

TASC FACT SHEETⁱ

THE FILING OF CRIMINAL CHARGES BY STAFF AGAINST INSTITUTIONALIZED CLIENTS: ANALYSIS AND RECOMMENDATIONS

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In the modern era of community mental health treatment, psychiatric hospitalization is reserved for individuals perceived to be the most acutely disturbed, individuals who have been found to be “a danger to themselves or others.” The United States Supreme Court recently held that a critical distinguishing feature of the kind of mental disorder that warranted involuntary institutionalization was a “special and serious lack of ability to control behavior.”ⁱⁱ Most state Supreme Courts have followed suit, as have many state statutes. The Supreme Court has also emphasized that the purpose of such hospitalization is treatment, and that the state’s purpose in providing treatment distinguishes involuntary institutionalization from incarceration. Thus, an individual whose symptoms create the possibility of danger to self or others that he or she has significant difficulty in controlling can be involuntarily hospitalized for the treatment of those symptoms.

Punishing institutionalized individuals for behavior manifesting those symptoms would be cruel, counterproductive, and possibly illegal or unconstitutional. Yet all over the country, a disturbing pattern is emerging of just such punishment: the use of the police and the criminal justice system to control the behavior of patients. The Center for Public Representation has received reports from P&As of hospitalized clients being tasered by police called into the facility by staff, of clients being threatened with arrest and actually being arrested for minor behaviors manifesting the psychiatric disability for which they were being treated, or being arrested for assault when they struggled with staff during a restraint.

The practice by professional staff of filing criminal charges against patients in their care, and the failure of administrators to respond to these practices, is extremely troubling. To subject hospitalized individuals to criminal sanctions for behavior arising out of their psychiatric condition contradicts the premise of hospitalization and betrays the patient. It may also be a sign of a hospital with fundamental leadership problems, deficiencies in its treatment system, and a distorted perception of its role in the mental health system. Hospitals that countenance the arrest of patients probably also have a high restraint and seclusion rate, since both actions reflect a culture of control rather than engagement.

Filing criminal charges against institutionalized individuals with psychiatric disabilities for behavior symptomatic of their conditions may also violate the patient's rights under the Due Process Clause of the fourteenth amendment to the United States Constitution, the Americans with Disabilities Act, and, potentially a number of state statutes, including patients' rights statutes. In addition, such actions raise licensing concerns as to both the facility and the professional who filed charges.

The practice of arresting clients for behavior symptomatic of their psychiatric condition is not confined to institutions. In some states, group homes have their clients arrested as a way to get rid of troublesome clients. One community provider even went to court to get a restraining order against the client coming near the facility. Increasingly, criminal charges are also being filed against children. Sometimes the mental health system serves as the gateway for a child or adult with no previous criminal charges *into* the criminal justice system.

Criminal charges have serious consequences for individuals with psychiatric disabilities, even when the charges are dropped or dismissed. The mere fact of having been criminally charged serves as a barrier to community treatment, housing, employment, education, and social integration (see below, Consequences of Arrest).

This Fact Sheet begins with a description of the kinds of clients who have criminal charges filed against them by staff members entrusted with their care. It continues by describing the consequences of arrest, raising and refuting arguments used to support the arrest of institutionalized clients, and then analyzes causes of action that P&As might consider in challenging state mental health agencies' acquiescence in this kind of action by staff. Finally, it concludes by making recommendations at all levels for P&As who wish to work with state agencies to address this disturbing trend.

I. **Profiles of Arrested Clients**

I represented a client charged by her psychiatrist with assault in 1995, and have paid close attention ever since to issues related to the filing of criminal charges against institutionalized and community clients by staff members entrusted with their care. During the last decade, I have consulted on dozens of cases around the country. In my experience, individuals with psychiatric disabilities who are subjected to criminal charges by staff entrusted with their care tend to have a number of characteristics in common. (There is a marked lack of research on this topic; articles on patient prosecution either concerned only one individual,ⁱⁱⁱ or focused primarily on how prosecutions affected patients and staff^{iv} rather than looking to the ways in which institutional factors predict the utilization of criminal

prosecution as a way of punishing difficult, complex and disliked patients, ridding the facility of individuals who are difficult to treat, or both. Unless they are fire-setters, a small but obviously significant minority who raise a host of issues beyond the purview of this article, individuals who are subject to criminal charges by staff entrusted with their care often have the following characteristics in common:

A. Most Clients Subject to Criminal Charges Will Have Histories of Childhood Sexual or Physical Abuse (Trauma Histories) That Has Not Been Addressed by the Facility

If a client is arrested, chances are high that his or her charts will reflect a history of childhood physical or sexual abuse. It is also likely that the clients' treatment plans will not reflect any response by the facility to the history of abuse, whether through the treatment plan, attempts to avoid seclusion or restraint, seeking outside consultation, or any kind of assessment of the interconnection between the abuse and the client's emotional difficulties or conduct. It is quite likely that the clients' abusers were not criminally prosecuted. The records will not contain any reflection by any staff member or supervisor about the impact on the client of being arrested or criminally charged for minor behaviors when adults who sexually molested him or her for years escaped the attention of the law entirely. These clients, often women, are often diagnosed with borderline personality

disorder, and elicit strong negative feelings in staff, who either explicitly or implicitly believe that the client can control her behavior, and is actuated by malice rather than manifesting a psychiatric disability.

B. The Clients Subject to Criminal Charges Will Present Difficult Medical and Psychiatric Treatment Issues and be Receiving Inadequate/Inappropriate Treatment

Many arrested clients present difficult medical or psychiatric treatment issues. Many will have histories of multiple hospitalizations, perhaps from an early age, with little indication of any progress. It is possible that treatment settings will resist admission of these individuals. Sometimes the client is deaf; sometimes the client ingests foreign substances; sometimes the client has mental retardation or severe learning disabilities. Often, there is a difficult, complex treatment problem associated with the client.

Often, a review of the charts of clients who have been arrested will reveal prescription of multiple medications in the same class, medications inappropriate for the diagnosed condition, excessive numbers and dosages of PRNs, or inadequate medical treatment for a physical condition. These inadequacies will be striking (i.e., treatment deficiencies or inadequacies will stand out even in a facility that routinely provides less than optimal treatment).

C. The Conduct for Which Clients are Arrested is Often Minor and Has Generally Occurred Before, Often on Numerous Occasions; it will Almost

Always be Possible to Find Other Clients In the Same Facility Exhibiting
'Worse' Examples of the Same Conduct and Not being Subject to Arrest

The behaviors for which clients are arrested are (with rare exceptions relating to fire-setting or very serious assault) generally in the realm of pushing, shoving, pulling hair, spitting, throwing chairs, and fighting back when being restrained. One client was arrested, charged, and convicted for marking a staff member with a pen. Two individuals were recently threatened with arrest on felony charges: one patient had been making repeated harassing (but not threatening) phone calls. The other patient threatened with arrest had loaned the first individual his cell phone without knowing the purpose for which it was to be used.

It is almost uniformly true that whatever behavior an individual is being arrested for has occurred before, usually repeatedly, has not been the subject of any kind of serious, sustained assessment or consultation or treatment plan. Arrest is, in this way, a perverse form of expressing staff frustration over a condition or symptoms they are unable to understand or effectively treat, or an extreme way of expressing staff conviction that the behavior is within the control of the individual institutionalized precisely for an inability to control behavior.

Finally, it is also generally true that other individuals in the same institution are behaving far more violently and not being subject to arrest. The motivations behind arrest are almost never the seriousness of the behavior involved (with the exceptions noted above).

D. Clients Subject to Arrest Are Frequently Secluded or Restrained

It is clear that these clients experience a great deal of restraint and seclusion, reflecting the staff's inability to develop successful and effective treatment and de-escalation plans. These clients often have records of excessive utilization of restraint; excessive duration of restraint; and restraint representing unacceptable levels of risk to the clients.

In addition, facilities where clients are arrested will often appear to have little concern regarding excessive restraints, even when they fall below accepted standards of professional judgment.

Conclusions about Institutionalized Clients Subject to Criminal Charges by Staff

The conclusion to be drawn seems fairly clear:

- 1) The clients who are arrested have serious psychiatric and often medical conditions. They are not faking these conditions. All have a long history of difficult emotional problems, and the behavior for which they were charged

will be a manifestation of those emotional problems. It will almost always be behavior that the client has exhibited many times in the past, for which he or she was not arrested.

- 2) The behavior will often be relatively minor, or arise from a situation where the staff person laid hands on the client first. For many, the behaviors for which they were arrested caused minor or no injury to the charging staff person, and often represent extremely characteristic behaviors of that client.
- 3) It is difficult to avoid concluding that these are clients who were perceived as extremely frustrating, burdensome and hard to treat by hospital staff.

These are repeat clients whose treatment has not been successful, whose care involves complex psychiatric, disability, or medical issues, and with whom the staff feels overwhelming frustration and powerlessness. When staff also dislikes the client, or perceives her as “manipulative” or able to control her behavior, the classic profile of the female client who is arrested is complete. There is rarely any effort to examine staff’s countertransference or their own behavior in precipitating whatever event results in arrest. Rather, there is ample evidence to support the inference that staff, overwhelmed by unsolvable treatment issues, took out their frustrations in punitive ways on

these clients, by restraining them, arresting them, and often using medication as a means of behavioral control.

II. Consequences of Filing of Criminal Charges Against Institutionalized Clients

As a general matter, an arrest record can impact a client's ability to obtain housing, employment, schooling, volunteer positions, social security benefits, and especially—a prerequisite for all of the above—community placement. Thus, at one of the most stressful and important periods for him, criminal charges were filed which could have destroyed his chance at placement, and nullified the months of work done by staff at all levels to apply for the placement.

For other clients, especially children, the mental health system that was supposed to help them has become the gateway to a criminal justice record. In a perverse reversal of criminal diversion programs, staff who file criminal charges against their patients ensure that these children will be diverted *into* the juvenile justice system. Increasingly, juvenile justice records are available to a variety of actors—courts, police, the mental health system, and others. The arrest records of children and adolescents will impede community placement, and may make it difficult for them to complete their education. A record of arrest may also extinguish their ability to secure necessary student loans.

For the adults, subsidized housing authorities and independent housing rental agents often undertake background checks of applicants for housing, thus reducing the opportunities of arrested clients to obtain community housing. Because community residential opportunities are so rare, and community providers able to pick and choose the individuals they accept, already difficult community placements will become even more unlikely. This is particularly ironic in the case of many clients with diagnoses of borderline personality disorder. Although people with this diagnosis are among the groups most likely to be arrested, the research literature indicates that people with this diagnosis, especially those with histories of sexual abuse, deteriorate in hospital settings.^v Yet the actions of hospital staff in filing charges increase the chances that such individuals will have to spend unnecessary time in hospitals because they increase the chance that community residences will reject clients with arrest records or criminal histories.

The number of employment—and even volunteer—positions for which background checks are required and which exclude people with arrest or criminal records is increasing. These include many entry level occupations, such as working at day care centers, nursing homes, school cafeterias, or being home health aides. Nor can an individual with such a record hold out much hope of joining the

military, being a school bus driver, security guard, or any law-enforcement related occupation. Any number of occupations which require licenses, including taxi drivers, dental technicians or hygienists, also require criminal background checks.

Filing criminal charges has effects that may include divesting clients of the minuscule amount of pocket money that they use to pay for snacks, greeting cards, or gifts for family members. Many clients use scarce resources to pay back criminal fines for minor infractions.

III. Response to Justifications of Arrest of Institutionalized Clients

Justifications for criminal prosecution of institutionalized individuals have evolved over the years. Initially, the argument was made that such prosecution was somehow “therapeutic” for the individual prosecuted (usually by conveying that behavior had consequences; proponents of prosecution did not discuss whether that message could be conveyed in less drastic terms). Although the theory that criminal prosecution somehow serves treatment purposes has largely been discredited since it was first advanced in the 1980s, for those who still advance this argument the response should be to ask whether the patient has a right to refuse this “treatment” of criminal prosecution. If the patient is competent, he or she presumably has the right to refuse. If the patient is not believed to be competent, it may be a violation of licensing standards to file criminal charges against a patient

believed to be incompetent. Often, the purpose of the hospitalization is to provide treatment for the very condition involved in the assault. Criminal prosecution, to say the very least, interferes with the treatment alliance and any sense of safety the patient may have had at the hospital, and makes a mockery of any initiative the state may have to divert people with psychiatric disabilities from the criminal justice system into the mental health system.

Another early argument was that criminal prosecution of individuals who assaulted staff improved staff morale. Indeed, many articles focused explicitly on prosecuting individuals for assault on staff or damage of facility property; harm to other residents of the facility was rarely a reason for prosecution. Although this argument is not made explicitly anymore, a crucial factor behind the unwillingness of administrators to take a stand against prosecution of institutionalized individuals is reluctance to offend nurses' unions, who have made "workplace safety" issues a national priority. Most prosecutions are, in fact, motivated by an individual staff member's anger and desire to punish a resident for his or her actions.

More recently, the argument has been made that prosecutions are "normalizing" (a concept which does not carry as benign a connotation as "therapeutic"). The argument that criminal prosecutions are "normalizing" ignores

the fact that hospitals are not “normal” community settings which the clients are free to leave. Nor are they settings in which freedoms, rights, and choices are balanced by responsibilities. The very fact that an individual is in the hospital reflects a judgment by the patient or others that he or she has a mental or emotional condition of sufficient severity that community life would not be safe for the individual or others. Indeed, civil commitment forms routinely include an assertion that the individual is dangerous to self or others.

Administrators and staff may be unaware of the enormous consequences for a patient of having a criminal record in obtaining housing, employment, credit, retaining parental rights, or myriad other examples crucial to reintegration into the community. A decision to criminally prosecute may foreseeably restrict the patient to unnecessarily longer institutionalization by restricting the patient’s options in the community.

In fact, patient prosecutions may be a signal that staff are feeling unsafe, untrained and unsupported by hospital administrators; sometimes hospitals initiate prosecutions to show support for staff. Both of these situations reflect “us against them” mentalities that clearly reflect problems in the underlying treatment environment, and certainly problems between the treating professional and the client. Prosecuting professionals have no further treatment relationship with the

client, and this should be accomplished in a way that is not disadvantageous or punitive to the client.

Sometimes criminal charges reflect frustration with a patient who is particularly difficult to treat, or who is perceived as “splitting staff.” These female patients, diagnosed with borderline personality disorder, are likely to have been sexually abused as children and to react defensively when they feel threatened. The triggering events should be identified and discussed with the patient and staff, so that staff are thoroughly familiar with them and can take pains to avoid them. Restraint procedures may well be very triggering for these women. For these women to be required to appear in court as a criminal defendant, often when their own abusers escaped unaccused and unpunished, is enormously traumatic and does untold damage. Thus, administrators should be encouraged to examine whether these factors play a role in the decision to prosecute a particular patient for assault, especially for an assault that is basically the result of a botched restraint procedure.

In addition, assaultive behavior can often be attributed to failures on the part of the facility to have staff sufficiently trained in de-escalation restraint procedures, or to provide treatment aimed specifically at the effects of trauma on behavior, or to appropriately provide for patient safety, or to have acted insufficiently to reduce

restraints. These failures may implicate constitutional or statutory rights of the patient.

IV. Potential Liability Associated with Arrests of Institutionalized Clients

A. Violation of Due Process Rights

The United States Supreme Court has had occasion to examine the constitutional distinctions between civil commitment and criminal incarceration quite closely in the last decade, as sexual offender commitment programs proliferated across the country. Because one of the major charges levied against sexual offender programs were that they were criminal confinements unconstitutionally disguised as civil treatment programs, the Supreme Court probed the boundaries that due process creates between the two in ways that are illuminating in the context of facility staff filing criminal charges against civilly committed clients.

In discussing the requirement that an individual be seriously impaired in his or her ability to control dangerous behavior as a prerequisite to civil commitment, the Court noted that “The distinction regarding lack of capacity to control behavior is necessary lest ‘civil commitment’ become a ‘mechanism for retribution or general deterrence,’ functions properly those of criminal law, not civil commitment.”^{vi} The arrest of a civil patient, especially one with no prior criminal

charges and a long history of serious psychiatric disability, for a minor infraction against a staff member—pushing, pulling hair, etc.—may well constitute a violation of the client’s rights under the Due Process clause of the Constitution. If the facility supports these actions, its leadership may be liable for damages under 42 U.S.C. 1983.

This is not mere speculation. At least one court has held that a facility violates its patients’ constitutional rights if it has a “policy of criminally charging patients for behavior resulting from their mental condition, regardless of whether the patient had the capacity to form the requisite criminal intent,” *McCartney v. Barg*, 643 F.Supp. 1181, 1183 (N.D. Ohio 1986). In *McCartney*, the plaintiff was arrested at the behest of the hospital and sent to jail, where she received no treatment for her mental condition, until she was found incompetent to stand trial after five months. The court rejected defendants’ argument that they could not be held responsible for the conditions in the jail, noting that they could have dropped criminal charges against the patient and regained custody of the patient at any time. The court found that the allegation that defendants had adopted a policy to file criminal charges against patients stated a constitutional claim, and that such a policy could constitute “a substantial departure from professional judgment,

practice or standards” under *Youngberg v. Romeo*. At trial, the plaintiff won a \$250,000.00 verdict.^{vii}

As to underlying criminal charges, courts have found that “prosecution of an institutionalized person for acting out as might be expected is neither `constitutionally nor morally justified,”^{viii} and that conviction of such a patient would constitute cruel and unusual punishment under the Eighth and Fourteenth Amendments.^{ix} These were findings in criminal cases, dismissing the charges against institutionalized clients, but they might form the basis for charges of due process violations under the Fourteenth Amendment against the mental health agency, facility directors, and staff. As the Supreme Court has noted, “there are constitutional limitations to the behavior that a State may criminalize,” *Foucha v. Louisiana*, 504 U.S. 71 (1992)(distinguishing between standards for subjecting people to the criminal justice system and to the mental health system). In *Youngberg v. Romeo* the Supreme Court considered the conditions of confinement for involuntarily committed individuals, and underscored the familiar refrain that they “may not be punished at all.” It is difficult to understand a facility’s invoking the police and criminal justice system as a response to minor symptomatic behavior in any framework except that of punishment.

These cases often involve women with diagnoses of borderline personality disorder or PTSD and histories of severe childhood sexual or physical abuse, as in the clients discussed above. Often the clients are prosecuted for far less serious offenses than those for which their abusers escaped prosecution. There is considerable research showing that women with trauma histories do poorly in jail, and a deliberate decision by a nurse or psychiatrist to knowingly expose a patient in his or her care to possible jail time, may constitute a substantial departure from professional judgment or, at the least, violation of professional ethics for which a licensure investigation would be appropriate.

B. Violation of the Americans with Disabilities Act

In a number of cases, criminal charges were filed against institutionalized patients for behavior that would not have resulted in criminal charges against non-disabled, non-institutionalized individuals. It is difficult to imagine charges being filed against an individual who did not have a psychiatric disability for pulling someone else's hair.

Title II of the Americans with Disabilities Act prohibits discrimination against individuals on the basis of disability by public entities. State mental health agencies constitute public entities under the Americans with Disabilities Act.^x While individuals such as staff members who file criminal charges cannot be sued

under Title II of the Americans with Disabilities Act, or Section 504 of the Rehabilitation Act, public entities such as state mental health agencies can be sued for injunctive relief if they can be shown to have administrative policies or practices that discriminate on the basis of disability, countenance such discrimination, or result in discrimination. The premise of an ADA claim would be that criminal charges were being filed because of the client's disability, either in the sense that the behaviors resulted from the disability, or in charging violations of the law for behaviors for which non-disabled persons would not be charged criminally (such as deeming pushing or hair-pulling to be assaults). Thus, persons with disabilities are burdened because of their disabilities in ways that non-disabled persons are not. It should be noted that discrimination charges under the ADA do not require a comparative class, *Olmstead v. L.C.*, 119 S.Ct. 2176, 2186 (1999).

When a state mental health agency is on notice that its staff are discriminating against its clients by filing criminal charges against them in circumstances in which non-disabled individuals would not be subject to criminal charges, it will be under an obligation to develop administrative practices to ensure that this form of discrimination is prevented to the extent possible, as outlined in the recommendations below.

C. Violation of Federal and State Confidentiality Rights

Both federal regulations to the Health Insurance Portability and Accountability Act (HIPAA) and all state laws strictly regulate divulging information about patients. HIPAA specifically provides that if the state law protecting client confidentiality is stronger, then that state law governs as against any inconsistent provisions in HIPAA.

The information provided by the staff in criminal charges may violate state statutes against breaching the confidentiality of patients, and, possibly, federal regulations under HIPAA. While HIPAA permits disclosure to law enforcement by the facility of “criminal conduct that occurred on the premises of a covered entity,”^{xi} it also severely circumscribes the protected health information that can be divulged under this exception. Since the facility can only report factual information that it believes in good faith constitutes evidence of a crime committed on its premises, it cannot report an individual’s diagnosis, past history, or any information that does not constitute evidence of criminal conduct.

HIPAA also permits the filing of charges by a staff member (“a workforce member of a covered entity”) as the purported victim of a crime.^{xii} Again, the protected health information that can be disclosed is limited to that which would assist law enforcement in locating a fugitive or suspect, limits the information

disclosed to “ name, address, date and place of birth, social security number, blood type and rh factor, type of injury, date and time of treatment (and death, if applicable) and a description of distinguishing physical characteristics.”^{xiii} Any information given to law enforcement by staff that exceeds these limits is a violation of HIPAA. In most cases, staff will violate HIPAA either in initially reporting the crime, or in later interviews with police. Police investigating a crime must seek appropriate court orders for protected health information,^{xiv} but as a practical matter, this rarely happens. Because facilities are so sensitized to HIPAA, complaints and advocacy along these lines may be particularly useful in limiting or eliminating staff prosecution of patients.

D. Licensing

Depending on how the State’s licensing authority operates, and what its priorities are, a licensing complaint may be considered. Mental health professionals are governed by ethical principles that include the obligation to preserve client confidentiality^{xv}, avoid conflicts of interest^{xvi}, act in the best interests of their patients, avoiding harm to their patients.^{xvii} In many cases, filing criminal charges against one’s own patient might be seen as implicating these ethical considerations.

Although complaints to licensing boards for breach of confidentiality are an appropriate response when professional staff at institutions and community residential facilities breach the confidentiality of their clients, the best way to approach this issue is by preventive systemic intervention rather than by reacting to individual cases. A mental health agency or facility can institute policies aiming at preventing or curtailing prosecutions by its staff if it gives them notice when they are hired of the existence of these policies. It is far more difficult for an agency or hospital to interfere with an individual staff member who has already filed the criminal charges. Education of district attorneys, many of whom do not want to pursue these cases in any event, may be useful. In the same way, working with the judiciary to emphasize the harm to patients of these criminal prosecutions, and the degree to which they indicate treatment failures, may be fruitful.

V. RECOMMENDATIONS

A. Mental Health Agency Recommendations

1. Adopt a Policy Identifying Staff Filing of Criminal Charges Against Patients as Presumptive Treatment Failures

The state mental health agency should recognize the parallels between use of restraint and seclusion and the practice of arresting clients. Both are devices used by staff as a mechanism to both maintain control of clients and to “get them out of

sight.” Both are used punitively, often by frustrated staff who are unable to devise appropriate approaches to difficult patients. Both are the result of situations that have escalated out of control. Both reflect an institutional philosophy that the penalty for these escalated situations is explicitly levied on the client, who is focused upon as the cause of the problem. Both should be considered treatment failures. This is similar to the adoption of such a position by the Pennsylvania Department of Public Welfare regarding restraint and seclusion of patients. Pennsylvania state officials attribute much of their success in virtually eliminating restraint and seclusion from state facilities to the central office leadership taking this position on restraint and seclusion.

2. Require Notification Prior to Staff Filing Charges Against State Clients

The state mental health agency should require that any staff intending to file criminal charges against an institutionalized client must give the director of the facility at least three (3) working days’ notice prior to filing charges. The staff member would be required to come in for a meeting with the facility director in order to ensure that he or she was fully aware of the consequences to the client of filing such a charge (see below).

The director of the facility would be required to notify the central office of the state mental health agency, the facility Human Rights Officer and/or Protection and Advocacy agency, the client's attorney of record or the local public defender's office, and family members, if the client so desires. The rationale for notification is that the therapeutic and administrative consequences of such charges to the patient charged and to other patients will be borne by the facility and the mental health agency, and that the vulnerable client in the state's care, being prosecuted by a staff member working for the state, should have the benefit of independent advice and counsel so that he or she would not incriminate himself or herself. The records reflect that staff frequently demand that patients apologize for misbehavior. These "apologies" to staff that have filed criminal charges could be construed as evidence in police investigations and trial proceedings, and staff should be instructed not to ask for them under those circumstances.

3. Sentinel Event/Root Cause Analysis

Because staff filing criminal charges against a client represents a system failure and a treatment failure, the state mental health agency should require the Director of a facility to treat any filing of criminal charges as a sentinel event subject to a root cause analysis to be concluded by the facility within one week and reviewed by the director of the mental health agency. This analysis would include,

at a minimum, the events leading up to the conduct for which the client is being arrested and the context of the client's distress; the level of training received by the charging staff member, the response of the leadership on the unit, the prior treatment of the patient, the patient's clinical and social history, including any history of sexual or physical abuse, an analysis of the impact on the patient of charges being filed, and a report of steps taken to protect the client's rights and prevent clinical deterioration, including transfer of the charging staff member.

4. Ensure Compliance with All Applicable Confidentiality Regulations

The state mental health agency should also assume the responsibility of ensuring that if any staff person files a criminal charge against a patient and violates the regulations pertaining to client confidentiality of the Health Insurance Portability and Accountability Act (HIPAA) or the state confidentiality statute, that the staff person is appropriately disciplined by the mental health agency as well as being reported to appropriate professional licensing authorities, and to the Center for Medicare and Medicaid Services (CMS).

In addition, the mental health agency should adopt a policy that no facility, facility director, or professional staff member at a facility can consent to release of records in criminal prosecution of clients. Legal counsel for the mental health agency can be asked to oppose court orders to release such records, and to defend

facilities that oppose release of client charts in criminal proceedings brought by facility staff.

5. Authorize Consultations on Difficult Patients

Many clients who are subject to criminal charges present extremely difficult treatment issues. Yet staff rarely have the benefit of outside consultation to help devise treatment strategies for these clients. Even when a state has extremely limited budgetary resources, there are many ways to obtain consultations that are relatively inexpensive. For example, consultations with experts at state universities may be helpful. In addition, the National Association of State Mental Health Program Directors maintains a Technical Assistance Center with a great pool of expertise in treating patients with histories of sexual and physical abuse who self-injure and/or ingest foreign objects. As members of the National Association of State Mental Health Program Directors, the State could call upon NASMHPD's expertise in these areas relatively inexpensively.

In addition, the federal government's Substance Abuse and Mental Health Services Administration (SAMSHA) also funds a center that maintains a list of experts in areas related to the treatment of patients with trauma and sexual abuse histories, including patients diagnosed with borderline personality disorder and those who self-injure.

6. Initiate Independent Research and Data Gathering

The state mental health agency should be urged to gather data as to the prevalence of institutional and community staff filing charges against patients in their care. This study should go back two years, and data gathering should be ongoing. Because this phenomenon reflects failures at the facility level in leadership, it is expected that some institutions will have no staff members filing criminal charges, while other facilities with similar client profiles may have a number of staff members doing so, especially when staff perceive that they have the facility director's "permission" to file criminal charges against their patients.

The clinical consequences to the client of having criminal charges filed against him or her by a staff member should also be studied by an independent entity. Although some defend the filing of criminal charges against a client as a way of making the client take responsibility for his or her actions, even articles favorable to the procedure acknowledge that in the majority of cases, such a change does not occur. This is probably because, like ingestion of foreign objects, the actions in question are symptoms of an emotional disturbance that the client does not desire any more than the staff. If possible, the hypothesis that the patients who have criminal charges filed against them by staff are not the most criminally responsible but rather the most difficult to treat should be tested.

In addition, the consequences to the treatment milieu should be studied. This should include the effect on other patients. Past studies of the effects of filing criminal charges against a patient have focused exclusively on the effect on staff, and some have found that filing criminal charges raises staff morale, perhaps because staff who otherwise feel disempowered and helpless perceive filing criminal charges as asserting control over an environment in which they feel out of control. Again, this implicates a leadership and systemic failure which the state mental health agency should investigate.

B. Facility Directors

1. Staff Education and Training

a. Training on the Consequences of Filing Criminal Charges

Staff members often do not have any idea of the collateral consequences to the client of criminal charges. Facility directors should prepare information sheets and counsel the staff person about those consequences. In addition, the facility director should have the responsibility of informing the staff member that Central Office, the P&A, the facility Human Rights Officer, and the client's attorney or the Public Defender's office will have to be notified and will likely wish to interview the staff member. The facility director should begin to seek the information necessary to complete the Sentinel Event review at this meeting as well. Finally,

the facility director should reiterate the importance of maintaining confidentiality, ensure that the staff person knows the federal and state rules relating to confidentiality and the consequences of violating those rules. The facility director should ensure that the staff person is transferred from direct care of the patient if he or she does bring criminal charges (and possibly even if he or she does not, given the countertransference implications of a staff person contemplating such a step).

It is possible that after reviewing the ways in which a criminal record will obstruct the already difficult task of reintegration into the community, some facilities or truly well-intentioned professionals will recede from their determination to prosecute.

These discussions should not be limited to those instances in which staff members are contemplating filing criminal charges, but should be part of the training received by all staff members. After existing staff have been trained, the training can be done for all incoming staff members.

b. Training on De-escalation

A number of cases involving criminal charges arise out of events taking place during a restraint procedure. Staff who have received extensive training on de-escalation may never reach the point of contemplating filing charges against clients for assault because there may never be occasion to lay hands on a client.

The more often that staff lay hands on a client to control him or her, the more likely it is that physical injury will occur, and that civil or criminal litigation will follow. Most arrested clients are restrained frequently, increasing the chances for violence and injury to both patients and staff. The facility director should make reduction of restraint a priority, and training of staff in de-escalation techniques can only benefit both patients and staff.

2. Avoid Conflicts of Interest

Because of a number of clinical and legal problems associated with having staff treating a patient against whom he or she has filed criminal charges, the facility director should ensure that any staff member who files criminal charges against a client is immediately transferred from his or her care. Clinically, issues of the treatment alliance and the trust required between patient and care provider are clearly disrupted by the adversarial nature of the criminal charges. The filing of the charges itself indicates a substantial risk of countertransference by the staff member. The staff member also has an inherent conflict of interest between his or her own interest in maintaining and proving the case and the duty to support and care for the client. Material that the staff learns as a treatment provider may ultimately end up as evidence in criminal court.

All of these issues are so serious that if there is no other position available for the staff member, he or she may have to be suspended or transferred. However, doing this is preferable to having a staff member continue to work with a client against whom he or she has filed criminal charges.

3. **Ensure that Charting Does Not Become Evidence**

In addition to adopting a policy of refusing to release facility charts to be used as evidence in criminal proceedings, facility directors should instruct mental health workers not to talk about any incident for which a client is being charged criminally with the client, since such workers are not protected by any evidentiary privilege and their testimony can be compelled by a court. If the subject does come up, the director should instruct the mental health worker to inform the client only to discuss this matter with a psychiatrist, psychologist, or social worker, for whom evidentiary privilege rules would apply, and not to include any information about the client's disclosure in his or her chart.

VI. CONCLUSION

When staff file criminal charges against institutionalized psychiatric patients with histories of extreme physical and sexual abuse for minor acts causing little or no physical injury, it is difficult to see how the state mental health agency providing care for the patients can be said to provide quality services, encouraging

treatment in the most integrated setting possible, respecting individuals and their strengths, or any of the other aspects of state mental health mission statements.

Rather, criminal charges are, in fact, very intrusive and disruptive, affect an individual's entire future and ability to successfully integrate into the community, and arrests are the attempts of a facility that is providing inadequate treatment to shift the blame from itself to the client entrusted to its care.

ENDNOTES

ⁱ TASC is the Training and Advocacy Support Center. Support for the development of this document comes from a federal interagency contract with the Administration on Developmental Disabilities (ADD), the Center for Mental Health Services (CMHS), and the Rehabilitation Services Agency (RSA) and a grant from Iowas Protection and Advocacy Services.

ⁱⁱ *Kansas v. Crane*, 534 U.S. 407, 412 (2002).

ⁱⁱⁱ Conrad Schwartz and Gregory Greenfield, "Charging a Patient with Assault on a Nurse on a Psychiatric Unit," 23 *Canadian Psychiatric Association Journal* 197-200 (1978); Lillian Phelan, Mark Mills and Jane Ryan, "Prosecuting Psychiatric Patients for Assault," 36 *Hospital and Community Psychiatry* 581-82 (1985).

^{iv} Thomas Gutheil and Timothy M. Rivinus, "The Cost of Window Breaking," 7 *Psychiatric Annals* 47-51 (1977); Steven K. Hoge and Thomas Gutheil, "The Prosecution of Psychiatric Patients for Assaults on Staff: A Preliminary Empirical Study," 38 *Hospital and Community Psychiatry* 44-49 (1987); Robert D. Miller and Gary J. Meier, "Factors Affecting the Decision to Prosecute Mental Patients for Criminal Behavior," 38 *Hospital and Community Psychiatry* 50 (1987).

^v Peter Dawson and Harriet MacMillan, Relationship Management of the Borderline Patient: From Understanding to Treatment (Brunner/Mazell 1993).

^{vi} *Id.*

^{vii} Personal communication from Jane Randall, counsel for plaintiff.

^{viii} *State of Wisconsin v. Jennifer Hartman*, No. F-933164 (Circuit Ct. Milwaukee County June 15, 1995)(transcript of hearing available from the Center for Public Representation), *quoting State v. Cummins*, 403 A.2d 67 (N.J.Sup.Ct. 1979).

^{ix} *State v. Cummins*, 403 A.2d 67 (N.J.Sup.Ct. 1979).

^x 42 U.S.C. 12131 (West 2004).

^{xi} 45 C.F.R. 164.512(f)(5).

^{xii} 45 C.F.R. 164.503(j)(2).

^{xiii} 45 C.F.R. 164.512(f)(2).

^{xiv} 45 C.F.R. 164.512(f)(2)(A) and (B).

^{xv} American Psychological Association, *Ethical Principles for Psychologists and Code of Conduct: Ethical Standard 5.0* (American Psychological Association: 2001).

^{xvi} American Psychological Association, *Ethical Principles for Psychologists and Code of Conduct: Ethical Standard 1.13* (American Psychological Association: 2001).

^{xvii} American Psychological Association: *Ethical Principles for Psychologists and Code of Conduct: Ethical Standard 1.14* (American Psychological Association: 2001).