FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
16-110-9016
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 did not receive treatment to attain fitness after 90 days of being at the facility.**
2. **A recipient was denied access to his chart.**

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5 et al. and 725 ILCS 5/104), the Confidentiality Act, the Code of Criminal Procedure (725 ILCS 5/104-17) and the Code of Federal Regulations (45 C.F.R. § 164.524).

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 stated that he had been a patient at Chester Mental Health for approximately a year after being found unfit to stand trial. However, the recipient believed that the facility had not done anything to help him attain fitness. Upon arrival, or shortly thereafter, he was given a written fitness test, which he passed, and nothing else was done. He stated that he now attends an attaining fitness group but that he was there for 90 days before being enrolled. He said there were reports filed stating that he was not cooperating with treatment by not taking medications therefore a Petition for Administration of Authorized Involuntary Treatment was filed on March 24, 2016 and an order for court enforced medication was filed on April 6, 2016.

The recipient stated that he had not been given access to his records even though he had asked staff twice. He stated that the first time he dropped his written request in the mailbox on the unit and the next time he gave the written request directly to his therapist. He did not have copies of his written requests. He wanted to review his forensic evaluation to see why he was found unfit. However, staff told him they could not give that to him because it was private

paperwork and when he again requested verbally, staff told him that he could not have his chart to review.

B. Therapist: The HRA interviewed the recipient's therapist to see what type of fitness treatment he received. The therapist stated that the recipient attended a few groups but mostly had individual therapy sessions. The therapist explained that his main barrier to fitness was not a lack of understanding of the court system and procedures but rather, due to his mental illness, he could not assist his attorney with his defense. The therapist had individual sessions with the recipient to work on giving him a greater understanding of the need for medication as he was in denial that he needed medications and stated that they also worked on attaining coping skills and anger management. The therapist also explained that when he was placed on court enforced medication, his grandiosity and aggression decreased and his mood improved which allowed him to cooperate with his attorney. The therapist stated that fitness groups help individuals understand the court terms and the process. This recipient already knew those things which were indicated by conversations with him and also the fact that he passed his fitness test. Therefore 1:1 therapy sessions to address the "problems" listed above were what he needed to attain fitness.

II. Clinical Chart Review:

A. Reports to Court: The recipient was admitted to the facility on 1/12/16. The Initial 30 day treatment plan report for court was dated 1/13/16 and signed by the Psychiatrist and Therapist. The recipient's "UST date" was 11/20/15. The diagnosis is listed as Primary: Bipolar NOS (not otherwise specified), marijuana Abuse; Secondary: Deferred and Medical Diagnosis of Left Foot Fracture. The problems impeding fitness are listed as *"Clinically unstable due to psychosis and aggression; unable to participate in own defense; unable to understand the basics of the criminal court procedures."* Treatment Modality is listed as *"pharmacotherapy, Individual and Group Therapy and a Fitness Restoration Program."* The goal to be reached is *"stabilization of symptoms in order to achieve mental and behavioral stability sufficient to be recommended as Fit to Stand Trial by October 2016."* The 90 Day Fitness Evaluation/Progress Report dated 4/1/16 reported the following general information *"…He was diagnosed with Bipolar Disorder characterized by mood lability, paranoid and grandiose ideas of quasi-delusional intensity, episodic agitation, belligerent, threatening behavior and physical aggression towards staff necessitating restraints on 1/27/16 and 3/22/16."* The Interventions were reported as "*Has been noncompliant with treatment since his admission. Emergency Enforced Treatment was instituted on 3/22/16 due to his aggressive behavior with imminent risk of harm to others. Emergency Enforced Medications include Olanzapine 20 mg PO HS, if patient refuses PO, Olanzapine 10 mg IM to be instituted for psychosis and aggression. His attendance in Fitness Education classes will be possible after stabilization of his psychotic and behavioral symptoms. In addition to medication, [recipient's] treatment at Chester Mental Health Center includes Fitness to Stand Trial restoration counseling; Individual Counseling with his therapist; Recreational Therapy and other Therapeutic Interventions. [Recipient's] participation in programming has been poor. Overall, [recipient's] progress has been poor due to continued presence of psychosis and aggression."* The current mental status is described as *"alert, uncooperative and non-compliant with treatment. He continues to have aggressive thoughts stating that he will 'up the ante' if given the opportunity. He continues to exhibit paranoid and grandiose ideation, blaming staff and talking about the need to challenge authorities….since being placed on emergency enforced*

medication, the patient has shown some improvement with longer periods of calm behavior during the day and decreased frequency of aggression…." The form was signed by a psychiatrist at the facility. The HRA found two 90 day reports dated 6/13/16 signed by two different psychiatrists at the facility. The first report was done by the same psychiatrist that completed the 4/1/16 report. The treatment was listed as *"In addition to medication [recipient's] treatment at Chester Mental Health Center includes Fitness to Stand Trial restoration counseling; Individual Counseling with his therapist; Recreational Therapy and other Therapeutic Interventions. [Recipient's] participation in programming has been good. Overall, [recipient's] progress has been good."* On the second page the assessment section noted that the recipient *"has remained noncompliant with treatment since his admission…has not attended fitness educational classes due to the continued presence of mental illness symptoms and severe episodic aggression."* Under the opinion section, this psychiatrist stated that the recipient *"is currently unfit to stand trial. There is a substantial probability that [recipient] may be restored to fitness over the next 6 months following emergency and court enforced treatment."* The second court report with the same date of 6/13/16 was completed by a different psychiatrist. The first page reported verbatim what the first report also stated. On the second page, the progress section describes a *"favorable response to treatment in that symptoms associated with his psychiatric condition have subsided and his social function is free of maladaptive behaviors. He also is able to accurately describe his current legal situation and he states he will comply with court proceedings as well as work with his defense attorney in a cooperative manner."* Under a fitness data section, the reason for finding of UST is stated as *"knew the roles of the various participants in a court of law and had a reasonable understanding of the legal process in which he is engaged, but was recommended as unfit due to not being able to productively assist his attorney nor control his behavior…all of this strange, driven, impulsive, suicidal behavior warrants an inpatient evaluation."* At the time of the report the recipient was noted to have an understanding of the legal process, aware of his charges and possible outcomes and had expressed a willingness to work with his counsel. It was noted that the opinion of the treatment team was that the recipient was fit to stand trial at that time.

B. Utilization Review (UR): The HRA reviewed a UR Form dated 6/2/16. The pertinent history section included a handwritten note that stated *"Patient signed consent on 5/25/16 for medication. The treatment team plan to meet with [recipient] next week. If [recipient] can continue to engage in treatment with no behaviors he will be returned to court as Fit to Stand Trial."* The form was signed by the facility director, an administrative assistant and the director of nursing. An addendum of questions and answers was attached to the UR and was also dated 6/2/16. This form noted the following regarding barriers related to fitness restoration: to the question "Does mental illness preclude the person from being able to obtain fitness?" the answer is yes and "Do behavioral issues contribute person from being found fit?" the answer is yes "What is the anticipated time of restoration?" the answer is "soon to be fit to stand." Under the strengths related to fitness restoration section it was noted that the recipient was able to understand the nature and purpose of the proceedings against him; was actively involved in fitness activities; was taking medication as prescribed; was having a favorable response to prescribed medications, however it noted that he was unable to assist/cooperate in his defense.

C. Clinical Group Progress Notes: The HRA found documentation that the recipient was enrolled in Unfit to Stand Trial; Medication Education and Creative Thinking Groups. Two

progress notes for the fitness group were found. The first was dated 2/4/16 and the topic was "intro to group." The progress notes indicated the recipient attended and was actively participating and was appropriate. The summary stated that he "completed introductory assessment" and was signed by a social worker. The other progress note reviewed was dated 2/11/16 and signed by the same social worker. It noted that the recipient attended, actively participated and was appropriate. The summary noted that they "reviewed [illegible] test and unit 1." The HRA found no other progress forms relating to attending an actual "fitness class." A 2/10/16 Social Work note stated that he completed the UST test with a 95% and noted that the one question he missed, he actually knew the answer too, but had inserted his opinion into the answer. The note continued to state that he insisted he was only to be at Chester for 72 hours and that the UST process had been explained to him on numerous occasions.

D. Treatment Plan Reviews (TPRs): The HRA reviewed treatment plans dated 1/29/16, 4/19/16, 5/17/16, 6/13/16 and 7/7/16. The recipient was found UST on 11/13/15 and admitted to Chester Mental Health Center on 1/12/16. His diagnosis is listed as Bipolar NOS (not otherwise specified), Cannabis Use Disorder, in remission in a controlled environment and post left foot fracture. The 4 problem areas to be addressed during treatment are listed as Unfit to Stand Trial; Aggression Towards self and Others; Psychosis and Potential for Substance Abuse. His medication is listed as Valproic Acid 250 mg am and 500 mg HS (hour of sleep) for mood stabilization. The 1/29/16 TPR stated that the recipient knew his charges and appeared to have a good understanding of the court system, but more time was needed to assess his ability to cooperate with counsel. He was enrolled in UST group on Thursdays at 3:15 p.m. The recipient signed his TPR and noted agreement with it and the form also documented that he was offered a copy of his TPR and declined. The remaining TPR forms were different from the 1/29/16 TPR and did not include sections that indicated whether or not the recipient had attended fitness classes. The 4/19/16 TPR noted the recipient was placed in a physical hold and restraints one time on 3/22/16 after attacking staff and had emergency enforced medication 17 times and that the recipient was placed on court enforced medication of Olanzapine 10 mg PO HS for 5 days then discontinue and start Aripiprazole 10 mg PO AM. The order was set to expire 7/6/16. His barriers to fitness are noted as "inability to cooperate." The patient's input was documented as being "very anxious to return to court as fit. At today's meeting he tried to persuade the team that he was fit and had trouble accepting the team's recommendation." The recipient stated "I'm not asking, I'm demanding to be declared fit for trial." Under the progress section it was documented that the recipient has completed the UST fitness test with a 100%, knows his charges and has a good understanding of the legal system. He showed distrust of his attorney and had expressed that he may not be able to cooperate with his counsel. The extent to which benefitting from treatment stated that he "needs more time to show consistent mood stability before he can return to court as fit." The 5/17/16 TPR stated verbatim what the previous one had on the first page with the exception of stating that the recipient "denies need for mental health treatment." The nursing note stated that he had not been in restraints that reporting period but did utilize the quiet room once after being attacked by a peer. He refused as needed medication and was also attacked two other times with "only minor abrasions noted." It also noted that he was on court enforced medications and refused once therefore he had an injection that day due to his refusal. The interventions section stated that the therapist "will provide Fitness Education for the purpose of helping [recipient] to attain competency to stand trial." The TPR did not state how often this was to occur. The TPR did state that the therapist would meet with him "one time

weekly to provide anger management skills and assistance in following module rules." The barriers to transfer were listed as non-compliance with medication and inability to cooperate. The extent to which benefitting from treatment section stated that he attended his TPR and was on court enforced medication. He had been in a physical altercation and had refused court ordered medication. It also noted that he was "having problems with his defense attorney, he believes it is his lawyer's fault that he is UST." It was noted that he had passed the fitness test and his behaviors were stable for the most part, but that he was reluctant to continue with treatment and does not believe he has a mental illness. The 6/13/16 TPR documented that the recipient stated he will cooperate with his attorney and has been recommended as Fit to Stand Trial. It also noted that he had consented to medication and was no longer exhibiting grandiose beliefs or rapid thought, but did continue to exhibit little insight into his need for continued treatment. The nursing note also documented that he was taking Olanzapine and on 5/25/16 he signed a medication consent and was no longer on court enforced medication. He had not been in restraints and had no further problems. The barriers to transfer section also noted that the recipient had demonstrated that he was Fit to Stand Trial and could assist in his defense. The extent to which benefitting from treatment section noted that he had no symptoms of depression, no auditory or visual hallucinations or suicidal or homicidal ideation or plans and that he was aware of his criminal charges. The 7/7/16 TPR documented that the recipient was happy and motivated to attend his upcoming court date.

E. Progress Notes: A 2/22/16 social work note documented that she had facilitated a phone call with the recipient and his public defender and stated *"Initially the conversation seemed ok but as progressed [recipient] was insisting his attorney take a different action, it sounded like the attorney was explaining UST process, then without warning [recipient] hung up on him. He does not feel he can work with this PD he knows court terms and shows no issue with mood or psychosis. He is untrustful of his attorney and the court system but at this time this seems to be more a result of personality and not a mental illness. He will continue to be met with regularly to work /counsel on UST."* There were several case notes following this indicating that the recipient refused medication for a period of time and then had suicidal ideations and was put on protocol for that and eventually was placed on court enforced medication due to aggressive behaviors. A social work note dated 3/2/16 stated that the recipient was denying the need for medication and presented as evasive and grandiose when [recipient's] misconceptions and lying were addressed, he stated 'everyone in the court lies!' [Recipient] also stated it was impossible to commit suicide [at Chester Mental Health] and would tell staff if he had any suicidal ideation…will continue to work with patient and educate him on the importance of mental health treatment." Several case notes followed documenting the recipient's continued refusal of medication and that the therapist was encouraging the recipient to engage in treatment and gain insight into his need for mental health treatment. One social worker note documenting a restraint episode stated that the recipient was being released from the chest posey and pulled back on it and stated that he was trying to get into the Guinness Book of World Records and that if he was released from restraints that would defeat his purpose. He approached the nurses station the next day stating that his throat hurts and that he had a "crushed larynx, crushed blood vessels and bruises" The nurse's exam was negative with the exception of small petechial hemorrhages and noted that an injury report was completed, OIG was notified and the physician was contacted. Two notes were found for the medication education class; one was dated 4/13/16 and the other was dated 4/20/16; both indicated the recipient attended and actively participated. Three notes

were found for the creative thinking class. The first one was dated 4/9/16 and listed the topic of "Do April showers really bring May flowers?" The second one was dated 4/16/16 and listed the topic of "What is the first thing you will do when you leave here?" Both indicated the recipient attended and actively participated. The final note dated 4/23/16 listed a topic of "if you only had one thing to eat and drink the rest of your life what would it be?" This form stated that the recipient refused to attend.

There was one social worker note on 3/25/16 which stated *"patient was provided with a copy of his master treatment plan. He was informed that he would have to speak to his attorney to get a copy of his forensic evaluation."* Three hours later another note indicated that the patient was given his public defender's office number per his request. He attempted to make the call but did not get in touch with his attorney. A social work note dated 3/29/16 documented that the recipient was given a copy of his consent to medication form per his request. This note also documented that the recipient "no longer exhibit grandiose thinking and appears more calm." It was also noted that the recipient had "shown improvement since being placed on emergency enforced medication" which the HRA assumed meant court enforced medication since earlier in the note reference had been made to court enforced medication. The HRA found no other case notes indicating that the recipient had requested to see his chart or anything indicating he was denied access to his chart. A psychiatry note dated 3/31/16 stated that "the recipient was on emergency enforced medication, continues to exhibit poor awareness into the nature of his illness. No exacerbation of paranoid delusions. Admits to having aggressive thoughts but has not become aggressive." Another psychiatry note dated 4/1/16 stated "doing better since patient was placed on emergency enforced treatment with no increase in aggression and no exacerbation of paranoid delusions. A social work note on 5/5/16 documented that the recipient called his defense attorney. The recipient continued to "be demanding and argumentative" with his attorney and that the recipient believed it was the attorney's fault he was UST. The recipient demanded a blank motion form so he could file his own but when asked if he was going to represent himself he stated no. The therapist stated that he was going to have to get the paperwork on his own and gave him an agency to contact. The therapist then attempted to discuss why the treatment team believed he was unfit to stand trial. On 5/20/16 a social work note documented that the recipient stated he was willing to work with his attorney and had no evidence of delusional or paranoid thought. It was noted that he was making progress towards his fitness goals.

III...Facility Policies:

A. IM 03.01.04.34 Facilitation Patient or Guardian Access to Their Clinical Records policy provides that *"Chester Mental Health Center will ensure that any patient or guardian will have access to their clinical records."* The policy specifically states *"Any patient who wishes to read their record will be allowed to do so.*

I. Any patient who wishes to read their record will be allowed to do so.

II. 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.

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

IV. A professional staff person shall be available to clarify, interpret and answer any questions the patient may have.
V. The patient/guardian may submit a written statement concerning any disputed or new information. This statement will be entered into and become a permanent part of the clinical record.
VI. The coordinating therapist or other professional staff shall be responsible for documenting the process in the clinical record."

B. RI 03.05.03.01 Patient or Guardian Access to Their Clinical Records policy states that *"A patient who wishes to read his record will be allowed to do so."* The remainder of the policy states verbatim what the above policy does in sections II through VI.

B. 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."

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. 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 of Criminal Procedure (725 ILCS 5/104-17) states that "*If the defendant's disability is mental, the court may order him placed for treatment in the custody of the Department of Human Services, or the court may order him placed in the custody of any other appropriate public or private mental health facility or treatment program which has agreed to provide treatment to the defendant. If the defendant is placed in the custody of the Department of Human Services, the defendant shall be placed in a secure setting. During the period of time required to determine the appropriate placement the defendant shall remain in jail. If upon the completion of the placement process the Department of Human Services determines that the defendant is currently fit to stand trial, it shall immediately notify the court and shall submit a written report within 7 days. In that circumstance the placement shall be held pending a court hearing on the Department's report. Otherwise, upon completion of the placement process, the sheriff shall be notified and shall transport the defendant to the designated facility. The placement may be ordered either on an inpatient or an outpatient basis…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 5/104-19) Says this about records. *"Any report filed of record with the court concerning diagnosis, treatment or treatment plans made pursuant to this Article shall not be placed in the defendant's court record but shall be maintained separately by the clerk of the court and shall be available only to the court or an*

appellate court, the State and the defense, a facility or program which is providing treatment to the defendant pursuant to an order of the court or such other persons as the court may direct."

The Confidentiality Act (740 ILCS 110) provides that *"The following persons shall be entitled, upon request, to inspect and copy a recipient's record or any part thereof:*
(1) the parent or guardian of a recipient who is under 12 years of age;
(2) ***the recipient if he is 12 years of age or older****…Assistance in interpreting the record may be provided without charge and shall be provided if the person inspecting the record is under 18 years of age. However, access may in no way be denied or limited if the person inspecting the record refuses the assistance. A reasonable fee may be charged for duplication of a record. However, when requested to do so in writing by any indigent recipient, the custodian of the records shall provide at no charge to the recipient, or to the Guardianship and Advocacy Commission, the agency designated by the Governor under Section 1 of the Protection and Advocacy for Persons with Developmental Disabilities Act 1 or to any other not-for-profit agency whose primary purpose is to provide free legal services or advocacy for the indigent and who has received written authorization from the recipient under Section 5 of this Act to receive his records, one copy of any records in its possession whose disclosure is authorized under this Act."*

Conclusion

The first allegation is that a recipient did not receive treatment to attain fitness after 90 days of being at the facility. The recipient was admitted to the facility on 1/12/16. The HRA found documentation on 2/4/16 and 2/11/16 that the recipient was enrolled in fitness group and attended and also that he was given the fitness test on 2/10/16 which he passed showing he had a good understanding of the court procedures. The HRA also found several documents stating that the recipient's main barrier to fitness was his unwillingness/inability to work with counsel in his defense and his therapist confirmed that statement during the HRA's interview. It was decided and written into treatment plans that the recipient would have individual counseling once a week to address anger management skills and work on attaining a better insight into his need for mental health treatment including medication. The HRA found case notes documenting sessions with his therapist once a week and sometimes more frequently and those issues were addressed in the sessions as documented by his therapist. Therefore, this allegation is **unsubstantiated**. The following suggestions are offered:

1. The HRA found several case notes from the psychiatrist and therapist referring to "emergency enforced medication" some of those case notes appeared to mean just that, medication was given because such treatment was necessary due to the recipient's risk of causing "imminent physical harm to the recipient or others and no less restrictive alternative is available" as required under the Mental Health Code (405 ILCS 5/2-107). However, the HRA also found instances documented as "emergency enforced medication" which, in context, seemed to mean "court enforced medication" as outlined in the Mental Health Code (405 ILCS 5/2-107.1) meaning medication was given as a result of a court order. The HRA suggests that the psychiatrists and therapists be retrained on the difference of the two meanings and each of the requirements under the Mental Health Code and ensure appropriate documentation in the future to avoid

confusion and possible repercussions as a result of emergency enforced medication being given when it is not appropriate as required under the Code.

2. The HRA found a therapist's note dated 2/22/16 documenting that a telephone call had been facilitated between the recipient and his public defender. The case note stated *"Initially the conversation seemed ok but as progressed [recipient] was insisting his attorney take a different action, it sounded like the attorney was explaining UST process, then without warning [recipient] hung up on him…"* The HRA contended that this documentation shows a violation of the recipient's right to "unimpeded, private and uncensored communication by mail, telephone, and visitation" as required under the Mental Health Code (405 ILCS 5/2-103). Although Chester's policies provide for phone calls to be arranged by the therapists under certain circumstances, staff should be retrained on the requirements under the Code for recipients to have private conversations and ensure that privacy is given when calls are arranged by therapists or other staff unless such privacy has been reasonably restricted by the facility director as allowed under the Code (405 ILCS 5/2-103) "to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction shall be given to all recipients upon admission."

The second allegation is that a recipient was denied access to his chart. The HRA found documentation in the 1/29/16 TPR that the recipient signed his TPR and although he was offered a copy of his TPR he declined. A social worker note dated 3/25/16 stated "patient was provided with a copy of his master treatment plan. He was informed that he would have to speak to his attorney to get a copy of his forensic evaluation." Finally, a social work note dated 3/29/16 documented that the recipient was given a copy of his consent to medication form per his request. Although it was documented that in some cases, information requested by the recipient was provided, there was also documentation that he was not provided a copy of everything he requested. When the HRA inquired with the therapist as to why the evaluation could not be provided, it was explained that a copy was denied because that document was created by a third party ordered by the court and he would have to go to the originator to obtain a copy. The Confidentiality Act (740 ILCS110) provides that a recipient shall be entitled, upon request, to inspect and copy his record or any part thereof. The report is to be made available to the facility that is providing treatment as per the Code of Criminal Procedures, thus it should also be accessible to the service recipient as guaranteed by the Confidentiality Act. Therefore the allegation is **substantiated**. The following **recommendation** is made:

1. **Upon request by a patient, the facility should ensure that access to the patient's chart and any part thereof be made available and a copy provided, if requested, as guaranteed by the Confidentiality Act (740 ILCS 110).**

2. **Therapists and other pertinent staff should be retrained on the requirements of the Confidentiality Act pertaining to a patient's access to his records.**