Entry for the APT-DICES Award for Excellence in Risk Assessment & Management 2017

Management of Rational Appearing Aggression in a Low Secure Unit – a Case Study

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In 2016, a complex and difficult patient was admitted to the specialist sexual offenders service at Kemple View. His initial presentation was that of overt hostility, low tolerance to frustration and poor emotional and behavioural controls. Staff responded in the usual way, to be supportive and try to develop an initial therapeutic rapport in this time of transition. Unusually, what resulted was an increasing number of complaints via every perceivable system available to a detained psychiatric patient, both internal and external. This was a long-standing feature of the patient's presentation, and as such was not a surprise: what was a surprise was the impact upon staff members across the hospital.

Initial risk assessments, the START, HCR-20 (version 4) and the SVR-20 began. It was not possible to do this collaboratively with the patient, as he could not tolerate even mentioning the risks he posed, or anything about this own behaviour. Initial treatment goals changed to that of improving his emotional regulation.

The team were split on how to manage the impact this patient was having on staff, and other patients, and the risks that he posed in terms of retention, stress, job satisfaction and real risks to job security and career prospects. Hiding under the bushel of "My right to complain" had reduced the confidence of staff to challenge his behaviours, and had resulted in very effective rational appearing aggression.

Risk assessment of imminent harm – violence, sexual violence, self-harm, suicidality have all leapt forward with the Structured Clinical Judgement approaches, scenario planning and communication strategies. Staff feel confident in making decisions based on the comprehensive use of these structures. This allows for care plans or be developed that instruct staff and the patient as to the options that will be considered in order to assist the patient in desisting from these behaviours. With rational appearing aggression, however, such as constant complaining, it became clear that staff felt unconfident in challenging his "rights" to complain, that they "should be fine with it" and that every aspect of their care is open to scrutiny and "It is the patients right to do it".

In true RAID style, we were able to identify the complaining behaviour as one of the "shade of green" behaviours, as it appears to have replaced self-harm and sexual offending as the "red" behaviours to target. However, it soon became clear that a full functional assessment of the complaining behaviour on a team basis was going to be essential in order to be able to provide appropriate care and treatment.

Core schemas of entitlement, vengeance and retribution underpinned his behavioural responses to feeling upset or confused: which were to "blame the messenger", and then

complain, via telephone, letter and in person. These behaviours were immediately reinforced by the reaction of the person being “criticised and threatened”, the reaction to him of expressing concern and showing interest in hearing his point of view from the “person on the telephone”, and then the “playing out” of the process – being interviewed, receiving important looking post, attending meetings. An important part seemed to also be about seeing the person who had “hurt” him get increasingly stressed, worried, have to engage with the process, maybe even be moved wards. This reinforcement was inherently both positive and negative.

The team initially struggled with achieving a balance between the need to provide appropriate care and treatment, and also being able to safeguard staff (including themselves) from the psychological abuse that was very clearly influencing their own reactions to the patient. Increased observations were initially used, which was perceived as punitive by the patient, and caused some divides within the team. An initial behavioural management plan was developed to try and minimise the reinforcing nature of the complaining, and to provide attention for making compliments and discussing how to make the ward better. An external opinion was sought, which supported the use of a clear behavioural management plan, so the team worked hard to develop something comprehensive, with a fine balance between acknowledging that the patient may have legitimate things to complain about and needed to be able to voice these and feel heard and listened to.

A very clear and detailed risk management plan was developed collaboratively with the patient, and communicated to all staff. Initially it was aimed at clearly specifying the complaints process to be used, taking everything back to ward level, and the process deciding when things needed to be escalated, not because the patient chooses to escalate it to be more aggressive. This was balanced with set sessions weekly to review his concerns, and other sessions with the clinical team to increase his emotional regulation and develop his problem solving skills. The plan also aims to develop his “complimenting ability” with reinforcement being provided when he engages in discussions about what is working well, suggestions on how to improve things and engagement in activities of any sort.

The initial risk management plan had to co-ordinate the responses of the clinical team, the hospital complaints department and the hospital Senior Management team in order for the risk management plan to be effective. However, perhaps the more unique part was that due to his use of legal proceedings and other “high level” complaints procedures, it soon became essential to discuss and help to manage the responses of other major organisations involved in this patients care. The risk management plan, therefore incorporates the agreed responses from the organisations centralised complaints team, the local advocacy services, NHS England Commissioners, the NHS England complaints team, the gatekeeping team, the local MP, and more recently even the police have been actively working with the risk management plan and the team to minimise the positive reinforcement achieved by the rational appearing aggression used by the patient, preventing victimisation and psychological abuse of all professionals involved in his care, whilst ensuring that his rights and wishes are listened to and upheld.

The risk management plan is beginning to be effective, but we have a long way to go. The patient's ability to work with the team and his understanding of this behaviour is beginning to develop. As expected, he has attempted to find new organisations to complain to and achieve the old results; his ingenuity is a real strength, but the team work hard to link any new organisations into the care plan, with the patient's permission. There are still spikes of complaints when he is very stressed, but we have not seen a return of the old "red" behaviours which was a concern when we started to manage this risk behaviour.

It is still early days, and we reinforce his behaviour sometimes, but reflective practice for the team and regular discussions are helping to keep the risk management plan in place. Probably the biggest difference is in the confidence and attitude of all staff in working with these patients. Staff are motivated to work through these issues with the patient, and assist him in developing new behaviours. They understand the process, and see the complaints as annoying but an inevitable part of the journey with this patient. The willingness of outside agencies, clinical and non-clinical, to work with a process that is aimed to minimise the risks posed by this patient has been phenomenal, and the success of the risk management plan can be judged by the efforts made by all in co-ordinating what are essentially massive reinforcers, in order to work with this patient on his use of aggression to achieve his aims.

The early identification of this behaviour as "rational-appearing aggression" and offence-paralleling behaviour for this patient has enabled us to develop a system wide risk management plan that minimises his current use of psychological abuse to create victims of all the people involved in his care and provide the appropriate treatment and opportunities for him to develop pro-social ways to deal with his distress. Psychological abuse of staff is not an acceptable form of problem-solving, and is not the "human right" of any patient. This risk management plan balances this with the right for this patient to be heard and access the safeguards that the system puts in place for him.