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Egyptian Regional Human Rights Authority
Report of Findings
14-110-9011
Chester Mental Health Center

The Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations of rights violations at Chester Mental Health Center:

A recipient is not being served in the least restrictive environment

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102), the Illinois Administrative Code (59 Ill. Admin. Code 112.20) and Chester policies.

Chester Mental Health Center is a state-operated mental health facility serving approximately 240 recipients; it is considered the most secure and restrictive state-operated mental health facility in the state.

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

I. Interviews:

A. Recipient: The Recipient informed the HRA that during his treatment plan meetings he is told that until he takes medications he will not be able to get out of Chester Mental Health. He does not feel that he needs medication and is not under court enforced medication. The recipient stated that he has not been aggressive or required restraints or seclusion and does not understand why he cannot be transferred to a less secure facility to "finish out his time." He stated that when he asks about this in his treatment meetings he is told that he "perceives things abnormally" but the treatment team does not explain what he is saying that is wrong and needs to be corrected and when he questions it, the team tells him that he just needs to calm down. He feels his "unbalance" is caused by "environmental issues" at Chester Mental Health. He explained how he feels that staff make comments about his increased calorie diet and say he should not have it just to irritate him. He expressed several complaints about the food he is served and body searches that occur at the facility. He stated that these "environmental issues" are the cause of his "unbalance."

B. Treating Therapist: The recipient's treating therapist informed the HRA that the recipient was still under court supervision on extended Unfit to Stand Trial (UST) status and reports are filed with the Court every 90 days to provide an update on his treatment. She said the recipient is involved in programming and is progressing. He is making small improvements and has some

degree of quality of life because he is actively attending classes and is not segregating himself as he had in the past. She stated that he has "thrived" in Chester Mental Health. However, some barriers to his treatment and transfer include his potential for aggression, lack of insight into his mental illness and paranoia. When he is outside of a structured environment his aggression increases due to his paranoia. She stated that the treatment team should be able to report to the court that his mental illness has been modified in some way for him to obtain a transfer to a less secure facility and right now they cannot say that. The HRA asked if that is possible without medication to treat his mental illness symptoms and the therapist responded that it is unlikely that his symptoms will improve without the help of medication but since he is refusing medication, they are trying other avenues such as counseling sessions and medication education. The HRA asked if court enforced medication had been pursued and the therapist stated that it had at one point before she was treating him and the court did not order medication. She is trying to build trust with the recipient and therefore, she does not want to take on an adversarial role by pursuing forced medication. She is trying to help him gain insight through counseling and education to see if he will choose to take medication on his own. The HRA asked how long this approach should be attempted without success and if medication would be pursued again at some point. She had no answer for that question as it depends on how he is responding to other forms of treatment and she cannot put a timeline on his recovery and how long it should take, but he is improving in small steps. The therapist explained the process for someone to be transferred as follows: First, the treatment team has to agree that he is ready for a transfer, next the administration has to approve the transfer and find an appropriate placement and finally, beds have to be available at the receiving facility.

II. Clinical Chart Review:

Court Order: The recipient was admitted on 5/18/2011 having been found unfit to stand trial (UST) and was declared Not Not Guilty (Extended UST) from 4/11/12 to 5/11/13. He was not able to obtain fitness and on 5/21/13 the Court entered an Order which stated "This Court having jurisdiction hereby remands defendant [name] to the Department of Human Services under the legal status G2, involuntary commitment. D [defendant] is unfit to stand trial and will not attain fitness. Defendant's maximum term date is December 4, 2017."

It is stated in treatment plan records that the patient, as of 6/07/2011, was suspicious, guarded, and evasive. Throughout his Treatment Plan Reviews (TPRs) it is stated that the patient entered into angry arguments and often shared irrelevant information. On 5/07/2012, the individual still had symptoms of psychosis but was more cooperative. Facility personnel and treatment plan notes affirm that there was progress and that soon the patient would be considered fit to stand trial. On 6/05/2012, the patient gave correct answers to legal fitness questions, had no thoughts or plans to harm himself or others, and was willing to cooperate with his attorney. However, the forensic clinical services evaluator did not concur with the psychiatrist that the recipient was fit and recommended to the judge that the recipient remain UST. Therefore, the recipient was returned to Chester Mental Health.

Treatment Plan Reviews (TPRs): TPRs dated from January, 2013 through July, 2014 were reviewed by the HRA. Some of those TPRs are detailed below. All of the TPRs reviewed stated that the recipient had not been physically aggressive, is cooperative with staff and lists restriction of rights as "none."

The 1/14/13 TPR summarized the recipient's reason for admission as outlined above. The D***iscussion*** section stated that "during the month of July, 2012 [the recipient] continued to show

signs of weight loss appearing emaciated and further decompensation in his psychiatric symptoms. He was increasingly paranoid, talking about his food being poisoned and/or rotten. He voiced more frequently complaints that others were persecuting him. He refuses to be weighed, have vital signs taken, blood for lab work drawn and continues to not be fit to stand trial due to refusal to take psychotropic medication. Therefore the court was petitioned for authorization for involuntary treatment with psychotropic drugs. On 8/6/12 the [county] court denied the petition for authorized involuntary treatment. [Recipient] continues to refuse to take psychotropic medication voluntarily." The section continued by saying that the recipient was irritable, hostile and showed no insight but is attending approximately 55 activities [per month]. The treatment team attempted to reason with him concerning his claims of medical problems due to his diet but he refused to comply with testing to determine any medical problems. The recipient's ***Diagnosis*** is listed as "Axis I: Schizophrenia, Paranoid Type; Axis II: Antisocial Personality; Axis III: PPD Test Positive; Axis IV: (dates) Psychiatric hospitalizations in DHS x 3; Legal problems, UST for Residential Burglary (date), changed to Not Not Guilty (4/11/12) Axis V: GAF [global assessment of functioning] 40." The ***Current Medication and Intended Outcome*** section stated "None because he could not be reasoned with." Below that in the ***Response to Medication*** section further detail was provided which included statements the recipient made in response to medication inquiries stating on 6/7/11 "That will cause chemical imbalance, I barely have Serotonin in my body." This section also said that in 2011 his PPD test was positive but he could not be reasoned with to cooperate with further testing (Gold Test). At his 8/2/11 TPR he stated "I need no psychiatrist. You talk about medication and that is verbal abuse, verbally disrespect me. I am constantly being neglected for millennium." On 4/11/12 the recipient returned from court as Not Not Guilty stating "Judge had no business sending me here, he overpowered me. That is discrimination. I am sitting here bullied by the system. I am being abused by the system." Finally, at this 1/14/13 TPR the recipient was making delusional statements about his food stating that "Food is dehydrating my lips, I can see alcoholic stuff on my sandwich." It was also stated that the recipient refused a blood test for vitamin deficiency. Therefore, the team determined he was still unfit for trial. The ***Problems/Goals*** section lists <u>problem 1</u> as "Unfit to Stand Trial." Some of the objectives listed are "Will take medication as prescribed and display a decrease in symptoms such as auditory hallucinations by…Will demonstrate an increased understanding of medication dosage, potential side effects and expected effects…will express intent to continue medication after leaving this facility." The psychiatrist stated that the recipient could not be reasoned with to take medication; the RN stated that he refused to consent to psychotropic medications; the STA (security therapy aide) stated that the recipient had two BDRs [behavior data reports] for non-compliance and that the recipient mostly "keeps to himself and continues to remain highly guarded and untrusting of some staff and the system in general remains the same and non-compliant with mostly medical issues." <u>Problem 2</u> is listed as "Noncompliance with Medication and Treatment." Some objectives listed are "Will state the symptoms of his diagnosed mental illness…will be able to identify factors that have contributed to decompensation of mental condition in the past…will demonstrate increased understanding of medication dosage, potential side effects and expected effects." The RN stated that the recipient was provided information on TB (tuberculosis) and was encouraged to comply with blood draws and doctor visits but the recipient continued to refuse. In the section entitled ***Extent To Which Benefitting From Treatment*** it stated that the recipient "continues to be unwilling to begin psychotropics and presents circumstantial speech. He appears to be suspicious and guarded. His thoughts are circumstantial and/or disorganized…he has shown a

marked increase in his activity level and he attends on average 55 activities per reporting period." In the ***Criteria for Separation*** section it listed criteria for fitness which included "be able to communicate with counsel and assist in his own defense, be able to appreciate his presence in relation to time; place and things; be able to understand that he is in a court of justice charged with a criminal offense; show an understanding of his charges and their consequences as well as court procedures and the roles of the judge, jury, prosecutor and defense attorney; have sufficient memory to relate the circumstances of the alleged criminal offense and demonstrate that there has been significant reduction in aggressive behavior." His strengths are listed as "[recipient] has not been physically aggressive; he is cooperative with staff direction and appears to be of average intelligence." The recipient was present for the TPR meeting but refused to sign the form.

The **2/11/13 TPR** stated in the ***discussion*** section that the recipient's attendance of off unit activities had decreased and he complained about feeling "miserable" but would not elaborate except to say that he does not like being at Chester Mental Health Center. The remainder of the TPR was similar and in some places verbatim to the 1/14/13 TPR. The ***Fitness Statement*** section stated that based on behaviors and psychiatric interviews as of 2/18/13 the psychiatrist opined that the recipient "was suffering [from a] psychiatric disorder diagnosed as Schizophrenia Paranoid for which he has always refused psychotropic medication. He knows his legal charges 'Residential Burglary, Felony' and length of sentence if found guilty. He also has factual knowledge of the Court proceedings against him, plea bargain, bench trial and jury trial but he basically doesn't understand the court proceedings against him. Due to his thought disorder and oppositional attitude, he is not able to cooperate with psychiatric staff and most probably he will not be able to cooperate with and assist his attorney in his own defense. He is still Unfit to Stand Trial. He will not attain fitness because he refuses to take psychotropic medication for his mental illness."

The **6/27/13 TPR** was the first TPR with his current therapist. The D***iscussion*** section noted that the last aggressive incident was reported in November, 2011. When asked about this, the recipient said "it's less stressful." The recipient was still refusing medication at that time but it was noted that he was showing signs of improvement such as signing Chester forms previously refused, increased participation in off unit activities and being more involved in his treatment and expressing interest in transferring to a less secure setting. In the ***Extent to Which Benefitting From Treatment*** section a paragraph was added which stated that the "clinician was assessing areas of strengths and deficits aimed at reinforcing adaptive behaviors and appropriate social interaction while promoting adaptive independent living skills." It noted that the recipient had responded well to behavioral prompts and had participated regularly in activities and therapy sessions. The last reported aggressive behavior occurred in November, 2011. The section concluded by stating that his "current therapeutic services aim at gaining fitness along with psychiatric and behavioral stability, a requirement for a future transfer to a less restrictive hospital environment." The R***esponse to Medication*** section of this TPR discussed how the recipient had transferred to his new unit about two weeks prior to the TPR and reported it was "less stressful" than his previous unit. It noted that he was polite with staff and had been cooperative even with procedures. During his TPR he was "very pleasant and indicated he was feeling good" and concluded the TPR by saying "have a nice day." The ***Fitness Statement*** section noted that it was still the opinion of the treatment team that he was unfit to stand trial. This TPR also had a section entitled ***Need for Mental Health Services and a Basis for Finding*** which stated that the recipient "has a long documented history of mental illness and violent

behavior. Given his history and his current clinical condition it is likely that he would pose a serious threat to the community, himself and others if he were not in a secure setting. It is the opinion of the treatment team that [recipient] is subject to involuntary admission and is in need of inpatient mental health treatment." Reasons for inpatient mental health treatment are listed as showing signs of weight loss appearing emaciated and further decompensation in his psychiatric symptoms; episodes of paranoia; talking about his food being poisoned and/or rotten; voicing complaints that others are persecuting him; refusal to be weighed, have vital signs taken, blood for lab work drawn and "continues to not be fit to stand trial due to refusal to take psychotropic medication." The section concluded by saying "he shows no progress related to his ability to communicate effectively and would not be able to care for his basic needs." This TPR had added the following statement under the ***Criteria for Separation*** section "in order to be recommended for transfer he must exhibit an ability to inhibit any significant impulses of violence towards himself or others. Additionally, he must express a genuine desire for transfer and behavior must be brought under a sufficient control in order to function appropriately. **As of the date of 6/4/13 TPR [recipient] meets criteria for transfer and a recommendation could be made**."

The **August, 2013 through December, 2013 TPRs** all said in the discussion section that the recipient inquired about transferring to a less secure setting, but did not communicate what is required in order to obtain a transfer. The J***ustification*** sections list his history of 3 DHS (Department of Human Services) hospitalizations; poor appearance; the recipient's statement that he has "lived on the streets for decades"; his behavior which is listed as being "suspicious, guarded, oppositional, angry attitude"; his affect being "inappropriate, irritability, frequent angry voice and facial expression"; Mood being listed as anxious and agitated; thought process being "slow, long pauses, irrelevant answers" and his thought content being "highly paranoid." This section also mentioned that he has generalized feelings and ideas of being mistreated by his lawyer, judge and people at this facility. His insight and judgment is listed as "highly impaired as he denied suffering of mental illness and need for treatment." It also stated that the recipient's history of "auditory hallucinations since age 13 and present delusions of persecution and disorganized thinking suggest the diagnosis of Schizophrenia Paranoid Type. Criminal history of arrests x 11 suggests Antisocial Personality." The other sections of these TPRs are verbatim to those held prior to it stating that a recommendation could be made but the treatment team is of the opinion that he remains unfit to stand trial. The **November, 2013 TPR** stated that the recipient was actively participating in psychosocial rehabilitation classes, especially excelling in art class. "Otherwise there have been no changes in his clinical presentation: no behavioral infractions; no insight, refusing to take medication affecting his ability to attain fitness. The patient remains highly paranoid and delusional. His thought disorder inhibits his ability to communicate and assist in his defense effectively. His participation in therapy is limited and superficial."

The **6/5/14 TPR's *Discussion*** section noted that he was refusing meals as a result of his distorted belief that his food is rotten and at times poisonous. The dietician met with him on multiple occasions to help alleviate his concerns and attempt to accommodate his wants and needs but did not have major success. It stated that his level of psychosis was affecting all aspects of his daily routine, presenting a serious concern for health and safety. His food intake and weight loss is closely monitored and concluded by stating "the patient continues to refuse any/all consideration of psychotropic medications as he denies his mental illness."

<u>Utilization Review (UR):</u> The HRA reviewed the UR from April, 2013 which stated in the **changes to discharge/transfer barriers** section that the recipient "remains unfit to stand trial;

medication non-compliant; extremely paranoid; has a history of multiple psychiatric hospitalizations; legal problems; no insight as to his mental illness or need for treatment…" The **recommendations from previous review** stated "continues to work on education for medication compliance." In the **progress made** section it stated that the recipient "remains chronically stable within his baseline and within this maximum-security setting. [name] is paranoid; has no insight; refuses all psychotropic medications; affecting his ability to attain fitness or significantly engage in therapy. His thought disorder inhibits his ability to communicate and assist in his defense effectively. His extended period of treatment expired resulting in the court founding him subject to involuntary admission (G-2) with a maximum term date of December 4th 2017. On a daily basis [recipient] continues to attend AT & Psychosocial educational classes without incidents. He continues to request a transfer to a less restrictive setting." The **changes to recommendations** are listed as "continue to work on education for medication compliance." This UR was signed by the Medical Director of the facility and unit staff members present are listed as his therapist and a social worker 4.

III...Facility Policies:

CC .01.02.00.02 Transfer Recommendation of Behavior Management Patients policy states "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."

CC .05.00.00.05 Continuity of Care Contact for Patients Who Are Unfit to Stand Trial policy states "It is the policy of Chester Mental Health Center (CMHC) to provide ongoing and coordinated discharge planning throughout a patient's tenure of treatment...The primary goals of the discharge planning process are to assist the individual in identifying treatment and recovery needs he will face upon returning to the community, identifying what resources are available (i.e., both personal and those in the community) that can address the patient's needs, and helping the person maximize his resilience in the community (or less restrictive environment) with minimal disruption or interruption in his ongoing recovery process."

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."

IV Mandates:

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… 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) provides that "The facility director of any Department facility may transfer a recipient to another Department facility if he determines the transfer to be clinically advisable and consistent with the treatment needs of the recipient."

V Conclusion:

Based on review of the chart information and discussion with the treating therapist, the HRA does not question that this recipient is in need of further inpatient treatment in a structured setting in order to address ongoing symptoms of his mental illness and he is in fact involuntarily committed to an Illinois Department of Human Services (DHS) facility until 2017. While the HRA recognizes the clinical judgment of the treatment professionals and course of treatment being pursued, it does question why treatment could not be received in a less secure setting given the lack of behaviors, cooperation with treatment, with the exception of psychotropic medications, documented progress he has made and the fact that the Court deemed his situation insufficient to meet the standards for court enforced medication. The TPRs from the last year stated month after month that the recipient requested a transfer to a less secure setting. The HRA also contends that the recipient has met the criteria to be recommended for transfer, which is listed on the TPR as *exhibiting an ability to inhibit any significant impulses of violence towards himself or others* (his last aggressive behavior was documented as November, 2011*); express a genuine desire for transfer* (the recipient repeatedly asked to be transferred to a less secure setting) and finally, *behavior must be brought under sufficient control in order to function appropriately* (The recipient had been attending classes and therapy sessions regularly, had begun signing forms that he previously refused to sign, had begun taking medication for insomnia). The only non-compliance documented in his TPRs were his refusal to take psychotropic medications and skipping meals for fear of contamination; which is a direct result of his mental illness and subsequent refusal to take psychotropic medications. The HRA contends that the recipient is not being allowed to fully exercise his right to refuse medication if his refusal is being responded to by continued restrictive placement and a transfer to a less secure setting is contingent upon his acceptance to take psychotropic medication. It is the opinion of the HRA that those final issues could be addressed in a less secure setting as required by the Code (405 ILCS 5/2-102). Therefore the allegation is **substantiated** and the following **recommendations** are made:

1. Chester Mental Health Administration should ensure that this recipient's right to treatment in the least restrictive setting is upheld by reviewing his case with the treatment team.

2. Given the recipient's ongoing requests for a transfer, the recipient's documented progress in all areas accept medication compliance, the inability to meet the criteria for court-enforced medication, and the achieved discharge criteria, schedule a clinical care monitoring meeting for this recipient to address his continued placement in the most restrictive DHS facility in the state.