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Egyptian Human Rights Authority
Report of Findings
Choate Mental Health and Developmental Center
HRA #14-110-9015

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving complaints of possible rights violations in the care provided to an inpatient at Choate Mental Health Center located in Anna, IL. The allegations are as follows:

1. Staff are not adequately doing their job duties when they do not intervene in peer to peer aggression.

2. Recipients' preferences are not being considered when programming is planned.

If substantiated, the allegations would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Choate Mental Health Center is a facility with 79 beds devoted to male and female residents for both civil and forensic admissions.

To investigate the allegations, these matters were discussed with staff involved in this patient's care. Relevant policies were reviewed as was the Mental Health and Developmental Disabilities Code.

COMPLAINT SUMMARY

The complaint states that the staff are not appropriately intervening when it comes to peer to peer aggression. It is also stated in the complaint that the recipients' preferences at Choate Mental Health Center are not being considered when the programming is planned. The patient has since been discharged from Choate Mental Health Center, and the HRA was unable to secure a release to review the record. This case is strictly examining the policies, procedures and practices at Choate Mental Health and Developmental Center to ensure compliance with the Mental Health and Developmental Disabilities Code.

FINDINGS

Allegation: Staff are not appropriately intervening in peer to peer aggression.

Policy: In the Choate Mental Health Services Policy/Procedure it states, "It shall be the policy of Choate Mental Health Center to provide an immediate systematic response when the potential for imminent risk or danger is present."

Within the Mental Health Services Policy/Procedure the Code Orange (Immediate Response System) policy is used in cases of emergency with specific codes meaning certain things. In this case, code orange is used for situations in which there is potential for or imminent risk of harm. Any staff person can call the code. Code orange drills are conducted by the Crisis Prevention Intervention (CPI) instructors to evaluate the effectiveness of the system. The instructors will also review and report any issues that concern the code orange system with the Patient Safety Committee, Medical Executive Committee, and the Health & Safety Committee when it is needed. The code system policy does apply to recipients' aggression toward one another.

As per the policy titled, Mental Health Services Policy/Procedure: Master Treatment Planning, the behaviors of aggressive peers are not referenced in the treatment planning process; however, the policy does state that evaluations do take place when there is progress toward goals and objectives, for non-participation in active treatment, and reviewed at the 10 day treatment review, monthly, and following episodes of containment.

Statutes:

The Mental Health and Developmental Disabilities Code states under "**Freedom from abuse and neglect**" that "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect." (405 ILCS 5/2-112).

The Code also states under "**Resident as perpetrator of abuse"** that "When an investigation of a report of suspected abuse of a recipient of services indicates, based upon credible evidence, that another recipient of services in a mental health or developmental disability facility is the perpetrator of the abuse, the condition of the recipient suspected of being the perpetrator shall be immediately evaluated to determine the most suitable therapy and placement, considering the safety of that recipient as well as the safety of other recipients of services and employees of the facility." (405 ILCS 5/3-211).

Interviews:

Recipient:

The HRA interviewed a recipient over the phone. The recipient stated he stood up to a peer who was being "loud, obnoxious, and spitting on fellow peers." According to the recipient interviewed, staff did not see the peer spit on anybody nor were they told about the alleged incident; however, the staff members were near the situation. The same peer was being "loud and obnoxious", and was asked nicely to stop by a female peer who was sitting on the floor, but he instead became verbally abusive to her. The recipient stated that he stood up for her while staff

was close by and did nothing. The recipient allegedly ended up being pinned down on the ground, and the staff allegedly still did nothing. The recipient was reportedly asked to leave the lunch line due to the actions of the instigating peer.

Mental Health Technicians II (MHT II): The HRA interviewed some of the staff members who were reportedly on duty the day of the incident that was described in the initial complaint.

The first MHT II the HRA interviewed did not recall the incident that was described in the initial complaint. However, the MHT II stated that staff intervene in peer-to-peer aggression by asking a recipient to remove his hands from the peer, and if the recipient did not comply, staff would proceed with a CPI hold and call for help given that circumstance. Once staff gain control of the situation they would remove the recipient from the area the incident occurred, and ask him to calm down. If the aggression continues a medical nurse would be called to see if the recipient needed any medicine to assist him in calming down. After the recipient calmed down, staff would escort him back to be with his peers

The second MHT II the HRA interviewed did not recall the incident that was described in the initial complaint, but stated that no recipient would be allowed to sit on the floor due to it being a fire hazard. Staff would send both parties involved in the incident to separate areas to intervene. The MHT would write up the report, and give it to the nurse while the MHT puts the report into the respective charts. Staff stated that more often than not the nurse has to give PRN (as needed) medication to assist in calming the patients down.

Mental Health Technician III (MHT III):

The MHT III that the HRA interviewed stated that the lunch line usually goes smoothly, but there have been some incidents that have occurred in the past. The technician stated that training for handling emergency situations is adequate. (He/She) did not recall the specific incident described in the initial complaint.

Conclusion: Based on the available information obtained from the interviews, facility policies and the statutes, the HRA concludes that facility policies provide a mechanism for staff intervention during incidents of peer to peer aggression, thus, the complaint is **not substantiated**.

Allegation: Recipients' preferences are not being considered when programming is planned.

Policy: In the Choate Mental Health Services Policy/Procedure: Incentive Program For on/off Unit Programming it states, "It is the policy of Choate Mental Health Center to provide a therapeutic Incentive Program through which patients can work towards recovery and an enhanced level of independence. The Incentive Program will involve both on/off unit programming and a schedule shall be provided to individuals to be utilized on a daily basis. Individual patients shall receive a monetary amount based on the percentage of programs attended."

It also is documented in the Services Policy/Procedure: Incentive Program For on/off Unit Programming that, "following development or review of the treatment plan at the 72 hour staffing, the Case Manager shall update the Mental Health Services Program Treatment/Rehabilitation Schedule and shall include additions or deletions on the patient's complete daily program schedule."

According to the treatment planning policy at Choate Mental Health and Developmental Center, several general principles are to be followed when it comes to treatment planning. They are as follows:

a.) The admission and master treatment plan (the 3 day plan) shall be used for communication between the treatment team, the individual receiving services, and other appropriately involved persons such as family, guardian, community agency staff, etc.
b.) The admission and master treatment plan shall be written in a language that is clear, precise, and demonstrates measurable positive outcomes in the form of long and short term goals related to reason for admission. It should be patient centered and incorporate individual's strengths and weaknesses.
c.) The individual treatment plan shall be a flexible, "living" document, in that goals and objectives shall be attainable with new or revised objectives and interventions being generated as treatment proceeds. This includes prescribing skills based on therapy groups to enhance the client in progress toward discharge.
d.) An inter-disciplinary approach shall be utilized for all treatment planning activities. The treatment team shall include at a minimum the core treatment team which includes the patient, an RN, Social Worker, and Psychiatrist. As well, other disciplines, including but not limited to, Mental Health Technicians, Activity Therapists, Educators, Vocational Instructors, Psychologist, Speech and Hearing Specialists, or Medical Services staff may and should be included in the planning process as appropriate to the individual patient.

In the policy titled Mental Health Services Policy/Procedure: Master Treatment Planning it does clearly state, "The patient shall be interviewed and involved collaboratively in developing his/her treatment plan, incorporating his/her choices, using identifying strengths, supports, and barriers to discharge, to engage patient in being actively involved in the development of treatment and discharge planning goals. Patients and other members of the treatment team must sign the treatment plan." The treatment planning policy makes reference to "personal safety plans" which the HRA believes pertains to emergency treatment preferences of the patient. "The Personal Safety Plan shall be reviewed/updated at the 10 day treatment review, monthly, and following all episodes of containment (i.e., physical hold, seclusion, restraint)."

Statute: The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) states that: "(a) **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."

Interviews:

Rehabilitation Staff:

The HRA interviewed a rehabilitation staff member who reported that staff review classes offered with the recipients, such as: pool, pottery, games, fitness, swim, cook outs, etc. They ask what the patient is interested in and ask for feedback on a survey each quarter. Recipients who have higher level passes can go to the gym or out in community. Recipients on restricted pass levels participate in unit programs led by a nurse or a mental health technician. If a recipient does not like the classes offered then the case manager is called who can switch the classes. If the patients are in the same class for more than four months the staff encourage them to explore new classes.

Mental Health Technician (MHT III):

The HRA interviewed a MHT III, and they stated that the AT (activity therapy) staff sets up all the programs, and it is the patient's decision to attend classes. If the patient decides to leave the class a MHT will take the patient to the dayroom, and do individual activities with them (i.e. call family, color, games, TV, or they can go to their room). The patients have structured activities each night called recreational education, and the activities that recreational education includes is ping pong, movie night, reading, and coloring, etc.

Social Worker (SW II):

The HRA interviewed a SW II, who stated, "The rehab screens [patients] on admission to get a Master Schedule within 72 hours to get their schedule based on mental health needs, such as Mental Illness and Substance Abuse (MISA), Trauma, and patient preferences." The patients can tell the SW if they would prefer specific program enrollment or discharge. When program attendance drops below fifty percent the team will discuss with the patient. They will attempt to address, and fix the any problem that may exist. The patient does have the right to refuse.

The SW and patient do meet 1:1 to touch base, but the SW will refer to the physician for individualized therapy. If the social worker is available to address concerns, he or she will ask the MHT about the complaint that the patient is expressing. If the stories provided conflict the supervisor will be notified, and the patient will be informed that they have the right to file a

Human Rights and Ethics Committee (HREC) complaint that will be reviewed in a safety meeting.

Conclusion: Based on the available information obtained in the policies, interviews and the statute, the HRA concludes that the policies are in compliance with the basic requirements of the Mental Health Code in regard to treatment planning. Therefore the allegation is **unsubstantiated**. However, the HRA is concerned that the policy's description of "personal safety plans" in reference to emergency treatment preferences may be confusing to staff and may not fully describe the Mental Health Code requirements related to the documentation and implementation of emergency treatment preferences. The HRA offers the following **suggestions:**

1.) The HRA strongly suggests that the treatment planning policy be revised to specifically identify emergency treatment preferences as such and to incorporate, as much as possible, the Code's requirements regarding the documentation and implementation of emergency treatment preferences.

2.) Help recipients feel included as much as possible when it comes to the program planning by providing opportunities for feedback during the treatment planning process.

3.) Remind recipients that peer to peer aggression is not acceptable and counsel recipients on what they can do to resolve conflicts that may result in aggression toward one another.

4.) Train all staff in direct contact with clients on CPI.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

Bruce Rauner, *Governor*

Illinois Department of Human Services

Gregory M. Bassi, *Acting Secretary*

CLYDE L. CHOATE CENTER
1000 NORTH MAIN ST. ANNA, IL 62906

March 2, 2015

Mr. Clarence Russell
Egyptian Regional Human Rights Authority
#7 Cottage Drive
Anna, IL 62906-1669

RE: HRA Case # 14-110-9015

Dear Mr. Russell,

It is noted that the findings on the allegation in this case is unsubstantiated but that there are suggestions from the HRA, as follows:

1). The HRA strongly suggests that the treatment planning policy be revised to specifically identify emergency treatment preferences as such and incorporate, as much as possible, the Code's requirements regarding the documentation and implementation of emergency treatment preferences.

2). Help recipients feel included as much as possible when it comes to program planning by providing opportunities for feedback during the treatment planning process.

3). Remind recipients that peer to peer aggression is not acceptable and counsel recipients on what they can do to resolve conflicts that may result in aggression toward one another.

4). Train all staff in direct contact with clients on CPI.

We appreciate the suggestions as they allow us the opportunity to improve upon the services we provide at Choate Mental Health. Attached is the response to your suggestions.

Sincerely,

Linda Parsons, Acting Hospital Administrator

cc: Bryant Davis

Finding/Recommendations/Suggestions	Response
1). The HRA strongly suggests that the treatment planning policy be revised to specifically identify emergency treatment preferences as such and incorporate, as much as possible, the Code's requirements regarding the documentation and implementation of emergency treatment preferences.	Per MSO.062, it is the policy of the Clyde L. Choate Mental Health Center that each patient admitted to Choate is assessed for risk of potential for harm and/or violence. An ongoing multi-disciplinary system of risk assessment is utilized during the patients stay. A Personal Safety Plan (PSP) is drafted for each patient based on the risk assessment results. The PSP will identify calming strategies to utilize with patients in advance of crisis, identify triggers and early interventions for patient care, solicit patients self-determination regarding course of care including measures to be utilized in emergency situations. Reassessment is an ongoing process during hospitalization with review and revisions to the PSP part of the treatment planning process in which the patient provides input. PSPs are individualized and readily accessible to staff.
2). Help recipients feel included as much as possible when it comes to program planning by providing opportunities for feedback during the treatment planning process.	Treatment planning is an ongoing process that includes a multidisciplinary team and the patient. The patient is involved collaboratively in developing his/her treatment plan, incorporating his/her choices, using identifying strengths, supports, and barriers to discharge, to engage patient in being actively involved in the development of treatment and discharge planning goals. Treatment plans are reviewed during the admission and changes made as appropriate with the input of the team and the patient. Patients and other members of the treatment team shall sign the treatment plan. Others, as appropriate, or as designated by the individual (community agency staff, family, guardian, etc.), may be involved in the development of the Treatment Plan. Treatment planning utilizes a person centered approach and will incorporate individual strengths and preferences, and identify a prescribed list of skills groups and treatment groups.
3). Remind recipients that peer to peer aggression is not acceptable and counsel recipients on what they can do to resolve conflicts that may result in aggression toward one another.	It is the policy of Choate Mental Health to facilitate effective communication. Community meetings are held twice daily on each unit to facilitate the sharing of information, to encourage open discussion of possible improvement in the operation and general environment of the hospital and to instill and perpetuate a sense of community within and on the living units. Standing agenda items for both of the daily sessions include: Unit Safety (Issues/concerns/suggestions to improve environment) and Other issues or concerns/recommendations (getting along with peers/staff-patient interaction).
4). Train all staff in direct contact with clients on CPI.	CPI Training is a requirement for all staff and occurs during initial orientation and annually thereafter.