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Egyptian Regional Human Rights Authority
Report of Findings
15-110-9001
Chester Mental Health Center
July 30, 2015

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Chester Mental Health Center (CMHC), 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 did not receive treatment to attain fitness and false reports were filed with the Court.**

2. **There was an inadequate OIG investigative process that followed a mental abuse allegation.**

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2), the Mental Health and Developmental Disabilities Administrative Act (20 ILCS 1705/7), the Illinois Administrative Code (59 Ill. Adm. Code 50), and the Code of Criminal Procedure (725 ILCS 5/104-17 & 18).

To investigate the allegation, the HRA Investigation 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 staff members at the facility. 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.

Allegation 1: A recipient did not receive treatment to attain fitness and false reports were filed with the Court.

I. Interviews:

A. Recipient: The recipient informed the HRA that he was transferred to CMHC from the county jail approximately one month prior to the HRA's meeting with him. He was concerned because his Treatment Plan Review (TPR) stated that classes to attain fitness had started on June

18th but he had not been offered any classes or therapy sessions at that point. He stated that the facility reported to the Court that he was fit to stand trial because he had passed the fitness test which consisted of a questionnaire that he completed. The facility also allegedly reported to the Court that he was non-compliant with treatment; however he stated that he had not received any treatment for which he was non-compliant. The recipient stated that he was refusing medications because the facility diagnosed him as having Bipolar Disorder and wanted to start medication for that. However, his doctor at the Veterans Administration Hospital (VA) had stated that he did not have a Bipolar Disorder and he had not taken any medications for that since 2006.
Another doctor at the facility said that he was not fit to stand trial and that she was going to restart his treatment and get a new class schedule. The recipient stated that he signed his June TPR because the treatment team agreed to get him into classes. However, he stated that his treatment team still had not referred him to classes even though he wanted to go. He was then informed by his therapist that he had been found fit, therefore, he did not need to attend fitness classes. The recipient stated that he had told his therapist personally and in treatment meetings that he would like to attend a substance abuse group. The therapist stated she did not handle scheduling but would check into it for him. The Director of Clinical Operations spoke with him and stated that he was in the wrong place for that treatment but did not give him any direction on what to do to get treatment in an appropriate setting.

II. Clinical Chart Review:

A. Treatment Plan Reviews (TPRs): The recipient's admission date is listed as 6/2/14. The 6/3/14 3-day TPR detailed the reason for admission to CMHC as being found unfit to stand trial (UST) on 2 charges of aggravated domestic battery. The Discussion Section stated that the meeting was held to formulate his initial treatment plan. The treatment team discussed opportunities for involvement in programming *including "groups designed to assist him in attaining competency to stand trial."* The section also noted that the recipient "was very concerned that the treatment team was unaware of his 'combat scars'. He was assured that this information was known." The recipient knew that he was sent to CMHC because he was found UST and when asked if he felt that he was fit he responded "No." The Diagnosis is listed as "Axis I: Bipolar Disorder, NOS [not otherwise specified] Poly-substance Abuse (Marijuana and Alcohol) R/O [rule out] PTSD [post-traumatic stress disorder]. Axis II: Deferred Axis III: Hypothyroidism Axis IV: Legal Charges Incarceration Axis V: GAF=40 [global assessment of functioning]." The justification is listed as "history of Bipolar Disorder, Polysubstance Abuse. Patient has charges with aggravated domestic battery. Patient presented as irritable, racing thoughts, paranoid/persecutory delusions." The treatment and goals section listed **problem 1** as being UST with a goal to return to jail by 4/17/15 competent to stand trial. The treatment intervention is listed as "attend competency to stand trial group three days per week" beginning on 6/3/14. **Problem 2** is listed as Psychiatric Condition with a goal to "consistently exhibit adaptive social function with greatly reduced/eliminated positive symptoms of psychosis by 7/30/14." The treatment intervention is listed as "stabilization group conducted by the Unit Director, Clinical Staff and STAs is designed to assist the patient in understanding the reason for his admission; gaining insight into his psychiatric condition; developing a plan for addressing central clinical issues and following through with treatment recommendations." This also includes taking medication as prescribed. The start date for this was also 6/3/14. **Problem 3** is listed as Substance Abuse. The goal is to "engage in the recovery process for substance abuse by

7/30/14." The treatment intervention is "MISA [mentally ill substance abuse] Group is conducted by clinical staff on the unit and is designed to: educate the patient in the harmful impact of substance abuse; and to develop healthier decision making skills which do not include abusing alcohol." Again, the start date was listed as 6/3/14. **Problem 4** is Thyroid Disorder. **Problem 5** is listed as PTSD as reported by the patient "related to his active duty…" The start date for all of the interventions is listed as 6/3/14. The goal is to "engage in the recovery process for trauma related issues by 7/30/14. The treatment intervention is listed as "1:1 Cognitive Behavioral Therapy to address reducing PTSD symptoms…Understanding and learning the best way to live with his symptoms. Learning how to cope and deal with other problems associated with PTSD…identifying triggers of stressful memories. Become more aware of thoughts and feelings so the reaction to them can change." The TPR stated that the recipient was not on any medications at the time of the review. The recipient signed the TPR indicating agreement with the plan.

The 6/18/14 TPR stated in the Discussion Section that "*the treatment team met with [recipient] to discuss his response to treatment. It was noted that [recipient] has demonstrated competencies which result in the treatment team members being unanimous in believing he is fit to stand trial. He is able to accurately state his charges, and he is able to describe the seriousness of his charges. Based on competency to stand trial assessment, he has shown that he possesses knowledge of the various roles of persons in the court, and he shows the capacity to assist in his own defense. When [recipient] was informed that the treatment team considers him fit to stand trial, he voiced disappointment and he indicated that he did not want to return to court because he does not want to be placed in the Department of Corrections. [Recipient] also stated he wanted to have other therapeutic issues addressed. He was informed that his coordinating therapist is now [name]. [Recipient] was informed that [therapist name] will be meeting with him to address clinical issues.*" The recipient had been placed on Sertraline for depression, Vistaril for insomnia, Clonazepam three times daily and the TPR noted that the recipient had PRN [as needed] medication 5 times between 6/4/14 and 6/14/14. The recipient had refused Lithium/Depakote to help with impulse control issues. It was also noted that the recipient "attempts some groups and activities and is medication compliant." Under the Problem 1 progress section, the therapist documented that the treatment team was unanimous in believing he is fit to stand trial and did not mention attending any fitness classes. The therapist also noted that the recipient "attends and participates in community meetings" which are noted to address a number of routine issues including discussing their goals and importance of participating in treatment. The nurse noted that the recipient "participated in groups that have been offered on the unit." However, it was documented in this section that the team believed he was competent and did not list participation in any fitness groups. Under the Problem 2 progress section, the therapist noted that the recipient had "on occasion, presented elevated voice level" and documented dates that PRN medications were given. The nurse noted that "patient was given written information on prescribed medication. Has not been fully cooperative with medications, wants to be selective on what he take[s] but denies having any mental illness." Under the Problem 3 progress section, the therapist noted that the recipient "minimizes the role of substance abuse in harming his ability to function in the community." The recipient signed the TPR indicating agreement with the plan.

The 8/13/14 TPR noted in the Discussion Section that the recipient felt that he had "lost everything – specifically his family" and that he has been "held at this facility illegally." It was explained to him that he had been recommended to return to jail as fit to stand trial and noted that it "remains clear that [recipient] continues to be fit to stand trial. The Axis II diagnosis had also been modified to include Borderline Personality Disorder." In the justification section it stated that the recipient "exhibits social behaviors consistent with the diagnosis of Borderline personality Disorder." Under the current medication section it was noted that the recipient had "consistently declined to take psychotropic medications. His medications were discontinued on 7/2/14." In the response to medication section it also noted that during this 30 day TPR the recipient had stated "I have never received treatment…I never had a visit with a psychiatrist…I am unable to accept the fitness report…I do not know the 1st charge...that diagnosis is wrong [Bipolar Disorder]…he feels better off his meds Klonapine; Zoloft Vistaril… I do not want medicines…I have not been able to see any mental health staff…" After these quotes are noted it stated "continue with present treatment." The nurse noted in the Problem 1 progress section that the recipient "participates in recovery groups but does not have a positive attitude towards recovery, recovery goals or hope for future." The therapist noted in the Problem 2 progress section that the recipient "has consistently minimized his psychiatric condition and he has declined to take psychotropic medications." In the extent to which benefitting from treatment section it was noted that the recipient "has continued to participate in therapeutic programming at a fair rate, as documented in the active treatment section in the clinical record." The recipient signed this TPR checking the box stating he did not agree with the plan and included a note which said *"I have been here since June 2, 14 and have yet to receive treatment. I have not been able to focus on any part of my conditions due to ongoing resistance from staff and my treatment team."*

The 9/10/14 TPR documented in the Discussion Section that the recipient's rate of attendance/participation in therapeutic programming was at approximately 77%. It also noted that another Licensed Clinical Social Worker (LCSW) had been added to the recipient's treatment team as "co-therapist" as the current therapist had been transferred to another position. The doctor indicated that even though the recipient was fit to stand trial, he would benefit from some medication. It was noted that the recipient asked why he should comply with psychotropic medication and the doctor stated that she had explained this to him repeatedly and noted that he "continues to refuse this treatment." It was noted that the recipient was participating in therapeutic services twice a week with co-coordinating therapist and that he was cooperative with services and actively engaged in conversation. The recipient again stated that he had not received adequate treatment while at CMHC and when the therapist stated she would work with him on fitness issues he stated "I got a 100% on the fitness test and will continue to get a 100%…I was not sent here for lack of knowledge, I was sent here for treatment." In the Problem 2 progress section the new co-therapist documented that the recipient "meets with co-coordinating therapist twice weekly. He reports that he does not have a personality disorder, further he feels that he is not bi-polar but suffers from PTSD. To date most discussion has been around what [recipient] believes are discrepancies in the record and past legal history." In the Problem 3 progress section the co-coordinating therapist documented that the recipient reported that he would "only have one or two beers at night. He does not appear to connect alcohol use to the incident that occurred in regard to current charges. [Recipient] reports that he has a high BAC due to drinking after the incident with his wife and son. [Recipient] denies any alcohol

abuse at this time." The recipient signed the TPR and checked the box indicating he did not agree with his treatment plan.

B...Progress Notes: A 6/9/14 nursing note stated that the recipient was cooperative and calm and participates in active treatment and recovery groups. On 6/11/14 the therapist's note documented that the recipient attended UST group and stated *"he attempted to control the group i.e. answering all questions reciting legal violations during his arrest, discussing his past military experience and everyone that has wronged him in the past. He was asked several times by this writer to lower his voice and allow other members to answer questions and be respectful. He got upset every time he was asked to allow others to talk and lower his voice…"* A nursing note this same date documented that the recipient requested a PRN [as needed medication] as soon as he came out of UST class and he was given 1 mg of Clonazepam for increased anxiety and agitation. The note also stated that he was *"highly agitated complaining 'no one listens to me, they all think I'm lying and yelling at them' Patient requested to speak to [therapist name]. Left message…"* It was noted an hour later that he was still "argumentative with staff" and that the PRN was "mildly effective." A 7/21/14 therapist note documented a therapy session with the recipient on his living module. The session lasted approximately 50 minutes and included discussion about his history of trauma and loss of control which the recipient denied existed and became upset and stated *"I have perfect control."* When events that led up to his arrest were discussed, the recipient stated it was due to everyone being jealous of him because he had a good income and children of his own by the same mother. The recipient then became upset and "directed profanity and hostile statements" toward the therapist due to his belief that the therapist was "jumping to conclusions about him." The recipient eventually left the session due to becoming too upset. An 8/13/14 TPR Note documented that the recipient was stating that *"I have never received treatment…I never had a visit with a psychiatrist…I am unable to accept the fitness report…I have not been able to see any mental health staff."* It also documented that he was not taking any psychotropic medication and was contesting his diagnosis of Bipolar and stated that he was *"fit to stand trial. He has passed his fitness test"* The final note was to *"continue with present treatment."* A therapist note dated 8/25/14 documented that the issue of fitness to stand trial was discussed. The therapist stated that the recipient had been found fit by his treatment team and stated that *"the basis of their finding is not only the competency to stand trial questionnaire results but behavioral observation and clinical interview. [Recipient] is fit to stand trial as he 1. Understands his charges, he is able to state in detail his charges and he is able to describe the seriousness of the charges. He is able to state the potential penalty for conviction of the charges. 2. Demonstrates capacity to assist in his own defense. He requests frequent contact with his attorney and he is able to discuss strategies for his defense. For example, he indicates that his wife now 'says I really didn't choke my son.' He is able to state that she could be brought to testify. 3. Demonstrates an understanding of court procedures and he is able to describe the various rolls of persons in the court room."* An 8/27/14 Psychiatry Note documented a visit with the recipient who stated *"nothing has changed…I have had control of my mood, only agitated a couple of times…I spend most of the time depressed…I sleep at night for only a few hours…"* The psychiatrist noted that he informed the recipient that he needed to ask to see him and that he was available on Wednesdays and Thursdays to which the recipient replied *"I have asked twice and been denied…do you know how many times I have been told not to ask the same question twice."* The psychiatrist then noted that the recipient *"was mad and left the room in a flurry of anger. [Patient] refuses my treatment of medications and clinical visits."*

On 9/9/14 a therapist note documented a session for therapeutic services and stated that they discussed an aggressive behavior that occurred over the weekend with another peer as well as his past history. They also discussed "refraining from drinking when he is in the community as it appears that most legal issues have come up when alcohol is involved." However, the recipient stated he only drinks in a "safe environment." However, he did discuss past feelings of suicide and how he "*would be worth more to my kids dead than alive*" if he goes to prison. Coping mechanisms were again discussed with the recipient. A 9/12/14 therapist note documented a session with the recipient "for therapeutic services" The therapist offered the recipient a copy of his last treatment plan and 90 day fitness evaluation but he declined the copies and stated he wanted them all to go to his attorney instead. They discussed the issue of fitness and it was documented that the recipient "*declined fitness education stating 'the mistakes in here (his chart) are more important.*" The therapist informed him that they could always go over things covered in fitness education but the recipient simply stated "maybe later" and continued to report that he was able to pass the fitness test and "*was not sent here due to lack of intelligence, rather he was sent here to get treatment.*" The recipient also expressed disagreement with the Bipolar Disorder diagnosis and Borderline Personality Disorder diagnosis and stated that he has PTSD [post-traumatic stress disorder]. He also reported that he "*only felt manic when he was on medication*" and felt like he was handling himself better since he had been off his medication. On 9/17/14 a therapist note documented that she met with the recipient twice weekly for therapeutic services and documented discussions about his relationship with his children, coping mechanisms to deal with his feelings and suicidal thoughts as well as anxiety he had over an upcoming court date. Additional therapist notes were dated 9/19/14; 9/23/14; 9/5/14; 9/3/14; another therapist note dated 9/24/14 at 10:00 a.m. documented a session in which his fitness evaluation was discussed along with anxiety over a court hearing he had the previous day. They also discussed his current mental state and noted the recipient felt "spread out thin, short tempered and mildly depressed." They discussed suicidal ideations and the recipient stated he was "*going to do the best I can to get through this….I'm not going to lay my hands down and give up.*" Another therapist note at 4:30 p.m. documented that she met with the recipient and reviewed his discharge summary.

C. Clinical Group Progress Note: The HRA reviewed a few group progress notes found in the chart. The first one dated 6/2/14 documented that the recipient participated in a "Recovery" group with the registered nurse signing the form indicating participation. The form documents participation on a scale from 0-5 with 5 being "very good." The recipient received a 5 in every area. The comments section stated "had to be redirected a few times and informed to remain respectful to others' opinions." The assessment section noted that the recipient was "very knowledgeable on topic, wants to continually dominate discussion groups." The plan was listed as "engage in future education groups." The second was dated 6/3/14 and was also a "Recovery" group with the same registered nurse signing to indicate participation. The recipient was graded at a 4 for all areas. The assessment stated that he "listened attentively, offered appropriate feedback." The plan was to "continue coming to group and participating." The next note was dated 6/4/14 and was entitled "Competency to Stand Trial Group." The recipient received a 5 in all areas except comprehension/ability to learn where he received a 4. Some comments were also included next to "relevant comments" section stating "is very knowledgeable about the court process. He was quick to tell other members their answers were wrong and explain why." Next to "behavior/interactions" it was noted that the recipient "was not inappropriate, but more

arrogant about his knowledge of the court." Next to "comprehension/ability to learn" it was noted that the recipient "is capable of comprehending information that is given to him. He does not display any problems with reading, writing or comprehension." The comment section stated that the recipient was "cooperative and appropriate. He was administered the competency test and he scored 100%." The assessment section noted "did well in the group. His answers were appropriate and correct. He dominated the group. He was quick to answer the questions and when he was asked to wait until called on, he quickly corrected his peers when they were incorrect. He has the capacity to assist in his defense. If he assists with his defense is up to him. He is fully aware of the court room procedures. He is aware of the roles of the Judge, State's Attorney, Defense Attorney, Jury and Bailiff. He knows his charges and he will tell you exactly what the consequences could be if he is found guilty." The plan is listed as "assist [recipient] in mastering the fitness information and being found fit to stand trial.

In addition to the notes from classes attended, the HRA received a printout of the recipient's student attendance record from 6/1/14 to 7/22/14. The classes listed on Mondays were Leisure Education/Skills; Recover; Relaxation; Community Meeting and UST. On Tuesdays the classes of Self-Management and Healthy Living were added in addition to those listed above. On Wednesdays, the additional class of Sleep Hygiene was listed; on Thursdays, Creative Thinking was also added; on Fridays, Infection Control was added; Medication Education was also listed as an additional class on Sundays. The codes of A, E and R are listed to document attendance for the entire timeframe (6/1/14-7/22/14) with A representing 74% attendance; R representing 25% attendance and E representing 2% attendance. For Mondays only 2 documentations of E's are listed showing that the recipient attended 25-75% of classes offered. On Tuesday 4 E's are listed; Wednesday 5 E's are listed; Thursday 11 E's are listed; Friday 3 E's are listed; Saturday 2 E's are listed and on Sunday 3 E's are documented.

III...Facility Policies:

A. IM .03.01.01.03 Treatment Plan: states that the *Identified Patient Needs or Problems* section should include a list of needs or problems that are "based upon the critical treatment and/or medical issues, as presented from the results of the psychiatric, physical, nursing, security, social assessments, and Personal Safety Plan. Include the date the problem is established and provide all supporting evidence to justify the problem as a critical treatment and/or medical need. Any trauma, substance abuse, violence to self or others, suicidal or homicidal history identified during the assessment process must be included."

B. CC 05.00.00.05 Continuity of Care for Patients Who Are UST: This policy requires that ongoing care be directed toward and include planning for eventual discharge and 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 discharge planning process is a partnership of personalized care developed between the patient and the following: any family or significant other(s), the treatment team, and the designated community treatment provider(s). 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…E. The patient's treatment team will utilize the information obtained from identified individuals, along with data derived from clinical assessments and the community mental health provider, and collaborate with the patient to develop their treatment plan as well as their discharge plan… G. The therapist will document progress toward completing discharge planning in the patient's clinical record/Treatment Plan. H. In addition, the therapist will communicate with the legal guardian/**court**/community mental health center/liaison any of the following as applicable:*

1. *Any significant patient events or clinical changes in the patient's condition.*
2. *Any change in the patient's admission legal status.*
3. *Whenever a UST patient has a scheduled court/fitness hearing.*
4. *Whenever a UST patient has been recommended as having attained fitness, or other changes in their legal status.*
5. *Any changes in the patient's ongoing discharge plan.*
6. *The transfer of a UST patient to another state operated facility."*

Allegation 2. There was an inadequate OIG investigative process followed regarding a mental abuse allegation

I...Interviews:

Recipient: The recipient voiced concern because his therapist "quit" reportedly because she was afraid of him. The new therapist that took over was disrespectful and "did more harm than good." When the HRA asked for an explanation, the recipient replied by saying that the therapist stated to the recipient that he was an "egomaniacal, drug seeking addict" and stated that "he [the therapist] didn't care about his life." After these statements were made to him, he told a STA on the unit that the way the therapist spoke to him made him want to hurt himself. The STA allegedly told the recipient to "man up" and then "forced" him to take a PRN [as needed medication.] The recipient stated that another STA wrote a report over the incident and was stopped by a third STA in the hallway to review the report to "make sure it didn't hurt the STAs." The recipient stated that he completed a Human Rights Committee Complaint form regarding the incident and the OIG investigator came to see him approximately one week later and told the recipient that he had just been notified yesterday of his complaint and "threw the clipboard and ink pen at him and told him to fill out his own paperwork." Approximately 6 weeks later the Director of Clinical Operations came to see him and stated that she was going to find him a new therapist. Approximately one week later he met with a new therapist whom he reported was good and was helping him.

The recipient later voiced concern over not being able to access records upon request and a belief that the facility had his records confused with his father's records since he and his father had the same name. This belief was due to some inaccuracies he noted when he was finally able to review his chart regarding medication allergies and alcoholism.

B. Director of Clinical Operations: The HRA notified the Director of Clinical Operations of the recipient's concern that his records were somehow being confused with his father's. After a review of the situation, the HRA was informed that the Director found no record of the

recipient's father ever being admitted to Chester Mental Health Center or any other State Operated Facility. Therefore, there would be no way for his records to have been confused with the recipient's unless there was a mix up somewhere in the past with medical records prior to his admission to Chester Mental Health. However, the facility did double check on medication allergies to be certain that their record was accurate and it was found to be correct.

II. Chart Review:

A. Human Rights Complaints: The HRA reviewed two complaints that the recipient filed with Chester's Human Rights and Ethics Committee (HREC). The first complaint alleged that numerous requests had been made to review his chart, but the recipient had been denied access. The HREC notified his Unit Director of the request and the facility's obligation under CMHC policy and the Mental Health Code to comply and with that the complaint had been "determined resolved." The HRA did review case notes indicating that the recipient had access to his chart.

The second allegation was that staff was verbally abusive and the HREC responded stating that the allegation of mental abuse was forwarded to the Office of Inspector General (OIG) for further investigation and with that the HREC considered the complaint resolved.

B. OIG (Office of the Inspector General) Reports: The first OIG report that was reviewed by the HRA alleged that the recipient's therapist/unit director called the recipient an "ego-maniacal, drug seeking alcoholic who is a danger…to his family" which caused the recipient to want to engage in self-injurious behavior. The therapist/unit director denied the allegation and there were no witnesses to confirm or contradict the allegation since this allegedly occurred during sessions with his therapist. There was also no documentation of the recipient engaging in self-injurious behavior, therefore the OIG determined the allegation to be unsubstantiated.

The second OIG report that was reviewed by the HRA alleged that a STA called the recipient a "piece of shit" causing him to become upset and responding with profanities. The statement was allegedly made by the STA after he received water, however there were no witnesses in the area that heard the STA make the statement, but some witnesses did hear the recipient direct profanities at the STA. The video recording did show a "verbal exchange" between the recipient and the STA, however since there is no sound, the OIG could not decipher the context of the interaction. Therefore this allegation was also unsubstantiated by the OIG.

After inquiring on the number of complaints regarding this recipient, the OIG informed the HRA that there had been a total of 7 that the OIG determined as "non-reportable" requiring no investigation and 2 that had been investigated.

C. Case Notes: An 8/14/14 STA II Note documented that the recipient approached his former therapist in the hallway asking to speak with her. When she told him that his new therapist would speak with him when he returned, the recipient *"became hostile and cursing at [therapist name]."* The recipient was asked to return to his room to calm down and that he stayed back from the dining room and a tray was brought back for him.

A STA Note this same date documented that the recipient accused the STA of calling him a "piece of shit." When the STA denied saying it, the recipient became angry and yelled profanities at the STA and then requested a complaint form that was given to him.

III...Facility Policies:

A. Chester Policy RI .05.00.00.01 Code of Ethics states *"It is expected that all Chester Mental Health Center employees will serve as ethical role models for each other and for patients being served. Every employee, at every level of the organization, must continually evaluate the potential outcomes of the decisions he/she makes since action or inaction may affect the well-being of others. The employee must accept responsibility for any consequence resulting from his/her behavior."*

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

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

B. Chester Policy EC .04.09.00.08 Code of Conduct states *"at Chester Mental Health Center (CMHC) we strive to promote the welfare of those with whom we have contact and to prevent mental or physical harm. All patients, employees and visitors shall be treated with dignity, respect and courtesy…Chester Mental Health Center has zero tolerance for workplace violence and intimidating and disruptive behaviors. In accordance with AD .01.02.03.040 Rules of Employee Conduct and AD .01.02.03.170 Reporting Misconduct,"* under the section entitled unacceptable employee conduct it lists some **"zero tolerance" behaviors** as *"Harassment (verbal or physical conduct that denigrates or shows hostility or aversion toward an individual) - this includes: epithets, slurs, teasing, ridicule, making someone the brunt of pranks or practical jokes, negative stereotyping, threatening, intimidating, bullying, or hostile acts, racial jokes, stalking, malicious or mischievous gossip, written or graphic material showing hostility or aversion toward a group or individual. Improper Language - this includes vulgar, profane or loud/disruptive language. Threats- this includes direct, indirect and/or conditional threats of bodily harm… Physical aggression- this includes aggression toward patients, visitors, other staff and property. Being under the influence of illicit drugs or impaired by alcohol… Excluding or isolating individuals. Undermining performance, reputation or professionalism of others by deliberately withholding information, resources or authorization or supplying incorrect information…"* This policy continues to say that all DHS employees are required to expose without fear or favor, illegal or unethical conduct of others and states that *"All DHS employees who are victims of, witnesses of, or who become aware of any incident/behavior that undermines a culture of safety and the facility Code of Conduct policy,* ***must report it immediately to his/ her immediate supervisor and write an incident report*** *- CMHC-207 - concerning the incident."*

According to this policy, the supervisor is required to report any incidents to the hospital administrator and retain a copy in the employee's supervisory file and will respond by "taking necessary steps" to prevent further breaches in the Code of Conduct. The administrator is required by this policy to *"ensure that all reported incidents of Code of conduct violations are taken serious and addressed…ensure that disciplinary action is taken for any employee who intentionally violates his or her responsibility to report misconduct; intentionally makes a false report alleging misconduct; fails to cooperate with DHS OIG…"*

C. DHS Policy 01.02.03.040 Rules of Employee Conduct states *"Any employee who fails to comply with these rules will be subject to discipline up to and including discharge."* The listed rules include the following: not participating in or condoning fraud, dishonesty or misrepresentation in the performance of duties; providing full cooperation with OIG or any official investigative entity; not using vulgar, profane or loud/disruptive language in the workplace; an employee's conduct while off-duty may subject the employee to discipline up to and including discharge; an employee shall not make direct or indirect threat of bodily harm to another employee, client, recipient, student or any other person covered by the services of the department; an employee shall not demonstrate inappropriate behavior and/or discourteous treatment of the public, co-workers, clients and/or applicants. This policy also states that any violation of these provisions should be immediately reported by the observing employee to his/her immediate supervisor.

D. CMHC Policy RI .03.05.03.01 Patient or Guardian Access to Clinical Records states that *"Any patient who wishes to read his record will be allowed to do so."* The process is outlined as follows:

"I. A patient may make a request orally or in writing to read his clinical record. The request is to be directed to the coordinating therapist or other professional staff person.

II. The professional staff shall make the record available to the patient and shall arrange an area where the patient may read the record.

III. A professional staff shall be available to clarify, interpret and answer any questions the patient may have.

IV. The patient/guardian may submit a written statement concerning any disputed or new information. This correspondence will be entered into and become a permanent part of the clinical record.

V. The coordinating therapist or other professional staff shall be responsible for documenting the process in the clinical record."

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…."* Adequate and humane care and services is defined as "*services reasonably calculated to result in a significant improvement of the condition of a recipient of services confined in an inpatient mental health facility so that he or she may be released or services reasonably calculated to prevent further decline in the clinical condition of a recipient of services so that he or she does not present an imminent danger to self or others*" (405 ILCS 5/1-101.2)."

The Mental Health and Developmental Disabilities Administrative Act (20 ILCS 1705/7) states that Department facilities are to *"…provide the highest possible quality of humane and rehabilitative care and treatment to all persons admitted or committed or transferred in accordance with law to the facilities, divisions, programs, and services under the jurisdiction of the Department…."*

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-112) states *"Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect."* Section 5/1-101.1 defines abuse as *"any physical injury, sexual abuse, or mental injury inflicted on a recipient of services other than by accidental means." Section 5/1-117.1 defines neglect as "…the failure to provide adequate medical or personal care or maintenance to a recipient of services, which failure results in physical or mental injury to a recipient or in the deterioration of a recipient's physical or mental condition."*

The Administrative Code (59 IL ADC 50.60) states *"… After determining the finding in all cases, the Inspector General shall notify the complainant, the individual who was allegedly abused, neglected or financially exploited or his or her legal guardian (if applicable), and the person alleged to have committed the offense. The notice shall identify the outcome of the investigation and include a statement of the right to request clarification or reconsideration of the finding. In substantiated cases, the Inspector General shall provide the perpetrator with a redacted copy of the investigative report…"*

The Code of Criminal Procedure (725 ILCS 5/104-17) requires that *"…Within 30 days of entry of an order to undergo treatment, the person supervising the defendant's treatment shall file with the court, the State, and the defense a report assessing the facility's or program's capacity to provide appropriate treatment for the defendant and indicating his opinion as to the probability of the defendant's attaining fitness within a period of time from the date of the finding of unfitness. For a defendant charged with a felony, the period of time shall be one year. For a defendant charged with a misdemeanor, the period of time shall be no longer than the sentence if convicted of the most serious offense. If the report indicates that there is a substantial probability that the defendant will attain fitness within the time period, the treatment supervisor shall also file a treatment plan which shall include: (1) A diagnosis of the defendant's disability; (2) A description of treatment goals with respect to rendering the defendant fit, a specification of the proposed treatment modalities, and an estimated timetable for attainment of the goals; (3) An identification of the person in charge of supervising the defendant's treatment."*

The Code of Criminal Procedure (725 ILCS 5/104-18) also requires that progress reports be filed with the Court and states *"The treatment supervisor shall submit a written progress report to the court, the State, and the defense:*
(1) At least 7 days prior to the date for any hearing on the issue of the defendant's fitness;
(2) Whenever he believes that the defendant has attained fitness;
(3) Whenever he believes that there is not a substantial probability that the defendant will attain fitness, with treatment, within the time period set in subsection (e) of Section 104-17 of this Code from the date of the original finding of unfitness

The progress report shall contain:
(1) The clinical findings of the treatment supervisor and the facts upon which the findings are based;
(2) The opinion of the treatment supervisor as to whether the defendant has attained fitness or as to whether the defendant is making progress, under treatment, toward attaining fitness within the time period set in subsection (e) of Section 104-17 of this Code from the date of the original finding of unfitness;
(3) If the defendant is receiving medication, information from the prescribing physician indicating the type, the dosage and the effect of the medication on the defendant's appearance, actions and demeanor…"

Conclusion

Allegation 1. A recipient did not receive treatment to attain fitness and false reports were filed with the Court.

The recipient stated that his TPR had indicated that classes to attain fitness had begun in June; however, he had not been offered any classes and had not attended any. However, the HRA found documentation that he attended a fitness class on 6/11/14. He also expressed concern because reports to the court had indicated that he was non-compliant with treatment, but he contended that there was no treatment to be non-compliant with other than refusing medications, which he has a right to do. The recipient had also expressed an interest in receiving substance abuse treatment while at Chester Mental Health, but stated that his requests were not responded to.

The treatment plan noted a "problem" of substance abuse and listed the treatment intervention as MISA [mentally ill substance abuse] Group conducted by clinical staff on the unit designed to: educate the patient in the harmful impact of substance abuse; and to develop healthier decision making skills which do not include abusing alcohol. There were case notes to indicate that therapy sessions were held in which one of the topics discussed was substance abuse. The HRA also found documentation showing that in addition to therapy sessions, the recipient participated in recovery group.

The treatment plan also listed a "problem" of being unfit to stand trial and noted the treatment intervention as "attend competency to stand trial group three days per week." However, the recipient had passed the fitness questionnaire with 100% and there was documentation showing that when he attended UST class, he attempted to "control the group…answering all the questions and became upset when asked to allow others to respond…" The recipient was clearly able to voice understanding of the court proceedings and charges against him.

The class attendance record showed that the recipient attended the majority of classes offered including recovery group. The HRA found no documentation that reports to the Court referred to the recipient as being non-compliant with treatment and the recipient has since been transferred from the facility indicating that all Court requirements for treatment had been met. Therefore, the allegation is **unsubstantiated.**

Allegation 2. There was an inadequate OIG investigative process followed regarding a mental abuse allegation.

The recipient stated that his Therapist/Unit Director as well as a STA on the unit had both made statements to him that were ~~hurtful, and~~ made him want to hurt himself; he stated that he had filed several other complaints regarding staff mistreatment and not having access to his records but no one had come to interview him about those allegations.

The HRA reviewed a Human Rights Complaint response regarding records access, which had been addressed. The recipient was able to eventually review his chart because there were handwritten notes in his chart documenting the recipient's disagreements with some things noted in his chart. The HRA also reviewed the complaints filed with the Human Rights Committee regarding alleged verbal/mental abuse from both the Therapist/Unit Director as well as a STA on the unit. Additionally, the HRA found the OIG investigative reports of the two incidents proving that the allegations were addressed by the internal Human Rights Committee and forwarded to the OIG for further investigation and were investigated by the OIG as well. The HRA was also informed by the OIG that at least 7 other complaints were filed with the OIG but were determined to be "non-reportable" by OIG standards. Therefore, the HRA found that Chester Mental Health Center addressed the complaints and forwarded them to external agencies when necessary and it was the external OIG who decided not to investigate all complaints. Therefore, the allegation is **unsubstantiated**. The following **suggestions** are offered:

1. The fact that a Human Rights Committee complaint had to be filed before the recipient was allowed access to his records indicates that the recipient did face some difficulty in obtaining access. The HRA suggests that administration review the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4) regarding recipient access to records and their policy RI .03.05.03.01 with unit staff reminding them that patients have a right to review their charts and the procedures to be followed when a request is received.

2. The recipient's complaints regarding statements allegedly made to him by the therapist and STA were consistent to both the OIG and the HRA. However, since there were no witnesses to corroborate that the statements were made, the allegation could not be substantiated. However, the HRA was still concerned that the statements allegedly made to the recipient were repeated verbatim to the HRA when questioned at different times and was also the same statement verbatim made to the OIG. Therefore, the HRA suggests that policies regarding staff code of conduct be reviewed with staff to ensure that patients are being provided the highest possible quality of humane and rehabilitative care and treatment while at the facility as required by the Mental Health Code.