**THE LAW AND THE RIGHTS OF**

**PEOPLE WITH MENTAL ILLNESS[[1]](#footnote-1)**

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**Evolution of the Law / Rights of People with Mental Illness**

* 19th Century - Birth of Asylums
	+ Prior to institutions: family, street, jail
	+ No effective medications
	+ Philosophy of moral treatment within an institution (therapeutically structured environment)
	+ Bull St. - 1828 first patient admitted
* Civil Rights Era (1960’s – 70’s)
	+ Geraldo Rivera, new meds and de-institutionalization
	+ Supreme Court – constitutional rights
	+ Community Mental Health Centers Act 1963
		- federal funding for community mental health centers
		- John F. Kennedy’s New Frontier
	+ 1975 first SC commitment laws with due process safeguards
* 1980 to present-
	+ 1980 CRIPA (Civil Rights of Institutionalized Persons Act)
		- authorizes U.S. Justice Department to initiate actions
	+ 1986 PAIMI (Protection & Advocacy for Mentally Ill Individuals Act)
		- one in each state -external to the service delivery system
	+ 1991 SC Code Ann. § 44‑22‑10 et.al. (Rights of Mental Health Patients)
		- revision to existing law providing more scope and detail
	+ accreditation bodies

**Today’s Legal Landscape: Sources of the Law**

* United States Constitution
* Federal laws and regulations[[2]](#footnote-2)
	+ Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 701 et. seq. Section 504 protects qualified individuals from discrimination based on their disability. It applies to employers and organizations that receive federal funds such as hospitals, nursing homes, and mental health centers. Section 504 forbids organizations /employers from excluding or denying individuals with disabilities an equal opportunity to receive program benefits and services.
	+ The ADA (The Americans with Disabilities Act of 1990), 42 U.S.C. § 12101 et. seq. The ADA prohibits discrimination for people with qualified disabilities in employment, state and local government services, public accommodations, commercial facilities, and transportation. The ADA expanded the standards of Section 504 to private sector businesses and includes standards for architecture, transportation, and

communication.

* + CRIPA (Civil Rights of Institutionalized Persons Act of 1980) 42 U.S.C. § 1997 et. seq. CRIPA allows the US Dept. of Justice (DOJ) to investigate conditions of confinement for state/ locally owned jails, prisons, nursing homes, and facilities for people with mental and developmental disabilities. The DOJ may ligate actions on behalf of all residents (not individuals) if it finds systemic rights violations.
	+ HIPAA (Health Insurance Portability and Accountability Act of 1996), 42 U.S.C. § 201 et. seq. HIPPA sets federal rules and guidelines for the protection of confidential health information and well as clients’ rights to access their information. State laws can be more protective of the clients’ rights, but not less protective.
	+ EMTALA (Emergency Medical Treatment and Labor Act of 1986), 42 U.S.C. § 1395dd et. seq. EMTALA requires emergency department to stabilized and treat any person who presents at the ER, regardless of their insurance status or ability to pay.
	+ CMS (Centers for Medicaid & Medicare Services), CMS sets regulations for different types of facilities (psychiatric hospitals, nursing homes, psychiatric residential treatment facilities for children under 21) as conditions to receive reimbursement from federal funds.
* SC Constitution
* SC laws and regulations[[3]](#footnote-3)
	+ SC Code § 44-17-10 et. seq. - Care and Commitment of Mentally Ill Persons
	+ SC Code § 44-22-10 et. seq. - Rights of Mental Health Patients (1991)
		- Applies to residential facilities owned or operated by the SC Dept. of Mental Health
		- Includes the right to: writ of habeas corpus; counsel; least restrictive care and treatment; confidentiality of records; access to medical records; communication; visitors; religious practice; refusal of treatment; exercise ….
	+ SC Code § 44-23-10 et. seq. - Provisions Applicable to Both Mentally Ill and Mentally Retarded Persons
	+ SC Code § 43-35-10 et. seq. – The Omnibus Adult Protection Act;
* Case law (decisions of the federal and state courts)
* Common law
* Agency or company policies
* Accreditation bodies
	+ JACHO (Joint Commission on Accreditation of Healthcare Organizations)
	+ CARF (Commission for Accreditation of Rehabilitation Facilities)

**Patient Rights in Various Healthcare Settings**

Outpatient

* Negative rights – do no harm

Inpatient[[4]](#footnote-4)

* Negative rights – do no harm
* Affirmative rights – provide care & services
	+ Legal theory – if you take someone’s “liberty”, you take on responsibilities for their care
		- Adequate food, clothing, shelter (overcrowding)
		- Safety (from self and others)
		- Medical, dental care, etc.
		- Religion, communication, exercise
* Affirmative rights include “treatment” in some settings
	+ Juvenile facilities, psychiatric facilities, facilities for developmental disabilities
	+ The purpose of confinement drives the type of treatment
* Affirmative rights include the right to refuse care & services
	+ Freedom to refuse medical and other treatment
	+ Freedom to refuse medications
	+ Freedom from unreasonable restraint

**Rights are not absolute.**

* Right of the client is balanced against the facility’s purpose (state’s interest)
	+ Freedom from *unnecessary* restraint
	+ Freedom from *excessive* force
	+ Right to *adequate* medical care
* How much protection for the “right” depends on the type of confinement
	+ Prisons
		- 8th Amendment – no cruel or unusual punishment
	+ Jails / SVP / Forensic / Juvenile Justice
		- 14th Amendment + High Security Interest – no punishment
	+ Treatment facilities
		- 14th Amendment + Lower Security Interest – therapeutic environment
* What about treatment? How much? How good?
	+ Right to treatment = treatment that provides a *reasonable opportunity* to benefit from the purpose of confinement
	+ “…`the Constitution only requires that the courts make certain that professional judgment in fact was exercised. It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made.” Youngberg v. Romeo, 457 US 307, 321 (1982) (quoting Youngberg v. Romeo, 644 F.2d 147, 178 (3rd Cir. 1980) (en banc)).
* US Constitutional rights are the *bare minimum*
	+ statutes and regulations (state & federal) can create *greater* rights
	+ accreditation bodies can increase standards
* BUT statutes, regulations and accreditation standards do not *necessarily* create causes of action (“right to sue”)
	+ 42 U.S.C § 1983 created a right to sue for violations of constitutional rights
	+ CMS regs, JCAHO etc. do not create a private cause of action
	+ *However,* a violations of policies, standards, regulations may be used as evidence

**Helpful Hints & Strategies for Clinical Practice**

* Follow your policies
	+ polices may exceed legal standards but cannot go below the law
* Do what you were trained to do
	+ Treatment / Rehabilitation Standard
		- “… [A treatment decision] if made by a professional, is presumptively valid; liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment.” Youngberg v. Romeo, 457 UC 307, 323 (US Sup. Ct. 1982).
	+ What I tell my clients:
		- No legal right to a particular diagnosis, treatment, medicine, clinician…
		- Legal right to have the clinician hear and consider all factors, then exercise professional judgment
		- No guarantee of good outcome or protection against mistakes

*A bad outcome / even a mistake does not always = liability!!!*

*The decision must be negligent, grossly negligent, deliberately indifferent or a substantial departure from professional judgment*

* Remember a client’s right to refuse certain things
* Avoid paternalistic decision making and maintain professional boundaries
* Understand the difference between rights and privileges
	+ Beware of level systems tied to treatment
* Use the client advocacy system!

**Client Advocacy & Grievance Systems**

* Many names = One system
* Legal requirements:
	+ CMS regs require it for facilities receiving federal funds
	+ State law requires it for residential facilities operated by the SC Dept. of Mental Health
	+ CARF & JCAHO require it for certification
* Basic requirements for a Client Grievance System:
	+ Clearly communicated
	+ Formal grievance (complaint, fact finding, conclusion)
	+ Timely (written) response
	+ Opportunity for appeal
* Good treatment demands it:
	+ The advocate is not your enemy
	+ The advocate is a resource for good care:
		- Source for legal consultation
		- Source of clients’ perceptions of care
		- A useful team member
		- Information & referral for client’s additional needs

**Reporting Abuse & Neglect**

* Children
	+ S.C. Code § 63-7-310 thru -440
		- Duties to report, immunity, penalties for failure
	+ Tip for effective reporting - S.C. Code § 63-7-20
	+ Outcome of the report - S.C. Code § 63-7-1990(f)[[5]](#footnote-5)
* Adults
	+ Duty is only for Vulnerable Adults S.C. Code § 43-35-10(11)[[6]](#footnote-6)
		- Adults in facilities
		- Adults at home
* Persons required to report S.C. Code § 43-35-25 thru -85
	+ - Duties to report, immunity, penalties for failure
* Where to report S.C. Code § 43-35-15
* Definitions of abuse S.C. Code § 43-35-10

Duty to Warn

 Really a duty to protect an identifiable 3rd party

**Special relationship**

* + (to victim, perp, assume duty, create the risk or statute imposes)

or

* + ability to monitor, supervise or control the perp

**Determination pursuant to professional standards of profession that a risk exists**

* + specific threat of violence
	+ at a specific person (reasonably identifiable) not just foreseeable
		- EX. child abuser
	+ *threat is based on professional standards*

**Duty to protect- reasonable care to protect the intended victim**

* What acts discharge the duty?
	+ call police
	+ warn the victim, family etc.
	+ contract with the patient/ clinical intervention
* One or more steps, depending on the facts, to provide reasonable care to protect the intended victim
	+ *Reasonable steps are based on the standards of the profession*
1. This material is for general information only. It is not intended as legal advice. You should consult with a qualified legal professional for legal advice on individual matters. [↑](#footnote-ref-1)
2. This is NOT an exhaustive list. [↑](#footnote-ref-2)
3. This is NOT an exhaustive list. [↑](#footnote-ref-3)
4. These “rights” are derived from basic constitutional “liberty interests” such as safety and freedom from restraint. The difference between inpatient and outpatient is primarily based on “government action” by taking someone into custody. [↑](#footnote-ref-4)
5. (F) The department is authorized to summarize the outcome of an investigation to the person who reported the suspected child abuse or neglect if the person requests the information at the time the report is made. The department has the discretion to limit the information disclosed to the reporter based on whether the reporter has an ongoing professional or other relationship with the child or the family. [↑](#footnote-ref-5)
6. "Vulnerable adult" means a person eighteen years of age or older who has a physical or mental condition which substantially impairs the person from adequately providing for his or her own care or protection. This includes a person who is impaired in the ability to adequately provide for the person's own care or protection because of the infirmities of aging including, but not limited to, organic brain damage, advanced age, and physical, mental, or emotional dysfunction. A resident of a facility is a vulnerable adult. [↑](#footnote-ref-6)