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**FOR IMMEDIATE RELEASE**

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**Egyptian Regional Human Rights Authority  
Report of Findings  
16-110-9001  
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 allowed to communicate with his attorney.**
- 2. A recipient's rights have been inappropriately restricted.**

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2 et al.) and Chester policies.

Chester Mental Health Center is a state-operated mental health facility serving approximately 240 recipients; it is considered the most secure and restrictive state-operated mental health facility in the state.

To investigate the allegations, the HRA interviewed the recipient and facility staff, reviewed the recipient's record with consent, and examined pertinent policies and mandates.

**I. Interviews:**

**A. Recipient:** The HRA met with the recipient the end of June. He stated that his therapist would not let him call his attorney but gave him no reason other than he would not be allowed to call his attorney until he is fit. He thought that he was being recommended as fit to stand trial and had a court date on June 3<sup>rd</sup>; however he was not allowed to go. He asked his treatment team about it and was told that he had not been recommended as fit and they did not know when his next court date would be. He cannot talk to his attorney to find out what is going on because his therapist will not allow him to call. The HRA met with the recipient a second time in mid-August and he informed the HRA that he had been allowed to contact his attorney one time. He also stated he had court that day on a Petition for Court Enforced Medication but that the judge did not approve it. However, the doctor stated that if he refused, they would inject him with medication anyway, so he agreed to take it orally.

During the mid-August visit, he also shared with the HRA that he had been on unit restriction for approximately a month and as such, he was not allowed to go outside or to the gym. He was not given a restriction of rights form. The recipient told the HRA that on July 21<sup>st</sup> he had kicked a basketball when he was in the gym but did not kick it at anyone. A STA

[security therapy aide] escorted him back to his unit, placed him in seclusion and injected him with medication rather than letting him calm down on his own. His unit restriction started that week. He was under the impression that after 2 weeks he would be able to go to the library, gym, yard and cafeteria again. He also stated they would not let him go to the barber.

He stated that the water in his room was also turned off but he wasn't told why. He asked to see the allegations against him and it was documented that he flooded his room. However, he said he did not flood his room; he just turned the water on in a slow trickle to help him sleep at night. He had asked a doctor for Benadryl but the doctor said the medication was not good for him but did not offer an alternative.

B. Therapist: The HRA spoke with the therapist on August 25<sup>th</sup> regarding the recipient's restrictions and how long the restriction would be in place and also asked about his access to the barber. The therapist stated that he was not on any restrictions but had lost his "off unit privileges" due to physical aggression towards staff on July 23<sup>rd</sup> and 24<sup>th</sup>. The recipient injured 5 employees on those dates. She also informed the HRA that the recipient was refusing to take his medication as prescribed and was placed on court enforced medication. At the time of our discussion, the therapist stated that the recipient continued to remain verbally threatening towards staff, impulsive and explosive as recently as August 22<sup>nd</sup>. However the therapist did schedule the barber to come to the unit to cut his hair on that date. The treatment team had met with the recipient on August 24<sup>th</sup> and informed him that if he did not exhibit verbal or physical aggression, he would regain his off-unit privileges on Friday (3 days later).

C. Human Rights Chairperson and Director of Clinical Operations: The HRA asked the chairperson if any complaints had been received from the recipient regarding being on unit restriction. The response was that he did not have any record of receiving any complaints but agreed to follow up. Later that day, the chairperson informed the HRA that he had checked with the recipient's Unit Director and was informed that he did not have gym privileges for several days as a result of problematic behaviors he displayed while in the gym. The Director of Clinical Operations had also responded to clarify that Chester does not have "unit restriction" only "loss of privileges" that allow patients to attend activities off the unit. These privileges are evaluated periodically and when needed. However, if they do not go off unit, that is not considered a restriction, just a loss of privilege. The HRA asked the new chairperson [who had since taken over for the previous chairperson] for a list of what is considered "off unit activities." The following list of activities which are considered privileges was given:

- Dining Room
- Rehabilitation/Education
- Gym
- Treatment Mall
- Game Room
- Yards
- Barber
- Auditorium

The HRA met with the Facility Administrator and the Director of Clinical Operations to clarify why Rehabilitation/Education would be considered a privilege and not treatment. The explanation given was that Clinical Therapy/Active Treatment is conducted on the unit by Nurses, Activity Therapists and Social Workers (Licensed professionals). Rehabilitation/Education is conducted by educators/vocational rehabilitation professionals and therefore is considered a privilege to attend since the classes are things such as library, art, horticulture and activities of daily living (ADL). Some Art therapy is done on the unit when the treatment team considers it therapy for certain individuals but it is not typically considered active treatment. Groups for patients with intellectual disabilities for ADLs can come to the unit if those patients refuse to go to rehabilitation classes or if they do not have privileging levels.

## **II. Clinical Chart Review**

**A...Request for Transfer to Chester Mental Health Center Maximum Security:** The HRA reviewed the transfer request for the recipient to go from the medium security unit at Chester to the maximum security unit. His diagnoses are listed as Axis I: Schizoaffective Disorder, Bipolar Type; Axis II: No Diagnosis; Axis III: No Diagnosis; Axis IV: UST [Unfit to Stand Trial]; Confinement; Medication non-compliance; Axis V: GAF [Global Assessment of Functioning] 50. The Rationale for Request Transfer to Chester section states: *“On 6-6-15, a patient was being placed in restraints [recipient] attempted to block the access to staff members trying to get to an aggressive patient. He drew back his arm with a clinched fist. He was placed in a physical hold where he continued to struggle. He was then placed in 5 point restraints.”* Attempted Interventions were listed as *“PRN [as needed] medication, increased medication, individual therapy and restraints.”* The expected benefit of transfer listed the following reasons: *“needs a higher level of security and more structure. When given opportunities to engage in activities, he chooses to make bad decisions i.e.: pull the fire alarm, curse staff (“you backwards watch wearing [expletive]...You blue jean wearing [expletive]”; throwing cards in the face of staff; glaring at staff in an attempt to intimidate them. In order for [recipient] to return to Chester Medium security he will need to be clinically stable for a 3 month period, demonstrate that he is willing to work with the treatment team and follow the rules of the module.)”*

**B...Treatment Plan Reviews (TPRs):** The 6/8/15 TPR documented that the recipient was arrested on a felony charge of intimidation, found unfit to stand trial (UST) and was initially admitted to the medium security unit at Chester. Approximately 6 weeks later he was transferred to the maximum security unit due to aggressive behaviors towards staff. The recipient attended this treatment meeting and presented as “hostile and belligerent”, denying behaviors and stating staff were trying to set him up. This was his 3 day TPR since being transferred to the maximum security unit. It was noted in the TPR that he would be offered 2 stamps per week for mail communication and 2 free telephone calls per week with staff assistance and that there was also a telephone on the module. His preferences for emergency intervention were listed as 1) emergency medication 2) seclusion and 3) restraints. The Criteria for Separation section stated that in order to be recommended for return to the county jail as fit, the following criteria would have to be met: Be able to communicate with counsel and assist in his own defense; Be able to appreciate presence in relation to time, place and things; Be able to understand he is in a court of justice charged with a criminal offense; Show an understanding of his charges and consequences, court procedures and various roles of personnel in the courtroom; Have memory to relate the

circumstances surrounding the offense and Demonstrate that there has been a significant reduction in aggressive behavior

The 7/6/15 TPR documented that the recipient was present and continued to present as “hostile and belligerent”, denying his negative behaviors and “attempts to blame his behaviors on others.” The TPR noted that he received 18 behavioral data reports (BDRs) for being disruptive, noncompliant and threatening using profanity stating “I don’t give a \*\*\*\* about anybody else I do what the \*\*\* I want!” It also noted that on 6/7/15 his water was turned off, per doctor’s order, due to his flooding his room after plugging up his sink. On 6/13/15, he attempted to flood the module bathroom by plugging up the sink. It also documented that on 6/15/15 he was kicking a ball from one end to the other side of the gym. Staff asked him to stop due to him endangering other patients and he refused. The criteria for separation was the same as the 6/8/15 TPR. The individual preferences remained unchanged: 1) emergency medication 2) seclusion and 3) restraint.

A 7/24/15 Treatment Modification Plan was completed due to verbally threatening and physically aggressive behaviors towards staff. The recipient was described as “noncompliant and oppositional.” He had refused to follow the doctor’s medication recommendations and started refusing medications on 7/5/15. On 7/23/15 while in the gym, the recipient demanded a soccer ball to use in the yard; staff asked him to move so that he could walk through a door and the recipient began yelling at staff and stating he did not like him, then he jumped up and hit the basketball backboard. After that, the recipient began flipping his middle fingers and kicked a basketball against the wall. He was asked to return to the unit and during escort he was highly agitated and threatening staff. He was placed in a physical hold and placed in seclusion based on his preferences. He continued to escalate and staff attempted to enter to give a PRN [as needed medication] per doctor’s order, but the recipient “aggressively attacked staff” and was placed in restraints. The recipient injured 2 employees. That evening in the dining room, the recipient refused to throw his trash away stating “I don’t have to do a \*\*\*\*ing thing staff tells me.” On 7/24/15 the recipient sat his breakfast tray on the floor and refused to pick it up. After that, he walked by staff and “shoulder checked him.” He was asked to go to his room and the recipient started walking to his room but then spontaneously turned and punched a staff member. He was placed in handcuffs and 5 point restraints due to continued aggression. He injured 3 employees on this date. Due to these aggressive behaviors, the treatment plan was modified to include a step down process when he requires restraint. Once released from 4 point restraint, he is to be placed in 2 point ambulatory restraints. If his aggression is not contained, then 4 point ambulatory restraints will be utilized. Prior to release, the treatment team will meet to evaluate the need for ambulatory restraints as indicated. It was noted that 2 point restraints are deemed to be the least restrictive alternative to ensure protection of himself and others. While in ambulatory restraints, he will also have 1:1 staff to protect him from harm to self or others. The criteria for release is to be compliant with routine procedures, refrain from physical and verbal aggression, be able to express adequate coping skills relating to a loss in his family and continue to follow a plan to avoid future aggression, be considered to not be an imminent threat to self or others for 60 minutes and if at any time he is considered an imminent threat, he will be immediately evaluated by the treatment team for level of care. A general overview was also included as follows: 1) Recipient will be on 1:1 observation while in ambulatory restraints until determined by the treatment team; 2) during sleep hours, he will be released to a security room

and on routine observation; 3) the STA II will assign 1:1; and 4) A daily routine should be followed. The daily routine listed the following: he will receive all 3 meals on the unit, non-dominant arm will be released during the meals and also upon requests to use the restroom, the non-dominant arm will be released, showers will occur at 7 am and then he will be immediately placed in ambulatory restraints. Once showered he would be given the opportunity to join the module activity or return to his room, but would remain on "unit restriction." The recipient is allowed access to the telephone and communication. The recipient was to meet daily with his treatment team and have weekly TPR meetings while on special observation status. A log will be kept documenting all that he says and does.

The 8/3/15 TPR was the final one reviewed by the HRA. It noted that the recipient refused to attend his TPR meeting. He was placed on emergency enforced medication on 7/23/15 due to violent and aggressive behaviors causing physical injury to others while awaiting court approval for court enforced medications. It was noted that he remained uncooperative. An interim treatment plan was completed on 8/10/15 due to the recipient threatening staff on 8/8/15 demanding a PRN and to be placed in seclusion after attempting to barricade himself in his room. It was noted that the treatment team continues to encourage him to engage in treatment. His emergency preferences were still listed as 1) emergency medication 2) seclusion and 3) restraint.

C. Petition and Order for Court Enforced Medication: The Petition was dated 7/27/15 which described his current mental status and hospital course. He was admitted in April, 2015 to the medium security unit, but had to be transferred to the maximum security side due to aggression and paranoid delusions. His behavior was described as unpredictable and aggressive. It also stated that his condition had decompensated to the point that he became so unmanageable that the only way to contain his aggression was by giving him psychotropic medications against his will. The Psychiatrist completing the petition stated that without medications, "he may become an impending threat to become extremely violent and cause physical harm to others or hurt himself." The justification for court enforced medication was: "*chronic history of mental illness commencing at age 18 and has manifested a mixture of schizophrenic like symptoms which include disorganized behavior and thinking and auditory hallucinations and mood symptoms which include irritable and labile mood and loud, rowdy and disruptive behaviors. There are no indications that this is secondary to psychoactive substance or a general medical disorder.*" The Forensic Coordinator signed a certificate of faxing which documented that on 7/27/15 he faxed a copy of the Attorney Notification for Enforced Medication to the recipient's public defender in his county of record. On 7/29/15 an Order was signed which stated that the matter came before the Court on that date and an oral Motion of the State was made for a continuance. The Order also stated there was no objection from Respondent's counsel and the matter of court enforced medication was continued to August 5<sup>th</sup>. In addition, the Order stated that "*the Respondent shall continue to take all prescribed medications until the new hearing date.*" On 8/3/15 another Order was issued continuing the matter to August 19<sup>th</sup> and stated once again that "*The respondent shall continue to take all prescribed medications until the new hearing date.*" The 8/19/15 Order stated that the recipient was exhibiting a deterioration of his ability to function, suffering and threatening behavior and authorized involuntary treatment with Olanzapine and Lorazepam. The Order was signed by a judge and file marked 8/19/15.

D. Medication Orders: A physician's order to shut off water to the recipient's room "*to prevent flooding until evaluated by treatment team*" was signed on 6/7/15. On Thursday, 7/23/15 at 11:30 a.m. the physician ordered "*Olanzapine 10 mg IM [intramuscular] for control of psychotic aggression...atypical protocol.*" At 1:50 p.m. the physician ordered "*Olanzapine Enforce 10 mg BID [twice daily] for control of psychosis. If refuses give 10 mg IM...crush/observe atypical protocol.*" At 2:30 p.m. the physician ordered "*Enforce Emergency Lorazepam 2 mg PO [orally] BID if refuses give IM on agitation.*" On Friday, 7/24/15 at 9:00 a.m. the physician ordered "*Lorazepam 2 mg PO BID. If refuses give IM on agitation Olanzapine 10 mg PO BID if refuses give IM*" On Saturday, 7/25/15 at 8:00 a.m. the physician ordered "*24 hour emergency enforced medication Olanzapine 10 mg PO BID if refuses give IM Lorazepam 2 mg PO BID if refuses give IM for agitation.*" This same prescription was re-ordered daily through 8/9/15. Starting on 8/10/15 at 9:30 a.m., the 24 hour emergency enforced medication order changed to "*Olanzapine 10 mg PO AM and 20 mg at HS [hour of sleep] for psychosis If patient refuses PO, give IM. Lorazepam 2 mg PO BID for agitation, if patient refuses PO give IM.*" This order was continued daily through 8/13/15 at 9:30 a.m. On 8/14/15 the same order was changed to add the following to the above order: "*1 hour between Olanzapine IM and Lorazepam IM.*" This was re-ordered daily through 8/19/15. On 8/19/15 at 1:30 p.m. the order was discontinued and changed to "*Court Enforced Olanzapine 10 mg a.m. 20 mg HS to control psychosis. If refused give IM, Lorazepam 2 mg PO BID for agitation, if refused give 2 mg IM.*"

The Medication Administration Record (MAR) showed that the recipient received Olanzapine 10 mg PO BID (crush and observe) July 23<sup>rd</sup> through the 31<sup>st</sup> at 9:00 a.m. and 9:00 p.m. He also received Lorazepam 2 mg PO BID July 23<sup>rd</sup> through the 31<sup>st</sup> at 9:00 a.m. and 9:00 p.m. There was one documented refusal on July 23<sup>rd</sup> morning dose and Lorazepam 2mg IM was given. Lorazepam 2 mg one time PO was also given on July 27<sup>th</sup> at 6:00 p.m. for agitation as emergency enforced. On July 29<sup>th</sup> at 3:37 p.m. and July 30<sup>th</sup> at 2:30 p.m. Lorazepam was also given for agitation as a one-time order.

E. Injury Reports/Restriction of Rights (ROR): An injury report dated 7/23/15 at 11:25 a.m. noted bruising to bilateral inner biceps, a scratch on right inner bicep, bruise under left eye and neck stiffness. The recipient stated "this is all from them putting me in restraints." A physician exam was deemed not necessary. The report noted that the Office of Inspector General (OIG) was notified.

Another injury report dated 7/24/15 at 6:00 p.m. noted swelling of area on left posterior head that was discovered by a nurse in the restraint room. The recipient stated "they attacked me." It was noted that 3 staff were injured. A physician examined the recipient and Tylenol was given.

A Restriction of Rights (ROR) form was completed on 6/8/15 restricting sink water in his room. The reason identified is stated as: *recipient continues to run water in sink constantly. Refuses to follow directions to turn off water in his room.*" The restriction was effective that day and continued "*until reviewed by treatment team.*" On 6/29/15 another ROR was completed which placed the recipient on supervised pencil use. The reason documented was that "*Patient threw his new pencil in the trash. He remains noncompliant with therapy and staffs' direction. He remains impulsive and exhibits irrational thought.*" The restriction was for 6/29/15 until

7/29/15. On 7/23/15 at 11:31 a.m. another restriction of rights was given for emergency medication of Olanzapine 10 mg IM due to the recipient being “extremely agitated, poor insight to illness, cursing, verbally threatening to kill staff, fists clenched, defensive stance. Remains imminent risk of harm to self / others.” The recipient’s emergency preferences were utilized: 1) emergency medication 2) seclusion and 3) restraints. Another ROR form was completed at 2:35 p.m. that same day indicating emergency medication was given due to the recipient “*cursing, yelling, verbally threatening to kill staff, poor insight to illness, poses imminent risk of harm to self/others.*” At 8:00 p.m. another ROR was completed for emergency medication the reason was listed as “*does not take part in working towards ability to go to court, pt [patient] consistently attempts to start gang like activity with peers, pt has become physically aggressive towards staff many times that have resulted in staff injuries. Pt requires medication in order to help move toward assisting in his own defense.*” On 7/24/15 at 8:30 a.m. a ROR documented that emergency medication was given due to “*patient hurt two staff members this am. Remains aggressive, cursing and threatening staff while in restraints. Pulling at restraints, resisting and tugging.*” It was noted that his individual preference for emergencies was not followed because “*1<sup>st</sup> seclusion not used due to extreme [illegible] towards staff. Medication necessary due to mental illness and to prevent further injury to staff.*” Another ROR was given at 8:05 p.m. this same date for emergency medication stating the reason as “*Pt attacked staff on 7/23/15 and 7/24/15 requiring 5 pt FLRs [full leather restraints] He is physically and verbally aggressive, lacks insight to mental illness, without EEM [emergency enforced medication] pt poses imminent risk to self and others.*” The HRA noted that the TPRs all listed medication as first emergency preference, however the ROR forms listed his emergency preference as 1) seclusion 2) medication and 3) restraints. The HRA reviewed several other ROR forms dating through 8/19/15 at 8:45 a.m. stating emergency medication was used due to risk of harm to self and others. On 8/19/15 the ROR form stated court enforced medication was given at 8:00 p.m.

F. Progress Notes: On 6/7/15 a STA [security therapy aide] note stated that the recipient had been stopping up the sink in his room with soap and leaving the water running in order to flood his room. It was also noted that the staff had to unplug the sink several times that day to keep the room from being flooded. On 6/7/15 at 9:00 a nursing note indicated that an order was received from the doctor to shut the water off to the recipient’s room until it is evaluated by the treatment team to prevent flooding of the room. On 6/22/15 a social worker note documented that the recipient was provided with a phone call to his attorney. The recipient became agitated and stated he wanted the social worker to speak to the attorney’s secretary, after an authorization was signed. On 7/7/15 a social worker note documented that the recipient was informed that his sink was turned back on and he was no longer on gym restriction. However the recipient “*refused to discuss why he remains unfit to stand trial or his need for mental health treatment.*” It was also documented that the recipient “*demanded this writer call his attorney. He was informed that a call would not be made when he is verbally combative and threatening towards this writer. He was asked to calm down and refused. Therefore our session was ended at this time.*” On 7/10/15 a social worker note documented another meeting with the recipient and noted that he was more organized in his thinking and engaged in therapy. They discussed the importance of the recipient keeping his assigned pencil and why it was dangerous to throw it in the trash. The recipient was also informed that he would be removed from supervised pencil use “*due to decreased paranoid thoughts and agitation.*”

A nursing note dated 7/23/15 documented that the recipient was in the gym yelling, cursing, demanding, verbally threatening, and not following staff direction. He was escorted to the unit and was placed in a physical hold due to resisting and struggling and posing imminent risk of harm to self and others. He was placed in seclusion, his preferences were honored and a restriction of rights [ROR] form was given. The physicians were notified. At 11:20 a.m. a nursing note documented that the recipient was yelling, cursing, fighting staff when medication was attempted to be given. The recipient attacked staff "*fighting violently*" and 5 point FLRs were utilized at 11:30 a.m. Emergency enforced Olanzapine IM was given at 11:31 a.m. and ROR form was given and the physician was notified. At 11:35 a.m. a nursing note documented that the recipient reported alleged abuse by staff stating "I was punched in the left side of face." His vital signs were taken and the nurse documented "no notable injury noted. Dr [name] to evaluate. [OIG liaison] notified. Report filed." At 1:20 p.m. the physician evaluated him and completed the injury report. The physician also noted that "*condition quickly decompensated, refused medication, became unpredictable – unmanageable.*" The physician wrote a new order for enforced medication stating "*without enforced medications he may become an imminent threat to cause harm to self or others.*" At 2:35 p.m. a nursing note documented that the recipient was screaming, yelling and threatening staff. Another incident with a peer was occurring and the recipient was yelling at the peer to "[expletive] them up...get them good...I'll kill all of you...let me up." At that time the recipient was given 2 mg IM Lorazepam per physician's order. A ROR form was given. At 3:30 p.m. a nursing note documented that the recipient continued to scream and yell and threaten staff and then would cry at times. The recipient was described as "unstable and liable" It was documented that a new order was received from the physician for 4 point restraints. It was documented that restraints were released at 3:35 p.m. The nursing note at 5:30 p.m. documented a one hour post restraint check was completed in the conference room and the recipient was meeting with the OIG investigator. On 7/24/15 at 7:25 a.m. the recipient "*violently spontaneously attacked staff punching staff in the face.*" He was placed in 5 point FLR [full leather restraints] and at 9:00 a.m. the physician ordered 24 hour emergency enforced medications. At 11:30 a.m. the order for restraint was renewed due to continued aggressive behavior. At 3:30 p.m. the physician, Unit Director, Therapist, nurse and an STA were at bedside for review. The recipient continued to threaten and be verbally aggressive. The physician renewed the restraint order for 4 hours. At 6:45 p.m. another physician was at his bedside for review. The recipient continued to threaten, and specifically attack certain STAs and then began singing loudly. The restraint order was renewed. At 8:05 p.m. emergency enforced medication was given along with a ROR form. At 10:00 p.m. the recipient was argumentative upon review. The next nursing case note is at 7:15 a.m. on 7/25/15 and stated "*as per treatment team plan, placed into 2 point ambulatory wrist to wrist restraints. Pt remains agitated towards staff, cursing and demanding, VS [vital signs] 120/80 -80-18 Dr. [name] notified. ROR given. Circulation good x 2.*" The recipient was checked on throughout the day and given emergency medication at 8:30 a.m. and at 8:05 p.m. At 10:40 p.m. the recipient was released from ambulatory 2 point restraints and locked in the security room for hours of sleep per his treatment team plan. During waking hours, he was in ambulatory restraints, checked on throughout the day and given medication when needed for emergency enforced order as well as ibuprofen as needed for back pain and headache complaints. The recipient was documented as being non-compliant, refusing to answer the physician's questions, agitated and uncooperative upon reviews.

On 7/28/15 at 9:35 a.m. a social worker note documented that the recipient met with his treatment team to review the ambulatory restraints. The physician felt that he met release criteria and he was released. The social worker noted that he *“continues to deny his aggressive behaviors and blames others for his actions. [name] has made improvements since he was placed on court enforced medication. [name] will be continued to be encouraged to engage in fitness education and therapy.”* On 7/29/15 the social worker’s note indicated that he remained on *“emergency enforced medication.”* The HRA noted that the word “court” was marked through and replaced with the word “emergency” so it was assumed that the 7/28/15 note stating he was on “court enforced medication” was also in error. On 7/30/15 at 9:45 a.m. another social worker note had the same error of “court” being replaced with “emergency” enforced medication and stated that he presented as *“oppositional and belligerent and he stated that he would rather work with a trained monkey than the treatment team and abruptly left the conference room.. He refuses to engage in therapy and remains unfit to stand trial at this time.”* At 2:30 p.m. a nursing note documented that the patient requested a PRN medication for agitation; an order was received from the physical for Lorazepam 2 mg PO PRN, the patient accepted the medication. On 8/1/15 and 8/2/15, a physician’s note stated that the recipient *“suffers from a serious mental illness which renders him incapable of making reasoned decisions about his treatment. He has been very aggressive toward staff and has caused injuries requiring that he be restrained multiple times. The pt is unpredictable, presenting a risk of imminent harm to those around him. Continue emergency enforced medications for the safety of all.”*

It was also noted over the next few days that the recipient was compliant with the “emergency enforced” medication, however the physician documented that he refused to attend the review and was uncooperative. On 8/9/15 the physician entered a case note that stated “*the pt suffers from a serious mental illness which renders him incapable of making reasoned decisions about his treatment. He has been very aggressive toward staff, requiring that he be restrained multiple times. Yesterday the pt was severely agitated, threatened harm to others and was placed in seclusion. While in seclusion he blamed his behavior on his mother. The pt is uncooperative with staff and unpredictable, presenting a risk of imminent harm to those around him and/or self. Continue emergency enforced meds for the safety of all.*”

On 8/11/15 the social worker note stated that the recipient remained oppositional and continued to blame others for the results of his behaviors. He remained on emergency enforced medication, denied his need for medication and stated that he would not take it voluntarily. It was noted that he continued to display limited insight into his legal situation and need for mental health treatment. The social worker documented that he requested a phone call and was informed that it would be provided that afternoon. At 3:15 another social worker note documented that he was provided with 2 attempts to call his public defender that were unsuccessful. He was also provided an additional call to another person who did not answer. Similar case notes, from both the social worker and physician, were reviewed which were dated through 8/19/15 when the recipient was placed on Court enforced medication. All the notes documented that the recipient remained oppositional and hostile towards staff and that he was a danger to himself and others and the physician continued the emergency enforced medication until the Court Order was obtained on 8/19/15.

### **III...Facility Policies:**

Patient Telephone Calls policy states “*Per the Mental Health and Developmental Disabilities Code 405 ILCS 5/2-103 ‘a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of their choice by mail, telephone and visitation’. Thus, telephone communication is a right not a privilege to individuals receiving services... Procedure: All units will post scheduled phone times to meet the needs of their patient population. This schedule will list times when the phones will be available, and when they will be turned off to encourage treatment participation (i.e. community meeting, meal times, active treatment program times, etc.)...*”

*A.1.a. Patients are allowed to place local or long distance calls during scheduled hours on all units if paid by the patient using a pre-paid phone card, credit card, or by placing a collect call. If the patient does not have these resources long distance calls will be provided by the state as described later in this policy.*

*A.1.b. Telephone call duration should be limited to ten minutes. Abuse or misuse of telephone time limits may be referred to the treatment team. If the caller is speaking with an attorney related to their forensic/civil case, the treatment team will make alternate arrangements to ensure that they can conduct their business in the most expedient manner possible (e.g., use of phone outside of scheduled times, use of an alternate phone not used by other patients, etc.)*

*B.1.d. If an answering machine is reached and the patient chooses to leave a message, this will be documented as one of the two long distance telephone calls. If the patient does not leave a message, they have one more opportunity during that phone call period to place another*

long distance call. If the patient continues to have problems contacting their long distance party, the patient may inform the treatment team for assistance.

B.2. Non-routine phone calls: The patient may request team approval for non-routine (e.g. phone calls outside of regularly scheduled phone hours) phone calls through their social worker (or registered nurse/security therapy aide after normal business hours). The staff member will consult as needed with team members and may approve and/or facilitate the patient's access to calls.

B.3 Emergency Telephone Calls: The Unit Nurse or another team member can authorize emergency telephone calls 24 hours per day/seven days per week (e.g. patient has sick family member in the hospital, critical home issue causing marked anxiety for the patient, etc...

a. Phone calls to patient's Attorney, Governor, members of the General Assembly, Attorney General, judges, Office of Inspector General, Human Rights Authority, Equipped for Equality and other advocacy groups pursuant to a public act on State Telephones will not be restricted unless a written request to do so is received from one of the above parties. Telephone calls to the patient's Attorneys regarding their forensic/civil case involving their current hospitalization are unlimited. If the patient call length exceeds the recommended ten minute limit, alternate arrangements will be made through the treatment team to ensure the patient can conduct their legal business in the most expedient manner. Calls to attorneys regarding personal or legal cases unrelated to their current hospitalization will be allowed during scheduled phone hours and credited to the patient's two state paid long distance phone calls per week if long distance charges are applicable."

RI .01.01.02.01 Patient Rights: The Patient Rights policy states "It is the policy of Chester Mental Health Center (CMHC) to respect the rights of patients and not to abridge said rights without cause and without due process. Restrictions, as such, should have a clinical rationale and serve to facilitate a therapeutic treatment setting. Each patient admitted to Chester Mental Health Center shall be treated with respect and shall be ensured of all rights under Sections 2-100 to 2-111 of the Mental Health and Developmental Disabilities Code. Restrictions of rights and corresponding rationale shall be properly documented in the patient's clinical records." This policy states that a patient has the right to "be provided with adequate and humane care and services in the least restrictive environment pursuant to an individual treatment plan..."

#### A. Non - Emergency Restriction of Rights

1. A restriction of a patient's rights should be based on clinical assessment of the patient and/or the situation. A Notice Regarding Restricted Rights of Individuals (IL462-2004M) will be issued to restrict the patient's rights.

2. If any of the patient's rights as described in Section I. of this procedure are restricted then a Restriction of Rights of Individuals (IL462-2004M) will be initiated. This includes when a patient is restrained, secluded and/or subject to a physical hold.

3. The Unit Director or designee will ensure that the initiation of the restriction is reported, discussed, and approved at the Facility Morning meeting.

4. When a Restriction of Rights is implemented and reviewed by the treatment team – emergency or non-emergency they will ensure the restriction form is approved and signed by the Facility Director or designee. When the Restriction of Rights involves mail, access to the patient's room, or telephone, the form IL 462-2004M must be signed by the Facility Director or designee prior to initiation of the restriction.

**B. Emergency Restriction of Rights**

1. A restriction of a patient's rights should be based on an assessment of the patient and/or the situation affecting the safety of the patient or others by clinical staff on duty who oversees the patient's treatment plan. A Notice Regarding Restricted Rights of Individuals (IL462-2004M) will be issued to temporarily restrict the patient's rights. A progress note will be documented in the patient's record showing justification for the restriction of rights and explanation of actions taken.

2. A restriction imposed during off hours as an emergency intervention shall be reviewed by the treatment team on the next working day to determine whether continuation is indicated. If continuation is indicated the form IL462-2004M must be signed by the Facility Director or designee."

Violence Risk, Risk to Harm to Others policy states the purpose is "to establish a protocol for the assessment of risk factors leading to violence; reassessment of factors; initiate interventions to reduce risk of violence and provide staff education on proactive approaches to address patient violence." The policy states that upon admission all patients will be screened for violence risk to determine the need for safety measures by completing the VRAT (violence risk assessment tool.) Low risk patients will be reviewed at the monthly treatment team meetings. Medium risk patients will have immediate safety measures implemented with documentation completed in the progress notes. High risk patients will have immediate safety measures implemented along with a problem list with appropriate violence prevention measures incorporated into the treatment plan with interventions to manage and reduce the risk of violence. The policy continues by stating "when an incident of aggression/violence occurs, the treatment team will document the incident on the monthly patient to patient assault log, CMHC-786. Assault log information will be reported weekly on a designated day at the facility's morning meetings to provide unit leadership the opportunity to discuss trends and develop action plans. Patients identified as having up to 3 assaults within a 2 week timeframe will require immediate review for implementation of a new intervention to prevent further assaults."

**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 5/2-103) provides that "Except as provided in this Section, a recipient who resides in a mental health or developmental disabilities facility shall be permitted

*unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation. The facility director shall ensure that correspondence can be conveniently received and mailed, that telephones are reasonably accessible, and that space for visits is available. Writing materials, postage and telephone usage funds shall be provided in reasonable amounts to recipients who reside in Department facilities and who are unable to procure such items.”*

The Code (405 ILCS 5/2-100) guarantees that “*no recipient of services shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the receipt of such services.*”

The Code (405 ILCS 5/2-201) states that “*(a) Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to:*

- (1) The recipient and, if such recipient is a minor or under guardianship, his parent or guardian;*
- (2) A person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice;*
- (3) The facility director;*
- (4) the Guardianship and Advocacy Commission, or the agency designated under “An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named”, approved September 20, 1985,<sup>1</sup> if either is so designated; and*
- (5) The recipient's substitute decision maker, if any.*

*The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefor in the recipient's record.*

*(b) The facility director shall maintain a file of all notices of restrictions of rights, or the use of restraint or seclusion for the past 3 years. The facility director shall allow the Guardianship and Advocacy Commission, the agency designated by the Governor under Section 1 of “An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named,” approved September 20, 1985, and the Department to examine and copy such records upon request. Records obtained under this Section shall not be further disclosed except pursuant to written authorization of the recipient under Section 5 of the Mental Health and Developmental Disabilities Confidentiality Act”*

Section 5/2-107 states “*(a) An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. **If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available.** The facility director shall inform a recipient, guardian, or substitute decision maker, if any, who*

*refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services. (b) Psychotropic medication or electroconvulsive therapy may be administered under this Section for up to 24 hours only if the circumstances leading up to the needs for emergency treatment are set forth in writing in the recipient's record. (c) Administration of medication or electroconvulsive therapy may not be continued unless the need for such treatment is redetermined at least every 24 hours based upon a personal examination of the recipient by a physician or a nurse under the supervision of a physician and the circumstances demonstrating that need are set forth in writing in the recipient's record. (d) Neither psychotropic medication nor electroconvulsive therapy may be administered under this Section for a period in excess of 72 hours, excluding Saturdays, Sundays, and holidays, unless a petition is filed under Section 2-107.1 and the treatment continues to be necessary under subsection (a) of this Section.”*

Section 5/2-107.1 states “(a-5) *Notwithstanding the provisions of Section 2-107 of this Code, psychotropic medication and electroconvulsive therapy may be administered to an adult recipient of services on an inpatient or outpatient basis without the informed consent of the recipient under the following standards: Any person 18 years of age or older, including any guardian, may petition the circuit court for an order authorizing the administration of psychotropic medication and electroconvulsive therapy to a recipient of services... (2) **The court shall hold a hearing within 7 days of the filing of the petition. The People, the petitioner, or the respondent shall be entitled to a continuance of up to 7 days as of right. An additional continuance of not more than 7 days may be granted to any party (i) upon a showing that the continuance is needed in order to adequately prepare for or present evidence in a hearing under this Section or (ii) under exceptional circumstances. The court may grant an additional continuance not to exceed 21 days when, in its discretion, the court determines that such a continuance is necessary in order to provide the recipient with an examination pursuant to Section 3-803 or 3-804 of this Act, to provide the recipient with a trial by jury as provided in Section 3-802 of this Act, or to arrange for the substitution of counsel as provided for by the Illinois Supreme Court Rules. The hearing shall be separate from a judicial proceeding held to determine whether a person is subject to involuntary admission but may be heard immediately preceding or following such a judicial proceeding and may be heard by the same trier of fact or law as in that judicial proceeding. **Psychotropic medication and electroconvulsive therapy may be administered to the recipient if and only if it has been determined by clear and convincing evidence that all of the following factors are present. In determining whether a person meets the criteria specified in the following paragraphs (A) through (G)...*****

*(A) That the recipient has a serious mental illness or developmental disability.*

*(B) That because of said mental illness or developmental disability, the recipient currently exhibits any one of the following: (i) deterioration of his or her ability to function, as compared to the recipient's ability to function prior to the current onset of symptoms of the mental illness or disability for which treatment is presently sought, (ii) suffering, or (iii) threatening behavior.*

*(C) That the illness or disability has existed for a period marked by the continuing presence of the symptoms set forth in item (B) of this subdivision (4) or the repeated episodic occurrence of these symptoms.*

*(D) That the benefits of the treatment outweigh the harm.*

*(E) That the recipient lacks the capacity to make a reasoned decision about the treatment.*

*(F) That other less restrictive services have been explored and found inappropriate.*

*(G) If the petition seeks authorization for testing and other procedures, that such testing and procedures are essential for the safe and effective administration of the treatment...*

### **Conclusion**

The first allegation of the complaint alleged that the recipient was not being allowed to communicate with his attorney. The HRA found documentation that on 6/22/15 the recipient was allowed a telephone call to his attorney. On 7/7/15 the recipient and social worker met and it was documented that he “*demanded*” that his social worker call his attorney. The social worker documented that “*He was informed that a call would not be made when he is verbally combative and threatening towards this writer. He was asked to calm down and refused. Therefore our session was ended at this time.*” There was no other documentation of phone calls until 8/11/15 when another social worker note documented that the recipient was allowed 2 phone calls to his attorney and one to another person, however none of the attempts were successful. The recipient was in restraints/seclusion and ambulatory restraints from 7/23/15 through 7/28/15 and there was no documentation that he requested to speak with his attorney during that time. However, the facility policy on telephone use states that phone calls to patient’s attorneys will not be restricted unless a written request to do so is received from the attorney. It also stated that telephone calls to the patient’s attorneys regarding their forensic/civil case involving their current hospitalization are unlimited. This policy also ensures that alternate arrangements for calls to attorneys can be made through the treatment team in order for patients to conduct legal business “in the most expedient manner.” Therefore the HRA found a violation of Chester’s policy when the Social Worker denied the recipient a call to his attorney for being verbally combative and threatening towards the social worker. The following is **recommended**:

1. **Social Workers and treatment team members should be retrained on Chester policy RI .03.05.02.02 specifically the section relating to patients’ right to unlimited and unrestricted contact with their attorney when it relates to their current forensic/civil case.**

The second allegation was that the recipient’s rights were inappropriately restricted. Specifically, he was placed on unit restriction for a month, water was shut off in his room and medication was given over objection without a court order.

The HRA discovered that at Chester there is no such thing as unit restriction, only loss of off unit privileges that do not require a restriction of rights form to be issued. This recipient lost his off unit privileges due to maladaptive behavior in the gymnasium which was documented in his chart and subsequently resulted in a restraint episode that injured several staff members. The water being shut off in his room occurred as a result of the recipient attempting to flood his room, according to documentation. Although the recipient stated he was not trying to flood his room and was only using the water as white noise to help him sleep. There are no other witnesses since this occurred in his room.

The final issue of medication over objection was also investigated. Although restriction of rights (ROR) forms were found for the occasions when emergency medication was given while awaiting for the Court’s ruling on the Petition for Court Enforced medication, the HRA

found that a few ROR forms listed reasons that would not be compliant with the mental health code guidelines for emergency enforced medication (to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available). Instead, the RORs stated the reasons for emergency medication on 7/23/15 as *“does not take part in working towards ability to go to court...consistently attempts to start gang like activity with peers...has become physically aggressive towards staff many times that have resulted in staff injuries. Pt requires medication in order to help move toward assisting in his own defense.”* On 7/28/15 the reasons listed included *“psychotic episodes, very paranoid delusions, refuses medication.”* On 7/30/15 the reasons included *“has been violent, psychotic thought process and paranoia, seclusion is only preference, requires medication for psychosis.”* Since there were several other RORs over this same period of time that showed proper justification for emergency medication, the HRA concluded that the recipient’s current mental state at that time justified emergency medication being used as treatment. The facility filed a Petition within the timeframe required by the Mental Health Code and the HRA found court documentation that the hearing was continued twice which contributed to the long period of time between the Petition being filed and the Order being signed for court enforced medication. Therefore this allegation is **unsubstantiated**. The HRA offers the following **suggestions**:

1. The TPRs reviewed listed the recipient’s emergency preferences as 1) emergency medication 2) seclusion and 3) restraints. However, the restriction of rights forms listed the preferences as 1) seclusion 2) emergency medication and 3) restraints. The documentation on the restriction of rights forms also indicated that the staff was unsure of the emergency preferences as some noted them to be seclusion first and others noted them to be medication first and stated that preferences were followed when medication was given. The HRA suggests that when the TPRs are updated monthly, the emergency preferences are also confirmed with the recipient and documented clearly in the TPR document to ensure that the correct preferences are being followed.
2. The HRA suggests that staff be retrained on the proper documentation on ROR forms when emergency medication is necessary to ensure that medication is only being given in compliance with the Mental Health Code requirements of current dangerousness to self or others.
3. Social work notes from 07-28, 07-29 and 07-30 incorrectly and prematurely reference medications as court-enforced; the record was corrected at some point. The HRA suggests that the status of medications be correctly referenced.
4. Review the practice of rehabilitation classes being considered a “privilege” when they are part of recipient treatment plans.
5. Consider including in treatment plans, step-downs from maximum to medium secure units as part of treatment planning.
6. Ensure that interventions are reviewed and documented when aggressive incidents continue as per Chester’s Violence Risk, Risk to Harm to Others policy.