FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY-NORTH SUBURBAN REGION

REPORT 20-100-9004
ELGIN MENTAL HEALTH CENTER

Introduction

On October 14, 2020, the North Suburban Regional Human Rights Authority (HRA) opened an investigation of possible rights violations regarding the Forensic Program at Elgin Mental Health Center (EMHC). The complaint alleged that EMHC has not provided the patient with adequate and humane services to move him toward release. Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Unified Code of Corrections (730 ILCS 5).

Section 5/2-102 (a) of the Illinois Mental Health and Developmental Disabilities Code states that 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. Section 5/5-2-4(b) of the Unified Code of Corrections (730 ILCS) states that the *Thiem* date: "shall not exceed the maximum length of time that the defendant would have been required to serve . . . before becoming eligible for release had he been convicted of and received the maximum sentence for the most serious crime for which he has been acquitted by reason of insanity."

Clients 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 several 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 290 beds.

Method of Investigation

To proceed with this investigation, the HRA reviewed the client's clinical record including court documents (with authorization), for calendar year 2020. The HRA obtained additional case information through an interview with the hospital administrator and the following members of the client's staffing team: a psychiatrist, RN2, and SWII. The HRA also reviewed relevant EMHC policies. The HRA acknowledges and appreciates the full cooperation of EMHC personnel in this investigation.

Treatment Summary
The client records indicate that on 6/5/2006 the client was adjudicated Not Guilty by Reason of Insanity (NGRI) on the charge of First Degree Murder. The Thiem date is 12/13/2062. The client was initially placed in Chester Mental Health Center and was transferred to the Forensic Program at Elgin Mental Health Center on 6/12/2018. EMHC records state that the client has a primary diagnosis of Severe Alcohol Use Disorder, Severe Cocaine Use Disorder, and Mild Cannabis Use Disorder. The treatment team reported to the HRA that the client has not used cocaine, alcohol, or marijuana in the 17 years that he has resided in state hospitals. The diagnosis of Substance Use Disorders is based on police reports that the client was smoking "crack" cocaine and drinking alcohol at the time he committed the crime. Successful completion of a Mental Illness Substance Abuse (MISA) program is a key treatment goal. The court report and the treatment plan documents indicate that the client has completed the educational component of the MISA program, but according to the December 2020 court report, the client has been unable to complete a relapse prevention plan because he denies having a substance use disorder. The records indicate that the client had not been prescribed psychotropic medication while at EMHC due to a lack of "active psychotic symptoms*"*.

The record describes the client as having a history of non-compliance with staff directives, making false allegations against staff, and being verbally abusive towards staff – primarily through racist remarks. The staff corroborated this information in their interview, although elaborated that from July 2020 through the present, the client ". . . has not [been] engaging in racial name calling or making false allegations against staff or peers." There are no violent behavioral incidents documented in the record, which staff corroborated in the interview.

EMHC staff reported in a note requested by HRA after the staff interview, that around July 2020 the client has been having video visits with family, who live far away and had not been able to visit for many years. Initially staff had to assist with these video calls, which helped improve the client's rapport with staff. This, along with more one-on one-sessions with staff have contributed to what staff described in an interview as the client's "night and day" transformation beginning in July 2020, continuing through the present.

The December 2020 court report states that the client's Supervised Off-Ground privileges were reinstated in October 2020, and a recent letter from the treatment team indicates that the client received Unsupervised On-Ground privileges in January 2021. During the interview, the staff indicated that the client currently has the highest level of privileges. The client is on track to be considered for conditional discharge, the client must "demonstrate the appropriate use of the court granted privileges and sustained stability." This will be assessed ongoing after Covid-19 safety restrictions are relaxed.

Analysis
During the investigative interview and in a letter afterwards, the EMHC staffing team provided sufficient evidence that the client has been steadily advancing toward the goal of timely conditional discharge. The staffing team made it clear that the client exhibited a marked behavior

improvement beginning July 2020. In July 2020 the client record begins to document some behavioral improvement from previous months. However, the written record *itself* does not present clear evidence of client progress, although the achievement dates of certain treatment goals are documented.

One example of this lack of clarity can be found in the monthly 1170-FTP Interdisciplinary Staffing reports. The response to the "Patient's Progress Since Last Staffing" indicates the client's adjudication history and provides a detailed description of the related crime, and does not mention the client's current cognitive, emotional, or behavioral functioning. Moreover, this response is repeated verbatim each month from January 2020 through December 2020, so it does not indicate change over time.

This documentation does not meet the document standard stated in EMHC's Forensic Treatment Program Policy Manual. *Policy 306: Treatment Plan Update* states that the Progress Since Last Staffing section should include a "statement of the current cognitive, emotional, and behavioral functioning of the patient. The information in this section is used as a progress indicator from one treatment update to the next."

Elsewhere in the written record client progress is described in terms of current behaviors, however there are numerous instances of information being vague, as well as repeated verbatim from month to month.

The following two examples from the treatment plan do not match the documentation standard presented in the policy manual. Policy 1545 describing Progress Note Documentation Procedure states: "Terse, isolated observations such as 'patient slept well,' 'no complaint,' or 'received patient in day room' are not sufficient and should be avoided."

The psychiatrist's 1175A report repeats the following Progress Toward Short Term Goals response verbatim each month from July 2020 through December 2020:
"The patient has been very cooperative and compliant with the treatment team and has not engaged in any disruptive or oppositional behavior and has not made any racial comments and has not made any false accusations against the staff."

The RN2 and RN1's 1175A report repeats the Progress Toward Short Term Goals response verbatim each month from January 2020 through November 2020:
"[Patient] continues to deny any hallucinations, no thoughts of harming self. [The client] still refuses to take any psychotropic meds."

While the above statements indicate that the client exhibits some positive behaviors and a lack of harmful behaviors, they provide little historical context to demonstrate progress, and because they are repeated from month to month they do not reflect any change in behavior over time. Additionally, the RNs' repeated statement does not indicate progress because, according to the record, the client has not reported hallucinations or plans of self-harm since arrival at EMHC, and psychotropic medications have never been part of the client's treatment plan.

Elgin Mental Health Center's Policy & Procedure Manual Policy 1520: Assessment of Patient Needs Procedure states: "Assessment is a continuous process achieved through the communicated observations of all staff . . .Whenever a change of condition is suspected, staff will immediately . . . insure prompt attention of the treatment team." When assessment and progress notes are copied and pasted from one month to the next, observations cannot be communicated in "real-time' and therefore a change of condition (in this client's case a positive one) cannot be addressed in a prompt manner.

Section 5/2-102 (a) of the Illinois Mental Health and Developmental Disabilities Code states that a recipient of services shall be provided with adequate and humane care and services . . ., pursuant to an individual services plan." This language prohibits the use of generic interventions to address specific client needs, and this requirement should also discourage the use of generic language to describe specific time periods.

Another important reason to maintain a written record that reflects client progress in specific and time-bound descriptions is that the medical record is a legal document that follows the client throughout life, as such it should paint a clear picture of past events and be an accurate reflection of care provided to the patient.

Case Findings

Based on the information obtained from the record reviews and interviews with clinical staff at EMHC, the allegation that EMHC has not provided the patient with adequate and humane services to move him toward release is *unsubstantiated*. The Human Rights Authority (HRA) found that the client *has* been receiving adequate care and services to move towards release from the NGRI commitment at the earliest point. However, the underlying documentation to support the release is inconsistent and not fully compliant with policy requirements. Thus, the HRA *substantiates* the complaint of lack of adequate treatment, regarding the documented record.

Suggestions

The HRA recommends that the client's demonstration of appropriate use of the court granted privileges and sustained stability be documented in the record following EMHC Policy Manual guidelines: Using detailed language that is specific and unique to each individual report or progress note. Copying and pasting from one note to the next is incorrect documentation practice and does not provide an accurate reflection of an individual's progress (or lack thereof) over time in the record. Provide the HRA with proof that documentation for this client, moving forward, is accurate and consistent with policy. Retrain staff on this policy and provide the HRA with proof of the training.

RESPONSE

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

JB Pritzker, *Governor*

Illinois Department of Human Services

Grace B. Hou, *Secretary*

Elgin Mental Health Center
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Ms. Mariah Balaban
Human Rights Authority
9511 Harrison Street, W-335
Des Plaines, IL 60016-1565

HRA# 21-100-9004

May 12, 2021

Dear Ms. Balaban:

Thank you for your letter regarding your findings. EMHC agrees that it is important that treatment interventions are documented specifically and accurately to demonstrate the progress of the patient. EMHC will engage the involved staff in further training of EMHC Policy and Procedure 1545 and 1520 regarding documentation within 30 days and will submit this evidence and evidence of ongoing documentation of the client's treatment as well.

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

Respectfully,

Michelle Evans, DSW
Hospital Administrator