The Prosecution of Psychiatric Patients for Assaults on Staff: A Preliminary Empirical Study

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A survey of five public hospitals yielded nine cases in which staff pressed charges against patients who assaulted them. Examining the effects of prosecution on the patients, the legal system, and the staff, the authors found that two patients benefited, three showed little or no change, and four were lost to follow-up. The legal system was responsive to the request to prosecute, although sometimes reluctantly, in six cases, but uncooperative in the rest. In five of the cases, staff were satisfied with the outcome of the legal intervention, even though it benefited only two of those patients. Among the authors' recommendations for dealing with assaults are to use appropriate clinical measures first, address any systemic problems that an assault suggests, and, because prosecution may alienate patients from the treatment system, obtain consultation from a psychiatrist outside the patient's care system before proceeding.

Assaults on staff in mental hospitals are an underreported occurrence (1) that is traumatic for all concerned. The caregivers are often torn on one hand by their anger and fear of the patient, and on the other by the professional imperative to understand the behavior. This conflict is manifested clinically by urges both to punish and to intervene therapeutically (2,3). The intervention the caregivers choose must be scrutinized for both motivations.

The literature relevant to prosecution as a staff response to assault is sparse. One case report suggests that prosecution may have a therapeutic and deterrent effect (4); another suggests that reporting may satisfy the public's right to know about assaults and should therefore be routine (5). The ethical, legal, and therapeutic impact of a policy to prosecute assaults remains largely unstudied.

To explore the phenomenon of the formal prosecution of an assaultive psychiatric patient by his or her caretakers, in 1986 we canvassed all 15 Boston-area university-affiliated psychiatric hospitals, both public and private, with inpatient units to identify any such cases involving either inpatients or outpatients. The hospitals were surveyed through phone contact with clinical directors, some of whom referred us to the treating psychiatrists. Only one or two failed to respond; but the private hospitals denied knowledge of any such cases. Thus our data derive from five public hospitals, some of which sent written information after the phone contact.

We sought the assaultive patients' clinical history, an account of the assault, and follow-up information about the cases. Even in instances in which the case had become public knowledge, we asked the hospitals to disguise data that could identify the patient before reporting the case to us.

In this paper we describe the cases, classify them into three heuristic categories, and then discuss the effect of the prosecution on the patients, the response of the legal system, and the level of staff satisfaction that resulted. Clinical and ethical considerations, including the risks and benefits of the legal approach, are taken into account in formulating some recommendations about whether to prosecute assaults.

Case examples
As a result of the survey, nine cases in which patients were prosecuted for assaults against staff were identified.

Case 1. A 30-year-old white woman with borderline personality disorder was hospitalized following decompensation. Her course was characterized by multiple episodes of assaultive behavior toward her therapist and the ward staff and by impulsive, destructive acts against hospital property. She was considered too suicidal to be discharged.

The patient's therapist felt that she was suffering guilt about the assaults; the patient viewed herself as infantile and "sick." To stem her accelerating regression, she was informed that the staff considered her to be responsible for her behavior and that charges would be pressed if assaults continued. Shortly afterward she jumped on a mental health worker's back, and charges were pressed.
The judge agreed to meet with the patient in chambers and to discuss sternly the seriousness of her actions and the possible consequences. After he did so, the charges were dropped.

The patient committed no more assaults and was discharged shortly after her court appearance. The staff considered the intervention successful. She continued as an outpatient with her therapist. For the next year and a half she required hospitalization only for brief periods, usually less than 24 hours, and no assaultive behavior occurred. Then, during a time of stress, the patient set a fire in her boarding house. She was prosecuted successfully for arson and imprisoned.

**Case 2.** A 40-year-old retarded white woman would strike out at times of frustration, particularly when limits were set by staff. During one admission she impulsively slapped or hit several nurses and mental health workers. The staff concluded that the clinical methods employed—restrictions, medications, and consistent limits—were ineffective and that the patient was capable of self-control. The patient was so informed.

The patient subsequently hit a nurse, and charges were filed. She was found competent and criminally responsible for her actions and was sentenced to two weeks in prison. Afterward she was transferred to another facility, where impulsive behavior was not a problem. The staff felt they had made a successful intervention.

**Case 3.** A 20-year-old single white woman with borderline personality disorder was subject to decompensations requiring hospitalizations; she presented in a whiny, repetitive fashion as incessantly needy, responded poorly to limits, and required a very high level of staff support. During one admission she serially assaulted several women staff members. The assaults were unpredictable, though they were generally preceded by nonfulfillment of a request for some sort of oral gratification, and they were severe, consisting of close-fisted punches, biting, or kicking. Front-line staff became increasingly angry as the assaults continued without any sign of the patient’s responding to any clinical measures employed. There was talk of a strike.

After the next assault, charges were filed. Because this charge represented a violation of probation from a prior, unrelated offense, the patient was remanded to prison; however, the court imprisoned her only as an interim step, believing that her behavior necessitated a different psychiatric setting.

Within a few weeks the patient’s transfer to a second hospital was arranged. There she assaulted a staff member (the circumstances were unclear), and charges were again pressed; she was briefly imprisoned on that occasion. The patient continued to be a severe management problem and was frequently assaultive. Treatment staff felt that they had done their best under the circumstances.

**Case 4.** A 30-year-old black man, with unspecified character pathology, hit a mental health worker without warning. The patient had asked to leave the ward and then hit the worker when the latter moved to make this possible. The patient claimed to have been assaulted by the worker during a previous episode of restraint.

The staff, feeling that the patient had acted intentionally, pressed charges. He was transferred to another facility for assessment of his competency to stand trial and criminal responsibility. For unknown reasons he was never tried and was subsequently lost to follow-up. At the time of this study the staff expressed anger at the episode and were puzzled that he was never tried.

**Case 5.** A 20-year-old retarded white man episodically lost control in the hospital and frequently required restraints. One day he became violently assaultive, hitting staff with his shoe and breaking a mental health worker’s nose. While being placed in restraints, he first threatened to bite another worker’s hand if not released and then carried out his threat, seriously wounding the worker. Because he was able to warn about the bite, it was felt that he knew what he was doing, and charges were pressed, including charges for the earlier assault with the shoe.

The prosecuting attorney reviewed the case and refused to bring it to trial. She reportedly told the staff, “That’s part of your job, it’s to be expected.” The staff felt confused and hurt. They reported that “we were laughed out of court.”

The patient perceived this development as vindication of his actions. He was reported to have said, “They aren’t going to do anything. I’m going to do it again.” He was subsequently discharged, and follow-up information was not available.

**Case 6.** A 30-year-old white woman with schizoaffective disorder had a history of multiple hospitalizations and of setting herself on fire, and she had frequently required restraints for assaultive actions. During an outpatient treatment session she unexpectedly slammed a nurse against a wall, hit her, and burned her with a cigarette. There was no history of strained interactions between the nurse and the patient. Because the nurse felt that the patient had been aware of both her actions and of the severity of the assault, charges of assault and battery were filed.

The patient arrived at a preliminary hearing having blacked both her eyes. She accused the nurse of beating her and acted in a grossly psychotic manner. The clerk of the court approached the nurse and asked, “Why are you doing this to her? This is an obviously crazy person.” Ambivalent from the start, the nurse felt guilty and agreed to drop the charges.

The patient continued in treatment with no apparent change in her baseline functioning. Although she made no subsequent assaults while she was an outpatient, whenever she was hospitalized the assaults continued.

**Case 7.** A 30-year-old black
woman with diagnoses of mild mental retardation and sociopathy would become grossly psychotic, disorganized, and verbally threatening after free-basing cocaine; at other times she would feign psychosis to gain access to the hospital. During one prolonged hospitalization she was treated with behavioral and milieu therapy, combined with multiple medication trials, but with minimal effect.

While in outpatient therapy, the patient assaulted her therapist and a nurse, inflicting injury. Her therapist decided that she was not amenable to psychotherapy and informed her that she would see her only about medication. She then severely scratched her face. Charges of assault and battery were filed. The court, initially not receptive, finally agreed to allow charges to be brought.

An evaluation at another hospital found the patient to be competent to stand trial and criminally responsible. She was tried, found guilty, and sentenced to a year in prison. The length of the sentence surprised her caregivers, who had expected a shorter term. However, on appeal her sentence was reduced to six months' probation.

Immediately after release the patient returned to free-basing cocaine; she threatened her mother as well as her child, and she was briefly hospitalized. After discharge she loitered outside the hospital for about two weeks, calling to workers as they entered and occasionally issuing verbal threats. Staff members frequently called security staff and the police to complain about her behavior, without effect. Ultimately she was assigned to a probation officer, but she failed to make her first check-in with him. For this violation she was returned to jail.

The patient was committed by the court to another facility, where she carried out serious assaults. She later escaped. Though staff at the previous facility who had pressed charges were traumatized by the prolonged legal proceedings, they were unified in the belief that they had no other choice for dealing with this patient.

**Case 8.** A female social work trainee was alone in an office in a publicly accessible administrative wing of a community mental health center. A 30-year-old Oriental man, who was diagnosed as paranoid schizophrenic, came into the office, closed the door, said, "I have a knife and I'm going to rape you," and assaulted her. Her screams and struggles quickly brought rescuers. She did not know the man, an inpatient in the center. He had a history of assaulative behavior but no known sexual assaults.

The trainee turned to the hospital administrators for advice. She felt no need to press charges, since the attack was not a personal issue; it was "faceless" in that any of the female workers might have been the victim. She believed, therefore, that the institution should decide on a response.

The administration decided that charges should be pressed to set an example of intolerable behavior and to demonstrate clear administrative support for staff. The trainee tried to file charges of attempted rape, but the legal system was unresponsive. She was told by the court clerk, "What do you mean? He's crazy! You can't press charges!" After being kept waiting for several hours, she was finally allowed to file.

The patient was sent to another facility, where he was found competent to stand trial and criminally responsible at the time of the assault. However, he pled guilty to a lesser charge of simple assault and was sent to a facility for the criminally insane. The trainee felt defeated by the fact that the patient had not faced the charge of attempted rape. Several months later the patient was transferred back to the first hospital. The trainee now felt frightened because although the initial attack was, in a sense, not "personal," it had become so because she had pressed charges.

The patient continued in treatment and had no more episodes of sexually assaultive behavior. His functioning was otherwise unchanged from what it was before the assault.

**Case 9.** A 30-year-old black woman with borderline personality disorder had a history of antisocial acts and of noncompliance with treatment. She had been charged with assault and battery by the staff at another inpatient facility, under unclear circumstances, was found not guilty by reason of insanity, and was hospitalized for treatment. Subsequently she was transferred to a different ward on a six-month civil commitment. She showed no signs of psychosis during her hospitalization.

After three months the patient's therapist informed her that she, the therapist, was leaving the facility. Shortly afterward, without warning, the patient slapped the therapist forcefully across the face. She was transferred for a forensic evaluation to another facility, where she was found to be competent to stand trial and criminally responsible.

The patient was found guilty but was returned on a court commitment to the facility where the assault occurred. She was ultimately discharged to the streets. No follow-up information was available. The staff universally agreed that the patient was impossible to manage in their facility.

**Types of assaulative patients**

These patients can be placed into three distinct categories: the decompensating assaultive patient, the intentionally assaultive patient, and the unexpectedly assaultive patient. Table 1 groups the nine patients by category and summarizes their characteristics and outcomes. We shall consider each group in turn. Two general points can be made about the sample. Their diagnoses are stacked away from major mental illnesses toward organic and character disorders, and the racial balance of cases parallels the catchment-area population.

- The category of decompensating assaultive patient includes cases 1, 2, and 3. In this group are two character-disordered women and
one mentally retarded woman, all inpatients, who before prosecution had established patterns of assaultive behavior. There is no indication that the prosecuted assault was more vicious or serious than previous ones.

In two of the three cases the staff discussed the plan of pressing charges and informed the patient that prosecution would follow any future assault. In these same two cases, the patient's behavior clearly improved. Regardless of the outcome, staff expressed satisfaction about the process, in part from perceiving the assault as clearly flowing from the patient's illness. In each case they felt they had done all within their power for the patient; prosecution itself was a final therapeutic maneuver.

- The category of intentionally assaultive patient comprises cases 4 and 5, two male patients with diagnoses of character pathology and mental retardation. This group is characterized by the deliberateness of the assault, which seems to have led directly to prosecution. Surprisingly neither patient was brought to trial. One patient, emboldened by the failure of the legal system, threatened further assaults, and both patients were lost to follow-up. Here the assault may well have seemed a "bad" rather than a "mad" act to staff.
- The category of unexpectedly assaultive patient comprises cases 6, 7, 8, and 9. This group is diagnostically the most heterogeneous.

Cases 6 and 8 carry diagnoses in the schizophrenic spectrum, and for cases 7 and 9 the diagnoses are character disorders; one of the latter patients also is mentally retarded and a substance abuser. Two were outpatients, one from each diagnostic group.

Patients in this group are characterized by the unexpectedness of their assault, although all had histories of assaultive behavior. The two outpatients and one inpatient, the patient in case 9, had been stable. In case 8 the patient had no history of prior sexual assault. The schizophrenic patients acted seemingly at random. The character-disordered patients apparently reacted to the impending loss of their therapeutic relationships.
Discussion
We will consider in turn the effects of prosecution on the patients, how the legal system responded, and staffs’ feelings about the legal outcome.

The patients
What impact did prosecution have on the patients? It benefited two patients in our survey, cases 1 and 2, both decompensating assaultive patients. Although the two schizophrenic patients who were unexpectedly assaultive did not repeat the behaviors for which they were prosecuted, their overall clinical course, including inpatient assaults by the patient in case 6, continued. The impact of prosecution is therefore difficult to assess for the schizophrenic patients.

The outcome for other patients was adverse; four were lost to follow-up. The patient whose case the prosecuting attorney failed to bring to trial threatened to repeat his actions; another, successfully prosecuted, continued to be assaultive in a second institution.

Does the category of assaultive patient influence outcome? It seems so. Two of the three decompensating assaultive patients improved after prosecution. The third patient in this group had failed to respond to any prior intervention, and her course seemed unchanged by prosecution.

Both of the intentionally assaultive patients were lost to follow-up. Though neither patient was successfully prosecuted, the adversarial nature of staff-patient interactions may have contributed to this result. However, it is likely that these patients, who were impulsive, noncompliant, and poorly motivated, would have left the mental health system under any circumstances.

The two unexpectedly assaultive patients who were schizophrenic continued in treatment. As noted, their clinical course was little if at all affected by prosecution, successful or otherwise. We do not suggest that schizophrenics per se are unaffected by being held responsible for their actions. Rather, it is likely that other factors, such as the patients’ acknowledged need for medication and their treatment responsiveness, provided a context in which follow-up for these patients was more likely.

The two characterologically disordered patients who assaulted their therapists had poor outcomes. Both patients had undergone extensive treatment and had been poorly motivated and noncompliant. Their prognoses were poor even before prosecution.

The legal system
The legal system was receptive to prosecution, in some instances reluctantly, in six cases (cases 1, 2, 3, 4, 7, 8, and 9). Among these patients were two who clearly benefited from prosecution (cases 1 and 2) and one patient who did not repeat his unprecedented sexual assault (case 8). Patients 7 and 9 were not benefited by prosecution; patient 7 continued to be assaultive.

In case 3 the court saw its role as facilitating a transfer between psychiatric facilities. In this instance the patient’s course also continued to be an assaultive one.

In cases in which the courts were uncooperative with the mental health system (cases 4, 5, and 6), no clearly beneficial outcomes resulted. The outpatient who unexpectedly assaulted a nurse continued to be assaultive as an inpatient. The two intentionally assaultive patients were lost to follow-up. Before discharge one patient threatened future assaults based on the hospital’s demonstrated impotence to set a limit.

The unexpected finding that two of the three patients not brought to trial were lost to psychiatric follow-up underscores the importance of a consistent interinstitutional posture. Inconsistency may give the patient the impression—and clearly did in one case—that his behavior cannot be controlled by the institution. In the other cases we can only speculate that the lack of consistency may have led the patient to be uncertain about his caregivers’ ability to contain him.

Are there factors that influence the courts’ decision to cooperate? Though we have no direct evidence, we can note some patterns. All the decompensating patients were successfully taken to court. This outcome may have been a result of the repetitive nature of the assaults; the courts may have perceived that the situation was desperate. Two patients (cases 3 and 9) who were successfully taken to court had had previous contact with the criminal system, which may have paved the way for them to be accepted by that system. Patients rejected as inappropriate by the legal system did not have a previous court history; they may have been perceived as belonging to the mental health system. The sole sexual assault was successfully prosecuted, probably because of its criminal quality, distinct from expected hospital behavior.

Five of the six patients in the court-accepted group were women, compared with one of three in the court-rejected group. It may have been that on some level the courts recognized the realities of the resources. The state of Massachusetts has a secure facility for dangerous mentally ill males but none for females. Therefore, even when the assaults of males were seemingly intentional (cases 4 and 5), the judges or clerks may have preferred that the mental health system contain the problem. When women were assaultive, the courts may have recognized the lack of a secure psychiatric facility and accepted the patient into their system. These observations are preliminary and heuristic; the legal system’s response to prosecution of assault by the psychiatric system warrants future controlled study.

The staffs
Staff satisfaction was evident in cases 1, 2, 3, 7, and 9. Their satisfaction depended not on patient outcome—prosecution benefited only two of the five patients—but on their professional pride at having exerted themselves for an extremely difficult, perhaps impossible, patient. It is not inconsequen-
tial that the courts were willing to press charges in each of these cases. In the three cases in which the court refused to cooperate, the staff felt abandoned, guilty, unsupported, and demoralized.

Support from the legal system, however, did not of itself determine staff satisfaction. Despite eventual prosecution of case 8, the involved clinician felt defeated and ultimately vulnerable and betrayed. The goals of prosecution were to set an example and support staff. Clearly prosecution had no explicit therapeutic purpose; perhaps without it the clinician had no clear expectations. The goals set for prosecution were thus too nebulous for staff satisfaction, and the adverse effects of prosecution dominated the issue.

The staff's reasons for prosecuting cases 4 and 5 were ambiguous. The intent did not appear to be therapeutic; it may be that, as in case 8, the staff in these cases wanted to "make a statement." This view is supported by their dissatisfaction with the outcome in spite of their having rid themselves of the patient.

Conclusions
An assault is a crisis point for patient and staff. Inpatient wards have available a wide variety of appropriate clinical interventions that can be directed toward the causes of the violence: seclusion and restraint, medication, transfer to secure facilities, and involuntary discharge as well as the use with the staff of exploration or debriefing, which should be an invariable response to any acting out. These measures should be the first line of intervention for assault.

Assaults may also signal systems issues such as problems in staffing, morale, treatment team unity, or resources. If the core problem lies in these areas, then prosecution merely scapegoats the patient. Preferable approaches would be attempts to remedy the underlying problem.

A further policy concern is related to the legal issues that impinge on the treatment alliance (6). In using physical interventions, such as seclusion and restraint, to protect patients from harming themselves or others, staff are given some benefit of the doubt for intervening early, before an escalating situation explodes; generally these interventions are not considered "assaults" for which patients should press charges. Similarly it would seem reasonable that some assaults on staff should be considered expectable events, for which appropriate responses and preventative exist. Such a tradeoff averts vicarious from charges and countercharges of the therapeutic effects of a setting (7).

An unexpectedly effective compromise in some cases of assault has been "pocket probation." Charges are pressed against the patient, and the patient and several staff members go down to the courthouse to appear before the clerk of the court (not a judge). The clerk admonishes the patient severely and states that he or she will keep the dossier open for the next year; if the patient appears again before the clerk, the charges will be put through the legal system to the full extent. The patient is thus on a kind of probation while the clerk keeps the file "in his pocket." This approach has been remarkably successful with a small number of patients in diminishing future assaults. It seems to offer some of the advantages, without some of the disadvantages, of using the legal system as a limit-setter. Time may tell as to its durable value.

In any case, based on our highly preliminary data, prosecution of the assaultive patient is a rare event that can serve both constructive and destructive ends. For the patient it may reverse an upsurge of acting out by setting limits. When the treatment institution has exhausted its therapeutic ammuniition with a difficult patient, prosecution may draw a clear line delineating acceptable behavior. Taking this step, however, may mean that some patients are lost to treatment or permanently alienated from the care system, as occurred with nearly half our subject population.

Patient outcome and staff satisfaction may be enhanced by greater mutual understanding by the legal and psychiatric systems. In each case administrative and clinical staff are responsible for educating the courts about the reasons for prosecution. This process will be aided by a more systematic, prospective empirical study now in the planning stages at the Massachusetts Mental Health Center.

Given the above uncertainties, we also recommend that when prosecution is being considered, consultation be obtained from a psychiatrist who has no direct clinical responsibility for the patient involved. Because prosecution may result in the termination of treatment, it is imperative that as part of the consultation, consideration be given to the actual ends that treaters seek, and the likelihood that they can be achieved. Such consultation will also provide an opportunity to explore alternatives, and to challenge motives that may be contaminated by countertransference issues.

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