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HUMAN RIGHTS AUTHORITY-SPRINGFIELD REGION

REPORT 15-050-9014
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 violations at Andrew McFarland Mental Health Center in Springfield. Allegations are that the facility has not provided a patient with an individualized treatment plan in the least restrictive environment, private communications and adequate dental care.

Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the rules for Department treatment services (59 Ill. Admin. Code 112).

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 her record with authorization.

Complaints say that therapies within the patient's treatment plan are selected from a generic list rather than being individually arranged to meet her needs. She requested individual counseling and now refuses to attend because the psychologist wants to discuss issues unrelated to her problems, and a court-ordered privilege upgrade was withheld because of her disabilities from Fibromyalgia. She was restricted from using the phone for an extended time because she asked to call the media regarding her legal case and nurses document what they overhear from her phone conversations and visits with her mother. And finally, she was reportedly denied antibiotics and pain medicine for an infected tooth. The swelling grew so bad that a dentist was eventually consulted, and he found the infection spread into her jaw, prescribed antibiotics and removed her tooth.

FINDINGS

Individualized treatment plan in the least restrictive environment

According to the initial treatment plan from admission in May 2014, the patient was charged with solicitation of murder for hire, found Not Guilty by Reason of Insanity, or NGRI, and was remanded to the Department for evaluation and treatment where she entered a secure unit, Lincoln South. Within ten days McFarland recommended a less restrictive setting and she was granted transfer to Monroe and then Stevenson, both minimum secure units. Major Depression and Personality Disorder were diagnosed, which contributed to her symptoms of mood dysregulation, anxiety and somatization per the authors. Separation from her children and their sexual abuse by her ex-boyfriend were noted severe stressors and her NGRI status, difficulties with past traumas, mood lability, limited coping skills and non-engagement were identified problems. Weekly and/or monthly social work, psychiatry and psychological supports were arranged either person to person or in group settings. The treatment plan included a variety of therapy groups and activities, NGRI Group, Coping Skills/Stress Reduction, Anger Management, Wellness Self-Management, Recovery, Building Resiliency and Emotional Wellness among them. Descriptors explained that each is designed to develop coping and recovery skills, increase empowerment, attain personal goals, understand the legal process and achieve a conditional release.

Monthly treatment plan reviews throughout 2014 referenced the patient's objections to having mental illness and being at the facility. Although she expressed reluctance with all therapies offered saying they had nothing to do with the rape of her daughter or that she already knew everything, she attended them regularly except for Anger Management and achieved staff privileges, meaning she could travel to other areas on grounds with staff supervision. She also met weekly with an individual therapist and in December transitioned to a new unit and began seeing a psychologist.

Service notes from that psychologist described her first meeting with the patient, how they distinguished each other's expected roles and how she allowed her to express feelings while guiding her to focus on working with a new treatment team on her new unit. The plan was for the patient to complete personality assessments and to meet more frequently. Two more meetings occurred where according to the documentation the patient was given extended sessions to fully express herself and be heard. The psychologist wrote that she searched for ways in the meantime to increase the patient's modes of affective expression, enhance self-esteem and improve coping skills. She described her time with the patient as rich, and the plan was to have more sessions in the new year.

Treatment plans into 2015 showed the patient attended her therapies while still reluctant and insisting that her crime was justified. Moral Reconation and Dialectical Behavioral Therapies were introduced. By March she was missing several groups however and not attending off unit activities regularly. Emphasis was placed on encouraging her to pick up attendance and working more closely with her treatment team; some of her goals and objectives were combined, revised or dropped and she continued to meet with her social worker, which continued through June.

The clinical and social staff we met with said that at the time of our September 2015 visit the patient was engaging once again and would be seeing her psychologist. She currently goes to groups but misses once in a while when she is not sleeping or feeling well, sometimes because of

Fibromyalgia. They always encourage group attendance but never force patients to go. In this case the patient has a different perspective of her overall mental health than clinicians do and finds most of the therapies beneath her. Therapies are discussed with the patient and treatment team and they are selected accordingly from a variety of options designed by professional clinicians; they are not random or generic. They are widely run by master's level clinicians and they believe they can help her through them. Asked for her experience, the psychologist said that she began seeing the patient after she and her attorney requested individual therapy. In the first sessions she allowed her the opportunity to direct the conversations and vent, and once she felt she had a grip on what to do the patient grew symptomatic. She does not agree with the patient's own characterization of her needs, rather, her primary issues are narcissistic and somatic. They are meeting again and agree to work on self-worth and esteem.

Regarding the allegation that a court-ordered privilege upgrade was denied because of the patient's disabilities, the record contained an order from June 11, 2014, in which the court authorized the Department to issue unsupervised on grounds and supervised off grounds passes to the patient "at a later date and at the discretion of the hospital administrator". Psychiatry notes at that time referenced how the patient was focused on her son's sexual abuse by his father and that they believed she was an elopement risk. She was downgraded to unit privileges for safety but was still slated to move to another minimum secure unit when available. There were no documented indications that the failure to promote her as court allowable was based on her problems with Fibromyalgia or any other physical limitation.

Staff verified the record and said that they were given discretion to award "to and from" privileges under the court order and are free to do so when the team and administration feel she has reached that level.

CONCLUSION

McFarland's treatment plan requirements (#TS101) states that planning is a fluid and ongoing process in which problems, goals, objectives and interventions are identified and monitored. Psychiatric, nursing and social staff work with the patient to incorporate his values, choices, empowerment and satisfaction. Plans are reviewed every thirty days. They are to include diagnoses, relevant problems and needs and the goals and objectives to attain or establish emotional health.

Granting Privileges to Adult UST and NGRI Patients policy (#MD402), 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."

The Mental Health Code establishes the right to 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 patient participation, and his views of least restrictive environment are to be considered. (405 ILCS 5/2-102a). Adequate and humane care and

services is defined as those reasonably calculated to improve the patient's condition so he may be released. (405 ILCS 5/1-101.2).

Although the patient's opinion of her personal health and circumstances is respected, the HRA has no evidence to say she is not being provided an individualized plan or a least restrictive environment where she finds herself. Diagnoses seem to drive the plan's arrangement and whenever she decided not to participate or requested particular therapies her choices have been honored, including time with or without a psychologist. A pretty exhaustive list of options has always been available and as described by clinicians those options intend to provide valuable improvement. She has been able to move to less restrictive units at different stages of her time there and there is no evidence that an ordered privilege was denied because of disability, instead an order gave discretion to grant the privilege when the hospital feels the patient qualifies. A rights violation is <u>not substantiated</u>.

Private communications

Nursing and social work entries from the patient's admission through mid 2015 were reviewed. A nursing note in July 2014 stated that all outgoing calls were restricted for forty-eight hours so the treatment team could consider her request to contact the media. A restriction notice referenced the same. It was determined that the circumstances did not meet the standards for restriction, an order was written the next day to restore her right and the restriction lasted about twenty-four hours.

There were several entries relating to the claim that nurses document what they hear from the patient's phone conversations and family visits. May 31, 2014: "…talks during the week about legal issues with personnel on phone as overheard, appears to understand the legal situation surrounding her well." June 20, 2014: "…on phone a lot with dcfs, attorney or family attempting to get legal things initiated." June 26, 2014: "…often on phone discussing legal situation with someone…." December 14, 2014: "…patient was also witnessed by staff on the phone telling her daughter to report her father to DCFS and the school counselor for neglect. She was stating to the daughter that her father only played video games all day, didn't help with anything, and that's why she wanted to divorce him. She was stating other numerous complaints to the daughter regarding turning her father in for neglect. Techs wrote note in aggression chart." A social worker followed up and noted more detail: "It was reported to me…[pt.] was on the phone for an extended amount of time and at times getting loud. It was also reported that she was heard speaking to her daughter…about how 'she just needs to get out of there. Had she ever thought of hurting herself. And had she ever just thought of running away?' Documentation was done and charted." Entered on the same day: "[Pt.'s] mother came to visit and this SW heard them discussing her concerns. [Pt.] stated to her mother that 'her treatment team just doesn't get it.' She stated that they don't care that she had tried everything she could and had no other choice than to do what she did. She told her mother that she even made a long list of all things she tried before and that the team wasn't interested in seeing it. She stated that, 'after 8 months and trying everything that she could think of to try to protect her daughter', that doing what she did, she feels that 'that was her only choice.'"

In a July 2015 written response to the patient's related record disputes, an administrator explained that the treatment team had met, found the phone restriction was not appropriate, reinstated her right to use it, and the staff were reminded of the criteria for restricting. Regarding the documentation, the letter stated that while patients have a right to privacy, conversations can be overheard by staff and peers, especially if the patient is talking loudly. Staff respect the right to privacy and do not censor or impede but overheard issues of concern would be documented.

Asked to clarify, the staff we interviewed said that in the case of the phone restriction calling the media would not have been harmful necessarily. The team took the next day to review it and the restriction was lifted. Banning all outgoing calls is no longer the practice, only those potentially harmful are restricted. On whether the documenting of patient conversations invades privacy, a clinical director said it does not, that he instructs his staff to write anything they overhear, particularly if a patient is loud. We pointed out potentially troubling documentation, the patient asking if her daughter ever thought of hurting herself or running away, and asked what was done with the information if the staff were indeed concerned and no one answered.

Phone locations and visiting areas were observed on Kennedy, Monroe, Jefferson, Stevenson and Lincolns North and South. All of the units have at least one pay phone and one non-pay or unit phone available. Kennedy, the largest unit intended for those with high privileges, affords the most privacy. Pay phones on the other units are situated across from nurses' and therapy aides' stations where privacy is more assured but all unit phones are adjacent to the stations within an approximate two or three feet; no more than one foot away on Lincoln South. With the exception of Kennedy, visiting areas on the other units are surrounded by offices and a conference room, just steps away within earshot of any personal discussion. An employee whose office door is open will, intentionally or not, overhear conversations as experienced by this writer who on two separate occasions on Lincoln North met privately with a patient and was interrupted by social workers, one telling the patient to stop ruminating and the other correcting him. Lincoln South is the only unit to include a small private meeting room with an observation window in addition to the common area. We were told that the conference rooms are generally not used for visits because people cannot be observed in them.

CONCLUSION

McFarland's Rights policy (#HR 126) states that individuals are allowed to conduct private telephone conversations and have private visits in suitable areas. Safe, supervised areas will be arranged for those with clinical contraindications. Restrictions only apply on physician order to protect from harm, harassment or intimidation. The policy was revised during the course of this review to limit initial restrictions to three days, continuations are individually determined.

Under the Mental Health Code, a recipient of services shall be permitted unimpeded, private and uncensored communication with persons of choice by telephone and visits, which can be reasonably restricted for the same. (405 ILCS 5/2-103).

The phone restriction in question was inappropriate as a call to the media was the patient's choice and was not harmful, harassing or intimidating. The staff erred on the side of caution, preferring to discuss the potentials as a team and reversed the restriction the next day. A substantiated rights violation occurred and was immediately corrected.

Documentation of this patient's personal time on the phone and during visits reveals a disturbing practice. The conversations recorded are not simply from overhearing but from listening intently given such detail and it seems to be supported by management. The HRA takes issue with the clinical director's position of privilege to document whatever they overhear, in fact instructing his staff to do so. The patient is not the service provider, McFarland is and the staff are responsible for providing a private environment with exception for harm, harassment or intimidation, not loudness. Much of the information repeated on paper was personal and gave no cause for alarm, and unless encouraging the daughter to harm herself or runaway did or presented a duty to warn, which did not seem to be the case according to the staff, the documentation is a substantiated violation of her right to private communication. And, given the current location of unit phones and visiting areas at such close range to staff, McFarland fails to even permit privacy, a substantiated violation of all patients' rights.

RECOMMENDATIONS

Stop instructing staff to document private phone and visit conversations unless there is need to protect from harm, harassment or intimidation.

Retrain all staff on private communication rights.

SUGGESTIONS

This patient may have been unaware at the time that her phone restriction was lifted so quickly. Be sure that all patients are informed immediately.

Instead of documenting what loud patients say on the phone or in visits tell them to quiet down and remind them to respect privacy.

Use unit conference rooms for visits. Staff can periodically monitor or non-recording cameras can reasonably be installed.

Adequate dental care

The first recorded reference of the patient's complaints was on June 10, 2014 when she was given ibuprofen for ear and jaw pain. The next was on June 14 when she received more for ear, jaw and throat pain. Naproxen twice daily was ordered as well. On June 19 a physician noted on examination that the patient complained of a tooth ache for the last few days, pain radiated down the left side of her face and there was oral cavity tenderness; she rated her pain a

three. Tramadol and an in-house dental appointment were ordered. She continued taking naproxen and tramadol through the month as corresponding charts showed the medications helped, helped a little or there were no further complaints in result; pain ratings however steadily increased to six. The physician re-examined for continued complaints on July 1. His entry states that the patient rated her pain a four at that time, reaching ten whenever she eats or drinks. He ordered an in-office dental appointment. Orders and nursing notes showed that the referral was made that day and the patient was taken to the dentist's office on July 7. The dentist wrote that the patient had an abscess, started her on an antibiotic and antibacterial and wanted to see her again in seven to ten days. A follow up referral was made on July 10, and the tooth was extracted at the dentist's office on July 16. She was ordered a soft diet and completed her medications through July 20. Nurses monitored her condition and noted no signs of infection or complaints of pain through July 23.

The staff explained that a dentist comes to McFarland about once per month, but with no set schedule. Referrals are made by general practice physicians in the facility who write orders for dental visits in-house or in-office, meaning either when the dentist arrives or when a patient needs to be taken to his office as was the case here. The staff, including a physician, felt confident that what transpired was appropriate and that the patient's care was not neglected. The cause of her reported pain was not immediately known and she rated it quite low until a physician saw her on June 19th. In his opinion there was no urgency and the patient was to be seen on the next dental visit whenever that would be. Seen again on July 1st, he elevated her condition and arranged for her to go out since the dentist had not been there.

CONCLUSION

McFarland's dental services policy (#MD212) states that the primary care physician and nurses are responsible for ongoing assessment of dental hygiene, treatment needs and referrals. A contractual dentist will perform in-house screenings and consultations and out-patient treatment; in-house on a regular basis. Urgent dental care is referred for out-patient treatment.

Department rules state that referrals to a dentist shall be made as conditions warrant. (59 Ill. Admin. Code 112.30). The Mental Health Code calls for all patients to receive adequate and humane care. (405 ILCS 5/2-102a). It also prohibits neglect, defined as the failure to provide adequate medical or personal care resulting in the deterioration of one's condition. (405 ILCS 5/2-112; 5/1-117.1).

According to the record and the staffs' account, this patient was seen by a physician within a few days of reporting pain. Her condition was not urgent in his clinical judgement and he sufficed to leaving it for the next dental visit, although being more certain of when that would be might have benefitted her. Nearly two weeks later he examined her again, found her condition unimproved, her pain rated higher, and he referred her to the dentist's office instead. The dentist took control from there. While it seems that waiting two weeks with an increased pain rating was excessive, the question of whether McFarland's physician should have suspected an abscess earlier and saved the tooth is out of our hands. A physician was monitoring the care and a violation of the patient's right to adequate care is not substantiated.

SUGGESTION

Work out a more concrete schedule with the dentist.

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 Chair
401 So. Spring St.
521 Stratton Building
Springfield, IL 62706

RE: Case #15-050-9014

Dear Mr. Bakunas,

This letter is in response to your recommendations for case # 15-050-9014 dated October 28, 2015 which include:

- Stop instructing staff to document private phone and visitation conversations unless there is need to protect from harm, harassment or intimidation.
- Retrain all staff on private communication rights.

On September 9, 2015, the Treatment Services Administrator met with the Clinical Directors and addressed the nature of this complaint with the staff. Specifically, no staff are to listen to and/or document information exchanged during phone conversations. This will also be addressed during a facility wide joint Unit Clinical Management Team meeting. We also understand that placement of some of the patient telephones are close to the desk. Upon request, patients may use other more private areas, including their Treatment Coordinator's office and conference rooms for calls that are sensitive in nature. On October 13, 2015 procedural guide NUR100, "Guide to Recovery" was revised to intensify the language on privacy. This, along with a letter outlining changes to the Guide, was distributed to all staff for review. This Guide has also been posted on all the units for staff to refer to.

Further suggestions include:

- Be sure patients are informed immediately when a restriction of rights is terminated, especially before the designated date and time.
- Remind patients to speak more quietly when they are on the phone to ensure privacy is respected as much as possible.

- Use unit conference rooms for visits.

Procedural Guide HR126, Individual Rights and Restrictions of Such Rights, will be clarified to ensure the language specifies that patients are notified when a restriction of rights is terminated prior to the stated date and time on the MHDD-4. Reminding patients and staff of the importance of privacy can be highlighted during community meetings. As stated above, the use of conference rooms and offices, if appropriate, are encouraged for private communications whenever feasible.

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

Sincerely,

Greg Donathan, LCSW