



69 questionnaires were excluded due to incomplete response. The incomplete response may be linked to the difficulties some of the people may have experienced while completing the questionnaire. These difficulties could be related to the framing of questions as well as the length of questionnaire, as reported by a few patients with cognitive impairment. However, with hindsight, recording apparent reasons for not completing the questionnaire would have been quite useful to explain fully the incomplete response. Furthermore, this information could have been used for future similar questionnaire-based studies. It is also, therefore, a possibility that if these incomplete questionnaires or the reasons for not completing them were included, it may have affected the overall satisfaction levels.

The key finding of the study was that, despite high satisfaction levels with out-patients, nearly half of users thought it preferable to be visited at home by another mental health professional (not necessarily a doctor). Although the questionnaire did not seek reasons for this statement, we feel that convenience factors for users and carers were the main reasons that people would prefer to be seen in their own home. It could be concluded that non-medical prescribing could be developed further, particularly for people taking cognitive enhancers. However, if services were to be reconfigured, staff training/supervision, staff time and transport costs would be factors to be considered, alongside patient choice; individuals attending out-patients in Sheffield have access to facilities for physical examination, phlebotomy and a specialist pharmacy on site, which would not be available in peoples' own homes.

There are thus many areas for further research including assessment of the practicalities and acceptability of home-based community clinics, and a

cost-benefit analysis of different models of service provision. As out-patient clinics are highly acceptable to service users (at least in Sheffield) and NICE guidance for cognitive enhancers requires frequent assessments, out-patient clinics for older adults should not be closed on the basis of changes in general adult psychiatry until alternatives have been evaluated.

Declaration of interest

None.

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Use and perceived utility of structured violence risk assessments in English medium secure forensic units

AIMS AND METHOD

We surveyed the usage and perceived utility of standardised risk measures in 29 forensic medium secure units (a 62% response rate).

RESULTS

The most common instruments were Historical Clinical Risk–20 (HCR–20) and Psychopathy Checklist – revised

(PCL–R); both were rated highly for utility. The Risk Matrix 2000 (RM2000), Sex Offender Risk Appraisal Guide (SORAG) and Static-99 were the most common sex offender assessments, but the Sexual Violence Risks–20 (SVR–20) was rated more positively for its use of dynamic factors and relevance to treatment.

CLINICAL IMPLICATIONS

Most medium secure units use structured risk assessments and staff view them positively. As HCR–20 and PCL–R/PCL–SV (Psychopathy Checklist – Screening Version) are so widely used they should be the first choices considered by other services.

Violence risk assessment is central to the work of forensic mental health services. Standardised methods of assessment have become more common but there is great variation between services in the use of such instruments.

The alternatives to clinical assessment alone are actuarial methods (e.g. using the Violence Risk Appraisal Guide (VRAG); Quinsey et al, 1998) that prescribe the collection and interpretation of data relevant to risk

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(e.g. previous violence, substance misuse, psychopathy); and structured clinical methods (e.g. Historical Clinical Risk–20 (HCR–20); Webster *et al*, 1997) which require collection of similar data but also require the use of clinical discretion in using additional information and in how to interpret the data).

The current consensus is that structured clinical assessment is the best option for clinicians (Monahan *et al*, 2001). Recent guidelines from the Department of Health's *Best Practice in Managing Risk* (Department of Health, 2007) and the Royal College of Psychiatrists' *Giving up the Culture of Blame: Risk Assessment and Risk Management in Psychiatric Practice* (Morgan, 2007) have further supported the use of structured clinical methods for assessment of violence risk. However, the extent to which UK forensic mental health services have adopted these methods remains unknown.

Method

The study aims were:

- to measure how many medium secure services use structured violence risk and sexual offender risk assessment instruments;
- to identify which instruments were used;
- to measure their perceived utility.

A search was conducted for all medium secure forensic services on an internet database (www.theforensicdirectory.com), giving a sample of 47 adult medium secure forensic units (28 National Health Service (NHS) units, 19 independent units).

A questionnaire was designed for the study. It covered unit size, case mix and staffing. Regarding violence risk assessment methods (see online supplement) we asked specifically whether named instruments, i.e. Psychopathy Checklist – Revised (PCL–R; Hare, 1991), Psychopathy Checklist – Screening Version (PCL–SV; Hart *et al*, 1995), VRAG, Violence Risk Scale (VRS; www.psynergy.ca/pdf/vrsummary.pdf), Iterative Classification Tree (ICT; Monahan *et al*, 2000), Offender Group Reconviction Scale (OGRS; Taylor, 1999), Risk Assessment and Management Schedule (RAMAS; O'Rourke, 1995) and Historical Clinical Risk–20 (HCR–20), were used 'frequently', 'occasionally' or 'never'. If used, respondents were asked to rate utility of each method in routine practice on a five-point Likert scale (ranging between 'not useful' and 'very useful'). If the unit accommodated people who were sex offenders, the process was repeated for sex offender risk assessments, namely the Rapid Risk Assessment for Sex Offence Recidivism (RRASOR; Hanson, 1997), Sex Offender Risk Appraisal Guide (SORAG; Quinsey *et al*, 1998), Static-99 (Hanson, 1997) and Risk Matrix 2000 (RM2000; Thornton, 2003). Respondents were asked to identify and rate any additional risk assessment instruments in use that were not listed on the questionnaire.

The questionnaire was sent in April 2007 to clinical directors with a covering letter (explaining the purpose of the study and maintenance of anonymity) and a stamped

addressed envelope. Reminders were sent to non-respondents who were also followed-up by telephone. Respondents were telephoned for follow-up qualitative interviews, the notes of which were analysed by simple thematic analysis.

Results

Responses were received from 29 (19 NHS, 10 independent) of 47 medium secure services surveyed, giving a 62% response rate. We attempted to obtain follow-up qualitative telephone interviews from all 29 responder units, out of which 11 (9 NHS, 2 independent units) were achieved. Clinicians at the other units were unavailable to give interviews.

Unit size ranged from 17 to 276 beds with a mean of 76.0 (median 59.5). Clinical teams included a mean of 5.5 consultant psychiatrist whole time equivalent posts (range 1–25) and 5.9 psychologist posts (range 1–19.5). Fifteen units (52%), all of which were NHS units, provided outreach or community forensic services, whereas 14 units (48%) did not. National Health Service and independent units differed significantly regarding the provision of outreach or community services, but not in any other way (regarding bed numbers, staff numbers and numbers of units using each risk assessment instrument).

Online Table DS1 shows the frequency of use and perceived utility of violence risk assessments (see online data supplement). The PCL–R and HCR–20 were used by most units, often being used together. Clinicians were trained in the use of the PCL–R and described it as familiar, simple and well validated. Many clinicians described the HCR–20 as an *'aide-memoire'* in clinical practice, and used it to guide clinical management. Clinicians also liked the fact that staff of all disciplines can use it, so it is easily incorporated into team working.

The START (Short-Term Assessment of Risk and Treatability; Webster *et al*, 2004), was rarely used but received the highest utility rating. Two forensic units used self-generated scales (mean utility rating 3.50); a clinician at one of these units expressed concern about the scale's lack of external validation and unfamiliarity to clinicians in other services.

Online Table DS1 also summarises the findings regarding the frequency of use and perceived utility of sex offender risk assessments. Sex offender risk assessments were being used in 20 (69%) of the responder medium secure units. The RM2000, Static-99 and SORAG were used by the most units. The Sexual Violence Risks–20 (SVR–20; Boer *et al*, 1997) scored highest for utility (rated 5 out of 5 by all six units that used it). Important factors in determining the utility of a sex offender risk assessment instrument were familiarity, training, validation and clinical usefulness of risk assessment scores.

Qualitative interviews found the HCR–20 was favoured because it was accessible to all disciplines; it provided comprehensive information about violence risk; it helped with risk management; it was tailored to the individual because it included specific risk scenarios; its



dynamic content allowed monitoring of change; and it was widely understood by other clinicians.

The PCL–R was thought to be useful in cases of suspected psychopathy. Clinicians liked the sophisticated psychological training, and the scale was widely used, thus facilitating communication.

Actuarial assessments were used frequently, but clinicians thought it best to use more than one and incorporate scores into a wider risk assessment involving clinical judgement. Thus, they were used as part of structured clinical assessment rather than as stand alone measures. Reasons for adopting a specific method included encouragement or insistence by the local healthcare trusts, and research evidence. Clinicians were unsure of best practices for sex offender risk assessment, as there was a bewildering array of tools, many developed from US prison populations with limited validation in UK populations. Personal preferences influenced choice of tools. The SVR–20 was highly rated because of the specialist training received before use, and clinical utility of the scores.

Forensic units used the results of risk assessments to predict risk scenarios; to reduce risk of absconding; to inform decision-making in CPA (Care Programme Approach) meetings and ward rounds; and to guide treatment, management and rehabilitation of individuals.

Discussion

This study is the first to examine the use of structured violence and sex offender risk assessments in UK medium secure forensic units and shows that these methods have been widely adopted in a relatively short time.

The study had limitations. First, the reliability of the new internet database (www.theforensicedirectory.com, used to identify the sample) is unknown and some forensic units may have been omitted from the sample. Second, although the response rate is respectable for surveys of this kind, given the small target population we would have preferred a higher response rate in both the postal survey and telephone interviews. There may be bias in that units that have not adopted structured methods may be less likely to respond.

Recent research showed actuarial risk assessment instruments, namely the VRAG (for violence risk) and Static–99 (for sex offender risk), which have high ‘margins of error’ at the group level, but so high at the individual level as to render risk estimates virtually meaningless (Hart et al, 2007).

Initially, it may appear worrying that actuarial methods of violence risk assessment (PCL–R) and sex offender risk assessment (RM2000, Static–99 and SORAG) were popular in our study. However, they were generally used appropriately as a supplement to clinical assessment. Clinicians acknowledged their limitations and used them responsibly, tailoring them to fit the individual patient. Both the VRAG and Static–99 were rated relatively low for clinical utility (3.60 and 3.33 respectively), but were nevertheless considered useful additions to comprehensive assessment.

Structured clinical instruments, particularly HCR–20 and SVR–20, scored higher for utility and were used by most units. Our interviews suggested that clinicians were persuaded of the value of these instruments in summarising risk factors and assisting the development of management plans (Doyle & Dolan, 2006).

The benefits of structured clinical risk assessment operate along two dimensions that are somewhat independent. First, they may increase accuracy of risk assessments, although it is debatable whether any particular instrument is superior to another. Specialist services are taking a sensible approach in applying more than one measure. The second major benefit is in providing transparency, plus a shared language for describing and communicating about risk. These are desirable goals in their own right, being fully consistent with broader aims of greater accountability and tighter clinical governance. Success in these aims depends less on actual instruments used than on consistency between services. Communication is best, and scrutiny easiest, when services use the same measures. Our study suggests the HCR–20 and PCL–R (or PCL–SV) are becoming the *de facto* standard within medium security, which should make them the first choices for other services.

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Declaration of interest

None.

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Continuity of care coordination, health needs and social deprivation

AIMS AND METHOD

Continuity of care is an important aspect of service provision. We retrospectively examined the number of changes over a 2-year period in care coordinator for new patients on enhanced care in a London borough. Deprivation score, length of hospital stay, and health and social needs were examined for association with continuity of care.

RESULTS

Twenty-six patients met the inclusion criteria; ten patients (39%) had a change in care coordinator. Patients having one or more changes in care coordinator were found to live in significantly more deprived council wards ($P=0.004$), but their needs score ($P=0.863$) or length of hospital stay ($P=0.368$) were not

significantly different than in those who did not have changes in care coordinator.

CLINICAL IMPLICATIONS

Social deprivation affects relational continuity of care in community teams but the mechanism requires evaluation.

Continuity of care has been highlighted as an important aspect of the care programme approach (CPA; Department of Health, 1999). Service users on enhanced level CPA have a designated care coordinator from the community mental health team, usually have more than one agency involved in delivering care and have regular multidisciplinary review meetings. When there are changes in care coordinator within a community team, service users need to adjust to a new staff member central to their care plan.

Continuity of care and its relationship with health outcomes has been examined for persons with severe mental illness in the Canadian health system (Adair et al, 2005). Using an observer and patient-rated continuity of services scale, continuity of care was found to be associated with a better quality of life, better community functioning, lower severity of symptoms and greater service satisfaction.

Haggerty et al (2003) in a multidisciplinary review define three types of continuity of care: informational, management and relational. To our knowledge, relational continuity has not been examined in the context of CPA care coordination in the UK.

Using changes in care coordinator as a proxy measure of relational continuity, we examined the length of stay in hospital, health and social needs assessment as recorded on CPA documentation and patient deprivation levels for association with continuity of care.

Method

Electronic records were examined for all patients referred to the London borough of Harrow's mental health service between 1 January 2004 and 1 January 2005; the service used the 'JADE Co-ordinated Care 2003' electronic record system. Patients previously known to the service were excluded to reduce potential confounding factors (patients known previously to teams may have developed a good relationship with a team member, reducing their chances of reallocation if care-coordinated by the same team member).

Patient's records were examined only if they had two or more enhanced CPA plans recorded between the date of referral and August 2006. Data-sets were then collected from these records.

Demographic information on age, gender, ethnicity and first language was collected. Diagnostic information was recorded from the most contemporaneous enhanced CPA record. The number of persons acting as care coordinator during the study period was recorded by comparing details on all enhanced CPA records in the study period.

Information from needs assessments was collected from enhanced CPA forms by examining the dichotomised tick box indicating whether a need was present or absent. There were nine domains of need covered on the enhanced CPA form: mental health, physical health,