GUEST EDITORIAL

The importance of scalable, evidence-based clinical assessment instruments in forensic psychiatry

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Numerous clinical assessment instruments have been developed to assist mental health clinicians which quantify parameters related to patients' diagnosis, prognosis, risk assessment, and outcome measurement (1-5). In forensic settings, there has been a particular focus over the last few decades on assessing risk and measuring outcomes (6,7). This is understandable given the risk profiles of the users of such services, services' public protection role, and the need to demonstrate effectiveness, given the high financial and human costs involved (8). The correct instruments used effectively have the potential to improve patient care, support service improvement, and aid research (9).

In some forensic settings, the use of certain instruments is mandated by commissioners or other agencies, such as insurers (10). For example, NHS England requires providers of forensic mental health services in England to report data on the use of the Historical, Clinical, Risk 20 (HCR 20) structured professional judgment tool (11) and the Health of the Nation Outcome Scale Secure (Secure) outcome measure (12). Questions have been raised about the additional burden on clinicians this creates and whether this translates to benefits that justify the cost (13). Where instruments are optional, uptake has been linked to the acceptability to clinicians, which in turn depends on how quick and easy instruments are to use (14).

Forensic mental health services worldwide are increasingly stretched, with many struggling to secure sufficient resources to provide high quality care (15,16). A workforce crisis affects multiple relevant professional groups in these contexts, including medical and nursing staff (17,18). Bureaucratic processes related to the commissioning and quality assurance of services can add to the demands on staff, increasing the risk of burnout and distract staff from providing compassionate care to their patients (19,20). This makes it difficult to justify requiring that any additional instruments be used and emphasizes the need to optimize the relevance of data generated from those that are implemented.

The development of clinical assessment instruments is often inadequate, with those promoted in practice frequently created many years previously using outdated methods (7,21). It is essential that the context of use is considered from the beginning of the design process and carried through to implementation (22). Central to this must be thinking about how instruments can be effectively integrated into routine clinical practice so that they contribute meaningfully to patient care, while adding as little as possible to clinicians' workload (23).

The development process for both risk assessments and outcome measures begins with the conceptualization of the instrument itself (24). Careful thought must be given to selecting items based on empirical evidence. Items must also have good face validity, be easy to accurately ascertain, and cover all important dimensions of interest, without being too numerous (25,26). Validation in relevant populations is then essential to ensure that instruments perform as required (27,28).

Often forgotten however is the messy process of implementation (29). The most well-designed instrument is worthless if not actually used. Detailed qualitative work with clinicians and patients can help elucidate barriers and facilitators (30). Digital enablers, such as online risk calculators can take the hard work out of collecting data on predictors and automatically produce summary predictive information, like overall risk percentages (2). Visual techniques can help in presenting data to clinicians and patients in accessible ways, such as graphs plotting risk or outcome over time (5). Finally, integration into existing digital systems, such as electronic patient records, is essential if these instruments are to be used in practice in any meaningful way (31).

Two examples of such scalable instruments are the Forensic Psychiatry and Violence (FoVOx) and the FORensic oUtcome Measure (FORUM). FoVOx is a 11-item risk calculator designed to predict the risk of violent reoffending within 12 and 24 months in patients released from a secure hospital (32). It was developed using large scale Swedish registry data and produces overall risk percentages, which can be presented as icons, tables, charts or text at the press of a button. Furthermore, it produces an easy to interpret summary risk category of low, medium or high, based on work with clinicians to map these to percentages (33,34). FORUM is an outcome measure for forensic mental health services with complementary patient and clinician rated scales (35). It was designed with extensive input from patients and clinicians and can be completed in just a couple of minutes (36). Implementation work is ongoing to understand how it can best be used in practice.

Seamless assimilation of a new generation of rapid empirical instruments within forensic mental health services would free up clinicians' time to focus on compassionate, patient-centred care, by replacing cumbersome outdated instruments, which add little to services (37,38). It would also offer the opportunity to improve care through the application of reliable, meaningful data (39).

Conflict of Interest: The author declares that they have no conflict of interest.

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