Managing Risk and Recovery: Redefining Miscibility of Oil and Water

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Recovery is becoming a dominant emphasis in mental[1] as well as in physical[2] health care. It calls for deliberate collaboration by clinicians with patients as empowered service consumers.[3,4] As a model for mental health care, recovery emphasizes a holistic rather than a purely therapeutic approach and focuses on the broader concern of the patient's quality of life rather than the narrow tableau of symptom reduction. It strives to prioritize the wishes of the patient and that individual's autonomy.[5] A large international survey of patients, professionals, caregivers, and advocates involved in institutional mental health care identified 11 elements as being essential to care. Their rankings of these components showed a strong consensus supporting the recovery model, beginning with quality of treatment and supportiveness of staff members and including human rights, self-management and autonomy, and institutional environment.[6] These striking results challenge once-dominant paternalistic values held by clinicians.

The change is most obvious on the inpatient psychiatric unit, where patients are expected to conform to the rules and dictates imposed on them. In the past, their consent to treatment, let alone their collaboration with clinicians, seemed irrelevant, since they were hospitalized for treatment of illnesses that were seen as compromising or even precluding their capacity to give such consent. Upon admission they relinquished considerable autonomy automatically, including their property rights and freedom of movement, association, and even of scheduling their time and choosing their food.

No more. Psychiatric inpatients are expected to take an active role in determining many key aspects of their treatment and their environment. From the day of admission they are called on to articulate their goals and expectations, prioritize their listing of problems, and collaborate in working toward their expeditious discharge. They are expected to weigh in on the selection and evaluation of treatment modalities, particularly medications. Caregivers no longer ask so much whether the patient is following articulated medication regimens. Rather, the question is whether the medications are delivering what the patient wants from them.[7] Reflecting this, the patient is beginning to disappear from the literature authored by some professional groups, replaced by the consumer.

Such developments as these are now the well-recognized, widely accepted, and generally approved results of the so-called recovery movement in psychiatry.[8,9] Although this recovery model is fitted to and considered efficacious in the civil inpatient setting, it remains out of place in the forensic inpatient unit. Of necessity, the restrictions and limitations imposed on the patient's autonomy far outstrip almost anything found in the civil inpatient unit before the recovery movement's influence. The impositions of the fundamental concern for everyone's safety principally include scaled back property rights, limitations on moving about, clothing restrictions including shoelaces and belts, limitations on freedom of communication, and diminished privacy.

Some newly admitted forensic patients experience a particularly rude awakening, especially if they happen to have had recent experience in the civil inpa-

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tient setting. Exacerbating this experience for most forensic inpatients is the knowledge that release will not come soon and that (depending on legal status) usually no one can say when it might occur. Moreover, the prerequisites for considering discharge are universally quite demanding and uncompromising. If there is any sense of relief or hope from having escaped the correctional system, it is prone to give way to despair over the prospect of a prolonged and indefinite confinement. Patients naturally begin to exchange information about their different behavioral histories and their legal situations. This can lead to understandable (although unrealistic) resentments.

For many individuals, this seemingly unfair loss of freedom and autonomy can lead to passivity and feelings of hopelessness, readily recognizable as the effects of institutionalization.[10] Once they are overtaken by such influences, even the most obsessive-compulsive of patients may need reminders to keep their living areas neat and sanitary. If not prevented, some patients may spend hours during the day lying in their beds in a darkened room. Reasons to be positively motivated seem remote if not impossible to attain. It is more than likely that patients having these experiences will at times become acutely dangerous to themselves or others, or both.

Recognizing what some of their patients are experiencing, staff members are bound to have concerns about the patients' safety as well as their own. They too can become prone to frustration as they struggle to motivate their charges and be of help to them. Becoming thus preoccupied with the need for violence prevention and risk reduction, they are kept from deploying their therapeutic skills as they would like. They are likely to experience a sense of frustration mirroring that felt by their patients. Too much of their energy is tied up in preventing injuries, not leaving enough to provide desperately needed treatment. As they attempt to combine therapy with safety, they may begin to feel as if they are struggling to mix oil and water. This tension is especially strong for those who happen to have encountered or come under the influence of the recovery movement.

In our experience the solution for this dilemma and its resulting frustration consists of two steps: first the staff members must enjoy a balanced and confident sense that they have learned to manage many situations that engender risks of suicide and aggression, and then they can join in working with their patients to promote a culture of recovery strong enough to dissipate the frustrations that otherwise threaten their effectiveness.

Mastering the risks of dangerous behavior among psychiatric inpatients requires both the generally accepted textbook information and a good working knowledge of one's patients. Considerable general information concerning suicide is now agreed upon. Each year it claims some 1,000,000[11] lives worldwide, including 32,000 in the United States.[12] Between 500 and 1,000 individuals complete suicide each year in U.S. hospitals.[13] For psychiatrists and psychologists,[14] it creates the greatest liability exposure.[15] The list of environmental risk factors is well-established, lengthy, and detailed. It concerns the need for controls such as break-away hardware and complete visibility, along with elimination of such items as belts, shoelaces, scissors, and toxic fluids. We know of the dynamic risk factors that treatment can reduce and of such static suicide risk factors as individual and family history, diagnosis, age, and gender.

Although it was slower to develop,[16,17] the general prediction of patient aggression toward others has become increasingly systematic[18] and has now reached a level commensurate with the assessment of risk factors for suicide. Several protocols for this purpose are in regular use and there is ongoing study and refinement of them. A textbook[19] on the subject is in wide use along with other substantial works.[20–22]

To establish a safe environment it is of course necessary to apply the information on risk factors to assess each individual patient's level of risk. A sketch emerges with the initial assessment during the admission process. Experience with electronic medical record keeping is demonstrating that it is ideal to provide electronic management of information about patients' risk factors.[23] It is invaluable to engage patients themselves from the beginning in ongoing frank discussions of how they understand their own static and dynamic risk factors for suicide and violence. Such engagement comes more easily to some patients than to others. It can be helpful to enlist the patients' interest in developing a list of simple practical measures that may help them regain control and avoid or at least abort a violent episode. Similarly, they should be engaged in discussions of various anniversaries and other recurring times or situations of potentially increased risk. For some patients, it is useful to collaborate in regard to their risk of having a serious fall or other adverse event that the

various surveying organizations probe on their accreditation visits.

A well-performed initial assessment and development of a master treatment plan enables the caregivers to gain the knowledge of the patient needed for them to approach their responsibilities with confidence and effectiveness. Striving for the patient's maximum participation throughout the process promotes the universal goal of a mutually respectful and working relationship. Reaching that goal requires clarity from the beginning about the distinction between the task of protecting society and the patient's wish to return to society as an autonomous citizen. In the forensic inpatient setting, the greater the strength of this working relationship, the better the control of the mutual frustrations that can lead both patients and staff members to feel as if they are expected to do the impossible, or in the words of a leading recovery movement expert and colleague, to mix oil and water.[9]

Once treatment is under way, regularly scheduled treatment planning meetings provide the ideal opportunity for patients and staff members to develop and strengthen their working relationships as members of a clinical team. Together, they can work to agree on a description of the patient's recent progress and decide whether the degree to which individual autonomy is being limited is commensurate with the responsibility that the patient has been demonstrating recently. The revision of the treatment plan itself then proceeds on this basis, identifying the interventions most suitable for challenging the patient to work toward the safe advancement of individual autonomy in the hospital and to make meaningful progress toward discharge.

The treatment planning session also provides an ideal opportunity to assure that there is agreement about the patient's current levels of risk for suicide, aggression, and other pertinent adverse events such as falling. It is also a time to strengthen the collaborative relationship by attending to the patient's general sense of well-being and hope, any feelings of stagnation or worsening, and plans and aspirations for the future. Particularly important is the individual's personal sense of progress toward discharge, along with the ability to recognize that his efforts are merely part of the process that determines when it will occur. Finally, it is often helpful to have a succinct institution-wide risk assessment form to be filled out as part of the updated treatment plan (and stored electronically).

Thus, it is clear that well-executed admission assessment and treatment planning should assist both patients and staff members to manage the frustration of striving to behave responsibly in keeping with recovery principles without seeing discharge move visibly closer. The staff members can gain a knowledge of their patients that enables them to conceptualize and provide care of high quality, supporting progress and thus promoting safety. Patients have the regular opportunity to offer suggestions and requests, getting used to the necessary limitations on their influence as they learn to contribute within those limits. In these ways, staff members and patients can thus assure that the water of protecting society does not get separated from the oil of quality care in keeping with recovery ideals. Instead, a culture of recovery can emerge from this staff and patient collaboration and act as emulsifying agent to produce the effects of some savory vinaigrette, to be flavored as desired.

The flavors will develop through the daily work of fulfilling treatment plans. It will require day-in and day-out perseverance and sustained hard work without an end in clear sight. Some modest structuring of the daily working routine will assure that staff members feel safe and empowered to provide treatments in harmonious accord with both their own understanding and their patients' legitimate wishes.

As a daily practice we recommend maintaining a list of each unit's patients at highest risk for suicide, violence, falls, and the like. Staff members note the contents of the list at the beginning of each shift and review the pertinent details during the change-of-shift meeting. Naturally, they also discuss any other patients of concern because their behavior has departed acutely from the usual (e.g., they have been quieter than normal). It is invaluable to maintain a table of all patients' anniversaries such as dates of birth, admission, index crime or arrest, and any notable family events.

For the attending psychiatrist and other unit leadership, taking part in the change-of-shift meetings can be an efficient use of time both to keep abreast in general and to assure that significant new information is addressed in a timely manner. Staff members appreciate the support communicated by their presence and are likely to learn how to use it to valuable effect. Often enough, a particular patient's need to be seen for a fresh reassessment comes to light. For the patient, this meeting can be an opportunity to contribute to the process of planning for safety, in keep-

ing with the recovery model. Similarly, the team may decide to see a few patients briefly to join in recognizing a birthday or other weighty anniversary, while noting whether the response suggests a concern for any increase in risks.

Of course, the need for an individual risk reassessment may arise at any time. The major examples are a dramatic worsening (or lifting) of mood, giving away prized possessions, global insomnia, marked withdrawal, looking for a fight one is sure to lose, and the like.[24] Such a situation calls for proactive formation and application of an effective set of interventions. Most likely, there will be a focused addendum to the treatment plan, along with an update of the unit's risk list. In keeping with the recovery model, the patient's list of preferred approaches to stress should be consulted (and updated if appropriate) as treatment plans are revised to address the episode.

Patients vary in their reactions to their experiences of the recovery movement's influence. Some of them respond to it with cynicism because they know very well that the legal emphasis on confinement for society's safety determines their prospects for release. At every legal hearing related in any way to release, the universal message is that no matter how much caring encouragement and quality treatment they might receive, it is up to them to eliminate or at least gain control of their risk factors for violence. Often it is legitimate for them to feel that this emphasis is on the increase. The recovery message also seems questionable when peers whom they know well from living together and who seem at least equally at risk for aggressive behavior are allowed to leave, usually due to legal reasons that patients often fail to appreciate.

Others may choose to express their cynicism by taking advantage of the opportunities to exercise their rights to decide important aspects of their treatment. They may decide to refuse medication because of side effects and withhold their cooperation with the therapeutic groups that they need most. They may move a few of their peers to behave similarly. Some may also take advantage of the opportunity to make excessive complaints.

Despite the inevitable cynics, we are finding that for most patients, encouraging a culture of recovery leads to improved quality of life for patients and staff members alike and with it the quality of care. Given the opportunity, patients are eager to generate practical ideas for improving their environment and join in making the necessary efforts, including challenging appropriately their cynical colleagues. They enjoy assembling to hear the stories told by peers who have been released and are brought back for structured visits. They have worthwhile suggestions for creating a variety of therapy groups. Some of these ideas might be recreation disguised as therapy; others are all the more effective because some of their needs are best appreciated by the patients themselves. They find encouragement to pay attention to others, to be responsibly creative, and to learn from experience. Staff members should be encouraged to join in the creation and leadership of therapy groups, with appropriate supervision as part of the encouragement.

Although the concepts related to the recovery movement continue to undergo refinement,[25] there is growing agreement on such components as supporting hope, celebrating small gains, emphasizing medication choice and effectiveness more than adherence to the regimen, pursuing goals as the patient defines them, and supporting helpful initiatives chosen by patients.[7] Although they may initially appear like oil and water, there is a growing sense that the recovery model may be readily compatible with evidence-based practices.[9] Our experience as recounted here suggests that it may be likewise miscible with the demands of the high-security inpatient setting. What is needed for this is the development of a culture of recovery that can enable clinicians to focus appropriate attention on managing risks while still viewing the patient as a whole person, a unique individual with likes and dislikes, strengths and weaknesses, trying to get various needs met. Nevertheless, we recognize that respecting and promoting patient autonomy at times conflict with interventions that are needed to mitigate directly the risks of suicide and aggression. Autonomy also conflicts with the reality of mandated treatment. The treatment of insanity acquittees,[26] end-of-sentence felons with severe psychiatric disabilities,[27] and sex offenders[28] involves the management of risk and has tended to pay little heed to the autonomy of these individuals. Nonetheless, we believe that a culture of recovery-oriented clinical care could contribute to the promotion of risk reduction for forensic inpatients, regardless of their legal classification.

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