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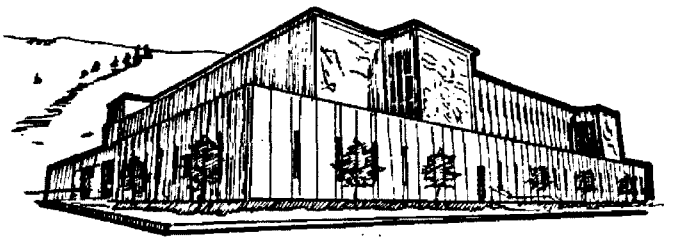
Complying with patients' rights on Montana's Forensic Treatment Facility: Issues and recommendations.

Edward B. Amberg
The University of Montana



COMPLYING WITH PATIENTS' RIGHTS ON MONTANA'S FORENSIC TREATMENT FACILITY -- ISSUES AND RECOMMENDATIONS

by

Edward B. Amberg

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Approved by

Jonathan Tompkins

Chairperson, Board of Examiners

Dean, Graduate School

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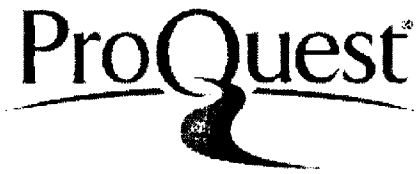

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Chapter 1

Introduction

Background

Forensic psychiatric hospitals have been characterized by Heller as institutions that combine the worst features of prisons and mental institutions.[1] The Joint Commission on Accreditation of Health Care Organizations (JCAHCO) describes forensic psychiatric facilities as:

> specialized units in which ordinary clinical practice and decision making are carried out in close reference to legal and correctional constraints. Judicial constraints on discharge and the need to maintain security for correctional patients, for example, may require special adjustments in clinical practice.[2]

Blending the features of both correctional facilities and psychiatric hospitals, forensic psychiatric units fulfill their mission in an uncertain arena of laws, social

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[1]Abraham Heller, "Extension of Wyatt to Ohio Forensic Patients," in Wyatt v. Stickney, Retrospect and Prospect, ed. L. Ralph Jones and Richard R. Parlour (New York: Grune and Stratton, 1981), 161.

[2]Joint Commission on Accreditation of Health Care Organizations, Accreditation Standards for Forensic Facilities (Chicago: Joint Commission on Accreditation of Health Care Organizations, 1989), 7.

philosophies, political agendas, and treatment practices.[3] Forensic psychiatric units serve the purpose of providing psychiatric evaluation and treatment services to people who are involved in the criminal justice system and sometimes to others who are regarded as very dangerous, in need of a secure environment, and/or suffering from severe mental illness.[4] The means by which this purpose is to be carried out is the subject of much debate, confusion, uncertainty, and legal activity.

Most research and public attention in the area of forensic psychiatry in recent years has focused on issues related to the "insanity defense."[5] A much greater need, however, is for information about forensic treatment clients, facilities, and programs.[6] Prompted by historical problems of abuse in forensic hospitals, often carried out in the name of treatment, issues related to the treatment of

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[3]Paul Rodenhauser, and Abraham Heller, "Management of Forensic Psychiatry Patients Who Refuse Medication - Two Scenarios," Journal of Forensic Sciences, 29 (January 1984): 237.

[4]Meredith Davis, ed., Mentally Ill Offender Systems in the Western States, (Boulder CO: Western Interstate Commission for Higher Education, 1983), 1; and Charlotte Kerr and Jeffery Roth, Survey of Facilities and Programs for Mentally Disordered Offenders, (Rockville, MD: U.S. Department of Health and Human Services, National Institute of Mental Health, 1987), 39.

[5]Davis, 1.

[6]Ibid; and William J. Curran, A. Louis McGarry, and Saleem A. Shah, Forensic Psychiatry and Psychology: Perspectives and Standards for Interdisciplinary Practice, (Philadelphia: F. A. Davis Co., 1986), 10.

clients are now receiving greater attention from the public and the legal system.[7] State and federal judicial systems, as well as state legislatures, have mandated many changes in mental health practices in recent years. No where have these mandates for change been more dramatic and controversial than in forensic hospitals.[8] Yet despite increased scrutiny and legal regulation, a lack of information about forensic treatment systems and standards leaves administrators and clinicians without a foundation upon which to base the everyday treatment and security decisions that must be made.[9]

Various security measures are necessary in forensic hospitals because of the nature of the patients who reside there. The American Correctional Association defines security in a correctional institution as the prevention of escapes, the control of contraband, and the maintenance of good order.[10] This definition is equally applicable to security procedures required in forensic psychiatric

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[7]Joyce K. Laben, and Colleen P. McLean, Legal Issues and Guidelines for Nurses Who Care for the Mentally Ill (Thorofare, NJ: SLACK Inc., 1984), 61.

[8]Ibid; and Kerr and Roth, 82.

[9]Joseph D. Bloom, "Building a Statewide System for the Mentally Ill Offender," in Davis, ed., 11.

[10]American Correctional Association, Correctional Officer Resource Guide (College Park, Maryland: American Correctional Association, 1983), 28.

facilities.[11]

Many security procedures in correctional and forensic psychiatric institutions involve actions that restrict the liberty and intrude into the privacy of facility residents. Examples of such actions include the confinement of people into a small area, searches of personal belongings, restrictions on visitors, and limitations on the type and number of personal possessions to which one is allowed access. Security procedures such as these have to be balanced with the rights that people retain when they enter such a facility. These rights became the focus of much legal action during the 1970s.[12] One of the biggest concerns facing administrators of forensic facilities today is how to establish appropriate security measures without violating patients' rights.[13]

As in the case of most other subjects concerning forensic psychiatry, very little has been written about how security and patients' rights issues should be balanced.[14] Most security procedures used in forensic facilities have been borrowed from corrections. Yet, there is a significant

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[11] Kerr and Roth, 82.

[12] Milton Greenblatt, "Wyatt v. Stickney: A Study in Psychopolitics," and Stephen J. Ellman, "Test Cases: Legal Battles and Latent Effects," in Jones and Parlour, eds., 131 & 181.

[13] Kerr and Roth, 77.

[14] Ibid.

need to develop security procedures for use in forensic facilities that are tailored to the unique characteristics of these facilities and their patients.[15] Even in the field of corrections, it is acknowledged that security practices must respect individual rights and that an overemphasis on security can result in a repressive atmosphere counterproductive to organizational goals.[16] Respect for patients' rights also enhances organizational performance and patient treatment in psychiatric facilities.[17]

The Montana State Hospital at Warm Springs operates a forensic unit as one of its six psychiatric units. This unit, named the Forensic Treatment Facility (FTF), opened in September, 1988, replacing older, inadequate hospital facilities. Since opening, the FTF has maintained an average daily census of between 70 and 80 patients. Patients are admitted to the FTF for one of several reasons:

1. Commitment to the hospital for an evaluation as part of pre-trial court proceedings.

2. A declaration of "unfit to proceed" in a

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[15] Joint Commission, 9.

[16] James D. Henderson and W. Hardy Rauch, Guidelines for the Development of a Security Program (College Park, MD: American Correctional Association, 1987), 40.

[17] Walter E. Barton and Gail M. Barton, Ethics and Law in Mental Health Administration (New York: International Universities Press, 1984), 226; and Carol T. Mowbray et al., "Evaluation of a Patient Rights Protections System: Public Policy Implications," Administration in Mental Health 12 (Summer 1985): 282.

criminal proceeding and an order to receive treatment in an effort to restore them to competency.

3. An order to receive psychiatric treatment at the hospital due to a finding of "Not Guilty by Reason of Insanity" or as a component of a court imposed sentence following a criminal violation and having not received administrative or court approval for placement in a less restrictive area of the hospital.

4. Transfer from the Montana State Prison or the Women's Correctional Center because of a need for psychiatric treatment.

5. Admission to the hospital on a civil involuntary or voluntary commitment, but presenting such life threatening behavior to others or to themselves that treatment in a highly structured, secure setting is required.[18]

Purpose of this Paper

Montana's Forensic Treatment Facility has been the subject of criticism for both its security and patients' rights practices.[19] As indicated above, little information exists to guide administrators and clinicians in their efforts to balance patients' rights and security requirements. This paper will explore the problem of complying with patient rights on Montana's Forensic

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[18] Montana State Hospital Operating Policy and Procedure, No: 1-0.051480. Subject: Role of Montana State Hospital.

[19] Mental Disabilities Board of Visitors, Review of Montana State Hospital [Review conducted in response to legislative mandate as identified in Section 53-21-104 of the Montana Codes Annotated and presented to the Governor of the State of Montana] (Helena, MT: Mental Disabilities Board of Visitors, 1989).

Treatment Facility. Once an understanding of how to comply with patients' rights requirements is gained, administrators and clinicians can make informed decisions regarding appropriate security procedures.

This paper will analyze the legal issues concerning the application of patients' rights statutes and case law. It will also describe practices used in other states or suggested in the professional literature to meet these sometimes contradictory responsibilities. These findings will then be applied to Montana's FTF. The result will be:

1. Identification of existing major policies and practices that comply with patients' rights requirements.

2. Recommendations for changes in other major policies and procedures in order to comply with patients' rights requirements while still ensuring that appropriate security is maintained.

3. A thorough discussion of patients rights issues as they apply to Montana's FTF which will serve to guide administrators and clinicians as they make day-to-day decisions regarding patient care and treatment on this facility.

The information contained in this paper and its findings are not intended to serve as a substitute for legal advice. It is meant to provide useful information to guide administrators and clinicians in the application of laws related to forensic mental health programs. Mental health law is rapidly changing, perhaps faster than any other area

of law.[20] Staff members must be aware of the current law as it applies to their actions or they risk being found liable for negligence or malpractice.[21] A thorough understanding of patients rights issues is essential to guide administrators and clinicians working in forensic facilities in the development and operation of treatment and security programs. However, they should not hesitate to seek expert advice when confronted with a legal issue. Unfortunately, well-informed legal advice for public mental health practitioners has usually been lacking.[22]

The operation of Montana's Forensic Treatment Facility is inextricably connected with the state's larger mental health, criminal justice, and political systems. Any significant issue must be examined from the context and viewpoint of these many different and often conflicting systems that influence FTF policies and practices. With a little research, administrators and clinicians can find information on most of the specific issues that they face

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[20] Mark J. Mills, Bonnie D. Cummins, and John S. Gracey, "Legal Issues in Mental Health Administration," International Journal of Law and Psychiatry 6, no. 1 (1983): 39.

[21] Paul S. Applebaum, "Legal Considerations in the Prevention and Treatment of Assault," in Assaults Within Psychiatric Facilities, ed. John R. Lion and William H. Reid (New York: Grune and Stratton, 1983), 180.

[22] Thomas F. Gutheil, Stephen Rachlin, and Mark J. Mills, "Differing Conceptual Models in Psychiatry and Law" in Legal Encroachment on Psychiatric Practice, ed. Stephen Rachlin (San Francisco: Jossey-Bass Inc., 1985), 16.

(e.g., security procedures, a particular patients' rights statute or case law precedent, mental health treatment practices, and standard clinical and administrative procedures). What is lacking is a model for making decisions that considers the many complex issues involved in the care and treatment of forensic psychiatric patients in a balanced and legally correct manner. While this paper will not fulfill this purpose entirely, it will help clarify the actions that administrators and clinicians can take to meet the requirements of complying with patients' rights while maintaining security on Montana's Forensic Treatment Facility.

Methodology

Library research was the principle method used to investigate patient rights issues that apply to forensic psychiatric facilities. This research was conducted along two lines. First, applicable constitutional provisions, statutes, and precedent-setting legal decisions were examined to determine the procedures and practices that by law must be followed on the unit. Second, administrative and clinical practices aimed at meeting patients' rights requirements that are used on forensic facilities in other states or suggested in the professional literature were reviewed. This research was conducted between December, 1988 and March, 1989, with the source of much of the material coming from libraries outside of the state of

Montana.

After this review of the relevant literature was conducted, interviews were held with five public officials who are familiar with the unit's operation. Each of these officials has some responsibility for overseeing or reviewing its operations. These interviews were conducted to confirm the applicability of findings from the library research to Montana's FTF and to discuss recommendations for strengthening existing operations as they pertain to patients' rights and security issues. Each person's interview was structured with the same series of twenty discussion items in an effort to solicit and understand differing viewpoints of the same problem. Those interviewed were:

Nick Rotering - Staff Attorney for the Department of Institutions; interviewed: April 4, 1990.

Kelly Moorse - Executive Director of the Mental Disabilities Board of Visitors; interviewed: April 4, 1990.

Allen Smith - Staff Attorney for the Mental Disabilities of the Mental Disabilities Board of Visitors; interviewed: April 9, 1990.

Robert Anderson - Administrator of the Treatment Services Division of the Department of Institutions; interviewed: April 11, 1990.

Jane Edwards - Superintendent of the Montana State Hospital; interviewed: April 17, 1990.

No one working directly on the FTF was chosen to be interviewed because the author of this paper is employed on the unit. The close working relationship between the author and other unit employees would have biased their responses to the issues raised during the interview. This close working relationship would also make their responses rather predictable to the author. The tension between compliance with patients' rights provisions and security is a common topic of discussion on the unit. The perspective of people from outside of the unit was felt to be of more benefit to this exercise.

Information from this research is presented in the following chapters. Chapter two focuses on the legal issues involved in applying patients' rights statutes and case law to forensic facilities. Chapter three presents the methods used in other states or suggested by experts for ameliorating the problem. Chapter four discusses the solutions for the problem suggested by those people who were interviewed for this paper. Finally, chapter five presents recommendations for changes in present operations in an effort to reduce the conflict between patients' rights and security issues on Montana's Forensic Treatment Facility.

Chapter 2

Legal Issues

This chapter will describe the major aspects of mental health law that apply to the assurance of patient rights and security on a forensic psychiatric facility. The information presented here is intended to provide a foundation of recent information in this area of law that can be applied to the development of policy in the forensic setting. There are some inherent difficulties in doing this. First, the law in this area is evolving rapidly and forcing many changes in mental health systems.[1] Second, many aspects of the law, such as definitions of mental illness, treatment, and dangerousness, are vague and ambiguous.[2] Third, the Supreme Court has failed to make authoritative rulings on many issues, leaving some conflict between federal district and appeals court decisions.[3]

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[1] James T. Ziegenfus, Patients' Rights and Organizational Models (Washington, D.C.: University Press of America, 1983), 5.

[2] Samual Jan Brakel, John Parry, and Barbara A. Weiner, The Mentally Disabled and the Law, (Chicago: The American Bar Association, 1985), 16.

[3] Stephen J. Ellmann, "Test Cases: Legal Battles and Latent Effects," in Wyatt v. Stickney, Retrospect and Prospect, ed., L. Ralph Jones and Richard R. Parlour (New York: Grune and Stratton, 1981), 181.

Finally, many legal principles are intricately intertwined with others, leaving guiding axioms yet to be fully developed.[4]

There are unique differences in each patient and in each situation that administrators and clinicians must deal with. Only the general principles of patients' rights law can be presented here. Legal expertise must be consulted whenever it is not clear how these principles should apply to a particular situation or patient. Nonetheless, administrators and clinicians need to have a basic understanding of the law in order to properly exercise their judgment when making treatment decisions and devising and carrying out organizational policy.[5] Many clinicians do not understand the law and frequently over react to it, abandoning good clinical judgment.[6] The intent of this chapter is to present the major areas of law that apply to patients' rights issues in the forensic psychiatric setting so that administrators and clinicians can understand the

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[4]Harold L. McPheeters, Implementing Standards to Assure the Rights of Mental Patients (Rockville, MD: U.S. Department of Health and Human Services, National Institute of Mental Health, 1980), 12.

[5]Joseph D.Bloom, "Building a Statewide System for the Mentally Ill Offender," in Mentally Ill Offender Systems in the Western States, ed. Meredith Davis (Boulder, CO: Western Interstate Commission for Higher Education, 1983), 22.

[6]Philip B. Kraft, "The Use of Legal Rhetoric in a Clinical Setting: Advocating the Advocates," Bulletin of the American Academy of Psychiatry and the Law 13, no. 4 (1985): 316.

basic legal tenets upon which policies and treatment decisions must be based.

Confusion in the Law

The rights retained by mental patients when they enter an institution are one of the most complex and disputed areas of law in the United States.[7] There are a number of reasons for the law's murkiness. One is that this is a rather new and rapidly changing area of law. Sadoff reports, "The treatment of the mentally ill has been relatively unregulated until recently."[8] Milner concurs:

> Traditionally, until the 1960's, courts or legislatures paid little attention to the activities within the walls of psychiatric institutions, so the discretion to treat was almost entirely in the hands of hospital officials. The U.S. Supreme Court repeatedly refused to hear cases challenging institutional conditions or the forms of care and treatment that people received.[9]

Referring to forensic psychiatric facilities, Kerr and Roth describe the last twenty-five years as a period during which an "avalanche of statutory revisions and court cases in the area of overlap between mental health and corrections" has

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[7]Brakel, Parry, and Weiner, 1.

[8]Robert L. Sadoff, Legal Issues in the Care of Psychiatric Patients: A Guide for the Mental Health Professional (New York: Springer Publishing Co., 1982), xv.

[9]Neal Milner, "Models of Rationality and Mental Health Rights," International Journal of Law and Psychiatry 4 (1981): 35.

occurred.[10] With mental health law suddenly becoming the focus of much activity after having been ignored for so long, it is no wonder that the law is so unclear. The dust has not yet settled.

Another reason for the law's lack of clarity is that the nature and stigma of mental illness has left this disadvantaged group of people without adequate representation in the political and legal system. The mentally ill can be compared to members of other minority groups who have been historically denied basic civil liberties. Trying to exercise rights in a system that has long shunted them away into institutions has been a difficult and painstakingly slow process for the mentally ill.[11]

Mental health law is also very ambiguous because the real purpose that people are institutionalized is often concealed. While much of the law is premised on ensuring treatment for mentally ill individuals, it can also serve a

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[10] Charlotte Kerr and Jeffery Roth, Survey of Facilities and Programs for Mentally Disordered Offenders, (Rockville, MD: U.S. Department of Health and Human Services, National Institute of Mental Health, 1987) 10.

[11] Patricia M. Wald and Paul R. Friedman, "Politics of Mental Health Advocacy in the United States," International Journal of Law and Psychiatry 137 (1978); reprinted in Paul R. Friedman, ed., Legal Rights of Mentally Disabled Persons (New York: Practising Law Institute, The Mental Health Law Project, 1979), 35-36.

de facto purpose.[12] It places many of societies' unwanted members in institutions far removed from the general population. Wexler reports a long history of abusive and unjust psychiatric practices and argues that we "may not be as far as we would like to think from the Soviet practice of confining nonconformist intellectuals and political dissidents in mental hospitals."[13] Contributing to this problem is the fact that there is no generally agreed upon definition of what mental disability or mental health really is.[14] The lack of a clear definition contributes to the problem of inappropriately applying mental health laws for the purpose of social control.

Parens Patriae and Police Power Doctrines

Mental health law is based on two major legal principles, the Parens Patriae and Police Power doctrines.[15] These two legal fundamentals can be traced back to ancient and medieval roots.[16] As a society, we

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[12]Howard H. Goldman et al., "The Multiple Functions of the State Mental Hospital," American Journal of Psychiatry 140 (1983) 296-300; reprinted in Mental Health Law Project, Protection & Advocacy for People Who are Labeled Mentally Ill (Washington D.C.: Mental Health Law Project, 1987), 61-65.

[13]David B. Wexler, Mental Health Law (New York: Plenum Press, 1981), 16.

[14]Brakel, Parry, and Weiner, 16.

[15]Wexler, Mental Health Law, 36.

[16]Brakel, Parry, and Weiner, 9.

believe that we should act benevolently in protecting our less fortunate members. This concept leads the state to take actions intended to assist mentally disabled individuals under the Parens Patriae doctrine.[17] In such a case, the state acts like a parent in protecting a child unable to care for itself. The state, through the actions of its officials, may substitute its judgment for that of the unfit person and act in what is regarded to be that persons best interest.[18]

The other doctrine, the state's police power, stems from the need of society to protect itself.[19] Normally used in the criminal process, it is also applied to situations where a person with mental illness is considered dangerous.[20] The state's police powers allow action to be taken against an individual in order to maintain social order and to protect the public. An example of this power in mental health law is the involuntary commitment. When invoked against a mentally disabled person, the premise is that the individual does not have the capacity to understand the law or to exercise sufficient self-control in order to stay within its bounds, so society must be protected.[21]

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[17] Ibid, 24.

[18] Wexler, Mental Health Law, 39.

[19] Brakel, Parry, and Weiner, 24.

[20] Wexler, Mental Health Law, 36.

[21] Brakel, Parry, and Weiner, 24.

These two doctrines sometimes conflict. Some elements of the law impose sanctions against the mentally ill for the protection of society. Others are intended to provide assistance so that people with mental disabilities receive needed care and treatment. This creates a basic conflict that society and the mental health system has yet to resolve.[22]

Mental Health Services in the United States, Pre-1960

In the Colonial era of the United States, mental illness was "treated" primarily through the use of punishment. Wealthy people kept their insane family members at home in specially constructed rooms in attics or cellars. The mentally ill who were less wealthy were considered felons if violent, and paupers if they were not. They were often kept in jails or alms houses and chained to the walls where they were whipped by their keepers.[23] Inducing terror in patients was the usual treatment modality used by the American psychiatrists of this period.[24]

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[22]Alan A. Stone, "The New Legal Standard of Dangerousness: Fair in Theory, Unfair in Practice" in Dangerousness, Probability and Prediction; Psychiatry and Public Policy, eds. Christopher D. Webster, Mark H. Ben-Aron, and Stephen J. Hucker (New York: Cambridge University Press: 1985), 14.

[23]Charles A. Kiesler and Amy E. Sibulkin, Mental Hospitalization, Myths and Facts About a National Crisis (Beverly Hills, CA: SAGE publications, 1987), 29.

[24]A. Deutsch, The Mentally Ill in America: A History of Their Care and Treatment From Colonial Times (New York: Columbia University Press, 1949); quoted in Kiesler and

In the late 1700s, Dr. Philippe Pinel reformed French mental hospitals when he unchained the patients held there. This act shocked Pinel's colleagues, but was soon found to decrease the violent tendencies of these people. Pinel applied a humanitarian and supportive approach to psychiatric therapy, termed "moral treatment." At the same time the English doctor, William Tuke, began to send mentally ill people to retreats in the countryside, where they could be sheltered from the stresses of urban living.[85] Both Pinel and Tuke recognized that previous practices had violated the rights of the mentally ill.[86]

These reforms were strongly advocated in the United States during the mid-1800s by Dorthea Dix. Her efforts directly led to the establishment of state-run mental hospitals in over 30 different states, greatly improving conditions for the mentally ill of this era. It was intended that patients no longer be terrorized or kept chained to walls. "Moral treatment" was prescribed for them.[87]

The state hospital, however, soon proved to be anything but a solution to the problem of treating the mentally ill.

Sibulkin, 29.

[85]Kiesler and Sibulkin, 30.

[86]Walter E. Barton and Gail M. Barton, Ethics and Law in Mental Health Administration (New York: International Universities Press, 1984), 207.

[87]Keisler and Sibulkin, 30.

These facilities grew to be very large, overcrowded, underfunded, and far removed from the rest of society. The medical profession created the expectation that a cure for mental disability could be found, but none was ever delivered, and many patients were never discharged. State institutions developed bureaucratic characteristics, becoming custodial facilities focused on efficiently managing large numbers of mentally ill people rather than individualized treatment. This situation continued during the first part of the twentieth century.[28] Commitment of people to state hospitals during this period was an informal process affording individual patients few legal protections.[29] Psychiatric treatment in state hospitals included procedures that were often abused, such as prefrontal lobotomies, fever therapy, insulin shock therapy, electroconvulsive therapy, and the use of such medications as opium, morphine, and chloral hydrate.[30]

It was not until after World War II that conditions in State Mental Hospitals began to receive significant attention from the public. The media drew national attention to the plight of the mentally ill by uncovering deplorable conditions in these facilities and the public began to force state governments to address the problem.

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[28] Ibid, 30-37 passim.

[29] Brakel, Parry, and Weiner, 20.

[30] Keisler and Sibulkin, 36.

Steps were taken in many states to improve ward environments and to allow patients increased privacy and dignity. During this same period, new psychotropic medications were introduced allowing many patients to be discharged from state institutions and receive treatment in the community.[31]

During the 1960s, social issues, including mental health, received much attention. The Civil Rights movement focused national attention on the plight of blacks. This led to an examination of their confinement in correctional institutions, and then to the only facilities where conditions were worse, hospitals for the criminally insane.[32] The disgraceful conditions of these facilities in many states shocked the public and proved ripe for the massive amount of litigation that was to be advanced by public interest lawyers.[33]

This has been only a brief sketch of the history of mental hospitalization in the United States, but it is necessary to understand this backdrop because it paved the way for the reforms in the mental health system that were to be taken in the name of patients' rights. Throughout history, society has taken steps to both remove the insane from the community and to provide for their welfare.

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[31] McPheeters, 2.

[32] Ibid, 3.

[33] Ibid, 2-3.

Institutions were built to provide humane care and treatment, but due to neglect and bureaucratic expediency, they were unable to fulfill their promise. The medical profession has held out the hope for a cure, but historically many treatment practices have been horrendously abusive. Modern medications have relieved the worse symptoms of mental illness for many people, but not for all. The noble idealism of the 1960s proved to be a catalyst for improving the sad plight of the institutionalized mentally ill. The patients' rights movement was a response to a social problem, a mental health system that was victimizing the very people it was supposed to help.[34]

Wyatt v. Stickney

The most important law suit in the area of patients' rights, Wyatt v. Stickney,[35] was filed in Alabama in 1970 as a class action suit by employees who claimed that patients would not receive treatment that they were entitled to if pending staff layoffs were to take place.[36] In this

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[34]Congress, Senate, Senator Lowell Weiker, Opening Statement on the Care of Institutionalized Disabled Persons, presented to The Subcommittee on the Handicapped, Committee on Labor and Human Resources, and Subcommittee on Labor, Health and Human Services, Education and Related Agencies, Committee on Appropriations, April 1, 1985. reprinted in Mental Health Law Project, Protection and Advocacy for People Who are Labeled Mentally Ill (Washington D.C.: Mental Health Law Project, 1987), 41.

[35]344 F. Supp.373 (M.D. Ala, 1972).

[36]Humphrey F. Osmond, "Model Muddles and the Wyatt Affair," in eds., Jones and Parlour, 5.

case, a United States District Court made history by ruling for the first time that a mentally handicapped person involuntarily confined in an institution had a right to receive treatment.[37] The Court set detailed minimal standards for the care and treatment of patients in institutions that encompassed nearly every aspect of institutional life. Among the rights and standards proclaimed by the court were (summarized):

> a right to privacy and dignity;
>
> a right to the least restrictive conditions necessary to achieve the purpose of commitment;
>
> a prohibition against restriction of civil rights (i.e., voting, driver's license, marriage) solely on the basis of a patient's involuntary commitment;
>
> visitation and telephone privileges similar to those of patients in other public hospitals;
>
> unrestricted access to communicate with attorneys and private physicians or other health professionals;
>
> prohibitions against limitations on a patient's access to use of the mail;
>
> a right to be free from unnecessary or excessive medication;
>
> a right to be free from physical restraint and isolation (standards for using isolation and restraints in emergency situations are set by the court);
>
> a prohibition against experimental research without the informed consent of the patient (or guardian if the patient is unable to provide informed consent);

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[37] John A. Talbott, The Chronic Mental Patient (Washington, D.C.: The American Psychiatric Association, 1978), 53.

> a prohibition against hazardous procedures such as lobotomy, electro-convulsive therapy, and aversive
>
> reinforcement conditioning unless informed consent is received;
>
> a right to prompt and adequate medical treatment;
>
> a right of patients to wear their own clothes and keep and use their personal possessions unless a mental health professional determines particular articles to be dangerous or inappropriate to the treatment regimen;
>
> a right to regular physical exercise several times each week;
>
> a right to be outdoors at regular and frequent intervals;
>
> a right to religious worship for any patient desiring such opportunity;
>
> a right to suitable opportunities to interact with members of the opposite sex;
>
> a right to compensation for labor performed that is of benefit to the institution;
>
> a right to an individualized treatment plan that is instituted promptly after the patient's admission;
>
> the appointment of a human rights committee to monitor rights compliance in state institutions; and
>
> regular reviews of the treatment plan to determine appropriateness of an individual's course of treatment.[38]

Judge Johnson also ordered minimal staff-patient ratios and temperature and space requirements within the hospital.[39]

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[38] Wyatt v. Stickney, 344 F. Supp. 373, 379-86 appendix A (1972), and 344 F. Supp. 387, 395-407, reprinted in Brakel, Parry, and Weiner, 298-299.

[39] Sadoff, Legal Issues, 30.

These standards became the basis for much legal action that followed in other states and for many state mental health statutes,[40] including those of the State of Montana.[41]

Other Important Court Cases

Although Wyatt v. Stickney, 1972, had the widest scope of any case and provided the most in the way of specific standards, numerous other court cases in the late 1960s and 1970s also served to stipulate the rights of patients in mental institutions.[42] To trace the course of every case that has set a precedent for defining the rights of patients would be a tremendous task. For the purpose of this paper it will be more practical to identify and discuss the major rights of patients that these court decisions recognized rather then to try to delve into each particular case.

It must be remembered that it took a series of lawsuits over commitment practices and conditions in mental institutions to force mental health systems to address patients rights issues and improve conditions in state

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[40] Brakel, Parry, and Weiner, 252.

[41] Many of the standards from the Wyatt case have provided the basis for statutes adopted by the State of Montana. See 53-21-142, Montana Code Annotated, "Rights of persons admitted to facility." In some cases the language of the statute has been adopted word for word from the Wyatt case (See Appendix A for statutes).

[42] Phillip J. Leaf and Michael M. Holt, "How Wyatt Affected Patients," in Jones and Parlour, 49.

institutions.[43] Prior to this period, rights of patients in these facilities were not generally recognized.[44] Wald and Friedman report that the major court cases,

> have made it clear that whether a state decides to run a mental health system is entirely within its own discretion, but once it decides to undertake this function, it must do so in a manner which does not violate constitutional rights.[45]

Kopolow stated about this period, "the courts are nationally stepping in to fill a serious vacuum in standards and peer review in the nation's mental health system."[46] In many of the original cases, clinicians and advocates were on the same side, seeking to improve conditions for the mentally ill.[47] Some of the early defendants in these cases recognized that their mental health systems would gain more by losing the case than by winning.[48] This series of cases greatly improved the mental health system, although many improvements continue to be needed.[49]

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[43] Brakel, Parry, and Weiner, 20-21.

[44] Ibid, 259.

[45] Wald and Friedman, 34.

[46] Louis Kopolow, "The Challenge of Patients' Rights," in Advocacy Now 1 (May, 1979): 19-20.

[47] Wald and Friedman, 42; and Robert D. Miller, "Involuntary Civil commitment: Legal Versus Clinical Paternalism" in ed., Rachlin 14.

[48] Phillip J. Leaf and Michael M. Hold, "How Wyatt Affected Patients," in eds., Jones and Parlour, 60.

[49] Mark J. Mills, Bonnie D. Cummins, and John S. Gracey, "Legal Issues in Mental Health Administration" International Journal of Law and Psychiatry 6, no. 1 (1983):

Right to Liberty

The 14th amendment to the Constitution enunciates a right to liberty that is seriously affected when a person is committed to a mental hospital.[50] This infringement has been recognized in numerous court cases over commitment procedures and institutional conditions.[51] The courts have accepted the philosophy of John Stuart Mill who wrote that "The only purpose for which power can be rightfully exercised over any member of a civilized community against his will is to prevent harm to others.[52] In accepting this theory, the courts have generally determined that the only basis for restricting a person's liberty is to prevent harm from occurring (police power), not just to serve what society feels may be the best interests of the patient (parens patriae).[53] The problem is that psychiatry is unable to predict reliably whether an individual actually is

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[50] Joseph L. Daly, "The Diverse Goals Involved in Treatment of the Mentally Ill, Is a Collision Inevitable?" Journal of Legal Medicine 8, no.1 (1987): 51.

[51] Lynn Walker and Arthur Peabody, "The Right of the Mentally Disabled to Protection from Harm and to Services in Institutions and the Community," in ed., Friedman, 569.

[52] John Stuart Mill, "On Liberty" in M. Cohen (ed.) The Philosophy of John Stuart Mill, (New York: Modern Library, 1961) quoted in Stone, "The New Legal Standard," 21.

[53] Wexler, Mental Health Law, 39.

dangerous.[54]

In the mental health system, measures are routinely taken to restrict a person's liberty based on what they might do, rather than what they are proven to have already done. This is preventative detention, an area where the law in our country is very uncomfortable.[55] Because of this, the law has invoked a quid pro quo rationale: a society that takes freedom away from a mentally ill person should provide adequate care and treatment for that individual and ensure that this is received by affording them substantive due process protections.[56]

The courts have delineated four general principles to balance the patient's medical interests against his/her liberty interests,

> a patient should be deprived of his liberty only when failure to do so either presents a risk of serious physical harm to himself or others or prevents medical treatment which has clearly shown to be effective;
>
> a patient should be deprived of his liberty only to the extent necessary to achieve the desired goal;
>
> a patient's right to choose among treatments should be protected whenever possible; and
>
> when a patient must be deprived of liberty, a set of strict procedures should be imposed to ensure that the infringements upon his liberty and

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[54] Bernard M. Dickens, "Prediction, Professionalism, and Public Policy" in Webster, Ben-Aron, and Hucker, 179.

[55] Wexler, Mental Health Law, 36.

[56] Daly, 51.

dignity will be kept to an absolute minimum.[57] These principles, stemming from the patient's liberty interest and the quid pro quo grant of other rights when liberty is infringed, form the basis for most of the patients' rights concepts that will be addressed in this paper, i.e., the right to treatment, the right to refuse treatment, the right to the least restrictive alternative, and informed consent.[58]

Right to Treatment

A right to treatment was the focus of many of the early lawsuits against mental health facilities (O'Conner, v. Donaldson, 1975; Wyatt v. Stickney, 1971; Welsh v. Likens, 1974).[59] Plaintiffs in these cases felt that patients in institutions were not receiving adequate treatment. The right to treatment stems from the opinion that to deprive a person of liberty by placing them in an institution because they need treatment, and then failing to provide that treatment, is a violation of the due process provision of

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[57]Elyn R. Saks, "The Use of Mechanical Restraints in Psychiatric Hospitals" The Yale Law Journal 95 (1986): 1841, reprinted in Mental Health Law Project, 411.

[58]Walker and Peabody, 571.

[59]Leonard S. Rubenstein, "Treatment of the Mentally Ill: Legal Advocacy Enters the Second Generation," American Journal of Psychiatry 143 (October, 1986): 1265.

the Fourteenth Amendment.[60]

In Rouse v. Cameron, 1966, Judge Bazelon defined treatment as,

> not only the contacts with a psychiatrist but also activities and contacts with the hospital staff designed to cure or improve the patient. The hospital need not show the treatment will cure or improve but only that there is a bona fide effort to do so. This requires the hospital to show that initial and periodic inquiries are made into the needs and conditions of the patient with a view to providing him suitable treatment for him [or her], and that the program provided is suited to his [or her] particular needs. Treatment that has therapeutic value for some may not have such value for others. For example it cannot be assumed that confinement in a hospital is beneficial environmental therapy for all.(p. 456)[61]

The American Psychiatric Association (APA) defines treatment,

> to include active intervention of a psychological, biological, physical, chemical, educational or social nature where application of the individual treatment plan is felt to have a reasonable expectation of improving the patient's condition.[62]

The law requires treatment to consist of more than medication alone and be comprised of actions that can be

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[60] Rudolph Alexander, "The Right to Treatment in Mental and Correctional Institutions," Social Work 34, no. 2 (1989): 109.

[61] Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966), quoted in Alexander, 109-110.

[62] American Psychiatric Association, "Task Force Report on the Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded" American Journal of Psychiatry 134 (March, 1977): 354-355, quoted in Sadoff, Legal Issues, 32.

reasonably expected to alleviate the patient's condition.[63]

The right to treatment has been extended to include people charged with committing a crime, but found not guilty because of mental illness. The logic is that a person cannot be punished for being mentally ill. Confinement in an institution without treatment that could be expected to improve one's condition results in punishment to the individual, and consequently is disallowed.[64] A court case in Texas, (Ruiz v. Estelle, 1980, p. 1332) found that mentally ill prison inmates have a right to have more treatment options than just medication, including counseling, group therapy, individual psychotherapy, or assignment to constructive activities.[65]

Historically, treatment has been lacking in public hospitals, with patients having little contact with professional staff.[66] Walker and Peabody suggest that lawyers for plaintiffs look for the following evidence to prove that treatment is lacking in psychiatric facilities,

> absence of adequate admissions criteria, evaluations, treatment plans and records;
>
> absence of adequate treatment and programming staff;

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[63] Sadoff, Legal Issues, 32.

[64] Alexander, 110.

[65] Ruiz v. Estelle, 679 F.2d 1115 (5th cir. 1980); quoted in Alexander, 111.

[66] Brakel, Parry, and Weiner, 29.

> excessive resident idleness which leads to mental and physical deterioration;
>
> use of restraints, seclusion, and drugs on a non-circumscribed, non-controlled basis; drug use will be closely reviewed;
>
> absence of specialized services in the areas of medicine, psychology, psychiatry, occupational, physical and group or individual therapy; speech and hearing, social work and direct care services;
>
> absence of adequate procedures and periodic reviews of resident progress and status.[67]

A Court may use this evidence to conclude that conditions of hospitalization not only deprive a person of a right to treatment, but that he/she is harmed by conditions that exacerbate mental illness by causing regression and deterioration of mental faculties and life skills.[68]

A fundamental problem with this right exists in deciding what constitutes an adequate course of treatment for a particular patient.[69] It is widely acknowledged that psychiatric treatment is very unspecific[70] and lacking in data about the effectiveness of most forms of therapy.[71]

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[67] Walker and Peabody, 572.

[68] Ibid.

[69] Martin Roth, "The Historical Background: The Past 25 Years Since the Mental Health Act of 1959," in Psychiatry, Human Rights, and the Law eds., Martin Roth and Robert Bluglass (New York: Cambridge University Press, 1985), 5.

[70] Barry A. Martin, "The Reliability of Psychiatric Diagnosis," in eds., Webster, Ben-Aron, and Hucker, 68.

[71] Jay Katz, "Disclosure and Consent in Psychiatric Practice: Mission Impossible," in Law and Ethics in the Practice of Psychiatry, ed., C. Hoffling (Brunner/Mazel, 1981), reprinted in Mental Health Law Project, 470.

Conger et al., report that the focus of the courts seems to be on treatment that is appropriate and individualized, not necessarily that which is the best treatment available.[72] Furthermore, this right can run into substantial problems in implementation, particularly because of funding limitations.[73] However, a number of court cases have found that a lack of resources is no excuse for failing to provide necessary treatment.[74]

The Right to Refuse Treatment

The notion that patients in psychiatric facilities should receive treatment for their disability has not been disputed by psychiatry.[75] But it was not long after the right to treatment was articulated that mental health law became confused by the recognition of a patient's right to refuse treatment.[76] The medical profession found this to be absurd, arguing that the right to treatment and the right

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[72]Rob Conger et al., Mentally Ill Offenders, A Training and Resource Guide (Salt Lake City, UT: Utah State Division of Mental Health and University of Utah, 1987), 58.

[73]Daly, 54.

[74]Phil Brown, "The Mental Patients' Rights Movement and Mental Health Institutional Change" International Journal of Health Services 11, no. 4 (1981): 527; and Richard T. Crow, "The Rights and Treatment of Prisoners" in Preservation of Client Rights, eds. Gerald T. Hannah, Walter P. Christian, and Hewitt B. Clark (New York: The Free Press, A Division of Macmillan Publishing Co., Inc.), 384.

[75]Milner, 36.

[76]Roth, 55.

to refuse treatment cannot be implemented at the same time. They argued that it was illogical for the courts to involuntarily commit someone to an institution for treatment and then allow them to refuse to accept the prescribed treatment.[77] The APA calls this right a cruel paradox that turns psychiatrists into jailers.[78] Barton and Barton cite a number of problems posed when patients refuse treatment,

> loss of credibility of physicians and mental health workers before the courts and lack of confidence in their therapeutic interventions;
>
> the hazard of treating patients by alternative methods that are not medically indicated;
>
> the prolongation of hospitalization from days to weeks and months;
>
> an increase in disability and chronicity;
>
> disruption of the patient-therapist dyad, with loss of confidence and the inclusion of an advocate or independent negotiator; and
>
> increased cost of care (longer hospitalization, court costs, legal fees, guardianship, and delay of the patient's return to earn a living).[79]

Opponents of the right to refuse treatment argue that it amounts to nothing more than a right for mentally ill people

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[77]Robert L. Sadoff, "Patient Rights Versus Patient Needs: Who Decides?" Journal of Clinical Psychiatry 44, no. 6 (Sec. 2, 1983): 28.

[78]The American Psychiatric Association, Issues in Forensic Psychiatry (Washington D.C.: American Psychiatric Press, Inc., 1984), 65-66.

[79]Barton and Barton, 218.

to remain psychotic.[80]

The right to refuse treatment has been litigated in a number of lawsuits in state and federal courts (e.g., Price v. Sheppard, 1976; Rennie v. Klein, 1978; and Rogers v. Okin, 1979). These lawsuits have not authoritatively delineated the rights of patients to refuse treatment.[81] For the most part, the law seeks to protect people from unwanted intrusions into their body integrity, personal autonomy, and privacy.[82] The law considers civilly committed patients to be mentally competent to make a decision to accept or reject treatment, unless a specific finding has been made that they are incompetent to make such a decision.[83]

The major area of disagreement in the right to refuse treatment concerns the administration of psychotropic medications.[84] There have been lawsuits over the use of psychosurgery and electro-convulsive therapy with the results leaving little doubt that these practices will be

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[80] Robert D. Miller, "Involuntary Commitment: Legal Versus Clinical Paternalism," in ed., Rachlin, 17.

[81] Ralph Reisner, 1987 Supplement to: Law and the Mental Health System: Civil and Criminal Aspects (St. Paul, MN: West Publishing Co., 1987), 69.

[82] Brakel, Parry, and Weiner, 342.

[83] Ibid.

[84] Seymour L. Halleck, The Mentally Disordered Offender (Rockville, MD: U.S. Department of Health and Human Services, National Institute of Mental Health, 1986), 98.

closely regulated by the Courts.[85] But medications are seen differently by legal professionals who tend to view them as mind altering, and medical professionals who tend to view them as mind-normalizing.[86] Most psychotropic medications have the potential to cause unpleasant and sometimes permanently disabling side-effects in those who take them,[87] and have been prescribed abusively in some institutions.[88] Others argue that the risk of these medications have been overemphasized, and that they are the best available treatment for most seriously mentally ill patients.[89]

The APA reports that behind much of the concern over the right to refuse medications is a "fundamental dissatisfaction with the quality of care in some mental health facilities."[90] Sadoff agrees, arguing that psychiatry tends to over-rely on medication as a treatment:

> The argument for this [right to refuse treatment] is that treatment is generally considered to mean a comprehensive treatment program including milieu

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[85] Brakel, Parry, and Weiner, 349-350.

[86] Mills, Cummins, and Gracey, 49.

[87] John G. Malcolm, Treatment Choices and Informed Consent (Springfield, IL: Charles C. Thomas Publisher, 1988), 13.

[88] Brakel, Parry, and Weiner, 341.

[89] Mills, Cummins, and Gracey, 44.

[90] American Psychiatric Association, Division of Government Relations, "APA Resource Document: Right to Refuse Medication" State Update, December 1989.

> therapy, psychotherapy, medication, nursing care, and other forms of treatment. No one appears to be arguing against any of the other forms of treatment except medication, especially if the patients are not properly observed, monitored, and treated. It is this particular concern that seems to be the issue at the present time. Thus, providing proper treatment with medication would result in providing patients with their right to adequate treatment and their right to refuse medication if they are competent and if they are not imminently violent. The right to refuse in such cases may be viewed as an integral part of the patient's right to adequate care and treatment. Certainly, the refusal of medication has led in some cases to a more precise manner of treatment, including other specific forms of nonchemical therapy that help a patient deal with his concerns and his fears.[91]

It does not seem unreasonable that forms of treatment besides medication should be available for patients. Yet, medication is regarded as the key approach to treating violent patients.[92] Once medication has reduced a patient's psychotic symptoms, other forms of treatment, such as psychotherapy, are more likely to be successful.[93]

The right to refuse treatment applies not only to civilly committed patients, but to those committed to psychiatric facilities through the criminal court process. Mentally disordered offenders, just like civilly committed patients, have a right to the least intrusive form of treatment available. Generally, the rule is that if the

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[91] Sadoff, Legal Issues, 38.

[92] J. P. Tupin, "The Violent Patient: a Strategy for Management and Diagnosis" Hospital and Community Psychiatry 34 (January, 1983): 37-40.

[93] Daly, 67.

patient presents no immediate danger, their refusal to take medication must be respected.[94]

The courts have customarily granted psychiatrists the right to administer medication in the case of an emergency.[95] The problem arises in determining just what constitutes an emergency. It clearly includes behavior that presents an imminent danger such as assaults or self-abuse. But what about destruction of property, or a deterioration of the patient's condition? In these areas the courts have not ruled definitively. Perhaps the clearest definition is found in the 1979 case of Rogers v. Okin. In this case the Federal Court of Appeals determined that an emergency consists of those situations in which immediate action is required to prevent either physical harm to an individual or a deterioration of the patient's mental health.[96] Yet medication cannot be continued after the emergency has passed if the patient continues to refuse.[97] In a model law written for the American Psychiatric Association, Stromberg and Stone suggest defining emergencies broadly:

> a situation in which the patient exhibits substantial behavior that is self-destructive or assaultive, threatens significant damage to

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[94] Halleck, 98.

[95] Brakel, Parry, and Weiner, 344.

[96] Ralph Reisner, Law and the Mental Health System: Civil and Criminal Aspects (St. Paul, MN: West Publishing Co., 1985), 450.

[97] Brakel, Parry, and Weiner, 344.

> property of others, or indicates that the patient is suffering extreme anxiety amounting to panic or sudden exacerbation of his severe mental disorder.[98]

One other area frequently coming under legal scrutiny on the basis of a patient's right to refuse treatment is behavioral modification programs. This treatment consists of specific actions that are taken to alter specific behaviors. Most techniques that are employed in this treatment are not offensive or abusive and consequently remain unregulated. However, aversive conditioning, where an unpleasant experience or sensation is imposed each time the patient exhibits inappropriate behavior, has been the subject of a number of lawsuits. In some instances, this form of behavioral modification may be considered to be a form of cruel and unusual punishment. The law has determined that patients have the right to withdraw consent for such treatment at any time.[99]

The right to refuse medications and other forms of treatment will continue to be debated at length until a definitive ruling on this issue is handed down by the courts. As will be discussed in the next chapter, some states have enacted statutes to address this dilemma. Some authors have suggested that the problem is not as great as

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[98]Clifford D. Stromberg and Alan A. Stone, "Statute, A Model State Law on Civil Commitment of the Mentally Ill" in American Psychiatric Association, Issues in Forensic Psychiatry, 78.

[99]Brakel, Parry, and Weiner, 350-351.

the amount of litigation over this issue would indicate. It can be argued that most patients eventually comply with their prescribed medication and that funding and resource problems have a much more detrimental impact on the mental health system than the right to refuse treatment.[100] Nevertheless, this is a major issue of concern to mental health administrators and clinicians.[101] Mills, Cummins, and Gracey state that administrators face a three-part task: "Keeping abreast of the developing case-law in this area; ensuring compliance with the law; and dealing with clinicians' concerns about treatment efficacy."[102] Administrators need to develop clear policy guidelines in this area with the assistance of a legal expert.[103]

Informed Consent

Concern over the issue of informed consent has increased in recent years as patients have sought to become more involved in the treatment decision-making process.[104] This issue is closely tied to the right to treatment and the right to refuse it. Patients have a right to know what treatment alternatives exist and to make an informed

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[100]Ibid, 348-349.

[101]Kerr and Roth, 93-94.

[102]Mills, Cummins, and Gracey, 43.

[103]Barton and Barton, 219.

[104]Malcolm, 4.

decision whether to accept or reject any particular alternative. In psychiatry, the issue of informed consent usually centers on treatments that are considered intrusive, e.g., psychotropic medication, electro-convulsive therapy.[105] Generally, the more intrusive the treatment procedure, the greater the need for informed consent.[106]

The doctrine of informed consent imposes two duties on physicians: (1) they must disclose relevant information to the patient; and (2) they must obtain the patient's consent before administering treatment.[107] Informed consent is defined by the American Psychiatric Association to mean,

> a knowing and voluntary decision to undergo treatment, evidenced in writing, and made by a person who has the capacity to make an informed decision, after staff of the treatment facility have explained to the person the nature and effects of the proposed treatment.[108]

Many physicians argue that these procedures create a legal ploy to trap them, and can cause the patient great anxiety, resulting in their refusal to accept necessary

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[105]Conger et al., 79.

[106]Joyce K. Laben and Colleen P. McLean, Legal Issues and Guidelines for Nurses Who Care for the Mentally Ill (Thorofare, NJ: SLACK Inc., 1984), 12.

[107]Malcolm, 61.

[108]American Psychiatric Association, "American Psychiatric Association Guidelines for Legislation on the Psychiatric Hospitalization of Adults" As approved by the Assembly of District Branches, October, 1982, Board of Trustees, December, 1982, American Psychiatric Association, reprinted in American Psychiatric Association, Issues in Forensic Psychiatry, 35.

medical treatment.[109] Others cite the inability of many mental patients to rationally comprehend the information put to them in this process.[110] Legally, patients are presumed competent to manage their own affairs unless there has been a specific determination of incompetency.[111] Sadoff cynically notes that physicians usually regard patients to be competent if they agree to the procedures recommended by them, but incompetent if they disagree.[112]

Laben and McLean describe four elements of informed consent:

1. An individual must be mentally competent and understand the procedures to which he is consenting.

2. The individual must have enough information on which to base a decision, including material risks A risk is considered material when a reasonable person would attach significance to the risk or cluster of risks in deciding whether or not to forgo the proposed therapy.

3. There should also be a description of the available alternatives to the proposed treatment and the "dangers inherently and potentially involved in each.

4. It should be noted that consent can be withdrawn at any time.[113]

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[109]Malcolm, 59.

[110]Laben and McLean, 12.

[111]Ibid.

[112]Robert L. Sadoff, "Competence and Informed Consent" in ed., Rachlin, 32.

[113]Laben and McLean, 12.

There are exceptions to this doctrine. The first is in an emergency where the patient's condition could worsen without treatment, and where the benefit of treatment outweighs the risks.[114] A second exception occurs when a patient waives his right to be informed.[115] A third exception applies when a physician feels that disclosure could be a detriment to the patient's well-being.[116] Mental health practitioners are cautioned against over-application of this last exception.[117]

The issues of informed consent apply in the forensic setting just as they do in others areas of psychiatric medicine. As will be explained later in this chapter, patients in forensic unit generally have the same rights as other psychiatric patients. Also, there are arguments that informed consent practices can be beneficial to the treatment process in the forensic setting.[118] It allows the patient to be seen as an autonomous individual with responsibility for their own actions, and its use can employ negotiation and compromise as a means to break down resistance to treatment.[119]

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[114]Ibid.

[115]Malcolm, 90.

[116]Ibid, 94.

[117]Laben and McLean, 12.

[118]Kerr and Roth, 28-29.

[119]Ibid.

Least Restrictive Alternative

The doctrine of "least restrictive alternative" is an important principle of mental health law. It has numerous applications: to the types of treatment that can be rendered;[120] restrictions on personal freedoms that can be imposed during the course of psychiatric hospitalization; emergency interventions that can be used;[121] and the alternatives to hospitalization itself.[122] This doctrine has its foundation in constitutional law and generally holds that, "the government should not broadly infringe on liberties when the government's end could be achieved by a means which infringes on liberties in a less restrictive manner."[123]

This doctrine has been applied to mental health practices in a number of cases (e.g., Phillipp v. Carey, 1981; Covington v. Harris, 1969; Eubanks v. Clarke, 1977).[124] As in other areas of mental health law, the doctrine seems to be difficult to put into practice, largely

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[120]Susan H. Garritson and Ann J. Davis, "Least Restrictive Alternative: Ethical Considerations" Journal of Psychosocial Nursing 21, no. 12 (1983): 17-23.

[121]Paul S. Applebaum, "Legal Considerations in the Prevention and Treatment of Assault" in Assaults Within Psychiatric Facilities, eds., John R. Lion and William H. Reid, (New York: Grune and Stratton, 1983), 180.

[122]Wexler, Mental Health Law, 121.

[123]Ibid.

[124]Brakel, Parry, and Weiner, 262-270.

because there is no means for determining what actually is least restrictive for a given case.[125] For example, in an emergency intervention it is not clear whether placement of the patient in seclusion, application of physical restraints, or injection of medication is least restrictive.[126] It can be argued that the least restrictive doctrine may conflict with the most clinically beneficial treatment.[127] Stromberg and Stone suggest that this doctrine should consider the treatment approach that will assist the patient in getting well in the shortest period of time.[128] In many instances the courts defer to professional judgment in this matter as long as it can be demonstrated that consideration of the least restrictive alternative, whether to a patient's placement in the hospital or to a treatment intervention, has been given.[129]

The doctrine of the least restrictive alternative has significant application to forensic psychiatric facilities. Court cases have made it clear that movement of patients to more secure settings, such as from a general psychiatric ward to a maximum security ward (forensic facility), are

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[125]Wexler, Mental Health Law, 145.

[126]David B. Wexler, "Seclusion and Restraint: Lessons From Law, Psychiatry, and Psychology" International Journal of Law and Psychiatry 5 (1982): 288.

[127]Mills, Cummins, and Gracey, 48.

[128]Stromberg and Stone, 76.

[129]Laben and McLean, 54-55.

considered a substantial infringement of an individual's liberty. Such actions can be taken only when the state can show a compelling need to do so, and when a consideration of less restrictive alternatives to this action has been made.[130] Due process protections of the Fourteenth Amendment to the Constitution should be used.[131] Jones v. Robinson, 1971, provides guidelines (summarized here) for due process procedures to be used in making a determination to transfer a patient to a maximum security setting:

1. An inquiry should be held by an independent official of the hospital;

2. Witnesses to the incident prompting the transfer should be interviewed;

3. The patient must be allowed to respond to the allegations;

4. If it will not adversely affect the patients involved, cross-examination and confrontation of witnesses should be allowed;

5. A person, not necessarily a lawyer, should be appointed to assist the accused patient in the inquiry;

6. A record of the proceedings should be kept and the reasons for the decision should be recorded; and

7. The decision of the investigator should be reviewed and affirmed by the superintendent of the hospital.[132]

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[130]Brakel, Parry, and Weiner, 263-265.

[131]Edward B. Beis, Mental Health and the Law (Rockville, MD: Aspen Systems Corp., 1984), 193.

[132]Jones v. Robinson, 440 F.2d 249 (D.C. Cir. 1971) reprinted in Reisner, Law and the Mental Health System, 472-473.

It is also strongly suggested that patients confined to a restrictive setting have their treatment reviewed periodically to ensure that their placement is actually the least restrictive setting necessary.[133]

Individualization of Treatment

One of the procedures commonly employed in state hospitals as well as other bureaucratic organizations is to establish policies based on a need to manage large groups or classes of patients.[134] Such policies may restrict or limit the rights and privileges of everyone belonging to that class. Many court decisions and state statutes ban such practices.[135] Staff members often believe that mentally ill offenders should be treated differently from civilly committed patients in terms of the rights that they are allowed and the conditions of their confinement.[136] Laben and McLean caution against such practices,

> Any recommendations that propose to treat the mentally ill defendant or prisoner in a manner that deviates from the regular procedures should be suspect. History illustrates extensive abuse when deviation from the use of regular procedures

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[133]Brakel, Parry, and Weiner, 267.

[134]Robert M. Daly, "Demise of a Hospital: Democratic-Autocratic" in State Mental Hospitals: Problems and Potentials, ed., John A. Talbott (New York: Human Sciences Press, 1980), 111.

[135]Hannah, Christian, and Hewitt, 8.

[136]Mark J. Mills and others, "Mental Patients Knowledge of In-Hospital Rights" American Journal of Psychiatry 140, no. 2 (February, 1983): 225-228.

is permitted.[137]

In Montana, all patients' rights, except those applicable to admission and discharge, apply to patients admitted through the criminal justice system, just as they do to civilly committed, involuntarily and voluntarily admitted patients.[138]

All too often, restrictions are placed on groups of patients and justified as necessary for treatment, management, or security.[139] Actions of this type will be carefully scrutinized by the courts with the burden on the administration to justify the imposition of the restriction by specifically detailing the nature of the danger or problem concerned.[140] Administrators must be able to show a compelling need for taking actions that limit the rights of certain classes of patients. Administrators of forensic facilities often unnecessarily place restrictions on all mentally disordered offenders based on what is appropriate for only the most dangerous of these individuals.[141] Such practices should be carefully scrutinized to ensure that

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[137]Laben and McLean, 74.

[138]Mary Gallagher, Your Mental Health Rights in Montana (Helena, MT: Montana Advocacy Program, 1989), v.

[139]Bruce J. Ennis and Richard D. Emery, The Rights of Mental Patients (New York: Avon Books, 1978), 142-143.

[140]Brakel, Parry, and Weiner, 256.

[141]Park Elliot Dietz and Richard T. Rada, "Interpersonal Violence in Forensic Facilities" in eds., Lion and Reid, 47-59.

restrictions are imposed only on those for whom it can be demonstrated to be necessary.

Seclusion and Restraint

Seclusion and restraint are intervention procedures used in mental health settings to control violent or disruptive behavior or to modify inappropriate behavior.[142] Seclusion can be defined as, "placing a person in isolated confinement."[143] Restraint, by contrast is, "a means of restricting a patient's ability to react physically by temporarily limiting his freedom of body and limb movement by the use of physical or mechanical restraints, such as cuffs, straps, mittens, or braces."[144] These practices are said to be a substantial infringement of a patient's liberty and dignity interests.[145] Many mental health professionals consider seclusion and restraints to be necessary procedures that are needed to control the violent or extremely disruptive behaviors of some patients.[146] Other

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[142]Bruce B. Way and Steven M. Banks, "Use of Seclusion and Restraint in Public Psychiatric Hospitals: Patient Characteristics and Facility Effects" Hospital and Community Psychiatry 41, no. 1 (January, 1990): 75.

[143]Brakel, Parry, and Weiner, 272.

[144]Reisner, Law and the Mental Health System, 471.

[145]Saks, 415.

[146]Thomas F. Gutheil and Kenneth Tardiff, "Indications and Contraindications for Seclusion and Restraint" in The Psychiatric Uses of Seclusion and Restraint, ed., Kenneth Tardiff (Washington D.C.: American Psychiatric Press, 1984), 11-12.

professionals and many lay people dispute the need for their use and cite instances where these practices have been abused in institutions.[147] A number of states have enacted statutes to regulate the use of seclusion and restraints.[148] However, uniform standards are lacking nationwide.[149] The use of these procedures will be addressed here briefly because of the significant amount of controversy involved in their use in institutions.

Gutheil and Tardiff provide the following guidelines for using seclusion and restraint procedures:

1. to prevent imminent harm to the patient or to other persons when other means of control are not effective or appropriate;

2. to prevent serious disruption of the treatment program or serious damage to the physical environment; and

3. to assist in treatment as part of ongoing behavior therapy.

Additionally, two other guidelines apply to the use of seclusion:

4. to decrease the stimulation a patient receives; and

5. to comply with the patient's request.[150]

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[147]Brakel, Parry, and Weiner, 271.

[148]Laben and McLean, 33.

[149]John R. Lion and Paul H. Soloff, "Implementation of Seclusion and Restraint" in ed., Tardiff, 21.

[150]Thomas F. Gutheil and Kenneth Tardiff, "Indications and Contraindications for Seclusion and Restraint" in Tardiff, ed., 12.

Courts have determined that patients have an interest in safety, freedom from bodily restraint, and to a lesser extent, habilitation.[151] However, these rights may come into conflict. Generally, the courts have sought to defer to clinical judgment for a determination on when the use of these procedures is necessary.[152] This means that the decision of a mental health professional will be presumed to be valid unless it is clearly shown that it departed from standard clinical practice. The courts have also defined a "professional" in broad terms: for example, "a person competent, whether by education, training, or experience to make the particular decision at issue."[153]

Brakel, Parry, and Weiner summarize the findings of several court decisions to suggest guidelines for mental health professionals to follow in the use of seclusion and restraints:

1. restraints and seclusion can only be used when the disabled person could harm himself or others and there is no less restrictive alternative available to control this danger;

2. restraints and seclusion may be imposed only pursuant to written orders;

3. such orders must be confined to limited time periods;

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[151]David B. Wexler, "Legal Aspects of Seclusion and Restraint" in ed., Tardiff, 112.

[152]Ibid, 113.

[153]Youngberg v. Romeo, 102 Supreme Ct 2452 (1982) reported in Wexler, "Legal Aspects of Seclusion and Restraint," 113.

4. the patient's condition must be charted at regular time intervals; and

5. if orders are extended beyond the initial period, the extension must be authorized by a doctor, often with review by the medical director or superintendent required.[154]

Wexler cautions against using seclusion or restraint as a punishment because people cannot be punished legally for behavior that occurs as a result of a mental illness.[155] Restraint and seclusion procedures may be considered intensive care treatments requiring a high degree of attention and justification by mental health professionals.[156] Clinicians and administrators have to ensure that these procedures impose no more restriction on the patient than absolutely necessary. Using restraints only as a last resort and requiring substantial accountability for their use is both good clinical practice and a legal requirement.

Montana's State Constitution and Mental Health Statutes

In addition to the U.S. Constitution and federal statutes, the rights of mental patients in Montana are protected by the State Constitution and a series of state statutes. Montana's Constitution contains a number of rights, such as the right to privacy, the right to dignity,

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[154]Brakel, Parry, and Weiner, 273.

[155]Wexler, "Seclusion and Restraint: Lessons," 293.

[156]Paul H. Soloff, "Seclusion and Restraint" in Lion and Reid, 261-262.

and the right to know, that demonstrate the commitment of the citizens of the state to individual liberty and freedom. Montana's constitution is also unique among the 50 states in that it contains a clause specifically addressing the civil rights of institutionalized patients:

> Persons committed to any .... institutions shall retain all rights except those necessarily suspended as a condition of commitment. Suspended rights are restored upon termination of the state's responsibility.[157]

The Montana Code Annotated contains two sections of statutes specifically pertaining to mental health. Title 46, Chapter 14, MCA, addresses issues of mental disease or defect related to criminal proceedings. The Mental Commitment and Treatment Act (Title 53, Chapter 21, MCA) addresses the commitment of seriously mentally ill individuals to in-patient settings and their treatment in such facilities. Those statutes specifically addressing the rights of patients in mental health facilities are found in the Mental Commitment and Treatment Act (see appendix A). As noted earlier, many of these statutes have been adopted from the standards for treatment set by the Court in the Wyatt case. For the most part, they are self-explanatory and specific in defining the duties and responsibilities of the state in the care and treatment of patients in mental

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[157]Montana Constitution, article XII 3(2) quoted in Alan Meisel, "The Rights of the Mentally Ill Under State Constitutions" Law and Contemporary Problems 45, no. 7 (1982); reprinted in Mental Health Law Project, 1003.

health facilities.

Enforcement of Rights

As has been shown, in recent years patients' rights have been embodied in statutes following a long history of court battles in many states. But how are these statutes to be enforced without further litigation? Rubenstein notes, "Having rights spelled out in statute is meaningless unless there is an enforcement mechanism."[158] Following enactment of legislation, many psychiatric facilities have simply posted a "Mental Patient's Bill of Rights" sign and claimed to be concerned about these issues without ever analyzing their policies and practices.[159] As Callahan et al. note, a change in statutes does not mean that the intended changes in system practices will occur.[160]

Enforcement of patients' rights is the responsibility of clinicians and administrators who can be held liable for negligent or malicious violations of statutes or constitutional provisions.[161] Barton and Barton also state that enforcement of patients' rights is the responsibility

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[158]Leonard S. Rubenstein, "APA's Model Law: Hurting the People It Seeks to Help" Hospital and Community Psychiatry 36, no. 9 (1985), reprinted in Mental Health Law Project, 261.

[159]Brown, 523-539.

[160]Lisa Callahan et al., "The Impact of Montana's Insanity Defense Abolition," (Delmar, NY: Policy Research Associates,July 1988), In Press.

[161]Wald and Friedman, 45.

of administrators:

> The responsibility for the enforcement of patient rights rests with the state's mental health authority and with the administrator of every mental health facility. A state's Department of Mental Health is given the responsibility for developing rules and regulations essential to achieving its assigned mission. It is the facility administrator who puts policy into operation and then assures that patient rights are preserved.[162]

Christian believes that patients' rights and good treatment practices go hand-in-hand:

> Practitioners and administrators alike must come to understand that there is not a dichotomy between client rights and good treatment. Rather, therapeutic practices of good quality encompass a sensitivity to the rights of clients as individuals in a free society. Every area of mental health programming must have goals, objectives, performance standards, procedures, and evaluation systems that protect client rights in conjunction with the delivery of the highest possible quality of services.[163]

Yet administrators and organizations sometimes fail or are unable to exercise their responsibilities in this area. When this happens, the law allows others to step in to ensure that mental health systems comply with patients' rights requirements. The U.S. Department of Justice can bring action against states that deny institutionalized patients their constitutional rights under the 1980 Civil

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[162]Barton and Barton, 210.

[163]Walter P. Christian, "Protecting Clients' Rights in Mental Health Programs" Administration in Mental Health, 11, no. 2 (Winter, 1983), 115.

Rights for Institutionalized Persons Act.[164] Such actions in a number of states have resulted in increased staffing levels; controls over the use of medications; improvements in physical environments; restrictions on the use of seclusion and restraint; provision of adequate food, clothing, and medical care; and improved record keeping.[165]

Advocacy programs are also a means for enforcing patients rights. Most, if not all, states have established, outside of the mental health system, programs for protecting patients' rights.[166] Other programs exist within the mental health system. These differences will be discussed in the next chapter. In general, advocacy programs serve three functions:

1. to educate and train the facility staff properly and to implement policies and procedures that recognize and protect patients' rights;

2. to establish an additional procedure to permit the speedy resolution of problems, questions, or disagreements that occur and that may or may not be based on legal rights; and

3. to provide access to legal services when a patient's legal right has been denied.[167]

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[164]Paul S. Applebaum, "Resurrecting the Right to Treatment" Hospital and Community Psychiatry 38, no. 7 (July, 1987), 704.

[165]Ibid.

[166]Paul S. Applebaum, "The Rising Tide of Patients' Rights Advocacy" Hospital and Community Psychiatry 37, no. 1 (January, 1986), 9-10.

[167]Laben and McLean, 41.

The "Protection and Advocacy for Mentally Ill Individuals Act of 1986" assists states in setting up Protection and Advocacy systems for the purpose of "ensuring" the protection and rights of people with mental illness, and investigating reports of abuse and neglect to this population.[168]

The State of Montana has an advocacy program that is an agency of the Governor's Office, the Mental Disabilities Board of Visitors (MDBV).[169] This board consists of five members appointed by the Governor, with staff members located in Warm Springs and Helena. The duties of this agency are to:

1. Make on-site visits to mental health facilities and audit or investigate: treatment plans and diagnostic information; medications; use of seclusion, restraint, and other extraordinary measures; consumer issues; environmental concerns; and reports of abuse and/or neglect;

2. assist patients or residents of facilities in resolving any grievance or rights related concerns regarding commitment and/or treatment;

3. respond to requests from patients and families for the review of care, treatment, and rights related issues; and

4. provide educational and technical assistance to groups and individuals on patients' rights

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[168]David Ferlinger and Steven J. Schwartz, "Protection and Advocacy for Mentally Ill Individuals Act of 1986, Implementation Analysis of the Act," (1986, p. 3) reprinted in Mental Health Law Project, 11.

[169]Gallagher, i.

issues.[170]

The Legal services program of the MDBV provides legal representation for patients at the Montana State Hospital.[171] Additionally, there are other non-government organizations, e.g., Montana Advocacy Program, Mental Health Association of Montana, Montana Alliance for the Mentally Ill, that provide advocacy services in the State.

Litigation is often used as a means to force mental health systems to comply with patients' rights standards.[172] The results of litigation have substantially improved the quality of services provided by mental health agencies.[173] The standards imposed by litigation assist administrators and clinicians in evaluating their own services and in requesting additional resources from state legislatures.[174] These standards have also improved the job performance and satisfaction of many mental health workers who now have clearer expectations of what is

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[170]Mental Disabilities Board of Visitors, Fact Sheet.

[171]Ibid.

[172]Miller, 15.

[173]Mills, Cummins, and Gracey, 41.

[174]James E. Favell, Judith E. Favell, and Todd Risley, "A Quality-Assurance system for Ensuring Client Rights in Mental Retardation Facilities" in eds., Hannah, Christian, and Clark, 348.

expected of them.[175]

Yet, there are significant problems in relying on litigation as a means of enforcing patient rights standards. Litigation can only be undertaken after a problem has occurred. It would be far more constructive to prevent disputes over rights issues from occurring than to have to defend one's actions in a lawsuit.[176] The results of litigation also do not guarantee that patients will receive quality treatment. Much time and energy end up being spent by staff members in documenting their activities and defending their actions instead of providing improved care and individualized treatment.[177] Even in the famous Wyatt case, full compliance with the judicially mandated standards was never achieved.[178] Kopolow notes,

> Litigation and judicial intervention into the mental health system have led to mass discharges without adequate aftercare planning, retarded the development of alternative care programs by redirection of funds into improving existing institutions and facilities, and caused the departure of many mental health professionals who did not wish their names immortalized in a lawsuit or who chose not to work under pressures of

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[175]Susan A. Ostrander, "The Impact of Clients' Rights Legislation on Hospital Staff" Administration in Mental Health 9, no. 1 (Summer, 1982): 257-258.

[176]Phil Brown, "The Mental Patients' Rights Movement and Mental Health Institutional Change" International Journal of Health Services 11, no. 4 (1981): 532.

[177]Philip J. Leaf and Michael M. Hold, "How Wyatt Affected Patients" in eds., Jones and Parlour, 49-106.

[178]Ibid.

judicial review or policymaking.[179]

Applebaum believes that more funding is the answer for meeting the needs of the mentally ill, not advocacy programs or judicially mandated standards:

> The improvement of conditions in mental facilities, from the elimination of physical abuse to the provision of better care is highly dependent on the availability of adequate funding for facilities, programs, and staff. This funding is almost nowhere in evidence. One has the sense that advocacy is being embraced as a substitute for adequate funding, an approach that is doomed to failure.[180]

The Courts are also taking a less activist approach to mental health litigation than they were 15 years ago:

> Courts are beginning to recognize that many of the proposed future reforms (particularly those involving the creation of effective community treatment programs) are extremely expensive, and state courts, in which most of this litigation will be heard, are becoming reluctant to make a legislative decision concerning the allocation of scarce resources. The current conservative trend in the country is another factor that may cause the interest of the judiciary in recognizing further rights for socially deviant persons to diminish.[181]

All too often mental health professionals and advocates end up at odds with each other over the status of mental health services. The result is that the two sides are

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[179]Kopolow, 20.

[180]Applebaum, "Rising Tide" 9-10.

[181]Miller, 19.

polarized into a "good guy-bad guy" dichotomy.[182] The real issue should not be a debate over who represents the true interests of the patient or of society, or which should take precedent. Pettifor believes that other factors besides litigation, legislated rights and adopted ethics codes are more important to bring about quality mental health services to institutionalized patients,

> 1. Public and professional education and understanding of both legal rights and ethical principles -- which, it is hoped, results in vigilant commitment to both law and values;
>
> 2. Recognition that, in real life situations, several people may have conflicting rights, that professionals may have legitimate conflicting loyalties, and that in choosing a course of action, all parties may not be satisfied; and
>
> 3. Recognition that, in addition to compliance with the law, there must be an ethical decision-making process to assist professionals in making the best decisions, and a rationale to assist patients in understanding why certain decisions rather than others are made.[183]

Enforcement of patients' rights is a difficult challenge. There are many different interests and issues that must be balanced. Advocates and mental health practitioners must have an understanding of the law in order to set goals for the treatment of institutionalized patients. Instead of

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[182]Jean L. Pettifor, "Patient Rights, Professional Ethics, and Situational Dilemmas in Mental Health Services" Canada's Mental Health 33, no. 3 (September, 1985), 20.

[183]Ibid.

attempting to seek minimal compliance with rights standards, the aim should be to provide quality psychiatric care and treatment targeted at the individual needs of each patient. If that is the goal, compliance with patients' rights laws will not be the volatile problem that it is today.

Chapter Summary

This chapter has presented the results of research into the law that applies to patients' rights in forensic psychiatric facilities. Mental health law is very complex and often unclear, the result of both its short history, and the need to balance the interests of both society and a mentally disabled individual. Many legal tenets of mental health law remain to be better articulated so that their practical application is made more clear. Nonetheless, compliance with patients' rights standards correlates with good clinical practice. It allows people with mental disabilities to exercise appropriate levels of autonomy and responsibility, which is beneficial in helping them to learn how to cope with severe mental illnesses. The goal for professionals should be not to minimally or grudgingly meet patients' rights requirements. It should instead be to provide high standards of care and treatment to the mentally ill. The next chapter will focus on procedures for implementing these major legal standards.

Chapter 3

A Review of the Literature on Patients' Rights Requirements

The purpose of this chapter is to present the findings of library research into methods used in other states to comply with patients' rights requirements in forensic psychiatric facilities. Additionally, recommendations of experts in the field will be presented. This portion of the paper was motivated by a belief that other states face problems complying with patient rights in forensic psychiatric facilities similar to those faced in Montana. Although the research reviewed below indicates that this is the case, it does not provide clear suggestions for solving these problems. There is however, hope for the future. This is in the form of recently release accreditation standards for forensic facilities from the Joint Commission on Accreditation of Health Care Organizations (JCAHCO).[1] These standards will be discussed at the end of this chapter.

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[1]Joint Commission on Accreditation of Health Care Organizations, Accreditation Standards for Forensic Psychiatric Facilities (Chicago: Joint Commission on Accreditation of Health Care Organizations, 1989).

Forensic Psychiatric Facilities Slow to Change

The need to address patients' rights issues prompted many changes in mental health systems during the 1970s and 1980s. However, these changes came about slowly and often grudgingly, particularly in forensic hospitals.[2] Zeigenfuss describes patients' rights, as a "mess" instead of a problem, i.e. "a system of interrelated problems, each of which cannot be understood out of its context."[3] No where in mental health is this more true than in forensic psychiatric facilities where most residents are not only mentally ill but criminal offenders.[4] McPheeters states, "Many of the established practices and procedures which grew out of the days of restrictive custody are no longer needed today, but often remain because of inertia."[5]

It will largely be up to administrators to institute the organizational changes necessary to ensure that programs

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[2]Ibid, 5.

[3]James T. Ziegenfuss, "Conflict Between Patients' Rights and Organizational Needs" Hospital and Community Psychiatry 37, no. 11 (November, 1986): 1086.

[4]William J. Curran, A. Louis McGarry, and Saleem A. Shah, Forensic Psychiatry and Psychology: Perspectives and Standards for Interdisciplinary Practice (Philadelphia: F. A. Davis Co., 1986), 7; and Seymour L. Halleck, The Mentally Disordered Offender (Rockville, MD: U.S. Department of Health and Human Services, National Institute of Mental Health, 1986), 98, DHHS Publication No. (ADM) 86-1471.

[5]Harold L. McPheeters, Implementing Standards to Assure the Rights of Mental Patients (Rockville, MD: U.S. Department of Health and Human Services, National Institute of Mental Health, 1980), 9, DHHS Publication No. (ADM) 80-860.

meet legal standards. Change in state psychiatric hospitals comes slowly, and must be nurtured so that the real purpose of the organization, effective care and treatment of people with mental illness, can move forward. McPheeters encourages administrators to take a more active role in promoting change:

> In the final analysis, the mental health administrators must change their administrative behavior if they are to keep or regain control of the system in which they work. Mental health programs often lack the resources they want and need, and the technology to do as much as they would like. They cannot make a major contribution so long as the American judiciary continues to intervene in the mental health system. While many administrators are understandably bitter about the judicial intrusions that have already taken place, they are not doing enough to prevent them from happening. They must abandon the somewhat lackadaisical administrative practices that have unduly compromised patient rights and treatment in the past. Mental health administrators can and must do better in assuring that standards and procedures are written and monitored regarding patient rights and treatment.[6]

Administrators need to take decisive action to determine how rights compliance is to be achieved. Without administrative leadership, employees are reluctant to give up the authoritarian control they have traditionally exercised over patients. This hinders organizational attempts to comply with patients' rights standards and creates unnecessary conflict.[7] It will only be through the

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[6]Ibid, 10.

[7]Susan A. Ostrander, "The Impact of Clients' Rights Legislation on Hospital Staff," Administration in Mental Health 9, no. 1 (Summer, 1982): 257-267; and Phil Brown,

diligent efforts of mental health administrators that a concern for the rights of patients will filter down through all levels of the workforce.[8]

The Mission of Forensic Psychiatric Facilities

One of the historic problems with forensic psychiatric facilities has been the lack of a well defined mission. It typically has been that of a combination prison and general psychiatric hospital.[9] The lack of a defined mission often creates situations where public and political furor over unusual, but dramatic events such as escapes, force inappropriate policy and program changes.[10] Forensic psychiatric facilities have the dual role of segregating dangerous people from society, and providing them with

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"State Mental Hospital Staff Attitudes Toward Patients' Rights," International Journal of Law and Psychiatry 8 (1986): 423-441.

[8]Douglas R. Wilson and Peter Steibelt, "Patients' Rights and Ethics Committee, Douglas Hospital Centre," Canada's Mental Health 33, no. 3 (September, 1985): 24-27.

[9]Park E. Dietz and Richard T. Rada, "Interpersonal Violence in Forensic Facilities," in Assaults Within Psychiatric Facilities, eds., John R. Lion and William H. Reid, (New York: Grune and Stratton, 1983), 47; and Abraham Heller, "Extension of Wyatt to Ohio Forensic Patients," in Wyatt v. Stickney, Retrospect and Prospect, eds., L. Ralph Jones and Richard R. Parlour, (New York: Grune and Stratton, 1981), 161-172.

[10]Ralph Muxlow, "Analysis of Recent Legal Developments Affecting Mental Health Care Delivery Services to State Prisoners in New Mexico," in Mentally Ill Offender Systems in the Western States, ed., Meridith Davis, (Boulder, CO: Western Interstate Commission for Higher Education, 1983), 70.

psychiatric treatment. Each function places constraints upon the other. The security/treatment dichotomy must be clearly delineated so that the public, administrators, clinicians, and patients understand how each function is intended to interact with the other.[11] Unless a mission is clearly articulated for a forensic psychiatric facility, this dual role will be the source of continued conflict.[12]

Because it is usually not clear whether forensic units should function primarily as prisons for psychiatric patients or as hospitals where mentally ill offenders are treated, many criminal offenders unlikely to benefit from mental health services are admitted to these facilities.[13] Stromberg and Stone argue that all too often criminal offenders with no serious mental disorders are "dumped" on the mental health system under the pretense that they will receive needed "help" in changing their criminal behavior while being retained in a secure environment.[14] But mental

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[11] Joint Commission on Accreditation of Health Care Organizations, 9.

[12] Charlotte A. Kerr and Jeffery A. Roth, Survey of Facilities and Programs for Mentally Disordered Offenders (Rockville, MD: U.S. Department of Health and Human Services, National Institute of Mental Health, 1987), 90, DHHS Publication No. (ADM) 86-1493.

[13] Ibid, 83-84.

[14] Clifford D. Stromberg and Alan A. Stone, "Statute: A Model State Law on Civil Commitment of the Mentally Ill," in Issues in Forensic Psychiatry, ed., American Psychiatric Association (Washington, D.C.: American Psychiatric Press, Inc., 1984), 66.

health workers claim that they cannot provide treatment to people who have as their primary disorder a propensity for criminal behavior.[15] Bloom writes,

> As much as possible, security hospitals and units should function primarily and mainly as mental hospitals and not as "psychiatric prisons." The proper role of these facilities as places for the care and treatment of persons with serious mental disorders will tend to be vitiated and eroded if they are used mainly for purposes of secure confinement. Thus, "hard-to-handle" prison inmates should not be "dumped" in security hospitals. Rather, necessary mental health consultation and services should be provided to correctional institutions.[16]

Patients who are resistive or disruptive to treatment programs create a need for increasingly restrictive security procedures and architecture further diluting the effectiveness of treatment programs.[17] The problem of people being inappropriately placed in mental health facilities by the courts has been noted in Montana,

> He [Dr. James Hamill, former Superintendent, Montana State Hospital] says the hospital staff argues with judges and prosecutors all the time about whether Warm Springs is supposed to be a hospital for treating patients or a place to lock up people and keep them off the street. His solution is for the state to build a separate institution "somewhere between a severe prison and

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[15]Henry J. Steadman, "Prediction at the System Level: Measuring the Presumed Changes in the Clientele of the Criminal Justice and Mental Health Systems," in Dangerousness, Probability and Prediction, Psychiatry and Public Policy, eds., Christopher D. Webster, Mark H. Ben-Aron, and Stephen J. Hucker (New York: Cambridge University Press, 1985), 147-158.

[16]Joseph D. Bloom, "Building a Statewide System for the Mentally Ill Offender," in ed., Davis, 22.

[17]Dietz and Rada, 53.

> a Swan River type of camp" for criminals who need a structured environment but who shouldn't be in the mental hospital mixing with psychotic patients.[18]

Frequently politicians and members of the public express sentiments that criminals who are not clearly psychotic are "beating-the-rap" when placed in a mental health facility.[19] This contributes to public dissatisfaction with both the mental health and criminal justice systems.

The mission for a forensic psychiatric facility will be strongly influenced by the philosophy of its parent agency. A survey of 127 facilities for mentally disordered offenders conducted by Kerr and Roth for the National Institute of Mental Health found that approximately two-thirds of these facilities are operated by mental health authorities, one-forth by corrections authorities, and the remainder by other social service agencies or a joint auspices between corrections and mental health.[20] If the segregation of dangerous people from the public is to be the main priority for facility operations, forensic services may be best governed by a correctional agency. However, if treatment of mental illness is to have priority for this population, a

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[18]Frank Adams, "Warm Springs Superintendent Oversees Hospital," Great Falls Tribune (Great Falls, MT), May 5, 1980.

[19]Gary B. Melton, Lois A. Weithorn, and Christopher Slobogin, Community Mental Health Centers and the Courts, An Evaluation of Community-Based Forensic Services (Lincoln, NB: University of Nebraska Press, 1985), 1.

[20]Kerr and Roth, 35.

mental health department is likely to have more expertise to carry out this mission. In either case the priorities of the organization needs to be clearly articulated to patients, staff, the courts, and the public to minimize conflicts and misperceptions about the content and expected outcome of forensic services.

The mission of forensic psychiatric services is often ambiguous because of competing priorities. Rodenhauser and Heller write that, historically, forensic psychiatric facilities have had three priorities: 1) service to courts (psychiatric evaluations); 2) public safety; and 3) treatment, with treatment always a weak third priority.[21] According to Heller, this ranking of priorities has always reflected the sentiments of the courts and the public,

> Nobody, practically, cared whether these forensic hospital patients ever got treatment. Hardly anybody, for the most part, really cares or not; the concern is more that the patient should not get out, should not be discharged from the institution. So, treatment in a forensic hospital always was a weak third priority, more nominal, more a way of talking.[22]

The mission of a forensic psychiatric facility is also clouded when civilly committed patients are housed on the

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[21] Paul Rodenhauser and Abraham Heller, "Management of Forensic Psychiatry Patients Who Refuse Medication -- Two Scenarios," Journal of Forensic Sciences 29, no. 1 (January, 1984): 240.

[22] Abraham Heller, "Extension of Wyatt to Ohio Forensic Patients," in Jones and Parlour, 167.

same wards as criminally committed patients.[23] The objectives of psychiatric commitment may differ between these two classes of patients with resulting disparities in the way they are treated.[24] Nationally, about fourteen percent of the patients in forensic facilities have been committed through civil commitment proceedings rather than criminal proceedings.[25] A 1983 survey of mentally ill offender systems in the thirteen western states found that mixing these classes of patients in forensic hospitals is common in Arizona, Montana, Nevada, and Wyoming, but not in the other nine states.[26] This practice has been a concern to advocacy groups in Montana who fear that it causes civilly committed patients to be treated like criminals. Legislation to end this practice (H.B. 473, "An Act to Clarify the Rights of Patients Under the Mental Health Code") was introduced during Montana's fifty-first legislative session (1989), but was defeated.[27]

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[23] Steadman, 147.

[24] Joyce K. Laben and Colleen P. McLean, Legal Issues and Guidelines for Nurses Who Care for the Mentally Ill, (Thorofare, NJ: SLACK, Inc., 1984), 67.

[25] Kerr and Roth, 39.

[26] Meredith Davis, "WICHE Survey of Forensic Hospitals in Western States," in ed.,Davis, 89.

[27] Tad Brooks, "Warm Springs Segregation Debated," Independent Record (Helena, MT), February, 14, 1989.

Criminal Court-Order Psychiatric Evaluations

It was noted above that conducting psychiatric evaluations for criminal defendants as ordered by the courts has traditionally been a major priority for forensic hospitals. However, increasingly it is recognized that conducting these evaluations imposes a tremendous burden on the resources of these facilities, usurping their ability to provide treatment to the larger majority of patients.[28] In many states criminal psychiatric evaluations are no longer conducted on an inpatient basis at centralized forensic hospitals. Curran, McGarry, and Shah state,

> It simply does not make any sense at all for criminal defendants to be sent routinely for forensic evaluations (for example, determination of competency to stand trial), when such screening evaluations could be done locally for a fraction of the cost.[29]

As an alternative to conducting criminal psychiatric evaluations on an impatient basis, Melton, Weithorn, and Slobogin advocate using personnel from community mental health centers to perform these services locally. Among the advantages they cite are:

> 1. The opportunity for rampant abuse of the forensic mental health system exists when [evaluation] services are provided on an inpatient basis. Among the potential costs

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[28]Heller, 163; and Saleem A. Shah, "Planning for Forensic Services" in ed., Davis, 21; and Rob Conger and others, Mentally Ill Offenders, A Training and Resource Guide (Salt Lake City, UT: Utah State Division of Mental Health and the University of Utah, 1987), 58.

[29]Curran, McGarry, and Shah, 14.

to defendants are deprivation of constitutional rights to bail and a speedy trial and de facto punishment without due process;

2. A carefully designed community-based forensic evaluation system results in a substantial reduction in inpatient admissions and a corresponding reduction in fiscal costs.

3. Designation of community mental health centers as the source of criminal forensic evaluations may have the side effect of increasing interaction between the mental health center and legal authorities on other issues.[30]

Other alternatives to the practice of conducting evaluations on an inpatient basis at a central forensic hospital include: (1) conducting them on an outpatient basis; (2) contracting for these services with private mental health practitioners; and (3) using traveling teams of state-employed experts to conduct the evaluations in community settings. Choosing one of these alternatives narrows the mission of the forensic hospital and allows more resources to be devoted to treatment services.[31]

Establishing an Environment Conducive to Rights Compliance

The environment of a forensic facility will significantly affect the organization's ability to comply with patient rights, provide treatment, and reduce violent behavior in patients.[32] The physical environment must be

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[30] Melton, Weithorn, and Slobogin, 112.

[31] Curran, McGarry, and Shah, 14.

[32] Dietz and Rada, 47-59.

clean, attractive, bright, and in a good state of repair.[33] Staff must treat patients with courtesy and respect. Policies and practices that emphasize the individual needs of patients rather than the management of large groups are important to prevent overly restrictive measures from being imposed.[34]

Henderson and Rauch believe that security is sometimes overemphasized in facilities housing criminal offenders. They claim this creates a cycle of repression: "Intensive security procedures can create an impersonal atmosphere conducive to counterproductive staff and inmate behavior, which can then necessitate the implementation of even more strict security measures."[35] For this reason, it is important that security procedures allow treatment and other programs to operate in as normal a fashion as possible.[36] Some forensic facilities attempt to create an expectation of "no-violence" upon a patient's admission. They reinforce to them that they are entering a hospital, not a prison, and are expected to act accordingly.[37] Deitz and Rada consider

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[33]Walter E. Barton and Gail M. Barton, Ethics and Law in Mental Health Administration (New York: International Universities Press, 1984), 226.

[34]Joint Commission, 9.

[35]James D. Henderson and W. Hardy Rauch, Guidelines for the Development of a Security Program (College Park, MD: American Correctional Association, 1987), 40.

[36]Ibid, 3.

[37]Dietz and Rada, 58.

this a wise practice:

> The issue of patient expectations has received insufficient attention. We suspect that much of the violent and disruptive behavior within forensic facilities reflects the success with which the institutional physical and social structures and the initial interaction with newly admitted patients convey the message that they are expected to be violent and psychotic. A wealth of experimental and survey data over the past decades documents the power of expectations and self-fulfilling prophesy in determining human behavior. We think that forensic facilities could be vastly different from what they are today and that major changes in the expectations held out to patients would be critical in implementing needed improvements.[38]

Orientation procedures are important for establishing expectations and informing patients about their rights.[39] Orientation procedures should be standardized so the information can be presented in an efficient, non-threatening and unbiased manner. Use of slide presentations and videotapes are a suggested means of doing this. This will also assist patients who may have reading difficulties. According to Christian, the use of formal orientation programs for informing clients about rights and services has the following benefits:

1. Services are more likely to be effective when clients know the how and why of the treatment they are to receive; and

2. the consent to treatment is more likely to be truly <u>informed</u> the more clients know about

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[38] Ibid.

[39] Walter P. Christian, "Protecting Clients' Rights in Mental Health Programs," <u>Administration in Mental Health</u>, 11, no. 2 (Winter, 1983): 120.

rights and services.[40]

Because admission procedures can be confusing, orientation information should be periodically re-presented to patients by their therapists until it seems to be well understood, or until there is a declaration of legally incompetency.[41]

Some authorities also suggest providing a statement of patient responsibilities to patients along with information about their rights. This is done to emphasize that treatment requires a cooperative effort between patients and staff.[42] Barton and Barton provide an example of a statement of patient responsibilities:

1. Every individual is responsible for the maintenance of his own health and should actively seek resolution of the problems that brought him into treatment.

2. The patient is expected to cooperate fully with the treatment plan proposed. The reasons for any part of the program will be discussed and questions will be answered by the therapy team.

3. It is essential to keep appointments for treatment.

4. The right to freedom from control presumes mature and trustworthy behavior.

5. Consideration of others and concern for their welfare and property are expected, as are good manners.

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[40] Ibid.

[41] Mark J. Mills et al., "Mental Patients' Knowledge of In-Hospital Rights," American Journal of Psychiatry 140, no. 2 (February, 1983): 225-228.

[42] Wilson and Steibelt, 24-27.

6. As a responsible member of the facility, the patient is expected to observe all rules.

7. The patient is expected to communicate and reach out to the staff, and to request assistance and aid from the doctor, therapist, nurse, and social worker.

8. The community and the state in which the patient lives have the responsibility to supply the resources essential to carry out the mission of the psychiatric facility. All citizens have an obligation to press their representatives in government, both local and state, to make certain the resources essential for evaluation and treatment are made available.[43]

Providing Treatment Services in Forensic Facilities

Treatment in psychiatry is considered by many to be a nebulous process, lacking in standards, with conflicting claims for the effectiveness of many widely used modalities.[44] It is difficult to make generalizations about treatment services provided in forensic facilities. The Kerr and Roth survey identifies the frequency with which different types of treatment services are made available in facilities for mentally disordered offenders, but makes no attempt to evaluate their appropriateness or effectiveness. A summary of this survey's findings are presented here:

97.6% of these facilities use psychotropic medications; in the facilities that use medication

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[43] Barton and Barton, 227.

[44] Robert Plotkin, "Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment," 72 Northwestern University Law Review 461 (1977), reprinted in Paul R. Friedman, Legal Rights of Mentally Disabled Persons (New York: Practising Law Institute, 1979), 879.

61% of the residents receive them;

weekly individual and group therapy programs are the other most commonly available treatment programs with nearly 90% of facilities offering these services; 60% of their residents receive group therapy and 43% participate in individual therapy;

occupational therapy is available in 69.6% of the facilities with 41% of their residents participating (O.T. is reported to be declining in the frequency with which it is offered; the decline is attributed to the types of tools and equipment used, and the fact that most facilities do not ordinarily discharge patients directly to the community where the skills emphasized in occupational therapy would be used);

psychoanalysis was reported to be available in 11.2% of the facilities with 11% of their residents participating;

academic programs (i.e., GED preparation, adult basic education) are available in 83.5% of the facilities;

recreational programs are available in most facilities (movies, 91.3%, outdoor sports, 90.5%, gymnasium, 74.8%);

vocational aptitude testing (61.4%) and in-patient job programs (62.2%) are also widely available;

community organizations (colleges, universities, vocational rehabilitation, medical and nursing schools, alcohol and drug abuse agencies, and service clubs) also frequently provide services (95.3% of facilities have programs).[45]

Kerr and Roth noted in their survey that when staff are encouraged to actively provide treatment programs, they act in a more professional manner and the amount of unstructured time that patients have is reduced.[46]

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[45] Kerr and Roth, 51-53.

[46] Ibid, 83.

Talbot and Flick recommend that in-patient treatment for the chronically mentally ill be centered around the following services (summarized):

> Evaluation and Assessment -- the focus should be on an assessment of everyday functioning, social functioning, and vocational functioning, as well as an assessment of the variety of networks used or needed by the patient, instead of only a personality or psychodynamic profile.
>
> Medication -- there is no question that a primary inpatient treatment modality for the chronic patient is psychopharmacologic.
>
> Psychotherapy -- on an inpatient basis, it should be goal-directed, task-oriented, and combine supportive and clarifying elements.
>
> Family treatment/psychoeducation -- formerly, families were seen as contributors to patients' illnesses. However, they are now usually viewed as potential therapeutic allies in the treatment regimen.
>
> Skills of Everyday living -- it is critical to know whether patients can truly survive outside a sheltering institution before they are discharged. Therefore, an adequate inpatient hospitalization both evaluates and trains patients in the skills of everyday living. These skills include self-care (hygiene, grooming, and dressing), transportation, banking, shopping, purchasing, and preparing food, and washing and cleaning clothes.
>
> Vocational Rehabilitation -- While the provision of a full vocational rehabilitation program may not be possible as part of a short-term hospitalization, both vocational evaluation and prevocational guidance are.
>
> Socialization -- Critical to the community retention of chronic patients is their ability to communicate, get along with others, and develop networks of support.[47]

With knowledge of the range of treatment programs

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[47] John A. Talbot and Ira Flick, "The Inpatient Care of the Chronically Mentally Ill," Schizophrenia Bulletin 12, no. 1 (1986), reprinted in Mental Health Law Project, Protection & Advocacy for People Who are Labeled Mentally Ill (Washington, D.C., 1987), 114-116.

provided in forensic facilities and recommendations from experts on the types of treatment services psychiatric in-patients require, administrators and clinicians can begin to evaluate existing programs. All treatment services should, of course, meet the individual needs of patients. But a wide range of services must be available in order to do this.

Addressing the Right to Refuse Treatment

As noted in chapter 2, the right to refuse treatment is very controversial and without clear guidelines to advise clinicians on how to proceed with patients who refuse. This is an area where, until well-defined legal standards are forthcoming, each facility needs to develop its policy in consultation with a legal expert. It should be noted that when staff show patience and allow a patient a chance to exercise some autonomy in choosing a course of treatment cooperation can usually be achieved.[48] If the patient is not dangerous, and his/her condition is not deteriorating, the decision to refuse treatment should be respected.[49] Of course, in an emergency situation, staff may treat the patient with medication until the emergency subsides, providing this is considered to be the least intrusive or

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[48] Barton and Barton, 215-218.

[49] Robert L. Sadoff, Legal Issues in the Care of Psychiatric Patients: A Guide for the Mental Health Professional (New York: Springer Publishing Co., 1982), 39.

restrictive means of treatment, and that appropriate standards of professional judgment are exercised in the matter.[50]

Many hospitals have established specific procedures that can be used to override a patient's medication refusal. These commonly include: 1) initiation of the process to secure a legally appointed guardian for the purpose of giving consent to medical and professional care; 2) a requirement that there be a determination of competency at the time of admission; 3) external review by an independent psychiatrist or review board to study the patient's previous response to treatment, or ability to make a rational decision; and 4) impartial review by an institutional medical standards committee.[51] It is also recommended that patients who refuse medication, be required to sign a form indicating that they have been informed of the possible consequences of their actions.[52]

Some states have dealt with this problem through legislation. Utah and Vermont have enacted statutes requiring that an involuntary commitment to an institution result in a legal determination that the patient is incompetent to participate in treatment decisions,

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[50] Ibid, 55.

[51] Barton and Barton, 219.

[52] Ibid.

abrogating their right to refuse.[53] The commitment statutes in other states (e.g., Wisconsin) have language in place that courts have interpreted as allowing officials to administer medication involuntarily when needed.[54] In Massachusetts, legislation has been enacted to identify specific due process requirements for overriding medication refusals.[55] If medication refusals create sufficient problems for clinicians and administrators, it seems that there are remedies that can be enacted through legislation. This type of legislation is encouraged by the American Psychiatric Association.[56]

Informed Consent

The informed consent doctrine consists of two elements, disclosure and consent. Conger et al. provide the following principles on which to base a formal informed consent process between physicians and patients that should include the use of a standardized form (summarized):

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[53] Sadoff, 39; and Barton and Barton, 218.

[54] Harvey W. Freishtat, "A View From the Nation's Courts," Journal of Clinical Psychopharmacology 7, no. 1 (February, 1987): 42-43.

[55] Ibid.

[56] American Psychiatric Association, "American Psychiatric Association Guidelines for Legislation on the Psychiatric Hospitalization of Adults" as approved by the Assembly of District Branches, October, 1982, Board of Trustees, December, 1982, the American Psychiatric Association, printed in: Issues in Forensic Psychiatry, The American Psychiatric Association, 54.

Disclosure

1. The doctor must disclose all risks to the procedure, regardless of how minimal. The standard used in determining what to disclose is: "What is reasonable for medical practitioners to disclose under the same or similar circumstances?"

2. Alternative treatments must be disclosed, along with the relative risks and benefits of the alternatives.

3. Actual procedures must be described in sufficient detail to aid the client's understanding.

4. The physician, therapist, and facility must be identified in documentation.

5. A consent document must be signed, dated, and witnessed.

Consent

1. Implied in the informed-consent doctrine is the notion that the patient must understand and comprehend the doctrine. The physician must have made a reasonable effort to convey sufficient information.

2. The doctor's only evidence that he made a reasonable effort to inform the patient is the consent document itself. Thus, it is imperative that the document reflect clearly and precisely all facets of the procedures, and that it be signed.

3. Consent cannot be rendered valid if it was obtained under coercion or duress.[57]

Mental health professionals typically oppose having a formal informed consent process, while the legal profession

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[57] Conger et al., 80.

strongly supports it.[58] The need to use formal informed consent processes in medical settings has become evident as patients demand to have control over the type of treatment they receive and as clinicians attempt to protect themselves from legal liability.[59]

Due Process Procedures

Due process procedures are required nearly any time a public entity intrudes into the life or affairs of an individual.[60] According to the doctrine, a person, against whom an action is proposed that may adversely affect life, liberty, or property is entitled to be notified of the intended action and afforded the opportunity for a hearing. Most mental health officials strongly oppose the intrusion of these types of legal procedures into their domain.[61] However, they are being required by the courts with increasing frequency, and sometimes to apparent extremes.[62] Due process essentially is a means to ensure that the

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[58] John G. Malcolm, Treatment Choices and Informed Consent (Springfield, IL: Charles C. Thomas Publisher, 1988), 82.

[59] Ibid, 61; and Conger et al., 79.

[60] Reed Martin, "Legal Issues in Preserving Client Rights," in Preservation of Client Rights, eds., Gerald T. Hannah, Walter P. Christian, and Hewitt B. Clark, (New York: The Free Press, a Division of MacMillan Publishing Co., 1981), 7.

[61] Barton and Barton, 191.

[62] Heller, 167.

government acts fairly and treats all people similarly situated in a comparable manner.[63] Different due process procedures are required for different types of actions. The severity of the action proposed against an individual will determine the level of due process procedures required.[64]

In the mental health setting, due process procedures may be required when a patient is moved to a more restrictive setting, has ground privileges restricted, or has such rights as telephone use, mail, or visits limited.[65] If formal due process procedures are to be instituted, it should be done with legal guidance. It is important to note, however, that administrators must understand the need to avoid actions that may be viewed as arbitrary or unfair. In the treatment setting the patient must be given an explanation for restrictive actions taken and an opportunity to respond to them. Some decisions may also need to be reviewed by an independent party. Generally, if administrators and clinicians keep these principles in mind and act fairly and with a strong regard for the rights of patients, the imposition of rigid and formal due process procedures by the courts can be kept to a

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[63]Samual Jan Brakel, John Parry, and Barbara A. Weiner, The Mentally Disabled and the Law (Chicago, IL: The American Bar Association, 1985), 252.

[64]Michael Perlin, "Other Rights of Residents in Institutions," in ed., Friedman, 1013.

[65]Ibid.

minimum.[66]

Staff Issues

Staff members working on forensic psychiatric facilities are responsible for ensuring that treatment is provided, security is maintained, and that patients' rights requirements are met. This takes a concerted effort on the part of many people and is difficult for many organizations to achieve satisfactorily.[67] As discussed in the previous chapter, concern with patients' rights is a relatively new phenomenon, as are requirements to provide treatment in forensic facilities. This has created a role change to which many staff members are very resistive.[68] Typically, this is because they no longer are able to exercise former levels of control over the patients in their care.[69] However, Brown states that resistance also stems from the fact that staff members, just like the general public, often misunderstand or fear mental illness:

> Mental health workers, like most people, hold many stereotypes of mental illness. For instance, they may feel that mental illness incapacitates people to the point that they can't make decisions about matters such as whether or not to accept a particular treatment. State hospital workers also

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[66] Rodenhauser and Heller, 237-244.

[67] James T. Ziegenfuss, Patients' Rights and Organization Models (Washington, D.C.: University Press of America, 1983), 11-12.

[68] Ostrander, 257-271; and Dietz and Rada, 48.

[69] Ostrander, 267.

> fear violence from patients, and believe that reduction of restraint, seclusion, and forced medication will increase that violence. Patient violence is a real fear, but dangerous behavior could best be reduced by overall structural reforms in the mental health system, not by maintaining the status quo.[70]

Administrators are responsible for overseeing the actions of other staff members. Supervisors or management personnel may be held legally responsible for the failure to train, failure to supervise, or the negligent retention of employees.[71] The provision of adequately trained and supervised staff can also be considered an ethical responsibility of mental health organizations.[72] Staff members in mental health programs have, historically, not been adequately trained in patients' rights issues, or encouraged and supported in efforts to improve treatment practices.[73] There is also a strong tendency in institutional settings for staff members to avoid interactions with patients.[74] Instead, they spend their time engaging in housekeeping duties, recordkeeping, or

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[70] Phil Brown, "The Mental Patients' Rights Movement and Mental Health Institutional Change," International Journal of Health Services 11, no. 4 (1981): 536.

[71] Henderson and Rauch, 29.

[72] Barton and Barton, 119.

[73] Martin, 4.

[74] Fames E. Favell, Judith E. Favell, and Todd R. Risley, "A Quality-Assurance System for Ensuring Client Rights in Mental Retardation Facilities," in Hannah, Christian, and Clark, 346-347.

socializing with other staff members. If facilities are to successfully comply with patients' rights requirements, solutions to these problems must be found.

A necessary step in changing staff attitudes and behaviors that have an adverse affect on patients' rights is the provision of adequate training. Christian suggests that training be "task-oriented," focusing on what staff members should do, instead of what they should not.[73] He believes that the task-oriented approach is more effective than traditional didactic training methods because many staff members have difficulty abstracting the principles of client rights and applying them to daily tasks. Christian recommends the following procedures for inclusion in training programs so staff members will understand how standard care and treatment procedures relate to client rights:

1. Operational definitions of client rights are presented to staff. In addition, staff should clearly understand the role of peer review and the Human Rights Committee.

2. Staff are given a set of step-by-step instructions that describe how each staff activity should be conducted so that rights violations do not occur.

3. Staff are given the opportunity to observe trained staff performing the procedures correctly and to ask questions.

4. Staff are given time for on-the-job-practice.

5. Supervisors observe staff and give them

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[73]Christian, 122-123.

feedback based on evaluation checklists that itemize the critical aspects of each procedure.

6. Staff are considered trained and certified on a procedure when they can perform with a 100% score on the checklist.

7. Substandard scores indicate a need for re-reading the procedures and/or additional observation and practice with feedback from supervisors.[76]

Mental health facilities frequently indicate a need to increase their numbers of staff members in order to comply with patients' rights requirements. But a number of studies have found that simply increasing the quantity of staff does not automatically increase the quantity or quality of services provided to patients. Without proper supervision, increased numbers of staff members usually results in more staff time spent socializing, rather than tending to job related duties.[77]

Employee supervision in mental hospitals is often a problem. Supervisors tend to have numerous other duties (i.e., distributing medication, recordkeeping, timekeeping) that take time away from their supervisory responsibilities. Frequently, they have little management training and find it difficult to motivate their subordinates. Feedback from supervisors to employees tends to focus on things that are immediately visible, such as ward cleanliness, instead of

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[76] Ibid.

[77] Favell, Favell, and Risley, 349.

the participation and progress made by patients in treatment.[78]

Attitudes toward patients' rights correlate strongly with the rank held by staff members in an institution. Higher level, professional staff tend to view patients' rights much more favorably than do lower ranking staff members.[79] Yet, lower ranking staff members have much more direct contact with patients. This illustrates the need for staff members at all levels to be involved in policy making. If this does not happen, policy developed at top-levels by administrators may not be carried out on hospital wards.[80] Talbot states, "top-down decision-making leads to solutions that emphasize procedures and regulations rather than clinical results."[81] Administrators and clinicians have a responsibility, not only for ensuring that policies for protecting rights are in place, but that they are carried out.[82] In mental health services, a good flow of

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[78] Ibid, 348.

[79] Paul P. Freddolino, "Patients' Rights Ideology and the Structure of Mental Hospitals" (Ph.D. diss., University of Michigan, 1977); and Brown, "State Mental Hospital Staff Attitudes," 423-441.

[80] Gail M. Barton, "Standards for Emergency Psychiatry," in Handbook of Emergency Psychiatry for Clinical Administrators, eds., Gail M. Barton and Rohn S. Friedman (New York: The Haworth Press, 1986), 237.

[81] John A. Talbot, "The Patient: First or Last?" Hospital and Community Psychiatry 35, no. 4 (April, 1984): 341.

[82] Barton and Barton, 226-227.

communication up and down an organizational hierarchy is found to correlate strongly with organizations that have little difficulty complying with patients' rights.[83]

Some states license psychiatric technicians. This allows standards for education, training, and experience to be set that employees must meet not only upon initial employment, but annually or bi-annually thereafter. This ensures that employees will receive more training than just a standard orientation program.[84] It can also provide a means of removing employees who do not perform satisfactorily in their positions. It has also been demonstrated that licensure systems result in employees who act more "professional."[85]

Attempting to comply with patients' rights means a change in roles for many staff members. Initiating change is often difficult and meets with much resistance. It is important to provide adequate training that allows employees to learn new ways of carrying out their responsibilities. In order for policy changes to work, they must be formulated with input from staff at all levels. Staff/patient interactions must be encouraged by making them an activity

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[83] Carol T. Mowbray et al., "Evaluation of a Patient Rights Protection System: Public Policy Implications," Administration in Mental Health 12, no. 4 (Summer, 1985): 272.

[84] Kerr and Roth, 90.

[85] Ibid, 101.

highly valued by supervisors. Supervisors must be allowed to focus primarily upon their responsibilities for directing and leading staff members, instead of numerous other duties that interfere with this. It takes a concerted effort by employees at all levels if mental health organizations are to successfully comply with patients' rights requirements.

Systems for Monitoring Patients' Rights Compliance

A system for monitoring patients' rights is an essential part of a mental health organization's compliance effort. Administrators and clinicians need to examine their facility's total environment (e.g., policy, training, staffing, organizational structure) to evaluate it's correlation with patients' rights requirements.[86] This requires the development and use of standards and evaluation mechanisms.[87] Operations must be continually monitored and assessed to ensure that policies and practices protect the rights of patients, and are being carried out as intended.

A necessary step in monitoring rights compliance is the development of performance standards. McPheeters states:

> Standards can be defined as the criteria and measures by which one can judge whether orders are being carried out. Orders, rules, or directives are not standards. Standards help answer the question, "How will we know whether the orders are being carried out?" It is vital that standards

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[86] Mowbray et al., 269.

[87] Christian, 116.

> for patients' rights be measures of performance -- not just standards for capacity. We must make certain that these procedures are being carried out.[88]

Standards must be valid and reliable, with consistent procedures used to assess compliance with them.[89] Many standards can be developed internally by clinicians, administrators, and others with responsibilities for facility operations. Standards are also suggested in professional literature on the administration of mental health facilities.[90] Administrators should develop checklists and rating systems that can be used periodically to assess the degree to which an organization meets patients' rights standards.[91]

Standards for mental health organizations may also be set externally through legislation, administrative regulations, or judicial actions. Frequently, the imposition of external standards on an agency will include the appointment of a person or committee to evaluate compliance with them. This provides an independent review of agency programs. It is not unusual for the compliance assessment of the independent monitor to vary considerably

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[88] McPheeters, 16.

[89] Ibid, 22.

[90] For examples of standards and monitoring systems, see: McPheeters; Christian; and Hannah, Christian, and Clark.

[91] McPheeters, 22.

with that of facility administrators, particularly when standards have been imposed by the courts. When mental health facilities are the subject of external reviews, it is essential that standards be specific and agreed upon by all concerned so that subjectivity in the evaluation process is minimized and the results are less open to dispute.[92]

Administrators and clinicians often solicit people from outside of their organization to provide an independent assessment of treatment procedures to ensure that they are in compliance with professional standards and patients' rights. Griffith advocates the use of peer review for this purpose,

> Professional peer review should be done for any controversial procedure to determine whether it places the client at risk. This helps ensure an assessment of the proposed treatment's consistency with program policy and its effectiveness.[93]

However, peer review and consultation services are costly, and sometimes delay the implementation of treatment procedures. Also, in many instances it is unusual for the review process to result in a recommendation for change from the course of treatment originally proposed.[94]

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[92] Ibid, 19-22.

[93] R. G. Griffith, "An Administrative Perspective on Guidelines for Behavior Modification: The Creation of a Legally Safe Environment," The Behavior Therapist 3 (1980): 5-7, quoted in Christian, 116.

[94] William A. Hargreaves et al., "Effects of the Jamison-Farabee Consent Decree: Due Process Protection for Involuntary Psychiatric Patients Treated With Psychoactive Medication," American Journal of Psychiatry, 144, no. 2

Christian also recommends the establishment of a standing Human Rights Committee to review institutional policies and procedures for compliance with patients' rights requirements:

> The Wyatt v. Stickney (1972) decision called for the development of Human Rights Committees (HRC) to review research proposals, service plans, and treatment procedures to ensure that the dignity and human rights of clients are preserved. An HRC is intended to provide safeguards to protect against inhumane or improper treatment. Such committees are essential if a mental health program is to be truly legal and accountable.[95]

It is suggested that the committee be made up of people from both inside and outside the organization, with external members representing the attitudes of clients' communities. The committee should meet at regular intervals to review facility programs, records, and treatment plans. Such a committee can benefit both clients and staff. It can advocate for quality care and treatment for patients, and the independent observers can provide unbiased feedback if questions are raised about whether an agency's services are humane and effective.[96] However, it should be noted that there is often substantial resistance to these types of committees by staff members who feel their ability and authority to do their job is challenged.[97]

(February, 1987): 188-192.

[95] Christian, 121-122.

[96] Ibid.

[97] Wilson and Steibelt, 26-27.

Advocacy Systems as a Means of Patients' Rights Enforcement

Internal and external patient advocacy systems are often used as a means of enforcing patients rights. The functions of advocacy programs are to: (1) educate staff; (2) help establish procedures for rights compliance; (3) resolve disputes; and for external advocacy systems (4) provide legal support for litigation when necessary.[98] One result of the large volume of litigation against mental health systems in the 1970s was a rapid growth in advocacy programs.[99] Originally, most of these programs functioned internally as a component of the mental health system. External systems are now becoming more common.[100]

Kerr and Roth found from an on-site survey of ten facilities for mentally disordered offenders that advocacy programs can be beneficial in keeping minor problems from becoming something greater:

> To help reduce the volume of litigation, two facilities had clients' rights advocates. In both facilities, each resident complaint was investigated by the advocate, who attempted to solve the matter internally, so that it did not reach the litigation stage. Some of the staff saw patients' rights as a "fly in the ointment--it is intrusive to the therapeutic relationship at times to have to figure out your legal relationship to

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[98]Louis Kopolow, "The Challenge of Patients' Rights," Advocacy Now 1 (May, 1979): 19-21.

[99]Harry C. Schnibee, "Changes in State Mental Health Service Systems Since Wyatt," in Jones and Parlour, 176.

[100]Paul S. Applebaum, "The Rising Tide of Patients' Rights Advocacy," Hospital and Community Psychiatry 37, no. 1 (January, 1986), 9-10.

> the patient." However, the majority of staff at both facilities felt that having a patients' rights advocate helped keep minor problems just that. If a patients' rights advocate kept one complaint from becoming a legal case, then the time clinicians were spared from preparing litigation support material and thus able to devote to treatment made the advocate an effective resource for the entire treatment team.[101]

Advocacy systems tend to be strongly supported by administrators, although opinions vary about whether an internal, external, or mixed system is preferable.[102] Internal systems have the advantage of easier program access and increased ability to work within the mental health system to make changes. External advocacy programs have the advantage of being less subject to cooptation and more able to push from outside when radical or costly changes are called for.[103] Kopolow compares the two systems:

> External systems make the advocate more loyal and responsible to the client than the system. Internal rights protection programs frequently tend to be highly efficient and effective in solving complaints about daily living and in planning for future needs. They have easier access to records and can participate in program development, better links with administrators, etc. An external advocacy system can use persuasion, but when persuasion fails, litigation is always a backup position.[104]

Mental health professionals and patients' advocates are

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[101]Kerr and Roth, 95.

[102]Mowbray et al., "Evaluation of a Patient Rights Protection Systems: Public Policy Implications," 280.

[103]Ibid, 269.

[104]Kopolow, 21.

frequently at odds with one another. Stone, a psychiatrist, interprets the differences between the two groups:

> Where we want the best treatment setting for our patients, they want the least restrictive alternative. Where we want careful treatment planning and continuity of care, they want immediate deinstitutionalization and maximum liberty. Where we are concerned about access to treatment, they are concerned about stigma and the right to refuse treatment. Where we are trying to salvage what is salvageable in the state hospital system, they are trying to close down the state hospital system. Where we want to advocate the medical model, they want to advocate the legal model.[105]

Many external advocacy systems, including the Montana State Hospital office of the Mental Disabilities Board of Visitors are run by attorneys. Gutheil, Rachlin, and Mills, cite differing tenets between the legal profession and psychiatry as a source of conflict:

> Another, often problematic, area involves the centrality of the adversary system in law; in contrast, alliance is central to psychiatry. The essence of law is the disagreement or conflict. If there were no conflict, there would be no case. The very fact that a case is being tried indicates both that disagreement exists and that efforts at compromise have failed. One implication of this central fact is that the outcome must define a winner and a loser; the law is a "zero-sum game." In contrast, mental health professionals think in terms of those who cannot fend for themselves. There is usually no real conflict as the law defines it, although disagreements are not uncommon.[106]

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[105]Alan A. Stone, "The Myth of Advocacy," Hospital and Community Psychiatry 30 (1979), 819, quoted in Brakel, Parry, and Weiner, 288.

[106]Thomas G. Gutheil, Stephen Rachlin, and Mark J. Mills, "Differing Conceptual Models in Psychiatry and Law," in Legal Encroachment on Psychiatric Practice, ed., Stephen

Another source of tension between the medical and legal profession is the degree to which it is felt desirable for advocates to act on the expressed wishes of a client whom clinicians and others may see as irrational. Schwartz and Fleishner consider it important that the advocate's judgment and personal preferences do not interfere with the client's wishes. They believe there are several benefits to this approach:

> A relationship built on deference rather than paternalism may enhance clients' sense of self-esteem; it allows the clients to make the crucial choices about their lives rather than having professionals make the choices for them; it encourages those same professionals to share information with clients in order that their decisions can be as knowledgeable as possible; it eschews the overly protective attitude that otherwise pervades the mental health system; it provides the clients a meaningful opportunity to be heard, and, to some degree, may even force others to finally listen to them; and it allows disabled persons, like the rest of us, the dignity to take risks and to assume the responsibility of their actions.[107]

In contrast, Pepper and Ryglewicz believe that advocates need to take a broader view of the needs of people with mental disabilities,

> The solution, of course, is not for attorneys to ignore patients' rights and their expressed desires, but for them to take a broader view of patient advocacy, considering not only what a

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Rachlin, (San Francisco: Jossey-Bass, Inc., 1985), 6.

[107]Steven J. Schwartz and Robert D. Fleischner [in response to Samuel J. Brakel], "Legal Advocacy for Persons Confined in Mental Hospitals," Mental Disability Law Reporter 5, no. 5 (1981), reprinted in Mental Health Law Project, 627.

> patient says he wants at a given moment, but also his state of mind and his own best interests. This broader approach requires attorneys to acquire some of the skills of the mental health professional. The need is comparable to that recognized by some responsible and psychologically sensitive divorce lawyers: to help the patient go beyond the impulse of the moment to a deeper and broader consideration of his situation. The need for attorneys to acquire or improve mental health skills is also comparable to the need mental health clinicians have confronted in the past decade to sensitize themselves to legal issues, and to go beyond their assessment of patients' needs to a heightened awareness of their rights.[108]

The medical profession also frequently cites irresponsible behavior on the part of some patient advocates as a source of conflict and interference in the provision of treatment.[109] Schwartz et al., acknowledge that on occasion this can be a problem, and caution advocates against attitudes of arrogance and superiority over mental health professionals.[110] Schwartz and Fleischner believe that it is important for advocates to maintain an adversarial relationship with the mental health system in order to bring about needed changes, but caution against

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[108]Bert Pepper and Hilary Ryglewicz, "Patients Rights and Patients Needs -- Are They Compatible? Does the Lawyer Serve the Mental Health Needs of the Patients?" Psychiatric Quarterly 54, no. 3 (Fall, 1982): 179.

[109]James T. Hilliard and Thomas G. Gutheil, "Comments on Dealing With 'Irresponsible' Patient Advocates," Hospital and Community Psychiatry 32, no. 11 (November, 1981): 803.

[110]Steven J. Schwartz et al., "Protecting the Rights and Enhancing the Dignity of People with Mental Disabilities: Standards for Effective Legal Advocacy," Rutgers Law Journal 14, no. 3 (1982): 541-569, reprinted in Mental Health Law Project, 605-619.

antagonism which only serves to further polarize the two sides.[111]

The degree to which advocates should hold an adversarial approach to mental health programs is subject to debate. Some believe that the approach need not be adversarial and that advocates should rely on their power of persuasion and skills in negotiations to act effectively on behalf of clients. To use these skills effectively, communication and good relationships with staff members and administrators are necessary.[112] Others believe that an adversarial approach is necessary so that independence for the advocacy program is maintained, and to ensure that legal advocates serve their mentally disabled clients in the same manner they serve clients without handicaps.[113] Freddolino believes that an adversarial approach to patient advocacy is often ineffective because it tends to be overly reactive, only responding to problems after they have arisen. He recommends a proactive and preventative approach to advocacy:

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[111]Schwartz and Fleischner [in response to Samuel J. Brakel], reprinted in Mental Health Law Project, 625.

[112]Carol T. Mowbray et al., "The Rapid Growth and Reduction of Recipient Rights Protection Staffing," Administration in Mental Health 11, no. 4 (Summer, 1984), 260; and Samuel J. Brakel [response to Steven J. Schwartz and Robert D. Fleischner], "Legal Advocacy for Persons Confined in Mental Hospitals," reprinted in Mental Health Law Project, 622-624.

[113]Schwartz and Fleischner, in Mental Health Law Project, 627.

> Greater emphasis must be placed on proactive services, in which staff approach potential clients to determine if there is any problem, as well as on preventative services for advocates, which might include staff education and training, participation in management decision-making, involvement in the design on new programs and policies, and less adversarial relations with administrators. The latter approaches are particularly viable for internal programs where advocates have the advantage of easy access to clients as well as some identification as "part of the team." The difficult task here, of course, is to avoid being coopted.[114]

There is a need for advocacy programs to define their mission and adopt standards to guide their operations. Schwartz et al. cite three reasons for doing this: (1) it prevents individuals or the office as a whole from taking actions that may be contrary to the overall direction of the project; (2) articulating a program direction allows the project to be seen as less reactive and more consistent in its actions; and (3) it provides a measure of accountability, both personal and collective, by establishing a standard against which to measure the values and actions of the project.[115] Through the articulation of an advocacy program's mission, its role and relation to the mental health system will be clarified for all. The advocacy program's success in fulfilling this mission can also be evaluated. This might allow mental health

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[114]Paul P. Freddolino, "Findings From the National Mental Health Advocacy Survey," Mental Disability Law Reporter 7, no. 5 (September-October, 1983): 421.

[115]Schwartz et al. in Mental Health Law Project, 610.

professionals and advocates to better understand each other's role and reduce the occasional competition and animosity between them.[116]

JCAHCO Accreditation

Critics of the mental health system have long complained that the practice of psychiatry is unspecific and lacking in standards.[117] When there are no professional standards to guide the delivery of services, or they are not adhered to, mental health services are scrutinized very closely by the judiciary.[118] This problem has been especially true for forensic hospitals. In 1978 a group of forensic psychiatry leaders met in Dayton, Ohio to begin developing standards for forensic psychiatric hospitals. Additional meetings took place in 1979. Heller reports that the results of these meetings were disappointing even though professionally developed standards of practice for forensic psychiatric hospitals were greatly needed:

> The voice of professional psychiatry cannot be easily concerted. Consensus on many implicit issues does not exist. Among forensic psychiatrists, there is a contingent who see the professional role as carrying out the legally imposed standards, rather than implementing

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[116]Freddolino, "National Mental Health Advocacy Survey," 421.

[117]Robert Plotkin, "Regulating Treatment Decisions for Civilly Committed Persons," in ed., Friedman, 868.

[118]Paul S. Applebaum, "Resurrecting the Right to Treatment," Hospital and Community Psychiatry 38, no. 7 (July, 1987): 703-704.

> professionally devised standards, which would provide more practical assurance of quality patient care in the more normal way and course of established health care. Such standards by professionals in the course of responsible and accountable practice would obviate the complications and questionable end of judicial involvement. The capacity of judicial activism to bring about acceptable standards of care has yet to be demonstrated, in Ohio, in Alabama, or anywhere else.[119]

The Joint Commission for Accreditation of Health Care Organizations has long established professional accreditation standards for health care services. JCAHCO has had specific standards for the accreditation of psychiatric hospitals for quite some time. As noted earlier in this chapter, JCAHCO has just released standards that apply specifically to forensic psychiatric facilities.[120] These standards are quite detailed and cover every major aspect in the provision of forensic psychiatric services. Stromberg and Stone call for legislation to be passed in each state requiring all state psychiatric facilities to meet applicable JCAHCO accreditation standards.[121]

JCAHCO is sometimes criticized for lax procedures in monitoring compliance with standards, and for being more concerned with paperwork than with actual treatment

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[119]Heller, 168-169.

[120]Joint Commission on the Accreditation of Health Care Organizations, Accreditation Standards for Forensic Facilities, 1989.

[121]Stromberg and Stone, 99.

procedures.[122] Nevertheless, JCAHCO accreditation is generally viewed in courts as proof that professional standards of care and treatment are met.[123] These standards provide clear guidelines to administrators and clinicians on how to proceed when faced with many of the problems presented in this paper. Without meeting the standards accreditation requires, a forensic facility is likely to have to continually justify its practices to its critics.[124]

Chapter Summary

This chapter has discussed procedures other forensic psychiatric hospitals use, or that have been recommended by experts, in order to comply with patients' rights statutes. These facilities have long resisted change and have lacked a clear mission. Traditionally, they have placed a priority on providing evaluation services to the courts and detaining mentally ill criminal offenders. But the need to address patients' rights issues is forcing a change of priorities. The treatment services provided patients in these facilities is now frequently scrutinized by patient advocacy groups and the courts. This requires the mental health and criminal

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[122]Walt Bogdanich, "Prized by Hospitals, Accreditation Hides Perils Patients Face," Wall Street Journal October, 12, 1988, 1.

[123]Edward B. Beis, Mental Health and the Law (Rockville, MD: Aspen Systems Corporation, 1984), 92.

[124]Heller, 170.

justice systems to better define the purpose of forensic psychiatric hospitals.

Compliance with patients' rights will take a concerted effort on the part of staff members, clinicians, and many people outside of the organization. But it is the administrators of these facilities who need to provide the most leadership in setting the agenda for high quality and legally sound services. They must understand the complex legal and treatment issues involved in program operations and mitigate resistance to change from others. Forensic patients and the public will be much better served if administrators take an active role in improving services rather than relying on the courts to impose standards that must be met.

Traditionally, conducting psychiatric evaluations for criminal defendants has been the main priority for forensic hospitals. But this is changing. Experts argue that evaluations can be conducted more quickly outside of these hospitals at far lower cost. By shifting to an outpatient evaluation system, mental health agencies can devote greater resources (i.e., staff, money) to providing treatment services in forensic hospitals.

The environment (physical structure and emotional ambiance) of the forensic facility will have a significant effect on its ability to meet compliance with patients rights statutes. In correctional facilities, security can

be overemphasized, leading to cycles of repression. The same is true for forensic hospitals. Security must complement treatment, not hinder it. Appropriate behavioral expectations for patients should be established upon their admission, and reinforced through orientation programs and treatment. Orientation programs are useful in communicating to patients their rights and responsibilities. These procedures can be effective in reducing the need to impose highly restrictive security practices on large numbers of patients.

A nationwide survey identified many different types of treatment programs commonly available in forensic psychiatric hospitals. Patients should have access to a variety of programs so that their individual needs can be met. Staff members working in facilities where treatment is emphasized usually act in a more professional manner than those where treatment receives less emphasis. With an emphasis on treatment, patients will have greater opportunity to put their time to constructive use, so they are less likely to engage in behaviors requiring increases in security.

The extent of the problem over the right of patients to refuse medication may be debatable. Yet, in most facilities it is an issue that needs to be addressed. When negotiation with the patient does not work, procedures can be developed with legal guidance for overriding medication refusals by

patients. This issue has also been addressed through legislation in some states.

Closely related to the right of patients to refuse treatment is the issue of informed consent. The need to develop formal informed consent procedures is increasingly recognized in the mental health field. Adherence to the principles of informed consent has the advantage of placing more responsibility on patients for the outcome of their treatment and provides some measure of legal protection to clinicians should an undesirable outcome occur.

Staff members will play a critical role in an organization's effort to comply with patients' rights requirements. It is no longer acceptable for staff to maintain the role of caretaker. Many are afraid of what these changes may bring. Their support in emphasizing treatment and the rights of patients can be cultivated through effective training, proper supervision, a role in policy development, and setting high professional standards.

There needs to be internal mechanisms developed in psychiatric hospitals to evaluate patients' rights compliance. The development of valid and reliable standards to guide service delivery is critical. Operations must be reviewed regularly to ensure that established policies and procedures are followed. The use of peer review procedures and human rights committees can provide program oversight and help guide facility operations. The regular use of

these review mechanisms can help spot difficulties in service delivery before they develop into bigger problems. They also provide a basis for public support of program efforts.

The role of advocacy programs in monitoring patients' rights compliance needs to be more clearly defined. The potential for these services to disrupt treatment and destroy therapeutic relationships is great. Yet, they are needed because for far too long the mental health system has not been adequately responsive to patient rights or needs. The function of an advocacy program must be clearly established with a stated mission and standards of practice, just like those they seek to impose on the mental health system. The degree to which advocacy programs need to maintain an adversarial relationship with mental health systems is open to debate, but clearly there is a need for the nature of the relationship to be understood by all.

The release of accreditation standards from JCAHCO for forensic psychiatric facilities holds great promise for the future. There is no other source of standards as comprehensive as those from JCAHCO to guide administrators and clinicians in the operation of forensic psychiatric hospitals. Adherence to these standards will diminish public and political criticism of these facilities as they attempt to maintain the delicate balance between missions that often conflict. They are not a solution to every

problem faced in the operation of these facilities, but they go a long way toward alleviating many of them.

Chapter 4

Interviews With Administrators and Patients' Advocates

This chapter presents responses from five Montana public officials to a series of interview questions on the topic of patients' rights compliance on Montana's Forensic Treatment Facility (FTF). These questions were submitted during oral interviews conducted between April 4 and April 17, 1990. Each of these five people have varying responsibilities for overseeing the operation of this facility. Those interviewed were:

Nick Rotering - Chief Legal Counsel for the Department of Institutions; interviewed: April 4, 1990 (has since left the Department).

Kelly Moorse - Executive Director of the Mental Disabilities Board of Visitors; interviewed: April 4, 1990.

Allen Smith - Staff Attorney for the Mental Disabilities of the Mental Disabilities Board of Visitors; interviewed: April 9, 1990.

Robert Anderson - Administrator of the Treatment Services Division of the Department of Institutions; interviewed: April 11, 1990.

Jane Edwards - Superintendent of the Montana

State Hospital; interviewed: April 17, 1990.

The purpose of these interviews was to confirm or disconfirm the applicability of findings from the library research presented in Chapters 2 and 3 to Montana's Forensic Treatment Facility, and to seek recommendations for strengthening the FTF's existing operations in the area of patients' rights. Each interview was structured with the same series of twenty questions in an effort to solicit individual viewpoints on major issues. Each question addressed a patients' rights or administrative problem raised during the library research. A list of these questions is contained in Appendix B.

A summary of the interview responses and a discussion of their applicability to the issues raised in this paper is presented here. A complete response from each interviewee to every question cannot be presented because the interviews were not recorded verbatim and would prove to be too lengthy. However, this summary is meant to accurately reflect the opinions of the interviewees on the topics addressed in the interview.

It should be mentioned that the Mental Disabilities Board of Visitors is one of several plaintiffs in a pending lawsuit against the Department of Institutions. Among the complaints in the lawsuit are allegations of patients' rights violations on the Forensic Treatment Facility. This was noted before each interview but did not seem to have a

significant effect on the responses of interviewees. Each of these people expressed interest in this project's outcome and hoped that it will help to provide clearer guidelines for operation of this facility.

The Need to Identify a Mission

It was noted in earlier chapters that the mission or purpose of forensic psychiatric hospitals is often not clear. Conflicts between security and treatment functions are common. Security can be overemphasized, resulting in a diminished capability to provide adequate treatment services. There also can be a negative impact on treatment services when priority is placed on conducting court ordered criminal evaluations.

All five respondents felt that these issues apply to Montana's FTF and that there is a need to better define the purpose of this facility. Presently, Curt Chisholm, the Director of the Department of Institutions, is conducting a review of every component in Montana's mental health system. This may result in a clearer delineation of the FTF's role within the system and prioritization of the services that it provides.

Edwards cited as the facility's primary purpose the provision of evaluation services as outlined in Montana's criminal statutes. Psychiatric care and treatment are the second priority. Other respondents also viewed court ordered evaluation services as a primary purpose, but one

that detracts from treatment services because of the amount of time that professional staff must devote to them. Smith stated that approximately 85% of the patients are admitted to the unit for treatment, yet the professional staff spend nearly all their time conducting court ordered evaluations.

All five respondents felt that there was no need for most, if not all, of the criminal court evaluations to be conducted on the FTF. All agreed that these cases should at least be screened in the community to determine whether any signs of a severe mental disorder are present prior to sending them to the hospital for evaluation. It was felt that this would eliminate the majority of evaluation cases from reaching the hospital. Each of the five interviewees also expressed a belief that the FTF's criminal evaluation services are "abused" by the criminal justice system. Edwards stated that defense attorneys often use evaluations to "buy time" prior to a trial. Rotering suggested that the practice is also encouraged by local law enforcement authorities because the costs of the evaluation are paid by the state. Since evaluation cases usually remain on the FTF for two months, counties save the cost of incarcerating people for this period.

Another major issue in defining the mission of the FTF will be to clarify its role in providing care and treatment to civilly committed patients (voluntary and civil involuntary admissions to the hospital). Rotering said that

the term "forensic" traditionally applies to psychiatric patients who are involved in the criminal justice system (i.e., admitted to undergo a court ordered evaluation to determine competency to stand trial; patients ruled unfit to proceed in a criminal trial due to mental illness; and transferees from correctional facilities). A large portion (approx. 70%) of the patients on the FTF are not involved in the criminal justice system. They have instead been admitted to the hospital through voluntary and civil involuntary commitment processes. These patients have been transferred to the FTF because they have exhibited violent or otherwise unmanageable behavior on the hospital's other, less restrictive units.

Anderson does not believe that the practice of mixing criminally and civilly committed patients on the FTF presents a serious problem. In his opinion, any patient needing a secure environment due to dangerous behavior should be housed and treated on the Forensic Unit regardless of their commitment status. He contends that the unit is treating patient behaviors, and that some civilly committed patients have the potential to be just as dangerous as those admitted through the criminal justice system.

Yet Smith argues that transferring patients from other hospital units when they misbehave does not result in the provision of adequate treatment for these behaviors. He contends that this practice is overly restrictive and

punitive. In his view, there is a big difference between patients that have been charged with or convicted of criminal offenses and those that simply misbehave on other hospital wards. Smith believes that by prohibiting civilly committed patients from being transferred to the FTF other hospital units would have to assume more responsibility for treating these behaviors.

An additional problem in defining the mission of the FTF concerns state statutes that allow the courts to sentence people convicted of criminal offenses to the hospital for treatment. These sentences generally are set for a number of years, with a maximum term determined by the nature of the crime. There are people presently at the hospital who have been sentenced to serve terms as long as 20 and 40 years. Upon admission, these patients are housed on the FTF, but may later move to other, less restrictive treatment units following an administrative review of their case.

The practice of sentencing patients impairs the hospital's ability to function primarily as a treatment facility. Edwards says that in her experience, very few of the patients sentenced to the hospital prove to be seriously mentally ill, but they are often very disruptive to patients who are. These people usually are unmotivated in treatment, and cannot be discharged when maximum benefit from hospitalization has been obtained. All five people

interviewed felt that this practice was an abuse of the mental health system and that correctional facilities are much better equipped to handle criminal offenders sentenced to serve lengthy terms. Overcrowding in the state's prisons was cited as a reason for more frequent use of this practice in the past year. These sentences are clearly imposed for the primary purpose of segregating criminal offenders from the public. As long as this practice is allowed, it will be difficult for the hospital and the FTF to emphasize its role as a treatment facility.

Security Issues and the Right to the Least Restrictive Area

The need to base security on the individual needs of patients was emphasized by all five people interviewed. Generally, it was agreed that security should be based on the patient's history of criminal and/or dangerous behavior, hospital behavior, and degree of escape and suicide risk. But it seems difficult to transform these general guidelines for assessing appropriate levels of security into actual meaningful procedures for preventing violence or escapes. This problem is even more difficult in forensic psychiatric settings than it is in corrections because of legal requirements to provide meaningful treatment. Classification systems are used frequently in prisons in an attempt to set levels of security according to objective criteria. However, Rotering does not feel that classification systems work very well, although the courts

generally allow administrators to exercise a considerable degree of discretion in their application.

Edwards cited political demands for a high level of security as a hinderance in the provision of effective treatment programs. She feels that there is substantial pressure from the public, the news media, and state officials to implement security procedures that minimize the risk of patient escapes and walkaways from the hospital. In her view, treatment programs require an eventual lowering of security restrictions so that patients can demonstrate their ability to function appropriately in society. She stated that it is difficult to comply with patients' rights statutes on the FTF because these statutes are primarily intended for application to civilly committed patients. The rights of those committed through the criminal justice system should be stipulated more clearly by the legislature, maintains Edwards.

Smith and Moorse felt that the practice of mixing criminally and civilly committed patients on the FTF contributes to much of the difficulty in determining the type of security procedures that need to be employed. Smith maintains that security procedures for the criminally committed patients should be reasonably restrictive, but that overly restrictive procedures are applied to civilly committed patients who have not been convicted or even accused of committing any crimes. According to Smith and

Moorse, different types of security practices are appropriate for each of the two classes of patients.

Edwards, Anderson, and Rotering do not feel that complete separation of these two populations is necessary. They did, however, express a need to institute policies for ensuring that civilly committed patients do not stay on the FTF any longer than necessary. Edwards suggested that a procedure could be used to review transfers of civilly committed patients to the FTF either before they took place or, in the event of an emergency, within two working days. The review should be conducted by someone independent from the FTF and the hospital unit transferring the patient. The purpose of the review would be to ensure that the transfer is necessary and in keeping with requirements that patients are held in the least restrictive environment. Edwards also suggested that civilly committed patients on the FTF have their placement reviewed periodically (e.g., the first 30 days after transfer, then again every 90 days) by certified mental health professionals to ensure the appropriateness of their continued stay on the unit. The problem in instituting this procedure, according to Edwards, is that the hospital's professional staff is already spread thin and would have difficulty handling the additional workload these procedures would entail.

Another issue involving the right of patients to be in the least restrictive area concerns housing practices for

patients on the FTF's High Security ward. In this area, patients are housed individually in cells like those commonly used in correctional institutions. These cells have heavy metal doors that are controlled electronically by staff members. Patients cannot open or close these doors by themselves. They are usually confined in these cells for long periods of time each day. According to policy, all male patients admitted to the FTF are housed initially on this ward (there is a separate women's ward, where cells are used only to house patients in emergency situations). After a period of time on the high security ward, patients are transferred to other, less restrictive areas of the FTF, if they have demonstrated appropriate, and non-threatening behavior.

A question can be raised over whether the placement of patients in these cells should be regulated in the same way as the confinement of patients in seclusion rooms (the definition of seclusion and applicable legal principles were discussed in Chapter 2). Edwards said that this is a major patients' rights issue on the FTF. She feels that these cells are probably more restrictive than the unit's Behavioral Control area, an area used to segregate patients from the general ward population because of problem behaviors or a need for close observation.

Edwards suggested that consideration should be given to eliminating the practice of requiring that civilly committed

patients transferred into the FTF be housed initially only in the High Security area. She suggested that it may be a better practice to make individual determinations at the time of transfer about which of the FTF wards is most appropriate for a particular patient. She noted that female patients transferred into the unit are not required to be confined in a cell. Smith expressed a belief that placement of patients in a high security cell should require justification by professional staff members, just like that required when patients are placed in seclusion rooms. He feels that requiring such justification would greatly reduce the amount of time patients spend confined in cells.

Treatment Programs on the Forensic Treatment Facility

All interviewees felt a need for more treatment programs than are currently offered on the FTF. Edwards believes that existing treatment programs are "appropriate and good." However, she expressed a desire to expand the types of treatment programs available, with a particular need for more group and individual psychotherapy programs. Additionally, she suggests that better assessments be conducted to identify individual patient needs, and that treatment should be based upon results of the assessment. Anderson said that too often hospital treatment systems are not flexible enough to meet individual needs. He suggested that greater use could be made of consultants and contracted services to provide specialized services that cannot be

provided by regular staff members. Both Edwards and Anderson declared that inadequate numbers of trained staff, budget limitations, and longstanding hospital traditions, make upgrading treatment services a long and slow process.

Patient treatment plans were strongly criticized by Rotering and Anderson. They feel that treatment planning has not been given enough attention. Rotering stated that unsuccessful treatment approaches should be changed, and that there should be more "creativity" and flexibility in treatment planning. He emphasized that legally the only reason for confining people involuntarily to an institution is to provide them with treatment. A well developed treatment plan is necessary to demonstrate that appropriate treatment is provided, maintains Rotering.

The need for improvement in treatment planning was echoed by Edwards who also believes that more patient involvement in the process would be beneficial. She feels that when patients are involved in planning treatment approaches, they are more likely to cooperate with the program. Too often the process is just an exercise in paperwork, a requirement that must be fulfilled, rather than a tool used to individualize and define a course of treatment, contends Edwards. She stated that there is a need to have a person on the hospital's administrative staff with responsibilities for ensuring the adequacy of treatment plans, patients' rights, and quality assurance.

Right to Refuse Treatment, and Informed Consent

Anderson, Rotering, and Edwards all see the right of patients to refuse treatment as one of the major patients' rights concerns on the FTF. As in most areas of mental health services, the controversy on the FTF centers on the involuntary administration of medications. The consensus of these three respondents is that most, if not all, involuntarily committed patients should be considered incompetent to refuse prescribed medications. Anderson stated, "if they were competent to make appropriate treatment choices, there probably would be no need for the courts to involuntarily commit them." All three of these officials feel that passing legislation to limit the right of patients in state institutions to refuse medication would be a good idea.

Rotering stated that the hospital can use an administrative hearing with the patient present to override their refusal to take prescribed medication. The hospital presently has a policy for this process, but, without elaborating, he stated that it needs to be strengthened. Briefly, the policy states that if a patient's behavior presents a substantial risk to others, and that medication is likely to be effective in treating the problem, a patient's refusal to take prescribed medication may be reviewed by a committee comprised of hospital physicians and other professionals who have authority to take action to

override the patient's decision. Edwards suggested that physicians from outside the hospital could be consulted in this process to provide an independent review of the need for medication.

Smith suggested that the issue of medication refusal should actually be considered a right to informed consent. He believes that most patients are cooperative with physicians and other professionals, but some want more of a voice in determining the type of treatment that they receive. Moorse agreed with Smith and suggested that staff members look at medication refusals as a treatment issue that can often be addressed by using other approaches (i.e., individual and group therapy, graphing behaviors, peer support) to help the patient develop insight into their illness.

Edwards expressed a need for the hospital to review its informed consent procedures. She believes that there would be benefits to using more formal informed consent practices when physicians prescribe medication. Some informed consent procedures are now being practiced, but are not adequately documented, according to Edwards. The use of signed consent forms would help resolve these problems.

Monitoring Rights Compliance

The need for better procedures to monitor rights compliance was mentioned by all respondents. Both Rotering and Anderson stated that there is a need for a position

within the Department of Institutions Central Office to monitor patients' rights and investigate abuse allegations in all of the Department's facilities. Anderson feels that having a person with these responsibilities would increase the ability of the Department to solve problems internally, reducing the need for involvement by the MDBV. Edwards mentioned that within the State Hospital there is a need for a position with these responsibilities. She also strongly asserts that the hospital should have an attorney on its staff to handle patients' rights and other legal issues.

Moorse and Smith believe that all mental health professionals need to be actively involved in monitoring patients' rights issues. They also hold that state statutes give the MDBV staff authority for enforcement of patients' rights in state institutions. Moorse and Smith say that their efforts to monitor rights compliance on the FTF is inhibited because they are allowed only limited access to the facility. They argue that allowing them more open access to the unit would make staff more vigilant in ensuring that patients' rights are not violated. Rotering counters this argument by contending that their presence on the unit is disruptive to patient treatment.

This leads to the issue of how much of an adversarial role should advocacy programs play in providing oversight to mental health systems. Rotering said that advocacy groups are disruptive to mental health systems in all of the

Western states. He maintains that the MDBV staff has interfered greatly with patient treatment on the FTF. Their relationship to the mental health system needs to be much more clearly defined, suggests Rotering.

Edwards and Anderson largely agree with Rotering. They contend that an adversarial relationship hinders the mental health system in its efforts to provide effective treatment services. Edwards calls on advocates and mental health professionals to work together in improving the overall quality of mental health services and to see that individual needs are met. Anderson suggests that emphasis on legal issues by advocates who are lawyers creates an unnecessary tension in the treatment process.

But Smith denies that he has interfered in treatment, and claims that an adversarial approach is necessary if advocacy programs are to work. He feels that the interests of individual patients cannot be adequately represented if the role of advocates is only to negotiate within the mental health system. Most mental health systems do not take advocacy programs seriously unless they do take an adversarial stance, according to Smith. He feels that the MDBV should have its oversight role enlarged to increase the accountability of the mental health system to patients and the public.

JCAHCO Accreditation

Accreditation for the Forensic Treatment Facility by

the Joint Commission for Accreditation of Health Care Organizations is seen by all respondents as a partial answer to the dilemma of ensuring compliance with patients' rights. Anderson states that a goal of the Department of Institutions is for all facilities to meet appropriate accreditation and certification standards. Rotering and Edwards believe that accreditation would relax some of the criticism of this facility by advocacy groups. Edwards also suggests that the need to meet accreditation standards would provide leverage when making appropriations requests to the legislature.

Smith and Moorse believe that adherence to JCAHCO standards would ensure that a greater level of active treatment is provided to patients. It also may make the hospital more attractive when recruiting new staff, suggests Smith. The only drawback to JCAHCO accreditation was mentioned by Edwards. She said that it entails a tremendous amount of paperwork that can take away from direct services to patients.

Chapter Summary

Problems in delineating a mission and setting service priorities exist on Montana's FTF. So do problems in providing adequate treatment services while maintaining security. In order to address patients' rights issues on this unit, it will be necessary to ensure that patients are placed there appropriately, and that security restrictions

and treatment programs are designed to meet individual needs. More formal procedures for documenting rights compliance are necessary. Responsibilities of staff members for monitoring compliance efforts also need to be more clearly articulated. Accreditation by JCAHCO will help to demonstrate that the FTF is meeting professional standards.

The interviews established two important points. First, the Forensic Treatment Facility faces similar problems in its effort to comply with patients' rights standards as those experienced in many other forensic hospitals and state-run psychiatric institutions across the nation. Second, despite tension between Department of Institutions administrators and Mental Disabilities Board of Visitors staff members, there is remarkable agreement on how many of these issues should be addressed. With this in mind, procedures for complying with patients' rights on the Forensic Treatment Facility can be designed and implemented.

Chapter 5

Analysis and Recommendations

This paper has presented a number of problems and issues on the topic of patients' rights compliance applicable to forensic psychiatric hospitals. The intent has been to use this information to recommend policy and to guide decision making on Montana's Forensic Treatment Facility. As documented above, this is a very broad subject with no easy answers or clear-cut solutions for many difficult questions. Few specific guidelines exist to aid administrators and clinicians of forensic psychiatric facilities in their attempts to provide proper care and treatment services to a demanding clientele. In addition, Forensic programs operate under constraints that include public demands for a high degree of security; limited resources with which to work; little public support; and, an unclear mission spanning the mental health and criminal justice systems.

There is little likelihood that these problems will be resolved any time soon. Historically, there has been only intermittent attention from the public to mental health issues. The public demands to have people with mental illness who might be dangerous placed in institutions, but

there is no reliable means for predicting dangerousness. Inhumane conditions in state psychiatric facilities have led to mandates from the public and the courts that active treatment be provided to institution residents. Yet these institutions typically lack adequate resources, and treatment for the chronically mentally ill is often ineffective. The dual purpose of mental health law (to confine the dangerous and to provide care and treatment to those who need it) requires psychiatric clinicians and administrators to fulfill the dubious role of both jailor and therapist at the same time. The problems of complying with patients' rights standards and providing adequate treatment services are compounded by the traditional practices and mores of psychiatric institutions that are difficult to change and often antithetical to new standards. Espousing patients' rights concerns is easy. Incorporating them into actual operating procedures for an institution, particularly a forensic psychiatric hospital, is a slow and arduous process.

Nonetheless administrators and clinicians have to take action to meet legal requirements. The historic evidence of the last twenty-five years shows that mental health programs need to voluntarily make an active effort to meet patients' rights standards. If they do not, litigation will likely result in the imposition of standards by the judicial system. The growing prevalence of advocacy programs for the

mentally ill ensures that the actions of mental health agencies will be closely scrutinized in an effort to guarantee that services are of sufficient quality and protective of patients' rights.

However, almost lost in the rhetoric over these legal issues is the fact that adherence to these standards is a therapeutically sound practice. Patients' rights require that people receive treatment according to their individual needs. Informed consent procedures help to educate patients about treatment prescribed to them and any available alternatives. Allowing patients to help plan their course of treatment increases the likelihood that they will cooperate with it. And dehumanizing practices that previously had been common in institutions are now forbidden.

The problems experienced in complying with patients' rights standards on Montana's Forensic Psychiatric Facility are similar to those faced by other forensic psychiatric facilities across the nation. Patients' have a right to treatment, but resources are limited and it is not always clear what types of treatment will be effective and should be provided. Institutional practices may be no more restrictive than necessary to achieve the purpose of hospitalization, yet administrators and clinicians have an obligation to prevent patients from escaping and committing dangerous acts. Many rights are intended to normalize

institutional living conditions (e.g., right to wear one's own clothes, right to keep and spend reasonable sums of money), but institutions, particularly forensic hospitals, are not normal environments. Administrators and clinicians on Montana's Forensic Treatment Facility are aware of many of the problems that exist in operating this unit, but it is difficult to institute needed changes. Hopefully, by providing background on these complex issues and recommendations for improvements, this paper will assist in their efforts.

The remainder of this paper consists of a series of recommendations for strengthening compliance with patients' rights standards on Montana' Forensic Treatment Facility. The rationale for each recommendation is also presented. These suggestions are based on the research material presented in earlier chapters. In many cases, recommendations are made for further study of a particular issue because there are several alternative courses of action that can be taken. Although the debate over patients' rights compliance on Montana's Forensic Treatment Facility will not be ended through the adoption of these recommendations, they will help to make existing practices more legally and clinically sound.

Recommendation 1: It is essential that a well defined mission statement be developed to guide unit operations and to identify service priorities. It will also serve to describe the function of the unit to

other government agencies and the public.

Forensic psychiatric hospitals often lack a clear statement of purpose or mission to guide operations. This is largely because of conflicting objectives for these services, created by their status as a hybrid of the mental health and criminal justice systems. The need to better define the purpose of Montana's Forensic Treatment Facility was stated by officials from both the Department of Institutions and the Mental Disabilities Board of Visitors.

Presently, it is not clear whether the primary purpose of the facility is as a place for the confinement or the treatment of the dangerously mentally ill. Establishing a priority on either function will affect the services that are provided. Failure to establish a priority will result in continued conflict between these two functions. If the primary mission is to segregate mentally ill offenders and other dangerous psychiatric patients from the public, then actions have to be taken to ensure that strict security procedures are imposed and that only people with these characteristics are admitted to the unit. If providing psychiatric treatment to this population is to be the primary function, then a diversified treatment program with adequate resources must be provided and some steps should be taken to ensure that people admitted to the facility are amenable to therapy. Whichever priority is chosen, all policies and procedures used to guide operations should

be in accord with it. Furthermore, the mission of the Forensic Treatment Facility must be made clear to the judicial system, advocacy groups, politicians, patients, other hospital units, and the public. This will help prevent people from being inappropriately admitted to the facility and clarify expectations for both patients and staff members.

Recommendation 2: The relationship between security and treatment must be clarified in policies and procedures at every level of unit operations.

The literature indicates that forensic psychiatric facilities often experience problems maintaining a proper balance between security and treatment. As much as possible these two functions have to be kept distinct so that the rationale for actions is understood and to clarify expectations for both patients and staff. One way that this can be done is to follow the JCAHCO standards requiring that orders for treatment or diagnostic purposes be signed by physicians, while orders issued for security purposes be signed by administrators.[1] Additionally, the rationale for an order in either case should be appropriate to the circumstances and explainable to anyone concerned.

When it is necessary to institute a general policy

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[1] Joint Commission on Accreditation of Health Care Organizations, Accreditation Standards for Forensic Facilities (Chicago: Joint Commission on Accreditation of Health Care Organizations, 1989), 48.

placing limitations on patients, a written rationale for the action should be included in the policy document. This will help to ensure that restrictions receive careful consideration before implementation. The rationale can contain an explanation of the way that conflicting interests between security, liberty, and treatment were weighed in making the decision. This practice will help to reduce conflict and misunderstanding over these actions. All such decisions should be consistent with the mission statement and other related policies and practices.

Recommendation 3: The practice of mixing criminally committed and civilly committed patients on the Forensic Treatment Facility needs to be reviewed. The review should consider alternatives to the current practice and the cost and impact of each option.

Presently, about 70% of the patients on the Forensic Treatment Facility have been admitted to the State Hospital on a voluntary or civil involuntary basis. They are transferred to the FTF from other treatment units after exhibiting violent or unmanageable behavior. On the FTF, these patients are mixed with more traditional forensic patients, those involved with the criminal justice system.[a] This practice has been strongly criticized by the Mental

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[a]Patients at the hospital under criminal court-order for evaluation status are an exception. One of two wings on the High Security ward is set aside for these patients. Opportunities for this group to interact with civilly committed patients are minimal.

Disabilities Board of Visitors and advocacy groups throughout the state. The legality of procedures used to place civilly committed patients in this restrictive setting may be questioned. Different types and levels of restrictions and security procedures may be appropriate for members of each group. Yet, when all options are evaluated, the present practice may prove to be the most appropriate.

Because of the questions and controversy that concern this practice, it needs to be reviewed. There are four major alternatives that can be explored:

1. Prohibition against housing any civilly committed patients on the forensic treatment facility.

2. Segregating these two classes of patients on different wards within the forensic facility and instituting treatment and security practices appropriate to individual members of each group.

3. Allowing the two classes of patients to be mixed, but instituting appropriate due process review procedures to ensure that the placement of civilly committed patients in this facility is justified.

4. Continuation of the present practice that permits these groups of patients to be mixed, with civilly committed patients transferred into the facility from other hospital units upon issuance of an order from a physician.

There are various costs and ramifications for treatment and security associated with each alternative. The law places a burden on administrators and clinicians to demonstrate the need to take restrictive actions against patients. One of

these alternatives should be chosen because it constitutes good policy, not because it the least expensive option or the easiest to implement.

Recommendation 4: Alternatives to the current practice of conducting criminal court-ordered evaluations on an inpatient basis at the Forensic Treatment Facility should be explored.

The literature indicates that many states have adopted alternatives to the practice of conducting criminal court-ordered psychiatric evaluations at a central state facility. The alternatives include screening criminal defendants for indications of serious mental illness prior to conducting a full-scale inpatient evaluation at a central hospital; the use of traveling teams of experts that conduct evaluations in local communities; contracting to have evaluations performed by private practitioners; and using community mental health center personnel to conduct evaluations. Each of these alternatives is less costly and faster than conducting all inpatient evaluations at a centralized state-run facility. Adopting one of these alternatives would also allow professionals on the Forensic Treatment Facility to devote much more of their time to providing treatment services. State statutes would have to be changed in order to alter the current practice. But given the high cost of the present system and the problems associated with it, other alternatives need to be explored.

Recommendation 5: Statutes allowing patients to be sentenced to the state hospital should be abolished.

This practice affects the entire state hospital by undermining its effort to function as a treatment facility. The problem is addressed here because patients admitted to the hospital on a criminal sentence are initially housed on the Forensic Treatment Facility. When a person is sentenced to an institution, whether it is a prison or a mental hospital, the purpose is primarily to incarcerate the individual, not to provide treatment. All five people interviewed for this paper vehemently believe that this practice is an "abuse of the mental health system." Statutes require that meaningful treatment be provided to all patients, yet it is difficult to provide meaningful treatment to an individual sentenced to be hospitalized for a period of 10 or 20 years. The correctional system is much better equipped to handle those whom the courts determine to be in need of incarceration. Adequate mental health services for this population should be provided in prisons rather than allowing them to disrupt the intensive treatment services that should be provided by psychiatric hospitals.

Recommendation 6: Active steps should be taken to educate the judiciary and other components of the criminal justice system about the purpose of the Forensic Treatment Facility and the services it provides.

The criminal justice system is sometimes accused of "abusing" mental health services, particularly forensic

psychiatric facilities. The major problem prompting these charges are inappropriate orders from the courts for people to be admitted to in-patient mental health services. This seems to occur frequently in Montana and across the country. Some judges apparently see the commitment of criminal offenders to mental institutions as a sentencing option less severe than prison, but more severe than probation. Additionally, it appears to the five officials interviewed for this paper that judges often order criminal psychiatric evaluations when they are not necessary. Efforts to explain the mission and services of the Forensic Treatment Facility should be made to officials in the criminal justice system in order to elicit their cooperation and support.

Recommendation 7: Specific procedures should be instituted for ensuring that the doctrine of the "least restrictive alternative" is adhered to on the Forensic Treatment Facility.

The doctrine of least restrictive alternative, though sometimes vague and difficult to institute in practice, is an important principle of mental health law. The doctrine is based on the concept that psychiatric treatment can be no more restrictive to an individual than necessary to achieve the purpose of his/her hospitalization. Some psychiatrists argue that consideration should be given to the type of treatment that is likely to be most effective in the shortest period of time. Difficulties arise because different types of restrictions cannot easily be measured or

compared along a linear continuum.

The concept of least restrictive alternative can be put into practice in several ways on the Forensic Treatment Facility. First, when restrictions are imposed on a patient, justification for the action taken should be documented, along with a rationale for not choosing other, less restrictive alternatives. Patients should also have the reason for restrictive actions explained to them. Second, algorithms and protocols can be devised for regular hospital procedures to guide staff members in making decisions based on the doctrine of the least restrictive alternative.[3] And thirdly, if civilly committed patients continue to be admitted to the Forensic Treatment Facility, they should not be required to undergo an initial confinement on the high security area if it appears that placement on other, less restrictive forensic wards is adequate to handle the problem for which they are transferred.

Additionally, when substantial liberty infringements or restrictive measures are imposed, such as the transfer of a patient from a regular hospital ward to the high security area, a due process review of the action should occur. The

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[3]Examples of appropriate algorithms and protocols are provided by Gail M. Barton and Betsy S. Comstock, "Protocols, Algorithms, and Procedures in Emergency Psychiatry," in Handbook of Emergency Psychiatry for Clinical Administrators, eds., Gail M. Barton and Rohn S. Friedman, (New York: The Haworth Press, 1986), 185-216.

review should be conducted by someone independent of both the Forensic Treatment Facility and the hospital unit making the transfer. The focus should be on whether the transfer is necessary and what is the least restrictive means of addressing the problem. The patient should be allowed to present his/her account of the incident prompting the transfer and to appeal an unfavorable decision. This process will put more pressure on other hospital units to try to treat behavioral problems instead of transferring them to the Forensic Unit.

Civilly committed patients should also have their placement on the Forensic Treatment Facility reviewed periodically to ensure that it remains the least restrictive alternative for them. Edwards' suggestion of conducting these reviews 30 days after the initial transfer, and then again every 90 days seems appropriate. The process for this review can consist of a mental health professional certifying that continued placement on the forensic unit is necessary to prevent or control a patient's dangerous behavior.

Recommendation 8: Clinicians and administrators should provide a written rationale when taking restrictive actions against individual patients.

When a restrictive action is taken against a patient, an explanation of the action should be given to him/her, and entered into their chart, treatment plan or both. Patients

should also be informed that they have a right to appeal restrictive actions through the patient grievance procedure. Although not always possible, staff members should try to elicit cooperation from patients in solving problems, thereby avoiding the need to impose restrictions. As recommended earlier, policies placing restrictions on groups of patients for security purposes should contain a written rationale for the action taken.

Recommendation 9: Seclusion and restraint procedures should be monitored closely to ensure rigid adherence to policies governing these procedures. Placement of patients in cells on the high security ward should require the use of procedures that are the same or similar to those used when placing patients in seclusion rooms.

Crisis intervention for psychiatric patients often involves the use of seclusion and restraint procedures. These procedures are very restrictive and controversial, although their use is regarded as appropriate and necessary under certain conditions by many professionals. Close scrutiny of these interventions is needed to ensure that they are used only when other, less restrictive alternatives do not exist. The hospital has policies in place to govern seclusion and restraint procedures. A concerted effort must be made to ensure that they are followed.

Additionally, the practice of housing patients in cells on the high security ward should be reviewed. When patients are locked in these cells for most of the day, this practice

is no different than seclusion. One alternative may be to significantly reduce the amount of time that patients spend locked in these cells. Another alternative could be to require written justification by mental health professionals on a daily basis for each individual confined to a cell (except in cases where a high level of security can be justified for individual patients admitted from the criminal justice system). Administrators and clinicians must realize that the practice of locking people alone in a room constitutes seclusion even if it is labeled something else.

Recommendation 10: An independent evaluation of the treatment program on the Forensic Treatment Facility should be conducted to determine its adequacy and to identify areas where improvement is needed. Steps must be taken to ensure that patients on the unit are afforded an opportunity to participate in meaningful and active treatment programs.

The right to treatment for patients in psychiatric facilities is clearly established. This paper has not attempted to determine the adequacy of the present treatment program on the Forensic Treatment Facility. Nevertheless, all five people interviewed for this paper expressed a belief that the current program needs to be improved and expanded. Treatment services should be seen as a priority on the unit. Assessment procedures should be used to determine the individual treatment needs of each patient with services based on assessment findings. Psychiatric

facilities have a legal and an ethical obligation to ensure that patients receive active and appropriate treatment services. Lack of funding, staff, or other resources are not acceptable excuses for an inadequate program. An outside review of the current treatment program will independently establish its adequacy and identify improvements that should be made.

Recommendation 11: A screening system should be used to determine the amenability of criminal offenders to treatment prior to their commitment to the Forensic Treatment Facility. Those unlikely to benefit from treatment should not be admitted.

The state hospital and the Forensic Treatment Facility are plagued by patients committed by the courts who are inappropriate for psychiatric hospitalization and unmotivated for treatment. This is a common problem in state psychiatric facilities. Its an expensive means of incarcerating these people, which is all that hospitalization amounts to for unmotivated patients or those resistive to treatment. For criminal offenders, this function is much better fulfilled by other components of the criminal justice system. Use of a screening process would better assure that limited resources are used to provide appropriate treatment to those most likely to benefit from it. Others, who are unamenable to treatment, would not be able to disrupt the programs of other patients receiving benefits from therapy. This practice would necessitate

changes in the State's criminal commitment statutes. This may be resisted by the judicial system because it reduces options for disposing of criminal cases, but it would result in better utilization of expensive psychiatric resources.

Recommendation 12: Treatment planning must be a priority for mental health professionals on the Forensic Treatment Facility. Treatment plans must be completed and reviewed according to legal standards and guidelines for good clinical practice.

All five people interviewed for this paper stated that treatment plans on the Forensic Treatment Facility need to be improved. The law in Montana stipulates certain criteria that must be included in treatment plans and time periods for their initial completion and periodic review. This document is intended to guide active, individualized treatment for all hospitalized psychiatric patients. This is done by identification of the patient's presenting problems and the approaches used to treat them. Goals are also set for the outcome of treatment, allowing progress to be measured. Without proper utilization of treatment plans, hospitalization often becomes custodial. No other document is as important for determining whether an individual's course of treatment is appropriate, adequate, and actually implemented.

Recommendation 13: Specific procedures should be instituted to identify the steps that are to be taken when patients refuse prescribed medication.

The refusal of patients to take prescribed medication has been cited in the literature and by the three people from the Department of Institutions interviewed for this paper as a major patients' rights issue. The refusal of patients to accept the one form of therapy considered to be most effective for treating severe mental illness seems to undermine the purpose of committing patients to an institution for treatment. By the same token, people should have a right to exercise control over any treatment that may adversely effect them, as is the case with medication side-effects. This is also an area of mental health law where a high volume of litigation has produced confusing and conflicting legal guidelines for psychiatric practice.

However, several steps can be taken. Patients should be informed and educated about medications prescribed for them. They must be told of the potential benefits and possible risks. Every effort should be made to elicit their cooperation and consent for treatment. Without cooperation, it is more likely to be ineffective. Patients who refuse to take the medication prescribed for them, but who pose little risk of violent or self-abusive behavior, should have their wishes respected. When clinically indicated, however, periodic, nonthreatening efforts should be made to explain to these individuals the possible benefits of taking prescribed medication. A patient's refusal to accept prescribed medication should not result in the loss of

privileges or imposition of restrictions. However, potentially dangerous behaviors that could be prevented with medication compliance may result in these actions. Legal consultation should be used in developing policies and procedures for involuntarily administering medication to patients during an emergency. It should also be used to establish procedures to be taken if professionals find it necessary to override a patient's decision to refuse medication. Additionally, professionals may want to consider asking that legislation be enacted to regulate the right of patients to refuse treatment similar to that passed in Vermont, Utah, Massachusetts, or other states.

Recommendation 14: Formal informed consent procedures should be used when prescribing medications and for any other forms of treatment that may present a significant risk to the patient.

Informed consent is an important legal principle regulating medical practice. Long resisted by the psychiatric profession, the need to use formal informed consent procedures has been mandated by the courts and is seen by many as having clinical benefits because it increases patient involvement in treatment decisions. Informed consent practices allow patients to assume a greater responsibility for the outcome of treatment, so generally, they will work harder to make it successful. Procedures to use in satisfying informed consent

requirements were discussed in chapters two and three. In chapter four, Edwards' expressed the belief that informed consent is often practiced at the hospital, but not adequately documented. If this is the case, it should not be difficult to implement formal documentation procedures. There may be other areas of service at the hospital where more formal informed consent procedures are needed. This should be reviewed with the assistance of a legal expert.

Recommendation 15: The Forensic Treatment Facility should seek Accreditation from the Joint Commission for Accreditation of Health Care Organizations by meeting this organization's standards for forensic facilities.

The new Accreditation Standards for Forensic Facilities from JCAHCO provide comprehensive guidelines for the administration of in-patient forensic psychiatric programs. These standards cover the following areas of service: patient intake; assessment; treatment planning; therapeutic environment; patient rights; and rehabilitation services. Prior to their release, there were no widely accepted professional standards specifically applicable to forensic psychiatric programs. This frequently resulted in confusion for everyone involved with these services, and litigation by patients and advocacy groups against forensic hospitals they considered to be inadequate or substandard. Hopefully, the magnitude of these problems will now be diminished, because accreditation indicates that professional standards for

patient services are met. This goes a long way toward protecting a program against lawsuits alleging substandard practices.

Money spent upgrading services to meet accreditation standards may result in future savings by (1) making the program eligible for reimbursement funding from the Medicare/Medicaid programs, or from private insurance companies; (2) resulting in better treatment programs reducing the length hospitalization for some patients and lowering recidivism rates; and (3) protecting the program against costly lawsuits alleging substandard services. The arguments for accreditation are very compelling. There is probably no other step that can be taken to better demonstrate the commitment of the Forensic Treatment Facility to providing high quality services based on the needs and rights of its patients.

Recommendation 16: A committee should be established to review hospital policies and procedures (including those of the Forensic Treatment Facility) to ensure compliance with patients' rights standards.

Formulating a committee to review policies and procedures to ensure that they comply with patients' rights standards will provide several benefits. First, it indicates to patients and staff that rights issues are important to the organization and worthy of significant attention. Second, it provides a wide range of viewpoints on these issues so that difficulties in the implementation

of new policies and procedures can be reduced. Third, by selecting committee members from throughout the organization, it will help to disseminate information, thus reducing misunderstandings and complaints that go along with organizational changes. And fourth, it results in an active approach toward patients' rights, addressing issues before they develop into major problems. Strong consideration should be given to including on the committee interested people from outside of the hospital who can provide an independent perspective on hospital services.

Recommendation 17: A staff position with direct responsibilities for monitoring patients' rights issues should be established either within the state hospital's administrative structure or in the Central Office of the Department of Institutions.

While patients' rights compliance is a responsibility of administrators and clinicians at all levels of the organization, current staff positions also have numerous other responsibilities. Establishing a position with specific duties for monitoring the organization's policies and practices with respect to rights compliance will help ensure that many problems are resolved internally before they burgeon. A person in this position will be able to work within the mental health system, monitoring patient services and advocating for high quality treatment programs. As long the person in this position has regular contact with patients and direct familiarity with hospital operations, it

is not particularly important whether the position is on the hospital's administrative staff or that of the Department of Institutions Central Office.

Recommendation 18: The Mental Disabilities Board of Visitors should develop standards for the operation of its programs, specifying the services it delivers to patients and its relationship to the mental health system.

Patients' rights issues cannot be fully addressed without mentioning the role of the Mental Disabilities Board of Visitors, the state agency authorized to provide oversight to the mental health system. The three officials from the Department of Institutions interviewed for this paper all expressed the viewpoint that staff members from the Mental Disabilities Board of Visitors have frequently overstepped their authority for monitoring rights compliance and have been disruptive to patient treatment, particularly on the Forensic Treatment Facility. Al Smith, a MDBV staff attorney maintains that mental health officials have failed to take patients' rights issues seriously, and cites a need for his program to maintain an adversarial relationship with the hospital in order to bring about needed changes.

Establishing standards for the MDBV program would help the two agencies develop a better working relationship while still allowing the MDBV to operate independently and actively in protecting the interests of hospital patients. These standards should cover such areas as the categories of

rights' complaints that the MDBV staff will handle; the types of support services that will be provided to patients; the methods to be used for informing hospital personnel of patient complaints; access to hospital facilities (particularly the Forensic Treatment Facility); access to hospital records; and procedures for mediating unresolved problems and conflicts. Through the adoption of standards, MDBV services will be more accountable to patients and the public, and less open to charges that staff members are disrupting patient treatment. While patient advocates and mental health professionals may hold differing viewpoints regarding the types of treatment and other services needed by patients, conflict between these groups is not advantageous to anyone.

Appendix A

Patients' Rights Statutes in Montana

These Patient Rights are identified in the Statues of the State of Montana, (see Montana Code Annotated). A copy of these rights are furnished and explained to every patient admitted to the Montana State Hospital.

53-21-142. **Rights of persons admitted to facility.** Patients admitted to a mental health facility, whether voluntarily or involuntarily, shall have the following rights:

(1) Patients have a right to privacy and dignity.

(2) Patients have a right to the least restrictive conditions necessary to achieve the purposes of commitment.

(3) Patients shall have the same rights to visitation and reasonable access to private telephone communications as patients at any public hospitals except to the extent that the professional person responsible for formulation of a particular patient's treatment plan writes an order imposing special restrictions. The written order must be renewed after each periodic review of the treatment plan if any restrictions are to be continued. Patients shall have an unrestricted right to visitation with attorneys, with spiritual counselors, and with private physicians and other professional persons.

(4) Patients shall have unrestricted rights to send sealed mail. Patients shall have unrestricted rights to receive sealed mail from their attorneys, private physicians and other professional persons, the Mental Disabilities Board of Visitors, courts, and government officials. Patients shall have a right to receive sealed mail from others except to the extent that a professional person responsible for formulation of a particular patient's treatment plan writes an order imposing special restrictions on receipt of

sealed mail. The written order must be renewed after each periodic review of the treatment plan if any restrictions are to be continued.

(5) Patients have an unrestricted right to have access to letter-writing materials, including postage, and have a right to have staff members of the facility assist persons who are unable to write, prepare, and mail correspondence.

(6) Patients have a right to wear their own clothes and to keep and use their own personal possessions, including toilet articles, except insofar as such clothes or personal possessions may be determined by a professional person in charge of the patient's treatment plan to be dangerous or otherwise inappropriate to the treatment regimen. The facility has an obligation to supply an adequate allowance of clothing to any patients who do not have suitable clothing of their own. Patients shall have the opportunity to select from various types of neat, clean, and seasonable clothing. Such clothing shall be considered the patient's throughout his stay at the facility. The facility shall make provisions for the laundering of patient clothing.

(7) Patients have the right to keep and be allowed to spend a reasonable sum of their own money.

(8) Patients have the right to religious worship. Provisions for such worship shall be made available to all patients on a nondiscriminatory basis.

(9) Patients have a right to regular physical exercise several times a week. Moreover, it shall be the duty of the facility to provide facilities and equipment for such exercise. Patients have a right to be outdoors at regular and frequent intervals in the absence of contrary medical considerations.

(10) Patients have the right to be provided, with adequate supervision, suitable opportunities for interaction with members of the opposite sex except to the extent that a professional person in charge of the patient's treatment plan writes an order stating that such interaction is inappropriate to the treatment regimen.

(11) Patients have a right to receive prompt and

adequate medical treatment for any physical ailments. In providing medical care, the mental health facility shall take advantage of whatever community-based facilities are appropriate and available and shall coordinate the patient's treatment for mental illness with his medical treatment.

(12) Patients have a right to a diet that will provide at a minimum the recommended daily dietary allowances as developed by the National Academy of Sciences. Provisions shall be made for special therapeutic diets and for substitutes at the request of the patient or the responsible person in accordance with the religious requirements of any patient's faith. Denial of a nutritionally adequate diet shall not be used as punishment.

(13) Patients have a right to a humane psychological and physical environment within the mental health facilities. These facilities shall be designed to afford patients with comfort and safety, promote dignity, and ensure privacy. The facilities shall be designed to make a positive contribution to the attainment of the treatment goals set for the patient. In order to assure the accomplishment of this goal:

(a) regular housekeeping and maintenance procedures which will ensure that the facility is maintained in a safe, clean, and attractive condition shall be developed and implemented.

(b) there must be special provision made for geriatric and other non-ambulatory patients to assure their safety and comfort, including special fittings on toilets and wheelchairs. Appropriate provision shall be made to permit non-ambulatory patients to communicate their needs to the facility staff.

(c) pursuant to an established routine maintenance and report program, the physical plant to every facility shall be kept in a continuous state of good repair and operation in accordance with the needs of the health, comfort, safety, and well-being of the patients.

(d) every facility must meet all fire and safety standards established by the state and

locality. In addition, any hospital shall meet such provisions of the life safety code of the national fire protection association as are applicable to hospitals. Any hospital shall meet all standards established by the state for general hospitals insofar as they are relevant to psychiatric facilities.

(14) Patients are transferred or discharged only for medical reasons, or for their welfare or that of other patients.

(15) Patients are encouraged and assisted, throughout the period of stay, to exercise rights as a patient and as a citizen, and to this end may voice concerns and recommend changes in policies and services. Patients will be free from coercion, discrimination or reprisal.

(16) Patients are free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient from injury to self or to others.

(17) Patients are assured confidential treatment of personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in case of transfer to another health care institution, or as required by law or third-party contract.

(18) Patients, if married, are assured privacy for visits by their spouse.

53-21-143. Right not to be fingerprinted. No person admitted to or in a mental health facility shall be fingerprinted unless required by other provisions of law.

53-21-144. Rights concerning photographs.

(1) A person admitted to a mental health facility may be photographed upon admission for identification and the administrative purposes of the facility. Such photographs shall be confidential and shall not be released by the facility, except pursuant to court order.

(2) No other nonmedical photographs shall be taken or used without consent of the patient's legal guardian or the responsible person appointed by

the court.

53-21-145. Right to be free from unnecessary or excessive medication. Patients have a right to be free from unnecessary or excessive medication. No medication shall be administered unless at the written order of a physician. The attending physician shall be responsible for all medication given or administered to a patient. The use of medication shall not exceed standards of use that are advocated by the United States Food and Drug Administration. Notation of each individual's medication shall be kept in his medical records. At least weekly, an attending physician shall review the drug regimen of each patient' under his care. Except in the case of outpatients, all prescriptions shall be written with a termination date, which shall not exceed 30 days. Medication shall not be used as punishment, for the convenience of staff, as a substitute for a treatment program, or in quantities that interfere with the patient's treatment program.

53-21-146. Right to be free from physical restraint and isolation. Patients have a right to be free from physical restraint and isolation. Except for emergency situations in which it is likely that patients could harm themselves or others and in which less restrictive means of restraint are not feasible, patients may be physically restrained or placed in isolation only on a professional person's written order which explains the rationale for such action. The written order may be entered only after the professional person has personally seen the patient concerned and evaluated whatever episode or situation is said to call for restraint or isolation. Emergency use of restraints or isolation shall be for no more than 1 hour, by which time a professional person shall have been consulted and shall have entered an appropriate order in writing. Such written order shall be effective for no more than 24 hours and must be renewed if restraint and isolation are to be continued. Whenever a patient is subject to restraint or isolation adequate care shall be taken to monitor his physical and psychiatric condition and to provide for his physical needs and comfort.

53-21-147. Right not to be subjected to experimental research.

(1) Patients shall have a right not to be subjected to experimental research without the express and informed consent of the patient, if the patient is able to give such consent, and of his guardian, if any, and the responsible person appointed by the court after opportunities for consultation with independent specialists and with legal counsel. If

there is not a responsible person or if the responsible person appointed by the court is no longer available, then a responsible person who is in no way connected with the facility, the Department, or the research project shall be appointed prior to the involvement of the patient in any experimental research. At least 10 days prior to the commencement of such experimental research, the facility shall send notice of intent to involve the patient in any experimental research to the patient, his next of kin, if known, his legal guardian, if any, the attorney who most recently represented him, and the responsible person appointed by the court.

(2) Such proposed research shall first have been reviewed and approved by the Mental Disabilities Board of Visitors before such consent shall be sought. Prior to such approval, the board shall determine that such research complies with the principles of the statement on the use of human subjects for research of the American Association on Mental Deficiency and with the principles for research involving human subjects required by the United States Department of Health, Education, and Welfare for projects supported by that agency.

53-21-148. **Right not to be subjected to hazardous treatment.** Patients have a right not to be subjected to treatment procedures such as lobotomy, aversive reinforcement conditioning, or other unusual procedures without their express and informed consent after consultation with counsel, the legal guardian, if any, the responsible person appointed by the court, and any other interested party of the patient's choice. At least one of those consulted must consent to the treatment, along with the patient's counsel. If there is no responsible person or if the responsible person appointed by the court is no longer available, then a responsible person who is in no way connected with the facility or with the Department shall be appointed before any such treatment procedure can be employed. At least 10 days prior to the commencement of the extraordinary treatment program, the facility shall send notice of intent to employ extraordinary treatment procedures to the patient, his next of kin, if known, the legal guardian, if any, the attorney who most recently represented him, and the responsible person appointed by the court.

53-21-167. **Patient Labor.**

(1) No patient shall be required to perform labor

which involves the operation and maintenance of a facility or for which the facility is under contract with an outside organization. Privileges or release from the facility shall not be conditioned upon the performance of labor covered by this provision. Patients may voluntarily engage in such labor if the labor is compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C., Sec. 206, as amended.

(2) (a) Patients may be required to perform therapeutic tasks which do not involve the operation and maintenance of the facility, provided the specific task or any change in assignment is:

(i) an integrated part of the patient's treatment plan and approved as a therapeutic activity by a professional person responsible for supervising the patient's treatment; and

(ii) supervised by a staff member to oversee the therapeutic aspects of the activity; and

(b) patients may voluntarily engage in therapeutic labor for which the facility would otherwise have to pay an employee, provided the specific labor or and change in labor assignment is:

(i) an integrated part of the patient's treatment plan and approved as a therapeutic activity by a professional person responsible for supervising the patient's treatment;

(ii) supervised by a staff member to oversee the therapeutic aspects of the activity; and

(iii) compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C., Sec. 206, as amended.

(3) If any patient performs therapeutic labor which involves the operation and maintenance of a facility but due to physical or mental disability is unable to perform the labor as efficiently as a

person not so physically or mentally disabled, then the patient may be compensated at a rate which bears the same approximate relation to the statutory minimum wage as his ability to perform that particular job bears to the ability of a person not so afflicted.

(4) Patients may be required to perform tasks of a personal housekeeping nature, such as the making of one's own bed.

(5) Deductions or payments for care and other charges shall not deprive a patient of a reasonable amount of the compensation received pursuant to this section for personal and incidental purchases and expenses.

53-21-162. Establishment of Patient Treatment Plan.

(1) Each patient admitted as an inpatient to a mental health facility shall have a comprehensive physical and mental examination and review of behavioral status within 48 hours after admission to the mental health facility.

(2) Each patient shall have an individualized treatment plan. This plan shall be developed by appropriate professional persons, including a psychiatrist, and shall be implemented no later than 10 days after the patient's admission. Each individualized treatment plan shall contain:

(a) a statement of the nature of the specific problems and specific needs of the patient;

(b) a statement of the least restrictive conditions necessary to achieve the purposes of commitment;

(c) a description of intermediate and long-range treatment goals, with a projected timetable for their attainment;

(d) a statement and rationale for the plan of treatment for achieving these intermediate and long-range goals;

(e) a specification of staff responsibility and a description of proposed staff involvement with the patient in order to attain these treatment goals;

(f) criteria for release to less restrictive treatment conditions and criteria for discharge; and

(g) a notation of any therapeutic tasks and labor to be performed by the patient.

(3) As part of his treatment plan, each patient shall have an individualized after-care plan. This plan shall be developed by a professional person as soon as practicable after the patient's admission to the facility.

(4) In the interests of continuity of care, whenever possible one professional person (who need not have been involved with the development of the treatment plan) shall be responsible for supervising the implementation of the treatment plan, integrating the various aspects of the treatment program, and recording the patient's progress. This professional person shall also be responsible for ensuring that the patient is released, where appropriate into a less restrictive form of treatment.

(5) The treatment plan shall be continuously reviewed by the professional person responsible for supervising the implementation of the plan and shall be modified if necessary. Moreover, at least every 90 days each patient shall receive a mental examination from and his treatment plan shall be reviewed by a professional person other than the professional person responsible for supervising the implementation of the plan.

53-21-104. **Mental Disabilities Board of Visitors.** The board shall employ and be responsible for full-time legal counsel at the state hospital, whose responsibility shall be to act on behalf of all patients at the institution. The board shall insure that there is sufficient legal staff and facilities to insure availability to all patients and shall require that the appointed counsel periodically interview every patient and examine his files and records. The board may employ additional legal counsel for representation of patients in a similar manner at any other mental health facility having inpatient capability.

53-21-168. **Statement of Rights to be Furnished and Posted.** Each patient shall promptly upon his admission receive in language he understands a written statement of all of his rights under this part, including the right to treatment, the right to the development of a treatment plan, the right

to and the availability of legal counsel, and the rules for patient labor. In addition, a copy of the foregoing statement shall be posted in each ward.

Appendix B

Interview Questions

1. In your opinion, what is the purpose of the Forensic Treatment Facility (providing treatment vs. segregating patients from society)? Is the facility, as it is presently operated, meeting this mission?

2. How does the mission of the Forensic Treatment Facility relate to other services in the Mental Health System? And what is its relationship to the Correctional System?

3. What are the major issues of concern to an administrator of a forensic psychiatric facility?

4. What type of treatment is the Forensic Treatment Facility expected to provide?

5. Should patients on the Forensic Treatment Facility have the right to <u>refuse</u> treatment (either medication or less intrusive treatments)?

6. What type of security is appropriate for Forensic Unit Patients? How should the level and conditions of security be determined? Should such determinations be implemented through a "physician's order" or through an administrative directive? [The Joint Commission for Accreditation of Health Care Organizations (JCAHCO), through its standards, express that, actions taken for security purposes should be separated from treatment decisions as much as possible. When physicians sign orders that have a security purpose rather than a treatment or diagnostic purpose, the distinction between security and treatment is blurred according to JCAHCO. The present procedure on the FTF uses physician's orders.[1]]

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[1]Joint Commission on Accreditation of Health Care Organizations, <u>Accreditation Standards for Forensic Facilities</u> (Chicago: Joint Commission on Accreditation of Health Care Organizations, 1989), 48.

7. What are the major patients' rights issues of concern on the Forensic Treatment Facility?

8. Who is responsible for monitoring patients' rights on the Forensic Treatment Facility? Are there any changes in the monitoring system that should be revised? Would there be any advantages to having an "internal advocate" or a committee to monitor patients' rights "in-house?"

9. Should rights be limited for patients on Court Ordered Evaluation Status? Those committed through criminal court orders as "unfit to proceed," or those transferred from MSP or WCC? What should be the process for more clearly defining the rights of these people: statute, administrative rulemaking, or hospital policy?

10. What would the beneficial and negative impacts be of conducting Criminal Court Ordered Evaluations in the community instead of bring them to Warm Springs?

11. Should voluntary and civilly committed involuntary patients be housed and treated on the Forensic Unit? What criteria should be used for the transfer? Is this presently being followed? What process should be used to make the transfer (physician order, following an emergency, or a hearing)?

12. What is the impact of having patients sentenced to Warm Springs? What treatment/security issues do these individuals pose?

13. What would be the implications of transfering responsibilities for mentally disordered offenders to the Corrections Division of the Department of Institutions?

14. What is the distinction between locking a patient in "seclusion" and placing them in a cell on the high security ward where they are confined to their locked cell for long periods of time (as much as twenty hours per day)?

15. What is the process that you feel should take place in planning a course of treatment for a patient? How should the patient be involved in this process?

16. The issue of informed consent has become increasingly significant in Mental Health. What are informed consent issues that relate to the Forensic Treatment Facility (i.e., medications, transfers, seclusion and

restraint)?

17. What should be the procedure used for informing patients of their rights?

18. How much of an adversarial role should an advocate play in providing oversight to mental health systems?

19. Is there any specific "data" or "information" that should be collected to enhance decision making regarding the population on the Forensic Treatment Facility.

20. What would be the benefit to the state, if the Forensic Treatment Facility were to meet JCAHCO accreditation standards?

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