 1:

Allegation 1: A recipient's discharge plan will inappropriately send him to another state operated facility than the one in his catchment area.

To investigate the allegation, the HRA Investigation Team (Team), consisting of two members, the HRA Coordinator and the HRA Director conducted a site visit at the facility. During the visit, the Team spoke with the Recipient whose rights were alleged to have been violated and the Chairman of the facility's Human Rights Committee (Chairman). With the Recipient's written authorizations, copies of information from the recipient's clinical chart were reviewed by the Authority. Facility Policies and Court documents relevant to the complaint were also reviewed.

I. Interviews:

A. Recipient 1:

The recipient informed the Team that his discharge plan is to transfer him from Chester Mental Health to another State Operated Facility that is out of his catchment area. The recipient would like to be transferred to a State Operated Facility in his catchment area to be closer to family. The recipient stated that although previous discharge plans indicated he would be transferred to his catchment area, it has been changed to the facility he was at prior to his Chester admission.

B. Chairman:

According to the Chairman, he spoke with the recipient's therapist who agreed it would be in recipient's best interest to be transferred to his catchment area. The admissions coordinator indicated that there was a Court order to be transferred to his catchment area when he is discharge appropriate. Seven letters of support were also received by family members. After the fact, the admissions coordinator discovered that the Court had rescinded the order subsequent to the recipient committing assault at his previous facility prior to coming to Chester. Therefore, Chester had no authority to send him anywhere except back to the previous facility which was out of his catchment area.

C. Social Worker:

The Social Worker was interviewed regarding transfer policies in general and relating to this case specifically. She said Chester doesn't do discharge/transfer planning as far as discharging to the street. When someone is deemed appropriate for transfer from the maximum security setting at Chester, they only have authority to send that person back to where he came from whether it's a hospital, jail or other facility. The only way Chester is allowed to send him elsewhere, is if his legal status changes or if there is a Court order for a non-secure setting. If a person is on a forensic commitment and his theim date passes, then he becomes a civil or voluntary commitment and at that point, Chester is able to transfer him to a facility in his catchment area. In this specific case, the recipient had an order for a non-secure facility, but it was rescinded therefore, Chester had to send him back to where he came from and could not send him to his catchment area because that facility is considered a non-secure setting. When questioned if that facility had a forensic unit, she said it did. She couldn't explain why it would still be considered a non-secure setting or how it differed from where this recipient was sent. She said that originally when someone is deemed NGRI as is the case here, the pre-placement division at the Illinois Department of Human Services (DHS) determines where the person is sent. She did not know why this individual was sent out of his catchment area to begin with, but said that Chester had no authority to send him anywhere except where he came from since his legal status hadn't changed and there was no Court order for a non-secure setting.

II. Clinical Chart Review:

A. Treatment Plan Reviews (TPRs): It was noted in the treatment plan dated 9/5/12, that the recipient asked for a transfer to a facility in his catchment area rather than being sent back to the facility he came from. Also noted was the fact that Chester has received seven letters from family and friends requesting he be moved to his catchment area. The plan which was signed by both the staff psychiatrist and coordinating therapist states "This request is clinically in the best interest of [recipient]. His family members are unable to visit with him due to the distance from [catchment area] to Chester, IL. He needs the support of his family and friends during this time when he is hospitalized."

The Team reviewed the recipient's treatment plan dated 11/28/12 which also noted the recipient's request for a transfer to his catchment area as opposed to transferring back to the previous facility. The exact same statements from his 9/5/12 facility as listed above were also listed on this TPR.

B. Transfer Recommendation: The Team reviewed transfer recommendations dated 7/26/12 and 11/28/12. Both summarized his psychiatric history showing he had been at Chester last year and was transferred back to a state operated facility out of his catchment area in June, 2011. He did well until recently when he allegedly struck a peer in his eye while the peer was sitting in the dayroom. He was readmitted to Chester in May of 2012. The recommendation on both forms states "[Recipient] is doing well on his medication….He has not presented any management problems at Chester. Therefore, it is the clinical opinion of his treatment team that he is appropriate for transfer to a less secure facility at this time."

C. Court Documents: The Team reviewed Court documents pertaining to the recipient's transfer:

a. On April 12, 2007 the recipient was found not guilty by reason of insanity and ordered to contact DHS for an evaluation as a condition of bail.

b. On July 27, 2007 there was an Order entered stating that the defendant was found to be in need of mental health services on an inpatient basis. He was released to Peoria County Sheriff's Department which was ordered to transfer him to DHS for treatment. No specific facility was listed.

c. On May 29, 2012 there was an Order entered stating "The Defendant is appropriate and suitable for transfer to a non-secure setting within DHS, subject to all terms, procedures and limitations of such transfer to and placement in a non-secure setting. The DHS shall implement said transfer within 30 days of this Order and if such transfer has not occurred within that period, the DHS shall report in writing the status to the Court and parties with an explanation for failure to transfer" and the case was set for review on August 2, 2012 with Defendant's appearance being waived for said hearing.

d. On June 19, 2012 a Motion to Reconsider Ruling on Defendant's Petition for Transfer to a Less Secure Facility was filed. This Motion stated that a doctor from DHS testified on March 15, 2012 that the Defendant should transfer to a less secure facility. On May 23, five days before the court issued its decision to grant transfer, the same doctor wrote an updated treatment plan which wasn't received by the State's Attorney until June 4th after the court's Order was issued. The updated treatment plan described an incident where the Defendant struck another patient and therefore the treatment team no longer felt he was appropriate for transfer to a non-secure setting and in fact, was attempting to transfer him to Chester, a maximum security setting.

e. On August 2, 2012 there was a hearing held on People's Motion to Reconsider the Order Transferring Defendant to a less secure facility. It is noted that there was "no objection by Defendant" therefore the People's Motion to Reconsider was granted and the previous order directing DHS to transfer the Defendant to a less secure facility was stricken.

f. On February 28, 2013 a Notice of Change in Status was filed showing that the Defendant was transferred from Chester to his previous state operated facility that was out of his catchment area.

III...Facility Policies:

Chester Policy

During a telephone conversation with a Social Worker at Chester, the Authority was told that the pre-placement division at the DHS is who originally determines where someone is placed when found NGRI. The only way Chester can transfer to a catchment area is if the

recipient becomes a civil or voluntary commitment. Otherwise, without a court order Chester can only transfer the recipient back to where he came from when he is approved for a less secure setting. The Authority asked for a specific Chester policy stating this and was told she's just always been told that and didn't know if there was a specific policy but she would check and forward if she found something. The Authority received a message from her on a later date stating that this would be per the forensics handbook and directing the Team to the DHS website.

Forensic Handbook

The Team reviewed the forensics handbook, the Department of Human Services - Forensic Services essentially has three general levels of custody for forensic inpatients: (1) Non-secure units - This is represented by the general unit structure in facilities. Even though the doors may be kept locked and residents need approved grounds pass before they may leave unescorted, the units are not regarded as secure. Civil inpatients are most often housed on non-secure units. Non-secure housing can only be used for forensic patients with prior approval by the courts. (2) Secure units - All areas of the State are served by a unit which fits this category. Fenced recreation areas, security screens, controlled access, and limitations on allowed personal items serve to differentiate these units from other units in the Department. (3) Chester Mental Health Center - Chester Mental Health Center is exclusively a maximum security facility and is the highest level of security available in the Department. The maximum security program at Chester has substantially restricted movement, a specialized physical plant with security monitoring, and nearly continuous observation. It allows a more physically dangerous or assaultive patient to be treated as well as those who present substantial escape potential. Again, the Illinois Legislature has mandated by statute that all defendants found Unfit to Stand Trial (UST) or those defendants found Not Guilty by Reason of Insanity (NGRI) are to be housed in a secure setting of the Department unless the criminal court orders otherwise. The court must also give prior approval before such defendants are granted any privileges such as being unescorted while on facility grounds and when being taken in the community. As a result of this, the overwhelming majority of such persons are housed either at the maximum security Chester Mental Health Center or in a medium security unit at Alton, Choate, Elgin, or McFarland Mental Heath Centers.

Section III of the handbook contains a flow chart that outlines the process once someone is found not guilty by reason of insanity (NGRI) which is the case of the recipient in this case. If found in need of inpatient treatment, the person is sent to DHS and the receiving facility is required to send reports to the court after 30 days and then every 60 days thereafter. The next steps would be DHS or the defendant petitions for release or it is the end of the NGRI commitment period at which point, the person can continue treatment in a DHS facility, be civilly committed or released from custody. The handbook continues to address how a facility or defendant can obtain a transfer to a non-secure setting by petitioning the court.

The Team could not find anything in the forensics handbook addressing treatment in transfer to a *less* secure setting. It only addresses secure or non-secure settings. However, the handbook does include the Mental Health Code which mandates treatment in the least restrictive environment. According to the handbook, Chester Mental Health is a maximum security facility whereas

Alton, Choate, Elgin and McFarland Mental Heath Centers are considered medium security facilities.

Conclusion

After interviews and review of the Court documents, the DHS forensics handbook and the recipient's clinical chart, the Team determined that the treatment plan at Chester specifically addressed sending the recipient to a less secure setting that was in his catchment area and even stated it would be in his best interest. According to the social worker's account, since the court Order was stricken that ordered him to a non-secure setting, Chester had no authority to send the recipient to another facility other than back to the previous one that he came from; however, the Team couldn't find any policy stating this. There was no documentation stating that the facility in his catchment area, that was the recommended placement per his treatment team, was ever contacted for possible placement. Since 405 ILCS 5/3-908 states "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 facility director may have been able to help with placement for this recipient, but there was no documentation that the facility director was ever contacted. There was also no documentation that the treatment team considered assisting the recipient or referring the recipient for assistance with petitioning the courts for placement elsewhere even though they had identified a preferred placement. Since the Team could not find any policies specifying how the transfer process within the DHS and specifically Chester Mental Health is to occur and because of the court order specifying a particular type of placement, the allegation that a recipient's discharge plan would inappropriately send him to another state operated facility than the one in his catchment area is **unsubstantiated**. The following **suggestions** are made:

1. When treatment team meetings are held and transfer issues come up, the treatment team should make a note of the request, but verify that specific placements are a possibility before including it in the treatment plan so as to avoid any confusion for the recipient that he will be sent somewhere that isn't a possibility. The treatment team should also provide recipients with written explanations for any delays in transfers to a less restrictive environment.

2. Transfer coordinators should work with the treatment team when someone is recommended for transfer and comply, whenever possible, with 405 ILCS 5/2-102 which mandates that a recipient shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The facility should also advocate for the recipient to be transferred to a specific facility if it has been deemed in his best interest, per his treatment plan, involving the facility director whenever necessary.

3. The facility should review any policies governing transfers within DHS with staff responsible for carrying out transfer requests.

Investigation Information for Allegation 2:

Allegation 2: A staff person verbally attacked a recipient after he voiced a complaint about her in a treatment planning meeting and Security Therapy Aides speak to recipients in a derogative manner.

To investigate the allegation, the HRA Investigation Team (Team), consisting of two members, the HRA Coordinator and the HRA Director conducted a site visit at the facility. During the visit, the Team spoke with the Recipient whose rights were alleged to have been violated, the Chairman of the facility's Human Rights Committee (Chairman) and the two Security Therapy Aides (STAs) who were allegedly involved in this incident. With the Recipient's written authorizations, copies of information from the recipient's clinical chart were reviewed by the Authority. Finally, facility Policies relevant to the complaints and an Office of Inspector General (OIG) report conducted regarding this incident were also reviewed.

I...Interviews:

A. Recipient: The recipient told the Team that a STA has been disrespectful and belittling to patients by calling them "retarded" and "boy". He brought this up at his TPR meeting which was held around August or September, 2012 and shared his concerns with his treatment team in her presence and after the meeting she approached him and verbally attacked him by saying "I'm not the [explicit] you made me out to be" and told him to "shut up". He did say that he apologized to this STA at a later date because "to get respect you have to give it." He said they have had no other issues since.

B. STA: The Team interviewed this STA who the recipient accused of being disrespectful and belittling. She told the Team that the recipient accused her of calling him a "boy" and "the N word" but she said he has since returned and apologized to her for the incident and said he just assumes all white people are racist until he gets to know them. The STA said he was angry with her at his treatment planning meeting and that he made these accusations during the meeting in front of other staff members. She said she did approach him after the meeting and told him she wished he would have come to her first rather than bringing up his concerns in front of everyone at the meeting. The STA denied using any disrespectful or belittling language and said she is a "hand talker" which is what was seen in the video that OIG referenced in their report and denies that her conversation was ever threatening in manner.

C… Recipient 2: This recipient who lives on the same module told the Team in a separate complaint letter on August 29, 2012 "staff member use unprefisional attitude when saying racial terms and perjudice words and meaning against patient [recipient 4]" [sic]

D. Recipient 3: This recipient lives on a different module than the first two recipients. However, he told the Team that in February, 2013 he was attacked by a peer and when he told staff about the incident the staff member said "I wasn't there so I don't care what happened, it ain't my problem."

E. Recipient 4: This recipient lives on the same module as recipients 1 and 2. He has reported to the Team that staff addresses him as "boy" and do or say things to provoke him to lash out such as saying he will never get out of Chester and calling him explicit names. It was noted that

an OIG report into the name calling was unsubstantiated because when questioned, recipient 4 denied that it caused him any emotional stress or maladaptive behavior.

II. Clinical Chart Review:

A. Treatment Plan Reviews (TPRs): The Team reviewed the recipient's treatment plan dated 9/5/12. There was no mention of any issues with this STA or the recipient's concern over how she interacts with him and other recipients.

The TPR dated 11/28/12 was also reviewed, again, there was no mention of any issues with this STA or the recipient's concern over how she interacts with him and other recipients or if the issue had been addressed by the STA's supervisor.

B. Progress Notes: The Team reviewed the psych note dated 9/5/12 stating the recipient attended his TPR today, is doing fairly well on meds with no management problems and is tolerating meds without any side effects. There is no mention of any problems with this STA being discussed in his TPR.

A therapist progress note dated 9/7/12 noted the recipient's request for transfer to a facility in his catchment area; that he has acclimated to his unit; has had no signs or symptoms of psychosis; that he has regular contact with his family and he discusses the classes he participates in. There is no mention of any problems with this STA being discussed in his TPR.

A therapist progress note dated 10/2/12 states that during his TPR last month 9/5/12, the recipient was extremely upset. He accused the STA of being disrespectful to him stating she called him "boy" he responded with "I'm a grown man, and I'm not a boy". He then stated that the STA is disrespectful to other patients on his unit. He stated she told him to "shut up". The STA attempted to explain something, but was cut off by the recipient. The recipient stated that he has taken care of it himself by calling an advocacy organization. The TPR was ended due to the recipient getting so upset.

III...Facility Policies:

A…Chester Policy RI 01.01.02.01 Patient Rights states "Each patient admitted to Chester Mental health Center shall be treated with respect and shall be ensured of all rights under Sections 2-100 to 2-111 of the Mental Health and Developmental Disabilities code. Restrictions of rights and corresponding rationale shall be properly documented in the patient's clinical records.

B…Chester Policy RI .05.00.00.01 Code of Ethics states:

"It is expected that all Chester Mental Health Center employees will serve as ethical role models for each other and for patients being served. Every employee, at every level of the organization, must continually evaluate the potential outcomes of the decisions he/she makes since action or inaction may affect the well-being of others. The employee must accept responsibility for any consequence resulting from his/her behavior."

"Chester Mental Health Center employees will act to safeguard and perpetuate the rights and interests of patients. Employees shall act as advocates for patients and strive to promote their well being. Employees will speak out to promote the rights, interests, and prerogatives of patients…will provide care with respect for patients' background, gender, religion and heritage. Every task performed by a Chester Mental Health Center employee must have, as it=s ultimate goal, to serve in a positive way, those patients in our care."

" Every employee of Chester Mental Health Center shall be expected to commit to the following principles: …To respect the similarities and differences among people arising from differences among their cultural, ethnic, religious, and personal backgrounds."

IV…Training Schedule

The Team also inquired about specific staff training that was held over the past year. Per the Staff Development Coordinator, all STAs and other staff participate annually in Ethics training from central office. In addition, Staff has annual training regarding topics such as cultural sensitivity, non-violent crisis intervention and patient safety. Staff also receive training on OIG-Rule 50 which covers a wide variety of situations on addressing and dealing with multiple patient issues and behaviors including how patients should be treated and/or what kind of treatment methods are acceptable. Some other specific training topics that were covered for staff over the past year include Trauma Informed Care, Types of Aggression, The Brain and Psychotropic Medications.

V. OIG Report

The HRA Coordinator reviewed the OIG report of the investigation of alleged mental abuse that was conducted and is directly related to the incident involving allegation 2. The outcome of the investigation was unsubstantiated with recommendations. According to the report, a video was reviewed which showed STA 1 entering the dayroom where the recipient was sitting on the couch after his TPR meeting. The following statement was made regarding this interaction. "[STA 1] was observed pointing and waving her finger at [recipient] who responded in kind by doing the same. No audio recording of the conversation was available to document the words spoken during the conversation. However, the recording revealed that the conversation became confrontational simply from viewing the body actions of both [recipient] and [STA 1]. The recording further revealed that [STA 2] asked other individuals in the area to leave as the conversation continued. [Recipient] terminated the conversation by standing up and leaving the area after approximately three minutes." The report further stated that since the recipient's only claim was that STA 1 told him to "shut up" and STA 1 denied making any cursing or inappropriate comments to recipient, which was corroborated by STA 2, the allegation was unsubstantiated. However, the OIG did suggest that the facility review the video of the alleged incident and determine if the actions of STA 1 were professional and within the code of conduct when addressing an individual. Also noted in the OIG report was the fact that other individuals were in the area at the time of the conversation were asked to leave when the conversation became disruptive in nature. According to this OIG report, STA 1 last completed OIG Rule 50 training on July 4, 2011.

Also noted in the OIG report was that Social Worker 1 stated that during the September 5, 2012 TPR, the recipient did want to discuss STA 1's behavior toward him. The recipient claimed that she was very rude and disrespectful toward him and treated him like a child. The recipient further expressed that he was a grown man and didn't appreciate this treatment. STA 1 attempted to address his comments, but he would not provide her an opportunity to respond stating he already took care of it through a complaint he had made to an advocacy organization.

Conclusion

After a review of the OIG report, the Team verified that there was an interaction between STA 1 and the recipient following his TPR which was initiated by STA 1 that appeared to be confrontational in nature based on body language in the video and the fact that others were asked to leave the area when the conversation escalated. The case notes in the recipient's clinical chart didn't document any negative interactions between recipient and STA 1. The TPR from September 5, 2012 made no note of the recipient voicing concerns about STA 1, however the social worker confirmed it was discussed during the treatment team review.

Chester policies require that each patient be treated with respect and states that "every employee, at every level of the organization, must continually evaluate the potential outcomes of the decisions he/she makes since action or inaction may affect the well-being of others. The employee must accept responsibility for any consequence resulting from his/her behavior." Employees are also expected to act as advocates for patients and provide care with respect for patients' personal background, gender, cultural, religious and ethnic heritage.

Although the Team was told on 3 separate instances similar stories of inappropriate staff interactions, these three recipients failed to mention specific staff names and when questioned, couldn't remember names. Therefore, the Team could not question specific staff on these 3 allegations in order to confirm or deny they indeed happened.

Based on the information from the OIG report, the confirmation from the Social Worker that STA 1's behavior toward the recipient was discussed in the TPR and the reference to the same by the therapist in progress notes, the allegation that a staff person verbally attacked a recipient after he voiced a complaint about her in a treatment planning meeting is **substantiated.** The following **recommendations** are made:

1. Follow Chester policies and Mental Health Code requirements relating to patient rights, staff to patient interactions, and approved treatment methods as well as OIG Rule 50 training requirements. Review with staff and provide the HRA with documentation of that review. Included in the review should be a clear mechanism for staff to report observed violations. Unit supervisors should monitor interactions more closely, ensure direct care staff training is up to date and counsel direct care staff if/when negative interactions occur.

2. When specific issues, concerns or allegations are brought up and discussed during a TPR meeting, those issues should be included in the discussion section of the

written TPR as well as a plan of action to address those issues or allegations. There should be follow up and discussion on how issues were addressed at the next month's review.

Since the testimonies of the other 3 recipients did not name specific staff members and there was no audio on the video referenced in the OIG report to confirm what was said, the allegation that Security Therapy Aides speak to recipients in a derogative manner is **unsubstantiated.** However, recommendation 1 listed above is reiterated as a **suggestion** for best practice relating to this allegation. The HRA also suggests that the facility consider more frequent reviews of the code of conduct.

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