U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20035

MAY 26 1993

REGISTERED MAIL
RETURN RECEIPT REQUESTED

U.S. v. Illinois
MR-IL-003-001

The Honorable James Edgar
Governor of Illinois
207 State Capitol
Springfield, Illinois 62706

Re: Chicago-Read Mental Health Center

Dear Governor Edgar:

I am writing in reference to our investigation of conditions of confinement at Chicago-Read Mental Health Center ("Chicago-Read") pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997 et seq. As required by statute, the purpose of this letter is to inform you of the findings of our investigation. State officials cooperated fully in this investigation and we wish to thank them for their cooperation.

Our investigation disclosed deficiencies in the following areas at Chicago-Read:

1. The absence of professionally based psychiatric programs for patients;

2. Overuse and misuse of physical restraints; and

3. Building hazards and environmental deficiencies.

In our view, these deficiencies constitute conditions which violate the constitutional rights of Chicago-Read patients to adequate medical care and reasonable safety. Cf. Youngberg v. Romeo, 457 U.S. 307 (1982). A detailed narrative describing the precise facts supporting our findings is set forth in the Attachment to this letter.

The minimum remedial measures necessary to correct these violations include the following:

The minimum remedial measures necessary to correct these violations include the following:

1. Develop and implement professionally based treatment programs for residents based upon generally accepted professional standards; hire and retain a sufficient number of qualified professionals to develop and implement these programs;

2. Modify restraint and seclusion practices to reflect professionally accepted standards; ensure that each use of restraint or seclusion reflects the exercise of professional judgment by a qualified professional; modify seclusion rooms to ensure patient safety; discontinue the simultaneous use of seclusion and physical restraint;

3. Eliminate building hazards and environmental deficiencies which threaten the health and safety of patients; and

4. Provide enhanced resources at the facility, including both staff and necessary staff training.

You may wish to contact appropriate federal officials of the Department of Health and Human Services to ensure that State officials have taken full advantage of any federal financial assistance which may be available to you in remedying these deficiencies. If we can assist you in this regard, please contact us.

In the interest of further assisting the State in improving conditions at Chicago-Read, we will provide to facility administrators, by separate cover, additional observations and recommendations made by our consultants regarding conditions at Chicago-Read. These findings, while representing deficiencies, do not currently implicate the constitutional rights of Chicago-Read patients.

In closing, let me thank you for the cooperation extended to us by your representatives and by facility administration and staff during the course of this investigation. My staff will contact appropriate State officials in the near future to discuss this matter further. If, during the interim, you or any member

of your staff have questions, please feel free to contact Arthur E. Peabody, Jr., Chief, Special Litigation Section, at 202/514-6255.

Sincerely,

James P. Turner
Acting Assistant Attorney General
Civil Rights Division

Enclosure

cc: The Honorable Roland Burris
Attorney General
State of Illinois

Mr. Jess McDonald
Director
Department of Mental Health
Developmental Disabilities
State of Illinois

Ms. Marva Arnold
Superintendent
Chicago-Read Mental Health Center

Michael J. Shepard, Esquire
United States Attorney
Northern District of Illinois

ATTACHMENT

Our investigation consisted of a three-day tour by each of three consultants, a psychiatrist, a nurse, and a life safety expert. These tours occurred between November 16-20, 1992. During the course of these tours, the consultants made observations, interviewed staff and patients, and examined numerous records, including incident, restraint and recidivism statistics and summaries, committee minutes, morbidity and mortality reviews, administrative policies and procedures, and patient records.

1. Psychiatric treatment

Our psychiatric consultant found that Chicago-Read is failing to provide "clinical programs" for patients and observed that psychiatric treatment for patients is "little more than custodial care." Significantly, he found that treatment programs for patients were not developed consistent with generally accepted professional standards. More specifically, with the exception of just three units, multi-disciplinary teams composed of various institutional professionals for the purpose of developing cohesive, meaningful treatment plans do not exist, a deficiency our consultant characterized as "profound." Those "programs" reviewed consisted of generic, printed forms with standardized "treatments" for various problems. Such programs were not individualized at all. In brief, psychiatric treatment programs fail to meet any known professional standard for such programs.

Efforts to establish professionally developed treatment programs have been seriously hindered by the absence of adequate numbers of professional staff. The complete absence of occupational therapists and various treatment specialists and inadequate numbers of nurses and social workers have seriously hindered the development and implementation of treatment programs. Our consultant also found that management problems impeded the available staff in their ability to provide necessary treatment. For example, he found that the involvement of psychiatrists and other professionals varied significantly from one part of the hospital to another and that no cohesive treatment approach was evidenced throughout the facility. Our investigation also disclosed that there are an insufficient number of nurses and that many nurses had not been adequately trained to perform psychiatric nursing functions. As well, nurses are not involved in an appropriate manner in the delivery of treatment programs in the institution.

In the absence of adequate treatment programs, patients spend many hours each day in idleness. Our consultants who toured the various units of the hospital routinely saw patients watching TV, playing board games, or sitting alone in a withdrawn state. Our nursing consultant who sought to ascertain the number of programmed or activity hours available to patients was advised

that of the approximately 480 patients, some 100 to 150 attend activities provided outside their residential unit during weekdays for an average of 3,000 hours per month. This means that each receives approximately five hours of activities per week. While efforts are made to provide some activities to the other 300 or more patients, our consultant was routinely advised that both space and staff are inadequate to provide programs and other activities for most of these patients. In these circumstances, patients remain in idleness for long periods which exacerbates their illnesses and protracts their period of hospitalization.

In sum, Chicago-Read has failed to develop and to implement professionally based treatment programs to patients that comport with generally accepted professional standards. Not only is the development of such programs seriously flawed, but even the programs that are devised are insufficient to meet patient needs. In addition, staffing at Chicago-Read is inadequate to develop and implement those programs which are needed.

2. Overuse and misuse of physical restraints

To control dangerous, aggressive, and otherwise disruptive patients, Chicago-Read resorts to the overuse and misuse of physical restraints. Particularly egregious is the facility's practice of using restraint and seclusion -- placement of a patient alone in a locked room -- together. Patients are placed in full leather restraints and confined in seclusion rooms. This practice is employed because seclusion rooms are unsafe. Such rooms cannot be fully monitored outside the room and they have other deficiencies, including suspended ceilings, hard edges and corners, and closets. Each of these features presents a danger to a disturbed patient. To avoid these hazards, patients are immobilized by physical restraints. The inability of staff to monitor the secluded and restrained patient, in addition to the hazards present in seclusion rooms, makes this practice dangerous.

Our consultants also ascertained that seclusion and restraint are often utilized without consideration of other more appropriate, less restrictive techniques to calm down an aggressive or very disturbed patient. The decision to utilize seclusion and restraint without consideration of other techniques can result in the use of such procedures for patients who do not require such an extreme form of restraint in order to regain control. In addition, only individual cases of restraints for six hours or longer receive any professional review. There is no mechanism in place for clinical review when the same individual is repeatedly restrained, nor any means of determining other factors which may contribute to the use of seclusion, e.g., lack of staff. Finally, seclusion and restraint are often administered by security staff due to shortages of staff. Except

in a rare emergency, the management of a clinical situation should be handled by qualified professionals.

The number and magnitude of injuries and other incidents occurring at Chicago-Read were not readily ascertainable during the course of our investigation. The facility fails to maintain any integrated summaries of injury or incident data that would permit facility administrators to review this information in a global manner and ascertain trends or identify other factors that may be contributing to such incidents. The facility's current data collection and quality assurance/improvement practices make it impossible to look for patterns or other circumstances which, if remedied, might reduce such incidents. In the view of our consultants, Chicago-Read is in need of a vastly more sophisticated system for uncovering, documenting, and tracking problems in care delivery.

3. Building hazards and environmental deficiencies

There are serious deficiencies in the physical plant at Chicago-Read. These deficiencies range from building hazards to environmental deficiencies.

In the Durso Building, all four units have nursing stations which are separated from patients by large locked glass doors. These partitions prevent nurses from hearing or seeing most of their patients. Moreover, nursing staff is not readily available to patients in these circumstances. Ventilation in the Durso Building is also inadequate. Further, additional attention is needed to ensure that fire extinguishers are sufficiently numerous and are recharged, as necessary.

There are inadequate amounts of hot water for bathing at the facility. While sanitation standards suggest that hot water should measure between 110 to 120 degrees, water temperatures taken by our expert at Chicago-Read consistently read far below this range, and even read as low as 80 degrees. Our nursing consultant found that many patients smelled of body odor; she was advised that many patients refuse to bathe because the water is too cold. More significantly, the water temperature may be insufficiently hot to maintain proper personal hygiene and kill bacteria.

Finally, there are inadequate isolation areas for patients with contagious diseases, and infection control procedures require review.