FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
13-110-9008
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 is not being served in the least restrictive environment.**
2. **A recipient was inappropriately removed from participation in rehabilitation classes.**

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2) and the Illinois Administrative Code (59 Ill. Adm. Code 112).

Investigation Information for Allegation 1: A recipient is not being served in the least restrictive environment.

To investigate the allegation, the HRA Investigation Team (Team), consisting of two members and the HRA Coordinator 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), the Facility Director, the Medical Director and the recipient's Therapist and Psychologist. With the Recipient's written authorization, copies of information from the recipient's clinical chart were reviewed by the Authority. Facility Policies relevant to the complaints were also reviewed.

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 feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the

treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan."

The Code (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 Code (405 ILCS 5/3-804) further states "The respondent is entitled to secure an independent examination by a physician, qualified examiner, clinical psychologist or other expert of his choice. If the respondent is unable to obtain an examination, he may request that the court order an examination to be made by an impartial medical expert pursuant to Supreme Court Rules or by a qualified examiner, clinical psychologist or other expert. Any such physician or other examiner, whether secured by the respondent or appointed by the court, may interview by telephone or in person any witnesses or other persons listed in the petition for involuntary admission. The physician or other examiner may submit to the court a report in which his findings are described in detail. Determination of the compensation of the physician, qualified examiner, clinical psychologist or other expert and its payment shall be governed by Supreme Court Rule."

According to the Illinois Administrative Code (59 Ill. Adm. Code 112.10), "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)."

I. Interviews:

A. Recipient: The recipient informed the Team that he has been at this facility since February, 2008 and he does not understand what he needs to do to get a transfer to a less secure facility because he had already served his time ordered by the Court for his legal charges. He said he participates in his treatment team meetings but is just told to stay on green level for at least 3 months and have no restraints or seclusions and he could be considered for a transfer. He said the facility operates on a level system, green is for good behavior, yellow is when you have had a minor behavioral issue and red is when you are restricted from privileges. He said whenever he gets close to meeting the goal of 3 months on green, staff do things to provoke him to act out or write him up for minor things so he gets a "behavior ticket" and then his level changes. He named a few staff specifically and also his therapist for trying to keep him at the facility. He does not know why the therapist would want to keep him at the facility, but suggested that it might have something to do with his charges from the past and that "they just don't want me to get out of here". The recipient went on to say that a treating psychiatrist had recommended him for a transfer to a less secure facility but his therapist "put a stop to that" by saying he had to have a risk assessment completed before he could be transferred. The recipient said he wrote a letter to the facility administrator advising him that the psychiatrist approved him for a transfer

but the therapist asked for a risk assessment and the recipient, in turn, requested that the risk assessment be done by an outside party. However he had not yet been given one. He also informed the administrator that because he had asked for a medication change, he was told he has to wait even longer for the team to observe his behavior before he could transfer. He concluded the letter asking for the administrator's assistance in obtaining the risk assessment. The HRA was able to verify this communication by obtaining a copy of this letter from his chart.

When asked for examples of how staff provokes him, he said they call him names like "boy" or "butch bitch". He also said another staff purposely handles his food tray roughly or touches his tray or food in a way she knows aggravates him. When asked for examples of minor things that he gets written up for he said "trying to get coffee in class, telling someone they look pretty today."

B. Therapist: The Team interviewed the treating therapist about the treatment and transfer process and also about this recipient specifically. The therapist's job title is Psychologist III. According to Central Management Services (CMS) job description, this job title requires a master's degree in psychology supplemented by two years experience in psychology or completion of the psychologist associate program. His role in the treatment process is to meet with individuals for counseling sessions, participate in the treatment plan review (TPR) meetings as well as prepare the treatment plan and communicate with the unit director. He said the core team, consisting of a psychiatrist, therapist, nurse, unit director and security staff, meets daily to discuss specific issues or problems that need to be addressed. The treatment team which includes a nurse, unit director, psychologist/social worker/therapist, psychiatrist, rehabilitation staff, security therapy aide (STA) and the patient (if they choose to participate) as well as anyone else the team or patient would like to be present, meets monthly to discuss progress, set and adjust goals and anything else involving treatment planning; the therapist and unit director then work together to ensure that the treatment plan is being implemented properly.

When a patient would like to be transferred to a less secure setting, it is brought up and discussed during the TPR meetings held each month. The team is supposed to discuss barriers to transfer and what needs to be done to address these barriers. Once the team feels a transfer is warranted, a transfer recommendation is written. On this specific recipient, some barriers to transfer include delusions that the therapist is working with the Chicago Mayor to keep him at Chester, and behavioral infractions including intimidation, manipulation and sexually inappropriate behavior towards female staff. The HRA Team discussed with the therapist a conflict of interest that was noted in the chart between him and the treating psychiatrist. The psychiatrist felt this recipient was ready for discharge and wrote a transfer recommendation. However, the therapist felt it was inappropriate and requested that a risk assessment be completed before the recipient could be transferred. The therapist told the Team about past cases where others have been discharged and committed repeat offenses and ended up back at Chester and stated that this recipient had been in and out of prisons and state operated mental health facilities for most of his life. He felt if this recipient was given a transfer to a less secure facility, they would discharge him "in no time" and he would commit offenses again as he had in his past when given the opportunity. He stated that "the taxpayers of Illinois pay me to keep people like him off the streets." The therapist said this recipient has not shown improvement in developing

insight into how his behavior negatively impacts others and when he is asked to discuss his maladaptive behaviors, he blames others for his behavior.

C. Psychiatrist: The Team interviewed the treating psychiatrist who had recommended a transfer for this recipient. His job title is Physician Specialist Option C. According to CMS job description, this position requires an Illinois license to practice medicine and American Board Certification in the position related to his medical specialty. His role in the treatment process is to attend morning meetings and treatment plan reviews and he sees his patients a minimum of one time per month.

The Team questioned him about the transfer process. He said normally, if someone is medication compliant, restraint and violence free for a stated period of time, then they are recommended for a transfer to a less secure facility. Once the team agrees a transfer is appropriate, the Psychiatrist prepares a transfer recommendation which is given to the medical director and then the facility director. The transfer recommendation is then given to the transfer coordinator who looks for placement. Once a receiving facility is identified, there is a video conference with that facility. They can refuse to accept the recipient and if this occurs, then the administration gets involved. The only reason a transfer is usually delayed is due to beds not being available in less secure facilities. **He said that a risk assessment being completed is highly unusual; this case is the first time he has seen that come up in the 3-4 years he's been employed at Chester.** He also said he was unaware that a risk assessment had even been requested until he was doing a follow up on this recipient and realized he was still at the facility. He said Chester normally doesn't discharge recipients "to the street," they are usually transferred to a less secure facility. The receiving facility will complete a risk assessment before discharging someone "to the streets" if/when they feel it is appropriate, therefore there is no real need to complete a risk assessment just to transfer a recipient to another facility. The psychiatrist stated that it is not their role to determine if someone is ready for discharge from state operated facilities altogether, only to determine if they require a maximum security setting or not. He agreed with the therapist that this recipient is not ready to be discharged "to the streets" however he feels this recipient has met criteria for transfer to a less secure setting. He said the recipient is not aggressive, is medication compliant and has only required one incident of seclusion/restraint recently and that was because he was trying to help a peer who was involved in an altercation. Therefore, he does not feel this recipient meets the criteria for a maximum security setting. The psychiatrist said recently the recipient asked to try Haldol instead of Risperdol due to nausea. The psychiatrist didn't see that he was displaying psychosis so he ordered a change in medication to Haldol. However, after the change he was getting worse and behaviors were increasing, so he switched him back to Risperdol and he has been doing fine with that and continues to be medication compliant. He also voiced concern that some members of his treatment team and staff look at his behaviors from the past not the current behaviors and feels that he should not be kept at Chester based on what he might do if transferred.

The HRA had received a complaint that there was a conflict of interest between this recipient and his therapist. Therefore, the HRA asked the psychiatrist if he was aware of any conflicts to which he answered yes. He said the therapist wants to keep the recipient here and feels he needs an independent exam. When asked if there was a formal process to address when a conflict arises within the treatment team, he said he was unaware if there was, but said he took

it to the medical director and the internal human rights committee for possible review. He and the medical director just "agreed to disagree". The psychiatrist stated his biggest concern is that the risk assessment would be done by the therapist; he felt that was definitely a conflict of interest and felt that the recipient should have an independent assessment done by an outside psychiatrist if it is going to be required for a transfer. He stated that an independent assessment was requested but has not occurred yet and he does not know why.

D…Chairman: After meeting with both the therapist and psychiatrist, the HRA Team asked the chairman to research 2 questions: If there is a disagreement among the treatment team members on whether or not a patient is ready for transfer, how is this disagreement resolved and when would a risk assessment be done prior to transfer and what is the procedure to accomplish this? He was told that the Clinical Care Monitoring (CCM) meeting is where disagreements would be resolved with the Medical Director present, and the Utilization Review (UR) process would then monitor the outcome of the CCM.

E…Medical Director: The Team spoke with the medical director several times during this investigation. The HRA was also told that the treatment team at Chester does an ongoing evaluation for appropriateness of transfer. When the treatment team makes the determination that a patient is appropriate for transfer to a less secure setting, then the team psychiatrist writes a transfer recommendation on Chester's form 143. In this transfer recommendation form they do the risk assessment. Chester's form 143 was reviewed by the HRA and the transfer recommendation that the psychiatrist completed included all the components of this form as listed below in the Clinical Chart Review section of this report. The HRA was told that this is usually the only risk assessment completed prior to transfer.

The Team voiced concerns over: the disagreement between the therapist and psychiatrist regarding transferring the recipient and how those disagreements within the treatment team are addressed; the CCM referral and independent risk assessment being accomplished; and, a possible conflict of interest between the treating therapist and recipient and how it impacts the therapeutic environment for the recipient. The following are details of the HRA conversations with the medical director.

1. Disagreement between the treatment team and CCM process: When there is a disagreement between the treatment team, the process to resolve this is the Clinical Care Monitoring (CCM) meeting which allows an outside person to look at difficult cases or conflicts and form an opinion as to the course of treatment. The Team spoke with both the medical director and a quality management representative. The process is as follows. 1. A member of the treatment team makes the CCM referral to the medical director with a summary of the problem. 2. The medical director then looks at a schedule for the CCM based on which facility doctors have expertise in the area of concern and when they are available. 3. The CCM is normally scheduled within 1-2 weeks from the referral date. In this case, the CCM referral was made on 3/18/13. On 4/16/13 this recipient was transferred to another unit. The medical director spoke with the employee that made the CCM referral and a decision was made to wait on the CCM since it was a moot point as the recipient had been transferred to another unit and the care of a different therapist. Also, the facility was working on obtaining an independent risk assessment to see if the

recipient would be appropriate for transfer. The decision was made to wait to see what happened with the independent risk assessment and the new therapist. When the HRA questioned the medical director as to why a CCM wasn't held within 2 weeks of the original referral as is standard practice, the HRA was told that the medical director had been on vacation and didn't immediately see the email requesting it upon her return from vacation. Once she found it, she immediately consulted with the referring employee to see if he still wanted the CCM. As noted above, a decision was made to wait and see what happened on the new unit and with the independent risk assessment. The HRA was also told that normally a Utilization Review (UR) would be held following a CCM to make sure the CCM recommendations were followed through, however since the CCM never occurred there was no need for a UR meeting.

2. Independent risk assessment: The risk assessment was originally requested by the assigned therapist after the treating psychiatrist recommended this recipient for transfer to a less secure facility, around September, 2012. The recipient, in turn requested that the risk assessment be done by an independent assessor, not connected with Chester Mental Health. Since Chester had to go outside their facility to find an assessor, the process took longer than normal. The HRA's email correspondence regarding this issue dated back to November, 2012 where the acting assistant facility director was "working on getting the status" but said "the unit director didn't think it had been completed yet". The email correspondence picked back up in March, 2013 when the HRA became aware that it still had not been completed. The risk assessment was completed on May 2, 2013. When the HRA reviewed this assessment, it was discovered that it consisted solely of a review of the most recent TPR and was done in the form of an email correspondence to the medical director and the DHS deputy director for forensic services. The HRA also voiced our concern of this process with the medical director and facility director.

3. Possible conflict of interest between therapist and recipient: Throughout the course of this investigation, the HRA Team became increasingly concerned about a possible conflict of interest between the recipient and the assigned therapist. When voicing this concern to the medical director, upon learning that the recipient was going to be returned to the previous unit with this same therapist due to a restructuring within Chester, the HRA was told that "at this time, there is no reason to believe that there exists a conflict of interest between [therapist] and [recipient]." The HRA relayed specific examples that led to the HRA's concern of a possible conflict of interest to both the medical director and the facility administrator which are listed as follows:

- In March, 2013 a concern was brought to the attention of the HRA that the therapist was not being objective where the recipient is concerned. This was based in part by statements the therapist allegedly made to another staff person at Chester including: "I don't care if [recipient] goes to classes or not, he's not going to become a Harvard graduate." "I think others on the treatment team other than [psychiatrist] feel he is ready for transfer, but are afraid to say so." "The tax payers of Illinois pay me to keep communities safe from people like [recipient]." "I don't care if Sigmund Freud comes back from the dead and says [recipient] is ready for transfer…" The therapist has also stated that he "is the only one who

understands [recipient's] dangerousness and if he had another therapist they would transfer him and if he ends up at another facility, they will discharge him." The medical director responded that if this therapist did make these comments, it is possible that they may have been made "jokingly" and then mis-interpreted by others.

- In March, 2013 a CCM referral was made by an employee of Chester Mental Health due to "therapist counter-transference." This CCM never took place because before this could be accomplished, the recipient was transferred to another unit with a different treating therapist and it was decided that it was moot at that point.

- Around April 19, 2013 the recipient was moved to another unit and assigned to a new therapist. In reviewing the chart since then, the HRA found that there has been a significant amount of work put into the recipient's behavior plan and formulating strategies to address his maladaptive behaviors. This type of treatment had not been reflected in previous treatment plans the HRA reviewed.

There were also several progress notes from the new therapist documenting that the recipient is often (at least weekly) anxious about his relationship with the previous therapist and that he has thoughts of persecution by him:

- 5/2/13 [recipient] wants to talk with therapist about [previous therapist]
- 5/10/13 [recipient] said his previous team did not want him to work with his family and he had to be reassured that he would have family contact. The new therapist documented where she facilitated phone calls for the recipient to contact his uncle.
- 5/10/13 unsuccessful in redirecting [recipient] from ruminating about [previous therapist] and thoughts of persecution.
- 5/17/13 unsuccessful in redirecting [recipient] from talking about [previous therapist]. He blames Chester staff for his inability to leave.
- 5/22/13 [recipient] again brought up [previous therapist] and has thoughts of persecution by him.
- 6/4/13 [recipient] brought up [previous therapist] and problems with him, ruminating about thoughts of persecution

F…Unit Directors: The HRA voiced concern with the medical director about the continual mention of sexually aggressive behaviors, and the recipient's treatment revolving around this behavior, but not being able to find recent examples of this type of behavior in the chart, only examples from the past. It was suggested that we speak with these two employees who are more familiar with this recipient's behaviors and could possibly explain it to the HRA. The first employee worked as a unit director on this recipient's unit a few years ago. She mentioned an incident around 2009 or 2010 where this recipient made something provocative out of clothing and wore it on the unit. The other examples of behaviors included intimidating lower functioning recipients, threatening staff members' families by saying "when I get out I'll…", "posturing" such as trying to come across the table during counseling sessions or slamming his

fists on the table, "glaring" at staff in an intimidating fashion and making inappropriate comments, mostly to nurses, such as "telling them they look sexy" or "making comments on their breasts". This staff has not worked with this recipient directly in about 3 years. The examples given were from when she did work directly with the recipient.

The second unit director we spoke with has worked with this recipient recently and sat in on his sessions with the most recent female therapist. He explained the current goals of these therapy sessions which focused on cognitive behavioral therapy and trying to develop social skills. This unit director's examples of the recipient's behaviors were similar to what the other unit director shared such as "posturing" when he disagreed with the therapist. Examples he gave of what he meant by "posturing" are suddenly moving forward or slamming his fists on table." He said the recipient will follow rules but manipulates and becomes assertive when his sexual issues come up in therapy sessions. The examples given of how this recipient may have acted inappropriately with the most recent therapist was him saying "I like your hair today" or "I like your blouse." When these comments were made, the therapist would tell him that was an inappropriate comment and immediately end the session. In this unit director's opinion, one of the recipient's biggest challenges is ruminating about his past. The more he ruminates, the more agitated he becomes and the further back in the past he would go. He was able to be redirected from the "posturing" and intimidating behaviors but it was more difficult to redirect him from ruminating about the past. When the recipient didn't ruminate he was easier to work with but he said this recipient has a short tolerance for disappointment and when faced with disappointment, he would begin ruminating. He also added that this recipient displays ruminating behaviors across all environments. The recipient had not had any aggression when he was on this unit director's unit. He said the recipient tried to "test the waters" at first and when he would get caught the recipient felt it was "never his fault."

G. Facility Administrator: The Team scheduled a meeting with the facility administrator to voice the HRA's concerns regarding the conflict of interest with the therapist and recipient as well as the disagreement between the therapist and psychiatrist relating to transfer and the independent risk assessment and how it was completed. The facility administrator agreed to look into the CCM not being accomplished as well as the elements of the independent risk assessment and how it was completed. The facility administrator was receptive to the HRA's concerns regarding a possible conflict of interest between the therapist and recipient and agreed if such a conflict exists, then it would disrupt the therapeutic environment for the recipient if he was returned to this therapist's case load. The facility administrator said he would discuss this with the medical director and see what accommodations could be made for the recipient to have another therapist. There were concerns regarding how many therapists were available and how their caseloads had to be assigned per union regulations. Another concern was if this recipient could be placed with a female therapist due to his history of sexual aggression, however over the past several months he had been assigned to a female therapist but with a male staff present and had displayed no sexually aggressive behavior. The HRA questioned if this could be repeated on his new unit. The administrator agreed to look into the matter and see what accommodations could be made. The HRA was informed after this meeting that the recipient was being assigned to a therapist on a different unit and his current unit director and this therapist would be "co-therapists" for him.

II. Clinical Chart Review:

A. Independent psychiatric evaluation dated 4/3/12: This evaluation was done by a psychiatrist employed by Chester Mental Health Center as per a request from the recipient at one of his civil commitment hearings for an independent psychiatric evaluation. The report states his history of 21 years in the Department of Corrections along with a commitment for psychiatric treatment during that time and finally returning back to Chester as a civil commitment requiring further treatment for psychiatric problems when his projected "outdate" arrived.

The mental status examination section of the report states "he was free from psychotic delusions or paranoid delusions. He was very calm….He does not exhibit any acute depression or other psychotic symptoms, not suicidal or homicidal. However, [recipient] was unable to fulfill the requirements of Unit B Treatment Team in order to be transferred to a lesser secured facility." This section went on to report what was in his chart regarding why he was unable to be transferred. "He lacked insight into his problems, often could not assist, in fact denied having any major problems relating to his sexual offenses. There is a possibility that he might pose a risk if he leaves back to the streets. [Recipient] was recommended continued stay here at Chester Mental Health Center. He intellectually appeared to be within normal limits. However, behavior from the last treatment plan indicated that [recipient] was unable to fulfill the criteria for any transfer." This section also stated that "regarding his behavior at Chester, he denied having any need for placement in restraints, except seclusion one time a long time ago. He stated that he is generally cooperative with his current treatment including medication."

The recommendation section of this report states "Due to his lengthy chronic psychiatric problems with multiple psychiatric admissions to different mental health facilities…and also placement in Department of Corrections serving many years of sentence for 2 sexual offenses requiring treatment while incarcerated as well. In the current mental status examination particularly his diagnosis and chronic symptoms, lack of insight, history of non-compliance, met essential criteria for his continued placement at Chester Mental Health Center. Without treatment he is likely to relapse very quickly and become immediate threat of physical harm to himself or others. This writer recommends continued stay at mental health facility for further treatment. The treatment plan is in place and if he meets criteria he would be considered as an appropriate candidate for transfer to another facility with a lesser secure environment."

B. Transfer Recommendation dated 7/17/12: This recommendation was written by the psychiatrist listed above in the interview section of this report. This recommendation also mentions the recipient's lengthy history of incarcerations and crimes committed and states that "he has served time, many years, since 5/26/79". It also notes his history of off and on medication refusal.

In the hospital course section of this recommendation, it states "[recipient] has had some episodes of inappropriate sexual behavior directed towards staff. He exposed himself, disrobing in front of the staff and again exposed himself on 8/3/11. Overall this type of behavior has lessened. On 4/14/12 he was placed in seclusion after an altercation with a peer. Prior to that, [recipient's] last containment was on 4/27/11 and he has not required further FLR's (full leather restraints) or seclusions since then. [Recipient] has had a history of non-compliance with

medications and did require crush & observe for a period of time. Subsequently, it was changed to observe with mouth checks, this was discontinued on 3/13/12. [Recipient] is medication compliant and states he will continue to take his medications upon discharge. [Recipient] continues to exhibit occasional aggressive behaviors; raising his voice, threatening, but overall it has improved. Substantially, he has not required a PRN in quite some time, last one being on 4/14/12. [Recipient] meets with his therapist on a weekly basis…attends groups/activities on a regular basis. [Recipient] is psychiatrically stable on current medication regime"

In the mental status examination section the psychiatrist states "he was pleasant and cooperative with the interview…no psychomotor agitation or retardation was noted…thought processes were logical and goal directed and coherent…He denied any suicidal or homicidal ideations. He denied any auditory or visual hallucinations or delusions...he is willing to take medications upon discharge."

The risk assessment section states "Aggressive Behaviors 1) Static factors: [recipient] has psychosis for which he may become moody and paranoid at times. He needs medications to control his symptoms and aggression prior to his release into the community. Without his medications he is likely to decompensate. 2) Dynamic factors: [recipient] needs a structure setting if he is released into the community to comply. Other risk factors (suicide, elopement, etc.) No history of prior suicide attempts, no history of elopement or arson. Patient is a registered sex offender in the state of union"

In the recommendations section the psychiatrist states "based on the above observations of his mental status and behaviors [recipient] is now appropriate for transfer to a less restrictive facility in a van with staff supervision."

C. Independent Risk Assessment email: This risk assessment, which was requested by the therapist prior to discharge, was completed by a psychiatrist from another state operated facility. This assessment was requested after the psychiatrist recommended a transfer for this recipient to a less secure facility, around August or September of 2012. It was completed on 5/2/13. This psychiatrist was chosen after consultation between Chester's medical director, the DHS state medical director and the DHS deputy director for forensic services. The assessment was sent in the form of an email from the independent assessor to Chester's medical director and the DHS deputy director for forensic services. In this email, which is 4 paragraphs in length, the independent assessor says he has reviewed the 4/9/13 TPR of the recipient and noted the following of particular relevance. The recipient has a significant criminal history of sexual and violent offenses "which will undoubtedly make discharge difficult." He then noted his diagnoses of schizoaffective disorder, bipolar type and paraphilia, NOS (Not Otherwise Specified) and stated that "neither of which is adequately addressed by his present medication regimen." His final observation was that "multiple instances of threatening behavior are documented" including an incident when he "threatened a peer with serious harm." He went on to say that this recipient is medication compliant, of average intelligence and likes music but in his judgment "the negatives outweigh the positives." He did state that if there was anything else they wanted him to consider, to please forward it on. The email was concluded with the following statement "On the basis of what I have reviewed I would not recommend a transfer to [another facility]. I do, however recommend the following: A. Consideration of adding a mood stabilizer to [recipient's]

medication regimen. B. Consultation with [another doctor's name] regarding the potential benefits of anti-androgen medication. C. Incorporation of music into a behavioral management plan. I also suggest that the treatment team reassess the utility of including 'developing an empathy for others as a criteria for separation unless we conclude that the MRT approach offers a reasonable prospect of success in this regard. Also, I suggest that we review and clarify the intended function of 'step-down units.'"

The HRA questioned the medical director if this assessment was based on anything other than the recipient's 4/9/13 TPR, if this assessor met with the recipient either in person or on the phone or videoconference or if he reviewed any other documents other than the 4/9/13 TPR. **The HRA was told that the assessment was based solely on review of his latest TPR.** The HRA also questioned whether there was a formal report written up or if there was a standardized assessment tool used that was shared with Chester or if the email from this psychiatrist was the only assessment they were given. The medical director said this email was all they received.

D. Clinical Care Monitoring (CCM) Report: The HRA reviewed a 5/9/13 CCM report which documented a meeting held to review, discuss and explore the implementation of the independent assessor's recommendations. Staff present were the medical director, the current treating psychiatrist (different from the one who recommended transfer), the nursing supervisor, the current unit director, coordinating therapist (different from the one this recipient has the alleged conflict with), director of rehab, an educator, the therapist (who has the alleged conflict of interest with this recipient) and the last unit director. The team reviewed the recommendations made by the independent assessor and the team endorsed the following recommendations: "1. based on [recipient's] current behavioral presentation which includes multiple instances of threatening behavior, the most recent being 3/11/13 and 5/4/13, and multiple infractions of module procedures (on current unit) he does not meet criteria for transfer to a less secure facility at this time. 2. [Psychiatrist] will explore the possibility of adding a mood stabilizer to [recipient's] medication regimen. [Recipient's] current maladaptive behaviors are not predatorily sexual. Therefore, consultation with [dr. recommended in independent assessment] regarding anti-androgen medication is not warranted at this time. [Recipient's] behavior will be monitored for sexual content and expression. Educator reported [recipient] is enrolled and engages in music therapy. [Treating therapist] will coordinate with educator to ensure maximum attendance with music therapy based on the current level system and 3. [Recipient's] development of empathy for others will be continuously monitored, assessed and evidenced as he progresses through his written treatment plan. The goal of [recipient's] treatment plan is the facilitation of treatment optimization with the potential for transfer to a less restrictive setting, based upon clearly delineated behavioral criteria and safety goals."

E. Treatment Plan Reviews (TPRs) and Progress Notes: The HRA Team reviewed several TPRs from both therapists and the available corresponding progress notes paying particular attention to the behavioral logs on the TPRs and differences between the TPRs. The findings are listed below.

Behavior logs listed on TPRs:

5/15/12 Recipient "was reported to have directed verbally threatening statements to staff. During the incident, he made a physically threatening stance and directed aggressive gestures toward staff." (HRA had no case notes prior to June, 2012 to compare to behavior logs).

6/24/12 Recipient "became involved in a physical altercation with a peer. In addition to the fight with the peer, security staff report [recipient] at times, responds to direction by becoming verbally aggressive." There were no case notes regarding the altercation or security staff report.

8/15/12 Recipient "made inappropriate statements to a female instructor in the Rehabilitation Department, and as a result, he was suspended from classes. During the 8/15/12 incident, [recipient] made an allusion to his history of sexually aggressive behaviors in order to intimidate the instructor. The female reported the incident, and she reported feeling 'very uncomfortable' with [recipient's] behavior." The therapist's case note states "[recipient] reportedly presented behavior in the rehabilitation department which resulted in the instructor feeling uncomfortable. A report was written by the instructor and states that [recipient] told the instructor who is a woman that 'given my history…I do not feel comfortable being in a class with a female instructor' the meaning of [recipient's] statements includes allusion to his history of sexually aggressive behaviors. [Recipient] was requesting to be moved to a class with a male instructor. [Recipient] has a history of presenting inappropriate sexual statements and gestures in the rehabilitation department. He has been removed from 2 classes with female instructors for this kind of behavior. I discussed the incident, which took place on 8/15/12 at 10:00 with [recipient] this afternoon. He was unable to acknowledge the impact his statements made on the instructor. He provided shallow, superficial statements indicating that he was sorry for his behaviors the immediately asked if he could return to school. [Recipient] has made no progress in developing an understanding of how others may perceive his behavior…"

10/19/12 Recipient "directed hostile, threatening statements to a female STA stating, 'I already have two felonies... I don't mind getting another one over you.'" The HRA did not have case notes for this timeframe.

11/19/12 "during a meeting with coordinating therapist, [recipient] became hostile toward therapist when risk factors were mentioned. [Recipient] angrily refused to discuss recent, as well as past, acts of verbal and physical aggression. During the meeting with therapist [recipient] stated he believed the therapist was receiving money from an outside source in order to keep him at this facility. He became hostile and left the meeting." The therapist's case note states "this morning I met with [recipient]...he had some questions about risk assessment. I explained to [recipient] that the risk assessment instrument included three major areas: historical items, clinical items and risk management items. This morning, I went over some of the historical items [recipient] became upset when I asked him about some of his early psychiatric admissions…when I asked him to explain his statements, he indicated that I'm working with someone on the outside to keep him in this facility…I indicated that his behaviors would be documented as uncooperative, he indicated that he did not care and left my office."

12/5/12 Recipient "experienced an episode of severe agitation, during the incident; [recipient] directed verbally aggressive statements toward a number of staff-he raised his voice

and directed profanity toward staff. It took a while until he was able to become calm." The HRA did not have case notes for this date.

12/25/12 Recipient "exhibited physically violent behavior toward a peer." Nursing note for this date states "pt was kicked in face by [another recipient's id number] nursing supervisor notified. (Illegible) noted under R eye. Denies pain or discomfort at this time. Minimal bruising around area under eye and slight redness. Small amount of swelling. Minor first aid given to pt. denies pain or discomfort at this time. Referral sent for broken glasses no physician call necessary." There were no case notes to indicate what or who started the altercation, just documentation of this recipient's injuries.

1/29/13 Recipient "was found to be stealing coffee. When staff prompted him to give coffee back [recipient] directed verbally aggressive statements to staff." The HRA has the case notes dated 1/19/13 to 1/31/13; however, there were no case notes at all for 1/29/13.

2/9/13 "[recipient] directed verbally aggressive (elevated voice level, cursing and threats) to a nurse." Nursing note states "pt became agitated because the prune juice was on the counter and not put in fridge. Due to the STAs just bringing them in. pt was informed they would be put away. Pt began threatening this writer and yelling at me, was offered a PRN and pt refused. Pt went back to his room without incident."

2/18/13 Recipient "stated he wanted to punch a female STA in the face." STA note states "it came to my attention that [recipient] said 'that [STA name] everyone is afraid of her she's lucky I haven't hit her in the face' therapist was notified of incident." A therapist note states "this afternoon I was informed that [recipient] has exhibited problematic behaviors at an increased rate. He had stated to a peer that he had been having thoughts of striking one of the female STAs. I spoke with [recipient] he presented with a somewhat hostile demeanor. He was more talkative than usual. His content of speech was more illogical than usual with increased paranoia. He stated that the unit manager had 'moved me over here to [unit] to make me fail… so you guys could get all that money' he stated 'I'm a grandfather now and I need to get out of here' he was unable to stay on topic of conversation and the more he spoke the more hostile he became. I will continue to monitor [recipient's] psychiatric condition as well as his change in behavior."

3/12/13 Recipient "experienced a period of decompensation with an increase in positive symptoms of psychosis, as well as an increase in hostility." The HRA has case notes dated 3/11/13 to 3/19/13; there were two nursing notes on this date. The first nursing note stated "pt on sleep log and has slept all night." The second stated "received med changes per [psychiatrist] see orders." There was a unit informational note from the unit director that stated "this writer received a referral for [recipient] per human rights complaint, he has requested an independent assessment of risk. The referral was forwarded to [medical director] on this date." There was a case note dated 3/18/13 that stated "recipient's paranoia is starting to cause him to show signs of aggression, recipient is becoming more short with staff. Recipient is also trying to manipulate his peers into doing things for him." A 3/19/13 nursing note indicated that the psychiatrist wrote a new order to discontinue Haloperidol and start Risperdone for psychosis, discontinue Lorazepam, Clonazepam for anxiety and that the order was sent to pharmacy.

TPRs:

All TPRs state that the plan is based upon the following assessments: Initial Psychiatric Assessment by a facility psychiatrist dated 2/29/08; Updated Violence Risk Assessment by the coordinating therapist dated 5/12/09; Functional Assess/Case Rev. by The coordinating therapist dated 5/12/09; Physical Examination by the facility physician dated 3/10/09; Initial Psych Nursing Assessment by a facility RN dated 2/29/08; Suicide Risk Assessment by a facility psychiatrist dated 2/29/08; Social Assessment Update by a facility social worker dated 3/21/08; Medical History by a facility physician dated 2/29/08; Personal Safety Plan by the treating therapist dated 3/12/09 and Case Review by the treating therapist with the same date as each TPR. The HRA shared their concern with the medical director, treating therapist and assistant facility administrator about the TPRs being "based on" outdated assessments and were told that the above assessments aren't usually repeated/updated on a regular basis.

This recipient's diagnoses are listed on each TPR as follows: Axis I: Schizoaffective Disorder, Bipolar Type, Paraphilia NOS and H/O (history of) non-compliance with medications. Axis II: Antisocial Personality Disorder. Axis III: Hypertension, Non-insulin dependent Diabetes Mellitus, Dyslipidemia, Overweight and Mild Spurring in lower back (pain). Axis IV: Chronic Mental Illness, Numerous Psychiatric Hospitalizations H/O Incarcerations. Axis V: GAF= 45.

The face sheet dated 2/26/09 lists his diagnoses as follows: Schizoaffective Disorder, unspecified; Personal history of non-compliance with medical treatment; unspecified psychosexual disorder, antisocial personality disorder, essential hypertension, unspecified, diabetes mellitus without complication type II or unspecified.

All TPRs reviewed list the recipient as being medication compliant and requiring no restraints or seclusions.

All TPRs list the following "Problems" and "Goals":

Problem #1 Inappropriate Sexual Behavior. "[Recipient] at times makes sexually explicit statements and gestures (especially directed toward female staff). He has, on occasion, exposed himself to female staff. He has two prior sexual offense convictions and current sexual offenses while in a structured setting. [Recipient] possesses minimal insight into the harmful effects his maladaptive/aggressive sexual behaviors have on others. Goal [Recipient] will exhibit adaptive social function without presenting inappropriate sexual behavior for six consecutive months…Frequency of inappropriate sexual behaviors will be measured by 1) Behavior Data Reports (BDRs) 2) Restraint/Seclusion data 3) Progress Notes and 4) Self-Report."

Problem #2 Psychiatric Symptoms. "Psychiatric symptoms include delusional statements-as when he refers to his belief that the coordinating therapist is working with '[Chicago mayor] to keep me here.' [Recipient] indicates he believes staff are receiving 'thousands of dollars' from [Chicago mayor] in order to keep him in this facility. Mood symptoms include lability-with a tendency to become enraged and hostile very quickly. Goal: [Recipient] will exhibit adaptive social function with significantly reduced/eliminated psychiatric

symptoms for six consecutive months." This goal will be measured by "1) monthly completions of the Brief Psychiatric Rating Scale 2) documented episodes of psychiatric symptoms in progress & nursing notes and on BDRs precipitating aggressive behaviors." The HRA voiced concern to the medical director about this quote being included on all of this recipient's TPRs as there is no mention of when this statement was made, if other, more recent, statements of delusion have been made, or if this symptom has been resolved with treatment. The medical director agreed that if the recipient is currently exhibiting signs of delusions more recent statements, if any have been made, should be included in the TPRs as well.

Problems #3, #4, #6, #7 & #8 are relating to his medical health issues and are irrelevant to this report. Problem #5 is Verbal and Physical Aggression. "[Recipient] at times directs threats of harm, profanity and other disparaging or upsetting statements toward peers and staff. He also occasionally punches and/or kicks at peers or staff. Goal: [recipient] will exhibit social function which is free of physically aggressive behaviors for at least 12 consecutive months. Frequency of verbal and physical aggression will be measured by 1) BDRs; 2) Restraint/Seclusion data 3) Progress Notes 4) Self-report."

6/6/12 TPR: The "Discussion" section stated "The treatment team met with [recipient] to review his response to treatment. It was noted he has exhibited continued occasional problematic behavior. On 5/15/12, [recipient] was reported to have directed verbally threatening statements to staff. During the incident, he made a physically threatening stance and directed aggressive gestures toward staff. During the meeting today, [recipient] became defensive about the report about aggressive behavior."

The "Patient Input" section stated "During the meeting, [recipient] was asked if he wanted to be transferred to the less secure setting. He responded by stating he did want to leave this facility. The coordinating therapist indicated that [recipient] has not met criteria for transfer to the less secure facility due, at least in part, to his inability to control aggressive impulses. [Recipient] has made minimal progress in: developing insight into the need to control his aggressive behaviors; and in demonstrating an understanding the impact these behaviors have on others."

The "Problem 1 progress" section included the following statements: The Vocational Instructor (female) stated "he was pleasant and cooperative in class and did not show any inappropriate behaviors." The Vocational Instructor (male) stated "he has expressed no s/s of inappropriate sexual behavior during the class time. [Recipient] has not displayed speech or behavior indicative of delusions."

The "Problem 2 progress" section included the following statements: The Psychiatrist stated "the patient was knocking on windows trying to get female staffs attention…made a threatening stance towards staff. Overall behavior is stable. No FLR [full leather restraints]/seclusion..." The RN stated "no refusals noted this past month…compliant with medication and observation with mouth checks". The Therapist stated "[recipient] continues to experience cognitive distortions and delusions. He often states that the former Mayor of Chicago is involved in a conspiracy to 'keep me in here.' His insight into the grossly illogical nature of his delusional statements remains limited."

The "Problem 5 progress" section included the following statements; The Therapist stated "On 5/15/12, he was reported to have directed verbally threatening statements to staff. During the incident he made a physically threatening stance and directed aggressive gestures toward staff. On 4/14/12 he required placement in seclusion as a result of physically aggressive behaviors." (This statement was contrary to the "response to medication" section of this same TPR which stated No FLR/Seclusion.) STA stated "[recipient] became threatening to staff on 5/15/12."

The "Criteria for Separation" section stated: "A recommendation for transfer will be submitted when [recipient's] behavior, sexual inappropriateness and psychosis has been brought under sufficient control to make it possible for him to function appropriately in a less secure facility. He will also demonstrate a consistent ability to function without engaging in physically aggressive behavior. [Recipient] will also demonstrate significant progress in the following areas: addressing cognitive distortions; discontinue minimizing seriousness of his maladaptive behavior; developing empathy for others (especially victims); managing his emotions (especially anger); and taking responsibility for his actions. [recipient] will also demonstrate proper compliance with treatment recommendations, including complying with his prescribed psychotropic medication regimen-consistently complying with his medication regimen, without requiring monitoring such as doctors order for 'crush and observe' or 'observe with mouth checks' for at least three consecutive months. He will consistently voice an understanding of the fact that he experiences a major psychiatric condition and that proper medication compliance is an important element in managing his psychiatric symptoms." (It was noted by the HRA that in the psychiatrist's transfer recommendation he stated that observe with mouth checks was discontinued on 3/13/12. "[Recipient] is medication compliant and states he will continue to take his medications upon discharge.")

10/23/12 TPR: The "Discussion" section stated "The treatment team met with [recipient] to review his response to treatment. It was noted that on 10/19/12 he directed hostile, threatening statements to a female STA stating 'I already have two felonies…I don't mind getting another one over you.' The treatment team related to [recipient] that these kinds of threats/statements are not consistent with meeting criteria for transfer to the less secure facility. It was also noted that another relatively recent incident occurred on 8/15/12 during which he made inappropriate statements to a female instructor in the rehabilitation department and as a result he was suspended from classes. During the 8/5/12 incident, [recipient] made an allusion to his history of sexually aggressive behaviors in order to intimidate the instructor. The female reported the incident and reported feeling very uncomfortable with [recipient's] behavior. The coordinating therapist indicated that the above incidents represent a pattern of maladaptive behaviors which suggest a poor insight and a limited regard for the welfare of others."

In the "response to medication" section it stated "PRN on 10/10/12, became agitated about not being able to go back to school. No FLR/Seclusions. Overall patient's behavior is stable. Patient is medication compliant. Transfer recommendation written."

The "Problem 1 progress" repeated the 8/15/12 incident in rehabilitation class and the therapist stated "[recipient] continues to minimize the incident-stating he was just trying to 'get

moved to a class that has coffee.'" STAII repeated the 8/15/12 incident in class and stated that his participation in the rehabilitation department remains suspended as a result of this incident. The vocational instructor (female) stated"100% attendance this review period. Per his request, he is being removed form this class as he stated he is no longer comfortable in a female instructor's class due to his history. Enrollment in the Product Marketing program is currently on hold due to this instructor filling in for another program. He will be enrolled back into the program when an opening is available." The vocational instructor (male) stated "[recipient] has been dropped due to some inappropriate threats towards another instructor. His obsession with coffee has led to his continuous decline down here." Another male instructor stated "[recipient] has not displayed speech or behaviors indicative of delusions."

The "Problem 2 progress" section included the following statements: The psychiatrist repeated the 10/10/12 incident of agitation over class. The RN stated "no refusals noted this past month. Compliant with medication and observation with mouth checks" even though according to the psychiatrist, "mouth checks" were discontinued in March, 2012. The therapist repeated verbatim his comments from the 6/6/12 TPR regarding a delusion about the Chicago mayor and added "He also consistently states that the coordinating therapist receives $13,000 a month in order to keep me here." (The HRA questioned the recipient about this statement which he denies saying and said the comment about the Chicago mayor was several years ago.)

The "Problem 5 progress" section included the following statements: The therapist stated "[recipient] continues to require monitoring for verbal and physical aggression." The STA made the exact same statement as the therapist.

The "Criteria for separation" section was verbatim from the 6/6/12 TPR.

1/17/13 TPR: The "Discussion" section stated "The treatment team met with [recipient] to review his response to treatment. It was noted that [recipient] engaged in physically aggressive behaviors directed toward a peer. The two patients became involved in a physical conflict after the peer became upset because he believed [recipient] was looking at his genitalia. [Recipient] admitted he did not control his actions. The episode of physical aggression took place on 12/25/12. Otherwise, it was noted [recipient] continues to have minimal insight into how his behaviors impact others. When he is encouraged to discuss how his maladaptive behaviors suggest risk of his engaging in potentially harmful behaviors once he is in the community, he rationalizes his behaviors and presents statements which indicate cognitive distortions. These cognitive distortions are especially pronounced once he experiences stress. [Treating Psychiatrist] stated he continues to be of the opinion that [recipient] should be transferred and that a transfer recommendation has been submitted."

The "Problem 1 discussion" section included the following statements: The therapist stated "[recipient] has not shown improvement in developing/expressing insight into how sexually assaultive behavior negatively impacts others. He rationalizes his behaviors and presents statements which indicate cognitive distortions." The statements listed from the STA and male vocational instructor are verbatim what the 10/23/12 TPR stated.

The "Problem 2 discussion" section included the following statements: the psychiatrist stated "patient has had no PRN's, FLR's or Seclusions. Patient is medication compliant." The RN's note continues to say the recipient is medication compliant with no refusals. The activity therapist stated "No change, [recipient] continues to display paranoid behavior, questioning daily about whether he has been written up, talked about or his behavior level changed. He did have one aggressive incident this reporting period with another peer."

The "Problem 3 discussion" section included the following statements: the therapist repeated the 12/25/12 altercation with a peer. The vocational instructor's statement was verbatim what was stated in the previous TPRs.

The "Criteria for separation" section repeated verbatim what the previous TPRs stated.

3/12/13 TPR: The "Discussion" section stated "The treatment team met with [recipient] to review his response to treatment which has been characterized by increased problematic behaviors and worsening in his psychiatric condition. [Recipient] has exhibited increased signs of irritability. On 3/11/13 he threatened a peer with physical harm. Earlier in the review period, on 2/18/13, he stated he wanted to 'punch' a female STA 'in the face'. [Recipient] stated to [psychiatrist] that he would like to have a medication change. He asked [psychiatrist] to discontinue the Risperdol and prescribe Haldol. [Psychiatrist] agreed and wrote the orders. There continues to be a difference of opinion on the issue of [recipient] being transferred to the less secure setting. The coordinating therapist is not in agreement with the transfer recommendation which was written/submitted in September, 2012. [Recipient] indicates he has contacted human rights organizations in order to gain assistance in being transferred to the less secure facility."

The remainder of this TPR is essentially the same as the previous TPRs. Each section details the BDRs that are discussed in the "Discussion" section. Some sections are verbatim to the previous TPRs while others have a few lines changed. It was noted that a "Problem 9 Substance Abuse" section was added to this TPR however it was noted that this objective is "placed on hold until [recipient] agrees to participate in treatment". The "Criteria for separation" section was also verbatim to previous TPRs.

4/9/13 TPR: The "Discussion" section starts the same as the 3/12/13 TPR and noted that after the recipient made a request for a specific medication change, he did not respond favorably to this change. He showed signs of increased paranoia and aggression. The psychiatrist described the recipient as "more psychotic" and "decompensating". On 3/19/13 the medication was changed back. The section concludes by saying "it was noted that [psychiatrist] remains of the opinion that [recipient] should be transferred to the less secure setting. There is significant disagreement regarding the appropriateness of a transfer to the less secure facility-specifically, the coordinating therapist is of the opinion that [recipient] has made minimal progress in meeting treatment objectives, and should not be transferred from this facility at this time."

The "Problem" sections remain essentially the same as the previous TPRs including the same statement of delusion regarding the Chicago Mayor that has been noted as far back as the June, 2012 TPR the HRA reviewed. It is still noted that he "continues to require monitoring for

sexually inappropriate behaviors." The behavioral log of this TPR has the last documented behavior of this nature occurring on 8/15/12 (8 months prior to this TPR). The goal for this type of behavior as noted in the "Problem 1" section is that he will not present inappropriate sexual behavior for six consecutive months by 9/2013. **The HRA was particularly concerned with the outdated information on this TPR as this was the one that the independent risk assessment was based on.**

5/8/13 TPR: This was the first TPR that occurred after the recipient was transferred to another unit and started seeing a new therapist. The "Discussion" section was more detailed than in previous TPRs consisting of 2 ½ pages. This section included a detailed list of the recipient's behavioral data since being admitted to the new unit. These behaviors included trading coffee, using the internal phone to access staff directly, ruminating about past events and access to rehabilitation classes, and not complying with STA instructions to remain in secured area. There was a team meeting to "get on the same page" regarding his behavioral presentation and a goal to move him forward in treatment. It was agreed he demonstrates challenging antisocial personality traits in the presence of increasing hyper vigilance/paranoia and that he attempts to "split" authority figures and circumvent protocol to meet his perceived needs/wants. It was agreed that he enjoys and will benefit from rehabilitation classes and that he will return to classes with male teachers only due to his comment that he did not "trust himself alone around females". The recipient and his therapist would develop a written behavioral plan which would include number of prompts, deterrents to splitting and maladaptive behaviors. The therapist and class instructor would explore potential behavioral reinforcers during his time in class. If rehabilitation staff feel threatened or unsafe, the recipient would be returned to his unit and not return to class until both teams meet and agree on a behavioral solution or plan modification. This section goes on to state that "[recipient] is attention seeking, oppositional and guarded". His May behavioral data was summarized which included ruminating about his past therapist, arguing with a STA, provoking/threatening a peer and accusing an educator of "rigging" a game. It also mentioned the results of the independent risk assessment and that the team met earlier that day to share the results with the recipient. It noted that "[recipient] was disappointed, however did not escalate his behavior." The treatment team will formally convene on 5/9/13 for a CCM to "assess his journey of recovery."

The same "Problem" and "Goals" sections from previous TPRs were repeated verbatim in this TPR. The new coordinating therapist's progress section under "Problem #1" stated "[recipient] has been demanding of excessive attention, very paranoid and behaviorally challenging. [Recipient] ruminates about his past and blames others for his legal charges, without develop/expressing insight into how his overall behaviors and sexually assaultive behavior negatively impacts others. He rationalizes his behaviors and presents statements which indicate cognitive distortions." STA and vocational instructor sections were verbatim as previous TPR.

"Problem #1" progress section stated that Risperdone was restarted on 3/19/13 and Haloperidol was discontinued. The RN noted no refusals and that the recipient was compliant with medication. The activity therapist stated that the recipient attended 26 (classes) and was doing well until he went on red level.

"Problem #5" progress section included the following statements: The therapist stated that "this psychologist has dedicated [recipient] an extensive amount of therapy time to insure that the patient is able to know clear boundaries, targeted behavior objectives and module routine expectations. [Recipient] verbally states his motivation to be transferred to a less restrictive hospital environment. To this end, this clinician is assisting the patient to gain insight and improve his behavior by meeting weekly and PRN for individual therapy. In addition, a behavioral plan was initiated to assist the patient with clear behavioral objectives and boundaries, an issue of primary concern for the patient's journey of recover (see enclosed BMP). This clinician continues to closely monitor aggression (verbal, physical, sexual, property). Since his first day of admission to [unit], the patient has engaged in multiple behavioral infractions (see this TPR discussion section). At the present time, [recipient's] treatment team unanimously concluded that the patient's clinical presentation remains fragile at best and unable to function outside this maximum security inpatient setting." The vocational instructor stated that the recipient has attended all classes this reporting period and that he would be enrolling him in some more vacancies to "get him off the unit". It was noted that the recipient recently began music therapy and stated "I believe this to be a step in the right direction as [recipient] is not allowed to attend other instructors." The STA stated "[recipient] continues to manipulate peers and staff. BDRs for threatening behavior this period."

The "Criteria for separation" section stated verbatim what the previous TPRs stated.

A behavioral intervention plan was attached to this TPR and included "what he does (target symptoms)" and lists things such as physical agitation, repeatedly talking about his past history, cursing, covering his face with his hands, repeatedly asking to see staff, paranoid ideation, leaving assigned area unauthorized (attempting to enter vocational instructor's class), unauthorized use of telephone, arguing with staff, not following module routine, trading and/or intimidating peers to get a desired item, inappropriate sexual behaviors/comments. The reverse side of this behavioral intervention plan lists steps to take when any of these behaviors are observed and included praise him if he complies when requested to stop a behavior. After 3 infractions he will be restricted from privileged activities for that shift. He will be sent back to his unit for 24 hours if there are any behavioral infractions in the rehabilitation department, and after 3 ejections from the rehab department in a week, he will be refrained for a one week period. Whenever any sexual acts/comments/threats, physical aggression or verbal threats to physically hurt others occur, he is to be asked to stop or blocked from visual access from intended victim, initiate seclusion/FLRs, offer a PRN and notify the therapist, RN and STAII. This behavioral plan was explained to and agreed to on 4/29/13 by the recipient.

The HRA also reviewed an email dated 4/23/13 which addressed the 4/19/13 incident of the recipient "using the internal phone to access staff directly" which was mentioned at this TPR and listed in the "Discussion" section of the TPR report. The email explained a situation that led up to the recipient using the phone to access staff directly as follows: The instructor and recipient were having a discussion about rotator cuff problems in class. The instructor showed the recipient a skeletal model and then requested the recipient grab his arm for a demonstration. At this time and STA walked by and saw the recipient in what she considered a physical hold. Reportedly when the recipient saw the STA he immediately let go and demonstrated contrition. The instructor and recipient explained to the STA what happened. The STA did not feel it was

worth an incident report, but sent the recipient back ten minutes early. The STA said when she went to work on the unit that evening she saw that two BDR's had been written on the recipient. The email went on to state "The anxiety created by [recipient's] perception that he was being suspended from school, precipitated his attempts to make outside calls to [instructor] and [STA name] in order to plead his case. [Recipient's] attempt to circumvent protocol is not acceptable, but understandable. I believe these types of reactions are typical for [recipient] in response to provocations, especially those involving restriction from education, given he only has one instructor willing to work with him at this point. I believe [recipient's] demonstrated anxiety is a very good sign. Even if his anxiety is about issues of self preservation; this can be utilized as a positive motivating factor for [recipient] by couching behavioral expectation in terms of what is in [recipient's] best interests."

7/31/13 TPR: The "Discussion" section of this TPR was also very detailed, 2 ½ pages in length, and included a behavioral summary chart listing staff that were working with this recipient when a BDR was given and included the months of April, May, June and July, 2013. In April, there were 5 BDRs (3 with one staff). In May there were 8 BDRs (2 with this same staff and 2 with the educator). In June there were 6 BDRs all with different staff and in July there were 17 BDRs (7 with the same staff and several were all dated 7/4/13 with different staff). The HRA noted that out of a total 36 BDRs in 4 months, 12 were with one particular staff person and the behavioral detail list mentions the recipient receiving a BDR on 7/12/13 and making reference to this same staff person saying "some people just want me to stay here". No other staff listed had more than 1 or 2 BDRs listed by their name on the chart. The July BDRs were for things such as bullying and intimidating, being paranoid accusing racism and the administrator of keeping him at Chester for profit, violating phone policy, and ruminating. The discussion section also mentioned that "[recipient]continues to present as angry and verbally accusatory towards security staff, ruminating about people whom he feels discriminated against him; feeling emotionally de-regulated when he is minimally redirected by security staff….[recipient] ruminates constantly about specific staff members to the point that his mood and overall daily social functioning is negatively affected. In the past month, the patient has been obsessing about [STAI] who is assigned to module [number] on a regular basis." The HRA noted that this is the same STA whom the recipient had the most BDRs with over the past 4 months. It was also stated that the recipient "made a superficial apology for his lack of honesty and thanked this therapist for her work". A specific discussion was held about the recipient's behavioral infraction of using a peer's phone card and the TPR stated "even though [recipient] was provided with the official account of his logged phone card use, he emphatically denied responsibility for his actions and blamed AT&T phone company for 'being against him'. [Recipient's] lack of personal responsibility for his actions is congruent with his diagnosed Axis II Antisocial Personality. [Recipient] continues to present positive symptoms of mood instability and altered perception along with engaging in oppositional and deceitful behaviors that require close monitoring in this maximum security setting for the safety of all."

III...Facility Policies:

A. IM 03.01.01.03 Treatment Plan: This policy lists all the necessary components of the TPR form and states that a psychiatrist, registered nurse or coordinating therapist must be present to hold a treatment plan meeting. It states that "the patient should be actively involved in the

choice of treatment goals and interventions." It also lists each specific section of the treatment plan and what each section should include. The "Discussion" section is to "provide information from the patient indicating if the patient was or was not in agreement with the treatment plan and any comments the patient writes on the Participants in Treatment Plan form CMHC-757. Describe the team's observations of the patient as he presented at the team meeting i.e., physical condition, emotional state, presence of hallucinations, delusions, signs of cognitive disturbance and behavioral problems." It does state the "Plans based upon the following assessments" section should include the historical assessments that were referenced in this recipient's TPRs, listed above in the TPR section of this report.

The "Problems and Goals" section should "list the needs or problems based on the critical treatment and/or medical issues" as presented from members of the treatment team and "include the date the problem is established and provide all supporting evidence to justify the problem as a critical treatment and/or medical need."

The "Individualized treatment/habilitation goals" should be "specific, measurable, and should relate directly to addressing an item on the needs/problems list encompassing the factor(s) that brought about the patient's admission to Chester Mental Health Center…Identify staff responsible for the intervention and the date the intervention will be initiated (start date)."

The "Criteria for separation" section should "describe the criteria that must be met before the patient can be transferred to another facility or be returned to court." In the "Criteria for determination of subject to involuntary admission and specified behaviors or conditions that demonstrate need for continued hospitalization" section it states "(for civil commitment) address whether the patient is a danger to himself, a danger to others, or is unable to take care of his own basic needs. Describe specific behaviors that justify the patient's need for hospitalization."

Finally, this policy states that the "Unit Directors will oversee the Quality of the Units Treatment Plans and Clinical Medical Record Audit Committee will audit the treatment plan process."

B. RI 05.00.00.01 Code of Ethics: states "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. **Employees will assure that patients will be involved in decisions regarding the care they receive to the extent that is possible…** Ongoing self awareness and continued self evaluation of adherence to standards of ethical behavior, as well as support, encouragement, and positive recognition for compliance with those standards, directly enhance employee morale, job performance, public relations, and Chester Mental Health Center=s reputation for assuring clinical outcomes."

C. PE 02.05.00.01 Clinical Care Monitoring (CCM): states "CMHC provides a mechanism for dealing with individual patients who do not respond to treatments and interventions as predicted

and may require consultations with individuals outside their treatment teams" The procedure is listed as follows: "As a treatment team member becomes aware of a patient who manifests one or more of the following general problems, he/she should report this to the coordinating therapist and request a clinical care monitoring (CCM) meeting. 1) Unresolved diagnosis problem 2) Unimproved recipients 3) Diagnostic errors 4) Complications in treatment and 5) Other treatment issues…. Participants will be members of the treatment team assisted by an off-unit consultant. The consultant may be a Social Worker, psychologist, nurse, educator, activity therapist, or an M.D. who is not a member of the treatment team. In selecting a consultant, attention is to be given to the relevance of the consultant's specialty and experience to the problem(s) being addressed. Problems relating to medication, diagnosis or other areas shall be addressed by consultants who are qualified to do so. The facility will maintain a listing of clinicians and their expertise….If CCM is being held for psychiatrically unimproved recipients then it is recommenced to have 2 psychiatrists (treating and from another unit) and Medical Director if deemed necessary to be among the participants." The CCM policy did not specifically state how soon after the referral the CCM meeting should occur. However, during an interview, the medical director and quality assurance staff member told the HRA team that CCM meetings are held within 1-2 weeks (maximum) from the referral date.

D. CC 01.02.00.02 Transfer Recommendation for Behavior Management Patients: includes the following "All transfers of behavior management recipients from the Chester Mental Health Center are effected in accordance with the Mental Health and Developmental Disabilities Code which mandates that treatment occur in the **least restrictive alternative appropriate to that recipient**. The recipient's treatment team must evaluate on an ongoing basis the recipient's continuing need for a maximum security environment. At such time the treatment team determines the recipient is clinically suitable for transfer to a less secure facility, the following must take place. 1A. The psychiatrist is to prepare a transfer recommendation." The policy goes on to state the components the recommendation must include and then states "1B. Upon completion of the transfer recommendation, the transfer recommendation, along with a current copy of the patient=s treatment plan review, will be forwarded to the Administrative Assistant who will coordinate the transfer with the receiving hospital. 1C. The treatment team shall meet with the recipient to address his transfer recommendation. Once the Transfer Recommendation is initiated, the Coordinating Therapist will focus on transfer issues, continuity of care concerns and help recipient prepare for transfer during individual/group therapy. Progress notes from that time on should address the said issues and recipient's ability to cope with the upcoming changes that correlate to his transfer…1E. A written notice is given to the patient by the Administrative Assistant or their designee, they shall write in the chart stating the date and time the transfer notice was given to the patient. The Unit Director shall be notified by the Administrative Assistant or their designee when the patient is scheduled to leave." **There is no mention in this policy that a risk assessment must be completed prior to transfer to a less secure facility.**

Summary

The following is a timeline of this recipient's commitment history:

- 3/23/07 admitted to Chester Mental Health Center (CMHC) from another correctional center on parole from the Illinois Department of Corrections (IDOC)

- 1/29/08 his parole was revoked and he was sent back to IDOC. His sentence then discharged him from corrections and he was admitted back to CMHC as a civil involuntary patient on 2/2/08.
- 3/4/08 the recipient signed as a voluntary patient.
- 5/27/08 the recipient requested discharge from DHS (CMHC)
- 6/4/08 the recipient was involuntarily committed.
- 4/21/12 during a court hearing for civil commitment, the recipient requested an independent psychiatric evaluation be completed. Upon review of his chart, this psychiatric evaluation was completed but was done by a psychiatrist from CMHC. The details are listed in the clinical chart review section of this report.
- 7/31/13 the recipient again signed voluntary.

The HRA had some specific concerns during the course of this investigation. A CCM referral was made to address therapist counter-transference and the issue of the psychiatrist and therapist disagreeing on whether or not this recipient was ready to be transferred to a less secure facility. The psychiatrist that recommended a transfer for this recipient, was not a part of the CCM that was held on 5/9/13, only the assigned therapist who was of the opinion that the recipient should not be transferred. If this was the CCM that was to address this disagreement between the treatment team, all parties should have been involved. However, after speaking with the medical director, the HRA was unsure if that was the intention of this CCM or if this CCM was only to review the independent risk assessment that was completed. The medical director had mentioned that the issue of the therapist counter-transference was moot once the recipient was moved to another unit; therefore that portion of the CCM was not necessary. She also stated that it was agreed upon by her and the referring staff member, to wait on the CCM to address the disagreement between the therapist and psychiatrist to see what happened with the independent risk assessment and the new therapist and that if a staff member feels a CCM is warranted to address the issue of transfer, then a new referral would need to be made. Either way, the HRA concluded that for best practice, the psychiatrist should have also been involved in this CCM meeting.

Another concern was the independent risk assessment that was completed. Per the medical director, the independent risk assessment was based solely on a review of the recipient's 4/9/13 TPR and this formal assessment to the facility consisted of only a short email to the medical director and the DHS deputy director for forensic services that stated the assessor's opinion that the recipient was not appropriate for a transfer. The independent assessor did not review the entire chart of the recipient, interview the recipient in person or over the phone or speak with all the members of the recipient's treatment team or direct care staff in order to form a truly independent opinion. The TPR which was reviewed included the recipient's reason for admission and old assessments dated 5 years prior to this review (2008 & 2009) and a recent case review (4/9/13) by the treating therapist. However, one of the assessor's suggestions was that "the treatment team reassess the utility of including 'developing an empathy for others as a criteria for separation unless we conclude that the MRT (moral recognition therapy) approach offers a reasonable prospect of success in this regard…'" Although it is beyond the scope of HRA to determine which criteria for separation should be used or which therapeutic approach would best meet this recipient's needs, the HRA did question whether or not the treatment team considered this suggestion when the CCM was held as this criterion appeared in all of the TPRs reviewed.

The HRA also concluded that for best practice, the independent risk assessment should have been completed by using a standardized tool and should be based on more than just a review of the most recent TPR if the assessor was to form a truly independent opinion.

Another concern was the process by which the transfer recommendation was carried out. According to Chester policy, once the treatment team decides a recipient is suitable for transfer or discharge, the psychiatrist is to write a transfer recommendation and send it along with the TPR to the administrative assistant who coordinates a transfer with the receiving facility. There is no policy saying a risk assessment has to be completed first. Also, there was concern that the psychiatrist was not notified of such a request being made in this case. The HRA did not find documentation in the chart to indicate that a written notice was ever given to the recipient that he would be transferred, only mention of it in the TPR meetings and in the TPR report that a transfer had been recommended.

Conclusion

The HRA found that the psychiatrist was of the opinion that the recipient was appropriate for transfer to a less secure facility and recommended a transfer. However, the therapist did not agree and requested that a risk assessment be completed before the recipient could be transferred. According to the psychiatrist, he was not made aware of this request and did not understand why it should be necessary for a transfer to a less secure facility. The recipient, in turn, requested that the risk assessment ordered by the therapist be done by an independent assessor. After 9 months the independent assessment was completed (requested around September, 2012 and completed on 5/2/13). However, it was conducted by a psychiatrist that the facility chose without any input from the recipient. Therefore, the recipient was not allowed to fully participate in his treatment planning by not having any input on who should conduct the independent assessment that he requested. Also, since the independent assessor did not communicate at all with the recipient, his views on least restrictive environment were not incorporated into his treatment planning.

The Mental Health Code requires that "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed **with the participation of the recipient**….In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided." (405 ILCS 5/2-102). Chester's Treatment Plan Policy IM 03.01.01.03 states that "the patient should be **actively involved** in the choice of treatment goals and interventions." Chester's Clinical Care Monitoring (CCM) policy PE 02.05.00.01 states "CMHC provides a mechanism for dealing with individual patients who do not respond to treatments and interventions as predicted and **may require consultations with individuals outside their treatment teams**." Chester's Transfer Recommendation for Behavior Management Patients policy CC 01.02.00.02 states that "All transfers of behavior management recipients from the Chester Mental Health Center are effected in accordance with the Mental Health and Developmental Disabilities Code which mandates that treatment occur in the least restrictive alternative appropriate to that recipient." Lack of this recipient's involvement in his independent assessment is a violation of the right to participate in treatment. Lack of movement on the transfer recommendation is a violation of the right to least restrictive environment as guaranteed

by the Code and Chester's policy. Lack of a CCM occurring to address the discrepancy between the assigned therapist and psychiatrist regarding the transfer recommendation is a violation of Chester's policy. Finally, the outdated treatment plans represents a violation of the Code and Chester's policy.

For these reasons, the HRA **substantiates** that a rights violation did occur and **recommends** the following:

1. **The HRA recommends that whenever an independent evaluation is conducted, a standardized assessment tool be used as one aspect of the independent assessment and that the assessment include a complete review of the chart, and involve interaction with the recipient and treatment team members. If the facility requires a risk assessment for this recipient, although the transfer policy does not require it, the risk assessment should be one using a standardized tool, completed by a qualified examiner, and with input from the recipient consistent with Mental Health Code provisions for least restrictive services and recipient involvement in treatment planning.**

2. **Upon review of the recipient's chart, it was noted that it includes a considerable amount of inaccurate, outdated and conflicting entries from staff. Chester's treatment plan policy IM 03.01.01.03 states that "Unit Directors will oversee the quality of the unit's treatment plans and Clinical Medical Record Audit Committee will audit the treatment plan process." The facility should review this policy with unit directors and the clinical medical record audit committee staff and ensure that up to date and accurate information is reflected in recipients' charts and especially in treatment plan review documentation as the information entered in the charts will follow recipients for life and more recent TPRs are used for court hearings and, in this case, an independent assessment. Current TPRs should contain up-to-date and accurate information on a recipient's current status.**

3. **That the facility ensures that if/when a conflict of interest exists between a recipient and his therapist, that measures are in place to address this before it possibly impacts the recipient's therapeutic environment and treatment, including whether or not the recipient can be transferred to a less secure setting.**

4. **The facility review with staff Chester policy 01.02.00.02 relating to transfer of behavior management patients and ensure the process set out in this policy is followed when a transfer is recommended.**

5. **The facility review with staff the CCM process, what the reasons for a referral are and the proper steps to making a CCM referral. Ensure that CCM referrals are addressed as soon as possible when they are received but no longer than the 2 week timeframe that has been established by the facility.**

Given the length of time this recipient has been at Chester Mental Health and the conflicts over a transfer to a less restrictive environment, the HRA concluded that based on Chester's policy PE 02.05.00.01 which lists reasons for a CCM referral as "1) Unresolved diagnosis problem 2) Unimproved recipients 3) Diagnostic errors 4) Complications in treatment and 5) Other treatment issues" that a CCM is warranted and **recommends that a CCM, specific to the disagreement between the assigned therapist and psychiatrist in regards to a transfer to a less restrictive environment, be completed for this recipient as was previously requested by a treatment team member.**

The HRA also makes the following **suggestions:**

1. The facility review the facility's Code of Ethics policy with employees and its requirement that "employees shall act as advocates for patients and strive to promote their well being." and "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".

2. The facility rethinks the function of reporting behaviors and considers which behaviors are significant enough to warrant a behavior data report (BDR). Clear guidelines for BDRs should be discussed during recipients' treatment plan review meetings and included in the treatment plan review summary so that all staff are in agreement as to what behaviors will result in a BDR being given to a recipient. The HRA questions whether or not a recipient expressing thoughts of racism or objections to his placement and ruminating should warrant a BDR being given.

Investigation Information for Allegation 2: A recipient was inappropriately removed from participation in rehabilitation classes.

To investigate the allegation, the HRA Investigation Team (Team), consisting of two members and the HRA Coordinator 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 recipient's therapist, the chairman of the facility's Human Rights Committee (Chairman) and director of rehabilitation. With the Recipient's written authorization, copies of information from the recipient's clinical chart were reviewed by the Authority. Facility policies relevant to the complaints were also reviewed.

Statutes

The Illinois Administrative Code (59 Ill. Adm. Code 108.60) states "A vocational program consisting of organized instructional experiences, training, and resource programs shall

be provided to recipients in accordance with their needs and as determined by the educational component of the individual treatment or habilitation plan."

The Code (59 Ill. Adm. Code 108.90) also states "After admission, the multi-disciplinary team shall perform the educational diagnosis and evaluation in accordance with subsections (e) and (g) of this Section so that the educational component of the individual treatment or habilitation plan can be developed in accordance with the time frames in the definition of the individual treatment or habilitation plan in Section 108.10. The educational component shall be developed in accordance with subsection (n) of this Section."

I...Interviews:

A. Recipient: The recipient told the Team that he said to his teacher he can understand why she dropped his 3 classes down to once a week because his history probably makes her feel uncomfortable. He said he feels the same way and that he would feel better with male teachers because he "got burnt" by 2 other female teachers before. He said that when he made these statements, his teacher wrote him a "ticket" for threatening her and he was dropped out of school. The recipient admitted that he wanted to drop her class so he could drink coffee in another class and said that she and other staff knew that but they just dropped him out of school all together. He enjoys rehabilitation classes and said that it is one of the few things that make him happy "in this place". He is concerned that he will be permanently removed from classes because Chester policy states you cannot miss more than 85% of class before being dropped and because they keep suspending him from class, he is afraid he will not be allowed to return.

On another occasion, the recipient was suspended from class for "trying to con coffee". At the time of our interview, he said he was only supposed to be out for one day but had been out for 2 weeks because his therapist "took away a check mark saying he could go to class" so now he is unable to attend. When asked why his therapist wouldn't approve his return, the recipient said he feels it is because his therapist is doing whatever he can to keep him at Chester.

B. Director of Rehabilitation (director): Regarding the first incident which occurred on 8/15/12, the director told the Team that the recipient made a statement that he wanted to be removed from a class due to "feeling uncomfortable being in a class with a female instructor." However, the suspension from the rehabilitation department was noted as the recipient "made threatening statements alluding to sexually aggressive behaviors." He was concerned that this may have been misinterpreted because it could have also been interpreted in the positive. The recipient did not have to disclose his thoughts and also he may have thought the situation was too risky for him, given how his interactions are often misconstrued and referred to the incident listed in this report on page 21 where a classroom demonstration was misconstrued as an aggressive behavior and the recipient received 2 behavioral reports. The director said according to attendance records, the recipient was returned to class on 11/14/12.

The director told the Team that on March 5, 2013 there was an incident in class over coffee. The instructor asked that the recipient to be held from class for one day. The director had discussions with the unit director and notified her that the recipient was only supposed to be out of class for one day and asked that his level sheet be changed to indicate that a return to

education is allowed. He also spoke with the therapist who told him that the education STAs didn't think the recipient was behaviorally ready to return to class. When the director spoke with the education STAs, he was told that the therapist told them to keep the recipient out for 2 weeks because he tried to strong arm his instructor for coffee. On March 12, 2013 the recipient still had not been returned to class.

When the HRA voiced concern to the director about the recipient still not being returned to class, he agreed to attend his treatment plan review (TPR) meeting to see why. The TPR was originally scheduled for 3/15/13, however the date was changed and neither the director nor the educator/case manager was informed of the date change. When the director arrived to speak with the therapist, he was advised that the TPR had just concluded. During this conversation, the therapist admitted that he was using class restriction as a punishment and that 2 weeks may have been excessive. There was a mental abuse complaint filed with OIG. Since he was unable to participate in the TPR, the director initiated a memo to the therapist, unit director, assistant facility director, OIG liaison, vocational instructor and the education STAs. This memo reiterated that the recipient was only expected to be out of class for one day and his return was supposed to be negotiated between the instructor and therapist per Chester policy. When the director spoke with the therapist, the therapist stated "I don't care if (recipient name) attends classes or not." The class instructor had told the director that he was "ready, willing and able to have the recipient return to class". The memo also indicated that there were no 207's (behavioral information reports) on the recipient therefore, he was not returned to the unit for security reasons. However, on that date (3/12/13) the recipient still had not been "checked" on the level sheet to return to education. The director then asked that this be corrected from the unit's end. The director was never told that the recipient's behavior, which resulted in his suspension from class, had not been resolved and also said that the recipient's return was to be negotiated between the instructor and therapist. The instructor only intended for the recipient to be out one day, but the level sheets generated at the unit level indicated that he was not allowed to attended class from 3/8/13 through at least 3/14/13. The recipient was returned to class on 4/24/13.

The director told the Team that he has instructed Education staff to complete Rehabilitation Reintegration Plans for anyone who is restricted from their normally scheduled classes to facilitate weekly staffings between the case manager and therapist, in order to avoid protracted time away from classes. The Team reviewed the Rehabilitation Reintegration Plan form which includes boxes to complete for "today's date, unit, therapist, case manager, ELOR (estimated length of restriction eg. 2 weeks, 2 days, 2 hrs etc), criteria for return and projected return date." However, he did not have copies of this form for this recipient's suspensions. The director said that the instructor may have them but he was off on medical leave at the time of our interview.

The director also shared with the Team that he scheduled a staff meeting for any staff to attend that may have safety concerns for this recipient attending classes, however no one attended. The HRA Team obtained a copy of this email dated 4/2/13 to the assistant facility administrator, unit director, unit manager and the recipient's therapist which said "The Rehabilitation Dept. will be having a staff meeting today at 1:00 p.m. Anyone with safety concerns, of this patient continuing to participate in Education classes is welcomed to attend and voice those concerns. Thanks." The HRA Team also viewed an email dated 4/11/13 from the

director to the instructor which stated "Develop a reintegration plan with [therapist] for [recipient] he has been out of education for over one year." To which the instructor stated "Not a problem."

II. Clinical Chart Review:

A. CMHC-207 (Information Report)Forms: On 8/15/12 the female instructor involved in the first suspension completed a 207 form stating that "On 8/15/12 at approximately 10:00 a.m. [recipient] came to the computer class and stated to me that he wants to be taken out of my class because he doesn't feel comfortable anymore being in a female's class, given his history." The form stated that she reported his statement to the STA staff and they reported it to his therapist.

On 3/5/13 the other instructor involved in the coffee incident suspension from class completed a 207 form stating that during the 9:45 a.m. class "[recipient] began requesting I make coffee. He did this at least 4 times during the hour, even after I told him no. He then begins talking about food I owe him from when he did work for me during the janitorial class. I told him that that was untrue and I didn't know what he was talking about. The class went on with no problems and [recipient] was scheduled for me at 1515. He attended that class and once again began to request coffee and talk of me owing him food. I got him to stop talking about it on several occasions during class, so I didn't see the need to remove him. There were no threats made by him, he was just trying to con me out of items…He becomes obsessed with me getting him something and begins asking/begging for items more times in class. I had decided after the incident on 3/5/13 to leave him out of class on 3/6/13 due to his continuous interruptions of class [recipient] knows when he gets me upset and if I were to bring him back today, he would be more disruptive by trying to be overly apologetic…" On this form, it lists the "behavior" as "continuous requests/begging for items. Food & coffee & more class time." It also lists the "consequence" as "kept him out of class on 3/6/13 at 0945."

B. Progress Notes: An 8/16/12 progress note by the therapist stated that the recipient presented a behavior in the rehabilitation department resulting in the instructor feeling uncomfortable and quoted the statement that the recipient made, which was relayed to the therapist, as "given my history…I do not feel comfortable being in a class with a female instructor." The therapist stated "The meaning of [recipient's] statements includes allusion to his history of sexually aggressive behaviors. [Recipient] was also requesting to be moved to a class with a male instructor. [Recipient] has a history of presenting inappropriate sexual statements and gestures in the rehabilitation department. He has been removed from two classes with female instructors for this kind of behavior." The therapist went on to say that he discussed this incident with the recipient and that the recipient "provided shallow, superficial statements indicating he was 'sorry' for his behaviors and then immediately asked if he could return to school. [Recipient] has made no progress in developing an understanding of how others may perceive his behavior."

An 8/27/12 therapist progress note states "[recipient] continues to be suspended from the rehabilitation department. The suspension is the result of an incident which took place on 8/15/12 during which [recipient] made comments alluding to his history of sexually aggressive behaviors. He directed these statements to a female instructor…"

A 3/6/13 therapist progress note states "It came to my attention that [recipient] had exhibited disruptive behavior while in the rehabilitation department. [Recipient] reportedly became upset when coffee was not available to him in the rehabilitation department. He directed verbally aggressive statements toward the rehabilitation department staff. As a result of the disruptive behavior, [recipient] was not allowed to attend class today. I met with [recipient] to discuss the issue. He became hostile toward me and walked out of the office."

III...Chester Policies:

PF .01.02.01.04 Rehabilitation Services Modification of Provided Services policy states "To provide quality patient care, the Rehabilitation Services Department provides educational and vocational programming regardless of age, disability, or dysfunction. Certain situations may require modification in a patient=s educational or vocational programming."

Modifications are listed as I. Mastery of adult education/vocational programming, II. Presenting problems and III. Medically limited for age-eligible patients.

Some examples of presenting problems are as follows: The patient has refused 50% of scheduled programming during a reporting period, the patient has requested to be removed from a program and the patient has exhibited inappropriate behavior while enrolled in programming.

This policy goes on to state that "all presenting problems involving modification of programming must be reviewed by the instructor and the patient's therapist. All contacts with the therapist must be documented on an Information Report (CMHC-207). The original and 2 copies are sent to the unit. One copy is filed in the rehabilitation services file. If the presenting problem involves inappropriate behavior while in programming, the patient is put AOn Hold@ [sic] from programming. This means that a patient is limited from programming pending review by the Treatment Team in consultation with Rehabilitation Services staff. The patient maintains his enrollment status and returns to regular programming consistent with the decision made by the Treatment Team and Rehabilitation Services staff." Further stating "In the event that all steps of the procedure have been implemented and the presenting problem has not been resolved, the Director of Rehabilitation Services in consultation with the Therapist and Treatment Team will make the final determination regarding any program modification."

EC .04.07.01.01 Patient Access to Rehabilitation Programming states "the Chester Mental Health Center staffs encourage and reinforce patient participation in rehabilitation programs, and to that effect have established procedure to ensure that patient access to such programming is consistent, properly monitored, and supervised" The policy states that a recipient may not attend programming in the rehab complex if "He is on any type of off-unit restriction when the behavior that resulted in the restriction is generalized to the Rehabilitation area. This must be reviewed weekly by the Treatment Team in consultation with Rehab services while the restriction is in effect."

The procedure that will follow the incident is listed in this policy as "a. immediately following the incident/issue/concern, the staff involved will fill out an Information Report CMHC-207 with the proper distribution to all staff. b. The Rehabilitation Services STA-I will

contact the unit charge aide (who will enter the information in the unit log book and as a progress note in the patient=s chart), while the instructor involved in the incident/issue/concern will contact the student=s case manager. Upon receipt of the original copy of the Information Report, the case manager will contact the patient=s therapist to determine the length of time the student is to be held out of classes, if applicable, and to establish the criteria for which the student must meet before resuming classes."

Conclusion

The first incident of class suspension occurred on 8/15/12 and was due to the recipient asking to be removed from a female instructor's class and put into another due to the fact that the recipient stated he did not feel comfortable being in a class with a female instructor, given his history. The therapist's case note indicated that he interpreted the meaning of this statement as making allusion to his sexually aggressive behavior from the past. As a result, the recipient was suspended from class until 11/14/12.

The second class suspension was due to the recipient "trying to con coffee." Based on review of the documentation, it was concluded that the rehabilitation instructor only intended for the recipient to be out of class for one day (3/6/13) yet he was not returned to class until 7 weeks later on 4/24/13. The therapist admitted that suspension from rehabilitation was used as a punishment and that it may have been excessive. There was also communication between the rehabilitation director and other staff members regarding the need to return the recipient to class and that the suspension was only supposed to be for 1 day and yet he was kept out of class for 7 weeks. Therefore, the HRA substantiates that a rights violation occurred and makes the following **recommendations**:

- **The facility reviews Chester policies PF 01.02.01.04 and EC 04.07.01.01 with staff regarding the proper procedures to follow when someone is suspended from class. Ensure that upon suspension, the length of time the recipient is to be out of class is determined and clear criterion are set for his return and shared with both the unit staff and rehabilitation department staff.**

- **The facility ensures that measures are put in place to facilitate communication between the rehabilitation department and the recipient's living unit to avoid a recipient being out of class longer than his instructor intended.**

- **The facility ensures that when a recipient is on class restriction, the treatment team, in consultation with rehab services, reviews the suspension weekly. In this case, a scheduled meeting time was changed without notification to the rehabilitation department.**

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