



Disability Rights  
WASHINGTON

# From Hospitals to Handcuffs

## Criminalizing Patients in Crisis

May 2020





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# Introduction

Imagine finding yourself in the midst of a behavioral health<sup>1</sup> crisis—you might be panicked, confused, or frightened. You would never expect that going to a hospital for help could lead to your arrest, jailing, and criminal prosecution. But in Seattle, as in many places, that is too often the case.

Disability Rights Washington (DRW) found that over the course of the a recent year, staff from seven Seattle health care facilities called police 201 times to report assaults involving patients; 102 of these calls resulted in arrest of a patient. This means that nearly two people per week are arrested out of health care and booked into jail. The majority of these incidents involved patients in behavioral health crisis. Most did not result in any visible injury to the victim. In fact, for many of the incidents the only alleged crime was spitting.

Without a doubt, staff in health care facilities face disproportionately high rates of workplace violence, oftentimes related to interactions with patients.<sup>2</sup> As a result, they may experience increased injury and stress.<sup>3</sup> They might also reach out to law enforcement for assistance.

Patients who are arrested are removed from medical and mental health care and instead placed into jail and criminally prosecuted. Many remain in jail for weeks or months where they face increased risk of suicide, harm from placement in solitary confinement, and decreased access to needed health care, among other things.<sup>4</sup>

“Carol,” who uses a walker, was getting treatment at Harborview’s inpatient psychiatric unit. She did not want to return to her room and argued with a nurse. Carol threw her paper cup, getting juice on the nurse’s shoulder but causing no injury. She was arrested for assault, removed from inpatient psychiatric care, and booked into jail. See pg. 18 for more.

*\*The names of all patients featured in this report have been changed to protect their identity.*



“Anthony” was brought to Swedish First Hill by his family for a mental health evaluation due to hallucinations and paranoia. In the waiting room, he became agitated and confused, yelling and throwing chairs. He struggled with hospital security, but caused no injury. Instead of getting a mental health evaluation, Anthony was arrested, booked into jail, and charged with assault. See pg. 11

Most importantly, the arrest and prosecution of these patients does not make any of these health care facilities safer for staff or patients over the long term.<sup>5</sup> Health care staff, especially those who work in mental health, have a difficult job and deserve recognition for the challenges they face on a daily basis. No one should have to experience violence at work, but criminalization of health-related behaviors does not reduce rates of workplace violence or help the patient recover from crisis. We must stop to consider the harms of arrest on individual patients and the failure of this response to improve workplace safety in the long term.

This report examines the ways in which Seattle-area health care facilities respond to patients who become disruptive or assaultive and how these patients ultimately experience our criminal legal system. We examine when and why health care staff call police and the discretion that police exercise over arrest. We then look at how prosecutors decide to criminally charge these patients and the results of prosecution.

Disability Rights Washington (DRW) finds that there is an unnecessary financial, societal, and—most importantly—human cost of arresting people who are experiencing behavioral health crises in a treatment setting. The report concludes with recommendations for a more effective and humane approach.

## About Disability Rights Washington

DRW is a private non-profit advocacy organization with a mission to advance the dignity, equality, and self-determination of people with disabilities and to pursue justice on matters related to human and legal rights. DRW has been specially designated to serve as the



federally mandated Protection and Advocacy system for Washingtonians with disabilities, including mental health conditions.<sup>6</sup>

Congress provided federal funding and mandated that each Protection and Advocacy system has authority to provide information and referrals, outreach and monitoring, as well as advocacy and education for policy makers regarding the rights of its constituents.<sup>7</sup> Under these statutes, Protection and Advocacy systems also have broad access authority to conduct investigations of abuse and neglect upon receiving complaints or probable cause to believe abuse or neglect has occurred or may be occurring.<sup>8</sup> DRW is releasing this report in furtherance of its mission and federal mandate to protect and advocate for Washingtonians with mental health disabilities.

## Background

Health care workers in the United States face disproportionately high rates of violence at work. Incidents of serious workplace violence are four times more common in health care than private industry; 80% of violent incidents occur in interactions with patients.<sup>9</sup> In a recent survey by the Washington State Nurses Association, more than 50% of member respondents

said they believe workplace violence is a serious problem where they work.<sup>10</sup>

*Psychiatric Emergency Services*

**NON-VIOLENCE STATEMENT**

This is a place to heal. To be a healing place there are certain expectations of everyone here.

One of these expectations is that we will work to keep this a *non-violent* environment.

**VIOLENCE INCLUDES:**

- Acts of hitting, throwing objects, or spitting
- Verbal abuse
- Disrespectful language
- Threats of *violence*
- Hurting yourself
- Making anyone a victim of these behaviors in any way.

With these expectations we can maintain a safe place where there is security and trust for everyone.

**EXPECTATIONS**

This is a place for people in crisis, a place of treatment and hope. *Violence* in any form, whether directed at yourself or others, physically or verbally, hurts the community and adds to crisis.

Everyone is responsible for safety. It is expected that you will respect the rights of all patients and staff, and keep yourself and others safe.

If there is injury to anyone or damage to property, such *violence* will be reported to administration and may have civil or criminal consequences.

**Poster in Harborview's Psychiatric Emergency Department explaining patient expectations**



Workplace violence can have serious consequences for staff well-being in terms of physical health, mental health, and perceptions of safety.<sup>11</sup> In addition to the physical injuries they may face, health care staff may also experience verbal aggression from patients and conflict with other staff on a daily level that increases workplace stress and related adverse health outcomes.<sup>12</sup>

A common response to these incidents is to arrest and prosecute patients who allegedly assault health care staff. An assault is generally defined as an intentional touch of another person in an offensive or harmful way.<sup>13</sup> An assault can be a misdemeanor when the level of violence or injury is relatively low or a felony when violence or injury are more significant.<sup>14</sup> Misdemeanors are punishable by up to a year in jail; felonies by over a year.<sup>15</sup> Criminal conviction, especially for felonies, can result in losing the right to vote, barriers to work and housing, and other serious challenges.<sup>16</sup>

**A simple shove, spit, or other minor, unwanted touching can become a felony solely because the victim is a nurse or doctor.**

Many states including Washington have passed laws that increase penalties for assault incidents in health care settings, converting what might otherwise be a misdemeanor assault charge into a felony *solely because the person assaulted is a health care provider*.<sup>17</sup> For example, a simple shove, spit, or other minor, unwanted touching can become a felony if the victim is a nurse or doctor.

A criminal legal response may remove disruptive patients in the short term, but it has not shown evidence of decreasing rates of workplace violence for health care providers.<sup>18</sup>



Instead, comprehensive workplace violence prevention programs, including safety and health training and data-driven, worksite-based interventions, have been shown to work.<sup>19</sup>

## Scope and Methodology

DRW examined assaults involving patients at seven Seattle-area health care facilities, all within the jurisdiction of the



**Mural created by patients at Navos**

Seattle Police Department (SPD). The list includes: Harborview Medical Center, Navos, Northwest Hospital, Swedish Medical Center (three locations: Ballard, Cherry Hill, and First Hill), and Virginia Mason. All provide varying levels of emergency or psychiatric care to patients. It is not the intention of this report to make conclusive comparisons between these different facilities.<sup>20</sup> DRW also reviewed policies and procedures related to workplace safety from most of the facilities.

DRW obtained a list of 275 calls from these facilities to the SPD reporting potential assaults that occurred between July 1, 2018 and June 30, 2019. SPD assigns each police call a code that represents the type of incident. The call dispatcher first codes the initial 911 call and then the police officer codes the incident after they respond. The 275 calls that DRW examined in this report were all specifically coded as assault by either the dispatcher or the responding police officer. DRW did not examine the hundreds of other calls that might be related to disruptive behavior by patients, but were not coded specifically as assault.

DRW determined that 201 of the 275 calls we reviewed described alleged assaults by patients against staff or other patients that occurred inside the health care facility. DRW examined the



manner in which these incidents were ultimately resolved by police, focusing especially on the 102 total calls that resulted in arrest. DRW then reviewed information obtained by the Seattle City Attorney’s Office (SCAO) and King County Prosecuting Attorney’s Office (KCPAO) to determine which arrests had criminal charges filed. DRW tracked the criminal prosecutions and outcomes of these cases.

## Facts and Analysis

### Treating a Patient in Crisis

Almost all of the assault incidents that DRW reviewed were related to a patient experiencing behavioral health crisis. In addition to the normal crises and stress experienced by any patient who needs health care, patients who are experiencing behavioral health crisis have additional, often predictable support needs linked to mental illness or substance use. Health care facilities should be able to meet these needs and provide necessary treatment.

### Health care facilities can resolve problems without calling the police

If patients become disruptive, threatening, or assaultive, health care providers and other staff can employ skills to avoid escalation or harm, allowing them to continue providing needed health care. Some techniques that nurses, doctors, and other facility staff use on a regular basis include: performing thorough assessment to identify an aggressive patient early on; using verbal de-escalation techniques; maintaining distance and avoiding threatening body

“Acute inpatient psychiatric settings may have patients who exhibit risk-prone behaviors, such as verbal aggression, attempts to elope, self-harming behaviors, refusing to eat or drink, and displaying aggression to objects or people....Patients come to the emergency department with hallucinations, hearing voices, or they may be under the influence of unknown substances.”

**- The Joint Commission, De-escalation in health care, 2019.**  
**The Joint Commission accredits and certifies 22,000 health care organizations nation-wide.**





language; implementing environmental controls, such as minimizing lighting and noise; clinically-driven use of internal hospital security staff; or using physical or chemical restraint.<sup>21</sup>

“Daniel” had a diagnosis of schizophrenia and was experiencing symptoms. Earlier in the day, he had been contacted by police for a crisis incident. At the conclusion of that police contact, Daniel decided to go to Swedish First Hill by ambulance to get treatment for an injured hand. Daniel panicked when hospital staff approached him on the ambulance gurney and became overwhelmed. He left the hospital before completing treatment, but returned later to get his medication. Daniel was seen near the ambulance doors yelling at no one in particular and appeared to be responding to internal stimuli. A security guard approached him and proactively took him to the ground after Daniel yelled at him. After a physical struggle, Daniel was arrested and booked into jail. The police report and witness accounts do not describe any assessment and planning by hospital staff based on Daniel’s known symptoms and behavior, nor do they evidence any de-escalation tactics.

DRW reviewed policies and procedures for health care facilities, which address how to handle disruptive patients and potential workplace violence. All require violence prevention training for staff. At Harborview, for example, training subjects include violence-predicting factors, de-escalation and restraining techniques, and appropriate use of medications as chemical restraints.<sup>22</sup> Harborview instructs staff to use verbal interventions, set limits as appropriate, or seek security or other staff assistance to counter threats.<sup>23</sup> Once any immediate danger is resolved, policy requires the patient’s care provider to make decisions about next steps. This may include creating a patient care plan (essentially written guidance for care options to minimize risk of future harm), placing electronic alerts in the medical record, or terminating care.<sup>24</sup>



While all the policies that DRW reviewed require staff to report patient incidents to the facility, they allow staff discretion about contacting police or cooperating in criminal prosecution. For example, Navos has a specific policy entitled “Discharge of a Patient to Jail,” which allows Navos psychiatrists to decide whether they think the assault was volitional or due to the patient’s psychosis.<sup>25</sup> Notably, even if the psychiatrist believes the assault was volitional and opts to contact the police, Navos policy states that it is the police officer, not facility staff, who should make the final decision about arrest.<sup>26</sup> Washington law requires health care facilities to keep their own records of violent incidents, including whether the act was committed by a patient and what steps were taken in response to the incident.<sup>27</sup> DRW obtained this

**Records demonstrate that health care facilities can and do respond to assaultive patients without contacting police and still reach a safe outcome.**

information from several of the facilities we reviewed. It confirmed that there are many incidents that might involve violent behavior from a patient but do not result in any calls to the police.

For example, Harborview reported well over 400 violent incidents over the course of the same year in which it called police 78 times to report patient-involved assault. Swedish provided narratives for violent incidents at its three Seattle facilities, many of which describe incidents in which staff chose not to contact the police in response to a patient’s threatening or assaultive

behavior, even when it resulted in injury. These records demonstrate that health care facilities can and do respond to challenging or assaultive patients without contacting the police and still reach a safe outcome for everyone involved.

Swedish also provided DRW with records documenting post-incident analysis which included staff ideas about how the incident could be avoided going forward. These analyses focused



heavily on improving staffing levels and training. Consider the following feedback from a nurse at Swedish after an incident involving a patient on the post-partum unit who displayed serious psychiatric symptoms, made threats, and became violent with staff:

*“Education regarding de-escalation is available for the remainder of the year at Swedish. As the unit manager, I agree that more tools, education and resources need to be available to care for this patient population. Patients who exhibit this level of threat and escalation are disruptive and threatening not only to themselves, but to staff and to other patients....There was a failure to follow policies in place regarding search and seizure given this patient’s behavior and psych needs. I ask that a policy and training is given to nursing, charge RN and providers as this level of care is becoming more frequent on our units.”*

Although DRW did not receive similar narratives and analyses from other health care facilities, the emphasis on adequate staffing levels and training is key for all health care facilities

struggling with workplace violence.



**Medical exam room at Navos where patients are screened shortly after entering the facility**



## Anthony's Story

*"I grew up in the Seattle area. In 2018, I lived alone, had a full-time job, and had never been arrested. I started to feel a lot of stress at work after a series of layoffs and mandatory overtime. I realized I wasn't acting like myself and I took some time off my job. Within a day or two, I started to lose touch with reality. This had never happened to me before and I didn't understand what was going on.*

*My parents and sister got worried about me and wanted to take me to a hospital for help. While we were driving on the freeway, I was talking really fast and I threw my wallet out the window. I couldn't even tell you why I did that—I think I believed that something big was about to happen and I wouldn't need the wallet. After that, my family drove me to the closest hospital emergency room at Swedish.*

*Staff told us to wait. I didn't understand what was happening, so I wanted to leave. I think I was getting loud and my family was trying to keep me calm. I remember that I threw one of those "caution: wet floor" signs and hospital staff were just staring at me. At some point, security guards showed up and they also just stood around and stared at me. No one from the hospital tried to talk to me or asked how to help. At one point, I remember walking outside, but security guards*

*One of the security guards stood in my brother's way and I clearly heard the guard say, "What are you going to do, hit me? Go ahead and hit me!" - **Kelly***

*followed me and surrounded me. One of them got into my face and wouldn't let me leave. I was scared. I remember knocking his glasses off his face. He said I punched him, but I didn't punch him.<sup>28</sup>*

*Suddenly all the security guards were on top of me and had me pinned me to the ground. One of them had a knee in my back and it was hard to breathe. I honestly thought they were going to kill me. The police arrived and I was relieved because I thought they were there to save me.*

*I'm a nurse. I know that you can't force someone to get treatment, but you need to do a real assessment for them. The hospital staff didn't seem to want anything to do with my brother. -  
**"Kelly," Anthony's sister and a nurse***



*Instead, the police arrested me and took me to jail. The jail guards told me to change out of my clothes. I was on my knees with my wrists behind my back when a guard shoved me forward so my face hit the floor. My nose was bleeding and my eye was bruised.*

*I had never been to jail and I was still really confused about what was happening and where I was. I remember thinking that the holding cell was an escape room, like it was a puzzle and I just needed to figure out the right codes to get out. I also tried to use the phone to call 911 for help, since I was so injured and confused.*

*They eventually took me from the jail to another hospital where I was admitted into the inpatient psychiatric ward for treatment. That was where I finally got a mental health evaluation and some psychiatric medication. My mind started to clear up so I could finally understand what had happened. I was really upset.*

*After I got out of the hospital, I had to keep taking full days off work to go back to criminal court for the assault case. It was incredibly stressful and I was worried about what an assault conviction could do to my life and my job. Six months later, they finally dismissed the case against me.*

*I still cannot believe what happened the day I got arrested at Swedish. I know I was acting erratic, but I was obviously having a mental health crisis and needed care. It really seemed like the hospital staff didn't know what to do with me and maybe could have used training in de-escalation. Hospital staff didn't interact with me or help me get treatment. In order for me to finally get that care, for some reason first there had to be an arrest, I had to go to jail where I was really hurt, and then there had to be a criminal case that eventually got dismissed anyways. Why? I just needed help."*

I told the police that this had never happened before and that I believed my brother was having a psychotic break. I told them he needed medical attention. Instead, they arrested him. **-Kelly**

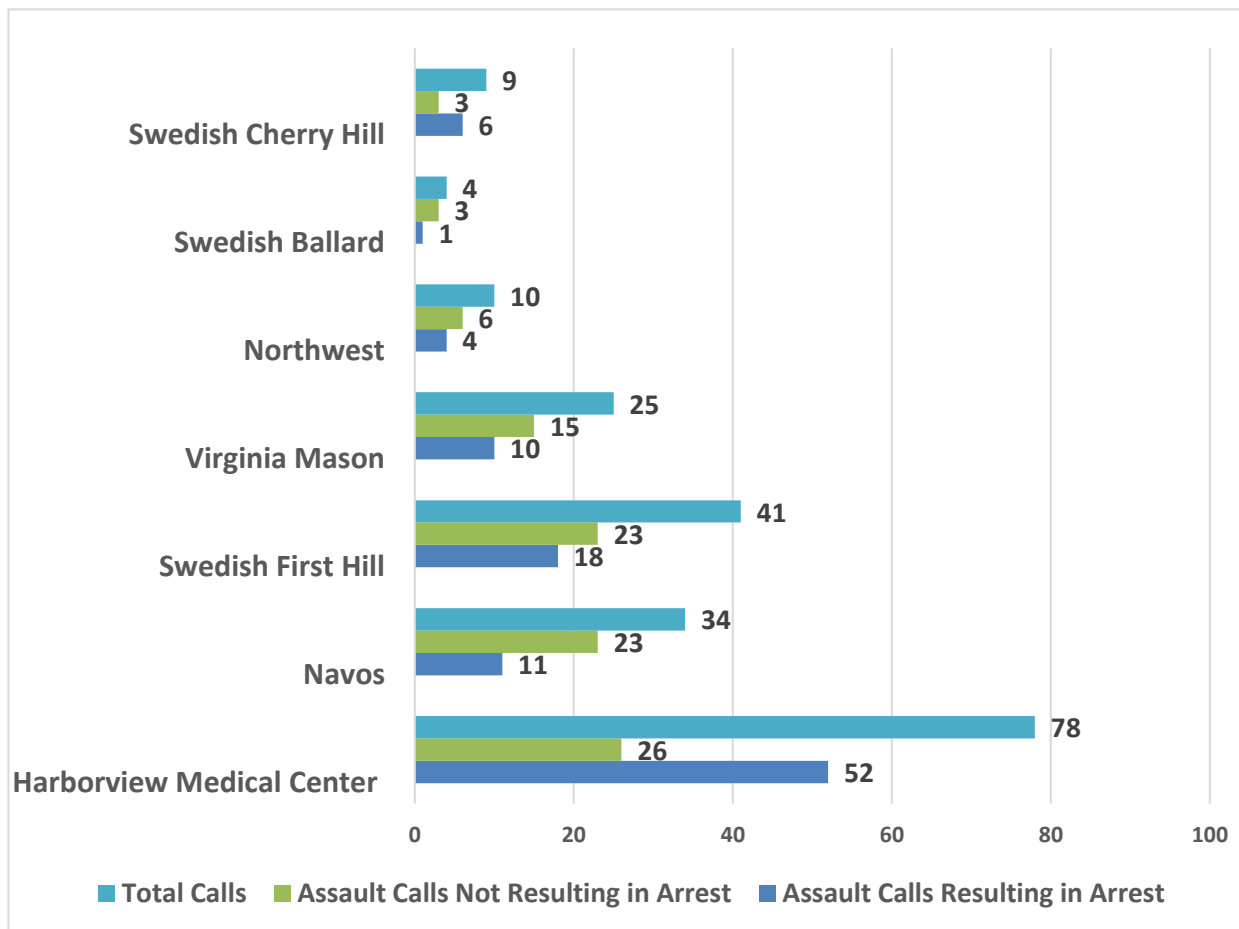


## Arresting Patients

Once health care staff decide to call the police and an officer responds, the officer must assess the situation and determine whether to make an arrest. A police officer must have probable cause to make an arrest, meaning they must have a reasonable basis for believing that a crime has been or is being committed.<sup>29</sup>

Police may exercise discretion not to arrest in most cases<sup>30</sup> and may instead choose to give warnings, make referrals to third parties for assistance (including health care providers or other supports), or provide information and counseling, among other things. They may also avoid an arrest in the moment and instead write an incident report that can be referred to the city or county prosecutor for potential criminal charges at a later date.

Bar graph showing assault calls to police from Seattle health care facilities





## Patient-involved assault calls result in disproportionately high arrest rates

The rates of arrest for assault calls from the facilities DRW reviewed varied substantially, but all were higher than the arrest rate for assault in Seattle. Harborview had the highest rate of arrest: 67%, or 52 of its 78 assault calls ended in arrest. Swedish Cherry Hill tied this rate, but with much lower numbers: 6 of its 9 assault calls ended in arrest. Swedish First Hill came in second with 44%, or 18 of the 41 assault-coded calls ending in arrest. Northwest and Virginia Mason had an arrest rate of 40% (4 of its 10 calls, and 10 out of 25 calls, respectively). About one-third of Navos's 34 calls resulted in arrest and Swedish Ballard had only one arrest out of their four assault calls.<sup>31</sup>

At Virginia Mason, "Derek" appeared to be experiencing symptoms of mental illness and insisted he needed an x-ray but would not explain why. When pressed on the matter by a nurse, Derek became agitated and aggressive. The nurse was walking him towards the exit door when he turned around and spit in her face. Derek was arrested, booked into jail, and charged with felony assault on a health care provider. He was found not competent to stand trial and ordered to undergo restoration. After a lengthy wait in jail for these services, the court finally dismissed the case.

In comparison, approximately 15% of the police calls that SPD coded as assaults city-wide in 2018 resulted in an SPD clearance code "A," meaning a physical arrest was made during the police response.<sup>32</sup>

DRW cannot conclude why a larger proportion of assault calls from health care facilities resulted in arrests. As this report will further discuss, DRW did determine that health care staff preference plays a significant role in dictating whether a patient is arrested. Very often, health care staff seek arrest of their patients.



## Health care staff exercise considerable influence over patient arrest

At Swedish Chery Hill, “Zachary” was brought to the hospital to receive a mental health evaluation. He was already in restraints and described as agitated. Hospital staff decided to remove Zachary’s restraints, but then changed their plans and tried to re-restrain him. He spit on a nurse’s clothing but caused no injury. The nurse told the police he wanted to press charges. Zachary was arrested, booked into jail, and charged with misdemeanor assault. The criminal court ordered an evaluation of his competency to stand trial and, when he was found not competent, dismissed the case. Zachary spent one month in jail.

What drives a police officer’s decision to arrest is complicated. Common sense and research suggest that officers are more likely to arrest for serious crime, especially resulting in serious injury, and if the perpetrator poses an imminent risk of danger to people or property.<sup>33</sup>

Based on DRW’s review of police reports, most of the patient-related assaults did not involve serious injury or imminent risk of danger. DRW found that only about 25% of the arrests resulting in misdemeanor assault charges and 50% resulting in felony assault charges involved visible injury to the victim. Visible injury most

frequently included redness or swelling, a scratch, or more lingering pain; it rarely included bleeding or more significant injury. Many incidents involved only spitting on the victim. Approximately 20% of the arrests resulting in misdemeanor assault charges and nearly 40% resulting in felony assault charges only involved spitting on the victim.

DRW also found that in the majority of cases any imminent risk of danger had been resolved by the time the police responded to the assault calls. Often, the hospital staff already had the individual under control when police arrived. In some cases, a patient was under the effects of a sedative medication or otherwise deemed medically unable to leave the health care facility at the time of police response.





DRW found numerous examples in which police requested that a nurse notify them later when the patient finished treatment so that police could return, sometimes even days later, to arrest the patient. If health care staff exercised that discretion to again call the police back, the person



**Cell at King County Jail**

would be arrested. If they did not—and DRW found that very often this was the case—the person was not arrested.

If not serious injury or imminent harm, what might explain the high arrest rates for health care facility assaults? Research has shown that victim preference strongly influences arrest decisions by police.<sup>34</sup> Indeed, DRW’s review found that health care staff preference seemed to make a considerable difference in how police ultimately resolved an incident. Although none of the treatment facilities DRW reviewed require staff to contact the police or to cooperate in a criminal prosecution, police reports revealed that staff often specifically requested patient arrest and criminal charges. If staff instead made clear to police that they did not want the patient arrested, the police generally followed this wish. In those cases, police would simply create a written record of the incident and sometimes refer it to the prosecutors for decision on whether to file charges at a later date.

Although the police officer holds discretion on whether to ultimately arrest the patient and remove them from care, DRW found that much power lies with individual health care staff in influencing this decision. Compare the following examples of similar incidents at Harborview in which health care staff were clear with police about their wishes:



A nurse was escorting "Marcus," a patient in the Harborview inpatient psychiatric unit, back to his room when he turned and spit in the nurse's face. Although she contacted the police, she told them that she "knew what Marcus did was an assault but did not believe, due to his mental state, that sending him to jail would be a good option for him. She asked to document the assault in the event Marcus attempted to assault someone again." No arrest was made and Marcus continued to receive inpatient psychiatric care.

"Ethan" entered Harborview in mental health crisis. While awaiting transfer to the inpatient psychiatric unit, he started smearing feces and threw a plastic spoon with feces on it, hitting a doctor's pant-covered leg but causing no injury. Ethan also made threats against staff. The doctor called the police, stating he was not injured but that he "felt assaulted" and wanted Ethan arrested. The police arrested Ethan and he spent two months in jail until trial. He was acquitted of misdemeanor assault but found guilty of harassment.

DRW's investigation revealed only a handful of incidents in which the police went against a specific request about arrest made by health care staff.

"Layla" was brought in to Swedish First Hill by family for a mental health evaluation. A hospital social worker called the police to report that Layla had given him a "light shove" and the social worker had decided he now wanted to press charges. He advised police that "he did not want this to escalate or set a precedent that Layla could behave this way towards staff." Police told the social worker that they felt it was better for Layla to get psychiatric treatment and that they could refer it to the Seattle City Attorney's Office for possible criminal charges. No arrest was made and no charges were ultimately filed.



## Arresting patients from longer-term inpatient psychiatric care raises serious concerns

DRW's investigation raised serious concerns about patients arrested out of longer-term, inpatient psychiatric care. These patients may have initially entered an emergency room in crisis, but had since been found to have psychiatric diagnosis and symptoms that require more intensive, specialized inpatient care. Some enter this care voluntarily, but many are held by court order on an involuntary civil commitment status in order to receive necessary health care.

Patients on an involuntary civil commitment status have specifically been found by a court to be gravely disabled or to present likelihood of serious harm to themselves or others as a result of a mental disorder or substance use disorder.<sup>35</sup> They are being held involuntarily for treatment.

Usually, before these patients can be released from psychiatric care, a court must review the case and determine they no longer present such risks. If they are arrested, however, that treatment and legal process is thwarted in favor of jail and criminal prosecution.

Four of the facilities DRW reviewed offer inpatient psychiatric care: Navos, Harborview, Northwest, and Swedish Ballard. At Swedish Ballard, all of the facility's assault-coded calls (4 in total) were for incidents on their 22-bed inpatient psychiatric ward, but only one resulted in

"Carol," a patient in the Harborview inpatient psychiatric treatment unit, uses a walker to get around. She argued with nurses when asked to return to her room. Carol then threw the contents of her juice cup at a nurse, getting juice on the nurse's shoulder but causing no injury. The nurse told police that she believed "the patient throwing the paper cup at her with liquid contents was behavior and she knew what she was doing." The police arrested Carol, removed her from inpatient care, and booked her into jail. Seattle filed misdemeanor assault charges, but dismissed the case in the interest of justice shortly thereafter. DRW does not know what happened to Carol after her release from jail.



arrest. That case involved an allegation that a patient had thrown a cup of water at another patient.

Harborview has a 66-bed inpatient psychiatric ward. Based on DRW's review of police reports, that ward generated ten assault-coded calls to police, seven of which resulted in arrest.

Navos's 70-bed inpatient psychiatric treatment facility generated 34 assault-coded calls. Eleven of these calls resulted in a patient being arrested and removed from inpatient psychiatric care. Two of these arrests were never referred to the prosecutor for criminal charges and one was declined by the prosecutor's office. Prosecutors filed charges on the eight remaining cases, but four of them quickly resulted in dismissal because the patient was found not competent to stand trial.

Northwest Hospital has an inpatient psychiatric ward serving older adults, but DRW did not find patient assault arrests there.

Navos psychiatric staff had recently ceased "Jacob's" anti-psychotic medication due to medical concerns. As a result, his behavior had become more erratic and he got into an altercation with a nurse. Jacob repeatedly punched the nurse, causing a bruise. By the time officers arrived, Jacob had been physically restrained and given a sedative medication. Officers did not immediately arrest him, but returned at a later date and made the arrest. Jacob was charged with felony assault on a health care provider and spent over one month in jail before he was found not competent to stand trial and as a result his case was dismissed.

### **Assaults on staff result in arrest more often than assaults on other patients**

DRW's investigation also raised concerns about the disparate outcomes for patient-on-patient vs. patient-on-staff assault. Navos presented the clearest example of this.



For most of the facilities that DRW reviewed, almost all of the calls to police and resulting arrests were for patient-on-staff assault. This could mean that patients are not assaulting other patients at these facilities or it could mean that patient-on-patient incidents are not generally reported to police at the same rate as patient-on-staff incidents.

Unlike these other facilities, Navos had far more calls to police about patient-on-patient assaults than it did about patient-on-staff assaults. Despite more patient-on-patient assault reports, the majority of the arrests made at Navos were for patient-on-staff assaults. DRW determined that 4 of the 5 (80%) patient-on-staff assaults that were called in to police resulted in arrest, but only 7 of the 29 (24%) patient-on-patient assaults calls resulted in arrest.

In fact, the police reports from Navos incidents reflect a great deal of thought and attention by both staff and police about how arrest could be avoided when the incident involved only patients. This was not the case when the victim was a staff member. Compare:

“Jordan,” a patient at Navos, punched another patient. When the police arrived, Jordan had been placed into isolation and appeared to be responding to internal stimuli. The officer’s report noted: “Jordan was already receiving psychiatric attention and new medication. This was the best solution for Jordan who was having a crisis episode. A safety plan was in place by staff to prevent any more violence.”

At Navos, a nurse reported to police that she intervened in a fight between one patient, “Sean,” and another patient, during which she was punched in the face. Police noted she had no visible injury. The responding officer asked the patient’s treating physician specifically whether he wanted Sean “removed from the facility and sent up to King County Jail.” The physician replied that he “would like Sean sent to jail for assault.” The officer then made the arrest.



DRW is not advocating that more patient-on-patient incidents result in arrest. Instead, we are suggesting health care staff and police officers apply the same thoughtfulness to avoid arrest for patient-on-staff assaults as they do for patient-on-patient assaults.

## Prosecuting Patients

Once an arrest is made, the police must decide whether and to whom to refer the arrest for criminal prosecution. In Seattle, a referral for misdemeanor assault prosecution will generally go to the Seattle City Attorney’s Office (SCAO) for potential filing;<sup>36</sup> for felony assault prosecution, it would go to the King County Prosecuting Attorney’s Office (KCPAO).<sup>37</sup>

### Prosecutors have significant discretion in pursuing criminal charges against patients

Prosecutors have immense power to decide whether to file criminal charges or not. The American Bar Association (ABA) Criminal Justice Standards for the Prosecution suggest that in exercising discretion over whether to initiate, decline, or dismiss a criminal charge, a prosecutor may consider numerous factors. These include but are not limited to: the impact of prosecution or non-prosecution on the public welfare; whether the likely punishment or collateral consequences are disproportionate in relation to the particular offense or the offender; and unwarranted disparate treatment of similarly-situated persons.<sup>38</sup> Washington law also provides prosecutors with similar guidance on charging decisions.<sup>39</sup>

“The prosecutor serves the public interest and should act with integrity and balanced judgment to increase public safety both by pursuing appropriate criminal charges of appropriate severity, and by exercising discretion to not pursue criminal charges in appropriate circumstances.”

**- The American Bar Association, Criminal Justice Standards for the Prosecution, 2018**



It is generally recommended best practices for a prosecuting attorney's office to develop its own internal guidelines and procedures to determine if criminal charges should be brought.<sup>40</sup> This is meant to avoid potential abuse of the decision-making power and to promote consistency in charging. Without such guidelines, prosecutors within the same office may make very different charging decisions when presented with similar incidents. Charging guidelines also have the benefit of letting law enforcement know what factors to consider before referring a case for filing.

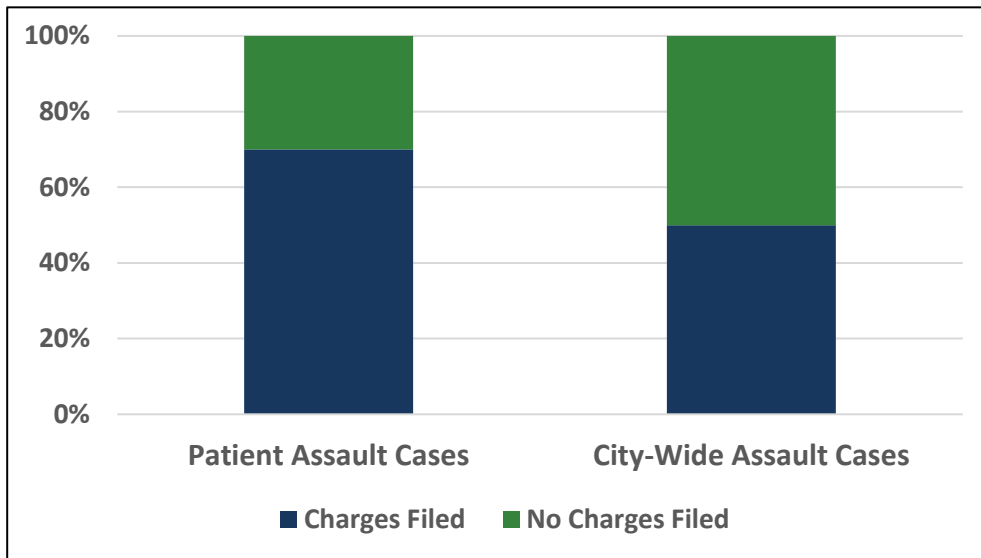
KCPAO has adopted *Filing and Disposition Standards* which describe a commitment to control the exercise of discretionary power in making filing and disposition decisions in criminal cases.<sup>41</sup> The SCAO does not have written standards or guidelines governing prosecutorial charging decisions.

## **Prosecutors are not using discretion to avoid unnecessary patient prosecution**

### **Misdemeanors**

Of the 102 arrests for patient assaults over the course of one year, DRW found that SPD referred 77 to SCAO for potential misdemeanor prosecution. SCAO screened the cases and declined to file charges in 13 (17%) of them, due mainly to problems with victim cooperation or the ability to ultimately prove the case. In comparison, SCAO declined to file nearly 50% of the misdemeanor assault referrals it received city-wide in 2018.<sup>42</sup>

Although SCAO was still reviewing some cases at the time of this report, the office did file misdemeanor assault charges in 54 of the 77 patient assault cases (70%). In comparison, SCAO filed charges in about 50% of the misdemeanor assault referrals it received city-wide.



Bar graph showing SCAO assault cases city-wide and those involving patients in health care facilities

About half of these patient assault misdemeanor cases were ultimately dismissed. Notably, the majority of these dismissals were due to the defendant being found not competent to stand trial due to mental illness.<sup>43</sup> In almost all of those cases, questions about the defendant’s competency to stand trial were brought within days of arrest, raising serious questions as to whether the defendant should have been charged in the first place. Although whether an individual is mentally competent to stand trial is a different legal question than whether they had the mental status necessary to commit the crime, the two are certainly related.

Only 12 of the 54 cases filed (22%) resulted in a plea or finding of guilt, largely for misdemeanor assault. That is roughly equivalent to the city-wide misdemeanor assault conviction rates.<sup>44</sup> Notably, ten of the 12 patient assault cases that ended in guilty findings received a suspended sentence, meaning the judge delayed any sentence in order to allow the defendant to meet certain conditions instead.

Thus, only two of the 54 filed misdemeanor cases resulted in the defendant being levied a punishment by a criminal court. Given the high rates of dismissal in the SCAO patient assault cases, especially based on incompetency to stand trial, DRW believes the SCAO could significantly improve its review of these cases before filing to avoid unnecessary charging.





DRW believes that SCAO should expand the use of diversion programs that focus on connecting defendants with behavioral health conditions to treatment instead of criminal prosecution. Finally, DRW also believes that the office must create charging and disposition guidelines.



**An inmate in solitary confinement at King County Jail**

## Felonies

Under Washington law, what could otherwise qualify as misdemeanor assault can be charged as a felony assault if the person assaulted is a health care provider.<sup>45</sup> Of the 102 total patient assault arrests that DRW tracked, 22 were referred to the King County Prosecuting Attorney's Office (KCPAO) for felony charges because the victim was a health care provider. KCPAO declined to file criminal charges in two cases—one due to not receiving materials from SPD and the other because the prosecutor determined that the facts did not meet the KCPAO's internal Filing and Disposition Standards.<sup>46</sup>

After making this determination, the KCPAO returned the case to the police for potential filing as a misdemeanor in municipal court. The assigned prosecutor's memorandum to the police further explained this decision.



Please refer to the probable cause certification for facts.

Thank you for your hard work on this case. This case is being returned for filing in municipal court. Assaults against nurses will normally be filed if the following exist:

(a) The health care provider has an injury or experiences significant pain as a result of the assault;

(b) The defendant bites the health care provider, spits in the health care provider's face or throws urine or bodily fluid on the health care provider;

(c) A substantial effort is required to stop the assault; or

(d) The suspect uses any object, not amounting to a deadly weapon, to assault the nurse.

Here, (a) the nurse experienced pain for about an hour, and there is no mention that it was significant pain. (b) NCD-RP did not bite or spit on the nurse. (c) While staff did have to intervene when NCD-RP chased the nurse, NCD-RP was not assaulting the nurse when this happened, but notably, this was the prong I was focused on the most in my analysis of the case. (d) No weapon was used to assault the nurse.

While I could possibly file Assault 3 based on the analysis under (c), the mental state of NCD-RP is what causes me concern. NCD-RP was in the hospital for what I presume was an ITA hold, or something that caused NCD-RP to be psychiatrically evaluated. Given NCD-RP's questionable mental state at the time of this incident, the defense would most certainly argue NCD-RP did not have the requisite intent to commit the assault against the nurse. That combined with the existing gray area of meeting our filing standards for Assault 3, is why I am declining to file felony charges and returning this case for filing of Assault 4 in municipal court. Thank you again for your hard work, and please do not hesitate to contact with questions.

**KCPAO redacted memorandum declining to file felony assault charges**

Despite the thorough review and analysis that this prosecutor appears to have given the patient's mental state in this case, KCPAO still filed felony assault charges against patients in 19 other cases. Five of these cases were dismissed by the KCPAO after filing, one for unclear reasons and four others due to the defendant being found not competent. Three cases were still pending final outcomes at the time of publication of this report. Seven felony-charged patients pleaded to a lesser misdemeanor charge. At the time of this report, only four of the 19 cases had resulted in a guilty plea or conviction of the original felony assault charge.



“Michael” had been brought to Harborview’s Emergency Department by family members concerned about his worsening symptoms of schizophrenia. They reported he had been awake for 4-5 days talking to himself and that he believed that police and security guards were demons. When he saw hospital security guards, he immediately got into a fight with them and hit multiple guards. Michael was charged with a felony and sent for a competency evaluation. He spent approximately 8 months dealing with delays related to competency evaluation and restoration services before finally being found competent and pleading guilty.

DRW review of the patient felony assault cases revealed that over one-third of them appear to qualify under factor (b), as laid out in the Filing and Disposition Standards. In these cases, the patient spit in the face of a health care provider. Were it not for where the spit landed, DRW believes these cases would not have met KCPAO’s standards for felony charges.

Like with the SCAO misdemeanor cases, DRW also found that many of the patients charged with felony assault appeared to have serious mental health issues that played a key role in their alleged crime. Many of the KCPAO cases were referred for competency evaluations, like the SCAO cases, raising similar concerns about the patient’s mental state and overall purpose of prosecution.

The time and resources invested into prosecuting these cases, including restoring these individuals to competency just so we can further prosecute them, is substantial. It should bring some benefit. Perhaps we would expect it to cause decline in workplace violence rates for health care workers, reduce criminal acts committed by the defendants in the long term, or improve health outcomes for defendants. Unfortunately, there is no evidence of that.



# Recommendations

We must consider better ways of responding to patients in behavioral health crisis. This starts from the initial point of contact with health care providers, continues through involvement of law enforcement or prosecutors, and ultimately raises larger questions of policy and resources.

## For health care facilities

- 1. Facilities should adopt effective workplace violence prevention programs that prioritize training and adequate staffing levels.** Implementing workplace safety plans and staff training provides effective, longer-term solutions to violence against health care workers, unlike arresting and prosecuting patients in crisis. Washington law requires health care facilities to develop and implement this type of plan<sup>47</sup> and the U.S. Department of Labor, Occupational Safety and Health Administration (OSHA) has published guidelines to help facilities reduce violence.<sup>48</sup> OSHA and the Joint Commission both emphasize the importance of training staff in health and safety, including de-escalation techniques. They also point to understaffing, especially a lack of adequate mental health staff on site, as increasing risk of violent incidents.<sup>49</sup> Health care facilities should ensure workplace violence prevention programs include adequate staffing levels and relevant staff training.
- 2. Facilities should provide training to staff on criminal legal interventions and outcomes for patients.** DRW determined that arrest and jailing often results in harm to patients and disruption in providing necessary health care. It does not reduce workplace violence rates for health care facilities. Many health care staff members who contact police may not know much about what happens to that patient after arrest. They may not fully appreciate the restricted access to meaningful mental health care in jail, the harms of solitary confinement, or the frequency with which these criminal cases are dismissed. Health care facilities should include



training and information on these topics for staff so that staff can make a more informed decision about contacting police or requesting arrest.

- 3. Facilities should review all incidents for whether and why criminal legal intervention occurred.** Washington law requires the health care facilities to review the frequency of violent workplace incidents “including identification of the causes for and consequences of violent acts at the setting...”<sup>50</sup> The consequences of these incidents include whether the police were called and a patient was arrested. In their analyses of violent incident cause and consequence, health care facilities must look at the decision to involve police and the criminal legal system. They should look to effects of arrest and incarceration on patients and consider whether arrest and prosecution is leading to an overall reduction in violent incidents in the workplace. If it is not, health care facilities should take other more effective steps to reduce workplace violence, such as prioritizing adequate staffing levels and training.

## For law enforcement

- 1. Officers should use discretion to avoid arrest when the patient displays symptoms of a behavioral health condition.** A police officer is not required to arrest a patient even if they have probable cause to believe an assault occurred and a health care provider wants them to make an arrest. In fact, Washington law *encourages* law enforcement to avoid making an arrest when a person is known to have a history of mental illness and there are treatment-related options available instead.<sup>51</sup> Police should use their discretion to avoid arrest of patients in behavioral health crisis whenever possible, especially if health care staff have already defused any imminent risk by de-escalating the situation. Police can avoid arrests and still ensure safe outcomes—for example, by providing verbal warnings or taking written reports.
- 2. Officers should not give undue weight to health care staff preference when making arrest decisions.** The arrest rates for assault calls were higher in these health care facilities than in Seattle at large. DRW found that health care staff preference holds great weight in



determining whether police ultimately arrested a patient. Police should consider the health care staff preference, but should weigh it as one among many variables. Police should place more weight on whether the patient is currently receiving health care, especially for a behavioral health condition, and whether arrest would unnecessarily disrupt that health care. Police should encourage health care staff who want an arrest to consider alternative outcomes, including having a written report taken that police can refer to the prosecutor without making an immediate arrest.

3. **When an officer feels an arrest of a patient might be warranted, the officer should postpone the arrest decision to allow the patient to continue to receive treatment.** An officer does not have to make immediate arrest. The officer may record the incident, may refer it to the prosecutors for possible charging later, or may suggest the health care providers follow up with police if patient problems persist. DRW found that when police suggested that health care staff call back in the future if necessary after patient care was complete, health care providers often did not require additional police intervention and arrest was altogether avoided.
  
4. **When an officer feels an arrest of a patient is absolutely warranted, the officer should not refer the case for felony assault charges unless the incident qualifies as Assault in the Second or First Degree.** Assault in the Third Degree is just a misdemeanor assault that is automatically converted to a felony assault because the victim has a specific status, including health care provider. Police are not required to refer a case for this heightened charge and should generally avoid doing so when a patient appears to have a behavioral health condition, especially if injury is minor or non-existent. If there is significant injury, Assault in the Second or First Degree has always been available as a criminal charge.

Heightened charging and criminal penalties do not reduce individual recidivism<sup>52</sup> and have shown no evidence of reducing workplace violence rates for health care providers. Instead,



felony convictions do make it harder to access stable housing and income,<sup>53</sup> two essential elements to behavioral health recovery.

## For prosecutors

- 1. All Prosecuting Attorney Offices should have written charging guidelines.** These guidelines should include a discussion of how a person's status as a patient, especially one displaying symptoms of a behavioral health condition, should generally weigh against filing criminal charges. These guidelines should consider specific factors, including minimal injury to the victim, patient history of a behavioral health condition, role of behavioral health symptoms in the current incident, and a history of competency evaluation and restoration. Prosecuting attorneys should receive regular training on this topic and the guidelines should be shared with law enforcement.
- 2. Prosecuting Attorney Offices should undertake a review of all their current patient assault cases.** DRW's investigation concluded that many of the criminal cases against patients described behavior that raised serious questions as to whether the patient had capacity for the requisite intent—a patient describing or demonstrating hallucinations, paranoia, or delusions may not be capable of understanding or controlling their conduct. Even setting aside the question of what level of intent is required in these cases, DRW found that some of the defendants in these cases had already faced questions of competency to stand trial on a current or recent criminal case. Individuals whose competency has so recently been questioned should certainly get closer scrutiny when considering additional charges. Prosecuting Attorney Offices should undertake a review of current patient assault cases with these factors in mind, and should review the outcomes with staff in order to improve future filing decisions.
- 3. Prosecuting Attorney Offices should expand the use of programs that focus on connecting individuals to treatment instead of prosecution.** There is increasing recognition of the benefits of diversion programs that promote alternative resolutions for



criminal cases. Seattle and King County have programs that aim to avoid criminal charges altogether, like Legal Intervention Network of Care (LINC) and Law Enforcement Assisted Diversion (LEAD). These programs provide substantial case management support and access to other resources, like housing. Prosecutors should use these types of programs more for patients arrested for assault.

Seattle and King County also have mental health courts that connect defendants with treatment as they attempt to resolve the criminal case.<sup>54</sup> Although these courts can help individuals access services and support, they often require intensive probation for lengthy periods, the ability to follow many specific directives, and the willingness to share confidential information.<sup>55</sup> Prosecutors should utilize mental health court more for patients facing assault charges, but should ensure they avoid a compliance-based model with unnecessarily lengthy supervision.

To ensure better participation and success in these programs for individuals with behavioral health conditions, prosecutors should also follow harm reduction principles.

- 4. Prosecuting Attorney Offices should refrain from charging Felony Assault based solely on the status of the victim as a health care provider.** Aside from an overall reconsideration of whether criminal charges are effective in patient assault cases, prosecutors should generally avoid charging what would otherwise be a misdemeanor assault case as a felony based solely on the status of the alleged victim. This is especially true if the patient has a behavioral health condition and was seeking health care at the time of the incident.

Assault in the Third Degree is an unnecessary felony charge carrying serious repercussions for defendants. Heightened criminal penalties do not reduce individual recidivism<sup>56</sup> and have shown no evidence of reducing workplace violence rates for health care providers. If there is a serious assault that would warrant Assault in the Second or First Degree charges, that remains





an option. As a criminal charge, Assault in the Third Degree is unnecessary, ineffective, and harmful to those in behavioral health crisis.

## For policy makers

- 1. State agencies should provide additional guidance to health care facilities on how to appropriately handle patients in crisis.** Washington’s law that requires health care facilities to maintain workplace safety plans also instructs facilities to “consider any guidelines on violence in the workplace or in health care settings issued by the department of health, the department of social and health services, the department of labor and industries, the federal occupational safety and health administration, medicare, and health care setting accrediting organizations.”<sup>57</sup> Thus, Washington state agencies should provide specific guidance to health care facilities on how to promote workplace safety while also ensuring access to health care and avoiding criminalization for patients with behavioral health conditions. Over the past two years, the state’s Department of Social and Health Services in particular has shown dedication and expertise in diverting people from the criminal legal system and into treatment.<sup>58</sup>
- 2. The state should better fund robust behavioral health treatment and social service systems that effectively serve people before they reach crisis.** Washington has been ranked near the bottom nationally when it comes to our mental health care system.<sup>59</sup> We have also seen a large increase in the number of people with significant behavioral health issues in our criminal legal system.<sup>60</sup> If people cannot get accessible and appropriate community-based behavioral health treatment, if they do not have stable housing or income, or if they cannot access crisis services that effectively stabilize them, they are more likely to end up like one of the many patients detailed in this report. Washington should prioritize funding robust behavioral health treatment and social service systems that promote treatment and stability, not criminalization.



- 3. The state should remove Assault in the Third Degree from Washington’s criminal code (RCW 9A.36.031).** Washington State already has criminal charges for misdemeanor and felony assault that thoroughly capture the range of assaultive behaviors and injuries. An Assault in the Third Degree (Assault 3) charge just converts what would otherwise be a misdemeanor into a felony based solely on the status of the victim. All too often, Assault 3 charges are used to further criminalize behavioral health conditions and disability-related behaviors. When someone with significant behavioral health symptoms encounters health care professionals (or other professions included on the Assault 3 victim list, like police officers or bus drivers), those encounters could be negatively affected by symptoms like delusional thinking, hallucinations, impulse control, and paranoia.

A major motivation for increasing criminal penalties is to disincentivize assault, but there is no evidence that this works, especially when we are talking about a population with active behavioral health symptoms. Instead, we are expending substantial cost and causing harm to vulnerable people without achieving our end goal. Washington State should not expand the list of status victims under our Assault 3 law, but instead should remove it from our criminal code.

## Conclusion

DRW’s investigation of assaults by patients in Seattle health care facilities determined that we are criminalizing behavioral health conditions without any real or long-term benefits. Health care staff should absolutely not have to face the stress and potential injury from workplace violence. There are effective techniques to treat patients with significant behavioral health needs that do not require arrest. Health care facilities must do a better job training staff, supporting, and encouraging these techniques.

In making decisions about arrest, DRW found that police often defer to health care staff preference with the end result being unnecessary arrest. Police and health care staff should



therefore understand the repercussions of their decisions on patient well-being and the futility of arrest in reducing workplace violence generally. Police officers should use their discretion to avoid arrest whenever possible and should work with health care facilities in these efforts.

Finally, prosecutors make important decisions about a patient's fate after arrest. DRW found that prosecutors are engaging in ineffective and potentially harmful criminal prosecution of patients with behavioral health conditions. Prosecutors must do better at providing consistent, thorough assessment of these cases and avoiding unnecessary harm.

When we arrest patients out of health care facilities, we remove them from treatment and book them into jail. This can cause serious harm to people with behavioral health conditions.<sup>61</sup> In arresting and prosecuting these cases, we often penalize behaviors that are a direct result of the person's health condition or disability—symptoms that significantly affect a person's perception of reality and their impulse control. When we go further and convert a misdemeanor into a felony based solely on who was assaulted, we amplify all of the disruption and harm of jail and a criminal case. Even worse, we do all this without any proven reduction in the behavior we are targeting.

Every person providing health care and every person who needs it deserves a system that is humane and responsive. No one should fear going to work just as no one should fear that the symptoms that brought them to a hospital will lead instead to jail.



## About the Author



Kimberly Mosolf is the Director of Disability Rights Washington's Treatment Facilities Program, working on behalf of people with disabilities in hospitals, Residential Habilitation Centers, nursing homes, and assisted living facilities, among others. As class counsel in *A.B. vs. D.S.H.S. (Trueblood)*, Kimberly also works to reform the forensic mental health system in Washington and to expand diversion opportunities for people with behavioral health conditions who are facing arrest and prosecution. She has

also worked to reduce the use of force by police against people with disabilities. Before joining Disability Rights Washington, Kimberly practiced law in New York City where she worked on behalf of parents caught up in the child welfare system, people receiving government benefits, sex workers, and people with mental illness. Kimberly was born and raised in Seattle, WA. She is a graduate of Columbia University School of Law.



## End Notes

<sup>1</sup> This report uses the term “behavioral health” to refer to conditions involving mental health and substance use disorders. There is significant overlap in people who experience both mental illness and substance use problems. The National Institute on Drug Abuse notes, “Multiple national population surveys have found that about half of those who experience a mental illness during their lives will also experience a substance use disorder and vice versa.” Nat’l Inst. on Drug Abuse, *Common Comorbidities with Substance Use Disorders* (2018) <https://www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders/part-1-connection-between-substance-use-disorders-mental-illness>. Although there are also cognitive disabilities that may play a role in patient behavior, including intellectual or developmental disabilities, dementia, or brain injury, among others, this report is not including those disabilities in “behavioral health.” In reviewing Seattle Police Department incident and arrest reports, DRW was generally able to determine if a patient was described as having mental health and/or substance use issues, but we could not reliably determine if they had other cognitive disabilities.

<sup>2</sup> See U.S. Occup. Safety and Health Admin., *Workplace violence in health care: Understanding the challenge* (2015) <https://www.osha.gov/Publications/OSHA3826.pdf>; Wash. State Nurses Ass’n, *Workplace Violence* <https://www.wsna.org/nursing-practice/workplace-violence> (last visited Jan. 28, 2020).

<sup>3</sup> See Erin L. Kelly, et al., *Well-Being and Safety among Inpatient Psychiatric Staff: The Impact of Conflict, Assault, and Stress Reactivity*, 43 *Adm. Policy Mental Health* 703 (2016).

<sup>4</sup> The negative effects of incarceration on people with behavioral health conditions are well documented. See, e.g., Seena Fazel, MD et al., *The Mental Health of Prisoners: A Review of Prevalence, Adverse Outcomes and Interventions*, 3 *Lancet Psychiatry* 871 (2016). In 2016, the Amplifying Voices of Inmates with Disabilities Program at DRW published a series of reports documenting these issues in Washington’s jails and prisons, including the use of solitary confinement and lack of adequate mental health care.

<https://www.disabilityrightswa.org/programs/avid/reports/>

<sup>5</sup> Little research exists about the specific effects of these “protected classes” assault laws, but there is ample evidence generally that increasing the severity of punishment does little to deter crime. See, e.g., The Vera Project, *The Prison Paradox: More Incarceration Will Not Make Use Safer* (2017) <https://www.vera.org/publications/for-the-record-prison-paradox-incarceration-not-safer>; Nat’l Inst. of Justice, *Five Things about Deterrence* (2016) <https://nij.ojp.gov/topics/articles/five-things-about-deterrence>; *Prison Time Served and Recidivism*, Pew Fact Sheets (Pew Charitable Trusts) Oct. 2013

<https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2013/10/08/prison-time-served-and-recidivism>; William Rhodes, et al., *The Relationship between Prison Length of Stay and Recidivism: A Study using Regression Discontinuity with Multiple Break Points* (2017) <https://www.ncjrs.gov/pdffiles1/bjs/grants/251410.pdf>. There is some evidence that certainty, not severity, of punishment improves deterrence, but that research assumes an



individual is making a rational decision, not dealing with a behavioral health crisis or serious mental health symptoms. In 2015, then California Governor Jerry Brown vetoed a bill that would have increased penalties for assault on a health care worker from a six month to a twelve month maximum sentence, citing a lack of any evidence that the additional jail time would deter these incidents. His veto message to the Assembly stated, “If there were evidence that an additional six months in county jail (three months, once good-time credits are applied) would enhance the safety of these workers or serve as a deterrent, I would sign this bill. I doubt that it would do either.” Gov. Edmund Brown, Veto Message for Assembly Bill 172 (Cal. 2015) [http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab\\_0151-0200/ab\\_172\\_vt\\_20151010.html](http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_0151-0200/ab_172_vt_20151010.html).

<sup>6</sup> See Protection and Advocacy of Individuals with Mental Illness (PAIMI) Act, 42 U.S.C. §10801 *et. seq.*; Developmental Disabilities Bill of Rights (DD) Act, 42 U.S.C. 15041 *et. seq.*, and the Protection and Advocacy of Individual Rights (PAIR) Act, 29 U.S.C. § 794e.

<sup>7</sup> 42 U.S.C. §15043(a); 42 U.S.C. § 10805(a); 29 U.S.C. § 794e(f).

<sup>8</sup> *Id.*

<sup>9</sup> U.S. Occup. Safety and Health Admin., Workplace violence in health care: Understanding the challenge (2015) <https://www.osha.gov/Publications/OSHA3826.pdf>

<sup>10</sup> Wash. State Nurses Ass’n, Workplace Violence <https://www.wsna.org/nursing-practice/workplace-violence> (last visited Jan. 28, 2020).

<sup>11</sup> See Erin L. Kelly, et al., *Well-Being and Safety among Inpatient Psychiatric Staff: The Impact of Conflict, Assault, and Stress Reactivity*, 43 *Adm. Policy Mental Health*. 703 (2016).

<sup>12</sup> *Id.*

<sup>13</sup> See Washington Pattern Jury Instructions—Criminal 4<sup>th</sup> WPIC § 35.50 Assault.

<sup>14</sup> RCW 9A.36.011 through 9A.36.041; *see also*, 21 *Am. Jur. 2d Criminal Law* § 19 (2019).

<sup>15</sup> RCW 9A.20.021

<sup>16</sup> See, e.g., U.S. Comm’n on Civil Rights, *Collateral Consequences: The Crossroads of Punishment, Redemption, and the Effects on Communities* (2019) <https://www.usccr.gov/pubs/2019/06-13-Collateral-Consequences.pdf>

<sup>17</sup> See RCW 9A.36.031. The American Nurses Association counts 35 states, including Washington. Am. Nurse Ass’n, Workplace Violence <https://www.nursingworld.org/practice-policy/advocacy/state/workplace-violence2/>.

<sup>18</sup> *Supra* note 5.

<sup>19</sup> See Arnetz J.E., et al., *Preventing Patient-to-Worker Violence in Hospitals: Outcome of a Randomized Controlled Intervention*, 59 *J Occup Environ Med*. 18 (2017); Hamblin L.E., et al., *Worksite Walkthrough Intervention: Data-driven Prevention of Workplace Violence on Hospital Units*, 59 *J Occup Environ Med*. 875 (2017); U.S. Occup. Safety and Health Admin., *Preventing Workplace Violence: A Road Map for Healthcare Facilities* (2015).

<sup>20</sup> Harborview Medical Center has an emergency department, including a specialized psychiatric emergency services department, and a 66-bed inpatient psychiatric treatment unit. Navos is not a hospital, but instead is a stand-alone, inpatient psychiatric treatment facility with 70 beds and no emergency department. Northwest Hospital has an emergency department, but also has a Geropsychiatric Center with 27 beds for inpatient psychiatric care specifically targeted to older adults. Swedish Ballard has a 22-bed inpatient psychiatric unit.



Swedish Chery Hill offers psychiatric social work services in its emergency department, but has no psychiatric inpatient unit. Swedish First Hill and Virginia Mason have an emergency department but no specialized psychiatric services or inpatient psychiatric unit.

<sup>21</sup> Professional organizations endorse and provide information and resources on these techniques. *See, e.g.,* Polly Gerber Zimmermann, *How to meet the challenge of disruptive patients*, *Am. Nurse*, June 2013 <https://www.americannursetoday.com/how-to-meet-the-challenge-of-disruptive-patients/>; Joint Comm’n, *Quick Safety: De-escalation in Health care* (2019) [https://www.jointcommission.org/assets/1/23/QS\\_Deescalation\\_1\\_28\\_18\\_FINAL.pdf](https://www.jointcommission.org/assets/1/23/QS_Deescalation_1_28_18_FINAL.pdf).

<sup>22</sup> *See* Harborview Medical Center, Administrative Policies and Procedures No. 125.9: Workplace Violence Prevention and Management (UW Medicine Policy).

<sup>23</sup> *Id.*

<sup>24</sup> *Id.*

<sup>25</sup> *See* Navos Mental Health Solutions, Policy 7195259: Discharge of a Patient to Jail.

<sup>26</sup> *Id.*

<sup>27</sup> RCW 49.19.040

<sup>28</sup> In the police report, the hospital guard reported that Anthony knocked his glasses of his face and punched his arm causing “transient pain.” Police noted there were no visible injuries to any guards. The report also indicated that Anthony’s sister, Kelly, explained to the police that Anthony had not been sleeping and had been reporting hallucinations, and that he really needed a mental health evaluation.

<sup>29</sup> *See* RCW 10.31.100; *see also, State v. Terrovona*, 105 Wash.2d 632 (1986).

<sup>30</sup> *See* RCW 10.31.100. Arrest for assault is not mandatory under Washington State law except for in certain domestic violence situations.

<sup>31</sup> While there are many different ways in which an officer can code the results of a call, the top three codes recorded for the assault calls reviewed by DRW were “Arrest,” “No arrest, report written,” and “Assistance rendered.”

<sup>32</sup> *See* Seattle Police Department Final Type (M.I.R. Codes), Form 7.23, Rev 3/10. According to Seattle Police Department, there were 10,738 calls in 2018 in Seattle that were coded as assault by the dispatcher or by the responding police officer. 1,633 received an “A” code by police, meaning they resulted in arrest.

<sup>33</sup> Univ. of Cal. Ctr. for Police Research and Policy, *Deconstructing the Power to Arrest: Lessons from Research 17* (2018) [https://www.theiacp.org/sites/default/files/2018-08/CPRP\\_Deconstructing%20the%20Power%20to%20Arrest\\_FINAL.PDF](https://www.theiacp.org/sites/default/files/2018-08/CPRP_Deconstructing%20the%20Power%20to%20Arrest_FINAL.PDF).

<sup>34</sup> *Id.*

<sup>35</sup> *See* RCW 71.05.150 and RCW 71.05.230

<sup>36</sup> Seattle City Attorney’s Office <https://www.seattle.gov/cityattorney/about-us> (last visited Jan. 29, 2020).

<sup>37</sup> King County Prosecuting Attorney’s Office

<https://www.kingcounty.gov/depts/prosecutor/criminal-overview.aspx> (last visited Jan. 29, 2020).

<sup>38</sup> *See* Am. Bar. Ass’n, *Criminal Justice Standards for the Prosecution Function*, Standard 3-4.4 Discretion in Filing, Declining, Maintaining, and Dismissing Criminal Charges (4<sup>th</sup> ed. 2017).



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<sup>39</sup> RCW 13.40.077 notes that “A prosecuting attorney may decline to prosecute, even though





technically sufficient evidence to prosecute exists, in situations where prosecution would serve no public purpose, would defeat the underlying purpose of the law in question, or would result in decreased respect for the law.”

<sup>40</sup> See Am. Bar. Ass’n, *Criminal Justice Standards for the Prosecution Function*, Standard 3-4.2 Decisions to Charge Are the Prosecutor’s (4<sup>th</sup> ed. 2017). From Standard 3-4.2: “(b) The prosecutor’s office should establish standards and procedures for evaluating complaints to determine whether formal criminal proceedings should be instituted.” See also Nat’l Dist. Attorneys Ass’n, *National Prosecution Standards, PreTrial Considerations: Charging* (3<sup>rd</sup> ed. 2009). From the commentary on PreTrial Considerations: Charging: “The chief prosecutor should establish guidelines by which charging decisions may be implemented. For the one-person office this formulation process will provide consistency of operation and an incentive to develop and articulate specific policies. The same holds true for other size offices. Some prosecution offices employ vertical prosecution with great success, making the use of guidelines important for consistent application.” <https://ndaa.org/wp-content/uploads/NDAA-NPS-3rd-Ed.-w-Revised-Commentary.pdf>.

<sup>41</sup> See King County Prosecuting Attorney’s Office, *Filing and Disposition Standards* (2019) [https://www.kingcounty.gov/~media/depts/prosecutor/documents/2020/FADS\\_-\\_Revised\\_December\\_2019\\_-\\_FINAL.ashx?la=en](https://www.kingcounty.gov/~media/depts/prosecutor/documents/2020/FADS_-_Revised_December_2019_-_FINAL.ashx?la=en).

<sup>42</sup> Data provided to Disability Rights Washington by Seattle City Attorney’s Office in January of 2020, on file with author.

<sup>43</sup> In Washington State, most people charged with a misdemeanor who are found not competent to stand trial are eligible to have their criminal charges dismissed. Only if the prosecutor can show a compelling interest can the court order a misdemeanor defendant to undergo restoration which could result in future prosecution. See RCW 10.77.088.

<sup>44</sup> SCAO Data, *supra* note 42.

<sup>45</sup> See RCW 9A.36.031.

<sup>46</sup> King County Felony and Disposition Standards, *supra* note 41. The Filing and Disposition Standards section on Assault states “Assaults committed by patients in a hospital or psychiatric setting should be carefully reviewed to consider the degree to which the patient’s mental state interferes with their competency, their ability to form the requisite intent for the underlying charge, and whether there is a foreseeable mental defense that the State is unlikely to overcome. In making this determination, consideration will be given to prior criminal history, prior history of assaultive behavior, and known mental health history.” *Id* at 52. The Standards further note that these types of felony assault charges shall normally be filed only if there is an intentional attack on the health care provider and one of the following exists: the health care provider has an injury or experiences significant pain, the defendant bites or spits in the face of or throws urine or bodily fluid on the health care provider, a substantial effort is required to stop the assault, or the suspect uses any object not amounting to a deadly weapon to assault the provider. *Id* at 51-52.

<sup>47</sup> RCW 49.19.020.

<sup>48</sup> U.S. Occup. Safety and Health Admin., *Guidelines for Preventing Workplace Violence for Healthcare and Social Services Workers* (2015) <https://www.osha.gov/Publications/osh3148.pdf>.



<sup>49</sup> *Id.* See also, *Physical and verbal violence against healthcare workers*, Sentinel Event Alert (Joint. Comm'n) April 2018

[file:///C:/Users/kimberlym/Downloads/SEA\\_59\\_Workplace\\_violence\\_4\\_13\\_18\\_FINAL.pdf](file:///C:/Users/kimberlym/Downloads/SEA_59_Workplace_violence_4_13_18_FINAL.pdf).

<sup>50</sup> RCW 49.19.020(2).

<sup>51</sup> See RCW 10.31.110.

<sup>52</sup> *Supra* note 5.

<sup>53</sup> *Crossroads of Punishment, Redemption, and the Effects on Communities*, *supra* note 16.

<sup>54</sup> See *e.g.*, Seattle Municipal Court, Mental Health Court

<http://www.seattle.gov/courts/programs-and-services/specialized-courts/mental-health-court> (last visited Feb. 6, 2020); King County, Welcome to the King County District Court Regional Mental Health Court <https://www.kingcounty.gov/courts/district-court/regional-mental-health-court.aspx> (last visited Feb. 6, 2020).

<sup>55</sup> See *e.g.*, Seattle Municipal Court, Transfer Request to Mental Health Court

<http://www.seattle.gov/Documents/Departments/Court/MHCReferralDir2019.pdf> (last visited Feb. 6, 2020).

<sup>56</sup> *Supra* note 5.

<sup>57</sup> RCW 49.19.020(3).

<sup>58</sup> See *e.g.*, the 2018 settlement agreement and resulting implementation plan in *A.B., by and through Trueblood, et al., v. D.S.H.S.*, available at

<https://www.disabilityrightswa.org/cases/trueblood/#How>.

<sup>59</sup> The national nonprofit Mental Health America ranks Washington 34<sup>th</sup> among the 50 states and District of Columbia, indicating high overall prevalence of mental illness and low rate of access to care. That ranking drops to 38 when looking solely at the adult care system. When it comes to adults with mental illness reporting an unmet treatment need, Washington's rank falls even further to 45. Mental Health America, *The State of Mental Health in America* (2019)

<https://mhanational.org/sites/default/files/2019-09/2019%20MH%20in%20America%20Final.pdf>.

<sup>60</sup> Wash. Dep't of Social and Health Services, Behavioral Health Admin., *Trueblood et al v Washington State DSHS: Where are we today?* <https://www.dshs.wa.gov/bha/trueblood-et-al-v-washington-state-dshs> (last visited Jan. 29, 2020).

<sup>61</sup> *Supra* note 4.