FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
16-110-9006
Chester Mental Health Center

The Egyptian Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegation concerning Chester Mental Health Center:

1. **A recipient isn't being served in the least restrictive environment.**
2. **A recipient is receiving inadequate treatment by not seeing his therapist frequently enough.**

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5 et al), 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, reviewed the recipient's record, with consent, and examined pertinent policies and mandates.

I. Interviews:

A. Recipient: The Recipient informed the HRA that he had been at Chester since November, 2013. He explained that he was admitted to Chester because the physician at the previous state operated facility where he resided took him off his medications that he had been on for several months. When his medication was removed, he aggressed toward a physician and had 2-3 weeks of "bad behavior" following this medication removal. He is now a voluntary patient and has not been recommended for discharge or transfer yet. He stated that staff are "forcing him to be at Chester against his will". He expressed an understanding of his right to request a discharge in writing, but he stated that he has not done that because he has been told that staff will just petition the court for an involuntary admission and he is afraid if that happened he would never "get out" [of Chester]. Every 6 months he is approached by staff to sign a voluntary admission form for another 6 month admission. He stated that even when he shows 2-4 months of good behavior the treatment team still refuses to discuss transfer recommendations. He stated that the treatment team requires 6 months of "good behavior" from him before transfer will be considered, however other recipients are being transferred with 3 or less months of "good

behavior." He contends that he does not start fights even when he was "in a fight" he was not the instigator and it was just for "payback" when a peer had hit him first. One example he gave was being struck on the back of his head by a peer when he was getting a drink of water and when he retaliated his transfer that was scheduled for December, 2014 was "screwed." He expressed feelings of frustration of having peers "attacking him" and then "getting in trouble" if he reacts in self-defense and does not let them "beat on him." He stated that he has anxiety and high blood pressure from being at Chester. At the time of our interview, the recipient stated that he had 6-10 months of "good behavior" and had been on green level for over a month.

Another concern expressed by the recipient was that he only meets with his therapist approximately once every 2 months. He stated that his therapist is not talking to the Hospital Administrator on his behalf about a transfer to a less secure facility. He also had some concerns with his medication and when he brought those to the psychiatrist, he was told that if he asks to increase them again the psychiatrist will decrease them and take him off of all his medications and allegedly stated that the recipient needed to "quit bothering him." He stated that he had "put it in writing" a request for a different psychiatrist but was told that there is nothing he can do to see another psychiatrist. The recipient stated he was currently taking Paxil, Risperidone, Valium, Lithium, Remeron and Buspar and felt "depressed and down." He described an incident of when he requested his anxiety medication which is prescribed as a PRN [as needed] medication and his request was denied by the nurse.

B. Chairperson: The HRA consulted with the Human Rights Chairperson at Chester regarding these incidents and asked for a review of the situations to see if a complaint had been filed internally. The HRA was informed that a formal internal complaint had not been made, but the response after speaking to the Unit Director and treating psychiatrist, was that it was confirmed the nurse did not give the recipient his PRN when requested and instead tried to "educate him on actually using the medication for anxiety versus using it just because it is prescribed to him every 4 hours. The nurse's observation was that he did not appear anxious at the time that he asked for it." When the treatment team was made aware of this incident, it was not well received and this nurse was "talked to" about the issue. Regarding the psychiatrist's alleged statements, the chairperson, after consulting with the psychiatrist, also informed the HRA that the recipient is very obsessive compulsive especially regarding his medications. The psychiatrist believed that he was now on the best regiment and it is approached with him as a "step by step process" due to his obsessive compulsive nature. The psychiatrist also was of the opinion that he has to be firm and limit setting with the recipient in how his medication issues are approached with the recipient. The psychiatrist stated that he and the recipient have a good understanding of each other and are working together again which they were hoping would be a positive thing for the recipient.

II. Clinical Chart Review:

A. Treatment Plan Reviews (TPRs): The 6/23/15 TPR states that the recipient was admitted to Chester from another less secure state operated facility due to "repeated episodes of agitation, aggression, and sexually inappropriate behaviors." It was also documented that he had at least three attempts of self-harm while at the previous facility and has a long history of self-harm. The discussion section of the TPR stated that he attended his meeting and signed in agreement with

his treatment plan. It was noted that he initially presented as lethargic, passive and had to be reminded several times to not lay his head on the table. He presented with *"depressed mood and subdued motor activity."* During the process of explaining clinical approaches and the reasons for each therapeutic intervention, he *"gained vivacity and increased animation…began to display obsessive thought constructs and evidential presentations of impaired judgment and insight. He attempted to engage the psychiatrist in a discussion centering on his delusions regarding various types of medication the patient believes will help him. The patient was redirected from this circular and compulsive line of reasoning and refocused on his current short term treatment goals…was educated specifically on how many of his problematic behaviors stem from a non-psychotic based foundation, but rather his personal inability to attempt to control impulses and conscious personality traits that elicit negative behavior patterns."* It was also documented that the recipient *"has made minor constructive and positive modifications to his documented behavioral presentations this reporting period. In part due to the intense daily therapy and observational hegemony that has been required to thwart his intensively aggressive and violent behavioral patterns, he has begun to reestablish more substantial constancy of stability. As such, the treatment team has begun to allow the slow progression of increasing his assigned treatment protocol benefits in an effort to promote self-sufficiency and self-control...nevertheless, when confronted on core physiognomies he still presents as one with propensity toward extreme aggression and violence toward self and others. While direct, observable and measurable negative behaviors have been addressed and potential for harm diminished as a result [name] remains highly refractory to treatment."* His Diagnosis is listed as Axis I Schizoaffective Disorder, Bipolar Type; OCT Axis II Cluster B Personality Traits (Antisocial & Borderline and obsessive-compulsive traits); Axis III history of HBP (high blood pressure), GERD (gastro-esophageal reflux disease), history of RBBB (right bundle branch block), history of Herpes Simplex Infection; Axis IV Chronic Mental Illness, history of Psychiatric Hospitalizations; and Axis V: Current GAF 45 (global assessment of functioning). The treatment/habilitation goals list the following problems to be addressed in his TPR: 1) Psychiatric Symptoms-obsessive thoughts and ruminations, depressive symptoms and delusional ideation. 2) Physical Aggression-verbal and physical aggression most recently against peers at staff at (previous placement). 3) History of self-harm – history of head banging, attempting to hang himself, drinking bleach and jumping off a bridge. 4) inappropriate sexual behavior – inappropriate touching of staff at (previous placement), exposing himself, masturbating, lude sexual comments to staff. According to the plan, the therapist was to meet with him twice per week. During this reporting period it was noted that the recipient *"had multiple PRNs and is currently on frequent observation [psychiatrist]…Patient is compliant with taking medication [RN]…has multiple instances of extremely violent and aggressive behaviors towards peers and staff. Often the themes of his threats and verbal outbursts center on death and rape of others. This behavior has advanced and became increasingly problematic over the course of his last reporting period. He has made minor positive behavioral progress this reporting period [Therapist]…the patient's behavior has been the same this period. He has been in FLRs [full leather restraints] multiple times for his behavior [Security Therapy Aide]…continues to display aggressive behavior this reporting period [Activity Therapist]."* The Extent to which benefitting from treatment section documented that the recipient *"is refractory to treatment. He continues to struggle with anxiety, agitation, and an inability to control his violent and aggressive verbal and physical outbursts. He has made multiple threats to kill or harm others including his family members, staff members and peers. He has had multiple verbal and physical altercations with*

staff and peers. [name] has required the use of restraints on multiple occasions (at times twice within the same day). [name] has attempted to escape the facility causing property damage. [name] behaviors have caused injury to self and to others. [name] has brief and short-lived instances of clarity and appropriateness when speaking with his therapist or when he wants to participate in special activities. Evidence of this type of behavior tends to yield itself to the determination a sufficient amount of his negative actions are elective rather than symptomatic of his mental illness." The Criteria for Separation section lists the following specific criteria:

> "-exhibit he is able to implement what he has obtained in his course of treatment by having no documented instances of behaviors that require the implementation of his chosen emergency interventions (medication, seclusion or restraint) within a twelve-month period from his last documented instance (April, 2015)
> -Have no documented instances of severe threats to staff or patient and/or any instance of physical aggression for a period of twelve calendar months (Currently April, 2015)
> -consistently demonstrate appropriate behaviors evidenced by receiving no more than an aggregate total of 5 BDR's relating to aggressive and/or threatening behavior in any 3 month period
> -demonstrate a willingness to participate in his assigned course of treatment by attending 100% of his assigned 1x month psychiatrist sessions and TPRs attending 75% of his assigned programming and remaining medication compliant
> -suitably meet and participate with his assigned therapist at least (1x week) to address treatment plan goals, objectives, and monitor progress."

The 7/20/15 TPR stated that the recipient attended and signed that he was in agreement with his treatment plan. The discussion section documented that he was calm, cooperative and passive presenting with depressed mood and subdued motor activity. He was described as being *"hyper-focused on discussing medications and when he could be released."* It was noted that overall his behavior *"substantially improved"* however he was still observed daily exhibiting signs of impaired judgment and extremely distorted thought processes and behaviors. It was documented that *"during individual therapy sessions [recipient] was educated specifically on how many of his problematic behaviors stem from a non-psychotic based foundation, but rather his personal inability to attempt to control impulses and conscious personality traits that elicit negative behavior patterns."* It did not document how frequently his individual therapy sessions were being held. It was also noted that during the close of the TPR meeting, he asked about his separation criteria and as that was being explained and reviewed with him he *"flew into a verbal rage, ripping up his paperwork and generally cursing the world for being unfair and blaming the black patients and staff on the wing for his issues. Simultaneously, he was escorted from his meeting for the inappropriate behavior."* In the treatment and habilitation goals section the treatment to help the recipient *"exhibit social function which is free of physical aggression and sexually inappropriate behavior"* is listed as *"coordinating therapist will meet with [name] twice per week to conduct replacement behavior training (to replace aggressive and sexually inappropriate behaviors with adaptive behaviors). The therapist will go over behaviors which are expected and give corrective feedback and encouragement."* It was documented that the recipient was medication compliant but according to the therapist, he had *"multiple instances of extremely violent and aggressive behaviors towards peers and staff…this behavior has advanced and became increasingly problematic over the course of his last few months. He has made minor positive behavioral progress this reporting period."* The Security Therapy Aide (STA)

documented that the recipient *"Walks around on edge most of the time. He continues to get upset and complains to staff about his treatment"* The activity therapist stated that he *attended 5 treatment malls, 11 gym sessions and 2 game rooms"* The extent to which benefitting from treatment section stated that the recipient hade *"displayed quite an improvement with the provision of ambulatory poesies to help control his assaultive behavior. He had subsequently been put on 2:1 then 1:1 then frequent [observation]as his aggressive, self-injurious as well as other inappropriate behaviors abated. He attended his TPR and the treatment team actually started to compliment him for his improved behavior. He curiously brushed this off and started questioning and demanding that his behavior management plan be discontinued indicating among other things, that it was unfair and that he should be able to strike back and defend himself if other peers attack him. He was advised about the reason why his behavior management had to be reiterated and implemented but to no avail. He became more agitated and escalated and shouted and yelled angrily and walked out of the TPR."* The criteria for separation section remained verbatim to the 6/23/15 TPR.

The 8/21/15 TPR documented in the discussion section that the recipient *"has shown minor behavioral improvements the last three weeks of reporting period...was exhibiting continual and increasing levels of violence toward self and others throughout the beginning of the reporting period. Additionally, he had multiple documented occurrences of bizarre, heinous, and non-compliant behavior throughout the reporting period. He had an attempted elopement whereby he punched through the ceiling of his room in an attempt to escape the facility. In response, a behavior modification plan was developed and implemented in an attempt to thwart such behavior. Specifically, the application of ambulatory restraints was an approved intervention…as such, he required multiple applications of ambulatory restraints throughout the reporting period which had a positive effect on his behavior. Additionally, following a medication review, multiple alterations to his medication array were implementing also seemingly having some positive impact. During the last three weeks of this reporting period his frequent observation was DC'd [discontinued] in accordance with his behavior plan and since he has only required the use of the quiet room or PRN's as evidence of his minor behavioral improvements."* In the extent to which benefitting from treatment section it was noted that the recipient is *"refractory to treatment…has attempted to escape the facility causing property damage. [Name] behaviors have caused injury to self and to others...has brief and short-lived instances of clarity and appropriateness when speaking with his therapist or when he wants to participate in special activities. Evidence of this type of behavior tends to yield itself to the determination a sufficient amount of his negative actions are elective rather than symptomatic of his mental illness."* This TPR also stated the therapist should meet with the recipient twice per week and the psychiatrist should meet with him once per month.

The 3/3/16 TPR was on a new form that the facility is transitioning to and it was noted that the recipient had a new coordinating therapist this reporting period. It stated in the extent to which benefitting from treatment box that the recipient *"attended his TPR and had multiple complaints. His thoughts are racing. He says that he has OCD as he feels his nose is not right. He says he does not feel relaxed. He says he is moody. He claims that he did well on Clozaril and Depakote. He had some issues with Clozaril and he talked about Thorazine." It was marked that he had received a restriction of rights form since his last review.* The current medication and intended outcome section simply stated *"Psychotropic Medication to decrease symptoms of*

mental illness." The Response to Medication section stated that the recipient "*continues to present a lot of somatic symptoms as well as present a variety of vague as well as seemingly exaggerated psychiatric symptoms. He continues to seek medications as the main vehicle to alleviate his symptoms and is resistive to efforts to get him to embrace psychotherapy as a necessary ingredient in treatment along with its enduring benefits. This has caused ongoing and daunting difficulties in effectively and appropriately sorting out his medication regimen."* The Criteria for Separation section remained unchanged. The barriers to transfer box noted that he was not yet clinically stable due to being *a "danger to self, danger to others, psychosis and treatment refractory."*

B. Progress Notes: Progress notes dated 5/19/15 through 8/30/15 were reviewed. On 5/20/15 a nursing note documented the recipient attempting to attack a peer for stealing his candy bar. The recipient was placed in a physical hold but continued to struggle and fight with staff therefore he was placed in restraints and released approximately 2 hours later. There are documentations after this noting the recipient complained of feeling anxious, PRN medication was given but it was noted that either the medication was not effective or was minimally effective. On 5/22/15 a nursing note documented that the recipient was fighting with a peer and was placed in a physical hold but continued fighting so was again placed in restraints. Two hours later he was released. There was an injury report completed when the recipient was hit in the head by the peer during the altercation and sustained minor injuries, superficial abrasion and mild swelling and redness. Later that night at 10:55 p.m., the recipient was found destroying state property in his room by tearing sections of his ceiling out. He was offered the "quiet room" to calm down but became verbally aggressive so the physician was notified and gave an order for PRN of Chlorpromazine and Diphenhydramine for severe agitation and he was moved to the security room due to destruction of property in his room. On 5/23/15 at 12:15 a.m., the recipient was complaining of feeling very anxious Alprazolam was offered and accepted. At 12:20 a.m. the patient was noted to be punching the walls with his fist and banging his head on the wall and verbally stating that he wanted to kill himself. He was placed in a physical hold and escorted to the restraint room and placed in 4 point restraints for the safety of himself and others. At 12:40 a.m. he was biting the back of his hand while it was in handcuffs so a chest poesy was applied to protect him from further SIB (self-injurious behavior). At 4:45 a.m. he was given Haloperidol and Lorazepam for increased agitation. At 5:30 a.m. the chest poesy was removed and at 6:15 a.m. a new order was given for the recipient to go on 2:1 observation for SIB and aggression when he is released from the restraints. At 10:45 a.m. the recipient met release criteria for release into 4 point walking poesies (ambulatory restraints) per the Medical Director and Psychiatrist. He attempted to strike out again while in ambulatory restraints at 3:15 pm. On 5/24/15 at 10:30 a.m. the recipient was seen by a Psychiatrist and was noted to still have violent and compulsive thoughts to hurt self or others; a 4 point ambulatory restraint order was renewed per the treatment team. On 5/25/15 he was noted to be making sexually inappropriate statements to female staff and making verbal threats to others. On 5/26/15 at 3:05 p.m. while in ambulatory restraints, the recipient began banging his head on the metal frame of the bed and had to be placed in a humane wrap and escorted to the restraint safety bed and placed in 5 point restraints. He was stepped down to 4 point ambulatory restraints at 7:00 p.m. The recipient's 4 point ambulatory restraint order was continually renewed until 5/27/15 at 11:00 a.m. when he was released from ambulatory restraints to 2:1 observation for aggression and SIB. The treatment team met and continued the 2:1 observation on 5/28/15 and 5/29/15. A STA (security therapy aide) note on 5/29/15 stated that

the recipient "is demanding to see or speak to various individuals and attempting to manipulate staff assigned to observe him. A therapist note at 9:30 a.m. documented contact from the recipient requesting to start sessions again but was reminded that this therapist was no longer his coordinating therapist. At 1:15 p.m. a nursing note documented that the recipient's mother had called the facility upset because the recipient had stated that staff beat him up and broke his nose and ribs, the OIG (Office of Inspector General) liaison was notified and an injury report was completed documenting that no obvious injuries were noted. The recipient refused to have an examination. The mother was informed of same and was "understanding and apologetic for her son's behavior." The recipient's 2:1 observation was continued until 6/3/15 when 1:1 observation began.

On 6/4/15 a therapist note documented meeting with the recipient on his unit and discussing a behavior incentive that he had met to receive one hour of (illegible) near bed time for therapeutic and relaxation purposes. The recipient was instructed about scheduling and given expectations for appropriate behavior during the activity. 1:1 observation was stepped down to frequent observation on 6/5/15. On 6/7/15 at 9:00 p.m. the recipient again attempted to attack a peer and 4/5 point restraints were required. While in restraints, the recipient also required protective mitts and medications due to biting staff, scratching at his sides and biting his own shoulder. On 6/8/15 at 1:15 a.m. while still in restraints, the recipient made verbal threats against a specific staff person stating he hated her and was going to rape her. He also threatened to punch someone in the throat if/when he was released from restraints so he could go to a high security prison instead. On 6/8/15 at 8:30 p.m. the recipient was stepped down to ambulatory restraints with 2:1 observation. The recipient was assessed at least daily by the psychiatrist and his ambulatory restraints renewed until 6/10/15 at 10:40 p.m. when he was released into the high security room for hours of sleep. On 6/11/15 at 11:00 a.m. the ambulatory restraint order was renewed, but stepped down to 1:1 observation while in restraints. The psychiatrist met with the recipient and treatment team and a new order for 2:1 observation for SIB/aggression was done per his behavior plan. A psychiatrist note on 6/15/15 documented the patient being seen to assess the need for continued 2:1 observation. And it was decided he could step down to 1:1 observation again. This level continued until 6/18/15 when he was stepped down to frequent observation. He remained on frequent observation through 6/30/15 when the psychiatrist discontinued it. The psychiatrist routinely met with the recipient during this time to renew the frequent observation protocol. There were several other case notes through 8/30/15 documenting frequent agitation and requests for PRN medication by the recipient for anxiety. There were a couple of psychiatrist notes documenting medication changes but no other case notes from the recipient's therapist documenting therapy sessions.

C. Miscellaneous: The HRA reviewed a Notice of Restriction of Rights for 7/1/15-8/1/15 which restricted his personal property due to being *"extremely violent toward staff and peers. History of threatening to stab staff with toothbrush and other items."* The HRA also reviewed a Reaffirmation of Voluntary Status in a State-Operated Center dated 12/9/15 in which the recipient signed himself as a voluntary patient for 60 days. The form documented that he had been on voluntary status since 5/27/14.

III...Facility Policies:

A. RI.01.01.02.01 Patient Rights policy states *"A patient shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual treatment plan."*

B. CC.01.02.00.02 Transfer Recommendation of Behavior Management Patients policy ensures that *"All transfers of behavior management recipients from the Chester Mental Health Center are effected in accordance with the Mental Health and Developmental Disabilities Code which mandates that treatment occur in the least restrictive alternative appropriate to that recipient. The recipient's treatment team must evaluate on an ongoing basis the recipient's continuing need for a maximum security environment. At such time the treatment team determines the recipient is clinically suitable for transfer to a less secure facility…the psychiatrist is to prepare a transfer recommendation."* The remainder of the policy outlines the specific steps to be followed when transferring a patient to a less secure environment.

C. IM.03.01.01.03 Treatment Plan policy requires that the facility *"shall ensure that each individual is receiving active treatment to address problem areas which precipitated hospitalization. Treatment planning is an ongoing process in which problems, goals, objectives and interventions are identified and monitored.* ***The multi-disciplinary treatment planning process is to be documented*** *upon admission and* ***throughout a patient's stay via*** *assessments, treatment plan, treatment plan reviews,* ***progress notes*** *and other documentation.…*

Treatment Plan Participation and Treatment Oversight:

Each person attending the treatment plan review will sign in with signature and title on the Treatment Plan/Review Attendance Record (CMHC-811f). Additionally, ***the Treating Psychiatrist will be listed as the person responsible for ensuring prescribed treatment is appropriate and occurs as specified.*** *This will be validated by the Treating Psychiatrists initialing next to their name when plan is being submitted as a court report…It is the responsibility of all disciplines to participate in the development of a multidisciplinary treatment plan.* ***It is the responsibility of the primary therapist to serve as the coordinator of the treatment plan, ensuring the following****:*

A. Treatment plan meetings happen within all the required time frames.

B. All discipline input is gathered and utilized for treatment plan reviews.

C. The plan is comprehensive and individualized based upon the assessment of the individual's clinical needs, strengths and limitations and is written in behaviorally defined and measurable terms.

D. The treatment plan reflects current treatment.

E. The patient is given a daily schedule of assigned groups and activities based on the interventions assigned in the treatment plan.

F. A copy of the Treatment Plan/Review Attendance Record (CMHC-811f), for the treatment plan is placed in the record on the day the meeting.

G. All Comprehensive treatment plan documents are typed and filed in the chart within the required time frame.

H. If the patient has a guardian, the therapist will notify the guardian of all scheduled meetings and this will be documented in a progress note, and a copy of the treatment plan will be mailed to the guardian.

I. Individuals are encouraged to involve their family or support system to participate in treatment planning.

J. If a patient is transferred to another unit within the hospital, the treatment plan must be reviewed by the receiving treatment team and updated with current interventions, staff names, etc. within 72 hours of the transfer."

D. TX.01.02.00.03 Group Therapy policy states that *"Group therapy at Chester Mental Health Center will attempt to give individuals a safe and comfortable place where they can work out problems and emotional issues. Patients will gain insight into their own thoughts and behavior, and offer suggestions and support to others. In addition, patients who have a difficult time with interpersonal relationships can benefit from the social interactions that are a basic part of the group therapy experience…Enrollment will be limited to 6 to 8 people per group. The patient's need for group will be determined by the treatment team during treatment plan meetings…Types of Groups: Each unit will decide the type of groups that will be utilized based upon the clinical needs of patients. Some examples of groups that would be effective for patients at Chester Mental Health Center are as follows:*

1. *Anger Management*
2. *Medication Education/Compliance*
3. *Fitness to Stand Trial*
4. *Activities of Daily Living*
5. *Dialectical Behavior Therapy*
6. *Social Skills*
7. *Wellness Education*
8. *Leisure Education/Skills*
9. *Team Building*
10. *Cognitive Exercises*
11. *Stress Management*
12. *Life Skills*
13. *Self-Esteem*
14. *Problem Solving…*

Treatment Planning: The patient's assigned therapist will ensure the recommendations for treatment are added to the treatment plan…The therapist providing treatment will ensure the progress in treatment is available for the patient's treatment plan review meeting. Changes in treatment may be recommended by the therapist providing treatment or the patient's treatment team. The patient's assigned therapist will ensure the group facilitator is informed of recommended changes to treatment." Upon inquiry with the Human Rights Chairperson at Chester Mental Health, the HRA was informed that there is no specific policy for 1:1 counseling sessions between patient and therapist. They do occur with certain patients but there is no policy that gives specific requirements.

E. TX .07.00.00.01 Guidelines for the Treatment of Patients with Severe Maladaptive Behaviors Policy states that *"Chester Mental Health Center provides treatment for patients exhibiting severe maladaptive behaviors. Treatment will focus on the replacement of maladaptive behaviors with more socially acceptable behaviors. The treatment program will teach adaptive replacement behaviors as well as provide the environment to practice these skills. The level system helps establish guidelines for both patients and staff regarding the type of behavior that is required in order to engage in specific activities within the treatment program.*

This will establish an environment that fosters improved social functioning and positive outcomes for the performance of adaptive behaviors… D. Treatment prescribed in a patient's treatment plan addressing the goal of managing or extinguishing maladaptive behaviors and promoting adaptive replacement behaviors will be identified in the treatment plan as a 'Behavior Intervention Plan.' It will include the following:

1. *Definition of the target behavior*
2. *A hypothesis on the function of the behavior*
3. *identifying a goal and objectives for the patient to achieve, including the replacement of the behavior with a more adaptive one*
4. *Interventions should include the method of implementation, strategy, support, teaching methods, motivation and reward if used, frequency, and circumstances under which the plan will be implemented*
5. *A condition for discontinuation*
6. *All interventions attempted*
7. *Data collection in order to monitor response to treatment*

Progress towards objectives is reviewed at each review meeting with the patient, and information collected during the reporting period is shared to determine whether the plan will remain in effect, or requires revisions… H. Severe behavior management issues may be characterized by the following:

1. *Unwanted or maladaptive behaviors which result in serious injury of self or another person.*
2. *The patient's behaviors warrant placement in restraints with consideration being given to ambulatory restraints.*
3. *The patient's behaviors are impeding his ability to achieve goals established for treatment as indicated by repeated episodes of seclusion or restraint.*

When a patient's behavior meets one or more of the above criteria, a referral may be sent from the treatment team to the Clinical Director, or designee, who will review the case. *The Clinical Director or designee may then recommend a psychologist to evaluate the patient. The purpose of the evaluation is to determine those factors which underlie the onset and maintenance of the maladaptive behaviors and may include a number of assessment instruments/methods including functional behavior assessment.*

The functional behavior assessment will include an operational definition of each targeted behavior, factors that may influence the target behavior, factors related to the function of the target behavior, defining events and situations that predict occurrences of the target behavior, and a summary listing precipitating events/settings or triggers and the possible function of the target behavior. In the event that behavior problems persist following the implementation of a behavior plan based on functional assessment, a psychological evaluation will be completed. The unit director of the patient's assigned unit will ensure a referral is sent to the Clinical Director or designee, who will ensure the need for an evaluation is assigned for completion...Treatment A. The patient will be offered alternative ways to cope with situations that result in the unwanted or maladaptive behavior. These skills may be taught in individual or group therapies, rehabilitation classes or activity therapies. Interventions found to be successful will be documented in the treatment plan in order to ensure continuity of care within the

treatment milieu and after transfer or discharge from this hospital. Each part of the treatment program offers an environment where appropriate social behaviors (such as replacement behaviors) can be learned and monitored to determine utilization of skills learned by the patient…C. Interventions not considered appropriate for use in treatment are corporal punishment or aversive techniques; one that could physically hurt or is a psychological risk to the patient; fear-eliciting procedures; time-out, which is a confinement to any area without the ability to leave at will; denial of basic needs, such as nutritional diet, water, shelter, and essential, safe, and appropriate clothing; any treatment intervention implemented by another patient; restraint and seclusion, if used to modify behavior rather than inhibit an individual's imminent dangerous behavior toward himself or others; and a collective group outcome based upon a single patient's behavior."

The HRA was informed that Chester does not have a behavior management committee but the following is how these issues are treated and/or addressed:

The individual treatment teams are responsible for developing "behavior management plans." If there are behavior management issues that continue to be chronic then those are addressed in three ways:

1. Clinical Care Monitoring (CCM's) is recommended to the Medical Director by any of the Treatment Team members with a consultant who may be a Social Worker, psychologist, nurse, educator, activity therapist, or a physician. who is not a member of the treatment team.

2. Utilization Review is a routine process with the treatment teams and hospital leadership to ensure that the patients are receiving proper care and that any barriers to discharge/transfer are being addressed, which also includes review of behavior management plans.

3. Referral to Clinical Director or designee for review and recommendations. However, currently the facility does not have the position of Clinical Director filled and the HRA was informed that this process will be resumed when this position gets filled.

<u>Statutes</u>

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) states *"A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan…"*

The Code (405 ILCS 5/3-209) requires that *"Within three days of admission under this Chapter, a treatment plan shall be prepared for each recipient of service and entered into his or her record. The plan shall include an assessment of the recipient's treatment needs, a description of the services recommended for treatment, the goals of each type of element of service, an anticipated timetable for the accomplishment of the goals, and a designation of the qualified professional responsible for the implementation of the plan. The plan shall include a written assessment of whether or not the recipient is in need of psychotropic medications. The plan shall be reviewed and updated as the clinical condition warrants, but not less than every 30 days."*

The Code (405 ILCS 5/3-403) states *"A voluntary recipient shall be allowed to be discharged from the facility at the earliest appropriate time, not to exceed 5 days, excluding Saturdays, Sundays and holidays, after he gives any treatment staff person written notice of his desire to be discharged unless he either withdraws the notice in writing or unless within the 5 day period a petition and 2 certificates conforming to the requirements of paragraph (b) of Section 3-601 and Section 3-602 are filed with the court. Upon receipt of the petition, the court shall order a hearing to be held within 5 days, excluding Saturdays, Sundays and holidays, and to be conducted pursuant to Article IX of this Chapter.1 Hospitalization of the recipient may continue pending further order of the court"*

The Code (405 ILCS 5/3-902) provides that a Director can initiate a discharge. *"(a) The facility director may at any time discharge an informal, voluntary, or minor recipient who is clinically suitable for discharge. (b) The facility director shall discharge a recipient admitted upon court order under this Chapter or any prior statute where he is no longer subject to involuntary admission on an inpatient basis. If the facility director believes that continuing treatment is advisable for such recipient, he shall inform the recipient of his right to remain as an informal or voluntary recipient. If the facility director determines that the recipient is subject to involuntary admission on an outpatient basis, he or she shall petition the court for such a commitment pursuant to this Chapter."*

With regard to transfers between state-operated facilities, the Code (405 ILCS 5/3-908) states *"The facility director of any Department facility may transfer a recipient to another Department facility if he determines the transfer to be clinically advisable and consistent with the treatment needs of the recipient."*

The Code requires in (405 ILCS 5/4—309) that *"(a) Within 14 days of admission, the facility shall prepare a written habilitation plan consistent with the client's diagnosis and needs. The Department shall fully implement habilitation plans. Every reasonable effort shall be made to involve the client and his family in the preparation and implementation of the plans. (b) The habilitation plan shall describe the habilitation goals; a projected timetable for their attainment; the services to be provided; the role of the family in the implementation of the plan; and the name of the person responsible for supervising the habilitation plan. (c) The habilitation plan shall be reviewed regularly, but at least once every calendar month, by the person responsible for its supervision. They shall be modified when necessary. The client and the persons specified in Section 4-206 shall be informed regularly of the client's progress."*

Conclusion

The first allegation is that the recipient is not being served in the least restrictive environment. The chart review revealed several documented incidents of aggressive, threatening, self-injurious and other maladaptive behavior such as attacking peers, fighting staff, attempting to elope by tearing out pieces of the ceiling, hitting walls, banging his head on walls and biting himself. The behaviors were such that he required a behavior intervention plan (BIP) which included the provision of ambulatory restraints to help control his assaultive behavior as well as a step down process for when he is placed in restraints. Following a restraint episode, his plan required him to be placed on 2:1 supervision, then 1:1, then frequent observation. He required multiple applications of ambulatory restraints throughout the reporting period, which was noted to have had a positive effect on his behavior. Staff documented that he "displayed quite an improvement with the provision of ambulatory poesies." However, his response to this BIP was that it was unfair and that he should be able to strike back and defend himself if other peers attack him. In July it was noted that overall his behavior "substantially improved" however he was still observed daily "exhibiting signs of impaired judgment and extremely distorted thought processes and behaviors". He also requested and received daily PRN medication for anxiety. He also had an attempted elopement whereby he punched through the ceiling of his room in an attempt to escape the facility.

The Criteria for Separation included the recipient having no documented instances of behaviors that require medication, seclusion or restraint within a twelve-month period from his last documented instance (April, 2015); and, to have no documented instances of severe threats to staff or patients and/or any instances of physical aggression for a period of twelve calendar months (Currently April, 2015) and to consistently demonstrate appropriate behaviors evidenced by receiving no more than an aggregate total of 5 BDR's relating to aggressive and/or threatening behavior in any 3 month period. It was well documented that the recipient had several instances of aggressive and threatening behavior within a 3 month period. It was also documented that he required the use of restraints and his behavior also warranted the implementation of a BIP with a step down process to be followed. Therefore, due to the recipient not meeting the separation criteria, this allegation is **unsubstantiated**. The HRA offers the following suggestions:

1. The recipient was under the impression that if he had 6 months of "good behavior" that he could be transferred. However, his TPR clearly stated separation criteria which included 1 year of aggressive free behavior along with other requirements. The HRA was concerned that the recipient did not have a clear understanding of his separation requirements and suggests that the therapist and/or treatment team review the requirements with the recipient and explain them in a manner in which he can understand to ensure his awareness of what his goals are and how he can achieve those.

2. The treatment team as well as administration should review the separation criteria which requires the recipient to have no behaviors requiring emergency interventions and no instances of severe threats to staff or patients or physical aggression for a

period of 12 months and consider revising the separation criteria to reflect a more attainable goal.

The second allegation is that the recipient received inadequate treatment due to not seeing his therapist frequently enough. In addition to the above, the criteria for separation also included the recipient to have the ability to demonstrate a willingness to participate in his assigned course of treatment by attending 100% of his assigned 1x month psychiatrist sessions and TPRs; attending 75% of his assigned programming and remaining medication compliant; suitably meet and participate with his assigned therapist at least (1x week) to address treatment plan goals, objectives, and monitor progress. The recipients TPRs all stated that he should be meeting with his therapist twice per week. However, when the HRA reviewed the chart and case notes from 5/19/15-8/30/15, only one documented therapy session was found which occurred on 6/4/15. The June TPR stated that the recipient's improved behavior was due to "intense daily therapy" but there were no case notes documenting what this entailed or if it was therapy with his therapist or just daily routine with staff on the unit. The July TPR stated that the recipient was having "individual therapy sessions", but did not state how frequently they were occurring and there were no case notes documenting any therapy sessions. Therefore, due to lack of documentation showing that the twice per week therapy sessions, which are required in the treatment plan, were occurring this allegation is **substantiated**. The HRA **recommends** the following:

1. Psychiatrists and Coordinating Therapists should be retrained on Chester Policy *IM.03.01.01.03 Treatment Plan* to ensure that therapy sessions as required in each patient's individual treatment plan are occurring as specified and that Psychiatrists are providing the proper oversight to ensure that prescribed treatment is appropriate and is occurring as specified.

2. Coordinating Therapists should be retrained on proper documentation of individual therapy sessions per Chester policy IM.03.01.01.03 *Treatment Plan.*

3. The TPRs documented that the recipient was "refractory to treatment" however; the HRA found no referral for a CCM and no documentation from the Utilization Reviews for this recipient per the procedures in place. The HRA also did not find a Functional Behavioral Assessment in his chart as required by Chester policy *TX.07.00.00.01 Guidelines for the Treatment of Patients with Severe Maladaptive Behaviors*. Staff involved in the treatment meetings including Unit Directors should be retrained on this policy and its provision for patients with severe maladaptive behaviors and Administration should ensure that this policy is being followed and appropriate referrals are made when necessary.

The following suggestions are also offered:

1. Administration should consider revising Chester Policy *IM.03.01.01.03 Treatment Plan* to require Psychiatrists to document their follow up/oversight ensuring treatment plans are being carried out appropriately.