FOR IMMEDIATE RELEASE

North Suburban Regional Human Rights Authority
Report of Findings
HRA #18-100-9025
Elgin Mental Health Center

Introduction

The North Suburban Regional Human Rights Authority (HRA) opened this investigation regarding Elgin Mental Health Center (EMHC), Forensic Treatment Program (FTP) K after receiving a complaint of alleged rights violations. The complaint accepted for investigation alleged that a patient had received an unjust restriction for a unit rule violation; a Restriction of Rights Notice was not issued and the restriction is not being reviewed by the treatment team.

The rights of patients receiving services at EMHC are protected by the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5).

Patients receiving services at EMHC's Forensic Treatment Program have been remanded by Illinois County Courts to the Illinois Department of Human Services (DHS) under statutes finding them Unfit to Stand Trial (UST) and Not Guilty by Reason of Insanity (NGRI). Placement evaluations determine the most appropriate inpatient or outpatient setting for forensic treatment based on a number of factors including age, gender, mental health diagnosis, and security need. Unless a person is specifically ordered to receive services in an outpatient setting, court ordered referrals under state forensic statutes call for placement in a secure inpatient setting. The Forensic Treatment Program has approximately 315 beds.

Methodology

To pursue this investigation, the HRA requested and reviewed facility policy relevant to the allegation and a portion of the patient's clinical record, with consent. A site visit was conducted at which time the allegation was discussed with the patient's Psychiatrist and Case Manager.

Findings

The complainant alleges that a female patient entered a patient's room without his knowledge or consent and he was sleeping when she entered the room. It was stated that his building pass was suspended, the treatment team is not reviewing the restriction and he did not receive a Restriction of Rights Notice.

According to the clinical record, the patient had been conditionally released from EMHC in January 2016; the release was revoked in November 2016 due to the patient intimidating and threatening his roommates.

On March 11, 2018, chart documentation showed that a female peer was found hiding in the patient's room, under the roommate's bed. The patient reported that the female peer came to his room to talk to him about voices she was hearing. He reported that he was sleeping at the time and when she woke him, he was disoriented. The record noted that both patients were fully clothed.

According to documentation, he was then placed on frequent observations for sexually inappropriate behavior and he was advised to keep his distance from this peer. Initially, the patients were restricted from sitting at the same table together. It was documented that there were several reports of one of them sitting with the other standing very close and they spent most of their time together. Due to the concerns that it was difficult to monitor the activities between the patient and the female peer, the patient was issued a restriction of rights notice on March 19, 2018 to remain on the male side of the unit. Chart documentation showed that the patient was given a copy of the restriction notice. The patient was subsequently transferred to an all-male unit on March 20, 2018. The treatment plan noted that the patient had psychosis and disturbance of mood as a problem area as evidenced by being a danger to others. It was documented that the patient has a history of violent behaviors and threatening, intimidating and manipulative behaviors with peers. The short term goals to addresses this issue was that the patient was to comply with medications, demonstrate zero incidents of aggression in response to psychosis or mood disturbance, participate in group and activities with being suspicious and accusatory.

At the site visit, it was explained that this unit is for persons found "not guilty by reason of insanity". It is for long term patients. The unit is mixed gender comprised of approximately 31 male and 16 female consumers. It was offered that the patient identified in this case has a history of engaging in sexual behaviors with females on the unit. The Physician stated that he talked to the female that had been found in the room and asked her if she intended to continue this relationship once discharged and she replied that they did. Given that answer, it was determined that a relationship was being formulated. The Physician offered that it was questionable whether the female was competent. He stated that some treatment team members thought she was, while others did not. Because the facility has limited beds for females, the male patient was transferred to another unit. It was further stated that the patient, since being transferred to another unit, has been relentless in contacting the female via phone to arrange for times/places to meet. Because the patient was on frequent observations, per policy, he was restricted to the unit and would not be allowed to use his building pass.

The FTP Manual Patient Expectations policy states that because the Forensic Treatment Program is a part of a larger institutional setting in a group living environment, it is necessary to have some expectations and rules to guide the behavior of all patients of the Program. The FTP Environmental Expectations that are shared with each consumer, verbally and via the Consumer Handbook at the time of admission include: "we are expected to practice respect and dignity for other consumers and staff-which includes no violence or fighting, and no foul language; we are expected to adhere to safety practices which maintain the safety of all consumers and staff; we are expected to maintain and respect the environment-which includes no destruction of others' property and keeping our living spaces and working spaces clean; we are expected to take care of our own property and not to borrow, lend, share, or give things away-which includes food and other items; we are expected to keep ourselves appropriately dressed, groomed, and clean both on the unit and off." The Handbook states that an example for a unit restriction being imposed might include the following: contraband or restricted items found in the room (e.g. candy/food), letting others use your debit card, electric razor found in the room, verbal abuse or fighting. When a restriction has been imposed, it is discussed with the consumer and the consumer is asked if he understands the stipulations presented. Each consumer is held to unit expectations -- no wavering. When on a restriction, the consumer is able to attend off-unit activities that are part of that consumer's treatment plan.

The Center uses the Illinois Department of Human Services Program Directive - Special Observation policy which states that a safe and therapeutic environment entails providing a level of observation for each individual served that is appropriate to the individual's clinical needs. In some

instances, an individual's clinical condition requires enhanced levels of observation/monitoring to ensure the safety and well-being of the individual and others.

The Illinois Department of Human Services Program Directive for Sexual Activity in Mental Health Facilities states that sexual activity between persons who are inpatients at a State-operated mental health facility is prohibited. Limited physical contact as a means of expressing affection (e.g. hugs, greetings or farewell embraces) may be socially appropriate.

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 2-102,"(a) 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.". Based on the information obtained, the HRA does not substantiate the allegation that the patient received an unjust restriction for a unit rule violation or that the restriction was not being reviewed by the treatment team. The chart showed that a Restriction of Rights Notice was issued when the patient was restricted to one side of the unit; rights were not violated.

RESPONSE

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

Bruce Rauner, *Governor*

Illinois Department of Human Services

James T. Dimas, *Secretary*

Elgin Mental Health Center
750 South State Street • Elgin, IL 60123

October 31, 2018

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

RE: HRA#18-100-9025

Dear Ms. Getchell:

Thank you for your thorough review. We are happy to hear these allegations were unsubstantiated. EMHC is proud of the quality of care and excellent medical care we provide to all our patients.

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

Sincerely,

Brian Dawson, B.S.
Hospital Administrator

BD/TZ/am