FOR IMMEDIATE RELEASE

North Suburban Regional Human Rights Authority
Report of Findings
HRA #16-100-9003

Elgin Mental Health Center

Introduction

The North Suburban Regional Human Rights Authority (HRA) opened this investigation regarding Elgin Mental Health Center (hereafter referred to as Center), Forensic Treatment Program after receiving a complaint of alleged rights violations. The complaint accepted for investigation was that patient rights are being violated because the unit environment is not safe. It was stated that a patient on this unit is violent both physically and verbally. It was stated that the facility is unable to provide the level of care required for this patient. The rights of patients receiving services at the Center are protected by the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5).

Patients receiving services at EMHC's Forensic Treatment Program have been remanded by Illinois County Courts to the Illinois Department of Human Services (DHS) under statutes finding them Unfit to Stand Trial (UST) and Not Guilty by Reason of Insanity (NGRI). Placement evaluations determine the most appropriate inpatient or outpatient setting for forensic treatment based on a number of factors including age, gender, mental health diagnosis, and security need. Unless a person is specifically ordered to receive services in an outpatient setting, court ordered referrals under state forensic statutes call for placement in a secure inpatient setting. The Forensic Treatment Program has 344 beds.

Methodology

In August 2015, the HRA requested masked (identifiable data removed) clinical progress note and physician order documents for all female patients transferred to the unit during a specific period. Clinical records were received in October 2015 however they did not meet the criteria requested so an additional request was made. The additional charts were received in March 2016. The site visit was conducted in May 2016 at which time the allegation was discussed with the unit's Psychiatrist, the unit's Nursing Manager and the program's Director.

Findings

The anonymous complaint reported that a patient residing on the unit attacks both peers and staff members and has destroyed property. The patient has been monitored by both one-to-one staff and two-to-one staff and the unit has made environmental modifications to no avail.

After reviewing the records requested, the HRA focused on one chart. This chart showed that the consumer was physically aggressive to both staff and others patients at least one to two times a week. Examples of the aggression included: throwing tables/chairs, elopement attempt, threatened to beat up a peer, pulled peers hair, hit peer with food tray, slapped staff member in the face, pulled staff member's hair, dug fingernails into staff, hit peer with plastic cup. Interventions included: frequent observations, line of sight, one-to-one/ two-to-one staff monitoring, private room, elopement precautions, emergency medication, restraints, and loss of privileges.

At the site visit it was stated that the unit will, at times, feel unsafe. It was stated that this, unfortunately is the nature of the beast. It was expressed that staff members are continuously looking into ways to provide a more stable environment, acknowledging that one unstable patient is stressful for the other patients and even staff members. Some methods have included: transferring a patient(s) to another unit, providing an area in the unit for aggressive patients, and eating utensils and supplies have been modified over the years (to prevent them from being used as a weapon). When asked about therapies, it was stated that the social workers provide the therapies to address anger management with the patient. It was offered that lately the hospital in general is seeing a more aggressive population because the pharmacy department will not approve some medication combinations and the courts are reluctant to force medication. It was also explained that some patients simply like to fight to show other patients and even staff members that they cannot be intimidated. The Psychiatrist stated that there is no medication to effectively treat this behavior. It was also discussed that a male patient showing continuous aggression might be transferred to a maximum secured facility; there is no such option for females.

In one of the charts reviewed, it was noted that that the Social Worker wrote that he/she and the patient had been working on Aggression Replacement Training, Methods of Anger Management, coping skills and, CBT/schemas (cognitive behavioral therapy- a treatment approach to help patients to address and modify patterns or themes, also known as "schemas" or "lifetraps.")

Conclusion

The Mental Health Code calls for adequate and humane care pursuant to an individual service plan. (405 ILCS 5/2-102a). The Code also mandates 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).

It was alleged that patient rights are being violated because the unit environment is not safe as a result of the facility being unable to provide the level of care required for aggressive patients. The problem was described to the HRA during the site visit as being less one of patients incurring severe injury, but more one of the psychological drama of not feeling safe in the environment. The Center's staff has been working on the issue for several years and across several units. They have been creative and persistent in attempting to solve the problem. Attempted solutions work for a while, but the problem then appears again, either on the same unit or on a different unit.

As stated, the interventions that were enacted in this case when the patient became out-of-control included frequent observations, line-of-sight, one-to-one/two-to-one monitoring, a private room, elopement precautions, emergency medication, restraints and loss of privileges. Because of the nature of the facility, the patient population and budgetary constraints, the HRA believes the difficulties in providing a completely safe environment for all patients will be ongoing. We encourage the Center to continue in their attempts to apply methods that may make for a physically and psychologically safer environment.

RESPONSE

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

Illinois Department of Human Services

Bruce Rauner, *Governor*

James T. Dimas, *Secretary*

Division of Mental Health – Region 2
Elgin Mental Health Center

RECOVERY IS OUR VISION
Recovery is a Personal Journey of Hope, Healing, Growth, Choice, and Change

July 19, 2016

Ms. Patricia Getchell- Chairperson
North Suburban Regional Human Rights Authority
9511 Harrison Street, W-300
Des Plaines, IL 60016-1565

Re: HRA #16-100-9003

Dear Ms. Getchell:

Thank you for your most thorough and thoughtful review of this concern. We agree wholeheartedly with your assessment. The safety of our patients and staff are our top priority. We have excellent staff who works every day to promote safety in a therapeutic environment with a very challenging Forensic population.

As noted in your report, staff utilize a wide variety of treatment interventions and are always striving for a better outcome. We also continually review key safety data to ensure timely follow up on unit issues.

Please feel free to include our response with any public release of your Report of Findings.

Sincerely,

Meredith Kiss, MA
Hospital Administrator

MK/JP/aw