Involving Forensic Patients in Treatment Planning Increases Cooperation and May Reduce Violence Risk

Daniel J. Papapietro, PsyD

Risk assessment in a forensic hospital is a complex process. Decisions made about individuals and their lives cannot be made lightly and must include relevant information from as many sources as possible. The forensic hospital and the greater legal system that oversees forensic treatment have an obligation to protect the safety of the community. Thus, any decision about a forensic patient's progress from high to low security or eventual transition and discharge into the community must be thoughtful and balanced, and must include input from the patients themselves. Eliciting and providing for patients to articulate how they perceive their own risk and potential stressors and triggers can be potentially helpful in managing their day-to-day progress, safety, and eventual transition out of the hospital.

J Am Acad Psychiatry Law 47(1) online, 2019. DOI:10.29158/JAAPL.003815-19

One of the greatest challenges in a forensic hospital is assessing patients' risk for immediate or future violence, particularly with respect to their progression to less restrictive environments and eventual release to the community. In the treatment of forensic patients who have already been dangerous (or just nearly so), assessing, predicting, and managing potential dangerousness is an important part of ongoing treatment and discharge planning. Although treatment itself is designed to help individuals to manage the symptoms and behaviors related to their mental illness, it is also provided to assess and mitigate risk so that forensic patients can make clinical progress and move to less secure environments. Whether we like to admit it or not, there is truth to the statistic that an individual who once was violent may be likely to become violent again, depending, of course, on past and future circumstances.[1] However, there are specific treatments that can work to identify, assess, and mitigate future risk of dangerousness once the underlying vulnerabilities of the forensic patient are identified.

Forensic assessment of risk is a complicated process in a complex system that tries to balance the need for security and the safety of the community with some measure of patient autonomy. Ray and Simpson[2] are correct when they argue for greater involvement of the forensic patient in the assessment of the patient's risk. I also agree that patients' understanding of their own risk is important to their successful rehabilitation. The philosophy of the recovery movement is that patients' involvement in guiding treatment can be helpful for their sense of autonomy, which can result in better cooperation with treatment plans, and a sense of ownership of the treatment-planning process. Patients' general improvement may in turn lead to decreased risk of future violence, in the hospital or after discharge, because of greater insight. In my view, Schaufenbil *et al.*[3] go too far when they argue that forensic treatment plans should include only matters directly related to the "legal reasons for admission and discharge [. . .] based on the commitment specific statutory language . . ." (Ref. 3, p 2), essentially rejecting completely the role of the patient, broad clinical progress, and the role and philosophy of the recovery movement.

Published online February 11, 2019.

Dr. Papapietro is an Assistant Clinical Professor of Psychiatry, Yale School of Medicine, Division of Law & Psychiatry, Yale University, New Haven, CT, and a Forensic Psychologist, Whiting Forensic Hospital, Middletown, CT. Address correspondence to: Daniel J Papapietro, PsyD, Forensic Psychologist, Chief, Psychotherapy Service, Whiting Forensic Hospital, PO Box 351, 1000 Silver St., Middletown, CT 06457. E-mail: daniel.papapietro@ct.gov.

Disclosures of financial or other potential conflicts of interest: None.

Recovery and Forensic Treatment

The problem of integrating a more patient-centered approach to risk assessment into a forensic setting is that, by the very nature of the forensic patients' legal situation, their autonomy is often largely stripped away and, similar to prisoners, they have few of the rights that individuals in general psychiatric hospitals continue to enjoy. The limited autonomy of forensic patients does not simply come about, as Jacob puts it, because of a "paternalistic culture" of physicians as undisputed experts who won't accept other's opinions.[4] This reduced autonomy is due instead to the reality of the patients' crimes, their mental illness, and the security-driven model of forensic hospitals' commitment to ensuring the safety of others. Plans that address level of security, length of hospitalization, and discharge ultimately are approved by the judicial oversight board, which has the final say on many treatment issues, regardless of the patient's expressed preferences.

However, on a day-to-day basis, forensic patients are encouraged to be involved in making choices and decisions about the kind of treatment and activity groups they personally believe would be helpful to meet clinical goals identified by their treatment team. Forensic treatment also includes options for individual and group therapy, social skills, vocational rehabilitation groups, and substance relapse-prevention groups. All of these optional and mandated treatments that become part of the patient's treatment plan address the goals necessary for eventual discharge.

How patients participate in treatment and their ability and willingness to discuss openly their thoughts and feelings are just as important to the assessment of their risk as are the efficacy of medication and the patient's clinical stability. Over time, as patients come to understand better the nature of the forensic setting and its expectations, they typically become more able and willing to participate in treatment. Consequently, as their ability to disclose candidly any changes in their mood, thoughts, or impulses improves, the better they will do and the faster they are likely to progress through the system. Those patients who are characterologically paranoid, hostile, or controlling and who refuse to participate in treatment or refuse to talk candidly about their crime, their illness, or their current thoughts and feelings eventually will find that their progress has slowed or stopped. However, regardless of how well the patient improves and participates in treatment, progress may be slow (or slowed down by the system) for reasons that are not directly related to the patient's cooperation and progress. In many instances, there may be concerns from the community or the system about a patient's security status because of the particularly heinous nature of the crime, the specific manner or location of the crime, or the choice of victim. Sometimes even when clinicians support a patient's progress, and especially in small states where hospitalized forensic patients often are not very far from the scene of their crime, the community may oppose the patient's progress toward discharge to the community. This opposition is often linked to memories of the trauma that was perpetrated in the community by the patient.

The Psychiatric Security Review Board, which oversees security and discharge decisions in a few states like Connecticut, is by design conservative, and is mandated to prioritize safety. Even when the Psychiatric Security Review Board largely agrees with the hospital's recommendations, it may still require some additional levels of supervision or some additional period of treatment or stability before agreeing to move the individual to a less secure unit. Security and discharge issues are where the recovery movement and the forensic system encounter the most friction, and where patient choice and autonomy realistically are limited. Schaufenbil *et al.*[3] argued (largely ignoring clinical matters), that ". . . in the forensic setting, discharge criteria [must] flow from the statutory language under which the patient is admitted . . . [and that] the discharge criteria need to reflect resolution of the mental health/criminogenic dimensions that have bearing on the patient's legal status" (Ref. 3, p 3). From that perspective, treatment of the individual forensic patient is far less important than simply moving patients through the forensic system based on whether patients are ready for discharge in accordance with statutory language of the law that controlled their admission. Such an approach seems rather limited and rigid.

Despite the sometimes poor fit of the recovery philosophy with a forensic setting, the clinical, ethical, and political philosophy of a forensic hospital nevertheless must be to help the patients recover to the highest level they can achieve, with all necessary treatment and supports. The goal is for them to transition into the community, all the while keeping

safety as an important determinant of progress. Safety of the community is related to perception of the individual forensic patient's level of potential risk for future violence. Guaranteeing the absolute absence of future violence is impossible. What we can offer is an opinion and a plan of intervention that mitigates the factors that would precipitate a decompensation and thus increase a person's risk of violence. Although the treaters are, and must be, the experts, they should endeavor not to exclude the patients' input about what they see as potential stressors and triggers, and what interventions they think might be most helpful. Providing forensic patients the opportunity to have input into their treatment, and of having that input accepted with respect and incorporated as much as possible, serves to create a genuine level of mutual respect. Out of respect comes trust and honesty.

Ray and Simpson[2] encourage us to explore ways to decrease (or at least to identify) a forensic patient's risk of stress-related decompensation and potential for violence by engaging the patient in planning treatment. The authors believe that by engaging forensic patients in contributing to their treatment plan and working with them to support their autonomy, the patients will develop trust for their treaters and will be more willing to participate in future risk assessments. For this to occur, treaters must include "the patient voice into risk assessment and management . . ." (Ref. 2, p 000), which can be done in several ways. Norko[5] and Simpson[6] both assert that forensic treatment can incorporate recovery principles simply by informing patients of their right to participate in treatment planning, listening to their input (their voice), and being respectful of them. Citing Manchek *et al.*,[7] Norko argued that "mandated treatment clients [do indeed] experience significantly greater therapist control . . . the quality of the relationships [nevertheless] remains affiliative and autonomy-granting" (Ref. 5, p 195). This suggests that mandated treatment, when done with respect, whether in the community or in a forensic hospital, can preserve some aspect of patient self-esteem and autonomy. Livingston *et al.*[8] also found that the effort to include the patient in decision-making, regardless of the depth of influence, resulted in patients reporting a sense of being seen in a more positive light by staff. As a result, patients experienced staff as being more supportive and hopeful about their recovery. Even with limited control over treatment, Livingston *et al.*[8] "found that patients' overall perceptions of recovery-oriented care were linked to greater service engagement . . . [and that] enhancing recovery-oriented care in a forensic mental health hospital may improve patient engagement in (and adherence to) services" (Ref. 8, p 357). It may be that the simple (and genuine) effort of asking for the patient's opinion or input, even if it is untenable, is all that is necessary to help create a more positive and cooperative outlook for the patient. In their exhaustive review of attachment disorder research, especially related to anxieties and phobias that co-exist with serious mental illness, Brown and Elliot[9] identify the specific importance of attachment related therapies, and research by Mikulincer and Shaver[10] concludes that "experimental and correlational findings indicate that attachment insecurities are involved in the generation of phobic symptomatology . . . [and therefore] the restoration of attachment security can have healing effects on phobic people" (Ref. 10, p 383). Such findings confirm the notion that relationships between a forensic patient and staff can play an important role in helping the patient develop the capacity to trust and to work productively with forensic treaters. For example, a positive relationship with staff allows the forensic patient to experience them as attachment figures; the safety of the forensic setting in general allows it to serve as a holding environment, and psychotherapy functions specifically as a critical holding relationship.[11–13]

In many forensic settings, in both maximum- and medium-security, and on both long-term and transitional units, patients are expected and encouraged to participate in their treatment planning. The specific goal is for the patients to have a clear voice in what they believe would be helpful to them for their clinical treatment, progress, and general mental health. Their input provides not just their personal preferences or advanced directives for future interventions they believe would be most helpful at times of crisis and stress or decompensation (e.g., music, meditation, time-outs, etc.), but it also includes room for their personal goals of physical wellness, education, spirituality, family reconciliation, and specific clinical or personal challenges to address. All of these elements may be used in the development of hopes and goals for eventual discharge. An important and long-standing guiding principle is that staff work cooperatively with patients to design a rational treatment plan that has reasonable goals. Of course, some

patients in forensic hospitals remain symptomatic and often are "unable to realize their own treatment needs" (Ref. 10, p 347). They either will refuse to participate or will offer unreasonable goals (e.g., "I want to get married . . . get pregnant . . . get discharged tomorrow . . . stop taking medicine . . . ."). The staff makes every effort to guide patients to identify realistic and appropriate treatment goals to go along with goals identified by the treatment team, all of which become the patient's individualized treatment plan.

Multidisciplinary treatment teams should review treatment plans regularly with their patients. In these meetings, patients should have legal representation and family members or other supportive persons present. These meetings mark the patient's progress toward achieving goals, identifying impediments to achieving the goals, and exploring areas where progress has stalled or looking for ways to help progress continue. Forensic treatment has the usual goals of rehabilitation and recovery, and it relies on traditional individual and group therapies (including social skills, stress management, rehabilitation, and recovery), cognitive and behavioral treatments, and pharmacological treatment, all of which are provided to patients to help them achieve their treatment goals. Patient involvement in all of these areas is crucial for the patients' sense of autonomy as well as to give them hope that recovery is possible, and with that comes a greater sense of cooperation and reduced risk of violence.

Individual Psychotherapy

Because the duration of a forensic hospitalization is often considerably longer than for individuals in a general psychiatric hospital, whom Cox referred to as "resident[s] without limit of time" (Ref. 14, p 216), there also is the opportunity to provide psychodynamically-oriented psychotherapy that would likely not be as suitable for short-term psychiatric hospitalizations. In forensic treatment, there is no better place than through psychotherapy to provide forensic patients an opportunity for their voices to be heard in determining appropriate treatment goals as well as to provide the necessary understanding of why their symptoms resulted in their index offense.

The forensic psychotherapy process in general can be very important in helping the patients, the treatment teams, and the greater forensic system understand the genetic, familial, and environmental contributions to a forensic patient's mental illnesses, the crimes and choice of victims, and underlying problems related to attachment or trauma. When appropriate to the patient, the psychotherapeutic exploration of these matters can lead to a deeper understanding of possible unconscious risk factors about which the patient and the forensic system need to be more aware.[15] Hegarty argued that "a psychodynamic understanding of an individual can enrich the forensic interview, specifically in terms of risk assessment and theoretical interpretations of the criminal act and motives for violence" (Ref. 16, p 438). Because only a small percentage of people with serious mental illness kill, maim, or hurt others, I believe it is important for the patient and the hospital to understand as much as possible why the individuals committed the crimes in the way they did and with the victims they chose. This understanding is then used to help guide decisions about necessary security and progress. The benefits and importance of psychodynamic treatment of forensic patients is well-established and summarized in several sources.[17–19] Life in a long-term forensic hospital can be very difficult and can present patients with significant stressors and triggers that mirror or exceed those they may encounter when they return to the community. As patients use psychotherapy to identify and to talk about these stressors, the therapist (along with feedback from the patient's treatment team) and the patient can understand the patient's capacity to tolerate stress and frustration. The patients then can begin to recognize their patterns of stress-related symptoms, their coping skills and defenses, and the degree to which the stress and break-through symptoms influence attitudes or behaviors that might predict the decompensation that precipitates violence.

Assessment of patients' potential for dangerousness requires understanding of the relationship between their mental illness and their social or environmental situation, and how these related to their crimes. There is no better place for this exploration than in psychotherapy. It is especially helpful for the patients and their therapists to understand how the patients chose their victims. A significant part of patients' future risk can be identified by thoroughly understanding whom they chose as their victims and why, the reasons they committed their crime at that particular time (as opposed to earlier or later), and whether someone in the future could match the dynamics of the first victim (See Ref. 19, Chapter 6).

The more insight patients have about this, the more they may understand their own risk. The more they can understand and talk about the details of their crimes in psychotherapy, no matter how gruesome or stressful, the better they may be able to understand their illnesses and the stressors and triggers that preceded the crimes. With such understanding, they may be more aware of their potential for violence.

In psychotherapy, patients truly have a voice to influence their treatment plans and futures. If they participate sincerely in the therapeutic process, they will come to understand and accept the reality of their crimes and illnesses, and they will be able to identify potential stressors and ways to cope with them. Forensic patients whose victim was an ambivalently loved family member eventually have to find a way in therapy to resolve some of their ambivalence toward the victim to grieve the loss of their family member. Not allowing a forensic patient to grieve that loss is to facilitate the persistence of the primitive defenses of denial and minimization, elevating the individual's risk of violence if he or she is suddenly overcome by long-repressed emotions about the crimes and victims or if other persons accidentally fall into roles vaguely similar to that of the victims.

Many forensic patients, as they become clinically stable and cognitively clear, are afraid to talk about their psychosis and violence during the index offense for fear it will overwhelm them. As they become more aware of how and why their decompensation led to their crime, they are likely to be less frightened by their illness and more inclined to participate in treatment to prevent any such decompensation in the future. In many cases, being able to identify the chain of events that led up to their crimes, sometimes with a link that goes back to childhood, along with being able to understand the interpersonal and intrapersonal stressors, anxieties, fears, or losses they experienced provides them with an understanding of their crime that makes sense to them and helps them understand the power and the danger of their illnesses and the necessity of treatment and medications going forward. As the patients slowly develop the emotional strength to tolerate the exploration of their crimes, they come to trust the psychotherapist, the team, and the hospital. Their ability to trust their treaters provides important reassurance to them that they can get help from others during times of stress, and more importantly, they come to trust themselves as being capable of asking for help to cope with stress in better and more appropriate ways.

Other Treatment Approaches

Talk therapy is not a singular treatment, nor is it appropriate for all forensic patients. Other equally important aspects of the patient's treatment and treatment planning occur through patient-focused, recovery-focused groups. These include emotion-regulation groups and social and independent living skills groups that help patients develop social and coping skills necessary for success in the community.[20] Often, forensic patients have impaired interpersonal skills and limited family and social support systems. Forensic patients may need to learn more appropriate social skills to benefit from relationships with peers and community treatment providers to obtain the necessary support for their recovery. These groups are provided to forensic patients who have progressed to the medium-security setting, where there is the likelihood of a gradual transition to life in the community and an eventual discharge from the forensic hospital. Slowly increasing levels of freedom that allow for staff-supervised walks on campus and closely supervised field trips into the communities for various normal activities like shopping, hiking, and attending movies are predicated on the individual forensic patient having a well-established period of stability, a proven track record of participation in treatment, recognition of potential stressors, and a reliable ability to confide in staff about their symptoms, stressor, or anxieties. Not all forensic patients are willing or able to participate meaningfully in their treatment planning, and they often refuse treatment, creating further risk for themselves.

Treatment Refusal

In a forensic hospital, patients have the same right to refuse treatment as if they were in a general psychiatric hospital, absent any imminent risk to self or others. Until there is an imminent risk of danger to self or others, coercion of any sort should be rigorously avoided. In a forensic hospital, with powerful judicial oversight, individuals who will not accept the recommended treatments may be seen as lacking insight into their mental illness and thus cannot be trusted to follow the rules in a less secure setting. Thus, it may quickly become a slippery slope when the individual refuses all or some of the necessary

treatments required to move forward but has not been aggressive, violent, or disruptive. Treatment refusal without decompensation or acting out can become complicated because the patient and lawyers press for progression through the system, arguing that the absence of disruptive or dangerous behaviors proves the individual is stable and safe. Legal arguments are not the same as clinical arguments, however, and these disagreements are resolved by higher judicial authority.

Forensic patients' exercise of their inherent right to refuse treatment, however, may suggest a fundamental lack of understanding of why they are in a forensic hospital. For those individuals with the most serious crimes or a history of treatment non-compliance, their refusal to accept treatment creates great apprehension and uncertainty. If an individual does not recognize the need for treatment and medication, then how could that person be trusted in a less secure setting to recognize and report changes in their mental state or a return of symptoms that portend an increased risk of dangerousness?

Because patients are not always cooperative or compliant with treatment, and because the forensic system may endorse a modified recovery model of offering choices and exploring opportunities for individual autonomy, I suggest consideration of an engagement process for patients who refuse to participate meaningfully in treatment. In this process, staff members are identified, often one each on first and second shift, to meet once or twice weekly with those patients to review their treatment goals and their lack of participation in groups and social activities, and then to work with them on what might help motivate them to increase their attendance and participation. This engagement process can proceed slowly over many months until the patient has made some significant improvement in participation. Sometimes the patient will refuse the engagement process, which then becomes a clinical issue for the treatment team to rule out cognitive impairment, psychosis, or depression, or simply to admit that it has become a power struggle that the patient needs to win. If the patient is allowed to win by the team's decision to discontinue the struggle, then eventually, when progress has stalled long enough, most individuals will begin to reconsider their resistance and exert their control to cooperate and to participate in their treatment. To some, this may seem a type of coercion, but allowing forensic patients to discover their own needs to work in treatment may be the best approach to making clinical progress. Therapy should always, and only, guide and lead a patient to change; it is never meant to push, pressure, or force. Only when individuals take personal responsibility for their situation and embrace a desire for change can they truly begin to feel a sense of genuine control over and influence in their treatment.

Conclusion

The best forensic approach to the assessment, management, and treatment of violence is to focus on treating and understanding violence and its causes, rather than simply providing management in the hope of preventing violence. Risk assessment in a forensic hospital must be based on a full understanding of the nature of the patients' biological illness, their unconscious conflicts, the strength of their defenses and coping skills, the multiple stressors that contributed to and led up to the forensic crimes, and the legal mandates that hold them in confinement. In other words, one must understand as much as possible about the patients to treat them in such a way as to mitigate factors or failings that could once more result in violence. However, this shouldn't be done by ignoring their input, potential insights, and their voices, all of which can facilitate their ability to trust their treaters and to report any return of symptoms or increased stressors that might threaten their clinical stability.

References

1. Weinberger LE, Sreenivasan S: Addressing ethics dilemmas in violence-risk assessment, in Ethics Challenges in Forensic Psychiatry and Psychology Practice. Edited by Griffith EEH. New York: Columbia University Press, 2018, pp 284–303
2. Ray I, Simpson A: Shared risk formulation in forensic psychiatry: a narrative review. J Am Acad Psychiatry Law 47:000–000, 2019
3. Schaufenbil RJ, Kornbluh R, Stahl SM, Warburton K: Forensic focused treatment planning: a new standard for forensic mental health systems. CNS Spectr 20:250–53, 2015
4. Jacob KS: Recovery Model of Mental Illness: A complementary approach to psychiatric care. Indian J Psychol Med 37:117–19, 2015
5. Norko M: Legislative consultation and the forensic specialist, in Bearing Witness to Change: Forensic Psychiatry and Psychology Practice. Edited by Griffith EEH, Norko M, Buchanan A, *et al*. Boca Raton, FL: Taylor and Francis Group LLC, 2017, pp 187–203
6. Simpson AIF: Commentary: civil commitment and its reform. J Am Acad Psychiatry Law 43:48–51, 2015
7. Manchek SM, Skeem JL, Rook KS: Care, control, or both? Characterizing major dimensions of the mandated treatment relationship. Law & Hum Behav 38:47–57, 2014
8. Livingston JD, Nijdam-Jones A, Brink J: A tale of two cultures: examining patient-centered care in a forensic mental health hospital. J Forens Psychiatry Psychol 23:345–60, 2012

9. Brown DP, Elliott DS: Attachment in psychopathology, in Attachment Disturbances in Adults: Treatment for Comprehensive Repair. New York: WW Norton Co, 2016, pp 166–221
10. Mikulincer M, Shaver P: Attachment in Adulthood: Structure, Dynamics, and Change. New York: Guilford Press, 2007
11. Adshead G: Psychiatric staff as attachment figures. Understanding management problems in psychiatric services in the light of attachment theory. Br J Psychiatry 172:64–69, 1998
12. Cox M: The 'holding function' of dynamic psychotherapy in a custodial setting: a review. J R Soc Med 79:162–64, 1986
13. Ginot E: The holding environment and intersubjectivity. Psychoanal Q 70:417–46, 2001
14. Cox M: Group therapy in secure setting. Proc R Soc Med 69:215–20, 1976
15. Simopoulos F, Cohen B: Application and utility of psychodynamic principles in forensic assessment. J Am Acad Psychiatry Law 43:428–37, 2015
16. Hegarty A: Commentary: Coming full circle—psychoanalysis, psychodynamics, and forensic psychiatry. J Am Acad Psychiatry Law 43:438–43, 2015
17. Forensic Psychotherapy Crime, Psychodynamics and the Offender Patient. Edited by Cordess C, Cox M. London & Philadelphia: Jessica Kingsley Publisher, 1996
18. Doctor R (ed): Murder: A Psychotherapeutic Investigation. London: Karnac Books, 2008
19. Pfäfflin F, Adshead G (eds): A Matter of Security: The Application of Attachment Theory to Forensic Psychiatry and Psychotherapy. London & Philadelphia: Jessica Kingsley Publishers, 2004
20. Liberman RP, Wallace CJ, Blackwell G, *et al*: Innovations in skills training for the seriously mentally ill: The UCLA Social and Independent Living Skills modules innovations and research. Available at: https://ps.psychiatryonline.org/doi/pdf/10.1176/ps.49.5.593. Accessed September 18, 2018