

Staff Assaults

Assessment, Legal, Ethical, and Clinical Considerations

{ Matthew R. Kruse, MD

- ⌘ I am the Director of Psychiatry at the Anoka Metro Regional Treatment Center in Anoka, Minnesota
- ⌘ I receive 100% of my income from the State of Minnesota
- ⌘ I am speaking today on my own behalf
- ⌘ I will not be discussing any off-label or experimental use of any medications or medical devices

Disclosures

- ⌘ Overview of staff assault and patient violence in healthcare settings
- ⌘ Potential impact of assault on staff and patient care
- ⌘ Legal and clinical options following an assault
- ⌘ A consideration of conflicts and methods for alignment

Objectives

The Issue



Dr. Todd Graham

The Issue



Dr. Ruth Mardoc

The Issue





The Issue – Who?

& Non-fatal assault rate
 & Hospital Workers 465 / 100,000
 & All Workers 82.5 / 100,000
 & 1992 Minnesota Workers Compensation
 & Nurses accounted for 7% of cases
 & Women assaulted 2x more frequently

The Issue – Who?

Gerberich, S. G. 2004

& 40% of psychiatrists reported being
 physically assaulted


The Issue – Who?

Privitera M et al 2005

- ⌘ Psychiatry Residents
 - ⌘ 25% physically assaulted during training
 - ⌘ 4% assaulted twice in one year

The Issue – Who?

Dvir et al. 2012

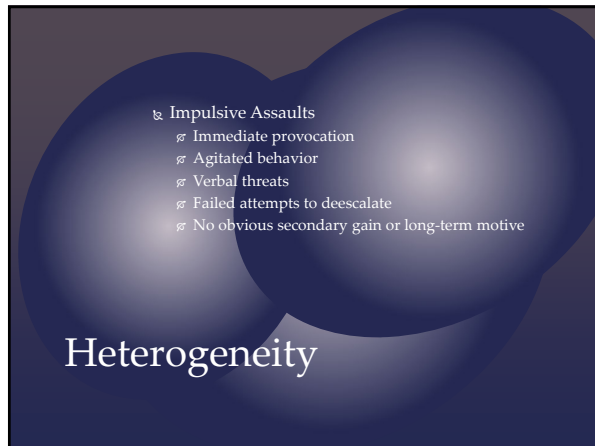


The Issue – Why?

- ⌘ Inpatients who committed > 2 assaults over one year period
- ⌘ Impulsive vs Organized vs Psychotic

Heterogeneity

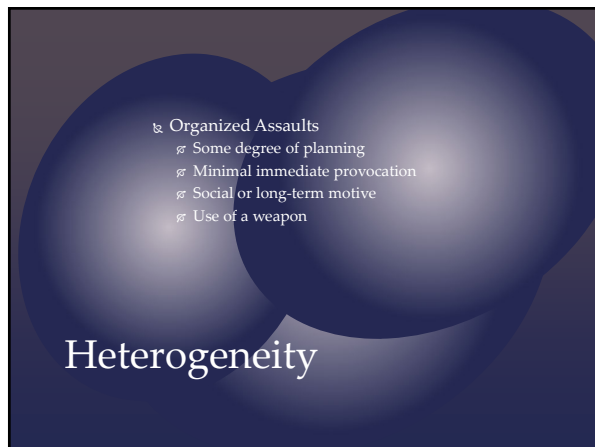
Quanbeck et al. 2007



↳ Impulsive Assaults

- ⌘ Immediate provocation
- ⌘ Agitated behavior
- ⌘ Verbal threats
- ⌘ Failed attempts to deescalate
- ⌘ No obvious secondary gain or long-term motive

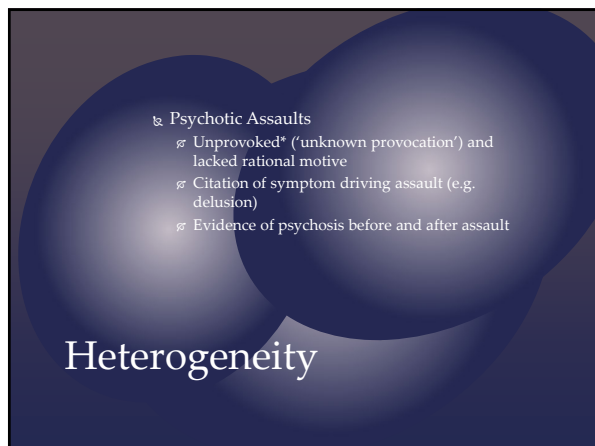
Heterogeneity



↳ Organized Assaults

- ⌘ Some degree of planning
- ⌘ Minimal immediate provocation
- ⌘ Social or long-term motive
- ⌘ Use of a weapon

Heterogeneity



↳ Psychotic Assaults

- ⌘ Unprovoked* ('unknown provocation') and lacked rational motive
- ⌘ Citation of symptom driving assault (e.g. delusion)
- ⌘ Evidence of psychosis before and after assault

Heterogeneity

↳ Impulsive 53%
 ⌘ Associated with redirection from unwanted behavior or refusal of patient request

 ↳ Organized 30%
 ⌘ Most driven by retaliation or intimidation

 ↳ Psychotic 17%
 ⌘ Fear of harm (43%)

Heterogeneity

↳ Assault, Rape, and Homicide consistently among top 10 types of sentinel events reported to The Joint Commission
 ↳ "More assaults occur in the health care and social services industries than in any other..."
 ↳ "Of greater concern is the likely **under-reporting of violence** and a persistent perception within the health care industry that **assaults are part of the job.**" – Occupational Safety and Health Administration

The Issue

↳ Psychiatry Residents
 ⌘ 20% increased vigilance
 ⌘ 10% avoidance
 ⌘ 9% anxiety
 ⌘ 2% change in career interest

Impact


Dvir et al. 2017

- ⌘ Loss of productivity and missed work days*
- ⌘ Compassion fatigue/Moral Injury
- ⌘ Fear and anger*
- ⌘ Guilt*
- ⌘ PTSD



Impact

Needham et al. 2005



Now What?


- ⌘ 1978: First report in literature of therapist filing criminal charges
- ⌘ Since then, major legal and ethical debate

Response

Appelbaum & Appelbaum 1991

- ⌘ Dual Roles
- ⌘ Questionable Justification
- ⌘ Confidentiality
- ⌘ Objectivity
- ⌘ Logistics


Against Pressing Charges



- ⌘ Provider
 - ⌘ Beneficence
 - ⌘ Non-maleficence
- ⌘ Prosecutor
 - ⌘ Adversarial
 - ⌘ Punitive

Against: Dual Roles

- ⌘ Some ethical interests can take precedence over others



Counter: Dual Roles



- ⌘ A question of retribution
 - ⌘ Can we ethically pursue punitive interests?

Against: Justification

- ⌘ Foregone Expectations

- ⌘ Responsibility
- ⌘ Stigma




Counter: Justification

"Mental health is your problem here. This was a very —based on preliminary reports—a very deranged individual. A lot of problems over a long period of time. We have a lot of mental health problems in our country, as do other countries. But this isn't a guns situation. I mean, we could go into it, but it's a little bit soon to go into it. ... But this is a mental health problem at the highest level." —Former President Donald Trump



Counter: Justification




↳ Reporting behavior breaches confidentiality

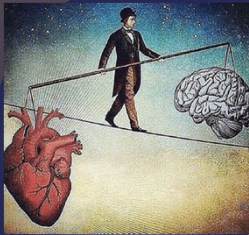
Against: Confidentiality

↳ Confidentiality and Privilege are NOT absolute

↳ Unrelated information not disclosed



Counter: Confidentiality

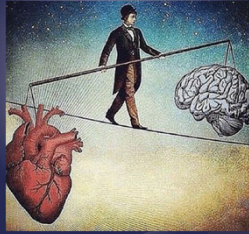


↳ There will always be an intrinsic bias

↳ Trauma will influence decision-making

Against: Objectivity

↳ With exception to solo practice, colleagues and system can help inform decision-making



Counter: Objectivity



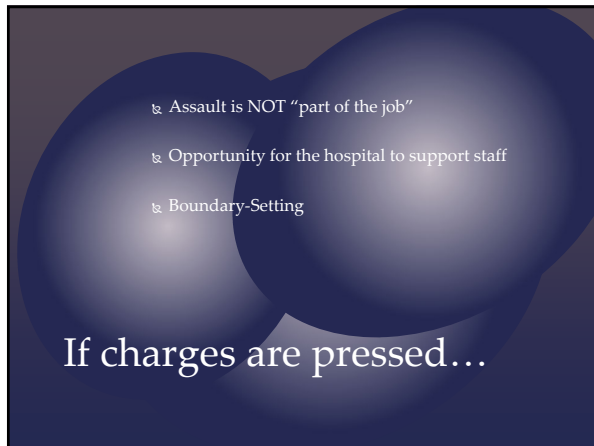
↳ Reluctance to Prosecute

Against: Logistics

↳ Creates Additional Documentation and Records

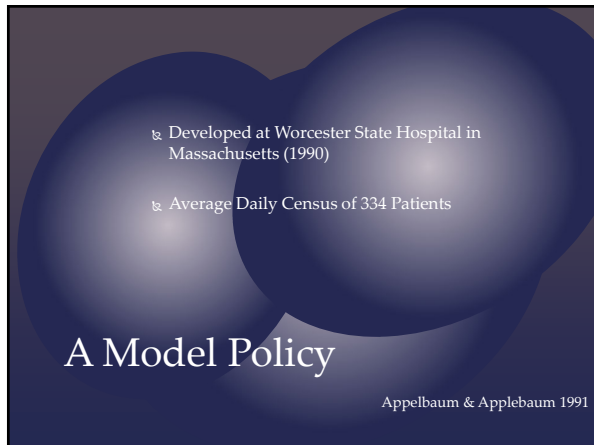


Counter: Logistics



- ⌘ Assault is NOT “part of the job”
- ⌘ Opportunity for the hospital to support staff
- ⌘ Boundary-Setting

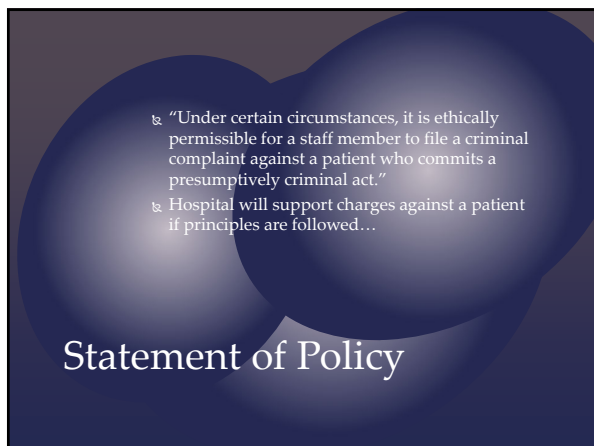
If charges are pressed...



- ⌘ Developed at Worcester State Hospital in Massachusetts (1990)
- ⌘ Average Daily Census of 334 Patients

A Model Policy

Appelbaum & Applebaum 1991



- ⌘ “Under certain circumstances, it is ethically permissible for a staff member to file a criminal complaint against a patient who commits a presumptively criminal act.”
- ⌘ Hospital will support charges against a patient if principles are followed...

Statement of Policy

⌘ Ethical principles are obligations that may be compromised for compelling reasons.

- ⌘ Necessity for retribution
- ⌘ Protecting third parties

Statement of Principles

⌘ Necessity for retribution

- ⌘ Only in cases of increasing violence **AND**
- ⌘ Decreasing relationship between illness and the act

Statement of Principles

⌘ Protecting third parties

- ⌘ All reasonable clinical interventions have failed
- ⌘ No other reasonable options exist

Statement of Principles

⌘ Patient advocates “appalled”


⌘ Others objected to restrictiveness

Policy Outcomes

⌘ Five patients were brought up for consideration

⌘ Consultation initiated, and treatment teams decided not to pursue charges in all five cases

Policy Outcomes: First Six Months



Daniel M'Naghten


Criminal Responsibility

§ "...the person shall not be excused from criminal liability except upon proof that at the time of committing the alleged criminal act the person was laboring under such a defect of reason, from [mental illness or cognitive impairment] as not to know the nature of the act, or that it was wrong."

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Criminal Responsibility



§ No clear history of mental illness or cognitive impairment

§ Clear motivation

§ Cleared area of witnesses

§ Took own life

Responsible?



Responsible?

- ↳ Assault in the Fourth Degree
 - ⌘ Peace Officers up to three years imprisonment and up to \$6,000 fine
 - ⌘ Emergency Medical Personnel, Correctional Employees, Secure Treatment Facility Personnel up to two years imprisonment and up to \$4,000 fine

Minnesota Statute
609.2231



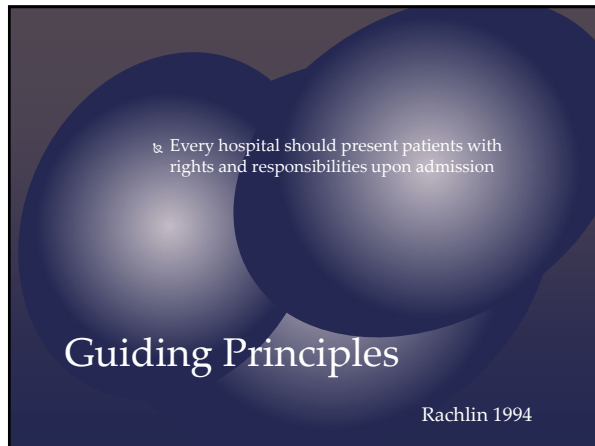
Rep. Joseph Atkins



↳ "Reportedly confused and disoriented."

↳ "I don't see how that would be a big deterrent."

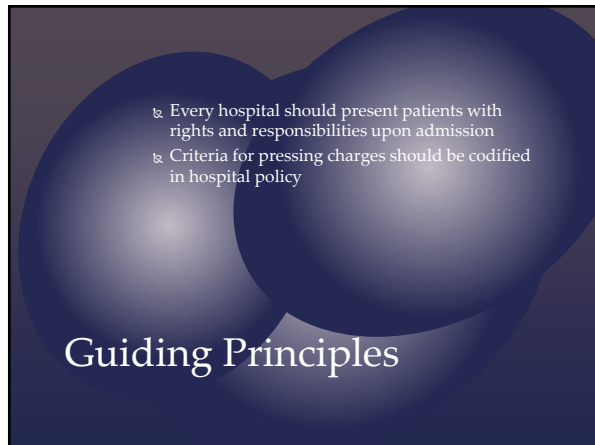
Responsible?



- ⌘ Every hospital should present patients with rights and responsibilities upon admission

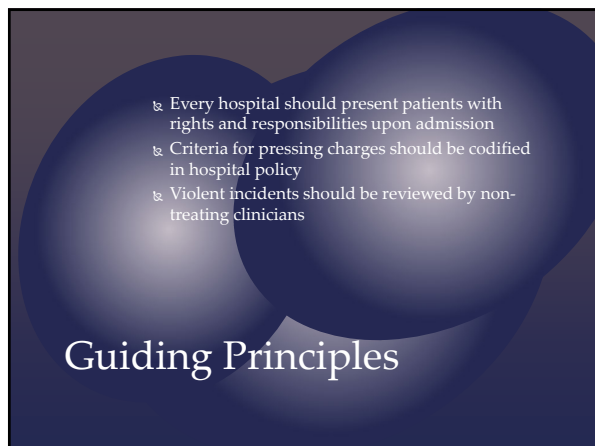
Guiding Principles

Rachlin 1994



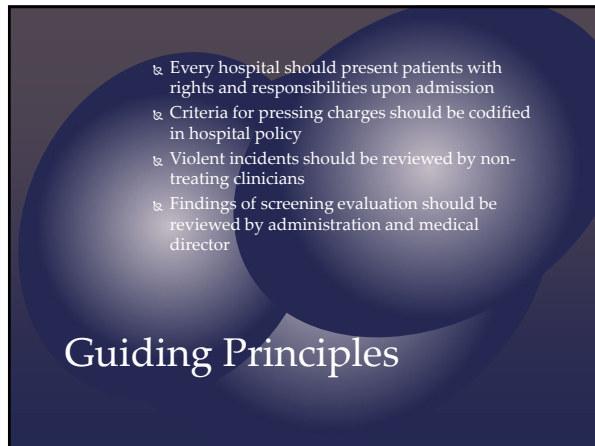
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- ⌘ Criteria for pressing charges should be codified in hospital policy

Guiding Principles



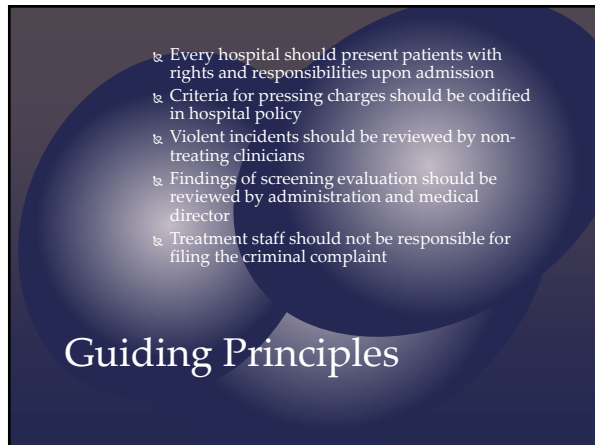
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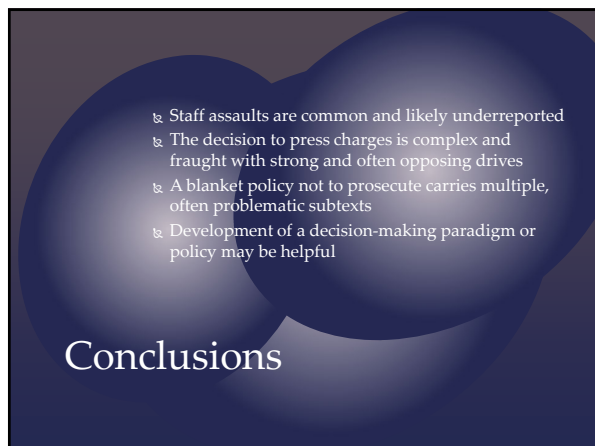
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- ⌘ Findings of screening evaluation should be reviewed by administration and medical director

Guiding Principles



- ⌘ Every hospital should present patients with rights and responsibilities upon admission
- ⌘ Criteria for pressing charges should be codified in hospital policy
- ⌘ Violent incidents should be reviewed by non-treating clinicians
- ⌘ Findings of screening evaluation should be reviewed by administration and medical director
- ⌘ Treatment staff should not be responsible for filing the criminal complaint

Guiding Principles



- ⌘ Staff assaults are common and likely underreported
- ⌘ The decision to press charges is complex and fraught with strong and often opposing drives
- ⌘ A blanket policy not to prosecute carries multiple, often problematic subtexts
- ⌘ Development of a decision-making paradigm or policy may be helpful

Conclusions

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3. Gacki-Smith J, Juarez AM, Boyett L, Homeyer C, Robinson L, MacLean SL. Violence against nurses working in US emergency departments. *J Nurs Adm* 2009;39:340-349

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8. Rachlin, S. (1994). The prosecution of violent psychiatric inpatients: one respectable intervention. *The Bulletin of the American Academy of Psychiatry and the Law*, 22(2), 239–247.

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