AAPL Practice Resource:

MANAGING VIOLENCE IN STATE HOSPITALS WITH FORENSIC PATIENTS

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1. Introduction

Since deinstitutionalization in the 1960s, the number of state hospital beds has declined dramatically, with much of inpatient care shifting to acute settings. The remaining state hospital beds have primarily been reserved for specific populations, including patients with histories of violence and serious self-injury, complex behavioral support needs, as well as for those involved in the criminal justice system (1, 2). Some states have specially designated "forensic hospitals," hospitals specifically designed for patients with criminal legal involvement or histories of such involvement, and those with tendencies toward behaviors that include outward directed aggression or threats. Even in the more general state hospital, it is typical to see growing proportions of patients with forensic histories or on forensic commitments (2). Over time, the demographics of state hospitals have shifted towards a more criminalized or "forensic" population, as well as one where histories of chronic behavioral dysregulation and violence are more prominent.

People with mental illness are more often victims of violence than perpetrators of violence towards others. Yet, one of the defining reasons for psychiatric hospitalization is when a person with a psychiatric condition has begun to act in a way that presents a risk of harm to others. As such, inpatient units see a skewed sample of patients, and work with these individuals during very challenging periods of their illness trajectory. Although not unique to state hospitals, violence and aggression occur more frequently on inpatient psychiatric units than in any other

mental health setting (3). A review of the literature by Hermanstyne (2015) noted that the prevalence of aggressive behavior on inpatient psychiatric units ranges from 8% to 44% (4). In a systematic review of violence across psychiatric inpatient settings that included large forensic hospitals, violence towards others appeared to be a common theme (5). Although comparisons of violence across decades of state hospital utilization have not been done, one author posited that with funding limitations and difficulty recruiting and retaining qualified psychiatrists, state hospitals have become more overcrowded, and violence at forensic hospitals has increased (6).

Forensic patients may be admitted to state hospitals for various legal reasons, including pre-trial evaluations, restoration of competence to stand trial, treatment after being found not guilty by reason of insanity, sex offending or problematic sexual behavior and evaluation or treatment of incarcerated persons. Such may also be committed under a variety of legal statuses that relate to a criminal adjudication, including, but not limited to, incompetent to stand trial (evaluation or treatment), not guilty by reason of insanity, or civil commitment as a sex offender. In addition, civil patients with no criminal-legal encumbrance may be admitted to a state hospital when their level of aggression overwhelms a general acute psychiatric hospital.

One literature review of 122 studies involving 70,000 patients found that violence on forensic wards1 occurs at almost double the rate on acute psychiatric units (7). Some of this may depend on the acuity of the illness demonstrated by the psychiatric patient, regardless of legal status. It is important in understanding violence to not generalize violence to particular patients with specific legal statuses. At the same time, apart from housing a population that has moved in and out of the criminal system, forensic hospitals differ from general acute psychiatric settings in other ways that may contribute to the high rates of violence. For example, forensic hospitals may have higher patient-staff ratios and, sometimes, prison cultures (8).

The inpatient forensic unit can be both a rewarding and stressful work environment, and violence in inpatient settings is associated with many negative consequences. Inpatient violence traumatizes patients and staff and is associated with various potentially long-term social, physical, and psychological effects (9). Violence also harms patients by delaying their recovery

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[1] This resource guide is primarily focused on state hospitals. Some state hospitals have forensic hospitals or forensic units within general state hospitals. Some states do not make these distinctions but do have forensic patients.

and leading to longer stays (10). Inpatient violence has increased stress among staff, with some even developing post-traumatic stress disorder (PTSD) (11). Other staff may quit their jobs due to the violence, which contributes to the often already-dire staffing deficiencies at forensic hospitals and leaves the door open for new hires who may not possess the necessary skills, training, and experience to provide safe and effective care to this challenging population. Hiring inadequately trained staff can increase the risk of hospital violence, in turn creating a positive feedback loop of worsening violence and higher turnover rates (8, 9).

Inpatient hospital violence can also cause additional financial strain for these often already-underfunded facilities. If a staff member is injured, the forensic hospital may be required to pay for the staff member's medical and legal expenses if charges are filed, although this often comes out of non-hospital funds for state facilities. At the same time, increased costs also come in the form of sick leave, hiring and training new staff, and paying overtime to meet staffing needs. When more workers' compensation claims are filed, insurance companies may consider the hospital a dangerous workplace, thereby increasing the hospital's liability premium (9).

Warburton (2014) argues that deinstitutionalization has created a new type of psychiatric patient: one with complex mental health, forensic, and criminogenic needs (6). Others have noted that the deinstitutionalization phenomenon was not the sole cause of individuals moving between psychiatric institutions and criminal systems; other complex social policies were occurring at the time of deinstitutionalization that shifted individuals to correctional systems (12, 13). Recognizing that older and often underfunded models of treatment have failed to eliminate violence and all too often fail to keep staff and patients safe, forensic hospital and other state hospital staff are increasingly faced with a complicated and often competing dual role: treating mental health disorders while also reducing violence (6, 14).

This resource document provides a broad overview of the types and theories of violence and the management of violence, as well as strategies to measure, monitor, and mitigate violence in forensic hospital facilities and state hospitals working with forensic populations, as well as examine these strategies among special patient populations prone to high-risk behaviors that can put others in harm's way. It also explores strategies to address longstanding challenges to best

support these patients and the staff, by detailing recruitment issues, current regulations, and ethical issues involved in working with this patient population.

2. Types of Violence

The relationship between mental health disorders and aggression is complex (15). Psychiatrists working in forensic hospitals and with forensic patients must determine the type of violence their patients are exhibiting because, as described below under the section titled "Treatment," management of the patient will vary based on etiology of the violent behavior (16). There are three primary types of violence among patients in forensic hospitals: impulsive, psychotic, and predatory (which is sometimes referred to as instrumental violence) (17, 18). This does not include patients for whom violence may be driven also by communication needs or other factors related to intellectual and developmental disabilities (19, 20). Because violence is generally conceptualized as fitting into one of these three categories, we present each in separate sections below. However, it is important for psychiatrists working in forensic hospital settings to recognize that there is limited research on violence etiologies and risk factors for the long-term, forensic hospital population (15).

Violence propensity and timing can depend on many factors. For example, for those with violence related to symptoms of psychiatric illness, forensic patients admitted with acute symptoms who have not been treated (e.g., some patients coming directly from jails), may show more violence until stabilized. Other patients who may be more stable may decompensate during the course of hospitalization, or those with more predatory behavior may show repeated violence and victimization of vulnerable other patients, leading to chronic management challenges. In addition, patients with intellectual and developmental disability may have behaviors that are related to other factors that require support plans. In addition to evaluating a patient's psychiatric symptoms that can contribute to impulsive or psychotic violence, forensic psychiatrists should also evaluate their patients' criminogenic risk factors (e.g., antisocial personality, vocational difficulties, antisocial peers). This is because in general, criminogenic risk factors may play a greater role in the patient's violence risk over the course of hospitalization. In other words, as acute psychiatric symptoms stabilize, ongoing violence is more likely predatory in nature and

associated with residual criminogenic risk (15). There are, however, a relatively small number of patients whose psychosis is refractory to treatment and continues to drive their aggressive behavior for long period during hospitalization.

2.1 Impulsive Violence

Impulsivity accounts for most violence in psychiatric inpatient settings (16). In a study of chronically aggressive inpatients at a large state psychiatric hospital, impulsive aggression was most common (54%) (21). Impulsive violence is characterized by emotional hypersensitivity, hyperreactivity to stimuli, exaggerated threat perception, and autonomic arousal (16). Impulsive aggression often involves a reactive or emotional response coupled with a loss of behavioral control and a failure to consider consequences (16). Impulsive violence is most often targeted at staff and frequently occurs when staff attempt to change unwanted behavior or refuse a patient's request (21).

Impulsivity is strongly associated with substance use disorders and is also linked to many other psychiatric diagnoses, including schizophrenia spectrum disorders, cognitive disorders, bipolar disorder, intermittent explosive disorder, antisocial personality disorder, and borderline personality disorder. Other psychiatric diagnoses linked to impulsivity include traumatic brain injury, post-traumatic spectrum disorders, attention deficit hyperactivity disorder, and depressive disorders (16).

2.2 Psychotic Violence

Although most individuals with mental illness are not violent, forensic hospitals house a population of individuals commonly with violent histories, and as such, they present greater risks related to their illness. Psychotic violence is attributable to positive symptoms of psychosis, is associated with autonomic arousal, and occurs when a patient misinterprets environmental stimuli (16). Quanbeck et al. (2007) found that among chronically aggressive inpatients at a state hospital, psychosis was the least common (17%) type of violence (21). The authors additionally found that the majority of patients who committed psychotic violence did so because they believed that the victim—usually another patient—intended to harm or was talking about/laughing at the perpetrator (21). The diagnoses associated with psychotic aggression include schizophrenia spectrum disorders and bipolar spectrum disorders. Additionally,

neurocognitive disorders such as Alzheimer's disease, vascular neurocognitive disorder, traumatic brain injury, and neurocognitive disorder with Lewy bodies can result in psychotic aggression (16).

2.3 Predatory Violence

Predatory violence is characterized by planned, goal-directed assaults and lack of autonomic arousal or remorse. Quanbeck et al. (2007) found that, among a sample of chronically aggressive state hospital patients, 29% of assaults were characterized as organized or planned (16, 21). This study found that acts of predatory violence were more likely to target other patients than staff and were most often motivated by the aggressor's desire to retaliate against their victim. It could also be perpetrated to intimidate others and dominate the unit milieu. Clinical characteristics associated with predatory violence include psychopathic traits and antisocial personality disorder (16).

3. Prevention

Although clinicians in forensic hospitals must be adept at managing and treating violence and its causes, it is essential to take a preventative, rather than simply reactive, approach (22). Thus, this resource document places the discussion of prevention of violence before the sections on management and treatment.

Effective clinical care can only be provided in a setting where patients and staff all feel safe (23). Therefore, prevention of violence in forensic hospital settings requires attention to the environment in terms of the physical plant and the multiple factors that contribute to a milieu that promotes safety, dignity, and respect.

3.1 Environmental

Physical Plant

The overarching goal of a secure forensic psychiatric hospital is to provide a shared sense of safety for patients, staff, visitors, and the community, while simultaneously creating a sense of dignity, autonomy, hope, and privacy for patients that enables and supports their recovery (24, 25). Several facilities that have been constructed in the 21st century have achieved these goals;

these have involved "open hand" unit designs with corridors radiating like spread fingers, enabling clear sight lines of the entire unit from a central observation point (25-27).

Many of the current efforts within the social justice architectural movement recognize trauma histories as common among patients, and the potential for staff to also have suffered trauma. As such, environments are planned with current considerations of sensitive and nurturing designs. It is important to consider these goals in the early decisions of designing a new construction (24, 25) because the successes and missed opportunities will last for decades. The following considerations are described in the literature as vital to the quality of care and quality of life within the facility (24-26, 28):

- Reducing the institutional and correctional feel of the facility
- Creating a more homelike environment
- Maximizing the amount of natural sunlight and views of nature
- Easy access to outdoor settings
- Open spaces and wide hallways/corridors
- Maximizing well-designed therapeutic spaces that support activities that parallel natural rhythms of the day in the world outside the hospital (i.e., sleep in one's room, go to "work" [e.g., therapy, rehabilitation, skill-building activities, vocational programming, and recreation] elsewhere during the day, and relax in a comfortable living space with others in the evening and on weekends)
- Avoiding unsupervised or unobservable spots (i.e., no blind spots)
- Creating calming places and spaces to allow patients and staff to de-escalate or avoid conflict. A comfort room (also known, for example, as a tranquility room, calming room, peace room, zen room, or relaxation room) is a room that provides a sanctuary from stress or allows a patient to experience their feelings within acceptable boundaries and engage in calming activities. (29)
- Maximizing casual observation (i.e., sight lines) to maintain safety while preserving privacy/dignity
- Avoiding overcrowding
- Reduction in noise
- Safety and durability of building materials, furniture, windows, fixture, etc.
- Mitigation of ligature risk
- Close monitoring of materials allowed on the unit, especially sharp objects and materials that can be fashioned into sharp objects (e.g., shanks)
- Effective security measures that are not unduly intrusive

Other opportunities for promoting safety (and other desirable outcomes) that arise with new construction include installation of technology that enhances videoconferencing capabilities (e.g., telecourt, tele-forensic evaluations, and telehealth activities); inclusion of a space for legal proceedings, reducing the need for transport outside of the facility (an activity that has been associated with violence) (30); comfortable secure space for visiting professionals and family/friends; design permitting maintenance access to systems from outside of the secure perimeter, reducing the need for security monitoring of maintenance and the chance of patient access to tools or materials; private secure entrances for patient admissions with safe, efficient, and comforting spaces for admission processes; delivery entrances outside of the secure perimeter; and the creation of publicly accessible spaces that increase community interaction, decrease stigma, and offer a sense of the quality and character of the care provided in the facility (25, 26).

Ongoing management of the environment is as important as the original or renovated design. It includes regular searches for weapons, broken items, contraband, missing hardware, and other items that can be used for self-harm or harm to others (31), proactive maintenance work, and rapid repairs of identified problems.

The environment should also be designed with staff efficiency in mind. The less time staff members spend moving between workstations and accommodating for design flaws like poor sight lines, the more time staff have for interacting with patients, including teaching and reinforcing skills and prosocial behaviors (25).

Milieu

A 2021 systematic review of the literature on factors associated with aggression on psychiatric units (32) identified a range of ward and staff factors that constitute elements of the milieu. Significant unit risk factors for aggression included a higher bed occupancy; busy locations on the unit; an environment in which people felt unsafe; a restrictive environment; a disorderly, unpredictable, or unstructured environment; smoking; and lack of privacy (32).

Staff Factors

The systematic review by Weltens and colleagues (32) also identified various staff factors that were correlated with incidents of aggression. These included poor communication between staff and patients, perceived lack of empathy or respect, lack of shared decision-making, and limit setting. Providing staff training on milieu therapy can produce desirable outcomes in ward atmosphere and patient satisfaction (33). A model of milieu management that has been designed to address many of these factors is Safewards (34). Safewards is an evidence-informed model (35) that has been studied on psychiatric and forensic psychiatric units in the United Kingdom, Canada, and Australia (34-37). Reported outcomes have included fewer conflict events and increased positive perception of ward atmosphere, enhanced safety, and respectful relationships (36, 37).

Another important element in preventing violence is early identification of individuals with high propensity for violence and subsequent early deploying of resources for mitigation. An initial psychiatric and multi-disciplinary evaluation soon after admission informs the treatment team of the patient's psychological profile, social history and needs, trauma history and potential triggers for violence, which can influence the development of behavioral guidelines or more comprehensive behavioral plans to prevent aggression. This intervention, along with timely application of the patient's preferred methods for self-de-escalation during periods of stress or agitation (identified preferably at admission and documented in the patient's personal preference form) provides staff with an opportunity to identify early warning signs of aggression and respond effectively to avoid further escalation.

The nursing staff, which includes nurses and unlicensed direct care staff (nurses' aides, technicians, etc.), is the largest workforce. Working in forensic facilities is stressful and emotionally and physically draining. Weltens and colleagues (32) identified overwork, tiredness, job dissatisfaction, negative staff morale, and poor satisfaction with leadership as risk factors for increased aggression on the unit. Staff supervision is of utmost importance, as it achieves many goals simultaneously. For example, it presents an opportunity for individual staff members to speak directly and privately to a supervisor when concerns arise. This, in addition to debriefing, allows senior clinicians to identify potential problems early and intervene as necessary, and for supervisors to remind individual staff members of new hospital initiatives (38). There are

different models for supervision of unlicensed direct care staff, such as psychiatric technicians. It is recommended that these staff members report to licensed nurses; if administrative supervisors are used, a close connection with nursing leadership should be maintained so there is a singular and clinically driven approach to care.

Patient Factors

Preventative factors to decrease the risk of patient aggression include recreational/rehabilitative therapies for maintenance of physical, mental, and emotional wellbeing. This is achieved through a variety of interventions, including music, relaxation, arts, and pet therapies (if available), as well as games, dance, and drama. Teaching forensic patients relaxation techniques, and other interventions to manage stress, anxiety, and agitation will help prevent some types of violence and decrease others (38). Chronically traumatized patients may benefit from the opportunity to lie down using weighted blankets when feeling frustrated or agitated. Other helpful interventions include sensory modulation techniques, alternative interventions for relaxation (tai chi, yoga, etc.), and structured vocational engagements.

When patients are involved in structured activities, they may be less likely to provoke each other out of the frustration of inactivity. Exercise and sports programs help in dissipating energy and in generating an overall feeling of wellbeing. Through team sports, patients learn to work collaboratively with others to achieve a common goal. These activities also provide opportunities for therapists to teach patients anger management and appropriate methods of coping with frustration and resolving conflicts (31).

Training

Staff training includes detecting aggressive behavior in its early phases and mitigating it before it becomes actualized (39). If all the best efforts of the treatment team come to naught and a patient engages in aggression towards others, it is essential that all staff be trained in the hospital's policies on handling aggressive behavior and maintaining a safe environment for their patients and themselves. Federal regulations, Conditions of Participation articulated by the Centers for Medicaid and Medicare Services (CMS), the Medicare State Operations Manual (40), and CFR 42 § 482.13 (41) require that all licensed practitioners and staff involved in patient care receive such training, and that training requirements and intervals for re-training must be specified in

hospital policy. Some hospitals choose to develop and teach their own strategies to de-escalate a crisis and prevent or safely manage aggression. For example, the Fulton State Hospital with the Missouri Department of Mental Health uses an in-house program called SMART (42). Other facilities choose to purchase a proprietary program of training from a commercial vendor such as Pro-ACT (43), the Crisis Prevention Institute's Nonviolent Crisis Intervention Training (44), and the Mandt System (45).

In-house and commercial training programs both have advantages and disadvantages. In-house programs are advantageous in that they can be tailored more closely to the unique capabilities and needs of a specific hospital's mission, staff make-up and job functions, physical plant, and patient population. These programs can be amended or altered at will to accommodate any hospital changes or unexpected challenges. The downside, however, is the potential for adverse findings by regulatory bodies such as CMS or The Joint Commission (TJC) if the program does not meet accepted standards. If an adverse outcome results from a patient incident, the hospital may be pressed to explain how its program was adequate to safely address the situation that occurred. On the other hand, commercially available products have often been recognized by regulatory agencies like CMS and TJC, which provides more assurance that such agencies will not find fault after an adverse event if the program was properly followed. One downside of commercial products is that vendors may be reluctant to endorse alterations to their program to suit a hospital's unique needs. Furthermore, some programs advertise their product to a wide range of agencies with varied patient populations. If a program's teachings do not uniformly apply to a specific hospital, officials faced with such a dilemma may need to rethink their approach if an acceptable workaround cannot be affected. Another drawback may be the need to either send employees away for training or assume the costs involved in hosting outside trainers for large training sessions. This problem can be mitigated if the vendor agrees to certify a select number of employees, who will then conduct the training for the remainder of hospital staff (i.e., train the trainers).

Regardless of which program is used, training and re-training of all staff, and most importantly, general acceptance and utilization by staff, is crucial. When incidents do occur, reviewing incidents and identifying any training gaps related to performance of staff can also help continuously improve approaches to escalating patient behavior. Having a formal program, as

opposed to just policies and procedures, gives employees a foundation of knowledge on which to base their response to a crisis. The act of training, usually done in groups, may serve to increase camaraderie among different levels of staff and develop more cohesive teamwork. It is essential, however, to carefully vet the employees assigned to train others if using in-house trainers. Senior officials should ensure that the training accurately represents the hospital's mission and program of choice; trainers that pass along incorrect or harmful techniques, theory, biases, or rumor and frightening storytelling, whether inadvertently or intentionally, can damage the organization. Finally, those same senior officials should attend the trainings at periodic intervals to ensure that the teachings remain appropriate for the mission of their hospital and the safety of their patients and staff.

Staffing Levels

Staffing is a significant component of effective milieu management and management of violence. Many variables affect staffing levels, including patient acuity, financial considerations, and availability of skilled professionals. Patient acuity frequently changes and must be continuously re-assessed to adjust staff levels to increase quality outcomes and mitigate safety concerns. The effectiveness of staffing ratios at preventing violence is in turn influenced by factors such as the culture of the unit, team cohesion and communication styles, and the degree of staff burnout. Equally important in the equation are factors such as the skill, experience, and temperament of the nursing and direct care staff.

It is recommended that higher staffing ratios be available in forensic unit settings (24, 46), not only because direct care staff members often feel more comfortable when higher staff-to-patient ratios are maintained (47), but also because there is an inverse relationship between patient assaults and the number of nursing staff (48). The American Psychiatric Nurses Association Position Statement on Staffing Inpatient Psychiatric Units states, "Aligning staffing based on patient needs and acuity is an important consideration for risk mitigation and safety on the unit" (49).

Nursing shortages are common because of the high rates of violence and relative low pay associated with working in forensic facilities. The COVID-19 pandemic exacerbated these shortages, causing facilities to adopt undesirable strategies for adequate coverage, such as hiring

inexperienced staff or mandating overtime (50, 51). Puzzo et al. (2022) found that, since the beginning of the pandemic, there has been an increase in physical assaults, forced medications, and restrictive interventions on forensic units (50). Therefore, it is more important than ever for forensic hospital leaders to take steps to improve morale and reduce patient violence, while at the same time advocating for competitive salaries and financial incentives for nursing staff.

Staff Trauma

Forensic hospital nursing staff experience high levels of trauma. A meta-analysis found that 75% to 100% of nursing staff on acute psychiatric units have been assaulted by a patient at least once (52). Another meta-analysis reported that psychiatric nurses are about three times more likely to be physically assaulted by patients than nurses in nonpsychiatric settings (53). Furthermore, 20% of psychiatric nurses report intrusive memories of patient assault (54). A recent comprehensive literature review of PTSD among nurses found that 6.7% to 95.7% of nurses exhibited at least one symptom of PTSD, and between 8.5% and 20.8% met criteria for PTSD (55). Violence at work was prominently associated with PTSD symptoms; 94% of nurses experienced at least one symptom of PTSD after a violent event (55).

Because forensic institutions house the most refractory patients often with significant violent histories, many staff experience fear (38). Physical violence against staff contributes to low morale, high rates of sick leave, and high staff turnover (52). This further contributes to low staffing levels and the presence of temporary staff, which can lead to increased adverse incidents (52, 56). In addition, the perceived threat of violence may result in greater use of seclusion, restraint, and forced medication, which can traumatize patients and trigger aggression rather than cooperation with treatment (52).

Psychiatric units in private or civil settings may have the ability to remove patients who endanger others by discharging them to the community, filing criminal charges and discharging them to law enforcement custody, or transferring them to another facility. Forensic hospitals generally do not have these options (though arrest of psychiatric patients from state hospitals does occur but is beyond the scope of this paper). Thus, the management of aggression from such patients becomes an ongoing challenge to the treatment team and hospital administration. It is thus important to acknowledge, recognize, and manage staff fear and trauma to mitigate

countertherapeutic approaches. Trauma-informed environments of care are meant to be comfortable, welcoming, and safe, not only for patients but also for staff who share the same space.

3.2 Measuring and Monitoring Violence

Tracking aggression and violence in forensic settings generally takes two forms. The first is clinical tracking, often of individual patients for the purpose of implementing supports and treatment plans and assessing the effectiveness of interventions. These plans are often tailored to individualized target behaviors of aggression (57). The second is administrative tracking for the purpose of program- and facility-wide quality improvement, safety, and regulatory oversight. Each of these approaches facilitates prevention, the former in individual patients, the latter for the facility as a whole.

Definitions of what is tracked can vary widely depending on the purpose. The American Psychiatric Nurses Association has called for standardizing the definitions of violence and aggression to facilitate research and practice improvement (58). TJC has specific definitions for patient safety events that must be tracked by accredited facilities. TJC also requires accredited organizations to use "data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality" ((59), p. 11). Specific to mental health facilities, TJC requires organizations to document the use of physical restraint and seclusion (59). Additionally, other regulatory and licensing bodies, consent decrees, and court orders may stipulate specific definitions of events to be tracked as they relate to patient aggression and violence, such as incidents of restraint and seclusion or violence-related injuries. Such tracking is important to informing prevention practices in the hospital by quantifying successful interventions and identifying areas in need of further development.

Tracking can take the form of ad hoc instruments and definitions based on unique facility-specific characteristics. There are also standard validated instruments for gathering and recording data. In the case of the former, unique facility features such as schedule, physical location, target of aggression, and identity of staff and patients involved might be useful items to track, in addition to elements regarding the severity, duration, required interventions, and noted triggers

for the aggression (60-62). Standard validated instruments collect and provide especially useful data for planning or revising preventive interventions.

Other authors have recommended a formulation-based approach to assessing violence, which seeks to understand and respond to the specific mental mechanisms underlying violence in individual patients (63). Categorizing events as psychotic, impulsive/affective, or instrumental can also be a helpful means of targeting clinical interventions based on the nature of the violence (17, 21, 64). Review of surveillance footage, if available, in addition to the medical record and incident reports, may be helpful in further characterizing episodes of aggression (65). Recent developments have also included the use of digital correlates of inpatient violence gathered through patient self-reports via smartphones (66).

Researchers have developed a number of standardized instruments for reporting problematic violent and threating behavior within healthcare settings, which are distinct from those designed to assess risk of violence. The systematic utilization of such scales permits clinicians and administrators to note and report the effects of various initiatives within a program or facility (for example, see (67)). Regarding forensic hospital settings, the Overt Aggression Scale (OAS) (68), Modified Overt Aggression Scale (MOAS) (69, 70), and Staff Observation Aggression Scale (SOAS) (71, 72) have the largest research body supporting their use, validity, and reliability (73). These instruments divide aggression into four categories (verbal aggression, aggression towards inanimate objects, aggression towards others, and aggression towards oneself) and invite observers to rate these aspects of the aggression over a given period on a Likert scale from zero (not present) to four (severe). These instruments can be used in concert with facility-specific indicators to improve reliability and translatability of findings.

3.3 Evaluation of Violence Risk

Screening and Assessment at Admission

Quality measures from TJC support the practice of violence risk screening on admission by a qualified professional, taking into account both threats of violence and/or actual commission of violence within the last six months as well as lifetime risk of violence as supported by both primary and collateral sources of information (74). Although many insanity acquittees who are hospitalized have committed some act of violence in the community, patients admitted for

restoration of competence to stand trial may not have such histories. In addition, the charges for which someone is arrested yield only partial information about the patient's potential risk for violence. Violence risk screening procedures are used to determine which patients need a more comprehensive risk assessment to inform risk management and the prevention of aggression. The use of a screening instrument allows for a brief overview, while violence risk assessments are more thorough.

The most important first step to assess for violence on admission is a thorough psychiatric assessment to include genetic and developmental risks for violence (including family history, adverse childhood events, developmental delays, substance use in childhood), psychiatric history (including past treatment response), history of violent behavior (including triggers and mitigating factors (75)), and assessment of the patient's current clinical status in context of the individual's trajectory of illness, recovery, and behavior. Mullen has described a model for the clinical evaluation of these factors in assessing and managing the probability of violence (76). The model includes pre-existing vulnerabilities (e.g., age, gender, history of childhood abuse), protective and aggravating influences in the social and interpersonal environment (e.g., social networks, living conditions, employment status), mental disorder, and substance use. Dvoskin refers to a similar model—in which the patient is assessed in context and over time—as the anamnestic method (77). Meloy's biopsychosocial model of violence risk similarly includes an individual/psychological domain (e.g., age, history of violence, attachments with others), a social/environmental domain (e.g., family of origin or peer group violence, economic instability, alcohol and drug use), and a biological domain (e.g., history of head injury, seizures, mental illness) (78).

The initial psychiatric assessment may indicate the usefulness of further risk assessment with structured risk assessment tools. There are also several screening tools to assess risk for violence, including sexual violence. Screening and brief assessment instruments for evaluating violence risk specifically in newly hospitalized patients or at time of discharge include the Violence Screening Checklist (VSC) (79), Clinical Assessment of Risk Decision Support (CARDS) (80), and the Alert Assessment Form (M55) (81). In addition, the Violence Risk Screening tool (V-RISK-10) screens for violence risk in both acute and general psychiatric settings (82).

Violence Risk and Protective Factors

According to Douglas and Skeem (2005), dynamic factors, which change over time, are the best short-term predictors of violence (83). Examples of dynamic factors include current mental health symptoms, substance use or intoxication, availability of weapons, treatment adherence, and psychosocial stressors (e.g., problems with employment, housing, or relationships). One dynamic factor that receives a lot of attention in the media is the presence of current psychotic symptoms. Research has found a small but positive effect size for the contribution of psychosis to violent behavior (0.12-0.16). Although psychosis in general is only associated with a small increase in violence, delusions specifically may prompt targeted violence that may otherwise be absent among individuals with non-delusional psychotic symptoms (84). For example, persecutory delusions in the absence of negative symptoms have been associated with severe violence (85). Therefore, it is important to focus on the presence of specific types of psychotic symptoms rather than on a patient's psychotic disorder diagnosis (86, 87). While management of mental health symptoms and substance abuse may influence impulsive violence, exploration of dynamic factors are less relevant or effective for managing predatory violence.

When assessing the likelihood of future violent behavior, it is important to evaluate both risk and protective factors. The Association of Threat Assessment Professionals (88) identified inhibitory or stabilizing factors that mitigate violence risk: treatment availability, utilization, and past receptivity; family and other social support; spiritual or religious beliefs that oppose violence; and connectedness and healthy affectional bonds with others. The presence of negative symptoms among individuals with psychosis appear to protect against their engagement in violent behavior (86, 87).

Standardized Assessments

The Violence Risk Appraisal Guide-Revised (VRAG-R) (89) is an actuarial assessment that estimates risk of recidivism in violent offenders by evaluating 13 key variables, including the individual's Psychopathy Checklist-Revised (PCL-R) Facet 4 (Antisociality) data or their Childhood & Adolescent Taxon Scale (CATS) score. The individual is rated as low, medium, or high risk for recidivism over the next ten years based on these scores. Although the VRAG is

used frequently, it is not as helpful in forensic hospital settings because it weighs heavily on static risk factors that are not likely to be ameliorated by hospital care. Rogers describes the problem of this "floor effect" of historical risk in the management and decision-making processes for forensic patients (90).

The Historical, Clinical, Risk Management-20, Version 3 (HCR-20, V3) (91) is a commonly used structured professional judgment evaluation. This assessment considers an individual's historical risk factors (e.g., problems with employment and relationships, substance use, trauma, antisocial behavior), clinical factors (e.g., recent problems with mental illness, insight, treatment compliance), and risk management factors (e.g., future problems with personal support, stress/coping, treatment response) (78). Because, unlike the VRAG-R, this tool incorporates dynamic factors, it is often used in forensic hospitals to identify treatment targets, track treatment progress, and assess readiness for discharge.

An instrument developed specifically to identify protective factors is the Structured Assessment of Protective Factors for Violence Risk (SAPROF) (92, 93). The SAPROF identifies 17 protective factors organized in three subscales: internal factors, motivational factors, and external factors. The internal factors are static; the other 15 factors are dynamic and amenable to change through intervention (93).

Another violence risk assessment instrument is the Short-Term Assessment of Risk and Treatability (START) (94), which specifically evaluates risk of aggression and violence in individuals with mental illness. Moreover, the START incorporates assessment of self-injurious behavior and suicidality, further increasing its utility in the psychiatric hospital setting.

Among inpatient settings specifically, evaluators may use the Forensic Inpatient Observation Scale (FIOS) (95) or the Dynamic Appraisal of Situational Aggression: Inpatient Version (DASA:IV) (96, 97), which continuously monitors risk of imminent aggression. Other instruments that have gained attention for predicting and assessing inpatient violence include the Brøset Violence Checklist, as well as the Dynamic Appraisal of Situational Aggression (98-102).

4. Management and treatment of violence

The complex relationship between psychiatric disorders and aggression benefits from a multidisciplinary approach to provide a full array of management and treatment options. Once the type of violence exhibited by a patient is identified, management and treatment can be targeted toward that specific etiology. Once the specific management and treatment strategies are identified, it may be helpful to create a formal violence management and treatment plan that incorporates the specific etiologies behind the violence risk (103).

4.1 Impulsive Violence

Psychopharmacologic Interventions

Impulsive violence can occur in a wide range of psychiatric conditions—schizophrenia, mood disorders, substance use disorders, and other psychiatric conditions. Treating the underlying disorder can often result in the resolution of impulsive violence. In particular, standard antipsychotic monotherapy, clozapine, and/or mood stabilizers (especially lithium, divalproex, and carbamazepine) may be helpful in treating impulsive violence. Other medications that may be useful include beta blockers and selective serotonin reuptake inhibitors (SSRIs). Although benzodiazepines may be helpful for the acute management of impulsive aggression, they can paradoxically worsen aggression by causing disinhibition, and long-term use can lead to tolerance, dependence, and withdrawal symptoms that worsen aggression. If these approaches fail, high-dose antipsychotic monotherapy or antipsychotic polypharmacy can be considered (104). For specific medication and dosing considerations, current pharmacological guidelines may be helpful (16).

Psychotherapeutic Interventions

Impulsive violence often results from emotional hypersensitivity and exaggerated threat perception (104). De-escalation techniques can be helpful at the first indication of escalating behaviors. Pre-assaultive behaviors may include verbal abuse, a raised voice, swearing, and standing uncomfortably close (103, 105). Other violence reduction strategies include providing options to retreat from triggering stimuli (24) and providing additional medications as needed

(3). A trauma-sensitive care approach can be helpful with some patients (106). Others may benefit from dialectical behavior therapy (104), cognitive behavioral therapies, and the identification of coping behaviors. Following an incident of violence, a formal post-incident review can assist in determining the cause of the incident, which can then inform further therapeutic interventions (3).

4.2 Psychotic Violence

Psychopharmacologic Interventions

The positive symptoms of psychosis can lead to psychotic violence, particularly paranoid delusions of threat or persecution and command hallucinations (104). Such violence has been linked to excessive neuronal activity in the mesolimbic dopamine pathway and often responds to suppression of this dopamine overactivity (104). Standard doses of clozapine or other antipsychotics may be effective. If not, higher doses or antipsychotic polypharmacy may be considered (104). Specific medication and dose recommendations can be found in current pharmacological guidelines (16).

Psychotherapeutic Interventions

Some studies suggest that cognitive behavioral therapy effectively reduces violence among certain psychotic patients. However, a 2021 review of studies on non-pharmacological interventions to reduce the risk of violence in patients with schizophrenic spectrum disorders in the forensic psychiatry setting found that, due to methodological limitations, no firm conclusions could be made regarding effective non-pharmacological therapies (107). This review highlighted the need for studies that apply enhanced methods regarding study design, sample sizes, and outcome measures (107).

A higher ratio of psychiatric and general medical physicians to forensic patients has been associated with lower rates of psychotic violence (107). Although more research is needed to ascertain the mechanism behind this finding, having additional physicians may lead to more treatment planning, frequent direct patient engagement, evaluation, and risk assessment, thereby improving patient outcomes. More physicians could lead to implementing more early

interventions to prevent violence. The presence of an increased number of medical staff may also enhance a patient's sense of security, leading to less aggressive and violent behavior (107).

4.3 Predatory Violence

Psychopharmacologic Interventions

Patients with predatory violence may also have psychotic or impulsive violence. In such cases, treatment of psychotic or impulsive violence can lead to a resolution of other types of violence, but predatory violence remains. Current research indicates no firm evidence that predatory violence responds to any psychopharmacologic interventions when comorbid symptoms are well-controlled (104). There is one small case series study of nonpsychotic, severely psychopathic patients showing a reduction in violence with administration of clozapine (108, 109)

Psychotherapeutic Interventions

No non-pharmacological therapies have been shown empirically to decrease predatory violence. However, recent psychosocial approaches, such as the risk-needs-responsivity model, have provided positive preliminary treatment outcomes (110). Nevertheless, predatory violence is the most difficult type of violence to treat on inpatient units, and these individuals may victimize other patients and staff. Given that the risk of continuing to hospitalize individuals exhibiting predatory violence may outweigh the potential benefits, in non-forensic settings, discharge may be pursued. In addition, treatment teams may consider filing criminal charges as described below in section 5.2, "Legal Ramifications." When a patient is at an increased risk of predatory violence, moving them to a setting with increased security may be essential to mitigate the likelihood of violence and provide safety for others (110). In one forensic hospital, clinicians successfully advocated for a modification of statute to allow patients admitted for restoration of competence to stand trial to be transferred to a correctional facility who represent "a significant security, safety or medical risk" in a psychiatric hospital. (111) In 2015, Washington state lawmakers enacted a provision (RCW 10.77.091) to transfer insanity acquittees from a state hospital to a correctional setting whose safety risk is not manageable in a hospital setting. The challenges of such a policy were discussed by Piel and Goldenberg. (112)

5. Response to Violence

When violence occurs, forensic hospital staff must respond immediately to ensure the safety of patients and staff involved in the event. The interventions used, the approaches through which they are employed, and the response to the physical, psychological, and legal aftermath of such events also bear important consideration.

5.1 Restrictive Interventions

The use of seclusion and restraint to manage violent or self-injurious behavior in forensic hospital settings must be implemented carefully and judiciously and avoided whenever possible. In the 1990s, the Hartford Courant's investigative series delving into several restraint and seclusion-related deaths prompted intense national scrutiny of the practice and led to calls from several regulatory and professional organizations to reduce reliance on their use (113). In the United States, regulatory/accrediting agencies such as TJC and CMS set standards that restrict the use of restraints and seclusion to emergencies in which there is an imminent risk that the individual may physically harm self or others.

Contemporary forensic hospital practices favor a balanced approach to seclusion and restraint use that strives to prevent and reduce the use of seclusion and restraint as much as possible while recognizing that, at times, their use may be necessary to prevent imminent harm. Just as in other non-forensic settings, efforts to reduce seclusion and restraint use focus on enhanced programming and treatment options for patients, de-escalation training for staff, and de-briefing processes to enhance the ability to prevent such episodes in future care. Despite these efforts, forensic inpatient units are often faced with the challenge of treating patients who exhibit aggression that is refractory to less restrictive interventions. As a result, some use of restrictive measures may still be necessary. The NASMHPD Research Institute (NRI) collects such restraint and seclusion data from all states to develop national metrics that hospitals can use as a benchmark for comparison.

The use of seclusion or restraint is often thought to exist on a continuum ranging from least restrictive to most restrictive (e.g., 2-point, 4-point, 5-point restraint, etc.). Still, the perception of degrees of restrictiveness may vary depending on the patient and nature of the violence to self or others. Ethics considerations in this analysis are complex (114, 115). For example, 2-point ambulatory restraints (see below) are used in some states and seen as less restrictive, but in other states they are viewed as more restrictive and are not permitted (116, 117). In all cases, these containment measures must be discontinued as soon as the imminent risk is resolved and less restrictive alternatives for treatment and safe management of the patient are available.

There are no published standards from any professional organization or empirical literature regarding many practical safety aspects of restraint and seclusion implementation in forensic settings (e.g., the number of staff needed to initiate or observe patients while restrained). Nor is there significant comparative empirical literature exploring the relative safety of different staffing compositions. Instead, many commercially available and home-grown safety intervention strategies have been developed, all of which generally emphasize de-escalation techniques preceding the use of physically restrictive interventions, with each promoting its standard protocols without significant evidence base to support their merit over any other option. The authors have anecdotal evidence from their states regarding using video monitoring to record restraint and seclusion events to assess staff performance and ensure patient safety, but similarly, no published guidelines or evidence exists regarding best practices. This may be influenced by the variability of such available resources in different regions.

There is often the consideration of whether seclusion and/or restraint can be eliminated, and recent evidence from one state hospital system suggests this goal may be achievable (118, 119). Just as in all other inpatient settings, implementing seclusion and restraint should be used only as a last resort after all other attempts to therapeutically de-escalate and safely manage the patient's risk of violence and self-harm have been attempted. Experts suggest that the best practice is to teach direct care staff verbal de-escalation, mediation, and conflict resolution methods to better detect and deter aggressive behavior at earlier stages in the violence prodrome before it reaches a critical threshold (39). Other experienced professionals who support the ongoing use of physically restrictive interventions maintain that when a patient loses control and becomes

imminently dangerous to self or others, it is appropriate to use seclusion or restraint to maintain safety (120). Either way, systematic efforts and regulatory changes have dramatically reduced their use over the last several decades. Current literature continues to examine how to foster further trajectory toward their elimination while recognizing the balance that must occur to prevent violence and self-harm on inpatient units (121, 122).

Some things are clear in this complex landscape. First, seclusion and restraint should never be used as punishment or for staff convenience. Second, seclusion and restraint should consistently be implemented using the least restrictive methodology and only for the shortest duration necessary to manage the imminent risk of aggression; and third, psychiatrists can play an essential role in continuing to lessen this use (121). The psychiatrist ordering seclusion or restraint should be aware of regulations and policies regarding allowable duration in restraints, monitoring of restrained or secluded patients by a licensed practitioner, and monitoring of the patient's physical health during and after restraints/seclusion (123). Updated regulations continue to require these provisions, as well as the importance of debriefing staff and patients to learn more effective strategies to prevent their use in the future.

The exact means of restraining individuals range from physical holds (also called physical restraint) to using "mechanical" devices to restrict movement. Historically, patients were chained to walls or placed in very narrow "cribs" to restrict their movement (i.e., the "Utica Crib") (124). Today, there are multiple mechanical restraint devices that include metal or Velcro restraints placed around the wrists and ankles, as well as "soft" restraints comprised of rip-resistant cloth tied on one end to a fixed object and the other end to the patient. When a patient is restrained mechanically, forensic units may use restraint beds that can restrain the individual through fabric or leather restraint at various points of the body to a bed that is fixed to the floor. In addition, some institutions use "restraint chairs," which have seatbelt-like straps to hold an individual in place. Recent evidence in non-forensic hospital settings suggests potentially more beneficial safety outcomes with the use of restraint chairs (125). Still, these restraint chairs have also been associated with death and neglect in correctional settings (126) and can be considered "triggering" for patients that have experienced restraint chairs in correctional settings. Given the controversy surrounding restraint chairs, their use may be limited in state hospital settings.

In some circumstances, preventive aggression devices, also known as "ambulatory restraints," are used in state hospital settings (117). Such ambulatory restraints usually consist of arm and leg restraints connected to a waist belt that allows the individual to remain ambulatory while restricting the movement of their extremities to reduce the risk of violent aggression. However, even in the most extreme cases of violence, it is very challenging to justify the ongoing need for ambulatory restraints after the acute emergency has passed. In addition, once started, it is difficult to assess when it is safe to discontinue their use.

The term "chemical restraint" has been used to describe the practice of using psychotropic medications solely to sedate and restrict movement of aggressive patients (127). The practice of medicating patients over their objection solely to sedate them or restrict movement has been heavily criticized for failing to follow medical practice standards and doses and violating patient rights to be free from seclusion or restraint that is not medically necessary. If medications are used in an emergency over objection, they must be used in a way that is medically indicated to address symptoms, even if they have the side effect of sedating a patient. Even in these circumstances CMS and the Joint Commission require that all regulatory requirements for physical restraints be followed. Many hospital systems prohibit the use of psychiatric medications as a "restraint" and instead use other terminology to make that distinction (such as "emergency involuntary treatment"). CMS requires that patients not be exposed to "chemical restraints...that are not required to treat the resident's medical symptoms. (Ref 40, A-1566, §483.12(a)(2)). Instead, psychotropic medications are best used to treat the underlying causes of aggression (e.g., psychosis, impulsivity) rather than to restrict movement, sedate the patient, or for staff convenience.

The clinical use of mechanical restraints for transporting patients outside of the hospital is a domain unique to forensic units but is also an area where standards of practice have not yet been established. In criminal contexts, using mechanical restraint devices in transporting detainees, defendants, and prisoners to and from the court, outside appointments, and between correctional settings is standard practice. Nevertheless, the transportation of prisoners has been identified as one of the highest-risk situations encountered by correctional and law enforcement officers (128). Similarly, transporting forensic patients, many of whom have been transferred from

correctional environments, from the forensic hospital to the community is also a high-risk event, particularly if one is trying to prevent individuals from leaving without authorization. However, unlike in correctional environments, decisions regarding whether and how to restrain inpatients during transportation from the hospital are often not made by correctional staff. In contrast, in many jurisdictions, decisions regarding whether to mechanically restrain such patients are influenced or wholly decided by clinical staff. Such risk assessments are drastically different and more future-oriented and preventative than the typical clinical assessments made when determining whether to use a restraint/seclusion in a clinical environment because of a patient's imminent risk of harm. The benefits of clinically informed decisions must be weighed against the potential harms of misappropriating clinical tools to accomplish or justify what could be considered to be solely a security function.

To date, no professional organizations have proffered guidelines on using restraints during forensic patient transportation. Such guidelines presumably would focus primarily on the risk of leave without authorization, with the risk of violence as an additional but secondary consideration. In the hospital setting, where such decisions are often made or influenced by clinical staff, striving for objective mechanisms to determine when to employ restraint can be beneficial. In 2015, Dike et al. described a transportation risk assessment tool implemented at one forensic psychiatric hospital (30), while Wasser and colleagues delineated empirical evidence quantifying the impact of its use (129). However, given that this risk assessment tool is unique to one jurisdiction, it is unclear whether these results are generalizable or what the risk assessment tool's utility would be in other settings, especially those that use security rather than psychiatrists to make transportation restraints decisions. Many states and communities are establishing non-law enforcement alternative means of transportation of psychiatric patients, and there may be some lessons learned from this that will also impact forensic hospital practices(130). Additional empirical work exploring the impact of alternative risk assessment procedures may be helpful to guide national professional or regulatory organizations in developing practice guidelines in this area.

5.2 Legal Ramifications

When violence occurs in an inpatient forensic setting, there are many potential victims, with other patients and hospital staff being most likely impacted. Hospitals are responsible for keeping all patients safe from physical harm from their peers. Following an assault, interventions must be implemented to protect the victim's safety and legal rights. If the victim is another patient, the victim patient should be given the opportunity to pursue criminal charges if desired. The hospital must ensure such avenues are made available to the patient without influencing their decision to pursue such charges. Generally, if a patient decides to pursue charges, it is advisable to physically separate the aggressor from the victim (if possible) to reduce the risk of retaliation.

Amongst hospital employees, psychiatric nursing staff often bear the brunt of violent attacks from patients (131), which some, unfortunately, see as an occupational hazard (132). Despite the seriousness of some of the attacks, it has been previously described that in forensic settings, nursing staff are generally more sympathetic and forgiving when they perceive the assaults as secondary to an obvious psychotic process (38) or developmental disorder and much less so when they perceive the assaults as secondary to substance use or a personality disorder when the assaults are often considered volitional (38). However, one acute care civil hospital study found that staff were most likely to press charges against violent patients when their assailants were younger, had a criminal justice history, and had a psychotic illness (133).

There are significant and legitimate concerns about managing serious violence in a treatment environment and what steps are available to maintain staff safety. Just as with patient victims, the immediate concern is to ensure the physical safety of the staff victim and that they receive appropriate medical evaluation and treatment as well as psychological support. In the past, unit staff relied on the use of mechanical restraints, bed or ambulatory, to contain the patient for as long as was deemed necessary, leading to significant violations of patients' rights; for example, some were placed in ambulatory restraints for several months and even years at a time. With the implementation of important increased restrictions and scrutiny of mechanical restraints (123) and the elimination of ambulatory restraints by many institutions, such responses to patient violence are no longer permissible. Hospitals may, when feasible, choose to move staff victims

to a work location away from their aggressor, though staffing limitations and other considerations may preclude this option in some circumstances.

Once the staff member's physical and psychological safety is tended to, they may wish to pursue criminal charges against their assailant. When this occurs, hospitals are left balancing two important considerations – the staff member's right to freedom from bodily harm and the patient's right to privacy and need for ongoing care. Staff should be free to request that the police agency with relevant jurisdiction pursue criminal charges against the aggressor, and hospitals must be careful not to impede this process. However, the hospital and its staff (even the victim) continue to have a duty of confidentiality and a duty of care to the assaultive patient. All staff involved in the assault must be advised of this responsibility and limit their statements to police to their role as a fact witness (i.e., sharing only those facts that were physically observable during the assault). For example, staff may share that they observed the patient assault their co-worker. Still, they cannot share protected health information about the patient (e.g., diagnosis, medications, mental status, etc.) unless they received written permission from the patient or their legally appointed decision-maker or are directed to do so by a judicial order (134).

In practice, situations involving the pursuit of prosecution of psychiatric patients are often quite complicated. For example, some staff members frustrated with repeatedly assaultive patients, may encourage their physically assaulted colleagues to press charges against the patient hoping the patients would then be transferred to a correctional facility where the staff believe they belong. However, this goal may not be as easily accomplished as the staff may hope, as police may be reluctant to pursue criminal charges against psychiatrically hospitalized patients. Furthermore, prosecutors may be reluctant to proceed with criminal legal processes that would essentially move psychiatric patients to correctional institutions because they believe containment in a forensic hospital facility functions as treating the patient and protecting society.

Pressing legal charges against a patient also creates other challenges for the hospital facility when it forces hospital leadership to consider separating the assaulted staff members from the patient due to challenges in the adversarial relationship. Indeed, the staff assault and the resulting criminal action against the patient could rupture the therapeutic alliance between the patient and all staff members of the unit or even the forensic facility, depending on the size of the facility

(135). Moreover, sending a psychiatric patient to a criminal environment without appropriate transfer of care could lead to other problems, and the correctional environment may clinically not be appropriate for the patient, raising ethical challenges for the managing psychiatric clinicians and administrators at the forensic hospital. Finally, another type of legal issue can arise when a patient or family of a victim-patient sues a hospital for failure to keep their loved one safe. Additionally, oversight bodies that examine hospital practices including Protection and Advocacy, the Department of Justice, Occupational Safety and Health Administration (OSHA), and others may lean in and demand further review and remedy.

5.3 Debriefing

It is essential to support staff in these high-pressure environments; evidence shows that debriefing after a traumatic event helps manage stress (55) because it provides an outlet for distressing emotions. Yet, debriefing in its formal sense is not just about examining "what happened" it is examining "why" and what might be done differently to prevent such a thing going forward. The importance of unit leadership and supervisors participating in debriefing incidents, both informal and formal, cannot be overemphasized. Not only does this practice support the involved staff, but it also helps identify mechanisms for response optimization in similar incidents, identify and mitigate behavior patterns, and remove organizational barriers to future needs. If technologically feasible, anecdotal evidence from the authors suggests it may also be beneficial to use video recordings of assaultive incidents to conduct video reviews with involved staff and hospital leadership to enhance recall and walk through the event to better identify precipitants to the assault and discuss opportunities for improvement.

6. Special Issues

6.1 Neurocognitive Disorders

As our general population ages, the number of elderly individuals involved in the criminal justice system is increasing (136). Approximately 5-8% of individuals over 65 and almost 50% of individuals over 80 are diagnosed with a major neurocognitive disorder, and over 50% of patients with neurocognitive disorders exhibit aggression (137, 138). Neurocognitive disorders

cause dysfunction in brain regions involved in violence, executive functioning, emotional processing, sexual behavior, and self-awareness. These neurologic changes can lead to new-onset criminal behavior later in life (139). Aggressive behavior in this population is often caused by a mix of psychosis and impulsivity rather than predatory violence. A study of 99 elderly forensic evaluees found that 44.4% were diagnosed with dementia and 60.6% faced violence charges (136). Therefore, it is becoming increasingly crucial that forensic hospital providers understand how to treat aggression in the elderly forensic population.

The treatment of aggression in patients with neurocognitive disorders should begin with assessing the pattern, type, and severity of aggression and searching for any underlying causes. For example, complicated polypharmacy or an underlying infection can lead to delirium and worsening agitation. Untreated hearing loss can cause misunderstanding and confusion, and, in turn, aggression. Other potential causes of agitation in individuals with neurocognitive disorders include pain, sleep-wake disturbances, and underlying depression (140, 141).

Once underlying causes of aggression have been ruled-out, guidelines recommend that a comprehensive treatment plan be developed, including pharmacologic and nonpharmacologic interventions (16, 140). Nonpharmacologic interventions shown to reduce agitation include, but are not limited to, occupational activities, music therapy, bright light therapy, and touch therapy (142).

Pharmacologically, medications should generally be prescribed one at a time and titrated slowly to doses one-third to one-half of those used in young adults. The risk of under-dosing, especially in severe cases of aggression, must always be weighed against potential adverse effects from more aggressive prescribing (140). Given the U.S. Food and Drug Administration's black box warning that antipsychotics are associated with increased mortality when used to treat behavioral symptoms in older adult patients with dementia, some guidelines recommend that other pharmacologic interventions, such as selective serotonin reuptake inhibitors (SSRIs), carbamazepine, clonidine, or prazosin should be tried first (16, 143). Others argue that, given the limited data supporting the use of these medications, if the patient's aggression is severe or dangerous (as it often is in a forensic hospital), antipsychotics can still be considered an appropriate mainstay of treatment (140, 141, 144).

In the absence of delirium, guidelines generally recommend prescribing second-generation antipsychotic medications instead of first-generation antipsychotic medications. This is because studies evaluating a wide range of antipsychotic medications have found a higher risk of mortality with first-generation antipsychotic medications (16, 140, 144). However, effect sizes for both classes of antipsychotics are small, neither is clearly superior in managing agitation, and haloperidol may still have a role to play in emergent situations given its rapid onset of action relative to other intramuscular antipsychotics (140). When a standing antipsychotic agent is required, risperidone (dosed ≤1 mg/day), aripiprazole (dosed ≤ 12.5 mg/day), and quetiapine (dosed ≤ 75 mg/day) are recommended first-choice antipsychotic agents in patients with major neurocognitive disorders. These recommendations are based on data from randomized, placebo-controlled trials (140, 144). Caution is warranted when prescribing quetiapine, and even more so with olanzapine, given these agents' potential to exacerbate confusion (140, 144, 145). At the outset, a determination must be made regarding the patient's capacity to give informed consent to psychotropic medication treatment, and whether an alternative decision maker is needed to consent. Decisions around whether to medicate or what medications to administer in this population are complicated and require a nuanced balancing of the risks and benefits. These discussions may be better had with a court-appointed conservator of a person with medication authority if the patient lacks the capacity for consent.

The ultimate choice of antipsychotic agent should be driven by the agent's anticipated side effect profile for the individual patient. For example, patients with Lewy body dementia or Parkinson's Disease are at an increased risk of experiencing adverse effects from antipsychotic medications, including worsening motor symptoms and even irreversible cognitive decompensation or death (146). Therefore, if an antipsychotic medication must be used in this population, low doses of low-potency antipsychotics—specifically clozapine and quetiapine—should be used (16, 140, 145).

The American Psychiatric Association's Guidelines on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia indicate that antipsychotics should be tapered and withdrawn when a patient does not have a clinically significant response after a four-week trial (140). For severe, treatment-resistant cases of aggression in patients with major

neurocognitive disorders, combination therapy (with two antipsychotics or with one antipsychotic plus carbamazepine, citalopram, gabapentin, or prazosin) or electroconvulsive therapy (ECT) can be considered (1441, 145). Benzodiazepines and valproic acid should be avoided given their lack of efficacy, potential to worsen cognitive functioning, and other safety concerns (144, 145).

6.2 Intellectual Disability

Although only approximately 1% of the global population has an intellectual disability, individuals with impaired intellectual functioning exhibit higher rates of violent and criminal behavior (147), which can be related to multiple factors beyond criminogenic risks. Differences in study methodologies and diagnostic approaches have made it difficult to determine the proportion of criminal offenders with intellectual disability; however, intellectual disability is overrepresented in forensic mental health settings (147, 148). Although many of these patients have mild intellectual disability and mental illness, unmanageable aggression in intellectually disabled persons without a comorbid psychiatric disorder could be the sole reason for admitting individuals with intellectual disability into forensic hospital facilities. Individuals with intellectual disability in forensic hospitals have higher scores on structured risk assessments and higher rates of aggression, likely due to communication difficulties and poor impulse control (149, 150). Poor social and coping skills can also lead to mood dysregulation in this population (151).

Since individuals with intellectual disabilities may have difficulty communicating their needs, clinicians should carefully explore causes for behavioral changes or worsening aggression. For example, pain and discomfort (including constipation), unmet demands, and paradoxical reactions to medications may all contribute to agitation and aggression (151).

Numerous medication classes, including antipsychotics, antidepressants, mood stabilizers, benzodiazepines, and beta-blockers are used to treat aggression and other behavioral disturbances in individuals with intellectual disabilities. Studies have found that up to 85% of individuals in the general population with intellectual disability are treated with psychotropic medication. Although these medications are sometimes used to treat comorbid psychiatric disorders, they are also often used off-label to treat aggression or other challenging behavior

(152). However, prescribers should be cautious about the off-label use of psychotropic medications in individuals with intellectual disabilities, and tendencies toward unnecessary polypharmacy, given limited evidence regarding their efficacy. In addition, side effects can be more challenging to assess in individuals with an intellectual disability because of communication barriers. Further, patients with an intellectual disability have more challenges with routine medication monitoring, such as drug levels (147, 152).

For these reasons, non-pharmacologic interventions should first be considered when treating aggression in this population. The most widely used methods shown to reduce aggressive behavior in patients with intellectual disability include behavioral therapy, cognitive therapy, or a combination of the two (153). More specifically, cognitive behavioral therapy aimed at anger management, manipulation of the environment (nidotherapy) (154-156), structured teaching, person-centered planning, and behavioral skills training can be effective (141, 157, 158).

Although non-pharmacologic interventions should be considered first-line treatment for aggression in intellectual disability, the availability of specialized treatment programs may be limited in forensic hospital settings. In addition, when there is a risk of harm to others, especially when the behaviors are frequent and severe, pharmacologic interventions may be appropriate (152).

Antipsychotic medications are the most widely used psychotropic medications in individuals with intellectual disability. Most research has focused on second-generation antipsychotics in this population, specifically risperidone and aripiprazole. However, the majority of studies looking at the use of risperidone and aripiprazole have been in children or mixed samples (e.g., individuals with both intellectual disability and autism spectrum disorders) (152, 153). Other study limitations include concurrent use of other psychotropic medications, variations in the severity of the intellectual disability studied, and inconsistent measurements of aggression (159).

The limited research that does exist shows mixed evidence for the use of antipsychotic medications. For example, out of three randomized controlled trials looking at the effect of risperidone in adults with intellectual disability, two demonstrated a reduction in aggression. In contrast, risperidone was not superior to either placebo or haloperidol in the other (152, 159).

Research regarding the use of other second-generation antipsychotics is similarly limited, and it is difficult to draw definitive conclusions regarding their efficacy from the current literature (152, 153).

Lithium is one of the other most-commonly prescribed medications to treat aggression in individuals with intellectual disability. Although several randomized controlled trials suggest that lithium may be beneficial in reducing violence in inpatients with intellectual disability, methodological concerns regarding study design make it difficult to determine whether the improvements seen in these studies were significantly greater than placebo. In addition, even though other mood stabilizers are often prescribed to individuals with intellectual disability, the data on carbamazepine, valproic acid, and lamotrigine to treat aggression in this population are even more limited (152).

Like mood stabilizers and antipsychotic medications, beta-blockers may help curb aggression in individuals with intellectual disability; however, further research is needed (152). Benzodiazepines and SSRIs may also sometimes be beneficial. However, they may also have unpredictable and paradoxical effects on individuals with intellectual disability. Therefore, these medications should only be used very cautiously.

In summary, individuals with intellectual disability who exhibit aggression are a challenging population to manage in forensic hospitals. Although non-pharmacologic interventions are the mainstay of treatment, these treatments are often resource-intensive and unavailable. Therefore, forensic hospitals need further research to determine effective pharmacologic regimens and interventions.

6.3 Traumatic Brain Injury (TBI)

Traumatic brain injuries (TBI) are a major cause of morbidity and mortality, especially in young people (160). Approximately 10% of individuals in the general population have experienced a head injury with loss of consciousness, and approximately 1% of the U.S. population experiences long-term disability from a TBI (160-162). TBIs are strongly associated with criminality and violence; however, the directionality of the relationships between the two is complex. More specifically, those with a history of risk-taking may be more likely to engage in criminal

activities and activities that place them at higher risk for developing a TBI. TBIs are also known to compromise executive functioning and capacity for emotional regulation, leading to impulsivity, poor decision-making, poor social judgment, and difficulty suppressing aggressive urges (160, 161). As such, people with TBIs with violent behavioral patterns are prone to engage in impulsive or psychotic violence, but more likely, a mixture of both. Unless there are underlying other personality issues that remain intact, they are unlikely to engage in predatory violence, meaning the TBI itself does not generally lead to predatory type behavior.

Approximately 25% of patients in low and medium-security forensic units in the United States have a history of TBI with loss of consciousness; this number is even higher in maximum-security units (163). TBI is a greater risk factor for forensic hospital violence than a history of substance use or schizophrenia. In fact, 42.2% of forensic hospital patients with a history of TBI exhibit inpatient violence (163). TBIs have also been associated with increased suicide risk (164).

Even though TBI-associated aggression is a major cause of morbidity and poor social outcomes, few high-quality studies support the implementation of specific treatments to address violence in this population. Those existing studies vary in terms of time since injury, patient population, study design, and outcome measures (165, 166). General principles to consider when treating aggression in patients with TBI include avoiding medications that may increase confusion or exacerbate cognitive functioning (e.g., benzodiazepines or anticholinergic medications) or lower the seizure threshold (e.g., antipsychotic medications) when treating individuals at a higher risk of seizures (e.g., those who have a history of post-traumatic epilepsy, with focal neurologic deficits, or a penetrating injury). Given that patients with TBI may be more sensitive to medication side effects, patients should be monitored closely after new medications are started (166). Guidelines also recommend that medications be continued at maximally tolerated doses for a full trial (i.e., 4-6 weeks) before being deemed ineffective and discontinued (16, 166).

Based on the limited data, the medications that show the most promise in reducing violence in individuals with TBI include centrally acting beta-blockers (e.g., propranolol and pindolol), mood stabilizers, methylphenidate, amantadine, and atypical antipsychotics. However, additional research is needed to draw firm conclusions about the efficacy of each of these medications in

reducing violence in individuals with TBI. Within the class of mood stabilizers, valproic acid has the most evidence for reducing aggression in this population. Small studies additionally support the use of carbamazepine. However, lithium should be used cautiously, if at all, given concern regarding neurotoxicity, especially since there are limited efficacy and safety data for use in this population (162, 166, 167). Finally, because antipsychotic medications can lower the seizure threshold and lead to cognitive delays and more severe motor effects in individuals with TBI, some experts recommend reserving this class of medications for refractory aggression, especially given the limited evidence supporting their efficacy (165-167).

Nonpharmacologic interventions that may reduce aggression in individuals with TBI include cognitive behavioral therapy, relaxation-based therapies, exposure-based treatments, behavioral interventions, and skills-training programs. However, like pharmacologic interventions, more research is needed into each of these approaches before definitive recommendations can be made (167).

6.4 Management of the Seriously Violent Patient

The role of forensic facilities, especially maximum-security units, includes the admission and management of individuals whose level of violence cannot be managed in regular psychiatric hospitals or who have a history of extreme violence that raises concerns about their future risk. But even maximum-security units may not be equipped to manage certain classes of seriously violent individuals. Severe violence could be a byproduct of psychosis, developmental disorders, substance use, personality disorders, or a combination of these and other factors.

Among those patients that engage in violent behavior, a subset of "extreme offenders" are especially violent and account for most of the violence seen on inpatient units and the most serious injuries (168). These patients inflict severe injuries at a rate ten times greater than other violent patients. In one study, for example, only 5% of patients accounted for approximately half of the violent behavior and more than half of the severe injuries (169). Recidivist violent patients can be of either gender. Convit and colleagues found that women who displayed this repeatedly violent behavior were more likely to present with an organic brain disorder or personality disorder than non-recidivist women (169). Recidivist men, however, more often carried the diagnosis of schizophrenia than did non-recidivist men (169).

Staff might feel that serious predatory violence would be better managed in a correctional facility than in a hospital. Some state statutes support this view. For example, a provision in Connecticut statute (CGS 54-56d(p)) allows a patient admitted for competency restoration to be transferred to the Department of Correction's custody when the hospital determines that the individual's aggressive behavior has outstripped the facility's ability to manage it (111). However, there is no such statute for patients with similar aggressive behaviors admitted for reasons other than competency restoration. This disparate response to serious violence based on the legal status of admission and not on the behavior itself raises interesting questions. At the same time, for patients who are significantly behaviorally dysregulated due to illness, a hospital provides a more therapeutic setting than a jail. Thus, other states, such as Massachusetts, allows for the transfer of certain inmates to a state hospital (MGL c. 123, s. 18(a)) for care and treatment.

Forensic facilities are challenged to develop strategies for managing extreme violence. Some strategies include milieu management, pharmacological and psychological interventions, and rehabilitative therapy services such as physical and occupational therapy (31, 38). In addition, the use of facility police or security staff as adjuncts in managing aggressive patients, though controversial, could be considered in some circumstances.

It would be prudent to place patients with a high risk of serious violence in single rooms to decrease sources of provocation and remove targets for violence. In addition, it could be necessary to dedicate a large area or even a section of the unit to the patient (complete with a dedicated bedroom, tv/music room, and bathroom), depending on the severity and frequency of physical assaults. Such patients may also require constant observation by one or two staff to observe and respond to increasing agitation or to respond quickly to behavioral emergencies. The risks of such intensive observation include overstimulating the patient, potentially increasing the risk of violence and the drain on staff resources.

Security Rounds and Posts

When all interventions to manage serious violence fall short, some clinical administrators have considered instituting frequent rounds on units by hospital security personnel or police, hoping

that the presence of security staff on the unit would discourage aggressive patients from acting out. Some administrators have considered formally assigning a security or police presence (post) on all shifts (38), like hospitals assign nursing staff. This practice is not without its opponents, as 'hardening' facilities and making them appear more correctional with security staff can be seen as opposing recovery principles and anti-therapeutic. In addition, security personnel need careful training and clarity of role and responsibility. The presence of hospital security or police on the unit may be counterproductive by increasing agitation in patients with negative perceptions of or history with the police, which could escalate to more violence. In summary, the presence of hospital security or police on the unit could be reassuring to staff, who may see this as an indication that the hospital administration is taking their concerns seriously, but their presence may present other problems leading to coercive treatment strategies, interfering with patient rights and role confusion.

The presence of police officers can be necessary in situations where a patient poses an "active threat." The U.S. Department of Energy defines active threat or an active threat incident as a dynamic, quickly evolving situation involving an individual (or individuals) using deadly physical force, such as firearms, bladed weapons, or a vehicle (170). The individual or individuals present an imminent danger to people by displaying a weapon, making threats, and showing intent to cause harm or engage in violence (170). Interestingly, TJC has not taken any position on the presence of police or on whether police should be allowed to use their weapons in a hospital but has encouraged hospitals to make decisions as appropriate for them (see https://www.jointcommission.org/standards/standard-faqs/critical-access-hospital/environment-of-care-ec/000001210/). Though not specific to forensic hospitals per se, the American Psychiatric Association similarly took a position offering caution about security presence in some clinical settings with regard to weapon use (171).

As noted above, it is important to define roles at the outset when security or police are present on the unit. Staff members are generally responsible for de-escalation and other interventions to manage aggression. It is important for staff members to take this role because staff de-escalation and restrictive intervention training—unlike standard law enforcement training—should be rooted in therapeutic principles and trauma-informed care. In other words, it is essential to maintain a clinical orientation and approach. Involvement of police or hospital security could

escalate the situation and lead to a worse outcome, as using force to subdue the patient instead of de-escalation could lead to serious injury to the patient or others.

However, in those active threat situations where a patient brandishes a weapon (such as a shank or other sharp object) intending to hurt themself or others, hospital security or police could step in to manage the incident and restore safety in those facilities that have protocols for this type of intervention. Staff training should include specific actions to take during these situations to decrease confusion and ensure clear communication between staff and security/police. As there are movements to reduce security and police presence to ensure the least restrictive interventions, many forensic hospital systems do not have police presence on the units, though they may have specially trained aids to help with the more significant violent acts. The management of security issues therefore varies across sites. Psychiatrists working in secure hospitals should familiarize themselves with protocols for managing all levels of aggression, and the facility's protocols for engaging security or prohibiting that engagement absent a very serious incident such as an active shooter.

6.5 Access to Media and Institutional Media Policies

Access to media (e.g., mainstream films with violent themes, video games, pornographic material, etc.) is a broad topic related to violence within forensic hospitals. There is a paucity of conclusive literature about how media might contribute to the risk of violence in these settings. However, one study found a decreased incidence of aggressive behavior following the removal of Music Television from patient viewing (67). Numerous studies examine whether media contributes to violent behavior in society, but results frequently lead to more questions and uncertainty than definitive answers (172, 173). Some argue that increased access to various forms of media in a forensic hospital setting increases the focus on recovery and improves the ability to therapeutically address media utilization in accordance with societal norms (173). Others note that adaptive media consumption can enhance coping and overall sense of well-being and, in some jurisdictions, is framed as a patient rights issue (173-175). Still, others express concern about the contribution of violent media, pornography, and violent video games to antisocial attitudes, interpersonal callousness, and objectification, as well as to the potential to create a treatment environment that is abusive to staff or reinforces misogynistic themes within

what is often a male-dominated environment (174). Given these varying formulations and considerations, there is a broad diversity of practices across jurisdictions (176). While much work is yet to be done regarding what constitutes best practice, particularly regarding violence reduction, some guiding principles are noted below.

Milieu Integrity and Therapeutic Management

Policymakers should consider the impacts of regulating media as it relates to commodifying media items within the facility. Clinical experience indicates that possession and trading of contraband materials, as well as a scarcity of approved materials (e.g., limited TV or game system time, scarce pornographic library, etc.), can lead to violent conflict. Therefore, mechanisms should be in place for educating patients about media policy, therapeutically managing policy violations, and arbitrating patient conflicts over limited resources.

Media Content

Media that depicts physical aggression, gore, or sexual violence ought to be closely scrutinized in concert with individual patient history and vulnerabilities. Media ratings may be helpful guideposts, but some facilities may employ a media review panel for vetting novel or unique material.

Legal Stakeholders

Any media access policy should address the legal constraints present in any given jurisdiction. For example, some jurisdictions may place statutory constraints on individuals as a function of their civil commitment, or probation or parole, particularly for those with histories of sexual violence (177).

Individual Risk Factors

Robust risk assessment of both the general risk of violence and the specific risk of sexual violence is key to identifying individual factors that may inform the phase of treatment in which clinical discussions of media access should occur and the content of those discussions.

Substitute Decision-Makers

Court-appointed guardians/conservators and other decision-makers may have particular insight into patient-specific vulnerabilities for violence related to media consumption.

Person-Centered Approaches

Policies should emphasize maximizing respect for persons and human dignity (both for patients and non-patients) in crafting individualized support for patients' media consumption. These supports may take the form of media restrictions but need not be employed in a punitive fashion. Restrictions framed as punitive may serve to increase the risk of violence.

Safety Features

Particularly for gaming devices, consideration should be paid to how devices might be utilized to harm self or others. They may require mechanical or storage features to deter tampering. Hospital staff may need to examine parts of the devices, such as controllers or games, to ensure their safe use. It is also worth noting that most modern gaming devices come with internet capabilities. Proper technical restrictions should be implemented to prevent using these devices for inappropriate or unauthorized internet access.

6.6. Strategies for Psychiatrist Recruitment and Retention

Projections published in 2018 estimated that up to 55% of the total psychiatric workforce will retire by 2028 (178), a number that will exceed the number of incoming psychiatrists during that period by a factor of two. Retirements and other workforce losses will not be exceeded by newly certified psychiatrists until around 2025 when the large cohort of retirees will have left the workforce (178). This workforce contraction is not expected to reverse for several years, adding to the already difficult challenge of replacing absent providers.

Hiring psychiatrists to work in forensic facilities is generally challenging because the word "forensic" can sound scary to many otherwise experienced and capable psychiatrists. Psychiatrists who work in these settings do not need to be fellowship-trained forensic psychiatrists. However, they should have ready access to forensic psychiatrists for consultation, risk management planning, and other clinical-legal issues. Potential psychiatrist recruits may be

found through a variety of search options. The best recruitment sources may be residency training and fellowship programs known to a recruiting psychiatrist, either through their clinical privileges or a teaching appointment. These psychiatrists-in-training will learn of any open position directly, and the recruiting psychiatrist will, in turn, have the opportunity to conduct an informal professional appraisal that will likely be much more informative than that gained from an interview or a reference. Psychiatrists should make a concerted effort to include medical students and undergraduates for job shadowing, as familiarity with the system decreases concerns and encourages a desire to work in the setting after medical school and psychiatry training.

Advertising is another method of searching for recruits. Advertising in professional journals may reach a more targeted audience and provide a good return on a modest investment. Job boards and postings are other options, though anecdotal experience suggests that the yield is low. Professional recruitment agencies are likely the most expensive means of advertising for a psychiatrist and come in two primary forms: contingency and retainer. Contingency firms take the position's details, execute a contract, and begin a search. They are paid based on making a successful referral, with payment usually due upon signing the employment contract with the recruited provider. On the other hand, a retainer firm receives advertising fees upfront or on a scheduled basis, with only a modest fee, if any, upon finding a successful recruit.

Recruitment agencies may pose a dilemma to state-run forensic institutions because of their usually tight budgets. State officials may not understand the effort and expense required to find and sign a good provider, and state hiring and purchasing rules may set limits on the amount of money that can be paid; any request for a higher amount would conflict with expense regulations (and involve significant bureaucratic maneuvers). Furthermore, since the market is tight and competitive, a recruiting firm may see little benefit to working with forensic hospitals hampered by such rules, as they will likely find a quicker and more profitable deal in private establishments.

The challenge with recruiting allied health practitioners is very similar to that of psychiatrists, and there are headhunting firms that specialize in recruiting nurse practitioners and physician

assistants. Similar to recruiting for psychiatrists, there is often no better recruiting tool than a student rotating through the facility who becomes comfortable working in that environment.

7. Regulatory and Oversight Issues

Forensic hospital facilities must manage violence in accordance with laws and regulatory agencies. Because hospital violence is increasingly a focus of concern, state and federal entities have taken numerous actions and provided resources aimed at ensuring safe workplaces and adequate care within institutions regarding patients who pose a safety risk.

The Occupational Safety and Health Administration (OSHA), a federal agency, is part of the U.S. Department of Labor. Local OSHA representatives work with state hospitals to help ensure that workplace safety has been sufficiently addressed. OSHA and its state counterparts can cite hospitals that neglect workplace safety under its General Duty Clause as provided for in Section 5(a)(1) of the Occupational Safety and Health Act of 1970 (179). The General Duty Clause requires employers to provide a place of employment that is "free from recognized hazards that are causing or are likely to cause death or serious physical harm" (179).

At a state level, there are many vehicles for monitoring and providing oversight of activities within state hospitals. These include quality assurance activities, formal investigations, and complaint and grievance processes. Typically, policies delineate how hospitals need to work through identified problems. In addition, medical staff bylaws and governance structures are put in place to monitor staff performance.

Patient rights staff (sometimes referred to as "patient advocates" or "recipient rights officers") hired by the hospital, or under some governance of the hospital or the state, offer another opportunity to examine the practices of staff or particular trends and situations that might reflect patient abuse and neglect. Disability Rights organizations also have important powers, including the right to review patient records and to investigate allegations of abuse, neglect, or rights violations for individuals with certain disabilities, including those who reside in forensic hospitals receiving care and treatment. Disability Rights organizations are separate from "patient

advocates" but provide external scrutiny that can bring problematic practices to the facility's and the public's attention. They also can litigate against forensic hospitals when they believe there are abuse, neglect, or rights violations.

The Civil Rights of Institutionalized Persons Act of 1980 (CRIPA), (180) is a U.S. federal law intended to protect people in various institutions, including public correctional and mental health facilities. Through CRIPA, the Department of Justice can ensure that public correctional and mental health facilities provide reasonable safety for their patients, such as safe physical conditions, attention to persons with disabilities, appropriately limited use of restraints and seclusion, and safe medical care and practices (180).

Not all forensic state hospitals are certified or accredited by TJC. For accredited institutions, TJC sets standards that must be followed to maintain accreditation. In 2021, TJC published new and revised workplace violence prevention standards that went into effect in January 2022. The details of these standards are beyond the scope of this Resource Document but include requirements such as the development of a workplace violence prevention program, continuous monitoring and investigation of safety and security incidents, and training on de-escalation and intervention techniques (181). As a national accrediting agency, TJC accreditation is often relied upon as evidence of meeting Medicare and Medicaid requirements. TJC works closely with CMS, using CMS standards in formulating TJC hospital performance measures (180). When facilities receive CMS funding, additional standards must be followed. TJC has been granted deemed status by the CMS, which means TJC's standards meet or exceed the CMS Conditions of Participation (183). Some states have "de-certified" or "taken offline" certain units from CMS certification, which allows these units to practice outside of such federal regulations. This may mean different approaches to seclusion and restraint, for example. This can be controversial, as the CMS standards are intended to uphold current national practices for the hospital level of care.

8. Ethics Issues

In a forensic hospital, there are two aspects to psychiatric practice: treatment and forensic evaluation (184). Ethical considerations vary for each situation, but both introduce a third party – the court or an administrative body – into the traditional doctor-patient relationship. A treating forensic psychiatrist has a primary ethical duty to the patient but also an obligation to a third party. For example, when court ordered to complete a status report, regardless of patient consent, the treating psychiatrist must weigh what information is necessary for the court versus what is confidential and should be protected.

The responsibility to multiple third parties and the complex ethical dilemmas that arise as a result, both for the treating psychiatrist and institution, are evident in a forensic hospital than when considering violence perpetrated by a patient. When such violence occurs, the psychiatrist and hospital leadership must consider the safety of the victim (patient or staff), other potential victims, and the aggressive patient's best interest and treatment needs. Balancing these competing interests is challenging, complicated, and rife with a multitude of pressures from hospital staff and administrators, patients, regulatory agencies, and disability rights groups (amongst others). Helping staff victims navigate their competing rights and responsibilities in the face of a patient assault, as discussed in section 5.2, is just one of many potential examples of these competing ethical responsibilities.

Although the American Academy of Psychiatry and the Law has developed Ethics Guidelines for the practice of forensic psychiatry (185), these guidelines do not provide guidance specific to this domain (nor does any other professional society's ethics guidelines). Thus, forensic psychiatrists working in such settings may be left to work through these challenges alone. The authors advise seeking guidance from existing supervisory structures within one's hospital, legal and risk management consultation, and peer support groups as potential avenues to carefully consider these dilemmas when they arise (185).

In forensic psychiatry, the term "forensic countertransference" (1864) refers to the strong emotional reactions a psychiatrist may experience working, for example, with patients in a forensic hospital who may have complex histories of violence. This countertransference can

become further heightened when a patient engages in violence against other patients, hospital staff, or the psychiatrist themself. Psychiatrists working in a forensic setting should be especially attentive to negative emotions or other factors that could influence their interactions or treatment recommendations for particular patients. Psychiatrists may seek supervision, consultation, or personal psychotherapy to help them strive to identify and appropriately manage their countertransference reactions. Psychiatrists unable to control their reactions should consider speaking with their supervisor regarding available options, including potentially reassigning care of the particular patient, if feasible.

Conclusion

This practice resource presents the best, currently available recommendations for the prevention and management of violence in forensic hospitals. It provides a broad overview of not just the assessment and treatment of aggression in individual patients, but also environmental, staffing, and regulatory factors that may mitigate or exacerbate violence risk hospital wide.

As described in the introduction, state hospital populations are becoming increasingly forensic. As a result, forensic hospitals are now focused on managing not just severe mental health symptomatology, but complex violence and criminogenic risk factors, as well. However, standardized risk assessments, ethical guidelines, and evidence-based treatment recommendations specific to this population are underdeveloped. Forensic hospitals are therefore left trying to apply practice guidelines for civil patients to this new population. Although these guidelines may be helpful, studies to validate these practices in forensic hospitals are lacking, and the recommendations may be difficult to implement given operational and regulatory differences between the settings. Therefore, although this practice resource helps to bridge this gap, additional research is needed.

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