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CRITICAL EVALUATION OF THE HCR-20 VIOLENCE RISK ASSESSMENT: THE PERCEPTION OF PERSONS WITH ABI OF THEIR INVOLVEMENT IN RISK DECISION MAKING

Análisis critica del HCR-20 como evaluación del riesgo de violencia: la percepción de personas con lesión cerebral adquirida en la toma de decisiones de riesgo

Análise crítica do HCR-20 como avaliação do risco de violência: a percepção de pessoas com lesão cerebral adquirida na tomada de decisões de risco

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Keywords: HCR-20; risk-assessment; patient; perspective; collaboration.

Palabras Clave: HCR-20; evaluación del riesgo; paciente; perspectiva; colaboración.

Palavras-chave: *HCR-20; avaliação do risco; paciente; perspectiva; colaboração.*

A B S T R A C T

This idiographic, qualitative research sought to investigate the perceptions of patients with ABI regarding the utility of a collaborative process when completing the HCR-20 risk assessment. Four male participants detained under the Mental Health Act (1983, amended 2007), in medium- and low-secure facilities completed semi-structured interviews to allow for rich, detailed accounts to be obtained. Anonymity and confidentiality of participant information was maintained throughout, including specific details of the hospital and violent behaviours they have portrayed. An inductive thematic analysis identified three themes at the semantic level forming the basis of the discussion. The themes identified were; 'comprehension of the HCR-20 assessment and effective communication', 'benefits of assessment engagement and motivation to change', and 'externalisation of behaviour, responsibility and control'. The findings led to recommendations for professional consideration that are believed to improve clinical-practice, specifically regarding the way HCR-20 risk assessments are conducted within medium- and low-secure hospital settings.

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R E S U M E N

Esta investigación cualitativa ideográfica ha buscado estudiar las percepciones de los pacientes con lesión cerebral adquirida acerca de la utilidad del proceso colaborativo cuando son sometidos al HCR-20 para la evaluación del riesgo de la violencia. Cuatro participantes detenidos por la Ley de Salud Mental inglesa (de 1983, cambiada en 2007), en instalaciones de media y baja seguridad, completaron entrevistas semiestructuradas resultando en relatos ricos y detallados. El anonimato y la confidencialidad de las informaciones de los participantes fueron mantenidos al largo de todo el proceso, incluyendo detalles específicos del comportamiento hospitalario y del comportamiento violento de ellos. Un análisis temático inductivo ha identificado tres temas de nivel semántico formando la base de esta discusión. Los temas identificados fueron: 'la comprensión de la evaluación HCR-20 y la comunicación efectiva', 'los beneficios de la participación evaluativa y la motivación para el cambio', y 'la externalización del comportamiento, la responsabilidad y el control'. Los resultados lograron recomendaciones para una consideración profesional que se cree permitir perfeccionar la práctica clínica, especialmente en lo que se refiere a la forma con que las evaluaciones de riesgo por el HCR-20 son conducidas dentro de las configuraciones hospitalarias de baja y media seguridad.

R E S U M O

Esta pesquisa qualitativa ideográfica buscou investigar as percepções de pacientes com lesão cerebral adquirida envolvendo a utilidade do processo colaborativo quando completam o HCR-20 para avaliação do risco de violência. Quatro homens participantes detidos sob a Lei de Saúde Mental inglesa (de 1983, alterada em 2007), em unidades de média e baixa segurança, preencheram entrevistas semiestruturadas permitindo que relatos ricos e detalhados fossem obtidos. O anonimato e a confidencialidade das informações dos participantes foram mantidos ao longo de todo o processo, incluindo detalhes específicos do comportamento hospitalar e do comportamento violento perpetrados por eles. Uma análise indutiva temática identificou três temas de nível semântico formando a base desta discussão. Os temas identificados foram: 'a compreensão da avaliação HCR-20 e a comunicação efetiva', 'benefícios do engajamento avaliativo e motivação para mudança', e 'externalização do comportamento, responsabilidade e controle'. Os achados levaram a recomendações para uma consideração profissional que acredita-se poder impulsionar a prática clínica, especialmente no que se refere à forma com que as avaliação de risco pelo HCR-20 são conduzidas dentro das configurações hospitalares de baixa e média segurança.

Introduction

The deinstitutionalisation movement in the 1980's saw individuals return to society without sufficient life skills, arguably reverting to increased recidivism as a maladaptive coping strategy to obtain treatment within prison (Steadman, Monahan, Duffee & Hartstone, 1984). Reflectively, it was noted that crime differed dependent on the offender and individualised treatment was essential (Cullen & Gendreau, 2001). For those with a mental health diagnosis this is frequently required within secure settings, however the emergence of the 'Tilt Report' (2000) had a significant effect around aspects of security within secure hospitals. Although primarily concerned with Britain's high-secure hospitals, the published recommendations were reverberated throughout medium- and low-secure hospitals alike. Accordingly aspects relating to risk were considered, and utility of the Historical Clinical Risk-Management-20 version 2 (HCR-20:V2) commenced. Around this time an influx of research regarding this third-generation risk assessment tool was published following recognition of its value (e.g. Belfrage, Fransson & Strand, 2000; Mossman, 2000; Philip & Witt, 2000), and it has since become government policy that service-users are assessed in terms of their potential violence-risk, with the HCR-20 being one of the most promising tools used to achieve this within forensic contexts (Gray, Taylor & Snowden, 2008).

Furthermore, the HCR-20's effectiveness as a violence-risk predictor (see; Dernevik, 1998; Fujii, Tokioka, Lichton & Hishinuma, 2005; Gray et al., 2008; McDermott, Edens, Quanbeck, Busse & Scott, 2008), including its ability to predict outward aggression within forensic-psychiatric, civil-psychiatric, and mentally disordered prison populations (Gray et al., 2003) is recognised. Hence, it is the most commonly used violence-risk assessment to guide risk management and prevent future violent behaviour (Pederson, Ramussen & Elsass, 2012; Singh, Desmarais & van Dorn, 2013) with well-informed assessments effectively reducing antisocial, intra-institutional behaviour (Ching, Daffern, Martin & Thomas, 2010). This is imperative, as the prediction of violent behaviour is a primary consideration within forensic settings, is paramount to

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decisions associated with clinical practice (McDermott et al., 2008), and is an essential component to patients' Care Programme Approach (CPA).

However, severe mental illness is reportedly associated with increased risk of aggressive behaviour and executive functioning deficits have been found to have detrimental effects on reasoning and purposeful behaviour, both of which are apparent in the target population of this research (Hodgins, Alderton, Cree, Aboud & Mak, 2007; McDonald, Flashman & Saykin, 2002). Furthermore, Gray, Taylor and Snowden (2011) state that although the HCR-20 is effective across a range of diagnoses, disorders characterised by impulsivity, common amongst patients with acquired brain injury (ABI) or Organic Personality Disorder, are problematic with regards to summary risk ratings. As completion of the HCR-20 encourages collaboration with the individual through interviews (Belfrage et al., 2000) insightful information relating to problematic factors can be highlighted, and the concept of professional judgement adding incrementally to the assessment arguably allows for specific considerations to be recognised (Yang, Wong & Coid, 2010). Irrespective of critique there are several meta-analyses that evidence support for the HCR-20, suggesting it is an effective tool for predicting violence-risk (see; Campbell, French & Gendreau, 2009; Fazel, Singh, Doll & Grann, 2012; Singh, Grann & Fazel, 2011; Rossdale, Tully & Egan, 2020).

Regrettably there has been little research concerning the experience of the patients investment to collaborative HCR-20 assessment, a consideration Maguire, Grubin, Lösel and Raynor (2010) state was previously overlooked concerning offender experiences of rehabilitation programmes following the rise of a 'tick-box culture', opposing the person-centred ethos of current practice. Research that is fairly pertinent comes from Troquete et al. (2013) who investigated the preventative effect of an alternate violence-risk assessment with out-patient participants and case-managers. They purported to be the first to do so with previous literature only considering the prediction effect of assessments, not the goal of recidivism-prevention. Conclusions highlighted that the Structured Assessment of PROtective Factors for violence risk (SAPROF), combined with shared decision-making in care planning, resulted in a preventive effect on violent criminal behaviour. With regards to the HCR-20 and the specific target population the author has been unable to identify preceding research suggesting that this could provide pioneering results that are arguably essential to evidence-based practice.

It should be noted that publication of the HCR-20: version 3 (V3) has occurred during the time of writing. Rationale is provided within the method as to why this version has not been discussed within this research.

Aims of the study

This research aims to identify whether patients believe that a collaborative approach when assessing violence-risk using the HCR-20 is effective. Through the use of a qualitative method, a "rich and detailed, yet complex account" of opinions can be explored (Braun & Clarke, 2006, p. 6). Furthermore, findings will provide contributions to mental health research and practice that yields invaluable insight to better inform person-centred provisions and service-user involvement (Thornicroft & Tansella, 2005).

Method

Design

The research utilises an idiographic, qualitative approach and will "provide a depth of understanding of issues that is not possible through the use of quantitative, statistically-based investigations" (Tewksbury, 2009, p. 39). Semi-structured interviews allow the researcher to partly guide the discussion whilst providing the participants independence to present detailed accounts of their experience.

Participants

The term 'participant' is used here, rather than 'subject' as the latter fails to recognise the active role of the individual serving as a data source (British Psychological Society (BPS), 2010). Four male patients within a specialised hospital providing medium- and low-security for patients with ABI were asked to take part in an interview, expressing their opinions on the collaborative approach utilised within the HCR-20:V2. Features of dysexecutive syndrome are prominent across the sample and are found to produce behaviour changes, including acts of violence and aggression (Prins, 2005). The small sample was considered appropriate following the saturation of information obtained through interviews (Braun & Clarke, 2006). Generalisation was not the aim here, rather an in-depth informative analysis of patient experience. It should be noted that

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accessibility of this hard-to-reach clientele was limited, although those involved provide a relatively heterogeneous sample of the target population.

All participants are detained under section of the Mental Health Act (MHA; 1987 amended 2007), namely section 3, 37, and 37/41. Pseudonyms are used to identify quotes as explicit personal information will not be disclosed, furthermore presentation of participant information will not be provided in order to maintain anonymity and confidentiality of those associated with the research. Perceptibly, the nature of index offences, and prior offences where there is a history of offending, depict acts of violence and aggression. Further, those who have not received convictions in relation to their section have demonstrated challenging behaviours that are unmanageable within the community and portray violence and aggression. All participants have been assessed with the HCR-20:V2 and demonstrate a low or medium level of future violence-risk. Those who were deemed to be of high violence-risk were not considered for engagement due to increased security risks.

Materials

Capacity

The two-stage test for capacity, set out by the MCA (2005), was completed to ensure participant suitability. Due to being directly concerned with the individuals at the time the decision was made the researcher completed the assessment, in accordance with the MCA (2005) Code of Practice. The decision was reviewed by the Responsible Clinician, Clinical Psychologist and relevant multi-disciplinary team members. All reasonable steps were taken and it was identified on the balance of probabilities that all participants had capacity to make the decision of engagement with the research. Each individual was able to understand relevant information about the decision, retain the information, use it to weigh the information as part of the decision-making process and communicate their decision through verbal means. Due to the nature of ABI and major mental disorder support for each of the elements was implemented to ensure that all possible steps were taken to allow the participants to make an independent decision.

HCR-20:V2

The HCR-20:V3 was published on 24th April 2013 and therefore should be used within clinical practice. Ethical approval for the research was obtained in March 2013 prior to the HCR-20:V3 publication and the associated organisation utilised the HCR-20:V2. Furthermore, at the time of the research, training in the use of the HCR-20:V3 had not been obtained and therefore it would have been beyond professional competence to have incorporated its use in the research (BPS, 2018). Subsequently, this highlights a training requirement for the organisation in line with best practice for the named violence-risk assessment, with such training allowing for significantly increased quality of assessments (Reynolds & Miles, 2009).

Additional materials

Further materials included the semi-structured interview format, allowing for flexibility of interview structure, a dictaphone for the recording of interview content, and a password-secure laptop to store the data.

Procedure

Ethical approval was obtained from Manchester Metropolitan University (MMU) with adherence to the ethical standards of the BPS (2018). The associated hospital did not have a standardised ethics procedure and therefore the approval gained from MMU was considered to be thorough and viable to allow for the research to commence. This decision was agreed by the Caldicott Guardian and documented and signed by the Clinical Psychologist at the hospital. As the associated hospital is within the private sector an Integrated Research Application System (IRAS) form was not required for ethical approval. Throughout the research adherence to the BPS Code of Conduct (2018) was maintained and utility of the MCA (2005) immediately preceding the interview ensured participant suitability. Furthermore, adherence to standard security provisions in line with organisational procedure (relational, procedural and physical) was upheld.

Interviews were conducted within a meeting room situated within each participant's respective ward, allowing for continuity of a familiar environment. The researcher and one male rehabilitation co-therapist staff member, both known to the participant, were present at each interview. Participants received a brief of the research including a compensatory aid that was visible to them throughout the process to assist with recall of information, prior to signing an informed consent form. Introductory, informal conversation occurred preceding the data collection to place the participants at ease, and once they

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were happy for the interview to commence the dictaphone was turned on. The interview format remained visible to the researcher with all planned questions posed to the participants', however the direction of interviews followed given responses. Occasionally the interview was led by the researcher if the participant demonstrated difficulty with the process, however it was ensured that sufficient time intervals were given to allow participants' opportunity to consider questions and responses.

Interviews generally lasted between thirty and sixty minutes, dependent on participant motivation, upon which time the participants were debriefed. Subsequently, the generation of transcription rules were applied following the seven principles outlined by Mergenthaler and Stinson (1992), and the researcher transcribed the interviews.

Analysis

An inductive thematic analysis was used, adopting a critical-realist perspective, to analyse the data at a semantic level and investigate the stated aims. This process was informed by the "6-phase guide" identified by Braun and Clarke (2006, p. 5). It has been noted that the BPS (2010) states:

In psychological research it is also relevant to acknowledge that a participants' understanding of the experience they have while taking part in the research will often be a valuable additional source of information and may well help to enrich the interpretation of findings. (p.6)

As the research considers several interviews to identify themes across patient perceptions respondent validation was considered to be inappropriate as assertions to gain refined explanations by an individual participant may be problematic and lead to discrepant accounts (Mays & Pope, 2000). Essentially, such requirements may be too complex and would place considerable demands upon the participants which would be unnecessary and possibly distressing (Barbour, 2001).

Results

Following an inductive thematic analysis, three key themes were identified that portrayed the participants' experiences of the HCR-20:V2; 'comprehension of the HCR-20 assessment and effective communication', 'benefits of assessment engagement and motivation to change', 'externalisation of behaviour, responsibility and control'. The themes also interlinked through the filtration of sub-themes (see Figure 1). For example there was an association between 'externalisation of behaviour, responsibility and control', and 'benefits of engagement and motivation to change' as participants identified areas of improvement in relation to aggressive behaviour, but minimised previous behaviour or attributed it to external factors. The identified themes were recognised across all interviews and are not a biased representation of individual statements. Descriptions of the themes, sub-themes and supporting quotes are provided here, and represented visually in Figure 1.

Comprehension of the HCR-20 Assessment and Effective Communication

A lack of understanding the HCR-20 was evidenced across all interviews despite participants being involved in their own assessments and having a compensatory aid to assist with their recall of the assessment. When asked if they felt engagement with the assessment was beneficial to them, responses such as "I haven't done that" (Ben, L:74) and "(3) erm (2) sorry" (Carl, L:116) were consistent. Subsequently, identification of effective communication for individual HCR-20 assessments was specified with participants' ideals being asserted.

Reference to compensatory aid

Utility of the compensatory aid was found to be beneficial to the participants in assisting comprehension of the assessment. References towards it included statements such as, "an assessment like this" (Carl, L:45) and "getting people like Psychiatrists and Psychologists to help me" (Daniel, L:38) if they were unsure or possibly required reassurance that they were considering a 'logical' response to the discussion. Hence a degree of reliance was demonstrated in order to support their understanding of the interview content. Furthermore, it appeared to allow better communication of their responses, "because that's a-a group of people there isn't it" (Ben, L:113), ultimately allowing utility of the compensatory aid to accompany their own comments.

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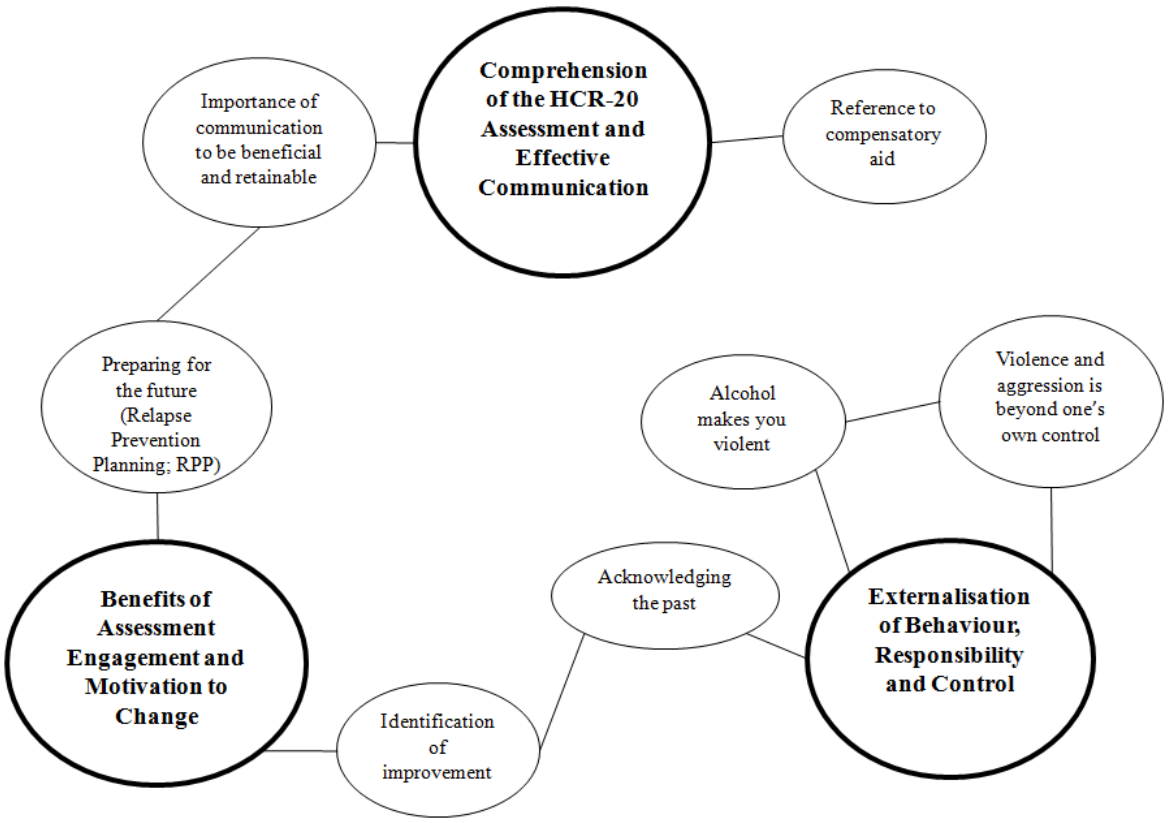
Figure 1.
Themes and sub-themes



Importance of communication to be beneficial and retainable

Succeeding the abovementioned sub-theme, there was an evidential requirement for the communication of information to be accessible within this client group. Responses identified that communication presented through "pictures and written and spoke" (Carl, L:63) was favourable with clarification that a preference, in addition to verbal explanations, was to have information "written down so it's easier to remember (2) and pictures are good" (Ben, L:85). This sub-theme was coherent with the participant's ability to retain information following their ABI, with reiteration being given that it was not an inability to understand, "I do know it's just keeping track (.) in my head" (Andrew, L:79).

Communication of information was also regarded as being beneficial to reducing violent behaviour, "that can make people violent as well sometimes when they- when their not- when they don't communicate" (Ben, L:149-150). With the inclusion of a multi-disciplinary, collaborative assessment being ideal, "people that care for you (.) are involved in your future but also you're important to be involved" (Carl, L:59-60), "talking to different people does help doesn't it... you get information from it" (Ben, L:114-115), and "you need to talk to someone about it" (Andrew, L:163).

Benefits of Assessment Engagement and Motivation to Change

Engagement with the HCR-20 was regarded as being positive to the participants' care pathway and rehabilitation. It was identified that the HCR-20 allowed the participants to "learn from the past" (Ben, L:56), and collaborative assessment "will help people out" (Andrew, L:166). Similarly to the prior theme, such expressions were identified following prompting from the interviewer, identifying an element of unity whereby the effective communication of concepts allows for recognition of the beneficiaries of collaborative assessment.

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Identification of improvement and need for help

Amongst the participants a demonstration of improved behaviour with regards to violence and aggression was conspicuous. This was evidenced through reflection upon their historical factors and vocalising a degree of insight to their circumstances; "I feel myself a bit ashamed (.) erm cause I can see back the way I came" (Daniel, L:93-94), "I thought it was good at the time" (Andrew, L:51) and "you don't actually see you need the help at the time" (Carl, L:88-89). In turn, this demonstrates consideration of dynamic factors and the benefits of having a sense of regained autonomy through a collaborative process whereby patients "can explain how I think I've got better" (Ben, L:41-42), and accept input from professional disciplines, "I think I've learnt too much now (.) maybe a bit more if if I (.) haven't talked about it" (Andrew, L:78-79). It was also stated that identification of historical factors allowed individuals to "learn how to improve" (Carl, L:180-181) and how identification of improvement through dynamic factors can "reassure you" (Carl, L:139).

Preparing for the future (Relapse Prevention Planning; RPP)

In relation to the former sub-theme, insight with regards to continual need for rehabilitation was identified, "I can still see I've got a little bit to go" (Daniel, L:97), although arguably the use of 'little' is minimising the extent of rehabilitation required and associates with the forthcoming theme. Nevertheless, participants identified the benefits of recognising risk management factors within the HCR-20 to aid their rehabilitation, and how this relates to their RPP through reducing aggressive and violent behaviours, "the help I'm getting here at the moment (2) i-it's really helping me out (Andrew, L:118-119), "I've learnt (.) loads since being here" (Andrew, L:127) and "them sorts of things help you for when you get back in the community" (Ben, L:106).

Externalisation of Behaviour, Responsibility and Control

Juxtaposing, yet arguably opposing the prior themes, the participants demonstrated a sense of distancing when faced with questions that considered their direct experiences of aggression, with responses identifying elements of displacement "I wouldn't class myself as a violent man... I'd use the word agitated rather than violent" (Carl, L:156-158). This was often contradictory to other comments and could be associated with the effects of ABI or a lack of insight to their level of engagement with behaviours identified as being "not acceptable" (Carl, L:105). Additionally, refraining from the use of 'I' narratives and assuming third party narratives was evident through the use of "the person (.) or the client" (Carl, L:152) and "I just wana help others out... they're not achieving anything" (Andrew, L:144-145). Consequently, the participants appeared to retract an assumption of responsibility when faced with questions that challenged them, in comparison to questions that identified positive attributes, or supported them (as identified in the former themes).

Alcohol makes you violent

Most commonly a tendency to place the blame for violent and aggressive behaviour on alcohol consumption was evidenced; "the drink makes you do it" (Daniel, L:50), "I've used alcohol and that has made me violent" (Ben, L:132-133), "I haven't been violent many times in my life anyway there's only a few (.) and that's only through alcohol" (Ben, L:31-32). Additionally, abstinence from alcohol within the hospital appeared to substantiate such statements and exacerbate perceptions of reduced risk "it will come back N/A like *laughs* not at all" (Andrew, L:41).

Violence and aggression is beyond one's own control

Interlinked with the former sub-theme, there was a tendency for participants to assume an external locus of control and blame acts of aggression or violence on exterior elements. For instance an ability to identify aggressive behaviour would be excused, "but that was all because of my condition (3) er (.) my brain injury" (Carl, L:33-34) and minimised through external objectification, "it was the paranoia so I was getting into (.) a bit of trouble" (Andrew, L:30-31). Furthermore, the emotion of anger itself was described as "a thing (.) entangles your feelings and you lose touch with who you are... it's an evil (.) inside you" (Daniel, L:62-64). This appeared to allow dissociation from antisocial behaviours that were observed to be socially unacceptable, suggesting that they were also victim to their behaviour; "it was a regret (.) coming here in the first place" (Carl, L:21-22). Alternatively, it could be argued that it demonstrates a significant lack of insight to their behaviours, consequently increasing their level of risk.

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Acknowledging the past

Reluctance to identify aggressive and violent behaviours was demonstrated which did not relate with the earlier sub-theme of 'identification of improvement and need for help' (see Figure 1). Despite participants identifying improvement, there was an unwillingness to reflect upon past behaviours that would demonstrate an acceptance of responsibility for previous violent behaviour "I'm not here to talk about the past" (Andrew, L:88-89) and "I don't tend to look (2) back" (Daniel, L:123). There was also one occasion whereby one participant appeared to rationalise with violent behaviour stating that he would be "sympathetic" (Carl, L:102) of others who are violent as he had "been through situations (2) and I can see (.) how- how things are" (Carl, L:112-113).

Discussion

This research sought to consider whether current literature highlighting the collaborative nature of the HCR-20 violence-risk assessment as being effective in practice, is reflective of patient experience. The themes identified are best acknowledged in the following order; 'comprehension of the HCR-20 assessment and effective communication', 'benefits of assessment engagement and motivation to change', and 'externalisation of behaviour responsibility and control'. An overarching premise suggests that each of the themes considered in respective order allows patients within secure hospitals to regain an element of autonomy over aggressive or violent behaviour traits, and subsequently reduce their level of violence-risk.

Explicitly, if the patient is able to comprehend the assessment through effective communication they can better understand its purpose. Consequently benefits of the assessment can be identified with regards to progression or rehabilitation, with identification of improvement being communicated within dynamic factors. This can lead to increased motivation to change, in turn requiring the patient to acknowledge antisocial behaviour and internalise responsibility for aggressive or violent presentation (see Figure 1). This theory will be discussed in depth through reflection on findings of the research.

Participants found the inclusion of the HCR-20 to be beneficial, with collaborative assessment being identified as valuable to person-centred rehabilitation, therefore being supportive of current research that highlights this assessment as effective in practice (Belfrage et al., 2000). However, retention of information regarding the assessment within the target population was negligible, with patients requiring use of the compensatory aid and prompts from the interviewer to assist with recall of information (MCA, 2005) which may negatively affect continuity of improved behaviour. Lack of comprehension is debatably unsurprising considering the long-term effects and consequential cognitive deficits of ABI and associated mental health problems (Hodgins et al., 2007; Gray et al., 2011). However, in a comparatively more general sense, despite an evident need for violence-risk assessments very few are conducted, and of those that are, few are completed (Rizzo & Smith, 2012). Therefore it could be suggested that there is a general lack of comprehension within the client-base receiving the HCR-20, beyond those represented within the current study.

Hence it is suggested that patients' individual risk summaries should be effectively communicated through adaptations that are appropriate to their needs. As is often the case, offenders with low levels of intellectual ability require adapted treatment programmes to target their treatment needs (Newberry & Shuker, 2011). Similarly this should be applied to the feedback, including scenario planning, concerned with individual assessments to effectively target responsivity and understanding of relevant information. If provided in a format that is easily accessible, they can retain information more effectively and better understand their case management plans. Participants explicitly identified that the inclusion of accessible pictorial summary sheets would be favourable alongside verbal explanation which is supportive of the dual coding theory that identifies retention of information is greater when presented by means of verbal and non-verbal processing. Therefore such considerations should be implemented within clinical practice. Although risk summaries are provided within clinical or nurse notes they are often written in a way that is non-accessible to the patient and possibly non-clinical staff, therefore the benefit posed by the inclusion of such communicative advancement is arguably implausible. As an aside it has been noted that collaborative risk management cannot always be possible if the individual displays poor insight (Bjørkly, 2006). However, incorporation within the assessment and informative outcomes should be offered as it can provide patients with a more informed understanding of the assessment and its purpose.

Benefits of assessment engagement were identified with specific identification being improvement within behaviour and devising feasible plans for the future, demonstrating willing for involvement in this element of their care and the opportunity for collaborative assessment. It could be that the patient assumes an increased level of autonomous development as restrictions are applied to many aspects of their daily living, hence this serves to provide them with an element of control

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over their life and implements motivation to engage with the assessment. Furthermore, collaboration with the HCR-20 could have significant benefits in recidivism-reduction or violent and aggressive behaviour. This would reflect the findings of Troquete et al. (2013) who identified that violence-risk assessment, combined with shared decision-making led to decreased recidivism, albeit with utility of an alternative violence-risk assessment to that used here.

However, although identification of the beneficiaries of engagement were evidenced during interviews, impulsivity amongst this target population means motivation to engage is liable to fluctuate and adversely negative emotional state has been found to significantly impact on recidivism (Day, 2009). The Readiness to Change Framework (Burrowes & Needs, 2009) states that consideration should be given to the individual, environmental and catalyst factors, with the process of motivation being influenced by internal and external factors. Therefore awareness of patient circumstance and positive therapeutic rapport is fundamental if effective collaborative risk assessment is to be achieved. Similarly, the Multifactor Offender Readiness Model states an ability to reflect is an effective feature within rehabilitation or treatment (Ward, Day, Howells & Birgden, 2004). However this was non-apparent within the current participant group accentuating their need to fully comprehend the assessment, whilst also relating directly to the latter theme.

A profound lack of internalisation was demonstrated despite identification of improvement as previously discussed. Whilst participant's insightfully demonstrated that they have had issues with aggression, they did not consider that this was still apparent despite presenting with a level of risk that requires support, rather claiming that aggressive presentation was secondary to external phenomena beyond their control. Further, there was evidential reluctance to demonstrate acceptance of previous behaviour stating that they were "not here to talk about the past" (Andrew, L:88-89). This could associate with research that identified differences between individuals with Dangerous Severe Personality Disorder (DSPD) within hospital and prison settings, whereby those in hospital were "more focussed on their entitlement to treatment than their role as offender" (Sinclair, Willmott, Fitzpatrick, Burns & Yiend, 2012, p. 253). Therefore it could be suggested that as the participants within this research are detained within a hospital setting, they perceive a need for treatment rather than recognition of problematic behaviour to be more important. Consequently, this demonstrates the original need for these individuals to be assessed for possible future violence, with an evidential lack of insight potentially increasing violence-risk (Bjørkly, 2006).

Being pioneering research with regards to identifying patient perceptions of the HCR-20 within practice, it is not wholly possible to identify whether the themes identified are complementary of previous research or reflective of other client groups. Nevertheless this research has led to worthy recommendations that should be given due consideration for future clinical-practice, and should encourage continuity of study within this area to better inform future practice.

Recommendations

- Incorporate accessible communicative summaries of the HCR-20 violence-risk assessment to aid with patient understanding of their potential risk factors.
- Conduct further research to identify patient experiences with the incorporation of other disciplines involved with patient care in secure hospitals. This should be in relation, but not exclusive to, patient experience of risk assessment in order to gain insightful considerations that better inform processes within clinical-practice.

Limitations to the research have been considered with primary focus on the dual role of the interviewer whom was known to the participants as a Trainee Forensic Psychologist. Whilst this allowed for a positive therapeutic rapport encouraging participants to give honest accounts, it may have negatively influenced the responses given within the interview. As the participants appeared to find regained autonomy beneficial to their progress the interview may have been regarded as an opportunity to promote perceived improvement to a member of staff leading to increased demand characteristics, despite awareness that this was being conducted for research purposes. Furthermore, as the HCR-20 assessment considers violent and aggressive behaviours, discussion with a female may have altered the way the topic was discussed. Debatably within westernised culture, violence is considered to be a male-dominated behaviour and there may have been a reluctance to convey pro-violence beliefs as this would be inconsistent with underlying dynamics of gender (see Bloch & Lemish, 2005).

Although the participant sample was small, it is not considered a limitation as generalisabilty was not the aim. Rather informative accounts provided by a specific group aimed to better inform clinical-practice within secure hospitals, specifically those that specialise with ABI patients. However, inclusion criteria restricting the use of participants who were currently deemed to be high risk of future violence may have impacted upon the findings as they may have presented alternative

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opinions to those interviewed. Nonetheless, clinical care-team involvement was required for decisions determining the suitability of prospective participants on the basis of capacity to consent (MCA, 2005), level of risk, and organisational policy. With regards to expressed opinions it was decided that respondent validation would not be carried out within this process as it may have been problematic for the specific client group, however the identified themes were verified with a second coder who did not know the participants to prevent researcher-bias and ensure transparency of themes. Undoubtedly future research would significantly improve practice within secure hospitals and forensic services and the inclusion of alternative disciplines involved with the risk assessment process as well as respondent validation would provide invaluable improvement to the findings.

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1) Semi-structured interview format

- Room layout

The room layout will include three chairs (two interviewers and one participant), and a table. A Dictaphone will be placed between the interviewers and participant and will be turned on following a brief explanation of what the interview session will entail, providing the participant is still willing to take part in the interview and has signed an informed consent form.

- Entering the room

Welcome the participant into the room.

I (Rachael Williams) have been working at this hospital since January this year as a Trainee Forensic Psychologist, and I'm also doing a course at University.

I am interested in finding out about your experiences of being involved in the HCR-20 risk assessment process. I have some information about what this will include and would like to talk to you about this if you want to?

Await response.

- Review the 'HCR-20 Assessment' information sheet

- Review the brief

Respond to any questions that are raised.

- Review the informed consent form

- Begin the interview

I will now turn the Dictaphone on and we can begin the interview. I might repeat some of the information I have just said to you for the purposes of the recording.

- Turn on Dictaphone

[Note: Additional dialogue may occur during the interview dependent on the responses given by the participant. The following plan is merely a suggested direction for the interview.]

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I am interested in your experience of being involved in completing the HCR-20 risk assessment and so I will be asking about the things that are important for you in the assessment. There is no right or wrong answer to these questions I would just like you to give me your personal opinion in as much detail as you can.

Are you OK for us to begin?
Await response.

OK. Can you tell me what different feelings or emotions you experience day-to-day?

How do you feel today/now?

What do you think your HCR-20 says about you?

Is it important for you to be involved in the HCR-20? *Ask for expansion on 'yes' or 'no' response if they do not give one.*

What was your attitude towards violence and aggression before you came to hospital?

What is your attitude towards violence and aggression now?

If there is a reported change in perceptions of violence and aggression. What do you think has changed your attitudes towards violence and aggression?

Has the HCR-20 changed your attitudes? *Ask for expansion on 'yes' or 'no' response if they do not give one.*

Do you think discussing your attitudes towards violence with staff will help you whilst you're in hospital? *Ask for expansion on 'yes' or 'no' response if they do not give one.*

Do you think that the HCR-20 has helped you to understand what you can work on whilst you are in hospital? *Ask for expansion on 'yes' or 'no' response if they do not give one.*

So what do you need to work on?

Do you think that your treatment plan, and the groups you attend at the moment, help you to work on risky situations that might lead to aggression or violence?

How do you think this assessment helps you to understand what you need to do in the future?

How important is it to you that you are involved in assessments like the HCR-20?

That is now the end of all my questions. Would you like to add anything else that you think would be helpful to the way we do this assessment?

Await response.
The interview is now completed. Thank you very much for talking to us about your experiences.

Turn off Dictaphone.

- Review the debrief form

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