FOR IMMEDIATE RELEASE

METRO EAST HUMAN RIGHTS AUTHORITY
REPORT OF FINDINGS
HRA CASE # 20-070-9012
ALTON MENTAL HEALTH CENTER

The Metro East Regional Human Rights Authority (HRA) has completed its investigation of a complaint at Alton Mental Health Center, 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 violates consumers' rights when it inadequately complied with court orders and when it fails to provide adequate and humane treatment.

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, obtained and reviewed agency policies, and reviewed the Alton Mental Health Center Consumer Handbook.

FINDINGS

The complaint states that a recipient sought and was granted a court order to attend his brother's funeral. The recipient and his attorney both state, that the judge approved him to be at the funeral the entire day. On Friday at 5pm, the day before the funeral, the patient was notified that he would only be able to attend from 9-11:30 a.m., and the patient was unable to contact the court as it was now closed for the weekend. On Saturday, as the patient was getting ready, he was notified by staff that they were all leaving immediately (8AM) and was only allowed to stay at the church with his brother's body for 20 minutes before leaving. He did not get to see family or mourn with his loved ones, and specifically was not allowed to attend the wake/funeral as the court ordered. The HRA also was concerned that the patient did not receive proper grief support after such a traumatic event and then was unable to mourn with family as he had expected.

The Court Order states: “DHS [Department of Human Services] to Transport (patient) to the wake/funeral for his (brother) at the (Baptist Church) at 10am on 6/6/2020 under such security provisions as deemed necessary.” The court order is stamped and is signed by a Judge.

The Forensic Control Station Call Log states that the patient arrived at the church at 8:50am and then left at 10:20am, arriving back to AMHC at 11:00am.

The HRA could find no record in the patient’s Psychiatric Review of Progress notes documenting that any type of grief counseling/grief support was being provided or that the loss of his brother and aunt had been addressed. On 6/8/20 there was mention of “The patient just lost his brother by a drive by shooting … He had requested to attend the funeral. He did go on Saturday, but the timing had been changed. So he basically just went there. He could not see his family and could not really attend the funeral. He just looked at the casket and then had to come back. He is very unhappy about it, and he is going to write a complaint about it, because he believes they should have coordinated it better.” The progress notes also state~~s~~, “The patient’s affect is flat. He is very sad. He is still dealing with his brother’s death and was disappointed that he could not see any of his family, because the funeral was two hours late …. He is really desirous to go home because his grandmother died. He was hoping to see her, that he would be released but that did not happen. Now his brother died so he has had several losses, but he is dealing with it okay.”

Several entries in Social Work Review of Progress documents mention continued supportive counseling provided for various family stressors over the past few months but does not directly state grief counseling.

Another Social Work Review of Progress document, dated 5/18/20-6/18/20 states, “He remains medication complaint and reports tolerating current meds well. He is utilizing good coping skills and was recently tested when his brother was killed in a shooting. The court did allow him to go to the service, but he was disappointed with all the restrictions (Covid-19 related) that kept him from being able to interact more intimately with his family.” The social worker mentions meeting with the patient weekly but never specifies working on the grieving process together. He mainly specifies working on patterns of behavior.

A physician made a note in the Progress Notes section of the patient’s chart on 6/4/20 stating, “Patient will be attending his brother’s funeral in Missouri 6/6/20. Will be accompanied by 2 STAs and he as he is on Supervised Off Grounds Pass (SOGP). Will take meds at 8am before leaving.” Another note made on 6/5/20 from a Psychiatrist’s PN states: “Patient is stated to have recently experienced the unexpected death of a family member. Pt requested and was granted a court order to allow him to attend the church showing scheduled for tomorrow. Pt will be granted an SOGP in staff for tomorrow 6/6/20 from 9am until 11:30 am. Pt … does not present in acute physical or emotional distress. He presents stable to go on OGP tomorrow as scheduled. No imminent signs of poor impulse control are … elicited. No acute or passive HI/SI are endorsed/verbalized.”

6/6/20 STA Note 1115 – "(patient) attended the viewing of his brother's body for approximately one hour. He was unable to stay and attend the funeral due to him having to be back at the facility by 11:30. He returned with no behaviors."
The driver for the trip stated that they arrived at the church early with the patient and they were the only ones there. The driver stated that the patient walked in and out of the church multiple times and would sit outside of the church for a while and go back in before deciding he was ready to leave after a young man working at the funeral home told them that the family would not be there for a while, per the driver's statement.
Another staff person who accompanied the patient on the trip stated, "We got there extremely early. We were there more than 2 hours early and his family didn't come to the church to spend time with (him) even after he called them to let them know that he was there early. He paid his respects to the decease and we spent time talking about their relationship for a while. We stood around waiting. Several nonfamily members showed up early but none of his family arrived. He felt like he had been there long enough and He requested that we leave. We left the Church and stood outside for another half of an hour or so just waiting to see some of his relatives. He made a couple of calls to them to see when they were coming. They gave a time that they were coming but never showed. It was kind of sad that his family had the opportunity to spend a lot of time with him and no one showed up. He calmly requested to leave the funeral to go back to AMHC. No behaviors observed…"

MANDATES/REGULATIONS

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

CONCLUSION

The HRA is concerned that the court order was not followed and therefore **substantiates** the complaint that the facility inadequately complied with a court order. Although the staff that accompanied the patient on the trip state that the patient chose to leave, records indicate that it was decided, in advance, that the patient would not be allowed to stay for the funeral/wake when given the time limit of 9:00am -11:30am and STA notes substantiate this claim when arriving back. An entry noted: "He was unable to stay and attend the funeral due to him having to be back at the facility by 11:30." The court order gave no time limits.
The HRA is equally concerned that the patient has not had specific grief counseling after suffering multiple losses in a short period of time. The HRA **Substantiates** the allegation that the patient is not receiving adequate and humane care with respect to coping with grief. This should have been addressed in his treatment plan as it was mentioned, in the chart, that the patient was sad and disappointed with the loss of his family members and not being able to attend the funeral.

RECOMMENDATIONS

The HRA **recommends** that Alton Mental Health Center follow court orders as they are written. AMHC should consult with their attorney and or the court on devising a policy on how court orders are to be carried out and provide the HRA with a copy of this policy when it is complete.

The HRA **recommends** that the treatment planning process should include all treatment for the patient, yet the loss of a family member and the grieving process that entails was not mentioned within the treatment plan whatsoever.

SUGGESTIONS

The HRA **suggests** that Alton Mental Health Center establish protocol/policies to assess and treat grief and offer grief counseling and/or grief classes for patients who have experienced the loss of a loved one or friend.