Hospital Security Officer Weapons Use in Behavioral Emergencies: Is it Ever Appropriate?

Jeffrey S. Janofsky MD

On February 12, 2016, the *New York Times*[1] and *This American Life*[2] reported on an incident where a patient with elevated mood and delusions was evaluated in a hospital emergency room. He had physically injured himself in an automobile accident prior to the ER visit. Although he told hospital staff, "I'm manic" and clearly presented to the ER with symptoms consistent with psychotic mania, he was not seen in the ER by a psychiatrist and was admitted to a medical floor. There he became verbally and physically agitated. Nursing staff called security for help. Hospital security (who were moonlighting police officers) equipped with Tasers and handguns responded and entered the patient's room without clinical staff. The patient threw a hospital tray at the police officers. The officers first deployed their Tasers, and then shot the patient with their service weapons, causing him serious injury. The patient later recovered from his original physical injuries, his gunshot wounds and his psychiatric illness. He was charged with multiple crimes related to his interactions with the police in the hospital

In a 2010 Sentinel event alert *Preventing Violence in the Health Care Setting*, the Joint Commission noted that health care institutions were confronting increasing rates of violence.[3] The alert addressed only physical assaults, rape or homicide of patients and visitors perpetrated by staff, visitors, other patients, and intruders to the institution. It did not address verbal threats or physical assaults by patients on staff. It made no recommendations on the use of firearms or Tasers by hospital security personnel. On January 2013 JC added as a sentinel event: Rape, assault (leading to death or permanent loss of function), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the health care organization."[4]

The FBI divides workplace violence into four separate typologies: Type 1: Violent acts by criminals, who have no other connection with the workplace, but enter to commit robbery or another crime; Type 2: patient or visitor on staff; Type 3: Violence against co-workers by current or former employees; and Type 4: Violence committed in the workplace by someone who doesn't work there, but has a personal relationship with an employee—an abusive spouse or domestic partner.[5] In a 2015 Health Care Crime Survey the International Healthcare Security and Safety Foundation (IHSSF) found that in United States Hospitals 90% of the assaults and 79% of the aggravated assaults were Type 2, patient on staff.[6]

In a study that searched the media to collect data on all hospital based shooting events from 2000 to 2011 Kelen et al. identified 154 hospital related shootings during the study period. In 26 (18%) cases, the perpetrators did not bring their own firearm and in 13 (8%) events, the shooting event was initiated by the perpetrator's taking a security or police officer's gun. In the other cases, security shot the perpetrator for other threats, such as wielding a knife.[7] Kelen found that only 4% of the shooting events were perpetrated by mentally unstable patients.

The TASER company, at its website, notes that: "At TASER we make communities safer with innovative public safety technologies that protect life and truth. Founded in 1993, TASER first transformed law enforcement with our electrical weapons. Today, we continue to define smarter policing with our growing suite of technology solutions."[8] The TASER website links to a 369 page document, *Brief Outline of Partial Selected CEW*[9] *Research and Information*. That document has a section linking to research supporting the use of TASERS in hospital settings and on mentally ill subjects.[10]

The Joint Commission does not have a current position on the use of Tasers, pepper spray, or lethal force by hospital personnel responding to behavioral emergencies. The AMA and APA have no current positions on this issue either. However CMS' interpretive guidelines states that, "CMS does not consider the use of weapons in the application of restraint or seclusion as a safe, appropriate health care intervention. For the purposes of this regulation, the term "weapon" includes, but is not limited to, pepper spray, mace, nightsticks, tazers [sic], cattle prods, stun guns, and pistols..... CMS does not support the use of weapons by any hospital staff as a means of subduing a patient in order to place that patient in restraint or seclusion." CMS goes on to state that security staff may carry weapons as allowed by hospital policy but that the "use of weapons by security staff is considered a law enforcement action, not a health care intervention." Furthermore CMS states that, "If a weapon is used by security or law enforcement personnel on a person in a hospital (patient, staff, or visitor) to protect people or hospital property from harm, we would expect the situation to be handled as a criminal activity and the perpetrator be placed in the custody of local law enforcement."[11]

Given this data, the APA's Council of Psychiatry and the Law has asked me to chair a workgroup to evaluate whether the APA should write a position statement on the use of handguns or non-lethal force devices in hospital and psychiatric settings. I would appreciate it if AAPL members could share their opinions and experiences with me on this issue. Please e-mail me directly at: jjanofsky@gmail.com with your thoughts and experiences.

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arises most often in the development of practice guidelines and evaluation of *amici*. Some of my most enriching experiences in AAPL have occurred when I've discarded previously held positions as a result of hearing the careful considerations and arguments of other members.

AAPL's stated goals are to "promote scientific and educational activities in forensic psychiatry" by facilitating the exchange of ideas and practical clinical experience through publications and regularly scheduled national and regional meetings; developing ethical guidelines for forensic psychiatry; stimulating research in forensic psychiatry, developing guidelines for education and training in forensic psychiatry for residents and fellows; and providing information to the public about forensic psychiatry.[10] As a result of functioning as the center of forensic psychiatry's moral economy, and in addition to its educational and research activities, AAPL has developed additional significant and often unrecognized attributes of a professional home.

A professional home should provide members with opportunities to develop and consolidate their professional identity throughout all of the successive stages of their careers. In addition to promulgating "rules and rites," a professional home should provide both formal and informal contact with role models; more senior colleagues who embody the principles, values, and spirit of the discipline. The organization should create formal contacts by encouraging younger members to become involved in the organization's structure. Informal contacts, though more difficult to establish, are often more enriching. A professional home can create opportunities for these contacts by instilling a culture of mentorship among its members and establishing formal mentorship programs.

I don't think my rich experience of contact with role models and mentors in AAPL is at all unique. AAPL supports many avenues for contact with senior members. However, it is incumbent on younger members to see them out. I strongly encourage Early Career forensic psychiatrists to join a committee that engages your interest. Ask to meet or speak with a senior member whose work is compelling to you. Volunteer to write a newsletter article. Participate in the business meetings at the semiannual and annual meetings. Become a role model of an Early Career forensic psychiatrist!

A professional home should also encourage contact between career-stage cohorts within the membership. There is a unique value found in these relationships. Peer support provides excellent reality testing during the stressful period of establishing a career. Some of the most helpful experiences I had early in my practice came about through sharing my concerns about reports, testimony, and billing. AAPL excels at this facet of a professional home. Early Career members can join the Early Career committee, and attend the Early Career breakfast and social event for current and prospective fellows.

A professional home should consider establishing a mechanism for formal or informal self-assessment. AAPL provides this by virtue of our Peer Review of Psychiatric Testimony Committee and Maintenance of Certification activities such as the self-assessment examination.

Finally, a professional home should offer opportunities for service throughout a member's career. It is natural to want to give back to an organization that provides so much to its members. AAPL provides these opportunities through continuing committee work, participating in leadership, and encouraging mentorship of younger members. Some mid-career members join the faculty of the board review course. Some senior members enjoy writing editorials for the journal. Others participate in AAPL chapter meetings. I look forward to continuing my service to AAPL for many years to come.

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Juvenile Incompetance

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Developmental immaturity formed part of a constellation of difficulties amounting to mental impairment in 10% of those cases opined unfit to stand trial. Of great concern, Armstrong and Friedman found that half of unfit youth were not engaged in education of any kind. The most common diagnosis among those opined Unfit to Stand Trial was Mental Retardation; co-morbid conditions were common. Younger age was not associated with incompetence in the opinion of the assessors, a finding which was surprising in the light of international literature suggesting that younger age places defendants at a relatively high risk of being incompetent (Steinberg, 2009). It is hoped that more jurisdiction-specific research will help contextualize these findings.

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clinical staff to be familiar with these issues, in order to provide targeted and appropriate care and treatment and ensure safety. Over the years, various lawsuits have been filed under the equal protection clause of the 14th amendment to ensure that women's facilities receive the same attention as men's do. We hope that ongoing research and work with the female incarcerated population will continue to move our knowledge base forward and allow more targeted treatment and rehabilitation approaches.

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