Legal Considerations of Psychiatric Nursing Practice

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KEYWORDS

• Confidentiality • Informed consent • Civil commitment • Liability

KEY POINTS

- There are major legal issues that affect psychiatric nursing and guidelines for practicing in a legal and responsible manner.
- Advances in understanding of psychiatric conditions and developments in how nurses care for psychiatric patients result in changes in regulations, case law, and policies that govern nursing practice.
- Professional development, keeping abreast of current research and literature regarding clinical practice and trends, and involvement in professional organizations are some of the ways that psychiatric nurses can meet the challenges of their profession.

INTRODUCTION

The current landscape of health care requires that psychiatric nurses have a wide breadth of knowledge to practice in a responsible and legal manner. The emphasis on participation of informed patients and families within a recovery model, expanding costs and efforts to contain costs, and the goal of exclusively electronic records all add to the demand for knowledgeable nurses. For psychiatric nursing in particular, continuing advances in understanding of mental illness, genomics that relate to mental illness, and debates about patient rights versus societal safety are factors that have an impact on care. With the evolution of psychiatric care, the definition of legal practice also evolves over time. Psychiatric nurses are held accountable to practice according to current laws, regulations, and standards. This article briefly reviews the major legal issues that affect psychiatric nursing practice today.

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STANDARDS FOR LEGAL PSYCHIATRIC NURSING PRACTICE

Legal parameters for practice are established through a variety of sources. Many measures exist against which a nurse's practice can be judged. State boards of nursing govern the scope of practice within a given state. Federal and state statues direct practice; for example, virtually all states have laws outlining the reporting of child and elder abuse. Case law (ie, legal findings related to particular court cases) also sets precedence for legal practice; for example, the Tarasoff case of the mid-1970s set a standard of the duty to protect third parties against harm that has become the benchmark in subsequent cases in other states. The Centers for Medicare and Medicare Services (CMS) sets stringent regulations for organizations that receive federal funding; for example, regulations define acceptable inpatient staff-to-patient ratios and proper training and use of seclusion and restraint. The Joint Commission is another body that sets rigorous standards for institutions that seek accreditation.[1] The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is responsible for setting national standards for the security of a patient's electronic health information. All nurses are legally responsible for understanding the rules and regulations that govern this federal legislation.

Psychiatric nurses look to professional nursing organizations to define safe and acceptable practice through published standards. The American Nurses Association, utilizing a task force made of members of the American Psychiatric Nurses Association (APNA) and the International Society of Psychiatric-Mental Health Nurses (ISPN), published the revised of *Psychiatric-Mental Health Nursing: Scope and Standards of Practice*[2] in 2014. This comprehensive document outlines levels of psychiatric nursing practice and identifies specific standards of practice for nursing activities and criteria for measuring the standards.

Key changes in the *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* include

- Emphasis on a recovery model with consumer participation in all aspects of treatment
- Paradigm shift toward prevention with psychiatric nurses promoting protective factors and environments and providing early screening and intervention
- Meeting the challenges of providing mental health care in integrated health care systems[3]

Similarly, the APNA and ISPN also have published standards that guide practice. Involvement in professional organizations can help nurses keep informed of current published standards as well as other issues.

Finally, developments in clinical practice guide legal practice. Advances in the study of the brain and behavior, neurochemical processes, new medications, the field of genetics, and the field of psychiatric nursing are constantly expanding.[3] Psychiatric nurses also continue to develop interviewing skills and therapeutic techniques. In addition to the foundation of knowledge and skills attained through basic nursing preparation, psychiatric nurses should remain current in clinical areas through participating in educational programs and reviewing the literature.

PATIENT RIGHTS AND NURSING RESPONSIBILITIES

Least Restrictive Alternative: Seclusion and Restraint

The use of seclusion and restraints is strictly regulated and psychiatric nurses are mandated to minimize if not eliminate the use of seclusion and restraint in psychiatric settings in the United States. Health care agency policies and governmental agencies

and psychiatric organizations provide stringent guidelines that dictate the use of these treatment options. Restraint is defined as restricting a patient from moving freely by holding or by use of a device. Seclusion is preventing a patient from leaving a confined area or room.[4]

Psychiatric nurses must be knowledgeable about the potential physical as well as psychological injury to patients that may occur with seclusion and restraint use. An agency's philosophy on restraint use and the organizational culture may influence how patients are managed and may serve to reduce the incidence of seclusion and restraints. Decisions regarding the use of seclusion or restraint require complex and rapid nursing assessment to consider alternatives and to determine whether these measures are the only safe option. The decision to initiate seclusion and restraint is made only to keep patients and staff safe in emergency situations.[5]

The CMS sets guidelines, which apply to all health care agencies accepting Medicare and Medicaid payments, for the use of seclusion and restraint. Within 1 hour of the initiation of seclusion or restraint, a face-to-face evaluation by a physician or licensed independent practitioner is conducted to determine the patient's current status, physical status, and any risks associated with the initiation or continuation of seclusion or restraint.[4]

Documentation regarding the decision to use seclusion should be objective and must support the need for such measures. Nurses are responsible to uphold these standards and to ensure that seclusion and restraints are not used as threats, as punishment, or for staff convenience. In the psychiatric setting, training focused on the prevention and use of seclusion and restraint must be provided during a staff member's orientation and at least annually thereafter.

Right to Refuse Treatment

The right to refuse treatment often is regarded as a patient's right to refuse medication. Patients have the right to be provided sufficient information to make an informed decision about the risks and benefits of treatment, Patients have the right to refuse medications unless court ordered to take the medication or in emergent situations and then with limited use. Nurses are responsible for assessing and documenting objectively in such cases.

Nurses may believe that the benefits far outweigh the risks of psychiatric medication; however, patients retain the right to make this decision. In addition to concerns about side effects, there are a multitude of reasons why patients might refuse medications, including denial and lack of insight about mental illness, the cost of medications, and the stigma of taking a psychotropic medication.

Even patients who are under involuntary civil commitment and prisoners who are mentally ill do not forfeit all their civil liberties and have the right to refuse medication. There is a separate judicial process by which a patient can be determined to be incompetent to refuse medication, in which case medications may be court ordered.[6] Although psychiatric nurses can inform patients about benefits, risks, and alternatives to medication, forcing a patient to take medication, without the aforementioned exceptions, exposes nurses to possible liability.

Confidentiality

Psychiatric nursing requires communication skills that promote trust and the sharing of personal information. The policy of confidentiality helps establish an environment of trust. Nurses must safeguard information shared by patients to be used for treatment purposes only except in cases otherwise required by law, such as reporting

abuse or where release of information, such as for insurance purposes or continuity of care with other providers, has been granted.

The American Nurses Association Code of Ethics for Nurses,[7] many state nurse practice acts, and most agencies that treat the mentally ill have statements regarding patient confidentiality. Because of the nature of psychiatric care, patients must be able to trust that what is shared is used for their care and is not released to parties who have no need to know or no legal right to know.

Nurses protect confidentiality by discussing patient care matters in private areas and protecting the medical record by not leaving computer screens or documents accessible or within the view of others outside the treatment team; properly disposing of discarded documents, such as report sheets; and closing computer screens displaying patient information when not in use. Patient information sent by electronic methods, such as texting, must be done with encryption or with consent of the patient. When in doubt, proper consent for release of information should be obtained.

Everyone involved in a patient care is responsible for understanding and maintaining the regulations in regard to the HIPAA.[8] It is important for psychiatric nurses to understand that the rules that apply to psychiatric mental health practice are more stringent under HIPPA. The privacy of information relating to psychiatric mental health care and developmental disability services directly prohibits the disclosure of patient information relating to such services without written consent. The World Health Organization supports more stringent standards for patients with mental illness, stating, "Mental health legislation is necessary for protecting the rights of people with mental disorders, who are a vulnerable section of society. They face stigma, discrimination and marginalization in all societies, and this increases the likelihood that their human rights will be violated."[9]

Privileged communication is a right of patients that protects information from being shared with a court of law. Although lawyer-client and psychiatrist-patient privileged communication rules have been established, not all states clearly define privileged communication between nurse and patient.[10] There may be cases in which a nurse could be compelled to share in court information considered confidential. In some circumstances, breach of confidentiality is legal, including the duty to warn third parties under certain circumstances and mandated reporting of abuse, which are discussed subsequently.

Duty to Protect

The principle—the duty to protect—states that when specific threats are made to a mental health provider about a specific victim, there is a duty to warn the intended victim. The Tarasoff decision from the 1970s[11] established a therapist's duty to protect third parties from foreseeable harm. In this case, a college student, Tatiana Tarasoff, was killed by a fellow student who had told his therapist of his plan to kill her and the therapist failed to inform the intended victim or her family.

There have been many variations among jurisdictions regarding the Tarasoff decision, which weigh a patient's right to confidentiality against the duty to protect a third party. In general, the duty to warn exists in cases when a patient makes a specific threat about a specific intended victim and in cases when a patient has a prior history of violence. Psychiatric nurses should be familiar with the laws pertaining to their jurisdiction. In general, clinicians are protected against breach of confidentiality when attempting in good faith to protect a third party.

Mandated Reporting

Virtually all states have mandated reporting laws for nurses and other health care workers regarding suspected child and elder abuse and neglect. Some states have

mandatory domestic violence reporting laws. State departments of social or human services oversee this reporting mechanism. There must be clear evidence of harm except in cases in which serious harm may result from neglect. Careful assessment and clinical judgment are invaluable in such cases.[12] Failure to follow reporting regulations is subject to legal action.

When reports are made with the intention of preventing harm, health care workers are protected from breach of confidentiality and civil action. Psychiatric home health nurses may find evidence of abuse or situations of imminent danger in patients' homes. In emergent situations, local law enforcement may be contacted. It may be helpful for home health nurses and other psychiatric nurses to inform patients of the duty to report during the initial assessment.[12]

Informed Consent

Nurses are often involved in the process of assuring that a patient has willingly consented to treatment. Informed consent is not simply the signing of a form. Informed consent is the process by which information is shared about treatment options, risks, and alternatives. Nurses often are involved in this process, and it may involve written information and a patient being asked to sign a form. The patient must have the capacity to understand the proposed treatment, have adequate information to make a decision, not be coerced, and have the option to make a choice.[13]

Treatment of Minors

Minors are considered legally incompetent to make treatment decisions for themselves, and parents of legal guardians have the right to make such decisions. The age of majority varies by state but is most often 18 years old. In general, persons younger than age 18 who are married or are in the military are considered emancipated minors. Some states also consider minors with children to be emancipated. Some jurisdictions make exceptions for minors to consent for certain types of treatment, such as substance abuse, prescribing contraceptives, treatment of sexually transmitted prevention, and suicide prevention.[14]

Documentation

Documentation is the primary method by which the record of treatment, progress and response, and patient care are communicated. Additionally, for purposes of internal and external auditing, the medical record defines what occurred in treatment. In a court of law, the medical record defines what occurred in treatment. Documentation is an important nursing responsibility that must be thoughtful and complete.[15]

The most critical information in protection against a malpractice lawsuit is clinical documentation. Important clinical information should be documented in a clear factual statement. When documenting unusual actions or treatments, the rationale must be documented to support the course of treatment. Documentation is the first line of protection against legal liability. The use of electronic medical records where check boxes and cut-and-paste functions are offered can lead to incomplete charting of care. Many medical records today are electronic or have checklists that limit the possible responses. Although these methods often make nurses' work easier, they may be too restrictive to allow for complete and individualized documentation, and additional entries may be necessary.[16]

Supervision and Safety

Nurses are key patient advocates essential to patient safety. The safety of patients with mental illness must be maintained in a variety of settings, such as the inpatient

psychiatric setting and emergency department. Psychiatric nursing skills include awareness, sometimes referred to as intuition, of subtle changes that may signal concern. Nurses are called on to respond to changes in patient condition that may threaten patient safety.[17] Often, nonlicensed personnel provide and document monitoring of patients, yet the responsibility ultimately lies with the nurse to ensure that proper supervision occurs.

Suicide Risk Assessment

One of the most crucial tasks of the psychiatric nurse is suicide risk assessment. As professionals who often have significant direct contact with patients, nurses play a key role in assessing the risk of suicide that may occur in a variety of settings, including outpatient clinics, inpatient psychiatric units, and emergency departments.[18] Although it is difficult to predict self-injurious behavior and it is rare for a nurse to be found liable in cases of completed suicide, thorough assessment and documentation are essential to decrease legal risk in cases of suicide.

Suicide risk assessment is a complex process that requires cooperation across disciplines and settings. Psychiatric nurses are often called on to provide expertise in this area. Training in suicide risk includes knowledge of screening tools, assessment skills optimizing the patient interview, prevention and intervention techniques, and the ability to apply this knowledge to clinical practice.[19]

FORENSIC PSYCHIATRIC ISSUES (PERTAINING TO THE COURT SYSTEM)

Civil Commitment Process

There were several factors that set in motion the mass exodus of patients from large state psychiatric hospitals a half century ago. Medicare and Medicaid, which are federal programs, were created in 1965, and patients living in state hospitals were not eligible for these benefits. As patients left the state hospitals, the cost of their care shifted from individual states to the federal government. The Lanterman-Petris-Short Act, also known as the California Community Mental Health Services Act of 1969, strictly limited the use of involuntary psychiatric admissions in duration and only in cases of imminent dangerousness. These standards implemented in California were soon replicated in other jurisdictions and are accepted standards of psychiatric care today, and the law currently favors individual freedoms of patients over societal concerns.[20,21]

Today, a wide variety of treatment settings exist, and inpatient treatment is reserved for patients who are mentally ill and require a high degree of monitoring for personal safety or the safety of others. Likewise, seclusion and restraint must be used only when other less restrictive means have been considered and ruled out.[20]

Civil commitment laws allow the state to treat a person with a mental illness without consent. Commitment laws are based on the "dangerousness standard" under which someone who is mentally ill can be involuntarily cared for when unable to care for himself or herself or when a danger to self or others. This process allows for family members or the police to seek commitment for persons with mental illness who are imminently dangerous yet refuse treatment.[21]

Specific criteria for commitment vary from one state to another. Common criteria for civil commitment include the stipulation that a person must have a mental illness, must lack the judgment to make decisions regarding hospitalization, and must be an immediate to harming self or others. Some states have statues pertaining specifically to alcohol and drug problems. Treatment is usually inpatient, although some jurisdictions

allow outpatient civil commitment. Courts have ruled that nurses should not be found liable for holding a hospitalized patient who is later found wrongfully committed.[22]

Civil commitment laws of the past half century favor supporting civil liberties of the mentally ill, resulting in deinstitutionalization, have been blamed for increased homelessness, morbidity, and criminalization of the mentally ill.

Competency

Within the criminal justice system, legal competency to stand trial is based on a defendant's ability to understand legal charges made and to aid an attorney in the defense. These criteria are referred to as the Dusky standard based on a 1960 Supreme Court case.[23] A person who lacks such capacity because of a severe mental illness or because of a severe developmental disability is considered legally incompetent. Defendants are considered competent unless there is some question about this presumption, usually raised by the person's behavior (eg, if the person exhibits bizarre behavior). Incompetence is not regarded as a static condition, and, if and when competence is reestablished, the person resumes the criminal process.

Other than competency to stand trial, there are many acts for which a patient might be considered competent within and outside the criminal justice system. For example, a patient agreeing to take medication or to undergo electroconvulsive therapy must be able to communicate a choice to be considered competent.

Insanity Defense

The defense of insanity is used in the criminal process when a person is considered so severely mentally ill as to lack free choice or rationality at the time of committing an illegal act, that is, the person did not know right from wrong and did not make a conscious decision to commit the crime. Not all persons who are mentally ill meet the criteria for the insanity defense, and the criteria have some variation among jurisdictions. Persons found legally insane do not receive prison terms but typically are remanded to treatment in forensic hospitals. State laws vary regarding the criteria, disposition, and release from treatment regarding the insanity defense.[24]

The insanity defense has received a great deal of recent attention because of the 2002 trial of Andrea Yates. Yates was found guilty in the drowning deaths of her children despite unsuccessful arguments by her attorneys for a finding of innocence by reason of insanity. Yates had a long-standing history of depression and psychosis and was under the care of a psychiatrist. The prosecution did not dispute that Yates was mentally ill but argued that she knew it was wrong to drown her children yet made a decision to do so anyway.[25]

LEGAL TRENDS

Legal Issues in Advanced Practice

Advanced practice psychiatric nursing involves additional legal concerns. The scope of practice for the advanced practice registered nurse and requirements for the use of protocols, supervision, and other limitations vary widely from state to state and are outlined in each state's nursing practice act. The American Association of Nurse Practitioners is one of the largest national professional organizations, representing all advanced practice nurses. This organization provides valuable information, such as legislative and regulatory updates, evidence-based practice guidelines, and business management practice resources.[26] Many state nurses associations and other organizations have resources dedicated to advanced practice registered nurses.

Advanced practice registered nurses are exposed to liability through prescriptive authority, billing practice, and the unique nurse-patient relationship of therapy. There are 4 important elements of malpractice: duty of care, breach of the standard of care, injury, and injury caused by the breach of the standard of care. All advanced practice nurses should understand their scope of practice and duty of care. A breach in these important elements can place both patient and nurse at risk.[27,28]

A recent case involving both an advanced practice psychiatric-mental health nurse practitioner (PMHNP) and a family nurse practitioner (FNP) focused on medications prescribed by another clinician highlights the risk of liability. A patient was being treated by both an FNP and PMHNP in the same clinic. The FNP managed the patient's medication for hypertension. The PMHNP managed the patient's mental health medications, which consisted of lamotrigine. Shortly after the lamotrigine was initiated, the patient was assessed by the FNP with a complaint of body aches and the FNP prescribed an antibiotic. Four weeks later the patient followed up with the FNP for a rash, resulting in the addition of a steroid to treat the rash. The patient was hospitalized 2 days later with Stevens-Johnson syndrome and toxic epidermal necrolysis. The patient sued the FNP and clinic for damages incurred by a lengthy hospitalization. The FNP was found liable because she was responsible for recognizing side effects of all of the patient's medications, even those prescribed by others.[27,28]

Liability Risks

Although there is no direct correlation to psychiatric nurses, it may be helpful to extrapolate data regarding malpractice claims against psychiatrists. For psychiatrists, the more severe a patient's illness, the higher the likelihood of legal action. Certification seems protective for psychiatrists, and psychiatric nurses should consider certification as validation of clinical expertise.

Common reasons for claims against psychiatrists include

- Incorrect treatment (often medications)
- Suicide or suicide attempt
- Confidentiality breach
- Drug interactions[29]

Gun Laws and Mental Illness

An increase in the number of mass shootings in the United States, including the 2012 tragedy at Sandy Hook Elementary School, in which 20 children and 6 educators were killed, has fueled debates about gun regulations and the mentally ill. As far back as the Gun Control Act of 1968, which introduced mental health restrictions for gun sales, there has been an effort to restrict the purchasing of fire arms to those deemed a danger to themselves or others, by virtue of mental illness, who have been court mandated to treatment.[30]

The Brady Handgun Violence Prevention Act of 1993 required mandatory background checks for the purchase of weapons from federally licensed firearms dealers, restricting the sale of fire arms to the mentally ill who had been adjudicated to mental health care. The trading or purchasing of firearms from private individuals is more difficult to enforce. The National Instant Criminal Background Check System (NICS) allows for instant background checks; however, many states do not require mandatory reporting of mental health records into the system. Such was the case when in 2007 a young man who 2 years earlier had been court ordered to outpatient mental health care due to threat of danger to himself was able to pass an NICS background check to purchase weapons to use to kill students at Virginia Tech. Events at Virginia in

2007 Tech led to the federally passed NICS Improvement Amendments Act in 2008 designed in part to increase reporting of mental health records to the online system, yet states have been slow to respond to requirements to submit records, citing privacy concerns.[30]

It is difficult for trained professionals to predict violence and most persons with mental illness are not violent. Sadly, of the 31,000 annual deaths from shooting in the United States, a majority of those deaths are due to suicide. Approximately half of all suicides are committed with firearms, and death occurs 85% of the time when a gun is used. The debates regarding gun laws and mental illness will likely continue to rage.[30–32]

Criminal Justice System and Mental Illness

As long-term psychiatric hospitals have closed and the number of inpatient psychiatric beds decrease, the numbers of prisons and jails with high populations of mentally ill have grown. Currently, approximately 3 times as many persons with mental illness are incarcerated as are in psychiatric hospitals. The psychiatric needs of prisoners are 4 times that of the general population. Poor access to mental health care may be a factor that contributes to persons with mental illness entering the criminal justice system.[33] Nurses who work with suspects, offenders, and victims of crimes are forensic psychiatric nurses, a specialty of growing need.[34]

Mental Health Courts

In response to a disproportionate number of persons in the criminal justice system with mental health needs, there are a growing number of jurisdictions that utilize mental health courts for defendants with mental health disorders. The goal of mental health court is to divert persons charged with crimes away from incarceration and into treatment, thereby reducing criminal recidivism and improving mental health functioning. Individuals agree to court-monitored mental health treatment while avoiding jail time.[35,36]

Disaster Nursing

The emergence of behavioral health services for world disasters is growing rapidly. World disasters, such as the 2015 bombings in Paris, France; terrorist acts of 9/11; and floods in India, are increasingly common. Mental health providers from around the world assist in responding to these disasters. The rules and regulations of the emergency operation system, such as the National Response Framework, apply to these situations as well as the local and national rules and regulations governing an industry. These emergencies are challenging in themselves but pose additional concerns. Special concern for psychiatric nurses are privacy issues, record keeping, relationships between provider and patient, and providing acute psychiatric services. What happens when legal rules and regulations governing a nurse in her home country conflict with another country in which services are provided? What is a nurse's legal liability and does immunity exist? These questions have yet to be clarified.[37]

SUMMARY

The landscape of psychiatric nursing is rapidly changing. Psychiatric nurses are required to be well educated and knowledgeable with strong clinical skills, which are judged against standards acceptable of professional peers. Laws, agency policies, and regulations evolve over time as do clinical practice standards. In addition to basic education, psychiatric nurses must continually participate in professional

development to understand changes in the field and develop new skills to meet these changes.[38,39] Becoming certified and involved in professional organizations is one way to help stay abreast of current trends and developments. To minimize the risk of litigation, nurses must be aware of laws, regulations, and standards that govern practice. Although it is critical for psychiatric nurses to practice with these parameters in mind, nothing can replace sound clinical judgment.

REFERENCES

1. Joint Commission. Manual for joint commission national quality care. Available at: www.jointcommission.org/specifications_manual_joint_commission. Accessed November 30, 2015.
2. American Psychiatric Nurses Association, International Society of Psychiatric-Mental Health Nurses. Psychiatric-mental health nursing: Scope and standards of practice. (2nd edition). Silver Springs (MD): American Nurses Association; 2014.
3. Kane C. The 2014 scope and standards of practice for psychiatric mental health nursing: key updates. Online J Issues Nurs 2015;20(1):1.
4. Springer G. When and how to use restraints. Am Nurse Today 2015;10(1):26–7.
5. Federal register, December 8, 2006, 42 CFR, Part 482.
6. Wettstein RM. The right to refuse psychiatric treatment. Psychiatr Clin North Am 1999;22:173–82.
7. American Nurses Association. Code of ethics for nurses with interpretive statements. Washington, DC: American Nurses Association; 2015.
8. U.S. Department of Health & Human Services. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security and Breach Notification Rules. 2015. Available at: http://www.hhs.gov/ocr/privacy/. Accessed November 30, 2015.
9. World Health Organziation. Mental health legislation & human rights. 2015. Available at: http://www.who.int/mental_health/resources/en/Legislation.pdf. Accessed November 30, 2015.
10. Wysoker A. Confidentiality. J Am Psychiatr Nurses Assoc 2001;7:57–8.
11. Vitaly Tarasoff et al. plantiffs and appellants v the regents of the University, et al. defendants and respondent, SF 23042. (1976). Pacific Reporter, 551p.2d, 334–62.
12. Dubowitz H, Giardiano A, Gustavson E. Child neglect: guidelines for pediatricians. Pediatr Rev 2000;21:111–6.
13. Schouten R. Law and psychiatry: what should our residents learn? Harv Rev Psychiatry 2001;9:36–8.
14. Muscari ME. When can an adolescent give consent. Am J Nurs 1998;98:18–9.
15. Mohr WK. Deconstructing the language of psychiatric hospitalization. J Adv Nurs 1999;79:1052–9.
16. Knoll JL. The psychiatrist's duty to protect. CNS Spectr 2015;20(03):215–22.
17. Dresser S. The role of nursing surveillance in keeping patients safe. J Nurs Adm 2012;42(7–8):361–8.
18. Good B, Walsh RM, Alexander G. Assessment of the acute psychiatric patient in the emergency department: legal cases and caveats. West J Emerg Med 2014; 15(3):312–7.
19. Grant CL, Lusk JL. A multidisciplinary approach to therapeutic risk management of the suicidal patient. J Multidiscip Healthc 2015;8:291–8.

20. Torrey EF. The insanity offense: how America's failure to treat the seriously mentally ill endangers its citizens. New York: WW Morton and Company; 2008.
21. Slovenko R. Criminal law standards in civil commitment. J Psychiatry Law 2012; 40:135–45.
22. Large MM, Neilssen OB, Lackersteen SM. Did the introduction of 'dangerousness' and 'risk of harm' criteria in mental health laws increase the incidence of suicide in the United States? Soc Psychiatry Psychiatr Epidemiol 2009;44: 614–21.
23. Gendel MH. Forensic and medical legal issues in addiction psychiatry. Psychiatr Clin North Am 2004;27:611–26.
24. Dusky v US, 363 US 402 (1960).
25. Torry ZD, Weiss K. Medication noncompliance and criminal responsibility: is the insanity defense legitimate? J Psychiatry Law 2012;40(2):219–42.
26. Asher E, Markley M. Victim's right's group praises verdict, yates backers:mental illness misunderstood. Houston (TX): Houston Chronicle; 2002. p. 29.
27. American Association of Nurse Practitioners (AANP). 2015. Available at: https://www.aanp.org/about-aanp. Accessed November 30, 2015.
28. Buppert C. The nurse practitioner's business practice and legal guide. Sudbury (MA): Jones & Bartlett Publishers; 2014. Available at: www.jblearning.com.
29. NSO, NP 2012 Liability. Available at: www.nso.com. Accessed November 30, 2015.
30. Reich J, Schatzberg A. An empirical data comparison of regulatory agency and malpractice legal problems for psychiatrist. Ann Clin Psychiatry 2014;26(2):91–6.
31. Goss KA. Defying the odds on gun regulation: the passage of bipartisan mental health laws across the states. Am J Orthopsychiatry 2015;85(3):203–10.
32. Swanson JW. Mental illness and new gun law reforms. JAMA 2013;309:1233–4.
33. Applebaum PS. "One madman keeping loaded guns" Misconceptions of mental illness and their legal consequences. Psychiatr Serv 2004;55(10):1105–6.
34. Kanapaux W. Guilty of mental illness. Psych Times 2004;21(1):40–50.
35. Brown KM. From nurse Ratched to modern forensic mental health nursing. J Psychiatry Law 2012;40:93–104.
36. Honegger LN. Does the evidence support the case for mental health courts? A review of the literature. Law Hum Behav 2015;39(5):478–88.
37. Burke MM, Griggs M, Dykens EM, et al. Defendants with intellectual disabilities and mental health diagnoses: faring in a mental health court. J Intellect Disabil Res 2012;56(3):305–16.
38. Flynn BW, Speier AH. Disaster behavioral health: legal and ethical considerations in a rapidly changing field. Curr Psychiatry Rep 2014;16(8):1–8.
39. Kesselheim AS, Studdert DM. The supreme court, preemption, and malpractice liability. N Engl J Med 2009;360(6):559–61.