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Supreme Judicial Court of Massachusetts,
Suffolk.

COMMONWEALTH OF MASSACHUSETTS, Plaintiff-Appellee,
v.
Richie ACCIME, Defendant-Appellant.

No. SJC-12081.
2016.

This Brief Contains No Impounded Material

Brief of the Center for Public Representation and the Mental Health Legal Advisors Committee as Amici Curiae in Support of the Defendant-Appellant

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***i** TABLE OF CONTENTS

Table of Authorities	iv
Corporate Disclosure Statement	1
Interest of Amici	1
Statement of the Issue	3
Statement of the Case	3
Statement of Facts	3
Summary of Argument	4
Argument	6
I. Introduction	6
II. Hospital Staff Illegally Detained, Medicated and Pepper-sprayed Mr. Accime, Who Should Be Entitled Under Such Circumstances to Claim Self Defense	8
A. The Conduct of Hospital Staff Persons Toward Mr. Accime Violated Laws Governing the Detention of Persons in Psychiatric Crisis and Informed Consent	8
1. Mr. Accime Was Illegally Detained	8
2. Mr. Accime Was Illegally Threatened with Involuntary Medication	9
B. Because Hospital Staff Criminally Victimized Mr. Accime, He Was Entitled to Reasonably Defend	12

Himself, and His Verbal Response Was Proportional and Reasonable

1. Hospital Staff's Conduct Was Criminal and Warranted a Self-defense Claim 12

***ii** 2. Mr. Accime's Defense Against the Illegal Threat and Use of Pepper Spray and Forcible Medication Was Proortional and Reasonable 14

III. Preserving The Right Of Self Defense When Hospitals Criminally Prosecute Patients Will Create Incentives For Hospitals To Deter Abuses and Improve Care for People With Psychiatric Disabilities 16

A. In the Course of Providing Needed Evaluative and Therapeutic Services to People With Psychiatric Disabilities Under Inherently Difficult Circumstances Patient Rights Are Frequently Violated 17

B. Providing Patients Who Face Criminal Charges Based on Incidents Occurring in Hospital Emergency Departments with a Defense in Appropriate Circumstances Will Provide a Counterweight Against Negative Approaches and Will Incentivize Improvement in Emergency Department Practices 26

1. Encourages the Provision of De-escalation Training 26

2. Promotes a Timely Evaluation Process 29

3. Supports the Prioritization of Treatment Over Security 30

4. Enhancing a Therapeutic Environment Will Encourage Those Who Need Care to Seek Help 31

5. Allowing a Self-Defense Claim Will Reduce Inappropriate Referrals to the Criminal Justice System 33

***iii** IV. Conclusion 36

Certification of Compliance 38

***iv** TABLE OF AUTHORITIES

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***1 Corporate Disclosure Statement**

Pursuant to Supreme Judicial Court Rule 1:21, amicus curiae **Center for Public Representation** states that it is a non-profit corporation exempt from taxation pursuant to Section 501(c)(3) of the Internal Revenue Code and is not a publically held corporation that issues stock. It has no parent corporation.

Pursuant to Supreme Judicial Court Rule 1:21, amicus curiae **Mental Health Legal Advisors Committee** states that it was established by the General Court in 1973 under the jurisdiction of the Supreme Judicial Court. G.L. c. 221, § 34E. It is not a corporation and issues no stock.

Interest of Amici

The **Mental Health Legal Advisors Committee** (MHLAC) was established by the General Court in 1973 under the jurisdiction of the Supreme Judicial Court. G.L. c. 221, § 34E. MHLAC provides advice and assistance to individuals with mental illness, to their families and to other attorneys. One aspect of its obligations is to monitor legal issues before the courts affecting the interests of individuals with mental health disabilities. MHLAC has long advocated ***2** for rigorous procedural protections and substantive standards and has a long history of weighing in on questions regarding the interpretation of the state mental health law statute.

The **Center for Public Representation** (CPR) is a national public interest law firm with offices in Northampton and Newton that advocates for the rights of individuals with disabilities, including individuals with mental health disabilities. Through its systemic activities and policy work during the past forty years, CPR has been a major force in protecting the rights of citizens with disabilities.

Together or separately, CPR and MHLAC have served as *amici* in numerous cases involving the substantive and procedural rights of persons with mental health related disabilities, utilizing the expertise gained from more than forty years of experience advocating for individuals with disabilities that are placed in and maintained in institutional settings on short or long-term bases. Both organizations have worked to protect and defend their clients' rights in the civil and criminal commitment process and against abusive practices violative of their bodily integrity. In particular, both organizations are strongly committed ***3** to protecting the rights of persons placed in and maintained in hospital emergency departments, which have come under increased scrutiny in recent years. This commitment is manifest in the prioritization of requests for assistance from such persons alleging abuse, as well as scholarly, policy and coalition work regarding such issues.

Statement of the Issue

Whether and under what circumstances a person brought to and maintained in a hospital emergency department should be permitted to assert a claim of self-defense when facing criminal charges arising from resistance to involuntary medication administered without legal authority.

Statement of the Case

Amici adopt the Statement of the Case as set forth in the Appellant's opening brief.

Statement of Facts

Amici curiae adopt the Statement of Facts as set forth in the brief of the Defendant-Appellant submitted in June 2015.

***4 Summary of Argument**

The Appellant, Richie Accime, was entitled to raise a claim of self-defense against the charges that arose from his loud objections to the threat and application of excessive force (pepper spray) used to subdue him so that he could be injected involuntarily with medication, as he did not intentionally disrupt the Boston Medical Center ("BMC") emergency department but rather reasonably defended himself against multiple rights violations (pp. 12 - 14). Mr. Accime was detained by BMC staff without apparent legal authority under G.L. c. 123, § 12 (pp. 6 - 7). The conduct of BMC staff in restraining and forcing medication on Mr. Accime in non-emergent circumstances violated his right to consent to medical care as well as G.L. c. 123, § 21 (pp. 6 - 13). Because BMC staff arguably falsely imprisoned Appellant and, given the record before this Court, assaulted and battered him, his verbal resistance to victimization was proportional and reasonable (pp. 8 - 13).

This Court's holding that persons in the circumstances faced by Mr. Accime have a right to reasonably defend themselves will create incentives for hospitals, which are charged with the challenging task of receiving and evaluating persons in mental distress, to adopt practices that will curtail abuse and improve care (pp. 14 - 21). In fact, despite existing protections set forth in case law, statute, regulation, and policy, persons perceived to be in psychiatric crisis detained in hospital emergency departments are not infrequently illegally medicated, restrained, and treated with excessive force (typically by security guards armed with dangerous weapons such as pepper spray), and, as here, referred for criminal prosecution (pp. 18 - 25). The accountability that would flow from the prospect of answering to self-defense claims could prompt reforms in hospitals, such as the provision of de-escalation training, timely evaluations, and an increased emphasis on treatment alternatives over the use of force in reaction to perceived threats (pp. 22 - 27). Such reforms would improve therapeutic environments in emergency departments, decrease the incidence of mistreatment that deters person with psychiatric needs from seeking care, and reduce criminal referrals of patients (pp. 24 - 31).

*6 Argument

I. Introduction

Richie Accime was confined in a small emergency department room for up to six hours and told he could not leave. Although involuntary hospital detention on the basis of mental illness must, under Massachusetts law, be supported by an evaluation by a designated professional who completes a standard Section 12(a) form, nothing in the record suggests this was accomplished. Mr. Accime was nevertheless told that he could not leave, and that he had to take medication that he did not want. When he objected, no mental health professional attempted to educate him about or explain the rationale for medicating him.

Instead, security guards, rather than mental health professionals, were deployed. He was threatened with pepper spray, then pepper-sprayed, strapped to a gurney and involuntarily injected with medication. This is not how anyone expects to be treated in an emergency department. But violence by hospital security staff against psychiatric patients is all too ***7** common and a subject of significant public concern and even federal regulation.[1]

Amici understand that hospital emergency department personnel face challenging situations when people in psychiatric crisis seek help at or are involuntarily brought to a hospital. However, we urge this court to adopt a rule that allows a patient that resists illegal detention or medication and is charged with crime resulting from the resistance to argue self-defense, with the success of the argument dependent on whether the patient's behavior was reasonably proportional to the perceived threat. Such a holding would create positive incentives for hospitals to pursue institutional cultures where distressed emergency department patients are seen as people in need of health care rather than potential security risks. A cultural shift such as this limits the potential for unfortunate incidents such as the one at bar and reduce their incidence.

*8 II. Hospital Staff Illegally Detained, Medicated and Pepper-sprayed Mr. Accime, Who Should Be Entitled Under Such Circumstances to Claim Self Defense.[2]

A. The Conduct of Hospital Staff Persons Toward Mr. Accime Violated Laws Governing the Detention of Persons in Psychiatric Crisis and Informed Consent.

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1. Mr. Accime Was Illegally Detained.

Mr. Accime's involuntary admission to the hospital was illegal unless it complied with G.L. c. 123, § 12 (a), which permits such confinement on a temporary basis, but only upon the finding of a "qualified person" that "failure to hospitalize such person would create a likelihood of serious harm by reason of mental illness." G.L. c. 123, § 12(a).[3] There was no evidence at trial that the hospital had authorization to involuntarily detain Mr. Accime.

*9 2. Mr. Accime Was Illegally Threatened with Involuntary Medication.

Absent limited exceptions, patients may not be given medication without providing informed consent. The informed consent doctrine is grounded in the common law and in a constitutionally-based "right to bodily integrity." *Norwood Hospital v. Munoz,* 409 Mass. 116, 122 (1991). The doctrine preserves an individual's right to decide for him or herself whether to accept proposed treatment. *Harnish v. Children's Hospital Medical Center,* 387 Mass. 152, 157 (1982).

Even a doctor who believes a patient's decision is wrong must ordinarily respect the patient's decision even if the doctor believes the decision will result in the patient's death. *Shine v. Vega,* 429 Mass. 456 (1999). Forced treatment is a severe interference with a person's interest in being free from nonconsensual invasion of his "bodily integrity." *In the Matter of Spring,* 380 Mass. 629, 634 (1980); *Guardianship of Roe III,* 383 Mass. 415 (1981); *Comm'r of Dep't of Mental Health v. Rogers,* 390 Mass. 489 (1983)("Rogers"); *Superintendent of Belchertown State School v. Saikewicz,* 373 Mass. 728, 746 (1977). ***10** Involuntary medication is a particularly profound intervention.[4] Like the informed consent doctrine, a person's interest in being free from such nonconsensual invasions is grounded in the common law as well as in a constitutional right of privacy. *Commonwealth v. Pugh,* 462 Mass. 482, 503 (2012); *Brophy v. New England Sinai Hospital,* 398 Mass. 417, 430 (1986). Accordingly, everyone, regardless whether he or she has a disability, has a right to refuse treatment. *Saikewicz,* 373 Mass. 728.

For persons that are incapable of making treatment decisions, the proponent of the treatment must seek judicial authorization. *Id.* The process for overriding a person's right to refuse treatment is respectful of personal autonomy. Courts conduct "substituted judgment" proceedings, which are designed to ascertain what choices the person would make if he or she were competent. *Saikewicz,* 373 Mass. at 750 n.15; *Spring,* 390 Mass. at 634.

A treating clinician may override a patient's decision to accept or reject treatment only in rare ***11** circumstances. A doctor may authorize a one-time, use of involuntary medication in certain emergency situations to prevent irreversible deterioration. *Rogers v. Okin,* 738 F.2d 1, 6 (1st Cir. 1984); Rogers, 390 Mass. at 511. Alternatively, a doctor may order a chemical restraint when there exists the "occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide." G.L. c. 123, § 21.[5] There was no emergency circumstance or incapacity that would support the reliance on any of these exceptions.

The hospital could not have failed to understand that Mr. Accime objected to being detained and forcibly medicated. He made loud assertions that he intended to resist medication.[6] However, these were met ***12** not by acceptance or even clinical attempts to persuade him, but by security staff that threatened him with pepper spray and then carried it out without legal authority.

Nothing in the record suggests that Mr. Accime's justified verbalizations of outrage, while isolated in a room and at times fully physically restrained, presented any threat to others or warranted emergency medication. To the extent there was an emergency, the hospital created it. The hospital had no right to subdue him by force and then medicate him.

B. Because Hospital Staff Criminally Victimized Mr. Accime, He Was Entitled to Reasonably Defend Himself, and His Verbal Response Was Proportional and Reasonable.

1. Hospital Staff's Conduct was Criminal and Warranted a Self-defense Claim.

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Because hospital staff lacked legal authority to detain Mr. Accime and nonetheless kept him in the hospital emergency room against his will, he was arguably falsely imprisoned. Further, Mr. Accime never consented to being medicated, but was nonetheless pepper sprayed, subdued, and forcibly medicated. The record does not suggest any justification for this conduct beyond Mr. Accime's verbalizing. The pepper ***13** spray threat gave rise to a reasonable apprehension of imminent harm and therefore constituted an assault. *Commonwealth v. Gorassi,* 432 Mass. 244, 247 (2000). Thereafter, he was strapped to a gurney and medicated without his consent. Again, since the six security staff members obviously were not defending themselves against Mr. Accime nor had any other apparent justification for charging in on him, this constituted a battery. *See Spring,* 380 Mass. at 638 ("Unless there is an emergency or overriding State interest, medical treatment of a competent patient without his consent is said to be a battery"). He was entitled to defend himself to a reasonable extent against an intended assault and battery, which was thereafter accomplished despite his efforts. *See Commonwealth v. Chapman,* 81 Mass. App. Ct. 1114 (2007).

This Court should not allow the hospital and the Commonwealth to characterize Mr. Accime's verbalizing as criminal. Mr. Accime reasonably defended himself by angrily responding in an effort to ward off criminal offenses against his person. This conduct cannot give rise to a conviction for disorderly conduct because Mr. Accime did not have the criminal intent to be a ***14** "disorderly person." G.L. c. 272, § 53(b). His intent was to defend himself.

2. Mr. Accime's Defense Against the Illegal Threat and Use of Pepper Spray and Forcible Medication Was Proportional and Reasonable.

Determining the proportionality of Mr. Accime's verbal response to the threat posed by the hospital security staff requires analysis of the severity of the threat. Mr. Accime's motivation to resist forced medication, already substantial, is amplified by the threat and use of pepper spray to accomplish this result. Indeed, the threat posed by the prospect of being pepper sprayed is very serious.[7] Mr. Accime's response to the violence threatened and then perpetrated upon him was proportional and reasonable.

As argued above, being forcibly medicated is a serious invasion of bodily integrity. But the use of pepper spray significantly compounded that invasion. Oleoresin capsicum, or pepper spray, is a dangerous toxin. It is associated with significant health risks, especially when the medical condition of the patient is unknown before the use of this weapon. Susan Stefan, *Emergency Department Treatment of the Psychiatric Patient* 28 (2006). Inhalation of both pepper spray and the solvents used in some of the aerosols which deliver it is associated with both bronchospasms[8] and cardiac arrhythmias.[9]

Using pepper spray indoors in a small and closed setting increases these health risks. At the point at which Mr. Accime was doused with pepper spray, the hospital did not know enough about his own health (or the health of nearby patients) to evaluate whether its use was safe.

Mr. Accime's use of loud, angry, and profane language to deter hospital staff from forcibly medicating him alone was not unreasonable. The use of the dangerous weapon of pepper spray only heightens the justification for his actions.

III. Preserving The Right Of Self Defense When Hospitals Criminally Prosecute Patients Will Create Incentives For Hospitals To Deter Abuses and Improve Care for People With Psychiatric Disabilities.

The question raised by this case could have significant bearing on how psychiatric patients are treated in emergency departments. Hospital emergency departments serve a vital function in the mental health system and have a difficult job. However, there is no question that there is a serious need for improvement in the care of these patients.

Unfortunately, Mr. Accime's experience is not uncommon. A decision to allow a patient to assert a self-defense claim when held illegally, or when a patient's behavior is inappropriately met with weapons such as pepper spray or Tasers, would deter abuses and promote better care. These changes would benefit both patients and staff.

Amici urge this Court to consider the incentives at work in hospital emergency departments and the potential for recasting

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them. Currently, hospitals that do not adequately address the needs of psychiatric patients are insulated from the fall out. It is likely that an incident that escalates unduly such as the one at bar will not result in a decision holding responsible staff accountable or even reflecting badly on them or the hospital. When criminal charges are filed against a patient such as Mr. Accime, particularly when they result in a guilty verdict, there is little impetus to closely examine the culpability of all involved. However, the prospect of hospital staff filing criminal charges against patients may be required to justify their conduct in the context of the patients' claim of self-defense will deter such filings and invite scrutiny that could result in meaningful reforms.

A. In the Course of Providing Needed Evaluative and Therapeutic Services to People With Psychiatric Disabilities Under Inherently Difficult Circumstances, Patient Rights Are Frequently Violated.

Over the last century, as psychiatric care has shifted from institutions to the community, the emergency department has become a critical source of care for many with psychiatric needs.[10] Indeed, about 10% of visits to emergency departments involve individuals with psychiatric illness.[11] Some hospitals, particularly larger ones like Boston Medical Center, have established specialized, separate psychiatric emergency departments, providing what is known as "psychiatric emergency services."[12] These facilities can see as many as 900 patients a month. Stefan, *supra* at 28.

Being received at an emergency department for evaluation of a mental health condition is fraught with stresses and complexities. From the patient perspective, one arrives, often in crisis, at a large, perhaps unfamiliar, institutional setting. The individual's visit may not be voluntary and may have been facilitated by police or ambulance staff. The individual likely enters a crowded, noisy environment. Once evaluated, a patient may spend long periods in the emergency department waiting for an inpatient bed.[13] These extended stays can generate tension and negative consequences for both patients and staff.[14]

From the staff perspective, the patient may be completely unknown, often an individual with a complex history and co-morbid medical and psychiatric diagnoses. The individual may present with a range of possible emotional responses and exhibit unpredictable behavior.

While these are difficult situations, to assist in navigating them there are standards set out in case law, statute,[15] regulation,[16] Department of Public Health guidance,[17] Department of Mental Health forms,[18] and professional accreditation requirements.[19] While these standards go a long way toward regimenting the course of psychiatric admissions to emergency departments, they cannot wholly alleviate the substantial strains that are experienced by both sides. Nor have these guidelines been effective in preventing serious problems in emergency department administration.

Too often, people with psychiatric disabilities encounter serious problems in hospital emergency departments, problems not faced by other emergency department patients. Many emergency departments are intolerant of psychiatric patients, approaching them with skepticism,[20] impatience, hostility, or contempt. Stefan, *supra* at 6.

Mr. Accime's experience is unfortunately not remarkable. As here, avoidable situations culminate in patients facing criminal charges. Psychiatric patients suffer a host of indignities.

Unlike medical patients, people seeking help in an emergency department for mental or emotional problems often have their liberty interests seriously curtailed. Even individuals who appear voluntarily at an emergency department may not be allowed to leave, despite the lack of any legal authority to hold them.[21] While confined, their ability to move about the emergency department freely may be restricted, they may be forced to disrobe, not allowed visitors, and even restrained or secluded in a locked room. Stefan, *supra* at 34, 41, 55. The impact of such deprivations of liberty have been compared to those of "criminal internment."[22]

Patients are not infrequently subjected to harsh treatment. As in this case, emergency department staff may coerce or physically force treatment, typically medication, on competent psychiatric patients without obtaining informed consent. Stefan, *supra* at 41. Hospitals often inappropriately use restraint or seclusion as a means to manage challenging patients with psychiatric disabilities or to compel treatment. Stefan, *supra* at 39. Restraint, particularly, has a host of negative physical and emotional consequences for staff and patients alike, such as traumatization, physical injuries, and interference with the establishment of clinical alliances.[23] Restraint and seclusion in emergency departments persists despite stringent regulations

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against their use. Stefan, *supra* at 40-41.

Enforcing these abusive practices often involves undue and excessive force. Psychiatric patients are subjected to a "level of force and coercion... that is not generally experienced by medical patients." Stefan, *supra* at 6. One study noted the use of force in 17% of the cases the authors observed in the emergency department of a large psychiatric hospital. Stefan, *supra* at 35.[24]

The use of force and coercion is typically accomplished, as here, by security guards that are routinely armed with pepper spray, mace, Taser guns, batons or even firearms.[25] Hospitals may resort to security officers due to a lack of qualified mental health clinicians[26] or ingrained tendencies to see manifestations of mental health symptoms as security matters rather than clinical issues.[27]

This reliance on security guards is problematic. Guards, particularly when armed, can make psychiatric patients feel frightened, agitated, intimidated or especially vulnerable, exacerbating what is already an inherently tense situation. Stefan, *supra* at 155. The presence of weapons in the hands of security staff in the emergency department compromises or even precludes the potential for a therapeutic environment and enhances the possibility that situations will unnecessarily escalate.

One particularly troubling consequence of exacerbating tensions in emergency departments is the filing of criminal charges against psychiatric patients. This is a growing problem.[28] While security officers might be particularly prone to relying on this tactic in light of their typical lack of clinical expertise and their law enforcement background, they are not the only staff persons to pursue criminal charges against patients.[29] It is a widespread practice, often creating dire situations for individuals with serious mental health needs.[30]

While emergency departments constitute an important part of our mental health system, current laws and standards have not sufficiently protected individuals with psychiatric disabilities who find themselves voluntarily or involuntarily in that setting. Providing such individuals with a claim of self-defense when criminal charges are filed against them in such settings would help redress this problem.

B. Providing Patients Who Face Criminal Charges Based on Incidents Occurring in Hospital Emergency Departments with a Defense in Appropriate Circumstances Will Provide a Counterweight Against Negative Approaches and Will Incentivize Improvement in Emergency Department Practices.

1. Encourages the Provision of De-escalation Training.

Allowing patients to assert a defense to staff use of force will encourage hospitals to make de-escalation of potential incidents a standard practice. Aggressive behavior, undertaken with the assumption that staff could file criminal charges against a patient as a cover for the behavior, will be deterred by the knowledge that patients can push back in the course of the criminal justice process. Stefan, *supra* at 137 (regarding security staff).[31]

An incentive to establish a hospital culture in which de-escalation skills are prioritized and rewarded is needed. There is little emphasis on this at present. In fact, emergency department workers often lack the proper training to intervene effectively with mental health patients.[32] Training staff in de-escalation and effective patient interaction is recognized as a key step in improving emergency department care for psychiatric patients.[33]

In addition to enhancing safety use of de-escalation techniques will result in better care in the short and long term. Psychiatric patients that avoid negative incidents in hospitals are better able to develop trusting relationships with emergency department caregivers.[34] Likewise, hospitals participating in the Institute for Behavioral Healthcare Improvement's 2008 learning collaborative found that they could reduce the length-of-stay of psychiatric patients in emergency departments and the use of seclusion and restraint on these patients, both considered positive indicators, by training clinical and security staff in de-escalation techniques.[35]

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2. Promotes a Timely Evaluation Process.

As noted, lengthy stays in emergency departments significantly contribute to the tensions that can result in violent incidents and criminal charges. As discussed above, emergency departments do not always have effective or adequate systems or resources to evaluate and care for people in psychiatric crisis, which contributes to this problem.

Facilities can improve their systems for serving psychiatric patients, including streamlining the intake process[36] and redoubling efforts to ensure that mental health clinicians are available for evaluation and treatment in a timely manner.[37] Injecting accountability into the criminal justice system by rendering criminal charges subject to effective rebuttal through self-defense claims could encourage hospitals to improve efficiencies in the evaluative process. This could allow prompter release of persons that do not require prolonged continued confinement and relieve pressures in emergency units.

3. Supports the Prioritization of Treatment Over Security.

The potential for successful self-defense claims will discourage hospitals from using security personnel as compliance enforcers instead of more properly as a last resort to ensure safety.[38] There are a number of steps hospitals can take in this regard.

As is the case in many hospitals, security guards could be denied possession of certain weapons, such as pepper spray. Additionally, hospitals might place more emphasis on training staff, including security staff, regarding the legal rights of patients, including the right to refuse treatment and the limited exceptions to that right. Respect for legal rights will promote a more respectful attitude toward patients as human beings.

Treating patients with dignity will avoid negative behaviors that can prompt unfortunate incidents. In a 1999 survey of psychiatric patients using an emergency department in Connecticut, the vast majority of those persons who rated their emergency department experience positively did so based on the respect and dignity they were afforded, rather than on the effectiveness of treatment received. Stefan, *supra* at 34. Reducing the dissatisfaction of patients confined to emergency departments will contribute to a more peaceful environment.

4. Enhancing a Therapeutic Environment Will Encourage Those Who Need Care to Seek Help.

Practices that rely on force and control, such as the use of restraints, deter people in psychiatric crisis from voluntarily using hospital services. Research confirms that these practices generate fear, erecting a substantial barrier between people with mental health issues and treatment.[39] Creating incentives to improve emergency department environments will reduce this impediment to care.

Effectively addressing undue use of harsh negative practices is feasible. Hospitals have reduced or even eliminated the use of restraint and seclusion without compromising staff or patient safety.[40] Such measures allow hospitals to be more effective in discharging their core mission.

Clinicians must build rapport with patients in order to help them: "it is very important that crisis professionals work with patients in a supportive, caring, and interpersonal manner, creating with the patient what is known as a therapeutic alliance."[41] This cannot happen unless hospital emergency departments move to become, more uniformly, therapeutic environments and lessen the extent to which they are a referral source for the criminal justice system.

5. Allowing a Self-defense Claim Will Reduce Inappropriate Referrals to the Criminal Justice System.

Becoming a criminal defendant is perhaps the most negative consequence that can ensue from a bad emergency department experience. Fear of prosecution poisons the potential for anything positive to come from the hospital experience and deters patients from seeking future help. In addition to the detriment of incarceration (including awaiting trial), filing criminal

charges against a patient results in a criminal record, which has far-reaching ramifications.[42] In addition to the sorts of effects that readily come to mind (e.g. diminished employment prospects), persons with criminal records may be less able to access quality mental health care, which might propel a long and painful downward spiral.[43]

Staff at MHLAC and CPR have repeatedly seen this happen to clients criminally prosecuted by hospital staff for psychiatric hospital unit incidents such as the one in this case. Charges often arise from situations that need not have escalated or that were not even the fault of the patient. Frequently, these individuals end up detained or sentenced at county houses of corrections or at Bridgewater State Hospital. Uniformly, the individuals have serious mental health needs made more difficult by confinement within the criminal justice system. In some cases, individuals are traumatized by their criminal justice experiences, whether from lack of appropriate treatment and clinical milieu, violence in the facility, abuse or lack of understanding and training by correction officers, or all these circumstances. The addition of criminal charges, and sometimes convictions, to these individuals' already complex problems imposes unwarranted and sometimes overwhelming burdens. Hospital staff truly concerned about their patients' welfare should do anything possible to prevent this result.

Unfortunately, regulatory limits on the use of weapons in hospitals have created a perverse incentive to send patients on the pathway to incarceration. The federal government prohibits hospitals from using weapons such as pepper spray for patient control, strictly limiting the use of these weapons to serious criminal circumstances.[44] This regulation has no impact on the majority of hospitals that do not permit their security guards to carry pepper spray or hospitals that very rarely use pepper spray. But in hospitals with a propensity to overreact to the conduct of patients in crisis, the Center for Medicare and Medicaid Services' prohibition on the use of pepper spray simply to restrain a patient has had ironic consequences. These hospitals are increasingly apt to pursue criminal prosecution of patients, after they have Tased or pepper-sprayed them, to provide cover for conduct that may be questionable under federal regulations. In a number of instances, psychiatric patients were Tased, shot, or pepper sprayed, and then arrested.[45]

This practice violates the spirit of federal regulations and Joint Commission standards and must be discouraged. This case provides both an example of this practice and an opportunity to reduce inappropriate hospital criminal prosecutions of psychiatric patients.

IV. Conclusion

Amici respectfully request that this Court find for the Appellant, holding that the Trial Court erroneously denied instructions to the jury on his right to refuse treatment and self-defense.

Footnotes

1 Elisabeth Rosenthal, *When the Hospital Fires the Bullet,* New York Times (Feb. 12, 2016) (describing cases of mistreatment from hospital staff), *http://www.nytimes.com/2016/02/14/us/hospital-guns-mental-health.html? r=2;* Association of Health Care Journalists, Report No. 11672, *http://www.hospitalinspections.org/report/11672* (reporting cases of hospital mistreatment).

2 Amici understand that Mr. Accime was acquitted on every charge but "disorderly conduct," and address whether his conduct, which we contend was a reasonable response to intended and actual violations of his rights, is a defense to this charge. The points made herein, however, are applicable to potential defenses to assault and battery charges.

3 A "qualified person" under § 12(a) includes appropriately qualified and licensed physicians, psychiatric nurses, mental health clinical specialists, or licensed independent clinical social workers. A police officer may apply for a hold on a person believed to meet the standard, but only if none of the other persons listed are available. There is no such assertion here.

4 *See, e.g., Guardianship of Roe III,* 383 Mass. at 437, referring to antipsychotic medication. It is unclear from the record exactly what medication was injected into Mr. Accime.

5 Another narrowly defined exception to the right to refuse treatment "comes into play when the patient is unconscious or otherwise incapable of consenting, when harm from a failure to treat is imminent and outweighs any harm threatened by the proposed treatment..." *Shine,* 429 Mass. at 467 (quoting *Canterbury v. Spence,* 464 F.2d 772, 778-779 (D.C.Cir.1972)). The first recourse in such circumstances is to consult with a close family member capable of giving consent. Id. "If, and only if, the patient is

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unconscious or otherwise incapable of giving consent, and either time or circumstances do not permit the physician to obtain the consent of a family member, may the physician presume that the patient, if competent, would consent to life-saving medical treatment." *Id.* at 466.

6 The verbalizing gave rise to the charge of assault, of which the Appellant was acquitted, as well as the conviction for "disorderly conduct."

7 Courts have recognized the dangerousness inherent in the use of chemical agents such as pepper spray, particularly for individuals with psychiatric disabilities. *See, e.g., Coleman v. Brown,* 28 F.Supp.3d 1068, 1079 (E.D. Cal. 2014) (even when used properly, weapons such as mace, tear gas and other chemical agents possess inherently dangerous characteristics capable of causing serious and perhaps irreparable injury to the victim); *Hughes v. Judd,* 2013 WL 1821077, at *11 (M.D. Fla. 2013) ("Pepper spray... can make the mentally ill more paranoid, fearful, angry, and less trusting, all of which compromises the ability to treat their mental illness.")

8 R.W. Fuller et al., *Bronchoconstrictor Response to Inhaled Capsaicin in Humans,* 58 J. APPL. PHYSIOL. 1080-1084 (1985); L. Daffonchio et al., *Effectiveness of Levodropropizine Against Cigarette Smoke-Induced Airway Hyperreactivity: Possible Mechanism,* 228 Eur. J. Pharm.: Environ. Toxicol. Pharm. 25-61 (1993).

9 C. Gregory Smith & Woodhall Stopford, *Health Hazards of Pepper Spray,* 60 N.C. Med. J. 268 (1999).

10 American College of Emergency Physicians, *Care of the Psychiatric Patient in the Emergency Department - A Review of the Literature 2 (2014), https://www.acep.org/uploadedFiles/ACEP/Clinical and P ractice Management/Resources/Mental Health and Substan ce Abuse/Psychiatric%20Patient%CC20Care%CC20the%CC20ED%202014.pdf.*

11 Leslie Zun, *Care of Psychiatric Patients: The Challenge to Emergency Physicians,* 17 W. J. Emerg. Med. 173-176 (2016) *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4786237/* (the 10% statistic excludes those without a formal psychiatric diagnosis).

12 *See* Scott L. Zeller, *Treatment of Psychiatric Patients in Emergency Settings, Primary Psych. (2010), http://primarypsychiatry.com/treatment-of-psychiatric-patients-in-emergency-settings/.*

13 The Joint Commission on Accreditation of Health Care Organizations (JCAHO) found that nationally average wait times in emergency departments for individuals with psychiatric disabilities is six hours or more with longer times for Medicaid patients, the uninsured or children with psychiatric emergencies. See Joint Commission on the Accreditation of Health Care Organizations, Advisory on Safety and Quality Issues, Issue 19: Alleviating ED Boarding of Psychiatric Patients (2015), *https://www.jointcommission.org/assets/1/23/Quick* Safe ty Issue 19 Dec 20151.PDF.

14 "Prolonged ED stays are associated with increased risk of symptom exacerbation or elopement for patients with mental health/substance abuse issues. External stimuli from the busy emergency department can increase patient anxiety and agitation, which is potentially harmful for both patients and staff. Elopement from the emergency department prior to definitive screening and treatment can lead to increased risk of self-harm and suicide." B. A. Nicks & D. M. Manthey, *The Impact of Psychiatric Patient Boarding in Emergency Departments,* Emergency Medicine Int'l (2012), https://www.hindawi.com/journals/emi/2012/360308/cta/

15 G. L. c. 123, § 12; G.L. c. 111, § § 3, 51-56.

16 See 42 C.F.R. 482.13 (2015) (Center for Medicare and Medicaid Services regulations regarding patients' rights in hospital settings); 104 CMR 27.00 (Mass. Department of Mental Health regulations); 105 CMR 130.000 (Mass. Department of Public Health regulations).

17 Department of Public Health, *Recommendations for Care of Patients with Psychiatric Disorders and/or Behavioral Issues* (Sept. 5, 2006); *http://www.mass.gov/eohhs/gov/departments/dph/programs /hcq/healthcare-quality/health-care-facilities/hospitals/emergency-dept/care-of-patients-with-psychatric-disorders.html;*
Department of Public Health, *Circular Letter: DHCQ 08-07-495: Forced Removal of Clothing of Patients in Hospital Emergency Departments* (2008), *http://www.mass.gov/eohhs/gov/departments/dph/programs /hcq/healthcare-quality/health-care-facilities/hospitals/emergency-dept/forced-removal-of-clothing-of-patients-in.html.*

18 See the forms listed at Department of Mental Health, Civil Commitment and Hospital Admissions Forms, *http://www.mass.gov/eohhs/gov/departments/dmh/civil-commitment-and-hospital-admissions-forms.html* (last visited Oct. 27, 2016).

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[19] *See* Joint Commission on Accreditation of Health Care Organizations Standards. For more information, see https://www.jointcommission.org/.

[20] The concerns of individuals with psychiatric disabilities are often not taken seriously in emergency departments, particularly with respect to medical symptoms. Stefan, *supra* at 6. This can be particularly true of individuals who have multiple visits to the same emergency department and may become known to emergency department staff as "frequent flyers." Their concerns are often minimized or even ignored, sometimes with dangerous or even life-threatening consequences. *Id.* Indeed, the literature suggests that while it is common for individuals with psychiatric disabilities to have comorbid medical diagnoses, emergency department staff nevertheless tend to discount the medical complaints of individuals with psychiatric disabilities. Stefan, *supra* at 43.

[21] *See, e.g.,* Rose Rummel, *Five Lessons I Learned from Visiting the ER with Suicidal Ideation* (2013), http://www.goodtherapy.org/blog/five-lessons-i-learned-from-visiting-er-with-suicidal-ideation-0920137 (woman voluntarily goes to emergency department for drug-induced suicidal ideation and is held illegally for "uncooperative behavior").

[22] Alexander Tsesis, *Due Process in Civil Commitments,* 68 Wash. & Lee L. Rev. 253, 256-257 (2011).

[23] *See, e.g.,* Daryl K. Knox & Garland H. Holloman, *Use and Avoidance of Seclusion and Restraint: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Seclusion and Restraint Workgroup,* 13 W. J. Emerg. Med. 35-40 (2012), *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3298214/; see also* Stefan, *supra* at 150, 152 (for decades, research has repeatedly demonstrated the significant emotional and physical harm that restraint and seclusion have on individuals with psychiatric disabilities).

[24] Citing Charles Lidz et al., *Coercive Interventions in a Psychiatric Emergency Room,* 11 Behav. Sc. & Law 269, 276 (1993).

[25] *See* Rosenthal, *supra* note 1 (table indicates that 56% of hospital security guards carry batons, 52% carry handguns, 52% carry pepper spray, and 47% carry Tasers).

[26] *See, e.g.,* OSHA, *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers* (2015), *https://www.osha.gov/Publications/osha3148.pdf* at 4.

[27] *See* Rosenthal, *supra* note 1.

[28] The first known report of charges being brought against a psychiatric inpatient was in 1978. Stephen Rachlin, *The Prosecution of Violent Psychiatric Inpatients: One Respectable Intervention,* 22 Bull. Am. Acad. Psych. & Law 239, 239 (1994), http://www.jaapl.org/content/22/2/239.full.pdf. Today, in the wake of the CMS interpretive guideline regarding use of weapons on patients, the prosecution level has increased substantially. See *Rosenthal,* supra note 1.

[29] For example, the Massachusetts Nurses Association has been active for years in seeking to facilitate criminal prosecution of patients for assault, Massachusetts Nurses Association, *Legal Interventions,* http://www.massnurses.org/health-and-safety/current-topics/workplace-violence/legal-interventions(last visited Oct. 27, 2016).

[30] Jails are the largest institutional setting for people with severe mental illness in the country; almost 18% of inmates meet criteria for serious mental illness, Fred Osher et al., *Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery* (2012), https://csgjusticecenter.org/wp-content/uploads/2013/05/9-24-12 Behavioral-Health-Framework-final.pdf.

[31] The decrease in violence likely has a positive impact on job satisfaction and retention of emergency department workers as well. Donna M. Gates et al., *Violence Against Emergency Department Workers,* 31 J. Emerg. Med. 331 - 337 (2006), *http://www.jem-journal.com/article/S0736-4679(06)00492-6/abstract?cc=y=.*

[32] Scott L. Zeller, *New Strategies to Reduce Psychiatric Patient Boarding in ERs (2014), http://www.psychiatryadvisor.com/practice-management/new-strategies-to-reduce-psychiatricpatient-boarding-in-ers/article/375672/.*

[33] Vidhya Alakeson et al., *A Plan To Reduce Emergency Room 'Boarding' Of Psychiatric Patients,* 29 Health Aff. 1637-1642 (2010), *http://content.healthaffairs.org/content/29/9/1637.ful 1; see also* Janet S. Richmond et al., *Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup,* 13 W. J. Emerg. Med. 17-25 (2012), *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3298202/* (traditional methods of treating agitated patients, including in emergency settings, i.e., routine restraints and involuntary medication, have been replaced with a much greater emphasis on a non-coercive, three-step approach involving 1) verbal engagement, 2) establishing a collaborative

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relationship, and 3) verbal de-escalation.)

34 Richmond, *supra* note 33, at 24.

35 Scott L. Zeller, *Treatment of Psychiatric Patients in Emergency Settings,* 17 Primary Psych., 35-41 (2010), *http://primarypsychiatry.com/treatment-of-psychiatric-patients-in-emergency-settings/.* Indeed, studies have found that with prompt intervention, the majority of psychiatric emergencies can be resolved in less than 24 hours, with no need for inpatient admission. *Id.*

36 American College of Emergency Physicians, *Care of the Psychiatric Patient in the Emergency Department - A Review of the Literature 2 (2014), https://www.acep.org/uploadedFiles/ACEP/Clinical and P ractice Management/Resources/Mental Health and Substan ce Abuse/Psychiatric%20Patient%CC20Care%CC20in%CC20the%20ED% 202014.pdf.*

37 B. A. Nicks & D. M. Manthey, *The Impact of Psychiatric Patient Boarding in Emergency Departments,* Emerg. Med. Int'l (2012), https://www.hindawi.com/journals/emi/2012/360308/ (appropriate access to psychiatric care would result in improved efficiencies of care... [which would improve] emergency department capabilities).

38 Hospital licensing requires that hospitals have adequate security. Stefan, *supra* at 35 (citing Joint Commission on Accreditation of Health Care Organizations, Comprehensive Accreditation Manual for Hospitals, Management of the Environment of Care (EC) Standards (2004)).

39 *See, e.g.,* Angela Sweeney et al., *The Role of Fear in Mental Health Service Users' Experiences: A Qualitative Exploration,* 50 Soc. Psy. & Psych. Epid. 1079-1087 -1087 (2015), *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4463981/; see also* Stefan, *supra* at 150 (respondents to a survey about emergency department experience that experienced restraints were unwilling to seek emergency department care voluntarily thereafter).

40 *See, e.g.,* Janice LeBel, *The Business Case for Preventing and Reducing Restraint and Seclusion Use (2011), http://store.samhsa.gov/shin/content/SMA11-4632.pdf.*

41 *See* Scott L. Zeller, *Treatment of Psychiatric Patients in Emergency Settings,* Prim. Psych (2010), *http://pprimarypsychiatry.com/treatment-of-psychiatric-patients-in-emergency-settings/.*

42 Susan Stefan, *Q & A - Criminal Prosecution of Institutional Residents by Staff, http://www.masslegalservices.org/content/q-criminalprosecution-institutional-residents-staff* (last visited Oct. 27, 2016) ("Administrators and staff may be unaware of the enormous consequences for a patient of having a criminal record in obtaining housing, employment, retaining child custody, or myriad other examples crucial to reintegration into the community.").

43 As one researcher explains, placement in a jail or prison not only results in the loss of liberty and other rights, but also creates a situation likely compounded by inferior mental health care. Cameron Quanbeck et al., *Mania and the Law in California: Understanding the Criminalization of the Mentally Ill,* Am. J. Psych. (2003), *http://ajp.psychiatryonline.org/doi/abs/10.1176/appi.a jp.160.7.1245?url ver=Z39.88-.*

44 The Center for Medicare and Medicaid Services considers weapons use by hospital security staff as a "law enforcement action, not a health care intervention," and declares that it "does not support the use of weapons by any hospital staff as a means of subduing a patient" in any circumstance that does not result in the "perpetrator" being "placed in the custody of law enforcement." *Center for Medicare and Medicaid Services, State Operations Manual, Interpretive Guidance, Interpretive Guidance to 482.13(e)* (2015).

45 WRAL, Violent Psychiatric Patient Exposes Policy, Communication Gaps in Rex ER (2015), http://www.wral.com/violent-patient-exposes-policy-communication-lapses-in-rex-er/14625943/ (federal government faults hospital for using Tasers to subdue psychiatric patient). See also Rosenthal, supra note 1 (hospital security shot and narrowly missed killing a patient who had sought help for bipolar disorder, after which he was arrested and charged with a crime).

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