A Review of Basic Patient Rights in Psychiatric Care

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ABSTRACT

Although patient rights is a concept that all nurse managers need to be aware of, this concept often becomes confusing when applied to patients undergoing psychiatric treatment. It is important for the nurse manager to understand the basic rights that psychiatric patients are entitled to, to best be able to help staff nurses under his/her supervision to protect these rights. The nurse manager on a psychiatric unit often serves as a reference for staff nurses, and even for physicians, when questions regarding patient rights present themselves. The nurse manager should be certain to discuss these issues with the facility's legal and risk management team to be aware of particulars of the law of the state in which the facility is located, as state laws may differ somewhat in their treatment of psychiatric patients.

An important issue for any nurse manager is recognizing the basic rights of their patients. This issue is magnified with regard to patients undergoing psychiatric evaluation and treatment because treatment of patients with mental illness may be more coercive and less open to public awareness and accountability than the treatment of patients with other medical conditions.

When a patient with a psychiatric disorder is admitted to a hospital, he/she may lose a number of abilities that we take for granted, such as the ability to come and go, schedule his/her time, and choose and control his/her activities of daily living. If the patient has also been determined to be legally incompetent, the patient will also lose his/her ability to manage financial and legal affairs as well as the ability to make important decisions. Given that psychiatric patients are subject to restraint on everyday activities that patients with other medical conditions are not, our legal system attempts to protect the few rights that these patients retain. Some of the rights that even a

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legally incompetent patient would retain include the right to communicate with an attorney, the right to send and receive mail without censorship, the right to have visitors, the right to the basic necessities of life, and the right to safety.

Because of the nature of their medical condition, psychiatric patients may require treatment that includes limitations on visitors. For example, the psychiatric patient may be prescribed a behavior modification treatment program that requires the earning of tokens to secure certain privileges or articles. Even though this treatment is appropriate, patients still retain the right to challenge such restrictions, and the facility may have to prove the value or necessity of this treatment if challenged by the patient or his/her family.

Restraints and seclusion are considered high-risk treatments because they are potentially dangerous interventions that can result in injury or even death.[1] From a legal standpoint, they are also high risk because the psychiatric patient may view these modalities as a form of punishment and because these modalities greatly inhibit the patient's freedom. It is for these reasons that accrediting agencies and governmental entities require policies and procedures addressing the use of these treatments. In addition, many states have passed laws that limit the use of restraints and seclusion within psychiatric facilities, and the federal government (Health Care Financing Agency) has issued strict guidelines for the use of these specific treatments in facilities that receive federal funds to pay for patient care. The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) has revised its standards guiding the use of restraints and seclusion several times in the last 15 years. These standards address the application of restraints or initiation of seclusion, monitoring of the patient while these methods are in use, and frequent reassessment for the need to continue their use. The JCAHO standards also specifically require the leaders of the organization to limit the use of restraints and seclusion to clinically justified situations.[2]

The profession of nursing includes the important role of advocating on behalf of our patients' rights. The nurse manager should consider including discussion of patient rights as applicable during team meetings and on patient rounds, as well as including these rights in the nursing care plan. The nurse manager also needs to ensure that unit policies and procedures include reference to how patient rights will be protected on the unit. These policies and procedures should be developed with assistance of the facility's legal counsel to ensure compliance with legal and regulatory requirements.

Informed Consent

Informed consent means consent that a patient or the patient's legal representative gives to treating healthcare providers in a process that enables him/her to understand a proposed treatment or procedure, including

- how the treatment or procedure will be administered
- the prognosis if the treatment or procedure is given
- adverse effects
- risks
- possible consequences of refusing the treatment or procedure
- other alternatives[3]

All patients have the right to give informed consent before receiving medical assessment and/or treatment. If healthcare treatments or procedures are done without proper informed consent, the facility and provider will be at risk for legal action by the patient against the provider and the healthcare facility. Most states allow a patient to bring a claim for battery (unconsented to touching) when their consent is not obtained prior to medical treatment being given. A patient may also bring a claim for failure to obtain informed consent if consent is not obtained, or if the provider does not give the patient the information noted above about the proposed treatment or procedure. Consent is an absolute defense against battery, which is one of the reasons why informed consent is so important in healthcare situations. In the case of *Canterbury v. Spence* (1972),[4] the court held that the patient could truly be informed only if the primary provider shared with the patient all things that the patient ''would find significant'' in deciding whether to permit or participate in a particular treatment regimen. To give consent, however, the patient must have legal capacity to give consent

The Patient Self-determination Act[5] went into effect on December 1, 1991. The Patient Self-determination Act requires healthcare facilities to provide clear written information for every patient concerning his/her legal rights to make healthcare decisions, including the right to accept or refuse treatment. Box 1 lists the rights of patients enumerated by this law.

Informed consent is also required when a patient is going to participate in experimental treatments and/or medical research. Any institution that does research on patients must have an institutional review board that evaluates research programs and provides oversight to ensure the protection of all human research subjects. Consent forms for research projects can be lengthy and challenging to read and understand and may pose a special challenge for patients with psychiatric conditions who have developmental comorbidities. It is especially important to assess the question of whether the patient is legally competent to give consent when a research consent is contemplated.

Pitfalls in Informed Consent for Psychiatric Patients

The threshold question that must be asked regarding any psychiatric patient before informed consent is

BOX 1. Patient Self-determination Act—Patient Rights

(1) The right to appropriate treatment and related services in a setting and under conditions that are the most supportive of such person's personal liberty, and restrict such liberty only to the extent necessary consistent with such person's treatment needs, applicable requirements of law, and applicable judicial orders.

(2) The right to an individualized, written treatment or service plan (such plan to be developed promptly after admission of such person), the right to treatment based on such plan, the right to periodic review and reassessment of treatment and related service needs, and the right to appropriate revision of such plan, including any revision necessary to provide a description of mental health services that may be needed after such person is discharged from such program or facility.

(3) The right to ongoing participation, in a manner appropriate to a person's capabilities, in the planning of mental health services to be provided (including the right to participate in the development and periodic revision of the plan).

(4) The right to be provided with a reasonable explanation, in terms and language appropriate to a person's condition and ability to understand the person's general mental and physical (if appropriate) condition, the objectives of treatment, the nature and significant possible adverse effects of recommended treatment, the reasons why a particular treatment is considered appropriate, the reasons why access to certain visitors may not be appropriate, and any appropriate and available alternative treatments, services, and types of providers of mental health services.

(5) The right not to receive a mode or course of treatment in the absence of informed, voluntary, written consent to treatment except during an emergency situation or as permitted by law when the person is being treated as a result of a court order.

(6) The right not to participate in experimentation in the absence of informed, voluntary, written consent (includes human subject protection).

(7) The right to freedom from restraint or seclusion, other than as a mode or course of treatment or restraint or seclusion during an emergency situation with a written order by a responsible mental health professional.

(8) The right to a humane treatment environment that affords reasonable protection from harm and appropriate privacy with regard to personal needs.

(9) The right to access, on request, to such person's mental healthcare records.

(10) The right, in the case of a person admitted on a residential or inpatient care basis, to converse with others privately, to have convenient and reasonable access to the telephone and mails, and to see visitors during regularly scheduled hours. (For treatment purposes, specific individuals may be excluded.)

(11) The right to be informed promptly and in writing at the time of admission of these rights.

(12) The right to assert grievances with respect to infringement of these rights.

(13) The right to exercise these rights without reprisal.

(14) The right of referral to other providers upon discharge.[6]

obtained is whether the patient is competent to give that consent. Many patients with psychiatric disorders are capable of giving informed consent. Some of the factors that can help the team determine if the patient is competent are the following:

- The patient is aware of their surroundings.
- The patient can understand what is being said.
- The patient can make decisions based on what he/she thinks is best for himself/herself.
- The patient can agree to treatments or procedures without coercion.
- The patient can ask appropriate questions based on the informed consent information given by the provider.
- The patient can correctly repeat in his/her own words what the risks, benefits, and alternatives of the proposed treatment are.
- The patient can clearly articulate his/her reasons for wanting to refuse the proposed treatment and can correctly articulate what the risks of refusal are.

It is important to remember that although the team may come to a determination that a patient is not competent, the ultimate question of competency is one that must be decided by a court of appropriate jurisdiction. As such, when a nurse manager becomes aware of potential concerns about the competence of a patient, it is crucial to get the facility's legal office involved so that an appropriate recommendation can be made about the need to take the question to a court for resolution. Ensuring that a patient gives legally adequate informed consent before treatment is an important part of psychiatric nursing care. The nurse manager needs to reinforce with nursing staff that the physician is the only person in most instances who can have the informed consent discussion with the patient. The nurse may appropriately witness the patient's signing of the informed consent document, but all providers need to remember that the signing of the document is irrelevant if the discussion has not occurred and the patient does not understand the risks, benefits, and alternatives of the proposed treatment.

Substituted Consent

When a patient is not competent to give informed consent, or the patient's medical condition is such that the patient cannot participate in the informed consent discussion (ie, is in a coma), healthcare providers must obtain substituted consent for necessary treatments or procedures. Substituted consent is the authorization that another person gives on behalf of a patient who needs a procedure or treatment but cannot provide that consent themselves. The appointment of a healthcare proxy or durable power of attorney for healthcare decision making is one example of a means by which the other person can give substituted consent.

Substituted consent may come from a court-appointed guardian or, if state law permits, from the patient's next of kin. If there is no appointed guardian and the patient does not have a power of attorney for healthcare decision making, then the facility may need to initiate a court proceeding to appoint a guardian so that the healthcare providers can provide the care required by the patient's condition. In most states, in an emergency, the patient who is in danger of harming himself/herself or others can be given medication or be restrained or secluded without the need to obtain informed consent.

Nurse managers need to be generally aware of the statutory requirements for obtaining substituted consent in their state. The issue of competence and whether a patient has a legal guardian or some competent person to consent for his/her care need to be addressed at the time of admission, as well as throughout the hospitalization to identify and respond to any changes in the patient's condition.

Confidentiality

Nurses have both a professional and ethical duty to use knowledge gained about patients only for the enhancement of their care and not for other purposes. Most nurse practice acts require nurses to maintain the confidentiality of patient information.

Confidentiality is especially important in the care of people with psychiatric disorders. Any breach of confidentiality of data about patients, their diagnoses, symptoms, behaviors, and the outcomes of treatment could possibly impact a patient's employment, personal relationships, and insurance benefits.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) outlines how patients' health information may be used and disclosed, identifies patients' privacy rights, requires certain privacy practices of healthcare providers, and requires the development and implementation of administrative, technical, and physical safeguards to ensure the security of patients' health information. The HIPAA's Final Rule (45 CFR Parts 160 and 164),[7] which became effective on October 15, 2002, provides standards for the privacy of individually identifiable health information. Under this privacy rule, healthcare providers and others must guard against misuse of individuals' identifiable health information. The Privacy Rule protects all ''individually identifiable health information'' in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information ''protected health information (PHI).'' Individually identifiable health information is information, including demographic data

- that relates to the individual's past, present, or future physical or mental health or condition; the provision of healthcare to the individual; or the past, present, or future payment for the provision of healthcare to the individual;
- that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual; and
- that includes many common identifiers (eg, name, address, birth date, Social Security Number).

Box 2 lists types of information that would be considered PHI. The rule also limits the sharing of this information and affords patients significant rights to enable them to understand and control how their health information is used and disclosed. Protected health information under HIPAA is broadly defined as any individually identifiable health information and includes demographic data that either identify the individual or could reasonably be used to identify the individual. Healthcare providers who transmit health information electronically are covered by the Privacy Rule. A major purpose of the Privacy Rule is to define and limit the circumstances in which an individual's protected heath information may be used or disclosed. Nobody can use or disclose PHI, except either (1) as the Privacy Rule permits or requires or (2) as the patient authorizes in writing. A provider must disclose PHI in only 2 situations: (*a*) to patients specifically when they request access to, or an accounting of disclosures of, their PHI; and (*b*) to Health and Human Services when it is undertaking a compliance investigation or review or enforcement action.

Providers may use and disclose PHI without consent and/or authorization when they are conducting treatment, payment, and healthcare operations. Information may be disclosed without consent or authorization if required to do so by state or federal reporting requirements such as those related to public health, abuse, neglect, and domestic violence. Providers may disclose protected information to law enforcement officials under a variety of specific circumstances. Providers may also disclose protected information without authorization to comply

BOX 2. What Is Protected Information?

X-rays

Photos

Medical records

Any information about a patient's condition

Information doctors, nurses, and other healthcare providers put in a patient's medical record

Conversations between providers about the patient's care or treatment

Information about the patient in the health insurer's computer system

Billing information about the patient

Not dependent on patient name—why?

Law says that information is protected if the information could be used alone or in combination with any other information to identify the patient

with laws related to workers' compensation, to a party responsible for paying the benefits, and to any agency responsible for handling the workers' compensation claim. Special provisions for authorization apply to psychotherapy notes. Providers need to be careful to follow their institution's policies and procedures for HIPAA compliance. A person who knowingly obtains or discloses individually identifiable health information may face a criminal penalty of up to $50,000 and up to 1-year imprisonment. The criminal penalties increase to $100,000 and up to 5-year imprisonment if the wrongful conduct involves false pretenses and to $250,000 and up to 10-year imprisonment if the wrongful conduct involves the intent to sell, transfer, or use identifiable health information for commercial advantage, personal gain, or malicious harm. The Department of Justice is responsible for criminal prosecutions under the Privacy Rule.

The nurse manager also needs to be aware that many states have their own laws protecting patient privacy, and it is equally important to comply with state law on patient privacy. For example, in the District of Columbia, 22 DC ADC Section 2022, Patient Rights indicates

> 2022.1. Each hospital shall protect and promote each patient's rights. This includes the establishment and implementation of written policies and procedures, which include, but are not limited to, the following rights. Each patient or designee, when appropriate, shall have the right to
>
> 1. respectful and safe care given by competent personnel;
> 2. be informed of patient rights during the admission process;
> 3. be informed in advance about care and treatment and of any change;
> 4. participate in the development and implementation of a plan of care and any changes;
> 5. make informed decisions regarding care and to receive information necessary to make decisions;
> 6. refuse treatment and to be informed of the medical consequences of refusing treatment;
> 7. formulate advance directives and have the hospital comply with the directives unless the hospital notifies the patient of the inability to do so; and
> 8. **personal privacy and confidentiality of medical records.**

Lastly, the nurse manager needs to ensure that nursing staff is aware that Board of Nursing Regulations in many states also address the duty of the nurse to protect patient confidentiality. For example, in the District of Columbia, 17 DC ADC Section 5416, Standards of Conduct reads as follows:

> 5416.1. A registered nurse shall adhere to the standards set forth in the ''Code of Ethics for Nurses'' as published by the American Nurses Association, as they may be amended or republished from time to time.
> 5416.2. A registered nurse shall respect the client's right to privacy by protecting confidential information unless obligated or allowed by law to disclose the information.

The same standard applies to practical nurses in the District of Columbia, 17 DC ADC Section 5516.

Standards of Conduct states

> 5516.1. A practical nurse shall adhere to the standards set forth in the ''Code of Ethics for Nurses'' as published by the American Nurses Association, as they may be amended or republished from time to time.
> 5516.2. A practical nurse shall respect the client's right to privacy by protecting confidential information unless obligated or allowed by law to disclose the information

The American Nurses' Association Code of Ethics for Nurses provisions impacting the nurse's duty to protect patient privacy state

> Provision 33. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.

3.1. Privacy

> The nurse safeguards the patient's right to privacy. The need for healthcare does not justify unwanted intrusion into the patient's life. The nurse advocates for an environment that provides for sufficient physical privacy, including auditory privacy for discussions of a personal nature and policies and practices that protect the confidentiality of information.

3.2. Confidentiality

> Associated with the right to privacy, the nurse has a duty to maintain confidentiality of all patient information. The patient's well-being could be jeopardized and

the fundamental trust between patient and nurse destroyed by unnecessary access to data or by the inappropriate disclosure of identifiable patient information. The rights, well-being, and safety of the individual patient should be the primary factors in arriving at any professional judgment concerning the disposition of confidential information received from or about the patient, whether oral, written, or electronic. The standard of nursing practice and the nurse's responsibility to provide quality care require that relevant data be shared with those members of the healthcare team who have a need to know. Only information pertinent to a patient's treatment and welfare is disclosed, and only to those directly involved with the patient's care. Duties of confidentiality, however, are not absolute and may need to be modified in order to protect the patient, other innocent parties, and in circumstances of mandatory disclosure for public health reasons.[8]

Responsible Record Keeping

According to *A Patient's Bill of Rights*[9] of the American Hospital Association, each patient has a right to a written record that enhances care. Accrediting agencies such as JCAHO also require each patient to have a medical record.[2] Documentation may be in any number of forms, including narrative notes, clinical pathways, or other formats. Records may be kept manually or electronically. Records are legal documents that can be used in court; therefore, all nursing notes and progress records should reflect descriptive, nonjudgmental, and objective statements. Examples of significant data include contemporaneous observations of the patient through the use of the nurse's critical assessment, an accurate report of verbal exchanges with patients, and a description of the patient outcomes of the care provided.

Verbal communication between providers regarding a patient's condition should be complete, clear, factual, and limited to those involved in the patient's care and treatment. The nurse manager should consider the best way to measure understanding and retention of these concepts regarding confidentiality among staff. Some facilities require staff to sign a form annually that certifies the nurse's understanding of and commitment to maintaining confidentiality.

Privileged Communication

Although communication between a patient and his/her healthcare providers is usually privileged and thus cannot be revealed by the provider to a third party not involved in the patient's care absent patient consent without potential repercussions, there are 3 exceptions that have great relevance in the care of psychiatric patients. These are (1) when the patient threatens to harm another person, (2) when the patient threatens to harm himself/herself, and (3) when the patient reports abuse, which the provider is required by law to report to authorities. The leading court case in this area is *Tarasoff v. Board of Regents of University of California* (1974),[10] which held that therapists might have a duty to protect a person who is threatened by a patient. Subsequent court decisions discuss the issues of foreseeable violence and the amount of control that the therapist could reasonably use to prevent the harm.[11] In these types of cases, courts have said that the mandate on providers to hold patients' communications in confidence ends when those confidences include threats against the lives of others.

Courts have held that, although the duty of confidentiality between patient and therapist should be recognized, a higher duty to protect the public safety intervenes and supersedes the duty of confidentiality. There are no published cases involving nurses on this point, but nurses must be aware that threats against other people cannot be ignored, especially when there is some reasonable opportunity for the patient to follow through on these threats.

Evolving Legal Rights

Our legal system provides rules of action that govern the behavior of people with respect to their relationships with their government and with others. Ideally, laws should reflect the moral values and beliefs of a given population and popular belief about the ''rightness'' or ''wrongness'' of particular acts. Although guided by ethical principles, which are foundational, laws change and evolve to reflect the changing values and beliefs of society.[12] Examples of healthcare issues that have evolved over time in the legal system are fetal tissue use, abortion, and rights of research subjects. Nurse managers need to be generally familiar with the law and legal system to ensure that their staff's practices are consistent under the legal system.

Right to Treatment

The idea that patients with psychiatric illnesses have a legally actionable right to treatment began to develop in the late 1960s and solidified in the early 1970s in the circuit court case of *Wyatt v. Stickney* (1971).[13] This case ruling gave us new rules about the rights of civilly committed patients with mental illnesses in state hospitals. The court stated that such patients do have certain treatment rights, which include the following:

- Treatment must give some realistic opportunity for improvement or cure.
- Custodial care is insufficient to meet treatment requirements.
- A lack of funding does not excuse the state from treatment responsibilities.
- Commitment without treatment violates the due process rights of patients.

The most important holding in this case concerns the 3 determinants for the adequacy of treatment: (1) a humane environment, (2) a qualified staff in adequate numbers, and (3) individualized treatment plans. The Supreme Court decision in *O'Connor v. Donaldson* (1975)[14] stated, however, that no state can confine a person with mental illness who is not a threat to self or others in a state hospital if he/she can survive safely in the community alone or with the help of willing, responsible family members or friends.

It is also a patient's right to have his/her care delivered in the least restrictive environment possible. As early as 1969, in *Covington v. Harris*, the court held that a person treated involuntarily should receive this treatment in a setting that is least restrictive to liberty but will still meet treatment needs. Least restrictive environments can be community resources instead ofhospitalization, open units instead of locked units, or outpatient or home care instead of inpatient care.[15] Nurse managers need to be sure their staff understands the importance of constantly assessing a patient's condition and status so that healthcare professionals can initiate more or less restrictive treatment alternatives based on the patient's evolving needs.

Patient Status and Specific Legal Issues

When patients with psychiatric disorders are hospitalized, the type of admission will dictate certain aspects of the treatment plan. Civil commitment admissions can be of 3 types:

- voluntary admissions
- emergency admissions
- involuntary commitments (indefinite duration)

Each state has specific laws pertaining to each type of admission status that will dictate certain procedures for admission, discharge, and commitment for treatment.

Voluntary Admissions

Patients who present at psychiatric facilities and request hospitalization are considered voluntary admissions. Likewise, patients being evaluated as to whether they are a danger to themselves or others or are so seriously mentally ill that they cannot adequately meet their own needs in the community but are willing to submit to treatment and are competent to do so have voluntary admission status.

Voluntary patients have certain rights that differ from the rights of other hospitalized patients. Specifically, they are considered competent (until determined to be otherwise by a court) and therefore have the absolute right to refuse treatment, including psychotropic medications, unless they are dangerous to themselves or others.[16]

Voluntary patients do not have an absolute right to discharge at any time but may be required to request discharge. This time delay gives the healthcare team an opportunity to initiate a procedure to change a patient's admission status to involuntary if the patient meets the necessary legal requirements. Many people with mental illness can be voluntarily treated; however, the state cannot require that a patient receive treatment in any setting if he/she refuses. Therefore, many people with psychiatric disorders whose behavior causes family, community, and social problems do not and cannot receive psychiatric care because they are unwilling to be voluntary patients.

Emergency Admissions

Patients have emergency admission status when they act in a way that indicates that they are mentally ill and, due to the illness, are likely to harm themselves or others. State laws define the exact procedure for the initial evaluation, the possible length of detainment, and attendant treatment available.

All patients who enter the hospital as emergency admissions require diagnosis, evaluation, and emergency treatment. At the end of the statutorily limited admission period, the facility must either discharge the patient, change his/her status to voluntary admission, or initiate/ attend a civil court hearing to determine the need for continuing treatment on an involuntary basis.

During an emergency admission, the patient's right to come and go is restricted, but the right to consult with an attorney to prepare for a hearing must be protected. Patients may be forced to take psychotropic medications, especially if they continue to be dangerous to self or others. However, more invasive procedures, such as electroconvulsive therapy or psychosurgery, are not permitted unless they are ordered by the court or consented to by the patient or his/her legal guardian. Providers need to ensure that treatment that would impair the patient's ability to consult with an attorney at the time of a hearing is avoided.

Involuntary Admissions

A person who refuses psychiatric hospitalization or treatment, poses a danger to self or others, is mentally ill and for whom less drastic treatment means are unsuitable may be subjected to involuntary admission status for an indefinite period by court order. The exact legal procedure will differ in each state, but the standards for commitment are similar.

Because involuntary commitment is a serious matter, the legal protections are strict. The Supreme Court held in *Addington v. Texas* (1979)[17] that in a civil hearing before involuntary commitment, the standard of proof of ''mentally ill and dangerous to self or others'' must

be beyond that of a ''preponderance of the evidence'' (the prior civil commitment standard). It must be instead ''clear and convincing evidence'' (a much higher standard). Because this is a Supreme Court decision, the laws of each state establishing involuntary commitment procedures must reflect this standard of the protection of the patient's right to liberty.

Forensic (Criminal) Patients

Mental health professionals become involved with patients who are charged with criminal acts (known as defendants) for 2 reasons:

1. evaluation of a defendant's competency to stand trial and administration of pretrial medical treatment, if needed; and
2. evaluation of a defendant's mental condition at the time of the alleged crime and administration of medical treatment if the defendant pleads and is acquitted on an insanity defense.

This specialized type of mental healthcare is called forensic psychiatry. Ideally, the mental health team responsible for providing forensic evaluations and services is composed of a psychiatrist; clinical psychologist; social worker; psychiatric-mental health nurse, clinical specialist, or nurse practitioner; and other nursing personnel who are active in the client's evaluation and treatment. Advanced practice nurses can be valuable members of the mental health team.[18] They are specially trained to perform mental status examinations and to function as individual and group therapists. In some states, they are qualified to be trained in competency evaluations and to testify in court as expert forensic witnesses.

Competency to Stand Trial

Competency to stand trial refers to a defendant's mental condition at the time of the trial. Mental health professionals determine whether the defendant is competent by assessing the defendant's

- ability to assist the attorney with defense of the case,
- understanding of the nature and consequences of the charge against him/her, and
- understanding of courtroom procedures.

The US Supreme Court's decision in *Jackson v. Indiana* (1972)[19] resulted in state statutes designed to protect the rights of criminal defendants who continue to be incompetent to stand trial because of their mental illnesses. As a result of this ruling, these defendants can no longer be detained for an indefinite time without the benefit of the same type of commitment hearing to which all civilly committed patients have a right. The ruling requires that these pretrial defendants return to court as soon as they are competent to stand trial, which should be the primary goal of pretrial treatment.

Pleas of Insanity or Mental Illness

If the defendant chooses to plead an insanity defense, mental health professionals can be involved in evaluating the defendant's mental condition at the time of the alleged crime. A person who is found not guilty by reason of insanity is typically involuntarily admitted to a psychiatric facility for an evaluation period. The length of this period will be determined by state law. During this time, mental health professionals evaluate the patient's need for hospitalization and other appropriate disposition. On completion of the evaluation, the professionals notify the court of their recommendations, at which time a hearing may be scheduled to determine the court's order for release or for continuation of mandatory commitment for treatment. As soon as patients are considered not committable, the law requires that they be released into the community, possibly with some mandatory requirements for aftercare.

There has been some controversy over time when patients commit notorious crimes, such as when John Hinkley shot President Reagan. As a result of this controversy, some states have passed a ''guilty but mentally ill'' plea, which mandates psychiatric treatment of criminals with mental illness in correctional facilities.

Minors

Minors present special legal issues related to psychiatric care. Typically, parents or guardians had an almost absolute right to admit their minor children younger than 18 years for mental health treatment. Many states now grant older minors (12–18 years old) the right to consent to mental health treatment themselves and to protest such treatment unless there are grounds for involuntary confinement such as the patient being a threat to self or others.

In 1979, the US Supreme Court, in *Parham v. J.R.*,[20] gave a more definite standard for juvenile admissions, to which state statutes and hospital policy should conform. The Supreme Court held that parents can authorize the admission of juveniles, but accompanying the admission, some neutral fact finder should determine whether statutory requirements for admission are satisfied. Furthermore, an adversarial hearing for admission is not required, nor does due process require that the fact finder be legally trained or be a hearing officer. By ruling in this way, the Supreme Court balanced the competing interests of the rights of parents and guardians to control the lives of their children with the right of children to due process before their liberty is limited.

Psychiatric-mental health nurses need to be mindful of these procedural protections for the benefit of their juvenile clients. Limiting hospitalization to statutory requirements is an important advocacy activity for pediatric patients with mental illness.

Conclusion

Patient rights is an important subject for all nurse managers to be aware of. Rights of patients undergoing psychiatric care are sometimes challenging to navigate. The nurse manager should be up to date on the laws in the state in which he/she practices, to be able to guide staff in appropriate care. The facility's legal office is a valuable resource for the nurse manager.

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