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HUMAN RIGHTS AUTHORITY-SPRINGFIELD REGION

REPORT 15-050-9007
Andrew McFarland Mental Health Center

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving complaints of possible rights violations in the care provided to a forensic patient at Andrew McFarland Mental Health Center in Springfield. Allegations state that:

1. The patient is not allowed access to his record.
2. Adequate and humane care has not been provided and the patient's views of least restrictive environment are not considered.

Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110) and the Mental Health and Developmental Disabilities Code (405 ILCS 5).

McFarland is a Department of Human Services hospital with a 50-bed forensics program. The issues were discussed with staff involved in the patient's care. Relevant policies were reviewed as were sections of his record with authorization.

To summarize the complaints, the patient's treatment team will not allow him to review his record saying it will only upset him; they give him copies of treatment plan reviews and court reports but nothing else. He wants transferred to another facility near his ailing father but is refused and not given the opportunity to attend appropriate therapies in order to do that. He has asked a clinical administrator about transferring and she reportedly will not respond. It is also claimed that the patient lost privileges for getting close with a female peer. The level reduction was supposed to be for thirty days but turned out to be for seven months during which time he was never allowed outside for a moment of fresh air or sunlight. Although he has regained his level since, court reports in the meantime are said to be intentionally false, reflecting his behavior in negative ways to impede transfer.

FINDINGS

1. The patient is not allowed access to his record.

According to the staff, this patient has never requested to review or copy his record as far as they are aware. There would be a treatment team discussion if he had, and if granted someone would sit with him to help with any questions or concerns. If denied, a restriction notice would be completed and entered and the treatment team would eventually reconsider. A physician offered that the patient tends to ruminate on what staff document and could suffer with that information. He said that he gets involved if any patient is persistent. He looks for potential psychological effects as meltdowns can be detrimental.

The record contained no restriction notices or other notations on whether the patient requested access. On a follow up inquiry the patient said he has never actually asked but at the time of this writing decided to and has seen his chart. We were also provided written statements from a social worker detailing her recent time spent with him going over the record.

CONCLUSION

McFarland policies on patient records access (#HIM405) was revised during the course of this review to include total access to one's record within three business days of his request unless there is need to prevent life endangerment, physical safety or substantial harm to anyone, based on the Privacy Rules (45 CFR 164.524). Denials must be forwarded to the hospital administrator for a second review and meet the standard or be reversed. Psychological detriment is no longer grounds for denial.

The following persons shall be entitled, upon request, to inspect and copy a recipient's record or any part thereof:… the recipient if he is 12 years of age or older;…(740 ILCS 110/4 a).

This patient has not been prohibited from inspecting his record and reports recent access to it upon request. The complaint is unsubstantiated.

2. Adequate and humane care is not provided and the patient's views of least restrictive environment are not considered.

This patient has wavered between forensic and unit privileges during his time at McFarland according to the staff. These are the lower of three levels: forensic, in general meaning the patient is restricted to the unit and is unable to use the comfort room or patio; unit, still restricted to the unit but able to use the comfort room and patio; and staff, he can travel to other areas on grounds under supervision. Risk issues among other therapeutic values drive clinical decisions on whether a patient earns or loses privileges and there are no set durations.

The patient is supported with appropriate therapies regardless of his privilege status and his views about treatment are considered. He usually attends treatment team meetings and often expresses his concerns. Treatment plans are reviewed with him and all goals and objectives are clearly outlined for him. He knows what he needs to follow and achieve in other words. Nursing staff explained that the patient however, displays certain stumbling blocks that hinder success. For example, they spend considerable time talking with him about their observations

like intentionally antagonizing or intimidating staff and peers, playing coy when confronted and then repeating them again. In the clinical director's view the patient continues to deny responsibility and often reports different versions of the truth. He needs to be able to tolerate frustrations, manage instant demands and maintain control. His therapy arrangements including weekly Dialectical Behavior Therapy, or DBT, and strategies will support him in doing that since they teach how to deal with everyday stressors. Regardless, his views are always considered, including his desire for transfer to another facility.

An administrator said that she has spoken to the patient about his transfer plans and has not ignored him. In fact, she has met with him and his brother a couple of times on the subject. A referral was made to the intended facility and a video conference was held with them where the patient's treatment was discussed. McFarland's medical director has rechecked on the status but has no additional feedback. At this point he is not denied; the facility claims to have no openings and McFarland continues to favor the transfer. His newest clinical director has since provided updates and reports that she remains in touch with the forensics bureau. The patient is still on a transfer priorities list according to the bureau, and the intended facility will respond when an appropriate bed opens. They are hopeful that will happen in the near future.

The record provided support. Treatment plan reviews throughout his time on forensic showed that DBT and strategies were among the groups he attended regularly. The only groups he was unable to join were AA and MISA (mental illness/substance abuse) although he took part in a health education group that had substance abuse components and he maintained contact with an AA sponsor. All reviews noted how he attended his groups consistently and that he would be able to return to the others once he progressed. He achieved unit level in July and substance abuse-related groups resumed; MRT (moral reconation therapy) was started. July's treatment plan review noted that his facility transfer request was sent to administration. August's review noted his transfer request to either another unit or another facility and that he was placed on that facility's waiting list. Most of the reviews throughout the year referenced contact with the patient's brother and his brother's involvement with team meetings; both of their comments and concerns were added, including their desires to transfer. September and October reviews referred to the patient, his brother and mother having met with administration about the request to transfer out and that it was denied. The administrator involved told us on the contrary, it was an inaccurate documentation and that they were simply awaiting an open bed at the other facility.

On the matter of whether the patient was kept from fresh air or sunlight for seven months, the staff said that it might be possible. General policy is that on forensic level you do not go outside. In this case the patient was indeed placed on forensic for seven months but no one was sure if he was allowed outdoors. An administrator verified after looking into it that he was not. She said that privilege levels are reviewed at morning reports and during monthly treatment plan reviews but at the time there was nothing in place to check how long a patient is on this level; policy was now under revision.

Our record review confirmed the same. Psychiatry and nursing progress notes, nurse incident notes, orders and treatment plan reviews showed that the patient was moved to another unit for having relations with a peer and was subsequently placed on forensic status on December 3, 2013. He remained on that status through July 3, 2014 when he gained unit

privileges and was able to have some outside time. Both orders were written by the same doctor. Entries for the duration described him as loud, argumentative, defiant, intrusive, uncooperative and unmanageable, but also non-aggressive, in one case referring to how he was attacked by another patient and walked away. Not a single concern for imminent physical safety was noted after a December incident of kicking a door to the med room. "Improved control of argumentative behavior" was cited on an annual psychiatric evaluation as the reason he achieved unit status.

Regarding court reports, information is gathered from observations and documentation as accurately as possible. There may have been a recent mix up where information was misunderstood. A social worker said for example, the author of one report based his comments on a nurse's inaccurate reference to the patient repeatedly calling staff on another unit. It turns out that the patient had approached that staff person once. They all insisted however that none of their actions or documentations is meant to impede the patient's progress and transfer or damage his image.

Two court reports specifically come into question. An author wrote in an October report that he got a call from another unit's clinical director saying the patient repeatedly called her with complaints and requests for transfer to her unit and she wanted it stopped. A nurse charted something similar in his record. In a follow up interview the clinical director denied the events as reported and said that instead the patient approached her once and she spoke with the nurse to say she preferred he take it up with them. She also denied calling the author of the report and had no idea why it was interpreted and documented that way. The same court report referenced an incident with a peer where punches were exchanged and his privileges reduced just a day before the report was written. After reviewing further with administration, it was determined that the incident actually occurred in November, a month later, and that a security report on the events and progress notes stated that the patient did not throw punches; he was not responsible and his privilege level was regained. In a December report the author mentioned the privilege reduction because of the November incident but failed to add that security revised their own accounts, found that the patient was not the aggressor and that he regained his privileges.

The HRA asked for the record to be set straight on behalf of the patient. A letter was sent to a judge in February acknowledging and correcting errors in each report.

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.

Granting Privileges to Adult UST and NGRI Patients policy (#MD402), effective 10/3/14, states that "Privileges will be granted incrementally based on the patient's progress in treatment and demonstration that he is able to function with decreasing structure without

presenting an elopement risk, unmanageable, dangerous or illegal behavior." Forensic, unit and staff supervision levels are listed as was described.

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…. 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 5/2-102 a).

Appropriate therapies are available and in place for this patient according to the clinical judgement of his treatment team. Participation in them depends on his willingness to engage and demonstrate progress, reviews on which are completed monthly. The record revealed that over the last year he has in fact moved from the lowest to the highest privilege levels. There is also evidence that his treatment team has not abandoned his request to transfer although you begin to understand his anxiety and rumination when inaccurate treatment plan reviews tell him his transfer is denied when in fact it is not. A violation of the patient's right to adequate and humane care, pursuant to an individual services plan, with his views of least restrictive environment considered, is in this regard unsubstantiated.

SUGGESTION

-Add transfer status and updates on each treatment plan review to allay the patient's concerns.

The same Granting Privileges policy (#MD402) was revised in June of this year. It previously restricted those on forensic supervision from moving beyond the unit's electronic doors except for medical emergencies or on physician order with ensured security. Revisions now allow secured patio area time with staff supervision unless otherwise specified.

For apparent clinical reasons the psychiatrist and treatment team thought the patient's continued troubles with arguing, noncooperation and reactions were cause enough to warrant forensic status. But seven months without a moment of fresh air in the meantime is inhumane, even in the most extreme circumstances. The psychiatrist, a member of the treatment team or any staff on the unit for that matter should have paid attention and alerted someone to give the man a break outside. McFarland's policy in place at the time contributed to his confinement as well and failed to assure the Code's protections. A violation of his right to adequate and humane care in the least restrictive environment is substantiated. The policy was immediately revised on discovery of this incident and has been addressed and corrected.

SUGGESTIONS

-The revised policy states that patients on forensic supervision may have patio time unless otherwise specified. The exception is not clear, but if it means that anyone with considerable risks can be excluded, then we suggest the policy also provides a clearly stated arrangement for stricter reassessment of the exclusion specifically to avoid another prolonged confinement. If

morning reports and treatment plan reviews are supposed to serve as the reassessment, then in this man's case they failed to catch it.

-It was offered that now a unit designate must provide administration with weekly reports of everyone who is not allowed outside as an added measure. This does not appear in the policy and should. It may satisfy the first suggestion.

-Perhaps using restriction notifications as outlined under 5/2-201 should be used for whenever patio time is "otherwise specified". While privileges are not guaranteed rights, least restrictive environment is and anything to trigger a second look at an outside restriction could be helpful.

Best practice in all healthcare fields dictates that records be authentic which is crucial in mental health care because the information follows the patient. There were some admitted errors in two court reports that when brought to McFarland's attention were corrected and forwarded to the court. Although the claim that these reports intended to hold the patient back is not discredited, there is no factual evidence of that or anything nefarious and a violation of the patient's right to adequate and humane care in this regard is unsubstantiated.