FOR IMMEDIATE RELEASE

METRO EAST HUMAN RIGHTS AUTHORITY
REPORT OF FINDINGS
HRA CASE # 18-070-9004
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 125 patients between the ages of 18-55. Of that number, approximately 110 (66 male and 44 female) are on 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 250 staff members to ensure that patients are supervised 24/7.

The allegation being investigated is: The facility does not adequately ensure the provision of humane services and least restrictive environment.

If found substantiated, the allegation represents violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5).

METHODOLOGY

To pursue the investigation, an HRA team interviewed the AMHC Administrator, the Director of Quality Management, as well as other staff, and obtained and reviewed agency policies and the Alton Mental Health Center Consumer Handbook.

FINDINGS

The complaint states that a line was placed on the floor, down the middle of the unit and patients were not allowed to cross the line without a staff member escorting them to the other side of the unit.
In October of 2017, the HRA Coordinator was speaking to an individual on C unit via phone and was made aware of a possible restriction of rights (ROR) violation that was occurring on the unit. The individual mentioned that the “bad” females had to stay on one side of the unit and the unit had been separated into 2 units. Females could not pass the middle without staff supervision. Upon further inquiry, the individual confirmed that ROR were not being issued, although the females were not allowed to cross the center line. The restrooms, dining area and comfort room are all on one side of the unit and the

females on the other side had to ask staff to escort them to the restroom. There is often only one staff person on the unit and he/she has other duties that must be completed therefore, the ability to escort a patient to the restroom in a timely fashion may not always be possible.

During the site visit on October 3rd, 2018, the administrator stated that a patient was attacking others and that she was "side restricted," however the other patients were not restricted. On October 4th, 2018 the HRA Coordinator called and spoke with a patient to verify the complaint and was told that the unit was made into 2 units, 1 "good" side and 1 "bad side" and the patients were only allowed to cross the line to use the restroom with a staff escort, but could not cross to use the telephone, watch tv or walk. The patient stated that this did help decrease the number of attacks on patients, however, RORs were not issued during this time. The HRA interviewed a staff member who stated that there were not enough females to keep both C1 and C2 open so the administrator decided to move the more acute, 5 or 6 females from C1 to the dining room side of C2, and the less acute C1 population would remain on C1 and would be moved to the medication room side. More staff were in place on the dining room side to work with the more acute patients who were acting out as per the staffperson interviewed.

In follow-up contacts done in April of 2019, a patient and a staff person acknowledged that the line is still in place on the unit, however it is no longer being utilized. The staff person acknowledged that the line had been used in the past (during the occurrence in question) to restrict individuals to one side of the unit and that RORs were not issued during that time.

MANDATES/REGULATIONS

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

> Sec. 2-102. (a) 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.

According to the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-201):

> 2-201. (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:
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> (1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian;
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> (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,[1] 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.

CONCLUSION

According to the Code, when any rights of the recipient of services are restricted, notice must be given to the recipient. 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 (405 ILCS 5/2-201).
The HRA **substantiates** the complaint that patients were not provided the provision of least restrictive environment when they were restricted to one side of the unit and required staff escorts to access the other side. According to the Code, 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 HRA finds that the patients were side restricted on the unit for safety concerns, however, RORs were not issued to the patients while they were being restricted. The administrator denied that the restrictions occurred, however, the administrator confirmed that at least one patient was "side restricted" and there were corroborating reports from patients and staff who verified that the restrictions did in fact occur. The HRA contends that the lack of free movement on a unit, especially to unit locations that had been previously freely accessed, that patients on other facility units can access, and that require staff facilitation to access, places patients in a more restrictive environment.
AMHC Policy 2B.01.008 Patients' Rights and the Restriction Thereof states: "Patients' rights may be temporarily restricted only when there is a need to protect the patient and/or others from harm, harassment or intimidation… This determination should be made after thorough clinical assessment of the treatment team, or, at minimum, by a registered nurse and licensed physician…A Notice Regarding Restricted Rights of Individuals (IL462-2004M must be completed in its entirety each time patient rights are restricted." AMHC administration did not comply with this policy when it restricted the rights of individuals and failed to issue a ROR.

RECOMMENDATIONS

The HRA recommends that AMHC ensure that patients are provided the provision of least restrictive environment at all times. It is not acceptable to restrict the rights of

patients to try and control the behavior of others. The offending party should have their behaviors addressed individually according to their treatment plans.

The HRA recommends that Alton Mental Health Center administration recognize that patients have rights and that in the rare event that it is necessary to restrict patients' rights to ensure the patient safety, a ROR must be issued to each patient at the time of the restriction and justification for the restriction must follow the Mental Health and Developmental Disabilities Code.

AMHC should provide training to staff and administration on the Mental Health and Developmental Disabilities Code to ensure that patients' rights are not being violated and the facility is in compliance with the Code.

The HRA recommends that AMHC administration and staff receive additional training on AMHC Policy 2B.01.008 Patients' Rights and the Restriction Thereof.

In the future, such blanket unit practices that change a unit's environment from the environment of other units, limits access to the unit's commonly used areas, and requires staff intervention to fully access the unit's common areas should be reviewed by the facility's internal human rights committee before implementation.