Use of HCR–20 in routine psychiatric practice

I read with interest the recent editorial by Maden (Psychiatric Bulletin, April 2005, 29, 121–122) and the paper by Dowsett (Psychiatric Bulletin, January 2005, 29, 9–12), which supported the use of the HCR–20 in routine psychiatric practice. I would like to suggest that the HCR–20 may be of particular value in clarifying the interface between generic and forensic services and in directing the allocation of resources.

In an audit of our local service, we used the HCR–20 to compare the level of risk of the community forensic service case-load with forensic in-patients in a low security facility and in-patients managed in the same locked ward environment by general psychiatry services. Despite sizeable differences in the demographic profile compared with Dowsett’s study, the size of the potential risk as measured by the historical sub-scale was similar for our forensic groups (mean=12.0 (s.d.=3.0) for community forensic patients and 12.3 (s.d.=2.2) for forensic in-patients). This compared with an H-scale mean of 7.2 (s.d.=2.2) for general psychiatry patients who were in the same locked ward environment. There is often a discussion as to whether particular patients in this unit should be admitted under forensic or general services. Similarly the combined clinical and risk management scores showed statistically significant and clinically relevant differences between community patients and the in-patient groups.

I would therefore support the call to incorporate the HCR–20 into standard risk assessment procedures. There are obvious advantages in using a tool based on empirically derived information. At the service level the HCR–20 may be useful in stratifying services according to the level of risk they should manage, such that an H-scale score could provide an initial indicator of the suitability for supervision by a community forensic team or a generic team. Stable low clinical and risk management scores for forensic patients could highlight their suitability for transfer to generic services. A full clinical assessment could then be instigated. The HCR–20 may also be useful in demonstrating to those who fund forensic services that expensive services such as assertive outreach or intensive case management are being directed to an appropriately ‘forensic’ and high-risk client group.

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What is the role of a community forensic mental health team?

The meticulous report of John Dowsett on ‘Measurement of risk by a community forensic mental health team’ (Psychiatric Bulletin, January 2005, 29, 9–12) illustrates nicely the use of a standard risk assessment instrument, the HCR–20, in an inner city context. The high scores on the historical scale of the eight (out of 47) patients who re-offended in the 2.5 years following data collection very much reflect that adage of forensic psychiatrists, that previous violence is the core predictor of future violence.

However, although harbouring doubts about the limits of risk assessment (e.g. Szumukler, G., ‘Homicide inquiries: What sense do they make?’, Psychiatric Bulletin, January 2000, 24, 5–10) we consider that pragmatic reviews, such as this study, more importantly call into question the role of a forensic community team. For reasons of history, resource limitations and serendipity, in City and Hackney (an equivalent inner-city area) we have no such agency, restricted patients being routinely handed over to the community mental health teams. These do have an integrated forensic community psychiatric nurse, but the forensic/general psychiatry interface is of the simplest indoor/outdoor type. Dowsett’s report that there are a number of patients in his team who have remained ‘stable for some years’ (and therefore could perhaps be handed back to generic services were it not for the fact that they committed a very serious offence!) certainly reflects part of our own experience with restricted individuals. They are often easier to manage than many ‘non-forensic’ patients, because the nature of the restriction order and their history of institutionalisation generates therapeutic and social control.

Likewise, another group of Dowsett’s patients are noted to be perfectly manageable on ordinary acute wards, and again he considers that there would be advantages, in terms of quick admission, were they to be managed by a local generic service. His third group, namely those with what might be termed ‘historically established criminality’ also do not benefit from a ‘forensic’ team, since there is no specific psychological intervention known to have an impact. In which case, why have an expensive resource ‘looking after’ such individuals, with no evidence of benefit given that criminality, per se, is not a treatable disorder. The cynic might even suggest that maintenance of a stable mental state in such a group enhances their likelihood of offending.

If such findings reflect the case-load of forensic mental health teams elsewhere, and anecdotal reports very much suggest this is the case, then is there not an urgent need to rethink the notion of a separate forensic capacity? As Dowsett has pointed out, it is important for forensic services to demonstrate expertise in managing this criminal group, but use of the HCR–20 is not especially difficult and reintegration with generic community mental health teams would perhaps be a much better option. It would help break down the often difficult interface issues of parallel teams, would enhance resources for those who do benefit from psychiatric input and would put the issue of risk exactly where it belongs, at the heart of all routine clinical practice. In its current specialist location it sustains the de-skilling and as yet unproven notion that an expert elsewhere may be able to manage risk more effectively. It might even enable psychiatry to withdraw from its untenable and exposed position that has made us the whipping boys of the government’s public safety agenda.

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Ward round practice – A need for urgent attention?

I read with interest and surprise the paper ‘A survey of ward round practice’ by Hodgson et al (Psychiatric Bulletin, May 2005, 29, 171–173). This paper greatly disappointed me in that standard practice in the West Midlands indicates that ward rounds are being run for the professionals rather than for patients. I wonder how the professionals surveyed would feel if they were interviewed by the consultant psychiatrist in front of a room full of strangers at a time when they were acutely ill and vulnerable. I have vowed never to subject patients to this practice.

A brief survey of the adult mental health teams working in Aberdeen City and Aberdeenshire who admit patients to the acute wards at Royal Cornhill Hospital, Aberdeen found that none of the 15 teams carry out ward rounds in the way suggested in the paper. The teams discuss detailed care plans for the next week at the weekly team meeting involving ward-based staff. Any interviews between patients and professionals are carried out separately and in privacy as patients have consistently indicated to us that this is their preferred model for in-patient assessment.

I am also surprised by the findings that no pharmacists attend the ward rounds of 96 consultants, since I and my colleagues clearly showed the benefits of pharmaceutical input to mental health teams as long ago as 1996 (Kettle et al, 1996). Within the service for which I am responsible, pharmacy staff are regarded as core and essential members of mental health teams and in our experience make an invaluable contribution to team meetings.

KETTLE, J., DOWNIE, G., PALIN, A., et al (1996) Pharmaceutical care activities within a mental health team. Pharmaceutical journal, 25, B14–B16.

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Wards rounds: for one or all?

Hodgson et al (Psychiatric Bulletin, May 2005, 29, 171–173) point out that little is known about ward round practice, and White & Karim (Psychiatric Bulletin, June 2005, 29, 207–209) found that 46 out of 100 patients experienced anxiety in relation to ward rounds.

Some years ago in Milton Keynes we tried a communal ward round, which all available staff and all the team’s in-patients (usually between six and ten) attended. After words of welcome and introducing the staff, the patients were told that if they wished to see the team on their own, they could do so at the end of the round, and could either stay until then or come back later (very few patients requested this). Then we went round the patients in turn, and their key worker would report on the week’s progress, discuss medication, level of observation, leave and work arrangements and plans for discharge.

There were several advantages. There was saving of time, as the welcoming and introduction of staff only had to be done once. Explanations of drug actions, side-effects and other matters, which often affected more than one patient, could be done once for all. Patients had less anxiety, because no one had to go in and confront the team alone, and no one was left wondering when, and even if, he or she would be summoned. An unexpected benefit was that the sometimes powerful intervention of fellow patients, for instance if one wanted leave or was reluctant to take medication, sometimes the other patients would try to set them right, saying, for instance, ‘Do you remember what happened yesterday? That shows you are not ready for leave yet’. This social pressure from peers was often more effective than advice from the team.

There were some disadvantages. New patients could not be presented in detail because of confidentiality, so they were dealt with at a separate meeting. It was not appropriate for spouses and family members to attend, and they were seen separately.

Most patients preferred the communal meeting, but this may have been because the unit was run on group lines, and, for instance, had a ward meeting every morning so the patients were accustomed to groups. In another type of setting it might have been less acceptable. Personally I found these group ward rounds more efficient and also more enjoyable than seeing patients one by one. My regret is that we did no formal audit. Perhaps someone else might try it.

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The first cohort of OSCE Part 1 candidates reaching Part 2

In her letter (Psychiatric Bulletin, February 2005, 29, 72–73) Dr Narula asked how the candidates taking the Part 2 clinical examination in May 2005 would cope? Unlike their predecessors, the current cohort has no previous experience of doing a ‘long case’ in the old-style Part 1 examination.

We are a team of specialist registrars who help run the Guy’s, King’s and St Thomas’ MRCPsych course. This, among other things, involves arranging mock clinical examinations. We observed that the candidates sitting the mock Part 2 examination in March 2005 struggled with the long case component. Candidates particularly had difficulties with their timing, often taking well over 10 min to present the case, and found it difficult to succinctly summarise the key features of the history of presenting complaint. The feedback we received from the candidates after the mock examination was that they were afraid to leave out what they perceived as important information from the history even if it meant going over time.

Given the increased specialisation of training posts and the changing working patterns owing to the European Working Time Directive, are candidates receiving less opportunity to take full histories from patients previously unknown to them? We recommend increased focus on basic skills during training, such as the ability to take concise but informative histories, which should be presented to supervisors during clinical work and in examination-focused teaching groups.

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Appraisal and the European Working Time Directive

Brown and Bhugra’s article on the European Working Time Directive has drawn much needed attention to the practical solutions which are being discussed to counter the difficulties following its implementation (Psychiatric Bulletin, May 2005, 29, 161–163).

Another important consideration has to be the introduction of revalidation and appraisal. Appraisal involves discussion of a doctor’s clinical practice, and planning improvements in their development as a clinician. For the time being, revalidation is undergoing a review by the Chief Medical Officer, Sir Liam Donaldson, following criticisms in the fifth report of the Shipman Inquiry (see http://www.the-shipman-inquiry.org.uk/fifthreport.asp). The review of the basic and higher training programmes provides an opportunity to introduce a process similar to appraisal during these years. An appraisal system could be based on the revised curriculum and allow an opportunity to incorporate other areas of particular interest to the trainee, all integrated in the form of a personal development plan (PDP). The College introduced PDPs in April 2001 and understanding the underlying principles at an earlier stage of one’s career will, over time, allow the system to
be refined in its usefulness and become integrated as part of everyday clinical practice, as major changes to clinical practice tend to be resisted by the medical profession.

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Physical health of patients in rehabilitation and recovery

Dr Greening’s survey of the attention paid to physical health parameters of patients in rehabilitation and recovery (Psychiatric Bulletin, June 2005, 29, 210–212) highlighted inadequacies in routine monitoring and a lack of clear guidelines from policymakers over what a full assessment might constitute (National Collaborating Centre for Mental Health, 2003). Standards of competence in physical examination among psychiatric trainees have been widely denigrated and suggestions have been made regarding expected practice (Garden, 2005).

In January 2005 we audited standards of physical healthcare on an acute psychiatric unit and found wide variations in the use of routine blood tests, urinalysis and body mass index (BMI) monitoring. With increasing attention paid to the metabolic effects of schizophrenia and of atypical anti-psychotics (Jin et al, 2004) it was felt that clinicians needed to agree a minimum standard for routine testing of all in-patients. Following discussion of this audit at the unit’s academic meeting, views were assembled over which tests should be regarded as routine. An investigations summary sheet was designed, similar to those used on medical units, and included BMI and prolactin. This allows changes over time to be tracked at a glance and has been added to the admission notes to prompt requests for appropriate tests. The aim is to re-audit these standards in 1 year in anticipation that they will have translated into a more rigorous approach to the physical health of psychiatric in-patients.

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