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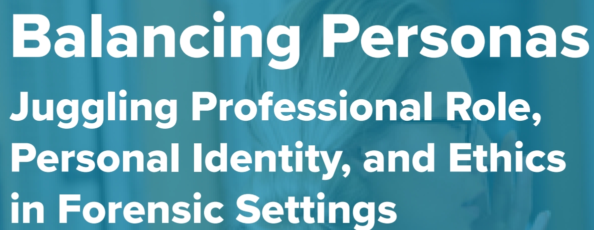

Balancing Personas

Juggling Professional Role, Personal Identity, and Ethics in Forensic Settings

Ethics

Forensic healthcare workers straddle two different ethical worlds. They strive to provide quality treatment to people who have SMI and also to function as agents of the judicial system.

Clinical forensic ethical concepts are still developing, and this list is not exhaustive. Yet here are common ethical dilemmas a healthcare worker may encounter in forensic settings.

Dual role – Restricting a person's liberty inherently poses ethical challenges. There are also tensions between community protection and the welfare of the incarcerated person (role clash). Within forensic settings, there's an inherent tension and potential conflict between the security of the facility (staff safety, patient safety) and patient clinical needs. Another duality is forensic evaluation vs. care delivery (e.g., conducting forensic evaluations for the purpose of answering a psycholegal question vs. clinically assessing a patient for the purpose of informing daily treatment decisions).

Confidentiality – Most codes of ethics emphasize confidentiality in physician-patient relationships. However, maintaining it in correctional institutions and forensic settings can be challenging. Confidentiality often may be superseded by security concerns.

Duty to warn – In most jurisdictions, there are situations where breaching confidentiality is necessary. Examples include when a child is in danger or when a person threatens bodily harm to a third party. Some jurisdictions have mandated reporting, whereas others are discretionary. It is important to assess the viability of the threat (i.e., Is this person in custody for the foreseeable future? Could they carry out this threat using other means?)

Reports of victimization – Peer assaults and victimization may place healthcare staff in complicated situations. They involve the need to weigh the risks to the victim (if no action is taken), deliberate on the overall safety of the facility, assess whether the victim wants to press charges, and determine whether the perpetrator can be safely moved elsewhere within the facility. Staff must also consider retaliation by peers if the victim was the one who originally alerted staff.

Disciplinary responsibility – Healthcare workers in forensic settings may be asked to provide input when a patient receives a disciplinary infraction or engages in dangerous behaviors, such as staff or peer assaults. This creates tension because staff are typically focused on the clinical care of patients, and staff may be put in the position of informally opining on criminal responsibility.

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Moral Injury

Moral injury is a form of psychological distress. It is primarily characterized by feelings of guilt and shame that can arise as a result of perpetrating, witnessing, learning about, or failing to prevent an act that defies an individual's own moral values. Moral injury is a source of stress and potential burnout for healthcare workers in forensic settings.

Subtypes

1. Between profession and system (e.g., restrictive context of forensic and psychiatric care, working in a medicalized system, cultural attitudes toward staff and patients)
2. Between relations with patient and relations with others (e.g., conflict between moral and loyalty to coworkers/institution, interpersonal conflict, power dynamics between the patient and others)
3. Between principles and practices (e.g., restrictive and coercive practices, balancing act between safety and ethical care, witnessing inadequate treatment of patients by colleagues)

Factors that Impact Workplace Culture

1. **Psychological safety and trust** – A climate of mistrust and blame can create a fear of reprisals or repercussions. This may ultimately prevent open dialogue, inhibit the capacity to learn from mistakes, or undermine the willingness to take reasonable risks.
2. **Siloing** – Splits between different groups within a service may create a sense of "us vs. them" and competition for resources and recognition.
3. **Passion for the job** – Having a strong sense of pride and commitment to work positively impacts workplace culture.
4. **Service structures** – Systems issues such as resourcing, technology problems, and poor support can be a source of frustration and impede work efficiency. Problems with working with external agencies often add to workload and redundancy (e.g., reducing system issues would have a positive impact on workplace culture). Positive culture can be promoted with leadership support, staff recognition/ appreciation (gift vouchers, awards, praise), and listening to the line of care staff's opinions.
5. **Staffing** – Staff shortages and slow recruitment negatively impact work culture.

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Team Dynamics Effects on De-Escalation

Psychological skills

- **Relationship building** – Staff engagement in personal disclosure and consistently meaningful interactions is key to building the trusting relationships necessary for de-escalation. Patients value honesty and directness during periods of escalation. Staff equivocation or avoidance of personal responsibility for bad news may further patients' suspicion and frustration
- **Emotional skills (self-regulation, empathic attunement to patient) and understanding the escalating person** – It is crucial for staff to remain attuned to both their own and patients' needs during potential violent incidents. Acknowledging one's own vulnerability can stimulate empathy in escalating patients. Staff psychological distress is linked to prolonged emotional suppression at work. Patients may feel that staff are more likely to "medicalize" the behaviors of patients with psychotic disorder diagnoses and hold stigmatizing beliefs that those patients are more dangerous.
- **Behavioral regulation (Debriefing and collaborative de-escalation planning)** – Post-event debriefs are imperative because they aid staff in processing traumatic incidents.

Social influences

- **Formal power structures as barriers** – Power imbalances act as a barrier to successful de-escalation. A primary example is when patients are excluded from decision-making about medication.
- **Ward manager role-modeling** – Staff need support, recognition, and modeling of vulnerability fromleadership.
- **Informal power structures as barriers** – Staff may present a negative bias towards "non-regulars" (i.e., non-regular staff, students, multidisciplinary team (MDT) professionals). More experienced staff may heavily influence culture. In addition, more experienced staff may foster a culture that harbors "contempt for vulnerability," which further psychologically distances staff from patients.

Environmental context and resources

- **Physical environment** – Claustrophobic ward environments and other resource limitations (e.g., no open access to de-escalation or seclusion rooms) may further hinder de-escalation attempts.
- **Resourcing** – Low permanent staffing numbers affect staff capacity for de-escalation and potentially pose a barrier to staff engagement with patients.

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