5.5: Patient Rights

When individuals with mental health disorders are admitted to a hospital, they may lose a number of abilities that we take for granted, such as the ability to come and go, schedule their time, and choose and control their activities of daily living. In many states, patients’ rights associated with inpatient admission to a mental health unit are spelled out in state law. Patients must be specifically informed of their rights as described in the Patient Bill of Rights document.

Clients who are determined to be legally incompetent also lose the ability to manage their financial and legal affairs and make important decisions. The Patient Self-Determination Act was passed to protect patient rights.[1]

The Patient Self-Determination Act was passed in 1990 and is considered a landmark law for patient rights. This law requires hospitals, skilled nursing facilities, home health agencies, hospice programs, and health maintenance organizations to provide clear written information for patients concerning their legal rights to make health care decisions, including the right to accept or refuse treatment. It also requires agencies to ask patients about advanced directives and to document any wishes the patient has in regard to the care they do or do not want.[2] Interprofessional team members, including nurses, have an ethical duty to ensure that patients know and understand their health care-related rights.[3]

See the following box for a list of patient rights included in this law. These rights are further discussed in the following subsections.

**Patient Self-Determination Act** [4]

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

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

3. The right to ongoing participation, in a manner appropriate to the 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 the person’s mental and physical condition, the objectives of treatment, the nature and significance of possible adverse effects of recommended treatment, the reasons why the recommended 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 course of treatment in the absence of informed, voluntary, written consent to treatments 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 to not participate in experimentation in the absence of informed, voluntary, written consent.

7. The right to freedom from restraint or seclusion, other than as a course of treatment during an emergency situation with a written order by a 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, one’s mental health care records.

10. The right of a person admitted to residential or inpatient care to converse with others privately, to have convenient and reasonable access to the telephone and mail, and to see visitors during regularly scheduled hours.

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

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**Informed Consent**

**Informed consent** is the fundamental right of an individual to accept or reject health care. Based on the Patient Self-Determination Act, clients have the right to give informed consent before receiving medical assessment or treatment (except in emergency situations when imminent harm may occur to themselves or others). Most states allow a client to sue for battery if consent is not obtained before medical treatment is given. However, a client must be competent and have the legal capacity to give informed consent.

**Competency** is a legal term related to the degree of cognitive ability an individual has to make decisions or carry out specific acts. Individuals are considered competent until they have been declared incompetent in a formal legal proceeding. If found incompetent, the individual is appointed a legal guardian or representative who is responsible for providing or refusing consent (while considering the individual’s wishes). Guardians are typically family members such as spouses, adult children, or parents. If family members are unavailable or unwilling to serve in this role, the court may appoint a court-trained guardian.

**Capacity** is a functional determination that an individual is or is not capable of making a medical decision within a given
situation. It is outside the scope of practice for nurses to formally assess capacity, but nurses may initiate the evaluation of client capacity and contribute assessment information. Capacity may be a temporary or permanent state. The following box outlines situations where the nurse may question a client’s decision-making capacity.\[7\] [8]

**Triggers for Questioning a Client’s Decision-Making Capacity**

- Unawareness of surroundings
- Absence of questions about the treatment being offered or provided
- New inability to perform activities of daily living
- Disruptive behavior or agitation
- Labile emotions
- Hallucinations
- Intoxication

When a client does not have the capacity to provide informed consent, health care providers must obtain substituted consent for treatments. Substituted consent is authorization that another person gives on behalf of the patient. For example, the activation of a client’s health care power of attorney is an example of substituted consent. Substituted consent may also come from a court-appointed guardian or if state law permits, from next of kin.\[9\]

Read more about informed consent and capacity in the “Other Legal Issues” section of Open RN Nursing Management and Professional Concepts.

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**Protective Placement**

Guardianships and protective orders are legal methods in states for appointing an alternative decision-maker and identifying required services for individuals who are legally incompetent. Legally incompetent individuals may have developmental disabilities, chronic and serious mental illness, severe substance use disorders, or other conditions that limit their decision-making ability. A court can issue orders for a person who has a guardian to be protectively placed. The legal standard basically states that without the protective placement, the individual is so incapable of providing for their own care and well-being that it creates a substantial risk of serious harm to themselves or others. Protective services may include case management, in-home care, nursing services, adult day care, or inpatient treatment. Protective placements must be the least restrictive setting necessary to meet the individual’s needs and must be reviewed annually by the court.

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**Psychiatric Advance Directive**

A Psychiatric Advance Directive (PAD) is a legal document that describes a person’s preferences for future mental health treatment or names an individual to make treatment decisions for them if they are in a crisis and unable to make decisions. Many people with mental illness, their family members, and health professionals are not familiar with PADs.\[10\]

For states that do not have laws regarding PADs, an individual can still draft a PAD under the more general statutes connected to advance health care directives and living wills. However, a PAD is more beneficial because of the unique
issues of mental health care and treatment, such as medication preferences and inpatient treatment considerations and the fact that a person with mental health disorders can experience recovery and wellness over time. Read more about Psychiatric Advance Directives on the National Alliance on Mental Illness website.

**Restraints and Seclusion**

**Restraints** are devices used in health care settings to prevent patients from causing harm to themselves or others when alternative interventions are not effective. A restraint is a device, method, or process that is used for the specific purpose of restricting a patient’s freedom of movement without the permission of the person. Restraints include mechanical devices such as a tie wrist device, chemical restraints, or seclusion. The Joint Commission defines a chemical restraint as a drug used to manage a patient’s behavior, restrict the patient’s freedom of movement, or impair the patient’s ability to appropriately interact with their surroundings that is not standard treatment or dosage for the patient’s condition.

It is important to note that the definition states the medication “is not standard treatment or dosage for the patient’s condition.” For example, administering prescribed benzodiazepines as standard treatment to manage the symptoms of a diagnosed mental health disorder is not considered a chemical restraint, but administering benzodiazepines to limit a patient’s movement is considered a chemical restraint.

**Seclusion** is defined as the confinement of a patient in a locked room or an area from which they cannot exit on their own. Seclusion should only be used for the management of violent or self-destructive behavior. Seclusion limits freedom of movement because, although the patient is not mechanically restrained, they cannot leave the area.

Although restraints are used with the intention to keep a patient safe, they impact a patient’s psychological safety and dignity and can cause additional safety issues and death. A restrained person has a natural tendency to struggle and try to remove the restraint and can fall or become fatally entangled in the restraint. Furthermore, immobility that results from the use of restraints can cause pressure injuries, contractures, and muscle loss. Restraints take a large emotional toll on the patient’s self-esteem and may cause humiliation, fear, and anger.

**Restraint Guidelines**

The American Nurses Association (ANA) has established evidence-based guidelines that a restraint-free environment is the standard of care. The ANA encourages the participation of nurses to reduce patient restraints and seclusion in all health care settings. Restraining or secluding patients is viewed as contrary to the goals and ethical traditions of nursing because it violates the fundamental patient rights of autonomy and dignity. However, the ANA also recognizes there are times when there is no viable option other than restraints to keep a patient safe, such as during an acute psychotic episode when patient and staff safety are in jeopardy due to aggression or assault. The ANA also states that restraints may be justified in some patients with severe dementia or delirium when they are at risk for serious injuries such as a hip fracture due to falling.

The ANA provides the following guidelines: “When restraint is necessary, documentation should be done by more than one witness. Once restrained, the patient should be treated with humane care that preserves human dignity. In those instances where restraint, seclusion, or therapeutic holding is determined to be clinically appropriate and adequately
justified, registered nurses who possess the necessary knowledge and skills to effectively manage the situation must be actively involved in the assessment, implementation, and evaluation of the selected emergency measure, adhering to federal regulations and the standards of the The Joint Commission (2009) regarding appropriate use of restraints and seclusion.\[16\] Nursing documentation typically includes information such as patient behavior necessitating the restraint, alternatives to restraints that were attempted, the type of restraint used, the time it was applied, the location of the restraint, and patient education regarding the restraint.\[16\]

Any health care facility that accepts Medicare and Medicaid reimbursement must follow federal guidelines for the use of behavioral restraints. These guidelines include the following\[17\]:

- When a restraint is the only viable option, it must be discontinued at the earliest possible time.
- Orders for the use of seclusion or restraint can never be written as a standing order or PRN (as needed).
- The treating physician must be consulted as soon as possible if the restraint or seclusion is not ordered by the patient’s treating physician.
- A physician or licensed independent practitioner must see and evaluate the need for the restraint or seclusion within one hour after the initiation.
- After restraints have been applied, the nurse should follow agency policy for frequent monitoring and regularly changing the patient’s position to prevent complications. Nurses must also ensure the patient’s basic needs (e.g., hydration, nutrition, and toileting) are met. Range of motion exercises and circulatory checks are typically provided hourly. Some agencies require a 1:1 patient sitter or continuous monitoring when restraints are applied or seclusion is implemented.
- Each written order for a physical restraint or seclusion is limited to 4 hours for adults, 2 hours for children and adolescents ages 9 to 17, or 1 hour for patients under 9. The original order may only be renewed in accordance with these limits for up to a total of 24 hours. After the original order expires, a physician or licensed independent practitioner (if allowed under state law) must see and assess the patient before issuing a new order.

Review safe use of restraints and alternatives to restraints in the “Restraints” section of the “Safety” chapter in Open RN Nursing Fundamentals.

Admission for Care

When clients with mental health disorders are admitted for inpatient care, the type of admission dictates certain rights and aspects of their treatment plan. Admissions may be voluntary admissions, emergency admissions, or involuntary admissions.

Voluntary Admission

Individuals over age 16 who present to a psychiatric facility and request hospitalization are considered voluntary admissions. Clients admitted under voluntary admission have certain rights that differ from emergency and involuntary admissions. For example, they are considered competent with the capacity to make health care decisions (unless determined otherwise). Therefore, they have the right to refuse treatment, including psychotropic medications, unless they become a danger to themselves or others.\[18\]

Clients with voluntary admission do not necessarily have an absolute right to discharge at any time but may be required.
to request discharge. This gives the health care team an opportunity to initiate a procedure to change the client’s admission status to involuntary if needed and associated legal requirements are met. [19]

Emergency Admissions

Many states allow individuals to be admitted to psychiatric facilities under emergency admission status when they are deemed likely to harm themselves or others. State laws define the exact procedure for the initial evaluation, possible length of detainment, and treatment provided. All clients who are admitted as emergency admissions require diagnosis, evaluation, and emergency treatment according to state law. At the end of the admission period, the facility must either discharge the patient, change their status to voluntary admission, or initiate a civil court hearing to determine the need for continuing treatment on an involuntary basis. [20]

During an emergency admission, the client’s right to come and go is restricted, but they have a right to consult with an attorney and prepare for a hearing. Clients may be forced to receive psychotropic medications if they continue to be a danger to themselves or others. However, invasive procedures like electroconvulsive therapy (ECT) are not permitted unless they are ordered by the court or consented to by the client or their legal guardian. [21]

Involuntary Admissions

There may be circumstances when a person becomes so mentally ill they are at risk of hurting themselves or others, and involuntary admission for care becomes necessary even though the individual does not desire care. An individual can have an involuntary admission to a psychiatric facility if they are diagnosed with a mental illness, pose a danger to themselves or others, are gravely disabled (e.g., unable to provide themselves basic necessities like food, clothing, and shelter), or are in need of treatment but their mental illness prevents voluntary help-seeking behaviors. The legal procedures are different in each state, but standards for involuntary admission are similar. [22] [23]

Because involuntary commitment is a serious matter, there are strict legal protections established by the U.S. Supreme Court. The standard of proof of “mentally ill and dangerous to self or others” must be based on “clear and convincing evidence.” Therefore, two physicians must certify the individual’s mental health status. Additionally, the client has the right to legal counsel and can take the case to a judge who can order release. If not released, the client can be involuntarily committed to a state-specified number of days with interim court appearances. Most states permit a 72-hour admission followed by a formal hearing. If the client feels they are being held without just cause, they can file a writ of habeas corpus (i.e., a formal written order to free the person). The court makes a decision based on the “least restrictive alternative” doctrine, meaning the least drastic action is taken to achieve the purpose of care. [24] [25] Review your state’s laws regarding involuntary admissions.

For example, Wisconsin state law, referred to as “Chapter 51,” dictates the requirements for involuntary admissions and is further explained by NAMI Kenosha County.

Involuntary Admission of Minors

Special considerations apply to minors receiving psychiatric care. Many states grant minors aged 12-18 the right to provide consent for mental health treatment and to protest involuntary admission unless they are a risk to themselves or
others. In many cases, a neutral mental health review officer is assigned to the case to ensure rights are upheld. State laws are complex; therefore, nurses must be aware of legal protections of minors in the state in which they work.

Read additional information about [Clients’ Rights for Minors](https://med.libretexts.org/Bookshelves/Nursing/Nursing%3A_Mental_Health_and_Community_Concepts_(OpenRN)/05%3A_...) in Wisconsin.

### Criminal Cases and Pleas of Insanity

If a defendant pleads an insanity defense in a criminal case, they are involuntarily admitted to a mental health facility for an evaluation period determined by state law. During this time an interprofessional team of mental health professionals (including nurses) evaluates the individual’s need for hospitalization and notifies the court of their treatment recommendations. This specialized mental health care is referred to as forensic psychiatry.

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### Discharge

When clients with mental health disorders are hospitalized, their admission status may impact their rights related to discharge. There are four main types of discharge:

- **Unconditional Discharge**: Unconditional discharge refers to unconditional termination of the legal patient and institution relationship. Discharge may be ordered by a psychiatrist, advanced practice provider, or the court.

- **Release Against Medical Advice (AMA)**: Clients who were admitted voluntarily may elect to leave an institution against the advice of the health care provider.

- **Conditional Release**: Conditional release means the client is discharged from inpatient care but requires outpatient treatment for a specified period of time. If the client was involuntarily admitted, they can be readmitted based on the original commitment order if they don’t participate in outpatient treatment.

- **Assisted Outpatient Treatment**: Assisted outpatient treatment means the conditional release is court-ordered. This treatment is tied to services and goods provided by social welfare agencies, such as disability benefits and housing.

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### Reporting Unsafe or Impaired Professionals

Patients have the right to humane treatment and reasonable protection from harm. For example, if a suicidal patient is admitted and left alone with the means of self-harm, the nurse has a duty to protect the patient and can be held liable for injuries or death that occurs.

Nurses also have a duty to protect patients from suspected negligence by a colleague. In many states, nurses have a legal duty to intervene and report risks of harm to patients. This may include reporting concerns to a supervisor, the institution, and/or the state Board of Nursing. For example, nurses must report suspected drug diversion by colleagues because it can impact safe and humane treatment of patients. Read more about drug diversion and substance use disorder in nursing in the "[Substance Use Disorders](https://med.libretexts.org/Bookshelves/Nursing/Nursing%3A_Mental_Health_and_Community_Concepts_(OpenRN)/05%3A_..." chapter.

View the NCSBN PDF pamphlet: [A Nurse’s Guide to Substance Use Disorder in Nursing](https://med.libretexts.org/Bookshelves/Nursing/Nursing%3A_Mental_Health_and_Community_Concepts_(OpenRN)/05%3A_...).

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