FOR IMMEDIATE RELEASE

METRO EAST HUMAN RIGHTS AUTHORITY
REPORT OF FINDINGS
HRA CASE # 17-070-9007
ALTON MENTAL HEALTH CENTER

The Metro East Regional Human Rights Authority (HRA) has completed its investigation of a complaint at Alton Mental Health Center (AMHC), a state-operated, medium security mental health care facility located in Alton, Illinois. The facility serves 120 patients between the ages of 18-55. Of that number, approximately 110 (88 male and 22 female) are in the forensic unit. The civil unit houses a maximum of 15 patients and includes one overflow bed which is used for emergency purposes only. Alton Mental Health Center employs 220 staff members to ensure that patients are supervised 24/7.

> ***The allegation being investigated is:*** The facility does not adequately ensure the provision of least restrictive environment and individualized treatment planning with recipient participation when it restricts unsupervised off grounds passes to therapeutic activities while failing to consider each patient's individualized therapeutic needs.

If found substantiated, the allegation represents violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) and facility policies.

METHODOLOGY

To pursue the investigation, an HRA team interviewed Alton Mental Health Center staff, and obtained and reviewed agency policies, the Alton Mental Health Center Consumer Handbook, and interviewed the consumer.

FINDINGS

The complaint states a patient was approved in June for an unsupervised off-grounds pass via the courts for 4 hours at a time. He wanted to volunteer at the Alton Library but there were no available volunteer opportunities, so the team agreed he could go to the library 1 x per week to use the internet, e-mail his sister and check out books. These activities were included in his treatment plan and he used public transportation to travel to the library, without incident, for about 8 weeks. Then, at the end of October, he received notice that he could not use the pass any longer although, according to the patient, he was not given a pass reduction; instead, the rationale was unclear. Initially the social worker told him

that the pass arrangements were out of compliance with laws that govern pass privileges but when he pursued further through his newly assigned case worker, she explained that, per the Clinical Director, the visits to the library were too isolative and not social enough. The patient contends the visits did provide an opportunity to interact socially via the public transportation system and with library staff. The patient was unsure if his treatment plan was updated to reflect the change. Another option for community interaction that had been previously discussed was working at the Hope Center as another recipient works there, but there is no public transportation to the location and AMHC must transport. AMHC refused this option because arrangements would be too complicated for him to also work there with a 4 hour limit while the other recipient is allowed to work longer. The patient is now unable to use his pass. The patient is scheduled for a court review on December 15th.

In order for a patient to use a pass at Alton Mental Health Center, the patient has to request to use the pass a week in advance and an order must be written by the patient's psychiatrist. In October, the treatment plan and orders show that the passes stopped being written without prior notice. The patient questioned his social worker as to why the pass had not been written for that week and per the patient, the social worker informed him that his trips were stopped because he was not receiving enough social interaction during the pass. AMHC policy, Privileges: Forensic Patient Privileging- Alton Forensic Center (AFC) states: "At no time should privileges be suspended as a punishment for behaviors unrelated to safety."

On December 16, 2016 the HRA Coordinator contacted the Clinical Director of Alton Mental Health Center regarding this complaint as well as the patient's Social Worker. The Clinical Director stated that the patient was not meeting the expectations of the Unsupervised Off Grounds Pass (UOGP) and that the UOGP privilege was part of an organized, monitored process and is not just in place to give the patients free time. The purpose of the pass is to reintegrate the patient to the community and for personal enrichment. He contended that visiting the library did not meet that criteria. He stated that "the patient is now in charge" and did not elaborate on what that statement meant. The patient's social worker contends that the trips to the library gave the patient an opportunity to learn to use public transportation, increase communication skills as he interacts with the bus driver, fellow patrons and the library staff and teaches him time management as he has to ensure he returns to the facility by a designated time. The social worker maintains that social enrichment comes into play with the patient initiating contact with family members via email and attempting to mend broken familial relationships. She stated that she did not agree with withholding the outings from the patient because he benefited from the trips socially and that the Clinical Director made the decision. She stated that trips to the library are very therapeutic to this particular patient because he isolates himself on the unit and when he goes on these trips, he is forced to communicate with members of the community.

During the site visit, the Administrator stated that the patient's pass level was never decreased; the patient was denied outings. She stated that decisions regarding pass level and pass usage are made by the patient's treatment team. The treatment team is made up of all the individuals involved in the patient's care and includes: the patients physician, psychiatrist, social worker, nurse, and security therapy aides. The team also consists of the Clinical Director and the Administrator although they do not provide direct patient

care. The Clinical Director was not present during this site visit. The Administrator also acknowledged that the patient's treatment plan was never changed to reflect the fact that he was not allowed to use his UOGP to visit the Library.

On June 20, 2016, a ruling was made in the Clinton County Court that states " …the defendant should remain in custody of IDHS [Illinois Department of Human Services] in a secure facility and continue his treatment. Court recommends that defendant be approved for unsupervised off ground passes. Court restricts that privileges as recommended by [doctor] that should be done in a slow progression. Period of time not to exceed 2-4 hours in duration, in a location close to his treatment location as long as defendant remains compliant with all of his treatment and medication as directed by his doctors." And on December 15, 2016, the following entry was made in the court records; "The court extends off ground privileges to six hours (over state objection) for reasons contained in the report, travel issues, all other terms imposed in June 20, 2016 to remain in place."

The patient's treatment plan dated December 16, 2016 states:

Goal 1 Progress:

During this review period, [Patient] focused on taking steps to secure a bus pass and worked with his attorned to receive an additional 2 hour extension on his UOGP in order to expand the number of volunteer opportunities available to him.

On 12/7/16, Patient received a Madison County Benefits Access Card which expired on 6/6/18. Patient was reported to be appropriate during the trip.

Use of Privileges: Patient utilized his UOGP on the following dates: 9/23/16, 9/2/16, 9/15/16, 9/23/16, 9/30/16, 10/6/16, 10/16/16 and 10/21/16. He continues to search for volunteer opportunities in order to increase the utilization of this privilege.

MANDATES/REGULATIONS

According to the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102):

> 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.

CONCLUSION

Records indicate that the patient used his UOGP appropriately and without incident on a consistent basis until late October of 2016 when abruptly and without prior notice, his request to use the pass was denied. The social worker stated that the team was not in agreement with the Clinical Director's decision to halt the patient's trips to the library. The patient's treatment plan and goals were not updated to include this decision. The HRA concludes that the decision was not made by the team as a whole, rather solely by the Clinical Director who is not involved in the day to day care of the patient and that the provision of least restrictive environment was violated when the patient's ability to utilize his pass was halted for no justifiable reason. The patient was not given the opportunity to speak with the team when this decision was made and was not involved in the planning process when his pass was denied. He was not notified of the pass denial or the rationale behind it until he discovered the order for the pass was not written. Therefore, the HRA **substantiates** that a rights violation occurred.

The HRA was made aware that this patient had been transferred to a less restrictive environment and contacted the AMHC administrator to confirm. Per email, she concurred that this patient "…did transfer to a less restrictive on 06/27/18 to [a community hospital] a step-down program for NGRI [Not Guilty by Reason of Insanity], in Springfield, IL."

RECOMMENDATIONS

The HRA recommends that Alton Mental Health Center ensure that measures are established to guarantee that patients are given the opportunity to utilize off grounds passes as the court ordered and the patient's condition allows.
When decisions are made that effect a patient, the patient should be notified in a timely manner as to not disrupt the patient's treatment process.

When changes are made that effect the patient's treatment, the treatment plan and goals should be updated to reflect such changes. There should also be a treatment team meeting that includes the patient and the rest of the team where the decision is discussed, and the patient's opinions are taken into consideration.

In addition, The HRA is concerned and discouraged that the treatment planning process was not utilized as intended by the Code (405 ILCS 5/2-102). Going forward, the HRA suggests that all decisions made regarding patient treatment are made by using the treatment planning process, which includes the patient and the rest of the team and also includes consideration of the patient's views on the treatment."