

## APA Official Actions

# Position Statement on Weapons Use in Hospitals and Patient Safety

Approved by the Board of Trustees, July 2018  
Approved by the Assembly, May 2018

“Policy documents are approved by the APA Assembly and Board of Trustees. . . . These are . . . position statements that define APA official policy on specific subjects. . . .” – *APA Operations Manual*

### Issue:

The Joint Commission reports that occurrences of armed violence have increased in the clinical and public spaces of hospitals.<sup>i</sup> Hospitals are designed as therapeutic environments. The vulnerability of many hospital patients and the need to be responsive to staff safety highlights the importance of maintaining a safe and secure environment. One study of hospital-based shootings identified 154 such incidents between 2000 and 2011.<sup>ii</sup> Contrary to the impression sometimes created by media reports, only 4% of these shootings were perpetrated by patients with mental illness. In most cases, the circumstances raised questions about hospital policy and practice. For example, in 18% of the cases, perpetrators obtained the firearm in the hospital. On 13 occasions, the shooting event was initiated by the perpetrator taking a security or police officer’s gun.

Further indirect evidence of the scale of the problem derives from data describing violence against hospital staff. Healthcare workers are at an increased risk for workplace violence. Eighty percent of violent incidents in hospitals are by patients on staff. Incidents of serious workplace violence (requiring days off work) are four times more common in healthcare settings than in private industry. Psychiatric aides experienced the highest rate of violent injuries in 2013 at approximately 590 injuries per 10,000 full-time employees. This compares to a rate of 4.2 injuries per 100,000 employees in U.S. industries as a whole.<sup>iii,iv</sup> Despite these statistics, the use of weapons by staff in hospitals warrants particular scrutiny and demands specific safeguards. When patients present with behavioral dysregulation, clinical responses are to be distinguished from security responses.

### APA Position:

**The American Psychiatric Association does not support the use of weapons<sup>1</sup> as a clinical response in the management of patient behavioral dyscontrol in emergency room and inpatient settings because such use conflicts with the therapeutic mission of hospitals. Weapon use by properly trained and authorized law enforcement personnel will occasionally be necessary to deal with armed individuals**

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<sup>1</sup> Weapons are here defined (as they are also defined in the CMS State Operations Manual: CMS. State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals Section 482.13(e) [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_a\\_hospitals.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf)) as "includes, but is not limited to, pepper spray, mace, nightsticks, tazers [sic], cattle prods, stun guns, and pistols."

to ensure the safety of patients and the public. However, recent reports have described situations where clinical staff failed to use appropriate clinical responses to psychiatric patient violence, weapons were used, and patients were harmed.<sup>v,vi</sup> The routine management of patient violence risk is a clinical task that should be properly resourced. Weapon use is not part of routine clinical management.

Clinical staff are not trained to decide when weapons should be used, and weapons do not have a role in clinical patient care, especially when that care involves restraint or seclusion of a patient.<sup>vii</sup> Measures known to reduce the need for weapon use are available. Hospital security personnel, the police,<sup>viii</sup> and clinical staff should receive regular training in safely managing and de-escalating agitated, disruptive, and violent patient behavior. Clinical staffing levels should be sufficient to ensure that weapon use by security staff to respond to patient violence is a last resort. Medication usage, in management of violent patients, is complex, requires psychiatric input,<sup>ix</sup> and remains the subject of ongoing research,<sup>x, xi</sup> but it has the potential to be an effective therapeutic tool. Seclusion and restraint reduction strategies used in clinical settings should be sensitive to issues of trauma among patients and staff.

The following steps are suggested to reduce weapon use overall by staff in hospitals when dealing with behaviorally disturbed patients<sup>xii</sup>:

- a) Hospitals should minimize the unauthorized presence of weapons on their premises. Where appropriate, these steps should include screening patients for weapons before admission to psychiatric emergency rooms and/or psychiatric inpatient units and where appropriate, screening patients assessed to be at high risk to others prior to admission to non-psychiatric inpatient units.
- b) Patients who pose a risk of harm to others should be managed by clinical staff using clinical approaches. These usual clinical approaches will typically involve psychological interpersonal interventions and may include, when less restrictive alternatives fail, the use of involuntary emergency medication, physical seclusion, and physical or mechanical restraint, following guidelines issued by The Joint Commission and CMS. If hospital security staff acting in a clinical capacity are needed to assist during an incident of patient violence, the particular security staff should have been trained in clinical approaches, and the chief clinician present should remain in charge of the usual clinical response to patient violence incidents. This clinical response does not involve the use of weapons.
- c) Hospital clinical staff and security staff acting under the supervision of clinical staff should receive regular training from the clinical perspective in safely managing the risks posed by patients who present with agitation and are disruptive and engaging in escalating behavior. Cross-training by security can help staff be prepared for more significant acts of violence.
- d) Hospital administration should ensure that clinical staffing levels are sufficient to facilitate proper approaches to the management of patient violence risk in order to resolve the great majority of behavioral incidents.
- e) Weapons should never be used by clinical staff or hospital security staff acting in a clinical capacity as a means of subduing a patient, or in placing a patient in restraint or seclusion or otherwise managing violence risk.

- f) **Hospitals should have a policy in place to define when clinical control of a situation is being ceded to law enforcement or hospital security staff acting in a law enforcement capacity for management of patient violence. This might occur when there exists an imminent risk of life-threatening injury that cannot be managed using the usual clinical response (e.g. active shooter situations involving a patient). Critical incident reviews should be conducted following such episodes.**

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- v 579: My Damn Mind, Prologue and Act One, This American Life, February 12, 2016, <https://www.thisamericanlife.org/radio-archives/episode/579/my-damn-mind> accessed 09/20/2017)
- vi Rosenthal E: When the Hospital Fires the Bullet. *New York Times.* February 12, 2016. <http://nyti.ms/1LkEjW> accessed 09/20/2017)
- vii CMS. State Operations Manual Appendix A Survey Protocol, Regulations and Interpretive Guidelines for Hospitals Section 482.13(e) [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_a\\_hospitals.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf) accessed 9/20/2017
- viii We recognize that some state and federal hospital facilities use sworn police officers as part of their routine security force. Such sworn police officers need special training in dealing with agitated, disruptive or threatening psychiatric patients, and should not respond with weapons as a usual clinical response.

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- 12 Hospitals in this document do not include correctional hospitals.