FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY-SPRINGFIELD REGION

REPORT 15-050-9003
Andrew McFarland Mental Health Center

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving complaints of possible rights violations in the care of a patient at Andrew McFarland Mental Health Center in Springfield. Allegations are that the patient is not being provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan as protected under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

McFarland is a Department of Human Services (DHS) hospital with adult civil and forensic programs, 50 beds on the forensic side for male and female patients with minimum to medium securities.

The issue was discussed with this patient's attending psychiatrist and his clinical social worker. Relevant policies were reviewed as were sections of his record with authorization.

COMPLAINT SUMMARY

The complaint states that the patient is not in the appropriate environment and that his psychiatrist continually assesses him unfit to stand trial although he is capable of facing his charges and thriving in a community setting. His treatment plan is unsupportive and he is said to be so distraught over his misplacement for such minor offenses that he has stopped eating most foods and is losing weight, his health is deteriorating and his placement is providing no benefit.

FINDINGS

Interviews

The patient was interviewed privately for his views on being remanded to McFarland and whether it is the appropriate, least restrictive environment. He said vehemently that he should not be there and that not eating was a willful matter of protest, rather than a symptom of illness as referred to in petitions from his psychiatrist. He described his legal charges and how he began

refusing food because he was wrongfully jailed. His hunger strike spanned from there into his admission at McFarland, about twenty-two days total. For his first week or so in the facility he not only refused to eat DHS food but also refused to shower or engage with anyone on the unit, spending all of his time out in the common area, napping during the day squatted against a wall and sleeping at night on a couch with his legs up and head down, all of which was purposeful avoidance. He feels unsafe in and around his room where other patients can be quite aggressive; he fears being assaulted, which he said is not uncommon there. For a time he accepted food and drink that staff brought him from outside but has since agreed to eat DHS food in the dining room after everyone is done. He showers and washes his clothes every three days as well. The turnaround he said was in realizing health implications and that his release looks uncertain. He still declines all group therapies calling them either unnecessary or ineffective, and says that although his psychiatrist does not visit him often, they talk for a few minutes about his situation when he does. The psychiatrist refers to his behavior as mental illness nonetheless, and the patient insists that he chose to start eating and bathing again before he was court-ordered on medication. He does not trust his doctor. He prefers to return to his native Turkey.

In a separate interview the psychiatrist described his patient as being very smart, holding a PhD in math. He has been in the states since 1998 and has a history of psychiatric hospitalizations within that time. He is diagnosed with Delusional Disorder, persecutory type, which he said is common to this kind of high functioning person. He demonstrates heightened suspicions that he is the one under persecution: claiming that a family friend abused him, that a jail inmate told him his brother was murdered and that various people in his apartment building were stealing or destroying his property and sexually assaulting him. In addition to damaging a neighbor's car several times, he was found roaming around mumbling to himself and his apartment had holes in the ceilings at the time of his last arrest. The psychiatrist explained that while his hunger strike may have been in willful protest, it is further symptomatic of his illness. He said that he knows this patient well having treated him here and at another facility over the years and believes that his primary problem is not being able to approach his situation rationally. He would not eat and rarely drank for the first couple weeks of this admission but then started accepting food and drink brought in by the staff. About five months in he now accepts food and drink from facility supplies. He initially refused to shower but has since complied with that as well. He still refuses to sleep in his room, opting for squatting against the wall or crouched on a chair in the common area instead. He declined an offer for a single room.

The social worker added that she sees the patient in the milieu but has to initiate all contact; he will not go to her office. Their conversations are limited but she tries to talk about the point system to encourage participation, which he seems to understand. He will not however attend treatment team meetings or go over his treatment plan. While he refuses to engage with other patients he will on occasion talk with certain staff about current events. She said that he now eats meals in the dining room but only after everyone else is done.

Regarding his treatment plan, both said that the arranged plan is meant to support. It includes group therapies on legal realities, relaxation, spirituality, recovery skills and exercise, none of which the patient attends. We asked how these groups help with Delusional Disorder and this patient's particular situation and whether one-to-one therapies or other treatment alternatives are attempted since he refuses to attend them. The social worker said she was new

and did not know. The psychiatrist said that generally every group contact has the ability to help. One-to-one therapies have not been attempted although they were trying to encourage an outside psychologist to visit him. Concerning the psychiatrist's personal involvement, he said his visits are not regularly set but occur at least once per week for ten or fifteen minutes. He tries to talk about treatment and getting back to court while the patient ruminates on his delusional conspiracies. He reminds him to take medication, engage with others and attend groups, all of which he refuses to do. He believes the patient understands their discussions.

Asked if he agreed the patient was perhaps delusional but not violent, the psychiatrist thought he was, recalling an incident when he pulled a knife on someone ten years or so ago. Asked whether there was trust in the therapeutic relationship between him and his patient, the psychiatrist contemplated and then replied that he did not know. He said that although it was painful to watch the patient seemed to be improving at this point. He is much cleaner now and after losing weight he is eating more. He expects continued improvement with different medications and with a new psychotherapy approach. He believes they are providing adequate and humane care in the least restrictive environment while the patient remains unfit and under court ordered medication.

According to McFarland updates at the time of this writing, the patient agreed to see an outside psychologist on several occasions. He has also been found not guilty by reason of insanity in the meantime with another year's commitment.

Records

A May 24, 2014 comprehensive psychiatric evaluation completed by another psychiatrist the day after admission found the patient arriving unfit to stand trial for charges of repeated damage to neighbors' cars and other bizarre and delusional behaviors. He refused to answer questions. The evaluation rested on historical information from jail and court records, which referred to the patient having no food, drink or shower since he was booked. He was taken to an emergency department for rehydration the day before where he had a hamburger, French fries and a full drink. The psychiatrist wrote that once at McFarland however, he would not to eat again, that refusing food was willful and that the patient said he would buy water to drink if he had money. He was noted as having two prior hospitalizations under similar forensic statuses, and was described at that time as being neat, not disheveled, very clear and articulate and although speaking little he was coherent and logical. He was said to be alert and aware of his setting but was unable to care for himself due to paranoia, lacked the capacity to consent to medications, was noncompliant with medications and had chronic mental illness and no insight. He was diagnosed with Schizophrenia, paranoid type. Court ordered medications were recommended. An admission physical exam likewise referred to the patient's poor nutrition intake and noncooperation. The clinical social worker wrote in her assessment four days in that the patient spoke about his situation, which she believed was delusional, but that he refused to answer her questions. The patient still had not eaten or slept by this time, only sitting down on occasion to rest his head. He was on frequent, special medical observation and was refusing medication. He remained resistant to participate in anything and his prognosis was not good.

Orders confirmed the special medical observations as well as frequent vital signs, forced if necessary for his safety. Food/fluid intake monitoring logs were started on order through July.

A treatment plan was devised a few days after admission in which three major problems were cited: his unfit to stand trial status, altered thought process and medication non-compliance along with corresponding goals to restore him to fitness, allow him to verbalize his delusions, function in the community, understand the importance of taking medications and increase fluid and nutrition intake. Objectives in reaching those goals by September 2014 were to demonstrate an understanding of legal proceedings, cooperate with his attorney, complete activities of daily living with monitoring, engage in reality based conversation with his social worker and psychiatrist, attend all restoration groups for fourteen consecutive days and verbalize the importance of ongoing treatment and medication compliance in the community. Interventions in completing those objectives included numerous group therapies like legal realities, recovery skills, daily living skills, WRAP or wellness recovery action plan, emotional wellness and health education. His social worker, a psychologist and nursing staff planned individual interventions for counseling, support/encouragement and treatment compliance. It was noted that the patient refused to meet with his social worker and participate in his plan's development.

The first treatment plan review from May 30 reported the patient's unwillingness to eat, drink, bathe or engage in therapies. He remained delusional about his circumstances and uncooperative with interviews and assessments. All objectives were continued without progress after just a few days to implement. Nutrition logs through the next month showed an occasional drink of water, tea or coffee and no food until June 3 when he still refused DHS meals but accepted snacks, soup and crackers off and on. His consumption increased steadily from there at dinner or snack time and by the 7th he was eating fruit, oatmeal, crackers, soup and sandwiches, albeit in the evenings only. He was showering about every three days as well according to patient care flow sheets from the same time. By the 13th he was eating breakfast and lunch several times per week and at the end of June almost every meal was taken.

A petition for involuntary treatment was filed earlier on June 10. It claimed that at that time the patient suffered from poor sleep, eating and bathing, in stark contradiction from nutrition and patient care logs, and being on his feet pacing for hours, all based on the psychiatrist's visit once per week and on "observations on the unit". The petition was granted.

The June 25 plan review stated that the patient's diet continued to be monitored. He would not attend group therapies but was taking court-ordered medications willingly. He ate in the dining room, showered every three days, washed his clothes when prompted and used the toilet in his assigned bedroom. He complained of a toothache but refused all offers for pain relievers unless they were given out of a nurse's personal stash. He refused to schedule a dentist appointment or engage with the treatment team. All goals and objectives were continued without change through July.

A plan review on July 23 noted much of the same: compliance with court-ordered medications, eating DHS food in the dining room, showering every three days with prompts and refusing to sleep in his room. He carried on with the same delusions, remained unable to cooperate with his criminal attorney and did not attend group therapies. All goals and objectives

were extended without change through September. Nutrition intake logs referenced full consumption of meals until monitoring was discontinued by the psychiatrist's order on July 16: "D/c log intake. Pt. eating regularly."

August and September plan reviews provided nothing different. He took his medications, the court order for which was about to expire, he expressed delusions, ate regularly, paced, slept in the milieu and refused to engage in treatment planning or attend group therapies. All goals and objectives were continued without change through November. The September review referred to the patient's expired court order and that he refused to accept medications pending a new hearing, the petition for which was filed on the 3rd. It cited a deterioration of functioning by sitting next to the unit door and pacing, eating meals sporadically, again in contradiction to social work and nursing documentation, and refusing to participate in treatment; he suffered from squatting against a wall, from being thin and having conspiracy delusions, all based on the psychiatrist's visits once per week or less since the last order. The petition was granted.

The psychiatrist was asked during our interviews about discrepancies between his petitions and various staffs' documentation of the patient's eating habits and his own order to discontinue nutrition intake logs. He offered that in court he more accurately reports an irregular pattern instead of an outright refusal that a petition might assert, which we pointed out as still inaccurate.

The patient complied with court ordered medications but further displayed a delusional disorder according to the October and November treatment plan reviews. He had no aggressions, followed directions and was interacting more with staff and peers. Objectives to engage with his social worker and attend group therapies were dropped while all others were continued through December and February. Patient care flow sheets showed that at the same time he was eating "ok" and "100%", was showering every three days and had an appropriate appearance.

December's review noted a recent NGRI ruling. There were no changes in the patient's food consumption or hygiene maintenance and no changes were made to goals or objectives. It also referenced an outside psychologist's attempt to meet with the patient who initially refused. The social worker provided notes from subsequent visits, which showed that the patient eventually agreed to meet and join in psychotherapy with him. The two came up with plans for moving toward conditional release while meeting three more times during the month. Four steps in that direction included improving cooperation with staff, establishing a normal sleeping and eating pattern and continuing with psychotherapy. They arranged to continue meeting in the new year.

CONCLUSION

McFarland's procedural guide (#TS101) states that treatment planning is a fluid process in which problems, goals, objectives and interventions are identified and monitored, the process for which is documented throughout a patient's stay by assessment and treatment plan reviewing. The patient, his psychiatrist, a nurse and a social worker are to collaborate in developing a plan. Changes are made when clinically indicated. Reviews are completed monthly. They are to

include the patient's responses to treatment and the amount of progress toward goals. A coordinator is responsible for assuring the plan is comprehensive and individualized based on clinical needs, strengths and disabilities. The plan is to include specific goals for the patient to attain, maintain or re-establish emotional and physical health and maximum growth and adaptive capabilities. The unit's clinical director is responsible for monitoring and assuring timely development, implementation and quality. The psychiatrist is responsible for approval.

Under the Mental Health Code, a recipient shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The plan is to be formulated and periodically reviewed with the recipient's participation to the extent feasible. 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. (405 ILCS 5/2-102a).

Adequate and humane care and services are defined as those reasonably calculated to result in significant improvement of a recipient's condition so that he may be released or to prevent further decline so that he does not present imminent danger. (405 ILCS 5/1-101.2).

The intent here is not to question legal status and diagnoses but whether the patient's rights while hospitalized are protected, which in every case must include adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. Two related points of concern are raised from this review: the unsuccessful treatment plan that carried on for five or six months without revision to any goal, objective or therapy approach and discrepancies in the psychiatrist's portrayal of the patient's eating patterns against the rest of the staffs'.

McFarland policy and the Code call for plans to address needs, promote significant improvement and be fluid and periodically reviewed with the patient's participation. In this case the patient refuses to exercise his right to that but the treatment team remains responsible nonetheless, which means there should be timely adjustments to what is not working, namely therapies. To be sure, there is evidence of recent improvement based on documentation of the patient finally engaging more with staff, in the milieu and in a new psychotherapy seven months in. But five to six months of no progress in identified therapies without revision seems excessive and fails to meet basic treatment planning requirements, a substantiated violation of the patient's right to adequate and humane care, pursuant to an individual services plan.

RECOMMENDATIONS

The treatment team must ensure at every monthly treatment plan review that the arrangement continues to meet the patient's needs, remains fluid and is attainable.

Add the new psychologist's appointments to the treatment plan as a formal objective and invite him in as a treatment team member.

There is evidence that the patient controlled his nutrition intake from the time of his arrest through his stay at McFarland. Records state that while he refused to eat jail or Department food he consumed a large meal during a brief emergency room visit in between. By June 3rd, ten days after admission, he was eating snacks and anything he believed staff brought to him from outside the facility and was having several drinks throughout each day. By the 7th he was eating almost every dinner and snack while a petition for involuntary treatment filed on the 10th proposed that he was still refusing everything, which the patient correctly insists is false reporting. Regardless of whether the psychiatrist insists it is symptomatic or whether the petition was granted, the information is simply inaccurate. The same continued in the September petition which referenced the patient's "sporadic" eating when all other documentation including treatment plan reviews and patient observation sheets showed almost no refusals and when the psychiatrist believed his patient's eating habits were regular enough to stop monitoring two months prior.

SUGGESTIONS

All treatment team staff should strive for accuracy and consistency in their documentation as there are short and long term consequences for the patient; that information follows him.

McFarland should meet with the patient and help him enter any dispute he identifies in his record, namely the petitions, as allowed under the MHDD Confidentiality Act (740 ILCS 110/4).

Neither the patient nor his psychiatrist said there was trust in their relationship, which would seem to be a key element if any relationship is to be therapeutic. Given that and the current success of the new psychologist and the fact that the Code requires consideration of the patient's views of treatment in the least restrictive environment, the treatment team should discuss a change of psychiatrists with the patient.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

Bruce Rauner, *Governor*

Andrew McFarland Mental Health Center
Greg Donathan, Hospital Administrator

James Bakunas, HRA Vice Chair (IGAC)
401 So. Spring St.
521 Stratton Building
Springfield, IL 62706

RE: Case #15-050-9003

Dear Mr. Bakunas,
This letter is in response to your recommendations for case # 15-050-9003 which include:

- The Treatment team must ensure at every monthly treatment plan review meeting that the plan continues to meet the patient's needs, remains fluid and is attainable.
- Add the new psychologist's appointments to the treatment plan as a formal objective and invite him to participate as a team member.

McFarland Mental Health Center is committed to providing quality health care. We continually strive to promote a culture of safety and recovery through service excellence. The Treatment Team has been reviewing Mr. treatment plan and progress toward his goals and objectives each month. Earlier in his stay, Mr. refused many services including medication, individualized therapy, groups and recreational activities. Attempts to engage Mr. in treatment activities is well documented. Over the last three months, Mr. has been participating in some groups and individual therapy which has resulted in his ability to make more progress toward attaining his goals and objectives. Dr. Fritz, his Psychologist, began providing supportive counseling since 11/12/14, which is reflected in Mr. s treatment plan.

Additionally, we have been making significant changes to our electronic charting system which includes the Treatment Plan and Treatment Plan Review documents. Specifically, the current electronic charting system is being revised to allow for an enhanced ability to create unique and individualized treatment goals, objectives and interventions. We are also making modifications to the system that will prompt treatment staff to better address lack of progress toward goals and objectives. Staff will be prompted to provide individual or small group activities to patients with an active high problem of non-engagement.

The system will include a documentation component to capture engagement efforts. The system will also require the clinical team to evaluate each patient's level of engagement on a daily basis. For those in need of enhanced engagement efforts, the system will "flag" the patient in order to assure individualized or small group treatment is provided. Mr. 's next treatment plan review meeting is scheduled for March 9, 2015. The Team plans to add an objective targeting non-engagement.

Thank you for the opportunity to address systems issues that allow our hospital to improve performance and patient safety.

Sincerely,

Greg Donathan, LCSW