An Exploratory Study Of The Right To Treatment Of The De-institutionalized, Civilly Committed, Conditionally Released Mentally Ill Patients From State Mental Health Facilities

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AN EXPLORATORY STUDY OF THE RIGHT TO TREATMENT
OF THE DE-INSTITUTIONALIZED, CIVILLY COMMITTED,
CONDITIONALLY RELEASED MENTALLY ILL PATIENTS
FROM STATE MENTAL HEALTH FACILITIES

A Thesis Submitted to the Department of Nursing
of Carroll College in Partial Fulfillment of the Requirements
for academic honors

by
Annie Marie Bartos
Helena, Montana
March 24, 1981
SIGNATURE PAGE

This thesis for honors recognition has been approved for the Department of Nursing.

Margaret Sammie
Director

Jo-Anne D. Scott
Reader

Rev. James E. Sullivan
Reader

March 24, 1981
DEDICATION

To Mom and Dad

We are shaped and fashioned
by what we
love...
ACKNOWLEDGEMENTS

In appreciation for their time given to educate, read, and to give me constructive counsel, I express my thanks to Jo-Anne Scott and Father Jeremiah Sullivan.

For the time, concern, direction, patience and encouragement, beyond the ordinary, I express my gratitude to Margaret Sammick.

For overseeing the academic development of me becoming a nurse, I wish to thank Dr. Therese Sullivan.
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CHAPTER I

OVERVIEW
OVERVIEW

In 1963, under President John F. Kennedy, federal legislation was passed toward developing new methods to treat the adult mentally ill in terms of decreasing the physical size of state hospitals, improving their resources, and extending services into the community. As a result, community after-care facilities were designed to continue the treatment of the de-institutionalized conditionally released patient.¹

In this program a patient may move easily from one kind of treatment to another as his/her needs change. This is called "continuity-of-care" and represents a key concept of the mental health program.²

In the late 1970's national attention was again directed toward the needs of the mentally ill within the community setting. In the 1978 publication of the Report of the President's Commission on Mental Health, the principle recommendation of the commission called for the establishment of a "new federal grant program for community mental health services to encourage the creation of necessary services where they are inadequate and increase the flexibility of communities in planning a comprehensive network of services."³
The report recommends that in the future mental health funding priorities be given to unserved and underserved areas; services for children, adolescents and the elderly; and specialized services for racial and ethnic minority groups and for the chronically mentally ill population. The report calls for further phasing down efforts of state hospitals.

The Montana Department of Institutions began a program of de-institutionalization of mentally ill civilly committed patients from Warm Springs State Hospital. Civil commitment of a mentally ill patient is a voluntary or involuntary placement of the patient into a restrictive environment so as not to be a danger to themselves or to others. This placement may be by court order. This program of de-institutionalization included transferring and relocating patients to nursing homes, group homes, and private residences. These patients were under the direct control and custody of the Department of Institutions pursuant to Court order.

Since 1975, over 608 patients have been de-institutionalized and are cared for in numerous facilities located throughout the state. These patients are involuntary civilly committed persons, and they are restrained in their free movement, and have been deprived of many constitutional guarantees because of their status as civilly committed mentally ill patients.

At the same time, Montana's Legislature enacted the
Mental Health Act of 1975. The Montana Legislature completely revised the procedures employed to identify and provide treatment for persons suffering from mental illness. The Act sets out the rights of the mentally ill and the quality of treatment they must receive. It contains strict requirements for the treatment of patients within mental health facilities. The same statutory and case law requirements of the right to treatment applies to these mentally ill patients who have been relocated, but who are under the control and custody of the Department of Institutions. The law must follow the patient until such time as the patient is discharged from the case and custody of the Department of Institutions and is restored to full personal rights.

A number of guiding principles underlie the structure of the Montana Mental Health Act. One of these principles is that mentally ill persons are human beings and must be treated with the dignity and respect which all human beings should enjoy. The Act requires that all mentally ill persons receive the treatment they need in the "least restrictive environment." Since return to normal life within the community is the goal of treatment for the mentally ill, treatment should be provided within the community whenever possible. Specifically, the Act and recent Court decisions mandate that a competent, well planned and well executed
treatment care plan be provided for all mentally ill patients, and that every person committed actually receives treatment.

The nurse, along with other members of a multidisciplinary team, initiates the development and implementation of the mentally ill patient's treatment care plan. This study was done because of the nurse's vital role in the planning and care of these patients. This study focused on the following objectives:

1) to determine whether the mentally ill patients conditionally released to after-care facilities are receiving their "right to treatment"

2) to provide the nurse with a rather detailed understanding of the principles and origins of the mentally ill patient's "right to treatment".
CHAPTER II

THE PROBLEM
A. STATEMENT OF PROBLEM

The Department of Institutions of the State of Montana has proceeded to deinstitutionalize and relocate mentally ill patients involuntarily committed to Warm Springs State Hospital. These patients are at the same time under the direct control and custody of the Department of Institutions pursuant to Court order and therefore deprived of full constitutional guarantees. In order to insure that these patients are restored to full constitutional rights, they must be provided with statutory and case law designed treatment care plans.

The actual implementation of these plans should be in their relocated residences throughout the state. The deinstitutionalized patient is not provided with the proper care or treatment that they would have received if they were patients at Warm Springs State Hospital.

B. STATEMENT OF SPECIFIC PROBLEM

Are the conditionally released mentally ill civilly committed patients who were relocated and physically transferred to local facilities, receiving
care and treatment so as to satisfy Montana State law and Federal and State Case law?

C. PURPOSE OF THE STUDY

Montana law provides that every patient shall have an individual treatment care plan. This extensive and detailed treatment plan shall be developed by appropriate professional persons including nurses and a psychiatrist, and shall be implemented no later than 10 days after the patient's admission to the facility. The purpose of this study is to determine whether these Montana conditionally released, mentally ill deinstitutionalized and relocated patients are receiving the required and mandated treatment to meet case law and statutory minimums in terms of design, implementation and evaluation of the treatment care plans for the patient.

D. LIMITATION ON THE SCOPE OF THIS THESIS

This writer will not address the following issues nor is it her intent to develop these issues. The issues are as follows:

A. Patient care at Warm Springs State Hospital or other state funded mental health facilities.
B. The right of mentally ill patients to refuse treatment.
C. Care for patients who are "discharged" as defined herein and are no longer under the control of the Department of Institutions or Court order.

D. Standards for commitment of these patients or petitions for commitment, (only to such extend as will effect the issue of deprivation of constitutional rights and incarceration by means of court order). Although this paper is limited to the analysis of treatment for conditionally released mentally ill patients, this paper will address one specific means of enforcement and protection in terms of the Montana State Board of Visitors and their statutory obligations to examine, evaluate and recommend changes in the implementation of the Montana Mental Health Law.

E. LIMITATIONS ON THE COLLECTION OF DATA

The Montana State Constitution protects all persons that live within the state. The Right of Privacy, to be free from examination of their personal life, protects committed patients as well. The right of confidentiality, as assured by this writer, presents limitations on the data collection. In many instances this writer had no access to the medical records to examine and evaluate treatment care plans. Frequently this writer had to rely on interviews from the administration of facilities, including hospital administrators, nursing home
administrators, directors of nurses and nursing staff in developing this thesis, without being permitted to verify the statements made by the administration.

The Department of Institutions and particular state mental health facilities refused to disclose information necessary to make a complete analysis of the issue presented. Due to the requirements of the Freedom of Information Act, it would have been necessary to exhaust administrative and court remedies to obtain many of these documents. However, in light of the limitations outlined above, an abundant amount of information, both actual and verifiable supports and clearly documents the findings of this study. This writer will not identify patients or patient records that have been disclosed to her, only by means of number and alphabet designation.

F. DEFINITION OF TERMS

The following terms are used consistently throughout this paper:


Statutory law: legislative enactments or statutes
that have been approved by a legislative body, either the Montana Legislature or the United States Congress and have become law.\textsuperscript{11}

\textit{Case law}: Federal District Court, Federal Circuit Court of Appeals, Montana Supreme Court opinions regarding the interpretation, creation, implementation and enforcement of statutory and case law and the rights guaranteed by the Montana and United States constitution.\textsuperscript{12}

\textit{Deinstitutionalization}: transferring and relocating civilly committed mentally ill patients from the Warm Springs State Hospital to other local care facilities including nursing homes and hospitals.\textsuperscript{13}

\textit{Conditionally released}: a civilly committed mentally ill patient who has been involuntarily committed to a Montana mental health facility and who has been released from that institution conditionally, that is released from the physical facility and relocated, but under the direct control custody and order of the state Department of Institutions, and a District Court.\textsuperscript{14}

\textit{Least restrictive alternative}: term describing the legislative purpose to allow a patient to be located in a facility that least restricts their freedom of movement and their personal constitutional right. The placement of the patient in a therapy setting that allows more freedom for a person.\textsuperscript{15}
Discharge: a complete release of the claims or control over a mentally ill patient who had been involuntarily committed by a court order. Discharge restores a patient to full constitutional rights. The major distinction between release and discharge is that a discharged person would be required to go through the involuntary commitment process in order to be committed whereas, a released person could be returned to Warm Springs State Hospital only upon the direction of the Director of Warm Springs, a professional person or a district court order.16

Mentally ill patient: a person committed by a court for treatment for any period of time. This patient has posed as a danger to himself or society.17

Professional person: a medical doctor, or a person educated in the field of mental health and certified by the department in accordance with the standards of professional licensing boards, federal regulations, and the joint commission on accreditation of hospitals.18
CHAPTER III

REVIEW OF LITERATURE
REVIEW OF LITERATURE

The review of literature reveals limited research specific to the right to treatment of the mentally ill.

The treatment and lack of treatment of the mentally ill has gained considerable attention from the media. Movies, network documentaries and magazine articles have focused on the plight of the mentally ill.19

The development of the women's rights movement, patient's rights and the Community Mental Health Act in the 1960's were important social forces that influenced mental health programs.20

This writer learned the basic structure of the mental health system while taking a Psychiatric Nursing course. This writer learned that basic patient rights should be assured to all individuals in the mental health system.

"Nowhere in nursing practice do nurses confront their feelings, values, integrity and knowledge more directly than its facing legal and ethical dilemmas."21

In order to understand the basis of these legal protections the writer conducted a limited review of the nursing literature and a more extensive review of the law related literature.
Lancaster formulated five theoretical principles as guiding percepts for use by nurses in the planning of after-care interventions. These principles include: 1) Community and institutional acceptance—a program designed to provide community or facility treatment for discharged psychiatric patients which takes into account the prevailing attitudes of community and facility residents. (2) Client advocacy—the nurse assisting the patient to negotiate with the system whether it be an after-care facility or community setting. (3) Individual supervision—the nurse visits each person in the caseload where an assessment is made of physical and psychological needs. (4) Patient education—teaching the patient basic skills of vocation, social, interpersonal and daily living. (5) Group supervision—conducting group sessions in the community provides for a valuable component of continuity-of-care. 22

"The nurse must protect the rights of the individual patient...Nursing has for a long time hidden behind the cloak of political neutrality...detached from legal issues." 23

From this initial awareness, that the law plays a critical role in defining the right to treatment for the mentally ill patient, and the professional nurse's duty to administer proper treatment, this writer began her research into the legal aspect of the right to
treatment. Numerous psychiatric nursing texts referred to legislative decisions about the right to treatment of the mentally ill patient. These narratives gave specific citations and references to this law related material. Several cases were relied on heavily as the authoritative statements of the professional persons duties in administering treatment for the mentally ill patient. One case in particular, Wyatt v. Stickney, in this writer's opinion, was the basis for Montana's Mental Health Act. This writer noted that the legal opinion was explicit in explaining the mentally ill patient's rights. In addition, the professional person's responsibilities were identified with specific instructions pertaining to treatment.

It is from this hybrid of nursing and the law that makes the Wyatt opinion and the other case law and statutory law to follow important.

A. SURVEY OF FEDERAL JUDICIAL CASES

1. Wyatt v. Stickney, The Basis for the Claim of a Right of Civilly Committed Mental Patients to Receive Treatment

The District Court for the Middle District of Alabama, and later the 5th Circuit Court of Appeals took the most extensive action in defining and enforcing the constitutional right of civilly committed mentally ill patients
to receive adequate treatment. Authorities and mental health observers have also given credit to the Wyatt decision for major and extensive reformations of countless mental health facilities in this country. 24

Wyatt v. Stickney demonstrated the extent and the determination of the federal courts to enforce and provide minimum standards for treatment of the mentally ill patient. Wyatt commenced as a class action brought on behalf of patients in Alabama's three state institutions for the mentally impaired. Ruling on a motion for preliminary injunctive relief, the District court originally held that the due process clause of the 14th Amendment requires that an involuntary committed patient receive such treatment as will give him a "realistic opportunity" to improve or be cured, and that Alabama's institutions failed to conform to "any known minimums" for the treatment of the mentally impaired. 25

The court reserved an action on the injunction, and allowed the Mental Health Board, the authoritative agency of Alabama's mental health facilities, to file a report within six months, setting forth minimum standards of adequate care, and at that time to explain to the court any progress made to achieve those goals.

Once the court received this report, it found the facilities to be wholly inadequate, and also found that
the institution continued to infringe upon the plaintiff (mentally ill patient involuntarily committed) rights by failing to provide a proper physical and psychological environment, sufficient number of qualified staff, or any individualized treatment plans.26

After hearing extensive arguments and explanations from national organizations regarding minimum standards of treatment for mentally ill patients, the court itself ordered minimum "medical and constitutional" requirements. Summarizing, the court ordered that certain standards guarantee basic patient rights to privacy, presumption of competency, communication with outsiders, compensation for labor, freedom from unnecessary medication or restraint, and freedom from treatment or experimentation without informed consent. In an unusual specific decree, the court established requirements governing staff-to-patient ratios, educational opportunities, floor space, sanitary facilities and nutrition. Perhaps the most significant action by the court was the order that individual treatment plans be developed, that written medication and restraint orders be filed, and that these be periodically reviewed.27

Constitutional Right

The Wyatt court reasoned that civilly committed patients
have a constitutional right to treatment because confining a person on the "altruistic theory" that he must receive treatment and then failing to provide it violates due process.

To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane and therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process. 28

2. Wyatt v. Stickney, the Appeal to the Federal Circuit Court.

The Federal Circuit Court upheld the lower court's extensive order, and created a legal entanglement; namely, the separation of powers. The Wyatt decision pushed to the limits the extent to which the judiciary can go, in setting standards of institutional practice which will require the legislative and the executive branch to raise the tax revenue to meet the Court order. Circuit Court Judge Wisdom, author of the opinion, held that "the Constitution guarantees persons civilly committed to state mental institutions a right to treatment, that the suit was not barred by the Eleventh Amendment, that the right to treatment could be implemented through judicially manageable standards, that the granting of relief did not invade a province of decision-making exclusively reserved for the state legislature and that adequate legal remedies were not available." 29
Wisdom dramatically illustrated the conditions that existed in the Alabama Mental Institutions.

The Court also noted the findings of the lower court as to the treatment available for the mental patients:

According to one consultant's testimony... care of patients was not suited to the needs of particular individuals, but instead was geared primarily to housekeeping functions-clean floors, cleaning beds, cleaning patients. Experts testified that the patients records kept at the hospital were wholly inadequate; that they were written in such a way as to be incomprehensible to the aide level staff that had prime responsibility for patient care; and that they were kept where they were not accessible to the direct care staff particularly in need of them.30

Appellants contended that the Constitution does not guarantee persons civilly committed to state mental institutions a right to treatment. The Court held:

This contention is largely foreclosed by our decision issued since the institution of this appeal, in Donaldson v. O'Connor, 493 F. 2d 5C7. In Donaldson, we held that civilly committed mental patients have a constitutional right to such individual treatment as will help each of them to be cured or to improve his or her mental condition. We reasoned that the only permissible justifications for civil commitments, and for the mass abridgements of constitutionally protected liberties it entails, were the danger posed by the individual committed to himself or to others, or the individual's need for treatment and care. We held that where the justification for commitment was treatment, it offended the fundamentals of due process if treatment were not in fact provided; and we held that where the justifications was the danger to self or to others, then
treatment had to be provided as the quid pro quo society had to pay as the price of the extra safety it derived from the denial of individual's liberty.\textsuperscript{31}

B. OTHER RELATED CASE OPINIONS

The right to treatment argument is not new. In early cases the Court held that persons who were not convicted of crimes, but who were committed for care and treatment under nominally non-penal statues, had the right to be confined in a setting more therapeutic than a jail.\textsuperscript{32}

Recently, in Rouse v. Cameron, the Circuit Court of Appeals, relied in part on statutory interpretation, and declared that "one mandatorily committed following an acquittal by reason of insanity is entitled to adequate treatment; that lack of institutional resources would not excuse denial of such treatment."\textsuperscript{33}

The United States Supreme Court has not spoken definitively on the question of right to treatment. However, the Supreme Court has adopted the rulings and rational of many of the Circuit Court opinions above mentioned.

In Jackson v. Indiana, a unanimous U.S. Supreme Court declared that, "when an individual is confined under commitment procedures involving abridged procedural and substantive protection, due process requires that the nature and duration of confinement bear some reasonable
relation to its purpose." The Court explicitly stated that "the state must either justify continued confinement by therapeutic progress or immediately release the patient." 34

Briefly, the elements underlying the Wyatt decision on a constitutional basis for the right of treatment include these elements:

1) Where an individual's liberty is as drastically curtailed as it is in civil commitment

2) without the procedural safeguards of the criminal process,

3) and the lack of such safeguards is justified by the benevolent purpose of the state, then safeguards are diminished, and needed treatment is afforded to the individual,

4) due process requires that he receive such treatment as will give him a reasonable chance to improve or be cured.

Also, the deprivation of the patient's rights and liberties may be compounded by the fact that his or her release is contingent upon his meeting a vague and potentially arbitrary standard of mental health which is more exacting than the standard required to avoid original commitment.

Whichever statutory purpose is invoked to justify confinement, due process is transgressed if adequate treatment is not provided. If the quasi-penal purpose of
protecting society is the basis for commitment, due process is infringed not only because of the lack of procedural safeguards, but also because only a small minority of patients are dangerous enough to require inpatient care for that reason. In addition, commitment for the purpose of protecting society, without adjudication of the potential dangerousness of individual patients may be a constitutional repugnant form of preventive detention.

...If the need for treatment is invoked to justify commitment, then due process is violated not only when treatment is ultimately denied, but also when the state initially fails to require evaluation of relevant factors such as the amendability of the patient to treatment, the capacity of the existing institutions to deal with his infirmity, and the term of hospitalization for which specific malady may be therapeutic. Moreover, confinement without treatment is a continuing violation of due process since failure to provide treatment denies the patient the very means of "getting well" and thereby securing release.

C. RELATED STUDIES, TREATISES AND REVIEWS ON MENTAL HEALTH TREATMENT


Possible Violation of the Eighth Amendment

The United States Constitution prohibits cruel and unusual punishment. Confinement without treatment constitutes unconstitutional punishment without even a criminal charge being filed. Courts have held that even the most humane incarceration may constitute punishment. Confinement without treatment may be regarded as punishment for a mere status-mental illness over which
the patient has virtually no control. A punishment of this type was declared unconstitutional by the Supreme Court in Robinson v. California. 36


A non-therapeutic confinement, of the non-dangerous mentally ill, may be regarded as cruel and unusual under the standards of "pointless and needless", "degrading to the dignity of human beings", or "unrelated to any valid legislative purpose" set forth recently by the Justices of the Supreme Court in capital punishment.

Long term confinement is particularly suspect because in many hospitals, active therapy for the patient ceases after about two years. One major study in Montana found that no hospital surveyed, did the number of patients undergoing active treatment exceed 15%. 37

If a patient remains for any length of time in a mental health facility, it is said the patient "burns out" from their original maladies. 38

Civil commitments involve fundamental liberties of people. The Courts have required not only that the legislation have a rational basis for its regulatory action, but also that it choose the "least restrictive means" of accomplishing its goals. 39 Following that general rule of law, states like Montana provide care in the least restrictive setting possible, and a level of treatment
which offers a genuine chance of recovery and return to the community. This is done by the use of conditional releases, to group homes, nursing homes, etc. The alternative may impose additional problems in a situation where an individual has not regained his personal rights, is transferred to a facility that does not provide the required treatment care plans.

D. MONTANA'S ENACTMENT OF THE MENTAL HEALTH AND COMMITMENT ACT

1. Title 53 of Montana Code Annotated

In response to the growing demands for recognition and preservation of the mental health patients constitutional and human rights, the Montana 44th Legislature, in 1975, passed two laws in which Mentally Ill and Mentally Handicapped citizens are to be cared for and confined for treatment. Prior to the enactment of SB 377, the Warm Springs Hospital was responsible primarily for care and custody of patients committed to the hospital voluntarily or involuntarily. The new legislation directed that mental health facilities would be required to treat actively and intensely the seriously mentally ill.

The purpose...is to secure for each person who may be seriously mentally ill or suffering from a mental disorder such care and treatment as will be suited to the needs of the person and to insure that such care and treatment are skillfully and humanely administered with full respect
for the person's dignity and personal integrity...and to assure that due process of law is accorded any person coming under the provisions of this act.  

The Montana legislature reacted to the initiative of the Judiciary in this area of complex and serious attention to human rights. Noting the date of passage, 1975, it is obvious that the legislature read the Wyatt decision, and the numerous court decree that followed the general Wyatt order.  

The legislation placed into the General Statement the rules announced in those prior decisions, and thereby made it a policy of this state to follow that rule. Treatment and the requirement that all patients have a right to adequate treatment stemmed from the argument that where the justification for commitment was treatment, it offended the fundamentals of due process if treatment was not in fact provided for or mandated by statute. The legislature took into account the language of Wyatt where treatment had to be provided as the quid pro quo for the safety the state derived from the denial of an individual's liberty.  

The new laws covering confinement and treatment of persons with mental disorders, specifically that "an alleged mentally ill person must be represented by an attorney during the commitment process; it provides for more extensive evaluation of persons alleged to be mentally ill; it broadens the professions which can
conduct evaluations of the mentally ill and it places greater emphasis on the provisions of evaluation and treatment. 43

The most significant developments in Montana law with regard to commitment is the detailed legislation relating to the minimum standards for treatment and disorders, thereby attempting to satisfy due process requirements, that the patient receive such treatment as will give him a reasonable chance to improve or be cured. The underlying objective of the legislation enacted in 1975 was to provide assurances that treatment will be administered and that the patient receives the tools necessary to "get well" and thereby secure release. 44

Throughout Title 53, Montana Code Annotated, patients admitted to a mental health facility, whether voluntarily or involuntarily have certain basic rights. Pervading of all of these rights specified by the laws is the fundamental "Right to Treatment." As all professional mental health administrators know, the right to treatment includes a whole spectrum of factors such as environment, atmosphere, living standards, responsibilities, etc. Also included in this single concept are the individual patient's right to privacy and dignity, the right to the "least restrictive" conditions necessary to achieve the purpose of commitment, the right to visitation, the right to personal possessions and clothing, the right to regular physical exercise
several times a week, the right to receive prompt and adequate medical treatment for any physical ailments, and the right to a humane psychological and physical environment.\textsuperscript{45}

2. Statutory Obligations and Responsibilities

A patient who is committed to a Montana mental health facility---"a public hospital or a licensed private hospital which is equipped and staffed to provide treatment for persons with mental disorders or a community health center or any mental health clinic or treatment center approved by the Department of Institutions" will be treated within a statutory period of time."

The statute provides that each patient who is committed for a period of more than seventy-two hours must receive a comprehensive physical and mental examination and a review of behavioral status within forty-eight hours after admission. Within five days after the patient's admission an individualized treatment plan must be developed and implemented for the patient by a team of professional persons.\textsuperscript{47}

3. The "Least Restrictive Alternative" Statute

Scholars have declared that the "least restrictive" doctrine is applicable and is substantiated within the Constitution.
"A deprivation of liberty because of the dangerousness of a patient to himself...should not go beyond what is necessary for his protection. The courts have authority to explore alternative facilities in order to guarantee that the least restrictive alternative is available and implemented."\(^{48}\)

To that end the Montana legislation has provided that courts may order a conditional release or release to alternative placements or types of administered treatment.

Court ordered release to alternative placement or treatment.

At any time during the patient's commitment the court may, on its own initiative or upon application of the professional person in charge of the patient, his next of kin, his attorney, or the responsible person appointed by the court, order the patient to be placed in the care and custody of relatives or guardians or to be provided outpatient therapy or other appropriate placement or treatment.\(^{49}\)

Montana Law also provides that when in the opinion of the professional person in charge of a mental health facility providing involuntary commitment treatment, the professional person may impose as a condition for early release the requirement of out-patient treatment, prior to the expiration of the period of commitment, and when that time is added to inpatient time, it cannot exceed the total time of commitment.\(^{50}\)
In reality, a mentally ill patient may be transferred to a nursing home, if within the professional judgement of the staff such transfer is desirable and beneficial to meet the least restrictive alternative policy. If the person is transferred to another facility, the court and the county attorney must be notified five days prior to release.

E. THE MEANING OF INDIVIDUAL TREATMENT CARE

1. The Treatment Care Plan

Montana statute has an individualized treatment care plan defined as a statement (a printed form, see Exhibit A). Several after-care facilities have entitled the treatment care plans by use of different words such as: Overall Residential Care Plan, Individual Habilitation Plan and Nursing Care Plan. The treatment care plan must include a statement of problems and needs of the patient; a statement of the least restrictive alternative condition; criteria for release which shall be required to be met by the patient.51

In addition to a statement of problem and needs of the patient, a description of short and long-range treatment goals for the patient with a timetable for achievement of these goals is provided (see Exhibit A); a description and explanation for the treatment methods which will be employed to achieve these goals, a description of the way in which various members of the staff
will be utilized to accomplish the desired treatment goals; the criteria which must be met in order for the patient to be released to a less restrictive setting and the criteria for discharge.

Right to treatment also includes the right that the mentally ill patient live in a physical facility that is clean, decent and safe. The hospital physical plant must contribute to rather than impede, the process of treatment. 52

Individualized treatment, as required by the new Mental Commitment Treatment Act involves the following considerations:

a) Development of a treatment plan in which the individual patient can participate effectively,

b) deciding on specific, concrete, achievable goals which can be met by the patient, the patient's family, the treatment team, and the community,

c) utilize a broad spectrum of professional services which cannot be rendered by one specific person,

d) an approach with a philosophy of mental illness that views mental illness as a multi-caused phenomenon tied to the patient's total life style, physical condition, psychological status, social capabilities and living-working environment.
2. Care and Custody

Adequate care must be given to each patient's need for relief. Medical care will be administered at all times. Diagnosis and individualized treatment must be developed in regard to each patient.

Custody includes protection of the rights of individual patients, to secure an environment for patients who are potentially dangerous to themselves or others, to provide a broad spectrum of medical and other psychiatric service, and respect for the everyday life of the patient.

3. Developmental Services

An individual treatment plan must be implemented in regard to each patient. The treatment plan must describe appropriate psychiatric intervention and approaches designed to return the patient to optimum functioning. Goals for the patient must be stated in each treatment plan, and these goals must focus on outcomes such as ameliorating thought disorders, emotional illness, social functioning deficits, language impairments, and vocational handicaps.

4. Community Related Services

The mental hospital has a responsibility to function effectively as part of the continuum of the statewide
system of mental care. As noted earlier, the hospital in these instances coordinates with other facilities to provide lesser restrictive environments.\textsuperscript{53}
CHAPTER IV
METHODOLOGY
METHODOLOGY

The descriptive survey approach was utilized to determine whether conditionally released deinstitutionalized patients from Warm Springs State Hospital were receiving the "Right to Treatment." This was obtained by evaluating whether the treatment care plan was 1) competent, 2) well-planned and 3) well executed as mandated by the principles of the Montana Mental Health Act and recent judicial decisions. Critical evaluations of treatment care plans and interview of mental health professionals were methods used to acquire data.

Five after-care treatment facilities and 27 treatment care plans were examined. Identical interview questions were asked to each of the administrators from the five after-care facilities.

The following consists of the questions posed:

1. Does your facility have any deinstitutionalized patients from state mental health facilities? How many? Are they conditionally released or discharged? Are they voluntarily or involuntarily civilly committed?

2. What is the process of transfer that the state mental health facilities currently engage in as the patients are transferred to your facility?
3. Is the mental health facility providing your facility with any type of discharge planning or suggested mode of nursing care or after-care plans? Is the mental health facility providing or suggesting subsequent training of personnel to facilitate continuity of care for the mentally ill patient?

4. Does the state mental health facility transfer the patient's medical record or psychiatric summary? Within what time frame? What information is included in the report sent with the patient?

5. Does the mental health facility or the Department of Institutions utilize any follow-up procedures to evaluate the care of the patient?

6. Do you like the process of transfer the mental health facilities are currently using in transferring patients to your facility?

7. Do the de-institutionalized patients have individual treatment care plans? May I examine them to determine whether they meet the statutory requirements of a treatment care plan?

   (Later, after examination of the treatment care plans)

8. Are you aware of the Mental Health Act?

   The treatment care plans were evaluated for specific requirements outlined in Montana law. The requirements are as follows:
1. The existence of an individualized treatment care plan.

2. Analysis of the treatment care plan to determine whether it meets statutory requirements including a statement of the problem.

3. Determine whether the treatment care plan refers to the application of "least restrictive alternative goals".

4. A description of short range and long range goals in treatment of the patient.

5. A description of, explanation and implementation of the treatment methods used or employed to achieve the short range and long range goals.

6. Appointment of professional persons and staff to accomplish the desired treatment goals.

7. A listing of criteria which the patient must meet in order to be released to a "lesser restrictive alternative" facility and the criteria for total discharge.

8. The treatment care plan's inclusion of an after-care plan.

9. Has the Montana Board of Visitors and/or other accredited governmental agencies examined the treatment of these conditionally released mentally ill patients.

The detailed information from treatment care plans and interviews with the administrators of the facilities
were systematically logged, and by request coded by letters (A, B, C, D, etc.) to avoid possible identification of the institution of the administrator. After numerous phone calls and correspondence with the administrators of potential after-care facilities to be used in the study, a personal interview and specific dates were established for the collection of the data.

Data requested and selected for this study included: treatment care plans of clients de-institutionalized and conditionally released from Warm Springs to after-care facilities.
CHAPTER V

DATA PRESENTATION AND DATA ANALYSIS
DATA PRESENTATION AND DATA ANALYSIS

1. Data Presentation

State mental health facilities release patients to twenty-three after-care facilities throughout the state. Due to limited time and resources, this writer sought information from five after care facilities.

Data was received from five independent and separate facilities within a 250 mile radius of the city of Helena, Montana. Each facility participated in this study with the understanding that identification of the particular facility would be confidential and would be noted only by means of letter and number. Therefore, facilities herein are referred to by corresponding code designations.

The general format of this data presentation is as follows. A brief description and summary of observations made of each facility precedes more specific data information. This initial information consists of facility occupancy, location, personal eye-witness observations as to patient care and morale.

1) The existence of an individualized treatment care plan,

2) Analysis of the treatment care plan to determine whether it meets statutory requirements including a
statement of the problem, needs of the patient and preliminary diagnosis,

3) Determine whether the treatment care plan or patient record refers to the application of "least restrictive alternative" goals,

4) A description of short range and long range goals in treatment of the patient,

5) A description of, explanation and implementation of the treatment methods used or employed to achieve the short range and long range goals,

6) Appointment of professional persons and staff to accomplish the desired treatment goals,

7) A listing of criteria which the patient must meet in order to be released to a lesser restrictive alternative facility and the criteria for total discharge,

8) The treatment care plan's inclusion of an after care plan. Was the treatment care plan continuously reviewed by the professional persons in charge of the case, and is there need of revision and if review is made, has qualified personnel made the necessary changes,

9) Has the Montana Board of Visitors and/or other accredited governmental agencies examined the treatment of these conditionally released mentally ill patients.

Each facility report will be concluded by a summary in order to clarify or connect faculty data. The plan's adequacy or inadequacy will be discussed by applying the
standards directed by the Montana Mental Health Statute. Data collection was made by observation of patients, examination of patients' records and files, supporting information, direct interviews with the facility's administrator and/or staff.
FACILITY A-1

This facility setting constitutes a forty bed modern nursing home located in a small rural community located within a 100 mile radius of Helena, Montana. The community population averages 1500. At the time of this analysis, the community was suffering economic problems and the third major employer was the facility. At the time the facility housed thirty intermediate and skilled nursing care patients. The writer observed patients lingering in the hallways, interacting minimally with the staff and other patients. All patients appeared physically cared for. The writer spent two days for a period of nine hours in observation. According to administration of the facility, three mentally ill patients, conditionally released from the state mental hospital were living there. They were released within the last ten years.

1. A treatment care plan was available for examination.

2. The treatment care plan included a statement of the problem and the immediate needs of the patients including prescribed medications. A preliminary diagnosis upon the admission of these patients were completed by the staff; however, each diagnosis was different as to the
amount of information provided. The diagnosis was identified within the treatment care plan. One patient was diagnosed catatonic schizophrenic, the other paranoid schizophrenic and the third patient diagnosed as manic depressive. Since the patients admission to this facility, no mental health professional has reevaluated the progress or changes in the patients' psychiatric condition. The times of admission are respectively, 2/4/74, 8/20/77 and 11/16/77. Although an area on the preprinted treatment care plan was available for patient needs and problems, individual mental and emotional problems failed to be identified.

3. Only one treatment care plan made any reference to conditions of limitation imposed on patients as least restrictive alternative. "Patient not allowed community leave." Restrictions were employed because the patient exhibited suicidal tendencies in the past. This restriction served as a safeguard against such patient behavior in the future.

4. No long or short range goals were identified for any of these patients.

5. Description or explanation of treatment methods for any possible implementation was absent from the treatment care plan.

6. No reference made to professional persons assigned to mentally ill patients nor were responsibilities provided for specifics of treatment care.
7. Criteria for patient release or discharge was non existent.

8. No after care plan or discharge plan existed.

9. Two of the three care plans were inconsistent and reexamination of the patients' needs and treatment application was not conducted by a professional person. One treatment care plan showed no renewal since September, 1978.

10. No Montana Board of Visitors examination report and no other examination was completed on the patients' records.

Summary:

Interviews and observations reflects staff neglect on these records and no knowledge by the administration and staff of the existence of the Montana Mental Statute or its application to these patients. The administrator contended that his personnel were all well trained and competent in providing skilled patient care, but did admit that direct treatment of the three patients' mental disorders had been lacking. "One of our staff nurses has some psychiatric experience and she provides the others with training on mentally ill patients." The nurse, however, is not assigned to examine the progress of the mentally ill patients nor to act as a psychiatrist in terms of the statutory language. Local physicians maintain treatment for each patients' physical needs but no record as to treating their mental needs.
FACILITY B-1

Facility setting constitutes a 104 bed nursing home, staffed for moderate and skilled care patients. The home is located in a community with a population of 30,000. The patients were observed physically cared for and interacting with staff members near the nursing station. Many patients were seated in a recreation room, others were wandering toward the dining hall for their noon meal. Residents include six patients who were conditionally released mentally ill patients. The facility administrator explained that the limit on the number of mentally ill patients is intentional because these patients require closer care and supervision.

1. Individualized treatment care plans existed for the six patients on pre-printed forms titled "Overall Residential Care Plans". General data included patient's name, birthdate and attending doctor.

2. Individual diagnosis were identified and each referred to a mental illness. Two patients were diagnosed with senile dementia, two with paranoid schizophrenia, and the other two with manic depression.

3. Problems were termed as "patients needs" and were identified and continuously updated to within the last week before the writer's examination. However, the needs
identified lacked any relation to the patient's diagnosis of mental illness.

4. The long and short range goals corresponded to the problems of the patient and contained a date for completion. Once again, the goals were related to problems not associated with the treatment of the mental illness.

5. Explanation and description of treatment methods, termed "approach" were charted.

6. The plan provided a key for responsible staff members: N-nursing, D-dietary, S.W.-social work. Associated with each identified problem was the key letter N. No other specific notation for nursing care or patient's treatment was recorded.

7. Criteria for "lesser restrictive alternative" was absent from the plan.

8. A psychiatrist has never examined any of the mentally ill patients since their admission.

9. No Montana Board of Visitors examination report of the treatment of the mentally ill patient was found or known to the administrator. The administrator questioned the group's origin and function as she admitted that she was unfamiliar with the legal justifications of such a group in an after-care facility.

Summary:

The administrator expressed her concern, because of the reluctant attitude of the Department of Institutions and
Warm Springs to assist the after-care facilities with planning and implementing psychiatric treatment for the released patients. The nursing home does not receive any psychiatric medical records or summaries dealing with the patients' mental disorder unless ordered by the home's administrator.
FACILITY C-1

This thirty bed facility is a state-funded and operated after-care facility serving a caseload of primarily geriatric-psychiatric patients. This facility resides outside of a small rural town located within a 250 mile radius of Helena, Montana. The community population averages 3500.

The only observable patients sat in the facility's recreation room, staring blankly at a television, while one elderly woman played the piano—consistently striking the same piano key. No interaction between patients was observable.

Twelve patients satisfied the criteria for the study.

1. Treatment care plans proved to be available for each of the twelve patients.

2. Only four of the twelve patients' plans made any reference to the mental illness. The other eight patients had no diagnosis evident in the plans. One diagnosis, schizoid, was identified with no additional information to classify it. Yet another diagnosis, termed hallucinations, made no reference to the origin of such behavior, type of manifestation. Two patients suffered
from senile dementia and chronic brain syndrome. Problems related to diagnosis were not included.

3. Any statement of the least restrictive condition was not available.

4. A description of short and long range goals was nonexistent.

5. No mention of treatment methods employed.

6. There were no specific treatment responsibilities for specific staff members.

7. No reference or planning toward release of the patient to a lesser restrictive setting was complete.

8. Psychiatric evaluations of these patients was never completed. No evidence of review of treatment plans or medications administered.

9. No Montana Board of Visitors examination report present.

Summary:
The director, who was hesitant to discuss the matter, stated that the treatment care plans have not been reviewed or updated because the director of nurses had recently been hired. In a discussion with the administrator's fiscal assistant, he indicated that the mentally ill patient was well cared for physically, as would any other geriatric patient. However, funding is limited and the staff is inadequately trained, prepared and equipped to follow the dictates of Montana's Mental Health Statute.
A psychiatrist has never, during this individual's three year employment period, evaluated or given a complete mental examination plan of therapy to any of the mentally ill patients. The patient's primary treatment, he explained, is psychotropic therapy as a means to keep the patient sedated, happy and easy to care for.
FACILITY D-1

This setting is an after care facility designed for deinstitutionalized patients from Boulder River School and also for patients from Warm Springs. The after-care facility is located in a community with an average population of 30,000. It is a 32 bed facility, presently filled to occupancy, with a waiting list of 20-30 patients.

The home's philosophy is to provide the disabled client with the social and personal skills needed to function semi-independently or independently as a member of society. At the time of this writer's survey, nine patients were diagnosed as mentally ill; however, six of those patients were conditionally released from Warm Springs. The facility's recreational therapist was interviewed.

He explained that four patients within the last two years had been re-admitted to Warm Springs without a repeat of the civil commitment proceedings, upon recommendation from the staff.

1. An individual treatment care plan existed for each of the six patients. The plans were organized and immediately available upon request by the writer.
2. The diagnosis of mentally ill was recorded for each patient. The majority of the patients were elderly suffering from depression, neurosis and schizophrenia. Individual problems were identified and categorized.

3. A statement of the least restrictive alternative conditions imposed on patients was lacking.

4. Behavioral goals and specifications for individual patient's attainment was outlined, although no goals were existent for problems related to mental illness.

5. A description of psychotrophic treatment was presented for each patient. No other therapy is instigated at the facility for the mentally ill patient.

6. A multi-disciplinary team is established for each patient. The client's physician, psychiatrist, social worker, nurse consultant, recreational therapist, speech therapist, guardian as well as the patient, participate in forming the Individual Habilitation Plan, and review the plan every 90 days.

7. Immediately after the patient is admitted to the facility (within five days) an Individual Habilitation Plan is developed and behavioral goals are formed in order for the patient's release into the community.

8. The Individual Habilitation Plan was signed by the participating members and updated approximately every 90 days.

9. The Montana Board of Visitors has never reviewed
the care provided for the mentally ill patient deinstitutionalized from Warm Springs at this facility.

Summary:

Warm Springs does not provide any patient records or psychiatric summaries on the patient's mental illness other than a listing of diagnosis and medications patient has been given.
FACILITY E-1

This facility is one of the 23 after-care facilities in which patients can be relocated. This setting is a nursing home located in a community with an average population of 30,000. It is the residence of 94 skilled care and moderate care patients. Upon discussion with the nursing home administrator, about the study and this writer's objective to evaluate the treatment of the mentally ill patient, he explained, "We do not take mental patients from Warm Springs. My nursing home is only for higher-class people. The reputation of this home would be ruined if we accept those kind of patients." He indicated that last year a social worker attempted to transfer three mentally ill patients from Warm Springs to the nursing home without the administrator's knowledge of their mental diagnosis or previous hospitalization. When the patients are admitted, no medications were administered, as a result the patients portrayed severe psychotic behavior—dangerous to themselves and the other patients. The director added, "The Department of Institutions was aware of this incident...they were behind sneaking those patients into the nursing home."

Negative attitudes toward deinstitutionalization
of this administrator can be recognized when he commented, "I prefer to never admit those kind of people into my nursing home. They belong in Warm Springs."

No treatment care plans were available, none offered. There was no knowledge of the Mental Health laws or its application in this facility.
2. Data Analysis

From five separate facilities located within a 250 mile radius of Helena, Montana, the writer gathered data to determine whether these patients were receiving the care as specifically mandated by statutes and case law. Specific questions were asked, and particular items were evaluated, all consisting of matters required by law. From this data the writer concluded that there are severe fundamental problems in many of these facilities preventing them from meeting even the basic requirements outlined by law. The following data analysis is by graphic representation. It consists of a similar format in presentation as was found in the Data Presentation. (See Table I.)
Table I. Graphic representation of treatment care plans with statutory requirements.
The four after-care facilities investigated maintained treatment care plans for the released mentally ill patient. A total of twenty-seven care plans were examined.

Nineteen of the twenty-seven care plans had a problem statement specific for the patient's psychiatric condition. Only one treatment care plan from Facility A-1 made any notation for the patients' least restrictive conditions. None of the care plans contained short or long range goals. Six care plans from Facility D-1 made reference to the psychiatric treatment implemented. Six care plans from Facility B-1 and six from Facility D-1 noted the specific professional person responsible for the patients' treatment. Six of the twenty-seven care plans (from Facility D-1) specified the criteria which the patient must demonstrate in order for release along with plans for the patients' discharge.

None of the twenty-seven treatment care plans were ever reviewed by the Montana Board of Visitors.
CHAPTER VI
CONCLUSION
CONCLUSION

Professional nurses, along with other members of the multi-disciplinary team, are responsible for the mentally ill patient's care. The multi-disciplinary team develops the patient's treatment care plan and implements the planned care for the mentally ill patients in after-care facilities.

It was the intent of this writer to determine whether the treatment care plans of the mentally ill were meeting specific statutory requirements mandated by Montana Legislation. From this study there appears to be fundamental problems with nurses and others responsible for designing, implementing and developing treatment care plans in the after-care facilities investigated.

Several solutions offered by this writer to begin to alleviate the problems that currently exist include:

1) An educational program presented to the nurses responsible for the care of the patient as well as the administrative staff of the facility. The program should familiarize the professional staff with the statutory requirements for care of the mentally ill patient and the patient's right to receive adequate care and treatment.

2) A specialized team consisting of the patient's
psychiatrist, social worker and along with a professional nurse as a member of such team, from the state mental health facilities should provide comprehensive discharge planning and follow-up on the care of the patient. This team's assistance to the after-care facilities will assure continuity-of-care as the patient moves between systems.

3) A community health nurse, employed by either the community mental health program or a local health department would serve as a coordinator of the patient's deinstitutionalization program. The nurse would function to provide assistance to the after-care facilities in teaching skills in caring for the mentally ill patient.

Before such solutions can be seriously attempted, more funding must be allocated by the Montana legislature to the State Mental Institutions and after-care facilities.

Because this study investigated after-care facilities limited to Helena's region, more nursing research into the nursing care of the deinstitutionalized mentally ill patient needs to be conducted.

Suggestions for further study include:

1) A comparative study of the nurses role in the planning and designing of the mentally ill patient's treatment care plan in other after-care facilities located in other regions throughout Montana.

2) An exploratory study of the nurse's role in the planning and implementation of the patient's treatment care
plans in other states which have statutory laws similar to Montana's.

3) An exploratory study in regional after-care facilities to determine whether nurses, along with other members of a multi-disciplinary team, are planning the treatment of mentally ill children and adolescents.
FOOTNOTES


2 Ibid., p. 384.


4 Ibid., p. 152.


13 Mental Commitment and Treatment Handbook (U.S. Department of Health, Education and Welfare, Partnership Grant No. 8-p-32/02.)
14 Ibid., p. 27.


16 Mental Commitment and Treatment Handbook, op. cit., p. 27.


18 Ibid.


22 Jeanette Lancaster, Community Mental Health Nursing, op. cit., p. 157-159.

23 Holly Wilson, Psychiatric Nursing, op. cit, p. 694.


25 Ibid., p. 845.

26 Ibid., p. 878.


28 Law, Psychiatry and the Mental Health System, op. cit., p. 785.


30 Ibid., p. 89.

31 Ibid., p. 90.


37 1980 Montana State Plan for Mental Health Services, (Montana Department of Institutions, Mental Health and Residential Services Division, 1979), p. 70.

38 Ennis, Emery, The Rights of Mental Patients, op. cit., p. 130.

39 Ibid., p. 57.


41 Ibid.


53 A Century of Service, Warm Springs State Hospital (Public Relations, Warm Springs State Hospital, Montana, 1977), no page numbers.

54 Ibid., no page numbers.
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Mental Commitment and Treatment Guide to the Revised Codes of Montana, 1947, published through the Mental Health/Mental Retardation Coordinator, Research Unit, Mental Disabilities Board of Visitors, and the Community Development Bureau, partial funding through the United States Department of Health, Education and Welfare, 1976.


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Personal interviews, communication and discussion with six health care administrators not identified for reasons of protecting a statement of confidentiality of sources and locations of facilities in this research analysis. Respective dates of communication and discussion occurred in the months of October and November, 1980.
## Warm Springs State Hospital Treatment Plan

### Diagnosis

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### Social Support

- **Director:**
- **Doctor:**
- **Psychologist:**
- **Social Worker:**
- **Rehab Therapist:**
- **Psychiatric Nurse:**

### Service Checklist

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### Other

- Additional notes or comments...

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Medical Program

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Diet

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Special Diagnostic Procedures

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