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COMMENTARY

Practicalities of HCR-20 implementation within secure psychiatric services

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The HCR-20 is established as the de-facto tool for the assessment of violence risk within forensic psychiatric services. Although much has been written about the value of the tool, less has been written about the practicalities of achieving meaningful completion of HCR-20 assessments at a service level. The present paper seeks to review recommendations within the literature and also those based upon the authors' own experiences in HCR-20 implementation, reviewing a number of the common issues and barriers encountered within the development of a strategic, service-level, approach to completion of the HCR-20. Possible solutions to these problems are also considered. We conclude that although there is not necessarily a single approach that is right for every service, certain principles need to be followed to ensure high quality assessments. Further, we develop a number of 'good practice points' which will be useful for services considering this issue on a strategic level, as well as commissioners evaluating the quality of HCR-20 completion within services.

Key words: HCR-20; clinical governance; risk assessment; violence; best practice guidance; audit

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Introduction

Within forensic psychiatric services, the HCR-20 has become accepted as the de-facto 'gold standard' in the assessment of the risk of violence. Its use is supported through government best practice recommendations (e.g. Department of Health, 2007), clinical quality standards (e.g. Royal College of Psychiatrists, 2013, 2014) and more recently through national commissioning standards (e.g. NHS Commissioning Board, 2013).

Consequently, all UK secure services, including low secure services, are expected to complete the HCR-20 as part of their routine clinical assessments within three months of admission, updating it on a six-monthly basis.

These recommendations and standards reflect the recognition that the HCR-20 is both effective and useful in helping to understand future violence risk and implementing meaningful risk management plans (e.g. Douglas & Reeves, 2010; Douglas et al. 2014; Strub et al. 2014).

Whilst there is acceptance of the importance and usefulness of the HCR-20 in the understanding and management of violence risk, and whilst there are clear guidelines about the process of completing an individual HCR-20 assessment (Douglas et al. 2013a), there are no practical service-level guidelines tailored to the UK secure psychiatric setting which ensure standardised practice. Nor is there guidance around the associated staff resource required to implement such a process. This is likely to drive considerable variation in how this task is approached between units; both in the process of completing the assessment and in the process of how, or even whether, clinical decisions are influenced by the HCR-20 (e.g. whether or not to grant area leave, how to best progress patients to other wards, and how to safely manage discharge). We have ourselves observed considerable variation in how different units have approached this task, and some research has highlighted weaknesses in service-level implementation (Sen et al. 2015; Gough et al. 2015).

We do not believe there is necessarily a 'right way' to go about the service-level implementation of the HCR-20. However, we do believe that there are common issues that must be resolved at a service level to ensure effective implementation. The HCR-20 is not something that can be embedded into routine clinical practice without a carefully planned strategy. Here, we consider some of these issues and some of the ways in which we have tried to solve practical problems that we have encountered in our own approach to this task. This leads us to suggest a number of 'good practice points' which we believe should be considered by secure inpatient units seeking to improve the standard of HCR-20 completion. We hope the sharing of our experiences is useful to other services.

Whose role is it to complete the HCR-20?

This is perhaps one of the first questions asked by services wanting to deliver the HCR-20. The easy answer is of course 'the whole team'. Although the HCR-20 manual indicates that multidisciplinary involvement does not necessarily make the HCR-20 any more effective at predicting risk (Douglas et al. 2013b) it does recommend multidisciplinary involvement on the basis that this encourages shared decision making, reduces the chance of information being missed and is likely to mean that risk management plans are more effectively implemented (Mental Health Commission, 2006).

However, resolving this issue in practice is never so easy. Rarely are multidisciplinary teams (MDTs) so functional that time consuming tasks are shared in the most effective way without clear processes and responsibilities. Services need to balance the availability of required competencies to complete the HCR-20, with the desire to ensure the widest practical involvement of the MDT. Completing an effective HCR-20 requires considerable skill across a range of clinical competences including clear report writing and clinical formulation; the HCR-20 manual further specifies knowledge of violence, expertise in individual assessment and expertise in mental disorder (Douglas et al. 2013b). Some staff may be more likely to have these essential competencies than others; other staff may (or may not) be able to develop some of these competencies through training and supervision.

We have considered and explored numerous models in regards to answering the basic question of 'who does the HCR-20?' We do not believe we have found the perfect answer. Presently, we will critically analyse some of the main models we have encountered.

The 'split it all up' or 'defined roles' approach

One approach is to allocate different parts of the HCR-20 to different professionals. For example, we have encountered systems in which the psychologist completes the historical items, the keyworker completes the clinical items and a psychiatrist takes lead for the risk management items. Then, somebody takes responsibility for pulling all the information together in regards to the scenarios, formulation and risk management plan.

Although this may seem an obviously egalitarian approach, it does have its weaknesses. Broadly, it can be said that these all revolve around the fact that the 'whole' of the HCR-20 is not simply a sum of its parts. There is significant cross-over between some of the HCR-20 items across the H, C and R domains (e.g. H6 and C3; H10, C5 and R5) and this may mean some duplication of work. It also may not be as egalitarian as first seems; in our experience it is the completion of the historical items, particularly H1, which takes the most time and effort. Further, by relying on three different people, the whole report may be delayed if one person does not complete 'their bit' and if the roles are not clearly defined, it is easier for clinicians to avoid prioritising their involvement.

However, we do not wish to rule out this approach entirely. If this model is implemented, we suggest that careful consideration should be given to the explicit responsibilities of different team members, including the identification of somebody who takes an overarching coordination role. Ideally, the role should form part of that person's job plan.

The 'rate it together, write it alone' approach

We have encountered other situations in which one person takes responsibility for writing the report but the scores are

made in a separate MDT meeting. Indeed, we have trialled this method ourselves. The temptation here is to tag the scoring process on to a regular meeting such as a CPA meeting (a meeting, typically six- monthly, where there is a formal review of a patient's care plan). This could be convenient in terms of regular updating, but even if time is well managed, this is likely to prolong the CPA considerably. For this reason we would caution strongly against trying to include this within an even shorter clinical meeting such as a ward round. As clinicians, we know that CPA meetings can be stressful and emotionally draining (for both staff and patients), and this is hardly the best context in which to make significant decisions about a patient's risk.

One of the modifications to this model that we also trialled was to use a separate 'risk rating' meeting with the MDT prior to the CPA. The disadvantage of this is an extra time commitment for every MDT member. Furthermore, in attempting to cover 20 risk items within a relatively short space of time, and ideally discuss possible scenarios, a formulation and a risk management plan, the likely consequence is that only a very short amount of time is devoted to any one item. This may mean that important clinical complexities are not discussed. We felt that this model is most likely to work when the patient's violence history is relatively discrete, which unfortunately does not characterise most of the patients we work with. However, it does at least provide an explicit focus on the HCR-20, and it can be made clear at this meeting who will take responsibility for writing the actual report. If timetabled appropriately, we consider that this is a better model than trying to 'squeeze' the HCR-20 ratings into another meeting such as a ward round or CPA.

In either scenario, once the meeting is conducted, the report itself is written up by a single member of the MDT. In our experience, this is usually the psychologist. Whilst psychologists should meet most of the competencies outlined in the HCR-20 manual, including particular strengths in formulation, it does mean the HCR-20 remains viewed by the wider MDT as a psychological assessment. This unfortunately may detract from its ability to influence multidisciplinary decisions, and given the typically limited available psychology resource, will also mean less time for psychologists to spend in direct clinical work.

The 'allocate to an individual' approach

Another way of solving the problem is to simply allocate the completion of the whole HCR-20 to a single member of the MDT. The author might involve the views of the various members of the clinical team to support scoring, or even delegate certain sections to others, but would use their own judgement to determine whose views were most important to include. The allocated clinician would broadly be responsible for the completion of the whole report. The obvious strength to this approach is that it is clear who is writing the report and, in theory, if the person completing the report has the necessary competencies, means that the report can be completed to a good standard, in a relatively efficient way. Allocation could occur on a rota basis, or one person could be nominated to complete all such reports as a formal part of their job role.

We have tried a number of variations of this approach, and each has had drawbacks. One of the most obvious drawbacks of the whole approach is that by not involving a team in any aspect of the 'production' of the HCR-20, others in the wider MDT may feel a lack of ownership, and this may discourage the use of the HCR-20 in decision making. Also, it feels that it goes against the ethos of the HCR-20 as a multidisciplinary document. We have attempted to involve the whole team by ensuring a draft report is always circulated by e-mail prior to the report being signed off. Typically, however, in practice few responses are received, and there is no certainty that the report has been read. A better approach might be for the report to be 'presented' at a specific meeting (perhaps most appropriately a ward round, to encourage its use in clinical decision making), but we have never managed to maintain this effectively over a longer period of time; we think largely because once the report is seen as 'done', the urgency of discussing it is lost and there is a temptation to cancel these meetings to meet other clinical priorities.

Of course the fundamental problem of this approach is how to decide which individual completes the report. One obvious solution is to nominate a specific individual whose job role it is to complete all HCR-20s. However, this has resource implications, and comes at the cost of multidisciplinary involvement. Another solution is to train as wide a group of clinicians as possible, in order to ensure that there is an effective 'pool' of clinicians who can take leadership in completion of an HCR-20. We have attempted this approach too, delivering our own training to psychologists, qualified nurses, psychiatrists, social workers and senior occupational therapists. Our hope was that these disciplines would develop their competencies in the HCR-20 through training and subsequent supervised clinical practice (offered by the allocated ward psychologist). Unfortunately, in many cases the reality proved different, and only a relatively small number of staff who completed the training went on to produce reports under supervised practice.

In addition, in our experience, the quality of submitted practice reports was variable. Some reports were completed with clear and thoughtful reference to the manual, were well structured, and provided meaningful conclusions. Others, however, appeared to be rushed, and lacked detail or substance. Sometimes, important and basic details had been missed and, on a number of occasions, it became clear to the supervisor that the supervisee required

further support in developing competencies in report writing. We had perhaps underestimated the extent to which supervision and support might be required, to ensure that these reports were of an acceptable standard. Of course, the training is likely to have been of a much broader value (see below), but it does not appear to have greatly assisted in substantially widening the range of professionals actually involved in HCR-20 completion. This has clearly been a learning point encapsulated within one of our 'good practice points' (see below).

Differences between first reports and updates

Once the time-consuming task of gathering the historical information is completed, significant efficiencies can be made in later updates, since only the events that have occurred since the previous report need to be added. This means that 'update' reports are potentially much easier and quicker to complete than initial reports. It may be possible that one of the variations of the 'allocate to an individual' approach discussed above may be to train some staff to solely update reports, though we would still argue that all members of staff doing this should have demonstrated the ability to write a report from scratch in supervised practice (otherwise, we cannot be sure that the clinician fully understands the use of the HCR-20).

Unless the report is rewritten from scratch every time it is updated, there are broadly two approaches to updating: appending or amending. Though this may seem an arcane point, the differences between the two methods can have long term differences for the sorts of reports that are ultimately produced, and hence their usefulness and usability.

If information is appended, this naturally has the advantage of preserving the previous information and scoring verbatim. This may mean that longitudinal changes can be more easily observed. This might be particularly useful for the clinical items for which it is important to identify the trajectory of change. This approach also makes explicit any differences in ratings between different clinicians at different times: if Clinician A rates a historical item as 'Yes/Definitely', but Clinician B later disagrees, the change becomes obvious in the report. Positively, this may highlight potential uncertainty about the item's scoring; negatively, this may mean erroneous scoring is perpetuated. The obvious downside is that if information were appended to all 20 items, every six months, then the HCR-20 report could quickly become so long as to be cumbersome. Further, this will not be appropriate in every case; we note that appending information to the risk management items makes little sense, since they need to be considered afresh with regard to the specific future plans being made by the clinical team at that time.

On the other hand, amending information in a previous report has its advantages, too. It allows the updating clinician complete flexibility over how they write the updated report. The report might remain more concise, particularly for sections where a macro perspective is needed (e.g. risk formulation, scenarios, management plans). However, unless recorded separately within the report, it means that it might be difficult to identify who the original or intermediate authors of the report were. Legally, this is unlikely to be an issue so long as the clinical records system ensures that a signed and dated copy of each report at each time-point is available, but it may cause the original author an injury to their pride if they later find a report which is largely their own work but no longer bears them any credit.

In sum, we suggest there may be some cases in which appending is more appropriate (e.g. the historical items), some cases in which amending is more appropriate (e.g. the clinical items; risk formulation; scenarios; management plan), and some cases in which complete rewriting is appropriate (e.g. the risk management items). 'Smart' electronic forms may feasibly be one way of making this easier for the clinician.

How long should it take to complete an HCR-20?

This is not an easy question to answer, but it is important to consider to allow service managers and commissioners to effectively plan and resource services. Our view is that the length of time taken to complete an HCR-20 properly is often underestimated.

The actual time taken depends on a range of variables about the patient being assessed and the information already available. If a patient arrives having had no previous contact with that service, then clinicians can spend considerable time sourcing historical information. Once they have this information, this then has to be read and summarised. To save time, we have typically attempted to complete as much of the historical section of the HCR-20 as possible as part of the summary. A separate summary may be beneficial if clinical records are particularly voluminous, and particularly if they are in no logical chronological order, or span a very long period. Transferring the chronological summary to the HCR-20 then highlights any gaps in the available information. We would suggest this process of reading and summarising rarely takes an experienced clinician less than a complete day, and frequently takes longer, though it is entirely dependent on the volume of information available and complexity of the case.

Of course, once the historical information has been analysed, time also needs to be allocated for the assessor to discuss the case with other involved clinicians (e.g. to rate the 'clinical' items) and often to interview the patient themselves (we note that we did not routinely interview

patients separately for the HCR-20; this is because in practice the person completing the HCR-20 is typically also conducting a detailed clinical assessment and through this will have generally good knowledge of most of the clinical items).

The actual process of rating the 20 items for presence and relevance is not in itself a particularly lengthy process, if the person making the ratings has the requisite clinical knowledge. We would suggest in this case that the process shouldn't take longer than an hour. Once this is done, then all the information needs to be pulled together in the scenarios, formulation and risk management sections. We would suggest here that for an experienced clinician working alone, this should take in the order of a few hours, again depending on the complexity of the case and associated formulation.

In total, therefore, we would be surprised if an HCR-20 completed from scratch would take an experienced clinician less than two full days to complete, frequently longer. One can envisage patients in which the reading alone may take several days. Subsequent updates would be expected to take significantly less time, perhaps in the order of a few hours if administrative procedures are smooth. We would argue that although this might represent a significant time commitment, there is little value in completing an HCR-20 if it is not done properly. We view this time as an investment which we would expect to pay dividends later, for instance in preventing the team from making repetitive and avoidable clinical errors, in ensuring that treatment is matched to need and, of course, in making safer clinical decisions. As the HCR-20 authors reminded us during HCR-20 training: 'there's no such thing as a quick risk assessment'.

How long should an HCR-20 be?

There seems to be a general agreement that there is a balance to be struck between conciseness and verbosity. This balance depends significantly on the underlying report writing skills of the author, and their ability to make judgements about the relative importance of the information they are including. Length, on its own, does not indicate quality; but on the whole, we would argue that it is better to risk verbosity and over- inclusivity if there is any chance of significant components to a person's risk being ignored or omitted. However, there are obvious risks to this too; we presume that longer reports may be a barrier to clinicians reading and using them, which means the report may become effectively useless. We also believe that whether a clinician reads or uses a report depends significantly on how much they value the report, how long they expect the report to be, and their familiarity with the 'structured professional judgement' (SPJ) approach. Experienced forensic clinicians should expect that reading an HCR-20 report will involve some meaningful investment of time.

We note that the HCR-20 version 3 coding form/ worksheet, provided in the manual, is 12 pages long. We would suggest that if this format is used as the rough basis or outline for an HCR-20 report, then 12 pages would be the expected minimum length. However, we also note that the worksheet includes relatively little space for including evidence against each of the 20 items. In our experience, it is useful to include detailed information to justify the scoring of each item, given the significant work that is involved in trawling through historical files. We argue this is especially important within H1, where a clear chronological account of all violent behaviour, summarising the known collateral information about the violence, should be included. This allows the HCR-20 to be viewed as a trusted source where all known information about past violent behaviour is summarised, and ensures that the scenarios, developed later in the assessment, fully reflect all possible types of future violence. Consequently, in some of our HCR-20 reports, the H1 section on its own can span multiple pages.

In sum, we do not believe there is a 'right' answer as to how long the HCR-20 should be. However, we believe that the determining factor in the balance between conciseness and verbosity should respond to the clinical value, acknowledging that a complex report may be necessary to do justice to understanding the risk of complex forensic psychiatric patients. The length of a report should not be dictated by a lack of appropriate resource or poor systems.

Training

We have now trained over 100 multidisciplinary professionals in implementation of the HCR-20. This has involved training sessions which were held across two days, facilitated by two qualified clinical psychologists with experience in completing HCR-20 reports, and with experience of training provided by the authors of the HCR-20, something we would strongly recommend. Protected time away from the wards was necessarily given to ward-based staff.

We split the two days of training, using the first day to go over the 'academic' parts of the HCR-20. Here, we cover an introduction to the SPJ approach as a whole, and highlight the historical use of the clinical and actuarial methods. We talk about the definition of violence and the practical process of completing an HCR-20 including discussion of the 20 items, providing examples for each. We consider how an HCR-20 should be used in decision making. Throughout all of this we highlight the importance of considering the individual formulation behind the patient's clinical presentation and how this links (or doesn't) to their risk.

The second day is much more 'hands on'. Participants form pairs or small groups (we initially used larger groups, but these have the disadvantage of diluting responsibility and leading to less active participation) and work through the process of completing an actual HCR-20 case with a patient who is known to them. Participants are requested to bring as much printed case material for this case as is available, and the first part of the day always involves reading and summarising this material. Participants often remark on how useful it is to have time to read the paperwork of patients they have been working with, sometimes for many years.

We encourage attendees to focus on making rough ratings for all 20 items and on the formulation section. We then encourage one of the pair to take away the ratings they have made and use this to write up the full HCR-20 report, encouraging them to use this as one of their 'supervised practice' cases.

The feedback from the training has been positive (113 completed feedback forms; mean rating for both 'enjoyment' of training and the extent to which it met their expectations was 8.8/10 (SD 1.3); mean rating for 'clear communication' 9.5/10 (SD 0.8)). Additionally, we asked participants to rate their confidence in completing the HCR-20 both before and after the training. The mean rating for confidence prior to the training was 2.7 (SD 3.0) and the mean confidence after the training was 7.3 (SD 1.7). Our view is that this may reflect a little over-confidence; most of the participants would not have completed an HCR-20 prior to the training and we would anticipate that high ratings of confidence (i.e. > 7) should only be given by people who have had relatively substantial experience in using the HCR-20 in clinical practice.

We have considered whether there were ways to adapt our training model to increase the number of staff following the training through to the supervised clinical practice component. An alternative model considered was to have a 'two phase' training where staff who possess the required competences to complete HCR-20 reports would complete the 'full' training, and other staff would complete, perhaps, some specific 'violence risk awareness' training. This is tempting, but does leave some questions, particularly what we would be attempting to 'do' in this training, and what the expected clinical benefit would be.

Another option we have considered is whether we should develop specific training for service managers. Whilst we would not have any expectation necessarily that the managers would complete the assessments themselves, we would hope to at least enthuse them in the principles of the HCR-20 and SPJ, and to allow discussion about shaping the service to ensure the HCR-20 became a more fully embedded process.

Patient involvement in the HCR-20

Shared decision making between patients and clinicians is often advocated as the ideal process within clinical settings (Charles et al. 1997) and has been applied within the context of HCR-20s (Henagulph et al. 2012). Indeed, within forensic services, the NHS standard contract specifies that 'the risk assessment and management should aim to support self- assessment and management through engaging the individual as much as possible and by providing the individual with information and support about the risk assessment process' (NHS Commissioning Board, 2013). However, this vision may not be universally applied in practice. Indeed, an audit within a low secure setting (Gough et al. 2015) indicated very poor levels of patient involvement within the risk assessment process.

Of course, patient involvement is a very broad term, and there may be considerable variation in what it looks like in practice. This variation may make it hard to know when 'patient involvement' is being meaningfully achieved. We will explore some of the most obvious methods, most of which fall on some continuum between simply discussing the final report with the patient; and at the other end of the spectrum, encouraging patients to take responsibility to rate the presence and/or relevance of risk factors, and 'co-formulate' their own violence risk with the clinician.

There are potential difficulties in directly involving patients with the actual writing up of their HCR-20. Even with a good professional relationship, it is fairly common for patients to disagree with some of the content of their HCR-20. The disagreement might reflect the fact that the patient simply does not perceive any need for detention or treatment. Pressing this disagreement may have the potential to cause a breakdown in professional relationships, which could consequently hinder recovery. A collaborative approach may therefore best focus on specific points in which some agreement can be reached.

Further, the uses of assessment tools in clinical forensic settings needs to be interpreted in line with the social desirability bias (e.g. McEwan et al. 2009). Possible self-enhancement could lead to inaccurate risk assessments and recommendations. In forensic settings generally, it is important to be aware of this bias, and other reasons for distorted information, and to 'triangulate' information provided directly by patients.

Positively however, given a good professional relationship with the patient, information gained through patient involvement can be incredibly useful and qualify the author to create a more accurate and meaningful formulation of their violence risk. Patient involvement promotes self-determination for patients (Deegan & Drake, 2006) which has the potential to aid recovery if the clinician and patient can reach mutual decisions and agreements on clinical plans.

We can only give this issue a brief overview and it deserves further discussion. We close by summarising that the extent to which patients should be involved in their HCR-20 should ultimately be an individual clinical issue. The aim should be to ensure that patients are involved to the greatest extent possible, and in a way that tries to lead to some therapeutic objective in encouraging shared decision making and an increase in shared responsibility.

Using the HCR-20 in clinical decision making

The HCR-20 is intended to be a live document that helps the clinical team make better decisions about risk. We know that as clinicians, we have a range of reasoning biases (Tversky & Kahneman, 1974; Norman & Eva, 2010) that mean that idiosyncratic decisions about risk made by clinicians based simply on 'expertise' or 'experience' are flawed (e.g. Meehl, 1954; Grove & Meehl, 1996; Lidz et al. 1993). Further, a lack of structured process means a deficiency in systematic accountability, and we note for instance that independent investigation reports of homicides committed by psychiatric patients have remarked upon incidents when HCR-20s have not been used to influence management plans and clinical decision making (e.g. Winchcombe, 2013)

But what does it mean to use the HCR-20 in clinical decision making? Should it be referred to before every decision? And what does it even mean to refer to an HCR-20? With a six-month update window, and clinicians who have perhaps 20 HCR-20s to 'hold on to' within this time period, is a quick scan of the scoring or formulation enough? Often, in practice, completion of the HCR-20 does not temporally coincide with a point in which decisions about progression, leave and so forth are made; even if such plans are considered within the 'R' items, risk management plan and scenarios. Further, in many scenarios the author of the HCR-20 and the ultimately accountable clinician (the Responsible Clinician for the patient's care), who may in practice make a 'final' decision, may well be different people.

We suggest that the only way of resolving these issues is through effective multidisciplinary decision making, with clear agreement within the team (and ideally the service) about how the HCR-20 should be incorporated into this process. Such a process might be most effective if it is implemented within policy.

Certainly, a lack of integration of the HCR-20 within the CPA process has been remarked upon within independent investigation reports following adverse incidents (e.g. Brougham & Hornby, 2014). Whatever process is agreed, we suggest that within a low or medium secure unit there should be a number of 'gateway decisions' (see below) which trigger the team, at a minimum, to ask 'What does the HCR-20 say?' and perhaps spend some time reviewing the extent to which the decision is covered within the R items, scenarios and management plan (see Box 1). We suggest that this is, in practice, a really difficult area for services to 'get right'.

Box 1. Gateway decisions: key points at which formal reference to the HCR-20 should be made

Should the patient:

- Get leave for the first time?
- Be transferred between wards?
- Have a significant change or extension to his/her leave?
- Regain leave after losing leave following a risk incident?
- Be discharged or progressed to a low or non-secure environment?

In an outcome-driven culture, it is very easy to see the completion of the HCR-20 report as the primary target. We must not forget that primarily, the HCR-20 is intended as a clinical tool to help us make better decisions. It is suggested that formal guidance issued by professional bodies may make it easier for units to compare their own practice in this area to a 'best standard' and hence improve accountability.

Finally, whilst the purpose of this article has been to focus on systems for the appropriate use of the HCR-20, these systems should not be so rigid as to lose sight of the main purpose of the HCR-20. Different risk factors, and different risk assessment approaches, may be more important for the management of short-term risk, or where risk of violence presents in specific context; e.g. sexual violence. In terms of clinical decision making, therefore, services need ensure that the clinical decision being made is, ideally, based on the use of the most appropriate tool; which may not always be the HCR-20.

Clinicians' cognitive distortions

We have informally encountered a range of opinions or beliefs that clinicians hold about the HCR-20. Perhaps most fundamentally, we would suggest that the extent to which a clinician believes the HCR-20 is a useful tool is one of the primary determining factors in the extent of its use. Some of these beliefs therefore may prevent effective use of the HCR-20. For the purposes of this paper, we have termed these beliefs 'cognitive distortions', a term that should be familiar to forensic practitioners (Beck, 1963; Maruna & Mann, 2006). These negative thought processes may demotivate the clinician in relation to completing the assessment, delay completion of the report or impact on its quality. We want to try to dispel some of the 'cognitive distortions' that we have encountered most frequently.

Firstly, the process of writing the report may sometimes be seen as 'another tick box exercise', taking up an

unnecessary amount of time which the clinician does not have. However, this belief is unjustified. As mentioned earlier, the original report may indeed take a substantial time; however, we believe the time is an investment in achieving better long term clinical outcomes. Further, once a thorough first HCR-20 has been written, future updates can be quickly completed. By taking time to do a high quality original report, less time and effort will need to be invested in the future, and potential rewards are high. On a service and human level, one does not have to prevent many serious violent incidents for a rigorous application of the HCR-20 to become worthwhile.

Another 'cognitive distortion', particularly prevalent amongst clinicians who started work in the service after the patient was admitted, is to assume that patients who have been in the service a long time will have always had a detailed summary of their historical records and that all relevant collateral information will have been obtained. However, we have frequently observed that this is not always a reliable assumption to make. Quite frequently patients move through services without any detailed analysis of their history being constructed. Furthermore, even when a case summary has been produced in the past, it is often out of date, inaccurate or incomplete. A time consuming, systematic assessment and summary of the material that is and is not held, is the only way to resolve this issue. Therefore, the HCR-20 can serve as an opportunity for professionals to develop this summary and find out what is known, and what is not known about the patient.

On a similar theme, we have also encountered the belief that it is possible to do a good HCR-20 without thorough information and that it is possible to base the report purely on either professional opinion, or an assessment of the patient's current presentation. However, the HCR-20 manual clearly states systematic analysis is needed to gather basic case information about the presence of risk factors, which should be the very first step in administrating an HCR-20. This information should then be integrated together to formulate a patient's risk (Douglas et al. 2013a,b). This process is essential to ensure the report is accurate and most clinically useful.

Finally, we have observed that some professionals have expressed a belief that once they have completed the report no one will read it. They are then unsure of the point of writing the report. Firstly, we would respond that by completing a detailed history and formulating the patient's risks, the involved clinician can at the least familiarise themselves with the patient's case in detail; something that by itself may result in safer clinical decision making. However, we would also reflect that whether or not a document is read does depend greatly on the extent to which the document is valued. In this regard, we would highlight that the HCR-20 has real-world value in predicting aversive outcomes, and that it is a much stronger basis than clinical instinct or actuarial methods alone (Doyle et al. 2014). Combined with an individual formulation, the HCR-20 is potentially a very powerful document, and when used properly has the potential to assist the team to avoid patient violence with catastrophic consequences for the individual and society alike. In this sense, it is very much not just 'another tool'.

Good practice points

We believe that the summary above leads us to identify several practical questions to which services need to give explicit thought:

- How will information for the HCR-20 be obtained? Who will obtain that information? Who will read it and summarise it?
- How will the ratings for the HCR-20 be made?
- Who will actually write the HCR-20 report?
- What are the specific roles of other team members? How will fulfilment of these roles be measured or audited?
- How will the HCR-20 be used in routine clinical practice? How will the HCR-20 interface with other risk assessments? Is there a different process for updating reports compared to initial completion?

In considering these questions, we suggest the following 'good practice points' as a useful starting point. These focus primarily on service and strategic practices, and less on procedures that we assume would form part of standard HCR-20 training (e.g. we do not emphasise, for instance, that a clear formulation should be included).

- Strategies for implementation need to occur on an organisational and management level, not just on an MDT level.
- People involved in the completion of the HCR-20 should have their responsibilities clearly outlined in a job plan.
- Resourcing should reflect real-world calculations of how long it takes to complete an HCR-20. We have suggested above that this time is often underestimated.
- Services need to be aware of the various competencies needed to complete the HCR-20, including those outlined in the HCR-20 manual (Douglas et al. 2013b), but also basic competencies such as report writing. Competencies should be borne in mind in terms of training, supervision and answering the question of who completes the assessment.
- Training should be provided by clinicians with significant experience of the HCR-20 who have attended formal HCR-20 training themselves.
- Trainers need to have expectations of the outcomes of training which are shared by the wider organisation.

- Following training, clinicians new to the SPJ approach should engage in a process of being 'passed out' by an experienced senior clinician (in our case this has become the remit of the ward psychologist). On-going supervision should be provided as necessary.
- Units should have an explicit process of how the HCR-20 is rated and written up, with clear roles and expectations outlined, and sufficient dedicated time. This should be audited (see below) and have management follow-up.
- Units should have an explicit process of how the HCR-20 is used to influence clinical decision making (e.g. decisions about leave, decisions about progression and discharge). This should be embedded on a policy level, likely alongside the CPA process.
- Services should consider the process of updating to be different to writing a report from scratch. We believe that it is efficient to 'update' reports rather than rewrite the whole report every six months. However, explicit thought needs to be given to which parts of a previous report to append, amend, or rewrite. In the same order, we propose these should relate broadly to historical, clinical and risk management items.
- Service managers need to have a clear understanding of how the HCR-20 can help the organisation make safer and more defensible decisions about complex patients. If managers see it as 'another target' that has to be met this will be echoed throughout the organisation. Clinicians who believe in and understand in the SPJ model should attempt to explain this model wherever possible.
- The HCR-20 is likely to be a relatively lengthy and detailed document, and it should be used by clinicians and services as the default source of a chronology of the person's violence.
- An HCR-20 report is only as good as the information on which it is based. It can be difficult to obtain historical information and clear processes and responsibilities should be outlined.
- Services should consider adopting minimum standards for obtaining collateral information. The HCR-20 manual provides some guidance on this point. However, in the UK context we believe this should include, as a minimum: Police National Computer (PNC) printout (or other verifiable document detailing official conviction history); collateral accounts of relevant violent incidents; detailed history of admissions and history of mental health presentation. Ideally, information should also be supplemented by developmental information (e.g. school records; social services history) and information from significant others (e.g. parents/carers).
- The HCR-20 should be passed on to any relevant agencies routinely after discharge. This should be reflected in policy. We encourage clinicians to note the Caldicott principles (Caldicott, 2013), which emphasise that 'the duty to share information can be as important as the duty to protect patient confidentiality'. Community services may need support to make best use of the document.
- Services should incorporate clear audit practices within their assessment of completion. These should extend beyond the simple check of whether a HCR-20 has been completed. Audit standards that we would recommend are detailed in Box 2. These might well be developed further. We recommend such audits might occur at 6 monthly intervals. Such standards may be useful for commissioners in monitoring quality of compliance simply as opposed to technical compliance.

Box 2. Recommended minimum audit standards for the HCR-20

- Is the author clearly identified (or if report produced by multiple people, are all contributing roles clearly identified?)
- Is the report clearly identified as a first report or update?
- Are ratings given to all 20 items for both presence and relevance?
- Does H1 specifically contain a relatively comprehensive account of all previous violence to date, based on appropriate sources of information?
- Are ratings in H6 and H7 based on clinical assessments of appropriate quality?
- Are ratings for all factors supported by appropriate narratives, which in turn are based on appropriate sources of information?
- Are the risk management items considered against a specific point in time or anticipated set of circumstances?
- Is there a clear formulation which provides a plausible explanation for the person's violence, based on the information already identified in the HCR-20?
- Are the scenarios clearly outlined, appear to relate to the formulation, and lead/connect to appropriate risk management plans? Do they consider imminence, severity, and likelihood?
- Does the risk management plan relate to a specific anticipated scenario?
- Throughout the report, is there evidence of use of appropriate triangulation of different sources of information, with evidence of detailed knowledge of available historical information expressed?
- Is there evidence of appropriate patient involvement?

References

Brougham, C. and Hornby, C. (2014) *Independent investigation into the care and treatment of Mr B*. Report for NHS England, North Region. https://www.england.nhs.uk/wp-content/uploads/2015/02/mr-b-final-report.pdf

Beck, A.T. (1963) Thinking and depression. I. Idiosyncratic content and cognitive distortions. *Archives of General Psychiatry*, 9(4): 324–333.

Caldicott, F. (2013) *Information: to share or not to share? The information governance review*. Department of Health. https://www.gov.uk/government/publications/the-information-governance-review

Charles. C., Gafni. A. and Whelan. T. (1997) Shared decision-making in the medical encounter: what does it mean? (Or it takes at least two to tango). *Social Science & Medicine*, 44(5): 681–692.

Deegan, P.E. and Drake, R.E. (2006) Shared decision making and medication management in the recovery process. *Psychiatric Services*, 57(11): 1636–1639.

Department of Health (2007) *Best practice in managing risk*. National Mental Health Risk Management Programme. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/478595/best-practice-managing-risk-cover-webtagged.pdf

Douglas, K.S. and Reeves, K. (2010) The HCR-20 violence risk assessment scheme: overview and review of the research. In: Otto, R.K and Douglas K.S (eds). *Handbook of violence risk assessment*. Taylor & Francis.

Douglas, K.S., Blanchard, J.E. and Hendry, M.C. (2013a) Violence risk assessment and management: putting structured professional judgement into practice. In: Logan, C., Johnstone, L. (eds). *Managing clinical risk: a guide to effective practice*. 29–55. Routledge.

Douglas, K.S., Hart, S.D., Webster, C.D. and Belfrage, H. (2013b) *HCR-20 v3 assessing risk for violence. User guide*. Mental Health, Law & Policy institute, Simon Fraser University, Burnaby, Canada.

Douglas, K.S., Hart, S.D., Webster, C.D., Belfrage, H., Guy, L.S. and Wilson, C. M. (2014) Historical-clinical-risk management-20, version 3 (HCR-20V3): development and overview. *International Journal of Forensic Mental Health*, 3(2): 93–108.

Doyle, M., Power, L., Coid, J., Kallis, C., Ullrich, S. and Shaw, J. (2014) Predicting post-discharge community violence in England and Wales using the HCR-20v3. *International Journal of Forensic Mental Health*, 13(2): 140–147.

Gough, K., Richardson, C. and Weeks, H. (2015) An audit of service-user involvement and quality of HCR-20 version 2 risk assessments on rehabilitation and low secure wards. *Journal of Psychiatric Intensive Care*, 11(S1), e2.

Grove, W.M. and Meehl, P.E. (1996) Comparative efficiency of informal (subjective, impressionistic) and formal (mechanical, algorithmic) prediction procedures: the clinical–statistical controversy. *Psychology, Public Policy, and Law*, 2(2): 293–323.

Henagulph. S., McIvor. R. and Clarke. A. (2012) Risk and recovery group for offenders with mental disorders. *Psychiatric Services*, 63(1): 94–95.

Lidz, C.W., Mulvey, E.P. and Gardner, W. (1993) The accuracy of predictions of violence to others. *Journal of the American Medical Association*, 269(8): 1007–1011.

Maruna, S. and Mann, R.E (2006) A fundamental attribution error? Rethinking cognitive distortions. *Legal & Criminological Psychology*, 11(2), pp. 155-177

McEwan, T. E., Davis, M. R., MacKenzie, R. and Mullen, P. E. (2009) The effects of social desirability response bias on STAXI-2 profiles in a clinical forensic sample. *British Journal of Clinical Psychology*, 48: 431–436.

Meehl, P.E. (1954) *Clinical versus statistical prediction: a theoretical analysis and a review of the evidence*. Minnesota University Press.

Mental Health Commission (2006) *Multidisciplinary team working: from theory to practice*. Discussion Paper. Mental Health Commission Ireland. http://www.mhcirl.ie/file/discusspapmultiteam.pdf

NHS Commissioning Board (2013) *NHS standard contract for medium and low secure mental health services (Adults)*. NHS England/C03/S/a. https://www.england.nhs.uk/wp-content/uploads/2013/06/c03-med-low-sec-mh.pdf

Norman, G.R. and Eva, K.W. (2010) Diagnostic error and clinical reasoning, *Medical Education*, 44: 94–100.

Royal College of Psychiatrists (2013) *Standards for community forensic mental health services*. Royal College of Psychiatrists Centre for Quality Improvement.

Royal College of Psychiatrists (2014) *Standards for medium secure services*. Royal College of Psychiatrists Centre for Quality Improvement.

Sen, P., Lindsey, S., Chatterjee, N., Rama-Iyer, R and Picchioni, M. (2015) An audit of the quality of HCR-20 violence risk assessments in a low secure service. *Journal of Psychiatric Intensive Care*, 11 (S1), e3.

Strub, D.S., Douglas, K.S. and Nicholls, T.L. (2014) The validity of version 3 of the HCR-20 violence risk assessment scheme amongst offenders and civil psychiatric patients. *International Journal of Forensic Mental Health*, 13 (2): 148–159.

Tversky. A., and Kahneman. D. (1974) Judgement under uncertainty: heuristics and biases, *Science*, 185(4175): 1124–1131.

Winchcombe, L. (2013) *Independent investigation into the care and treatment provided to Mr C and Mr D*. NHS England, London Regional Office. https://www.england.nhs.uk/wp-content/uploads/2014/06/ind-invest-mr-c-m-d.pdf