FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
17-110-9019
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 allegations concerning Chester Mental Health Center:

1. **A recipient is not being served in the least restrictive environment.**
2. **A recipient is receiving inadequate treatment.**

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5 et al.) and facility policies. Chester Mental Health Center is a state-operated mental health facility serving approximately 250 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, therapists and psychiatrist, reviewed the recipient's record, with consent, and examined pertinent policies and mandates.

I. Interviews:

A. Recipient: The recipient was first interviewed in April, 2017 and told the HRA that he was at Chester on a civil commitment. His date of admission was in September, 2016. His therapist had told him that in about a month they could look at transferring to a less secure facility. The recipient said he had not been in restraints and was medication compliant. When transfer was brought up in the treatment meeting the therapist denied making that statement. He has not seen his treatment plan and was not told that he could get a copy of it. When asked how often he meets with his therapist he said that he does not. The psychiatrist says that he does not need to meet with the therapist and the recipient stated that the therapist is not on the units very often. He has tried writing notes to her but she gets angry and says that she is too busy to see him. He is not currently in rehabilitation classes but stated that he is not sure it would be therapeutic for him. The last time he tried listening to music in the "treatment mall" it "grieved him" because it reminded him of how messed up his life has become. When asked how he spends his day, the recipient said he eats breakfast around 7:00 or 8:00 a.m. and then goes to his room to try to sleep or read. He said that he cannot sleep well at night because other patients are loud and crying out in their rooms and the lights in the unit rooms remain on at night for security reasons. The recipient was interviewed again in July. He described an incident when he was on his way to breakfast and heard a "thud" in another room. When he inquired as to what the noise was, the STA (Security Therapy Aide) told him to "back the f… up." He described another

incident when he refused medication because the psychiatrist had increased his Latuda to 160 mg from 80 mg. He said the 80 mg worked just fine and the psychiatrist gave no reason to him for increasing it to 160 so he refused the medication. After that an Order was done for court enforced Zyprexa medication and the nurse would threaten to give him an injection if he did not take the medication orally and told him he had no right to refuse now that there is a court order. He did not want to take the Zyprexa and was not sure why the medication had been changed from Latuda which he said works better for him. The Zyprexa causes dry mouth, confusion, weight gain and "brain fog." The recipient informed the HRA that he had a "cheek swab test" done at his community psychiatrist's office which showed that Zyprexa was not a good medication for him and that Latuda was more effective. He said his community psychiatrist had contacted staff at Chester about this test but he did not know the status of that conversation. He again told the HRA that his psychiatrist had told him 4-5 months ago that he would be transferred to a less secure facility in a month but there has been no movement towards that transfer. He told about abuse of another patient at the facility to his psychiatrist and the psychiatrist told him to "turn a blind eye" to what occurs with others at the facility and he believes that the psychiatrist is now being "punitive" towards him for reporting this and other incidents concerning patients at the facility. He again reported his concern about the psychiatrist randomly increasing the dose of Latuda and then switching it to Zyprexa. He has personally told the psychiatrist about the test his community psychiatrist has done but the psychiatrist at Chester dismisses his concerns and just says "no I'm keeping you on the Zyprexa." He also informed the HRA that he had been placed on telephone and pencil restriction and he did not know why. When the HRA again spoke with the recipient in September, he was still trying to advocate for himself to be placed back on the Latuda which he insists works best for him and his therapist just tells him that the psychiatrist won't change his mind on the Zyprexa. Last week the psychiatrist had told him to give him one month and they would contact a less secure facility. The recipient was concerned because he had an involuntary commitment hearing coming up that week and reported that he had been on green level for 3 weeks.

B. Psychiatrist: The psychiatrist was interviewed in December and asked what the recipient's barriers to transfer are. He informed the HRA that there are two reasons. The first is that he denies his mental illness despite his history. The second is because he refuses medications and has been on court enforced medication for a long while and will not comply with treatment, which makes it difficult to get a less secure facility to take him. The psychiatrist also informed the HRA that the recipient has not had any restraints and has not been on suicide watch recently so they have now recommended him for transfer to a less secure facility, but that facility currently did not have any beds available. When questioned about the medication issue, the psychiatrist told the HRA that he prefers Zyprexa as it has less side effects and on his previous admission, this recipient did well on Zyprexa and was discharged. However, he tried Latuda at the recipient's request. He started the recipient on a low dose and did not see results so he increased the dosage and then the recipient refused the medication. After the refusal the recipient began decompensating and was placed on court enforced Zyprexa. The psychiatrist also informed the HRA that a few days prior to our interview at the request of his mother and the recipient agreeing and signing consent, he was placed on Paliperidone which is a time released anti-psychotic medication. The plan was to give him 2-3 days of oral medications to check for side effects prior to the injection being given. He took the oral medication but refused the injection because he did not feel the medication was working for him and the recipient asked to

go back on Zyprexa. At the time of our interview, he was still on "crush and observe" medication but not court enforced. The HRA asked the psychiatrist if he was informed that the community psychiatrist administered a test which showed that Zyprexa was not a good medication for this recipient due to the way his body metabolizes medication and that Latuda was a more effective medication for this recipient. The psychiatrist admitted that he was aware of the test and had reviewed the results, but he was unfamiliar with that type of testing. He discussed it with the recipient's community psychiatrist, the treatment team and pharmacist at Chester, but he did not go any further with it because he had no directives on the efficacy of that type of testing. Therefore, he went with what was clinically indicated and Zyprexa had worked for this recipient during his past admission to Chester. The psychiatrist stated that his current therapist was working on a transfer to a less secure facility but there were no beds available. He was not sure why that facility was chosen for this recipient or if other options had been explored.

The HRA later reviewed therapist case notes from 12/13/17 confirming that the psychiatrist had prescribed Invega, which is a time released, injectible medication at the recipient's request and was tapering to discontinue the Zyprexa. The recipient requested to see the psychiatrist on 12/18/17 and requested to be taken off the Invega oral medication because he was "only able to get 8 hours of sleep a night on the Invega." He also "described having some discomfort in his head and chest." The recipient indicated that he would rather be back on the Zyprexa so he can sleep more and signed consent to take the Zyprexa.

C. Therapist: This therapist was interviewed in June. She informed the HRA that she had been the recipient's therapist since admission, but a month ago he had been transferred to another therapist at his request and also because he had "anger issues" towards her. Since changing to the new therapist, he has also had issues towards the new therapist and had written to this therapist with concerns that the new therapist is a spy. She stated that she had told him upon his civil commitment that if he has good behavior for a month, they would transfer to him to a less secure facility, per the judge's request. However, he did not make it one month and became hostile during his treatment meeting and threatened the psychiatrist. She could not remember the exact threat or issue he was upset about. She remembered the recipient becoming escalated when they were reviewing complaints that he had and the recipient walked out of the treatment meeting. The psychiatrist said at that time (a month into his admission) he was not ready for a transfer yet. The therapist also stated that he had a video conference upcoming in a couple of weeks to get things moving so he could transfer when he was ready, but stated that a week before our interview he had recommitted for 120 days. She said the recipient had complained to her about a lack of sleep so he was moved to a different module due to the patient next to him being loud. He also complained about the lights being on in his room, but per facility rules, they cannot turn the lights all the way out at night, they just dim them. She said that she met with the recipient once per week and when he was doing well he requested to see her more often and wrote letters to communicate with her also. After his civil commitment he was very angry and would just meet with her briefly to say "get me out of here." To her knowledge, he meets with his current therapist weekly. She said that in recent morning meetings, she had heard that he has had no behavior reports, but had been deteriorating the previous two weeks. He had been on "crush and observe" medication for about 2 or 3 weeks and he was not happy about that. She stated that he often is verbally threatening but does not require restraints. It had been months since he had been in restraints. The treatment team "fears for his anger towards his mother."

His mother had sent Chester staff "bundles of letters" that the recipient sent to her threatening to kill her. He blames her for his legal charges. When he was doing well he called his mother frequently but he would become angry and threatening to her and his father during the calls. The STAs also reported that he is more agitated after phone calls with his parents. He was refusing money orders that they would send but she believed he was now accepting them again.

D. Therapist: This therapist was interviewed in July. She had recently taken over the recipient's case because he had been threatening and "verbally violent" towards the former therapist who was also 7 months pregnant. He had also requested a therapist change. Therefore, the recipient was transferred to this therapist's case load. On day 1 he was cooperative with this new therapist but then he began accusing her and the psychiatrist of being Indian spies; she had no explanation as to why he was making that accusation. The therapist informed us that the recipient was on a 90 day involuntary admission and then a 180 day involuntary admission. When his legal charges were dropped in lieu of DHS admission, he had previously been at Chester so he just came back there after court. He had a video conference scheduled July 18th with a less secure facility but then he stopped taking his medication, had restraint episodes and on one occasion he had barricaded his door. Therefore, the video conference was cancelled due to him no longer meeting transfer criteria. The therapist said the treatment team tries to make sure that Chester's transfer criteria coincides with the requirements of the less secure facility so that a transfer can occur. This recipient will stop taking his medications because he does not believe he needs them. When he stops taking medication, his paranoia and aggression increase and activities of daily living (ADLs) decompensate. He will stand for hours and not move and experiences rage, especially towards his parents. The recipient had been physically aggressive towards staff. His behavior had escalated for about 4-6 months and they suspected that he was not taking medications. For these reasons, he was placed on court enforced medication and also placed on crush and observe to ensure he was taking the medication. Latuda does not come in an injectible form therefore his medication was switched to Zyprexa which does come in an injectible form in case that method had to be utilized. The psychiatrist had also stated that Zyprexa has fewer side effects than Latuda. The less secure facility will not take a transfer patient if they are on court enforced medication and the facility also requires 3 months of good behavior so these things delayed his transfer. He was also placed on phone supervision due to him calling 911 repeatedly and the police requested that staff dial his phone numbers in the future. The psychiatrist had recently said that in 30 days they would look at criteria for the less secure facility again to see if the recipient now met the criteria. This therapist meets with him several times a week and she had noticed significant improvement since being placed on Zyprexa.

II. Clinical Chart Review:

A. Psychiatric Evaluation: The evaluation dated 9/28/16 documented that the recipient was admitted as unfit to stand trial from the county jail. Upon arrival he was not providing verbal responses so most of the information was obtained from available records from the jail. His primary diagnosis is Schizoaffective Disorder; Secondary and Medical are both listed as "none." He was recommended by the DHS (Illinois Department of Human Services) evaluator for placement in a maximum secure setting due to behaviors displayed at jail. He has had 9 DHS admissions including 1 prior admission to Chester from September to December, 2013. He was

receiving Olanzapine (Zyprexa) and Lorazepam (Ativan). His parents removed him from their home when he was 20 years old due to him becoming threatening to them. He was in a homeless shelter briefly before moving to an apartment building the following month. Another evaluation/progress report dated 2/7/17 (Amended 3/6/17) stated that upon admission the recipient was extremely psychotic with clear cut features of catatonia. He refused treatment and *"required emergency enforced medication and was later taken to court for continuation of court enforced medication. He was prescribed Olanzapine 10 mg BID along with Lorazepam 2 mg PO BID as needed for agitation. He was compliant because of the enforced medication. He has a tendency not to take medication. He alleged that Latuda, which was prescribed to him prior to his arrest, was helping him. Initially he wanted it; however, as his condition improved we decided to stay on Olanzapine."* It was documented that in October, 2016 he was placed on court enforced medication and it was discontinued in January, 2017 since he signed consent. At that time his medication was Olanzapine and Lorazepam, as needed, for agitation. It was noted that in February and March the recipient displayed stable behavior without any psychosis, depression or anxiety and "prefers to return to the court and requested the treatment team recommend him so that he could be back in the community and take treatment as advised. He was deemed fit to stand trial and was "anxiously awaiting to return to court on 3/16/17." A secondary diagnosis of personality disorder not otherwise specified with antisocial and paranoid traits was added to this psychiatric evaluation.

B. Court Orders: The HRA reviewed a court order dated March 20, 2017 dismissing the recipient's criminal charges "without prejudice contingent upon and subject to involuntary commitment of the Defendant to the Department of Human Services…the Defendant shall be remanded to the custody of the Illinois Department of Human Services to initiate involuntary committal proceedings." On March 29, 2017 a Petition for Involuntary treatment was completed by the forensic coordinator at Chester along with two certificates, one signed by the psychiatrist and the other signed by the therapist. The certificates indicated that the recipient was admitted from jail as unfit to stand trial on September 28, 2016. The therapist's certificate documented maladaptive behaviors of making threats toward staff, engaging in property destruction and verbal and physical aggression to others as well as displaying catatonic symptoms such as urinating on himself, lying on the floor, standing motionless for long periods of time to the extent that a wheelchair had to be used to get him back to his room. The certificate also documented that *"on 10/26/16 court enforced medication was granted. Since that time, [recipient] has shown progress and some stability since being placed on court enforced medication. On 1/4/17 he signed consent for his medication and has been medication compliant. He continues to display anxiety and require PRN medication on a daily basis. He reports the stress and anxiety of being hospitalized is 'unbearable' to him. He recently has been screaming on the unit and being disruptive to his peers. [Recipient] is currently presenting a significant risk of harm to his mother…he has continued to make verbal threats towards his mother since his admission and blames her for his charges. [Recipient] openly admits he continues to have anger issues with his mother and is resistive toward working on his anger for his mother. He has voiced on numerous occasions that his family is against him."* An Order for Involuntary Treatment was filed April 4, 2017 committing the recipient to the DHS for 90 days. The Order also contained a notice that stated "an order for admission is initially valid for no more than 90 days. A subsequent order may be entered for an additional period of 90 days. Thereafter an order may be valid for up to 180 days. If the facility director does not discharge the individual during that period or petition for continued hospitalization, the individual must be released."

C. Treatment Plan Reviews (TPRs): The 4/3/17 TPR noted an increase in anxiety in the recipient. He stated that he should not be there; he was depressed about the whole system and sick of going through the process. He paces the module and reports difficulty in concentration, sleep and speaking clearly. The recipient was requesting PRN (as needed) medication daily. It was noted that he was medication compliant at that time and had no aggressive behaviors that reporting period. He was meeting with his therapist weekly but still experienced agitation when discussing his mother and had difficulty engaging in therapy to work towards resolving his feelings. It was documented that he was compliant with medication and mouth checks this reporting period and required 25 PRN medications for agitation and anxiety and he utilized the quiet room once for agitation. He met with the therapist and treatment team "several times this period." In the extent to which benefitting from treatment section, it was noted that his charges were dropped in lieu of involuntary commitment. He had a scheduled hearing in court on 4/5/17. He "is not taking this legal status change well. He states staying here at CMHC makes him worse and that he needs to be released into the community…Although he has had no physical aggression, he continues to show agitation towards his mother. He openly discusses his 'hate' for his mother and believes she is the reason he is hospitalized. When meeting 1:1 with his therapist he becomes fixated on his mother and quickly goes from crying to angry. [Recipient] does not actively engage in therapy concerning his anger. He quickly becomes irritated and will not take ownership for his actions…He spends the majority of his day pacing the module." The 5/30/17 TPR documented that the recipient's charges were dropped in lieu of involuntary commitment and he was involuntarily committed on 4/5/17. The discussion section of this TPR documented that the recipient was notified that he would have a new therapist and he smiled and replied "good." He stated "I don't feel that this hospital can do any more for me than what it has done." He stated that he wanted to be transferred to another facility which was less restrictive or at the least transferred to another unit replying "anything to get away from you, Doctor." He appeared angry when making that statement and then abruptly left the room. The psychiatrist noted that the recipient's therapist was changed because "he could not develop a positive rapport and preferred to have a different one." The psychiatrist continued his notes stating that the recipient was "paranoid and accusatory. Today during TPR he stated he had no trust in this writer. When questioned about going to a different unit he said send me, to get away from you. He got up and left. Refused to sign the attendance sheet. He is not fit for transfer." The therapist documented in her notes that the recipient "continues to present with anxiety and agitation. He is upset with the circumstances that lead to his admission, as well as his continued hospitalization. Meeting with his therapist and treatment team causes him agitation and his cooperation has been limited. His mood is unstable." The activity therapist concurred and documented that he "dislikes his parents and being at this facility and will tell any peer that will listen to him about it." He had no acts of physical aggression this reporting period. There was no rehabilitation enrollment due to "patient does not wish to attend at this time." Barriers to transfer were listed as "patient is a danger to others" His criteria for separation was listed as exhibiting the following *"1) a genuine, sincere desire for transfer and willingness to cooperate with the receiving facility 2) compliance with prescribed medication 3) Active participation in recommended treatment programs 4) absence of physical and verbal aggression and 5) absence of behaviors that are self-destructive to himself and/or behaviors that pose and imminent threat to the safety of the facility and community which include, but are not limited to physical harm to himself or others."* The psychiatrist signed and documented that based upon the recipient's

history and current presentation, it is his opinion that the recipient would present an imminent risk of harm to others if released at this time. The psychiatrist's progress note on the same date stated that the recipient was not on court enforced medication and was taking Lorazepam twice a day. It was also documented that the Olanzapine (Zyprexa) was changed to Lurasidone (Latuda) 40 mg daily and then increased to 80 daily and that Citalopram had been added for depression. The 8/21/17 TPR documented current barriers to transfer as "patient is a danger to self, patient is a danger to others, non-compliance with medication, psychosis." It was noted that he started refusing medication on 7/4/17 and significant clinical deterioration was observed. He was placed on phone supervision after making calls to 911. He required physical holds twice and restraints once. He was started on emergency enforced medication 7/10/17 and court enforced medication was granted on 7/19/17. He had made some progress since that time, but did attack a peer on 8/6/17 requiring another restraint and also required seclusion a few days prior to that incident. He had damaged the plaster surrounding two room doors from slamming his doors. The facility had received letters and reports from his mother indicating that the recipient demonstrated hostility and anger towards her during phone conversations and in letters. He had also made threats of harm toward himself if released to the community. His criteria for separation was listed as exhibiting *"a desire for transfer and willingness to cooperate with the receiving facility; at least three months of no physical aggression, property destruction or threatening statements toward others; participation in recommended treatment programs; insight improvement to the extent that he recognizes willfully the need for treatment including his prescribed medication; behaviors will demonstrate a reduced risk of harm to his mother as evidenced by: 1. For at least 90 days, will not voice that he has any intentions to harm his mother 2. For at least 90 days will not send any correspondence containing threats or derogatory, hostile statements toward his mother 3. For at least 90 days, will not have any phone conversations with his mother which contain threats or other derogatory, hostile statements toward her 4. Will be able to voice/describe how his mother may be at risk for harm due to his anger toward her."* The therapist documented in the 11/13/17 TPR that for a continuous 90 days the recipient has stated that he will not harm his mother upon release. He did state on 9/13/17 that "just because you wish someone were dead doesn't mean you would kill them." The recipient's mother was also denying any negative correspondence being sent since an incident in August. When the therapist contacted the mother in October, inquiring about negative correspondence, the mother told her that she was not going to tell the therapist any additional information about correspondence from her son for fear that it may keep him at Chester longer. The therapist noted that the recipient continues to write letters to the therapist and talk with her about his belief that his mother is responsible for his current admission and a recent letter indicated that he "hated his mother." The therapist also documented that the recipient denied that his mother may be at harm and stated that he is not the kind of person that would harm his mother and he does not understand why others feel that his mother may be at risk for harm. The STA had documented on this TPR that he spends his time reading, going to the gym and gets along well with staff and peers. He showers regularly and keeps his room clean. He has not been verbally or physically aggressive but will have occasional verbal outbursts in his room out of frustration. The psychiatrist documented that behaviorally he is doing better and is ready to transfer to a less secure facility. The therapist documented that the recipient offers "somatic complaints about his current medication regimen. He remains on court enforced medication. He does report that there are some things that he believes Zyprexa has helped him with but also offers complaints about the medication. More specifically about not being able to communicate/express his thoughts

appropriately while on this medication." Current barriers to transfer are listed as "patient is a danger to self, patient is a danger to others, non-compliance with medication"

D. Progress Notes: A psychiatrist progress note from May, 2017 documented that the recipient brought a lot of written information to his TPR meeting. Complaints/comments about his continued stay at Chester alleged the treatment team was not showing any interest to process his transfer to lesser secure facility. He was "quite unhappy, upset and agitated. He threatened this writer to report to OIG about some advice this writer provided to keep him out of trouble. He is unstable…his progress is not consistent or significant." On 3/16/17 a therapist note documented that she met with the recipient to complete discharge planning due to upcoming fitness hearing. Follow up appointments were made with his community psychiatrist and mental health center. A discharge summary was provided to the recipient and was faxed to both of the community providers. On 3/22/17 a therapist note documented that the recipient returned from court and his charges were being vacated in lieu of civil commitment with the DHS. The treatment team met with him to explain the order, he was upset but "took the news well." An hour after that meeting, the recipient requested a PRN for anxiety. Later that afternoon the treatment team met with the recipient to discuss his concerns and called his mother via speaker phone. The civil commitment process and treatment was explained to his mother and they discussed "possible medication change and his mother voiced her concerns that her son was not being truthful about his symptoms. [recipient] reported Latuda has been helpful in the past [recipient] signed a consent for Latuda today." The following day the recipient was pacing the module and had called his mother 7 times. He reported to the nurse that he felt scared and anxious and requested a PRN medication which was given. The psychiatrist note dated 3/27/17 documented that his medication was changed from Zyprexa to Latuda 40 mg to start with to be increased to 80 mg. On 3/29/17 the forensic coordinator met with the recipient to inform him of his upcoming involuntary commitment hearing and provided him with copies of his certificate and petition. On 3/31/17 the therapist documented a meeting with him where they discussed his anxiety about the upcoming commitment hearing. The recipient began to cry and stated he would be "stuck here forever." A psychiatrist progress note dated 4/2/17 documented the recipient attending his TPR stating "this place is stressing me. I shouldn't be here. I am depressed about the whole system. I am sick about going through the process. My mother does not want me to stay here." On 4/3/17 a social worker note documented that she had spoken with the recipient's mother regarding the upcoming involuntary commitment hearing. The mother stated that she feels threatened that the recipient would harm her if released. The mother stated she would be unable to provide support for him if released due to his history of aggression and threats." On 4/5/17 the recipient was found to meet criteria for involuntary admission. On 4/12/17 the therapist documented that the recipient had sent a letter to his parents where he had documented on the outside of the envelope that he hated his mother and she was too stupid to understand. On 5/3/17 a therapist note documented that a TPR meeting had to be ended due to the recipient's agitation and lack of cooperation demanding a transfer be facilitated to a less secure facility. On 5/12/17 the therapist documented that the recipient refused to meet with her and stated "just get me to [less secure facility]." She told him she was starting an anger management group and he stated that he did not want to be involved. He became angry and walked away and then returned and said that he could not work with her; he can only work with the less secure facility. On 6/12/17 the new therapist met with him. He stated that he has been on a lot of medications that have been harmful to him and that he did not believe he has a mental illness. He asked the therapist to

"take his side" and not believe all the "hearsay and slander" that is in his record about him being mentally ill. On 6/15/17 the therapist and psychiatrist met with the recipient per his request. He talked to the psychiatrist about side effects from his antidepressant and the psychiatrist discontinued the antidepressant that day. On 6/19/17 the therapist documented a meeting during which she discussed the threatening letters written to the recipient's parents. It was noted that the recipient had written a letter to his previous therapist indicating that he wants off all of his medication except for Ativan. He indicated in that letter that his current therapist "might have Indian descent" which relates to his "spy disconcert and the U.S. ongoing war with terror." On 6/20/17 a therapist note documented that the recipient was seen by another psychiatrist, the hospital administrator, unit director and therapist. The psychiatrist was consulted regarding the recipient's case, the recent letters received form his family and his desire to be transferred to a less secure facility. The consulting psychiatrist suggested increasing the Latuda on that date and possibly starting Clozaril in the future if his symptoms continue. On 6/22/17 a therapist note documented meeting with the recipient who stated that he had not been taking the additional dosage of Latuda that was prescribed for him on 6/20/17. On 7/4/17 it was documented in a nursing note that the recipient refused his medication stating, *"I told them I'd agree to taking the 80 mg Lurasidone and that's it not the 120 mg."* The following months' case notes document an increase in maladaptive behaviors of yelling and slamming his door to the point that mortar around the fame is cracking, attacking peers, continued threats to his mother and notes that he had required restraints and seclusion and also accused the facility of provoking him. On 10/4/17 the social worker documented that she appeared to testify at the recipient's involuntary commitment hearing but the recipient asked the court for an independent evaluation. The judge appointed a psychiatrist to complete the evaluation and therefore the involuntary commitment hearing was continued until it could be completed. On 10/26/17 the therapist documented a call with the recipient's mother inquiring if she had received any threatening letters or calls recently from the recipient. She stated that she had not but that he continues to make statements like "don't ever put me here again." The therapist encouraged her to contact her or mail the letters to her if they were threatening. The mother responded by saying "I don't want to do anything that will keep [recipient] there longer." The mother was told that the recipient will likely transfer to a less secure facility in the next few months if his behavior remained stable. The mother stated that she wanted him to transfer and she thought it would "be good for him." The therapist expressed concern over him eventually being discharged to the community but the mother stated that she would deal with it when the time comes and that she wanted her son to be able to get out of a hospital and she "minimized his risk of harm to her." The mother vocalized how upset she was that the treatment team ignored the swab study and put him on Zyprexa. She did indicate that he is more "rational" with Zyprexa but she did not believe it was the right medication for him. On 11/15/17 a social worker note documented that she attended his commitment hearing and testified that he was in need of continued involuntary commitment. The independent psychiatrist also testified that his opinion was also that the recipient needed continued involuntary commitment. The judge signed an order for involuntary commitment in the DHS not to exceed 180 days.

E. Medication Information: The HRA reviewed the GeneSight psychotropic results from the cheek swab test which was collected on 11/12/15. This test shows how a person's body metabolizes certain kinds of medications. If a person is a high metabolizer in a certain DNA strain and a mediation he/she is taking occupies that strain, the medication is going to be "burned

off" quicker and will not be as effective. The test listed results in three columns: Use as Directed; Use with Caution and Use with Increased Caution and with More Frequent Monitoring. This recipient's "**use as directed**" medication list consisted of Abilify; Saphris; Prolixin; Fanapt; **Latuda**; Invega; Trilafon; Seroquel; Risperdal and Geodon. Use with Caution medications were Thorazine; Haldol and Mellaril. **Use with Increased Caution** medications were listed as Clozaril, **Zyprexa** and Navane. The test information included a statement that "it has not been cleared or approved by the U.S. Food and Drug Administration. These interpretations are based upon data available in scientific literature and prescribing information for the relevant drugs…" The test was reviewed and verified on 11/18/15 and signed by a PhD.

The HRA also received a visit summary from the recipient's community health provider dated 6/24/16 which stated that while in a hospital, the recipient was started on Invega and had also been taking Latuda 160 mg daily and Lorazepam as needed. The recipient was noted to be "very concerned about being on the Latuda especially at this high of a dose." He also requested to be back on an antidepressant and it was noted that he did take sertraline in the past. The plan was to continue the Invega Sustenna (time released monthly injections) and to reduce the dose of Latuda slightly to 120 mg daily with a planned gradual taper. The psychiatrist noted that *"I am concerned however, because he just got out of being hospitalized and incarcerated so I do not want to make anything too significant in terms of changes."* The psychiatrist also added Sertraline which the recipient had been on in the past to target low mood symptoms.

On 6/21/17 the psychiatrist signed an order to increase Lurasidone to 120 mg "for control of psychosis." The HRA reviewed the recommended guidelines for Lurasidone on Drugs.com and the usual dose to treat Schizophrenia is listed as an initial dose of 40 mg daily, maintenance dose is 40-160 mg daily and the maximum dose is 160 mg per day. The recipient signed medication consent for "Latuda up to 160 mg and Lorazepam up to 6 mg daily" on 3/22/17.

Facility Policies

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."*

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.

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 signing the Treatment Plan. 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..."

The HRA contacted the Illinois Department of Mental Health (DMH) to inquire about the GeneSight (or similar DNA mapping tests for medication effectiveness) to see if there was a directive within the department regarding such testing/test results. The DMH contact informed the HRA that they were aware of such testing but there were no directives regarding it. There had been discussions about using it as an option for difficult to treat patients but was not sure what was finally decided. Currently the procedure is to hold a utilization review. The treatment team then follows the recommendations of the assessors or the most qualified person.

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."

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."*

Conclusion

The first allegation is that the recipient is not being served in the least restrictive environment. Upon review of the chart, the HRA found that the recipient was admitted in September, 2016 as Unfit to Stand Trial and taking no medications. In October he was placed on court enforced medication and then began taking medication voluntarily in January, 2017. In March, 2017 a fitness hearing was scheduled and the judge ruled to drop the recipient's criminal charges in lieu of continued treatment within the Department of Human Services. An Order for involuntary commitment was issued. The therapist told the recipient that he would be eligible for transfer to a less secure facility after 30 days if there were no behaviors warranting maximum security placement, as per the judge's instruction. However the recipient did not make it the 30 days and "became hostile during his treatment meeting and threatened the psychiatrist," therefore the psychiatrist said he was not ready for a transfer yet. In May it was documented that he was paranoid, anxious and agitated but had no incidents of aggressive behavior. The first therapist also stated in June that he had not required restraints "in months" but was often verbally threatening. Another psychiatrist was consulted in June and recommended an increase in Latuda from 80 to 120 mg and also recommended to add another medication if no results were seen from the increase in Latuda. The recipient began refusing the extra dose of Latuda. He had a video conference scheduled July 18th with a less secure facility. However, due to increased maladaptive behaviors that came with medication refusal, including restraint episodes and on one occasion barricading his door, the video conference was cancelled due to him no longer meeting transfer criteria of the lesser secure facility. After that he was placed on court enforced medication and his August, 2017 TPR noted "some progress" had been made. The November, 2017 TPR documented no incidents of aggression and that the treatment team was of the opinion that he was ready for a transfer to a less secure facility. According to the therapist, the intention was to begin transfer proceedings after 30 days of behavior meeting criteria for a less secure facility, but the recipient's behaviors did not warrant a transfer at that time. In the months following the recipient did not require restraints but still displayed paranoid, anxious and agitated behaviors along with verbal threats. An outside psychiatrist was brought in to consult and recommended the medication increase which the recipient refused and as a result he declined and the video conference that was scheduled for transfer had to be cancelled. The most recent TPR that was reviewed by the HRA indicated that the recipient had once again been recommended for a transfer to a less secure facility and was now just waiting bed availability. Therefore, based on documented plans to transfer the recipient to a less restrictive placement and subsequent behavioral incidents that thwarted the transfer, the allegation is **unsubstantiated**. The following suggestion is made:

1. On the November TPR, the treatment team decided that the recipient was appropriate for a transfer to a less secure facility. However, the current barriers to transfer section still documented that the *"patient is a danger to self, patient is a danger to others, non-compliance with medication."* Other chart documentation indicated that the patient was waiting for a bed to become available so he could transfer. The therapist should ensure that the treatment plan accurately reflects current treatment as required by the facility's treatment plan policy.

The second allegation is that the recipient is receiving inadequate treatment. The first portion of this allegation is due to the recipient allegedly not seeing his therapist enough. The recipient's initial therapist stated that she met with the recipient weekly and when he was doing well he requested to see her more often and wrote letters to communicate with her also. After his civil commitment he was very angry and would only meet with her briefly to say "get me out of here." To her knowledge, he meets with his current therapist weekly. Case notes also documented weekly visits in March and April before being transferred to a different therapist the end of May. The second therapist stated that she meets with the recipient several times per week. The case notes documented at least weekly sessions and sometimes more frequently. Therefore, this portion of the allegation is **unsubstantiated**.

The second portion of this allegation is that the psychiatrist did not consider the recipient's input on medication. The psychiatrist documented in a March, 2017 progress note that the recipient *"alleged that Latuda, which was prescribed to him prior to his arrest, was helping him. Initially he wanted it; however, as his condition improved we decided to stay on Olanzapine."* In May, the psychiatrist documented that Olanzapine (Zyprexa) was changed to Lurasidone (Latuda) 40 mg daily then increased to 80mg daily and that Citalopram had been added for depression upon the recipient's request. In June another psychiatrist was consulted regarding this recipient and recommended an increase in Latuda to 120 mg at which time the recipient began refusing the medication due to the increased amount that he did not feel he needed. In July court enforced medication was ordered and the medication was changed back to Zyprexa due to it coming in an injectible form and Latuda does not. The second therapist told the HRA that she had noticed significant improvement in the recipient since being placed on Zyprexa. The HRA also reviewed GeneSight test results that were done by a community psychiatrist which showed that Latuda fell under the "use as directed" category for this recipient and Zyprexa fell under the "use with extreme caution" category. The recipient's mother also vocalized how upset she was that the treatment team ignored the swab study and put the recipient on Zyprexa. When the HRA questioned the psychiatrist about this test results, he admitted to reviewing the results and discussing them with the community psychiatrist, treatment team and the pharmacist at Chester but chose to disregard it as he was not aware of the efficacy of such testing. Therefore he followed what he felt was "clinically indicated" and kept the recipient on the Zyprexa stating that was the medication the recipient had previously been on when at Chester and noted that he was able to be discharged. The HRA found no documentation from the psychiatrist in the chart indicating that he had reviewed the test results or his rationale for not following the recommendations of the test results. The Mental Health Code (405 ILCS 5/2-102) requires that treatment plans be formulated with the participation of the recipient and any other individual designated in writing by the recipient. The facility's Treatment Plan Policy says that treatment planning is an ongoing process in which problems, goals, objectives and interventions are identified and monitored. The treatment process is to be documented throughout a patient's

stay via assessments, treatment plan reviews, progress notes and other documentation. The Treating Psychiatrist is listed in this policy as the person responsible for ensuring prescribed treatment is appropriate. Due to lack of documentation of the GeneSight test and explanation as to why it was not utilized to ensure the Code's required appropriate, least restrictive treatment consistent with the recipient's views, this allegation is **substantiated.** The following **recommendations** are made:

1. **Psychiatrists and other treatment team members should be retrained on the facility's policy for treatment planning and documentation as well as Mental Health Code requirements that treatment plans be formulated with participation of the recipient, guardian and other individuals designated by the recipient.**

The HRA offers the following suggestions:

1. In May it was documented that the recipient was experiencing paranoia, anxiousness and agitation but had no instances of aggressive behaviors. Three weeks later the psychiatrists recommended an increase in the Latuda medication. The HRA questions if paranoid, anxious and agitated behaviors without any incidents of aggression towards others warranted a medication increase and suggests that the treatment team consider all factors when determining if a medication increase is necessary or if other treatment alternatives could be beneficial to the patient.

2. The HRA was concerned with the report from the recipient that the psychiatrist told him to *"turn a blind eye"* to what was happening with other patients. The psychiatrist had documented in a May progress note that the recipient had *"threatened this writer to report to OIG about some advice this writer provided to keep him out of trouble."* Administration should review this allegation further to clarify what was said to the recipient and ensure that proper standard of care is being upheld for all patients at the facility.

3. Administration should follow up with the Department of Mental Health on directives for DNA mapping tests and provide training for prescribing physicians on any directives that are in place and on the testing itself.