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HUMAN RIGHTS AUTHORITY-CHICAGO REGION

REPORT 18-030-9025
JOHN MADDEN MENTAL HEALTH CENTER

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of rights violations in the treatment provided to a patient at Madden Mental Health Center, a state-operated hospital in Hines. Allegations are that the patient was made to surrender his bracelets on admission, and when he argued to keep them he was jumped by several security guards, taken to the ground, put in a chokehold and injected.

Substantiated findings would violate right-to-refuse protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

The HRA met with administration and those involved in the patient's care to discuss the matter. Relevant policies were reviewed as was the patient's medical record with authorization.

FINDINGS

A matching incident was documented in the record. The intake psychiatric evaluation noted the thirty-year-old man to arrive angry, not allowing a routine search. He yelled at and threatened to harm the staff and was not redirectable. Restraints were applied and Ziprasidone, Lorazepam and Diphenhydramine were injected. There was no mention of security guard involvement. He was described as calm an hour later on release from the restraints but he still refused to complete the evaluation.

The emergency medication progress note for the same event provided more descriptive documentation by the administering nurse. She wrote that the patient became agitated in the search room and refused to comply with the initial body search. He yelled and kicked at the staff and tried to hit and bite them. Less restrictive alternatives like empathetic listening and other

diversions were unsuccessful before the injections according to the nurse's note, and she referenced nothing about security guard involvement either.

Emergency medication and restraint orders were completed by each that stated much of the same and a flow sheet was filled out every fifteen minutes throughout the duration. The corresponding restriction notice detailed reasons for the orders and it noted attempts to redirect him beforehand. The patient refused to provide any emergency intervention preferences or designate anyone to be notified of the restriction.

A personal property log listed several valuables and clothing items including two long strings that were taken from the patient and retained by the facility for safe keeping, all returned upon discharge.

The physician was no longer at Madden when we visited but the administering nurse explained what took place. She said the patient was initially calm but got upset quickly when they approached him for the body search. They asked him to remove his necklace and a bracelet made of two long strings, both of which she and the charge nurse considered potentially dangerous. They continued to persuade him to cooperate and he continually refused to the point they would need to restrain him to complete the necessary search and removal. Asked about security, she said two guards had to handle him. In her recollection, the patient shifted down from the chairs to the floor on his own when they approached him and each guard took an arm, lifted him up and walked him to where he would be restrained. At no time was he jumped, taken to the ground and put in a chokehold. The patient continued to struggle; he spit and kicked at them and carried on even after restrained which is why the meds were given.

CONCLUSION

Madden's patient property/intake policy calls for valuable items to be kept for the patient and returned on discharge. Items considered dangerous are confiscated. Under the Mental Health Code, possession of certain properties may be restricted to protect from harm (405 ILCS 5/2-104). A patient has the right to refuse treatment unless it becomes necessary to prevent serious and imminent physical harm and no less restrictive alternative is available (405 ILCS 5/2-107) and the physical abuse of any patient is prohibited (405 ILCS 5/2-112). Body searches are common and mandatory at all psychiatric facilities where safety is a paramount concern and all patients must be checked. This patient was given multiple opportunities to allow the search and surrender what was valuable or potentially harmful, and when he was approached by security guards he became aggressive, kicking, biting and spitting according to the staff present and their documentation, and there is no evidence to the claim that he was taken to the ground and put in a chokehold. The patient controlled the situation, and a violation of his rights is not substantiated.

SUGGESTION

The Order for Physical Hold, Mechanical Restraint or Seclusion form (IL 462-0044MR) states in pre-print that in the prescribers' assessments the restraints pose no undue risk in light of

the individual's physical or mental condition. The Code meanwhile, requires a statement of undue risk in light of the individual's physical or medical condition (405 ILCS 5/2-108), quite a different risk assessment that should be addressed immediately and changed on all forms.