

# Treating Aggression in Forensic Psychiatric Settings

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Forensic psychiatric units are high-risk environments for aggressive behavior. Many elements are necessary for the successful reduction or elimination of aggression in the process of creating a safe treatment environment. Many specific interventions have been attempted over the years with various degrees of, usually limited, success. Tolisano *et al.* present an integrated behavioral approach with solid theoretical underpinnings and opportunities to support significant safety improvements for select patients, albeit with several caveats.

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A recent meta-analysis suggests that almost 20 percent of patients on psychiatric units commit at least one act of violence during their hospitalization<sup>1</sup>; forensic psychiatric units have rates almost twice that.<sup>2</sup> Although some characteristics increase the actuarial risk of inpatient violence (e.g., male gender, substance abuse disorders, and history of violence<sup>1</sup>), developing therapeutic models for the successful mitigation of violence to create safe and therapeutic treatment environments remains a challenge, for multiple reasons. The use and applicability of Positive Behavioral Support (PBS)<sup>3,4</sup> is embedded in this context. To understand the applicability, potential benefits, and limitations of PBS, I believe it is important to understand its role among the many elements needed to create and maintain a safe therapeutic environment. The domains I wish to address include the milieu and physical plant, potential interventions, and the use of quality improvement data.

## Milieu

Forensic psychiatric units manage very complex and potentially aggressive patients. In parallel with efforts to reduce the use of force, whether by seclu-

sion or restraint, there has not been an equivalent growth in the development and use of alternative therapeutic interventions.<sup>5,6</sup> Inpatient aggression has increased over the years with significant patient-on-patient and patient-on-staff attacks and injuries. Simply telling someone to stop extreme self-injurious or violent behaviors will not work when the person is: too psychotic, agitated, or intoxicated; does not have alternative coping skills to use other than previously learned aggression; or is behaving with clear malicious or predatory intent. The most basic of these interventions include staff attitude, staffing complement, and the availability of program-oriented space.

The attitude of staff toward patients is foundational to the creation of a therapeutic and safe environment.<sup>7</sup> Creating and maintaining such an attitude requires substantial forethought and effort.<sup>8</sup> Staff training in de-escalation, motivational interviewing, and engagement and collaborative training to avoid the risk of staff splitting are all critical elements to this process. That said, if there are not enough staff to provide a safe environment, a therapeutic attitude is very challenging to maintain. What defines adequate staffing is an ongoing discussion and debate. Suffice it to say that adequate staffing patterns should derive from an examination of the work that needs to be done and should not be driven by how much money is available to provide staffing.

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Adequate space designated for programming and the design of the facility contribute to a therapeutic environment. Having appropriate group space, confidential therapy space, appropriate furniture, and an easily monitored design are each important elements of a safer inpatient environment.<sup>9</sup>

### **Prevention: Policy and Staff Training**

Violence prevention requires coordinated and comprehensive efforts. Institutional policy should address each point along the pathway, clearly operationalizing expected staff actions and responsibilities. First, it is important to have a risk assessment for newly admitted patients, based on historical information and initial assessment.<sup>10</sup> Communication among staff to share information learned and to coordinate management and treatment is critical, as well. Staff need training through both didactics and experiential practice to develop a skill set for inter-professional coordination and specific interventions. The skills needed may include de-escalation training, conflict resolution, active listening, and motivational interviewing.

### **Early Intervention**

The ideal time to address most potentially aggressive patients is on admission. Clear goals, expectations, and consequences should be articulated in understandable terms. For new patients, we (as an interdisciplinary profession) have generally developed the requisite skills for emergency intervention when the patient is grossly psychotic, agitated, or intoxicated: situations that usually arise in an emergency department. Avoiding the need for emergency intervention has proven to be more problematic for us.

### **General Skills Training**

Many situations present when the patient does not have alternative coping skills to use other than aggression or is behaving with clear malicious or predatory intent. These cases may allow for many milieu-oriented interventions, at least in milder or more moderate cases. Training staff in crisis-intervention techniques, de-escalation, and negotiation each has been demonstrated to be effective in inpatient psychiatric settings.<sup>11</sup> The basics of having adequate staffing, appropriate program and treatment space, and a genuine therapeutic approach to care delivery

make a substantial difference in the risk and rate of self-injurious behaviors and externally directed aggression. These attitudinal and training shifts for clinical and support staff are indeed critical for all interventions designed to empower recovery for our patients and to make the inpatient unit a safer and more therapeutic environment.<sup>12</sup>

### **Structured Interventions**

Over the past two decades, several cognitive behavioral therapies and skills-based interventions have been developed and implemented in forensic psychiatric settings. For example, reasoning and rehabilitation<sup>13</sup> and dialectical behavior therapy<sup>14</sup> have seen use with various degrees of success in violence reduction. Other structured interventions have also found support in forensic or correctional mental health settings (e.g., Ref. 15). Each of these programmatic plans shares a skills-based approach: empowering participants to change their behavior to more prosocial forms by providing functional, achievable alternatives that teach in affirmative language what one should do. In addition, mindfulness meditative techniques have found application in forensic and community inpatient settings.<sup>16</sup> These approaches have generally targeted patients who do not have effective coping skills to use, other than aggression.

### **Psychopharmacology**

The literature is replete with studies of psychopharmacologic interventions targeting aggression.<sup>17</sup> Although there are no medications with a federally approved indication for aggression, many classes of medication are used with various degrees of benefit. Much of this is arguably related to the great heterogeneity of the underlying psychopathology and neuropathology. Aggression associated with psychosis or impulsivity is more likely amenable to medication intervention, unlike to predatory violence.<sup>17</sup> Nevertheless, careful consideration of the potential value of medication-based intervention should be considered on a case-by-case clinical basis.

### **High-Intensity Options**

Behavior-management plans are a staple of managing aggression, whether externally directed or self-injurious, in residential, inpatient, and correctional settings.<sup>18</sup> Positive Behavioral Support (PBS) is a

logical extension of a behavioral management plan that brings multiple perspectives and resources to bear on the most complex cases.<sup>3</sup> As noted by Tolisano *et al.*,<sup>4</sup> PBS incorporates ecological strategies, specific programming, supportive strategies, and planned reactions to events in a comprehensive functional assessment. Effective implementation also requires effective data collection, staff training, fidelity to the plan, and active revision, as needed. Integral to PBS is a behavioral consultation team that includes a doctoral-level psychologist with specialized behavioral training.

PBS is clearly intended for the small but very important number of patients who have not responded to the standard armamentarium of interventions, including the potential use of clozapine. It requires sophisticated case formulation, understanding of motivation, and extensive staff training, feedback, and oversight on all shifts.

### Critical Limitations of PBS

I see several limitations to the implementation and sustainment of PBS in clinical settings. The first derives from diagnosis and underlying pathophysiology. It will not benefit those who are unable to acquire new skills. This includes those patients who are acutely psychotic, profoundly disinhibited due to traumatic brain injury, or profoundly intellectually impaired. It is also unlikely to benefit those who are violent by choice: those who are intentionally predatory.

PBS is very resource intensive. It requires a team approach, sophisticated case formulation, and close coordination among all staff across all three shifts and weekends. It requires a commitment of funding, oversight, and monitoring. In the real world of inpatient forensic settings, such requirements may be difficult to initiate and more difficult to sustain.

Furthermore, PBS is unlikely to be of value in the absence of a culture of safety reflected in extensive staff training, a therapeutic milieu, risk screening, conflict avoidance competence, and more generalized prosocial skills-training initiatives.

### Quality Improvement Data

Does PBS work? That is ultimately a question answered with data. It may work in one setting, but that does not mean it will work equally well in another setting, given potential differences in staff training,

case mix, physical plant, milieu, and all of the requisite predicates noted above. To determine benefit, it is necessary for each site to implement a comprehensive quality improvement process to track fidelity to the process, assess each episode of aggression, and monitor this effort in an interdisciplinary fashion over time.<sup>19</sup>

### Conclusion

Inpatient violence is an ongoing challenge that threatens the safety of staff and patients and damages treatment progress and the therapeutic milieu. PBS is a potentially valuable addition to the clinical armamentarium. However, PBS is a resource-intensive component intended for the relatively few extreme cases. Its greatest benefit is most likely to be found when added to the fundamental policies, procedures, therapies, interventions, and clinical skills that create a safe therapeutic environment for patients and staff.

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