FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
18-110-9008
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.**

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 280 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 was admitted to Chester Mental Health from jail in August 2017. When the HRA first interviewed him in December 2017 he told the HRA that at a court hearing on December 6th his status was changed to Unfit to Stand Trial (UST). He was involuntarily committed and was told that he would be transferred to a less secure environment but that had not occurred. He stated that he had passed his fitness test twice, is medication compliant and has not had any restraint episodes or restrictions. He stated that the courts had dismissed his charges and he was involuntarily admitted because the staff had said he would not take his medication upon release and were "falsely over-exaggerating documents" to the court stating he is a danger to himself and others. The HRA agreed to monitor his transfer status since the involuntary commitment was ordered just a few weeks prior to our interview.

B. Therapist: The HRA interviewed the recipient's therapist in May 2018 as a follow up because he had not yet been transferred to a less secure environment. At that time, the recipient was a voluntary patient at the facility. The therapist stated that he had been recommended for transfer to a less secure facility on April 30th and was just waiting on a bed to become available for him to be transferred. The process is that as soon as a bed becomes available, a telephone conference will be scheduled and after the telephone conference, a transfer usually occurs within a week. The recipient did not have any legal charges and should not have any barriers to transferring to a less secure facility. After that, his mother and an aunt had expressed willingness to have him move in with them when the less secure facility felt he was ready for discharge.

II. Clinical Chart Review:

A. Case Notes: A social work note dated 10/30/17 documented that the treatment team met to assess his response to medication. The patient was described as having disorganized thoughts which contained ideas of grandeur, persecutory and paranoid content, as well as religious pre-occupation and required redirection. It was discussed that he was on the highest dose of his medication and he did not appear to respond favorably. The recipient accused Chester staff of trying to keep him there longer. The recipient was "encouraged to consent to additional medication/medication change due to lack of progress." He refused to consent stating he was fit because he had passed the fitness test and had not been aggressive. It was noted that the treating psychiatrist was going to petition the court for enforced medication because the "probability of patient attaining fitness while on current medication is unlikely due to the severity of symptoms and patient's poor insight into need for treatment." Nursing notes on 11/1/17 and 11/15/17 documented that the court enforced medication order was received and documented the psychiatrist's new orders to taper his current medication until discontinued and then add the new medication. The first dose of the new medication was given on 11/16/17. It was documented that the patient was argumentative with this process and stated that his 90 days were up and he should go to court. The nurse documented that he "minimizes and attempts to cover up delusional thoughts and processes." Crush and observe medication was recommended at that time and a physician's order for the same was obtained. The recipient had court on 12/13/17 and was involuntarily committed for 90 days. A therapist's note documented that on 1/9/18 court enforced medication was discontinued and noted that the patient was showing improvement and was admitting that he had heard voices in the past and admitted to paranoid behavior of believing others are out to get him. The therapist documented that he "continues to have poor insight into how delusional thoughts impede his ability to make rational decisions." He was given an assignment by the therapist to address that issue. The recipient was transferred in June 2018.

B. Psychiatrist Progress Notes: The September 2017 note stated the recipient was taking medication and had no behavioral reports, restraints or seclusion. The recipient participated in some off-unit activities. The recipient had good insight/judgement and "resolved that he has a mental illness and needs to be on medication." The October note stated the patient was "status quo" and had passed his fitness test. He had no restraints/seclusion episodes, no auditory/visual hallucinations and no suicidal or homicidal ideation/plans. It was noted that he "feels peers persecute him…want to see him struggling." The November note stated that he had no behavioral reports and was compliant with medication. It was documented that he had decreased insight, was easily distracted, was psychotic, and had grandiose delusion and disorganized thoughts. He had no auditory or visual hallucinations and the plan was to continue that week's scheduled meeting regarding medication issues. The December note documented that his legal charges were dropped in court on 12/14/17 and he was now under involuntary commitment. He was presenting as paranoid, with a labile affect, disorganized thoughts and decreased insight and judgement but had no auditory/visual hallucinations, suicidal/homicidal plans, or restraint applications. The psychiatrist noted he was on court enforced, crush and observe medication. The January 2018 note documented that charges were dropped, and the recipient was civilly committed and had passed the fitness test twice. He had no restraint incidents, hallucinations, or suicidal/homicidal plans. The plan was to have the patient sign consent for medications and

discontinue the court enforced medication order. The February note documented that the recipient was taking medication and had improved insight/judgment and no hallucinations or suicidal/homicidal plans.

C. Treatment Plans (TPRs): The initial TPR in August 2017 documented that the recipient attended his meeting. He had reported that someone "put a chip in my head to gain control over me." He also reported hearing voices that tell him when people are trying to hurt him, but he denied hearing those voices at the time of the meeting and denied thoughts of harm to self or others. He signed a consent to take medications. He requested to take a fitness exam and the plan was to administer the test to him and to enroll him in the fitness group with activities according to his level. The October TPR documented that he again participated and was polite and courteous throughout the review. He had no instances of verbal or physical aggression and took his medication as prescribed. It was noted that he had slight improvement in his mental status but continued to verbalize paranoid and persecutory statements. His current barrier to transfer was documented as psychosis. The November TPR listed the current barriers to transfer as "non-compliance with medication" and "psychosis" along with "inability to cooperate." The February 2018 TPR noted "no significant change" as the recipient was still presenting with symptoms of paranoia and persecutory delusions. He was agreeable with taking his medication as he views this "as a means to transfer." It was noted he was aggression free and very active with off unit activities. He required a longer stabilization period before being considered for transfer "as he has just recently signed consent for medications."

D. Utilization Review (UR): In the history section of the UR form dated 1/18/18, it was noted that in 2015 when admitted to Chester the recipient was placed on the medium-security unit but required transfer to the maximum-security unit due to "knocking a peer's teeth out." He has a history of domestic violence towards members of his family and within the community. It was noted that during this most recent admission the recipient has been free of physical aggression and had no incidents of restraints, seclusion or as needed medication. Upon admission the recipient was agreeable to taking Abilify, but he did not have a favorable response and presented with psychiatric symptoms including persecutory grandiose delusions, disorganized thought process, and psychomotor agitation. He was later placed on court enforced Quetiapine due to refusing to consent to a medication. In January 2018 he signed a consent to take medication and the court enforced/crush and observe medication was discontinued. The discharge/transfer barriers are listed as "patient is not yet clinically stable, continues to be acutely ill." The team recommendation was to "continue to work with patient on current treatment plan goals." A handwritten note at the bottom of the page also noted that there had been a "recent medication adjustment. Continue to monitor [illegible] and medication adjustment." The form was signed by the facility director, chief social worker, director of nursing and the quality manager who were all listed as committee members present for the utilization review.

E. Progress Note/UST Fitness Assessment: This form dated 5/24/18 documented that the recipient was medication compliant, his behavior had remained appropriate and aggression free, he followed rules and participated in both on and off unit activities. It was noted that he met with his therapist regularly and they discuss discharge planning. It was documented that the

recipient was clinically stable on his medications and had been recommended for transfer to a less restrictive environment and was awaiting a transfer date at that time.

F. Order for Involuntary Treatment: The Order stated that the recipient is to be *"hospitalized in a Department of Human Services mental health or developmental center, which is the least restrictive environment currently appropriate and available."* It did not mention which facility or what level of security the facility was required to have.

F. Discharge Summary: Upon a subsequent chart review, the HRA found a discharge summary detailing a transfer which was to occur in June 2018.

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."*

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..."

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…"

Regarding 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 allegation is that a recipient was not being served in the least restrictive environment. The investigation revealed that the recipient was admitted to Chester Mental Health in August 2017 and transferred 10 months later in June 2018. In December 2017 the recipient had a court hearing where his legal charges were dropped in lieu of DHS commitment. The recipient claimed that he was told in court that he would be transferred to a less restrictive environment. However, the court Order for involuntary commitment ordered the recipient to be *"hospitalized in a Department of Human Services mental health or developmental center, which is the least restrictive environment currently appropriate and available."* At that time, the recipient was also under an Order for involuntary treatment of psychotropic medication due to a deterioration of his ability to function, suffering and threatening behavior. The court enforced medication order was dismissed in January 2018 and a Utilization Review meeting was held. The outcome of that meeting was that the recipient was not yet clinically stable, and the plan was to continue working with him on current treatment plan goals and it noted that he had a recent medication adjustment that was being monitored. The February psychiatrist note documented that the recipient was taking medication and had improved insight/judgment and had no hallucinations or suicidal or homicidal plans. The February treatment plan stated that he required a longer stabilization period before being considered for transfer as he had just recently signed consent for medications and had a history of non-compliance. The recipient was transferred to a less secure facility in mid-June 2018. The treatment documentation showed a steady progression of improvements from December through May when he was recommended to be transferred to a less secure facility. Therefore, the allegation is **unsubstantiated.** The HRA makes the following **suggestion**:

The Utilization Review form documented that on 11/15/17 the recipient was started on court enforced Quetiapine due to refusing to consent to a medication change. The HRA would like to take this opportunity to remind the facility that simply refusing to consent to a medication or a medication change is a guaranteed right and is not a justification for petitioning the court for enforced medications. Upon further review of case notes, the HRA discovered that on 10/30/17 it was documented in a social work note that the recipient was experiencing paranoia, grandeur thought processes and a deterioration in his ability to function sufficiently. Administration should review the UR forms and Petitions for Court Enforced Medication thoroughly and ensure that all information is accurately reflected and consistent with Code requirements.