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# Armed Law Enforcement in the Emergency Department: Risk Management Considerations

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It is hard to imagine a hospital permitting – or even recommending that – a security officer lead the resuscitation of a patient after a heart attack while more skilled clinical staff stand by. Certainly, having such an officer trained to identify and rapidly intervene if such an event occurs outside the emergency department (ED) can be lifesaving. But the officer would call a code and begin CPR; he or she would not run the code while the medical professionals stand in the background. Just as law enforcement officers should not be relied on in a medical setting to run a code, they should not be relied on in a medical setting to act as primary responders for agitated individuals.

Agitation is a common behavioral emergency resulting in an estimated 1.7 million emergency department (ED) evaluations every year.[1] Behavioral emergencies like agitation require a team of skilled clinicians with adequate skills, training and resources to intervene rapidly to minimize harm to the patient or others. When these teams are available, they may be able to effectively diagnose, manage and treat the patient with verbal de-escalation, medications, or other interventions.[2] Research has shown that using evidence-based guidelines and training focused on verbal de-escalation complemented by psychiatric and medical assessment, medication use, and physical intervention significantly decreases the frequency and duration of physical interventions needed in the ED.[3]

More than half of U.S. hospitals now have security officers with firearms, an increase compared to prior studies.[4] Recent media coverage[5] has spurred debate[6] about the risks of armed security in clinical settings. In essence, is there a risk that a patient who could have been verbally de-escalated could end up arrested or even shot? Further, how can a medical center understand and manage the relative risks and benefits of armed law enforcement or security officers as part of an overall security program?

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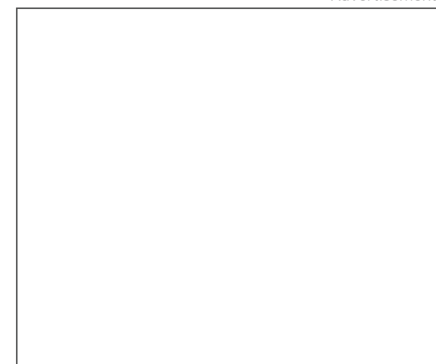

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**Municipal law enforcement responses to behavioral emergencies and agitation**

Municipal law enforcement has long recognized the importance of specialized response for behavioral emergencies in the community. For years, and with admittedly varied outcomes, law enforcement has striven to enhance and expand the use of verbal de-escalation and engagement and decrease the use of lethal force. Common recommendations include use of Crisis Intervention Teams (CIT) and Mental Health First Aid (MHFA) training.[7] CIT is a combination of a 40-hour training on mental health emergencies for law enforcement professionals with development of close working relationships with mental health professionals and agencies; MHFA is a day-long training in effective recognition and referral of mental health emergencies. Both programs are intended to provide officers with better skills for identifying, engaging, and safely intervening with people with behavioral emergencies and are intended specifically for law enforcement professionals; they are distinct from traditional behavioral emergency management training that may be delivered to clinical staff. The trainings can be time consuming; scheduling multiple officers for day- or week-long training is complex and expensive even in departments with low staff turnover. However, the trainings are helpful for a variety of outcomes for law enforcement and the people they interact with.[8]

MHFA and CIT trainings are not universally available, and their interventions are not universally effective. Lethal force against people with behavioral emergencies remains a very real issue for law enforcement professionals, and people with severe mental illness are disproportionately likely to be shot or killed in officer-involved shootings.[9] There is no available data on the prevalence of such training for hospital-based security or law enforcement personnel but the author's experience is that such training is uncommon. It seems reasonable that such training would be beneficial for the officers and the hospitals they serve.

**The case for armed security or law enforcement in EDs**

Many hospitals choose to have armed security or law enforcement to deal with high-risk security issues, including potential firearm-related threats. Additional responsibilities routinely include maintaining a secure perimeter, responding to severe violence, management of contraband, crime investigation or reporting and other traditional law enforcement functions. The presence of armed law enforcement or security may be especially valued in EDs which have higher rates of workplace violence[10] and shootings[11] than other healthcare settings. Security management in the ED is challenging: in addition to managing victims of gunshot wounds brought in emergently and potential follow up attacks, angry and dissatisfied patients and family members, and other crime and security issues, hospital security staff also need to be prepared for many other potential events. Notable examples include but are not limited to overflow of domestic violence against hospital employees,[12] suicides,[13] armed robbers seeking controlled substances,[14] accidental shootings,[15] physical altercations between prisoners and their guards,[16] and even armed abductions from inpatient units.[17] While firearm-related events like these may be relatively uncommon, they are not rare and must be considered in maintaining effective security programs.

The need for promoting a secure, safe, and accessible working environment is critical to the underlying mission of the ED and hospital. Use of armed security or law enforcement in ED settings may help support that mission. Efforts must be taken, however, to control novel risks that may emerge from armed security presence in the ED. Such risks include accidental shootings from firearms mishandled by security[18] and shootings of patients by security staff.[19] As many as half of all shootings by patients in EDs involved a firearm that was taken from security personnel, including outside law enforcement who were escorting a patient in custody.[20] Such events create significant risk for civil liability, regulatory scrutiny, public relations concerns, and even criminal investigation for the hospital.

Hospital security teams are highly diverse. Some security teams are staffed by sworn law enforcement in a hospital or university-based department, some use local officers moonlighting as security and some use internal or private security contractors. Design of a hospital security plan is complex and may take into account any number of factors, including current or readily available resources, state and federal legal limitations, cost, flexibility of internal or outsourced security teams, institutional values and leadership strengths, and costs. Because of the possibility of potentially lethal violence in some ED settings, facilities may choose to use armed security or law enforcement as a management strategy.

There are additional benefits to law enforcement presence in ED settings. Some people may be less likely to become agitated or threatening or de-escalate more quickly when they know that uniformed law enforcement officers are nearby. Clinical staff may be assaulted maliciously by patients, visitors or family members who are unhappy with a decision (e.g., patient not being admitted or provided with opioid analgesics) or outcome; having readily available law enforcement officers may expedite appropriate dispositions for bona fide criminal behaviors such as assault or terroristic threats.[21] Finally, many EDs frequently interact with local law enforcement; hospital-based law enforcement can

serve as an effective liaison and intermediary, especially in taking initial reports and maintaining chain of custody for evidence.

And, ultimately, there is the critical and difficult-to-measure factor of deterrence and prevention. Active shooters in ED settings are a significant concern by virtue of their magnitude and impact with liability exposure for hospitals and business partners, including security contractors.[22] Preparedness and response to such events has become a focus of Medicare and Joint Commission reviewers, as well.[23] It seems reasonable that visible presence of armed security or police presence in and near an ED may deter some number of potentially violent people from either attacking or escalating while in the ED. Unfortunately, the scope of such deterrence – while invaluable when it occurs – is also unquantifiable. It also needs to be understood that law enforcement response to active shooters is a specialized intervention requiring specific training, skills and expertise which may not be seen in all security or law enforcement officers.[24] There are no identified case reports, series or studies identifying such outcomes and no feasible way to study such an effect. That there is an absence of evidence of a protective or deterrent effect should not suggest that such effects are absent; it must be left to the balanced judgment of hospital executives and their advisors to weigh such issues.

**The case against armed security or law enforcement**

There is also a strong case to be made against law enforcement or armed security presence in EDs. The first concern is protection of doctor/patient communication – both limiting breaches of confidentiality and privilege and diminished disclosure of important clinical information by patients or families who fear legal intervention. Patients or families may misperceive the healthcare providers or hospital itself as extensions of law enforcement, making them reticent to fully disclose relevant information to clinical staff. Specific measures would need to be taken to assure protection of confidentiality of patients, such as clearly posted signage about confidentiality and specific policies about confidentiality.[25] Signage notwithstanding, at least one court recently allowed the spontaneous statement of a non-Mirandized hospital patient to a police officer at the bedside.[26]

Additionally, presence of uniformed security or law enforcement may increase aggression risk in some circumstances. While some patients may be less likely to become agitated if they know security or law enforcement is present, others may escalate for that very reason, triggered by the presence or appearance of the officers. Often in clinical settings a uniformed officer may be singled out by an agitated person as the initial or primary target. And at a basic level, when a clinician who lacks confidence or competence in managing behavioral emergencies knows that he can just call for a security response (or, sometimes, is instructed to call by policy), he may be less invested in preventing agitation or verbally de-escalating the patient or in maintaining those skills as part of his repertoire.[27] Verbal de-escalation is the preferred approach for management of agitation in clinical settings whenever possible.[28]

Arresting patients who are threatening staff or hospital operations and are acting out of malicious intent not reasonably attributable to acute psychiatric illness may be quite appropriate and even preferred over traditional clinical interventions. Nonetheless, such interventions should be uncommon and used only after careful contemplation of the clinical needs of the patient and security needs of the hospital and its staff.[29] Potentially, the presence of law enforcement officers in clinical settings may increase the likelihood of arrest of patients when diversion to mental health or social services and away from the criminal justice system is more appropriate.[30] It is a delicate balance.

Ultimately, law enforcement in hospital settings may be used rarely for their actual law enforcement function. This begs the question of efficient use of resources: whether officers are reliably effective at deterring against or intervening in bona fide life threatening assaults to such a degree that it outweighs potential liability and media risks of inappropriate use of force or accidental harm from their firearms. Hospital administrators may see the presence of armed law enforcement as a panacea when, at best, it is only one part of a comprehensive security program. And, even with the best designed and implemented security program, challenges can exceed resources: no perimeter is perfect and no amount of law enforcement or behavioral emergency expertise will suffice for every situation.

**Recommendations**

Many EDs may find that their needs are best met without using law enforcement or armed security guards. Others may find that these needs are well met by a combination of good clinical response to behavioral emergencies by frontline clinical staff through effective training and adequate staffing ratios, good preparedness for critical incidents through planning and training, and good relationships with local law enforcement fostered through regular communication and collaboration. Any time security staff are used in a hospital setting, close collaboration between clinical and security leadership is essential. Security or sworn officers in a clinical setting need to have the skill, training and flexibility to adapt their demeanor and interventions to each encounter, deferring to and supporting the clinical mission of the hospital, without compromising their important function of

security and law enforcement.

If armed security officers are used in a clinical setting, these recommendations may be considered:

1. Hiring

    a. Certified, sworn or accredited law enforcement officers are preferred over private security officers or armed clinical staff due to the assurance of extended training and certification.

    b. Adequate review of prior employment experience, disciplinary issues, behavior and conduct, especially in confrontations or conflicts, should be conducted as part of the hiring process. This should include a review of prior disciplinary incidents or allegations occurring in other security or police roles.

    c. Comprehensive assessment during the conditional hire and training phase should be conducted by a licensed psychologist and in accordance with accepted standards for law enforcement officer assessment and which addresses the specific nature of work in a healthcare setting. Careful attention to pertinent professional assessment standards will be needed to avoid possible Americans with Disabilities Act (ADA) liability.

    d. Officers with demonstrated experience in community oriented policing or clinical work may be preferable to private security or less experienced officers.

2. Training

    a. Armed security staff should receive training in recognizing and managing behavioral emergencies and agitation with an emphasis on verbal de-escalation and use of force, such as MHFA training or CIT training.

    b. Ongoing training and supervision to support the use of verbal de-escalation and less-lethal interventions should be standard for all security or law enforcement staff.

    c. Law enforcement officers based in clinical settings should have ready access to cross training and peer support with local law enforcement to support ongoing development and to mitigate the risks of isolation and burn-out.

3. Policy and Practices

    a. Hospital leaders should carefully weigh and memorialize their facility's distinct needs and the relevant and foreseeable risks and benefits justifying the creation of an armed security or law enforcement team. Armed or sworn officers should not be considered as a default arrangement but as a variation from unarmed, non-sworn officers.

    b. Policies, practices and culture should place primary responsibility and leadership for managing behavioral emergencies with clinical staff.

    c. Policies should expressly address use of force standards, rules of engagement, including identifying when intervention by law enforcement or security staff may occur without clinical staff input, i.e., imminent lethal risk situations.

    d. There should be integration of security and clinical staff and leadership in developing other appropriate policies and practices and in problem-solving potential issues.

    e. Processes should be in place to assure routine monitoring of process and outcomes for armed security staff and heightened scrutiny for outlier and high risk/sentinel events. This should involve clinical and security leadership alongside quality and risk management.

    f. Processes should be in place to assure appropriate education of security or police personnel to other pertinent hospital policies, especially for externally contracted staff or moonlighting officers.

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