Monday, 20 April 2026

(10.00 am)

THE CHAIR: Yes, Ms Langdale.

MS LANGDALE: Good morning, Chair. Please may I call the next witness, Professor Fazel?

THE CHAIR: Yes.

PROFESSOR SEENA FAZEL (sworn)

Questioned by MS LANGDALE

MS LANGDALE: Professor, you have been instructed as an expert to provide evidence to the Inquiry and you provided a report dated 22 February, 2026.

A. Yes.

Q. Are you satisfied the contents are true and accurate as far as you're concerned?

A. I am.

Q. Can I ask, please, that we have the first page on the screen, WITN0401001, page 1, and I'm going to ask you to tell us about your qualifications, your career and experience, and we can have 1 and 2 on the screen at the same time, please.

A. I'm a medical graduate from the University of Edinburgh. I finished by medical degree in 1993 and then trained in psychiatry and obtained membership of the Royal College of Psychiatrists, which is a post-graduate exam in psychiatry, in 1997. I then did a Doctorate of

Medicine, a research degree, in 2002 and completed my higher training in forensic psychiatry in 2003. Subsequently I was selected as a Fellow of the Royal College of Psychiatrists in 2011, so that's in terms of my qualifications.

In terms of my career and experience, as I say, I did medicine, worked as a House Officer. After my House Officer jobs I worked in neurology for six months and then worked in psychiatry where I trained in general psychiatry, and then subsequently some old age psychiatry and then in forensic psychiatry.

From 2003, I've worked as a Consultant Forensic Psychiatrist, both in medium and low-secure units and also in prisons locally, and more recently I've been working in a community forensic psychiatric team where we give advice to general psychiatry about risk assessment and risk management.

Other than that, I'm also a clinical academic, so I do research primarily in the association between mental illness and violence, but also other adverse outcomes including suicide and premature mortality, and I run a research team where we look at risk assessment risk management, how to prevent adverse outcomes in people with mental illness.

I've also provided evidence in homicide cases as an

expert witness instructed both by the prosecution and the defence. And also, in some international cases such as the Khmer Rouge tribunal where I was the UN appointed witness, the only forensic psychiatrist in that particular case. And I've been involved in some other cases which are highlighted in the report, including extradition cases and other advice to Supreme Courts in other countries.

Q. Thank you. We're going to go to some of your research papers in a moment which you set out in detail various findings in respect of the topics in which you are an expert. Before we do, can you just tell us the difference of expectation in terms of assessment of risk for general adult psychiatric teams and forensic psychiatrists?

A. Well, I think, in general terms, it's a lot to do with resources and time, and also the sort of skills that people have, the training they have.

So in general psychiatry we're dealing with situations where there's quite a high turnover of patients, most of whom will not present a high risk, and therefore, teams have to allocate resources efficiently, triage people, and so there the emphasis is on doing things in a scalable way which is efficient and practical, in a way.

In forensic psychiatry, you're dealing with people who have already usually committed serious offences and so there there's more time afforded to the risk assessment, because those people are more likely to have an increased risk going forward. They may be, for example, admitted to hospital and in hospital you want to know what risk management plans you need to put in place. But also, there's an issue about the safety in hospital as well. So the risk assessment has to be done quite carefully.

Then, when people leave hospital the risk assessment again has to be done very carefully with risk management plans put in place, because these are individuals who will have an elevated risk of violence. And so there's much more emphasis and time available in forensic psychiatry settings, and in general psychiatry there isn't that for many reasons: resources, but also high turnover of patients and the fact that most people are going to represent quite low risk.

Q. When you say "forensic psychiatrists see those who have already committed criminal offences", do you mean have been convicted of them before referral? What's the general referral for forensic psychiatry?

A. Well, there's different routes. So some of the referrals can come because people are concerned about

1 risk, so they may not have been convicted. They may
2 have, for instance, threatened violence to members of
3 the psychiatric team, for example, or they may have
4 perpetrated violence in an inpatient setting. So they
5 may not have been charged or convicted. That's one
6 route in.
7 Another route in is actually at the time someone has
8 been charged or arrested, that people want advice, the
9 courts want advice about where is the most appropriate
10 place for someone to be assessed and then treated, and
11 then ultimately sentenced. And that's another route in.
12 And then the third route in can be directly from
13 prison, where people who are in prison can present with
14 mental health problems, and their advice is sought about
15 whether those individuals should be transferred, for
16 example, to a forensic psychiatric unit for further
17 treatment.
18 **Q.** Can we look then, please, at one of your papers:
19 "Risk Factors for interpersonal violence: an
20 umbrella review of meta-analyses".
21 It's WITN0401002, page 1, please.
22 **A.** Yes.
23 **Q.** If we go to page 4 you present an overview of risk
24 factors for interpersonal violence, based on over
25 120,000 individuals. Would you like to summarise for us

1 the discussion there and the findings?
2 **A.** So this is looking at risk factors for interpersonal
3 violence in a general population setting, so you're
4 looking at the whole population, and you are asking the
5 question: what are the replicated, validated factors
6 that we know are associated with increasing risk of
7 violence? Any violence, this is, not just violence that
8 leads to convictions.
9 And what this table 1 is showing is the evidence for
10 the best quality, so the underlying research evidence
11 we've assessed in terms of quality, and these are the
12 five factors that we found had the best quality that
13 indicated that they are -- they increase the risk of
14 violence. Broadly speaking, four of them are
15 neuropsychiatric disorders, so antisocial personality
16 disorder is a lifelong mental condition; it's not
17 a mental illness but, broadly speaking, a mental
18 disorder.
19 **Q.** Apparent usually in childhood, adolescence with either
20 criminal acts, or destructive behaviour, that kind of
21 thing?
22 **A.** That's right. It starts presenting in adolescence with
23 rule-breaking behaviour and various other lifestyle
24 factors; impulsivity is a pattern that is quite commonly
25 seen. It leads to quite serious problems in someone's

1 life, so they have difficulty in maintaining work,
2 relationships, education. So antisocial personality
3 disorder is a broad category.
4 Then the other factors are the more severe mental
5 illnesses such as schizophrenia and other psychotic
6 illnesses, and these days we often talk about
7 schizophrenia spectrum disorders and they would be
8 included in this list of factors that increase -- that
9 are associated with increased risk of violence.
10 Bipolar disorder is there, and also being
11 victimised, and we know that there's often an overlap
12 between people who are victimised and people who
13 perpetrate violence, and they are often the same people
14 at different times in their lives.
15 **Q.** This work was conducted in 2018 and you say on the box
16 on the right, penultimate paragraph:
17 "A number of implications arise from this work.
18 First, it suggests many important risk factors for
19 violence are modifiable, and public health can
20 realistically include substantial reductions globally if
21 these factors are confirmed in treatment trials as
22 causal."
23 You also say:
24 "However diagnostic categories themselves are not
25 sole treatment goals, and active symptoms and

1 comorbidities, which mediate the above-reported
2 associations with violence, should also be targeted."
3 Can you tell us what you mean by that?
4 **A.** Yes, these types of studies are associations across
5 large numbers of people and sometimes those associations
6 can be explained away in a sense by other factors. So,
7 for example, it may well be that if you look at the
8 people with one of these factors, they may have other
9 risk factors such as having a very difficult traumatic
10 childhood, so that may explain everything about -- well,
11 explain most of the association.
12 So what we're saying here is that one of the best
13 ways of determining whether it's causal, so actually,
14 the illness increases the risk directly, not indirectly,
15 but directly, is through treatment trials where you
16 treat the symptoms of the illness and you give one group
17 an active treatment, another group with the same
18 illness, an inactive treatment or a dummy treatment, and
19 then you measure violence going forward. And that's
20 been done in schizophrenia.
21 So in schizophrenia there are around 12 randomised
22 controlled trials. In people -- every one has
23 schizophrenia and they give one group of people active
24 medication, and another group of people a dummy tablet
25 and they find that the people on active treatment,

1 there's quite a large reduction, over 50% reduction in
2 violence when they follow people up.
3 **Q.** That's a significant percentage, isn't it?
4 **A.** That's a very significant percentage. And that's
5 indicative of causality. So that suggests quite
6 strongly that this is a causal relationship, it's the
7 schizophrenia that leads to the violence, because that's
8 the one thing that's different between the two groups:
9 that you're treating the symptoms in one group versus
10 the other.
11 So that's one element of that. The other way to
12 test causality is by looking at other research designs.
13 So you can look at, for instance, epidemiological
14 studies quite closely, particularly those that are
15 longitudinal, so you know very clearly that the
16 diagnosis is made before people have been followed up
17 for violence and crime.
18 And the other question you asked me -- sorry,
19 I forgot the second part of the question -- you asked
20 about the causality issue.
21 **Q.** Yes.
22 **A.** But then I think you asked about modifiability.
23 **Q.** "... [the] diagnostic categories themselves are not sole
24 treatment goals, ... active symptoms and comorbidities,
25 which mediate the above-reported associations with

1 violence, should ... be targeted."
2 How do you target that or those?
3 **A.** Yes. So there that's really saying what's underlying
4 the -- this causal association, so we have a label such
5 as schizophrenia, that's a diagnostic label, but what
6 are the symptoms that mediate, so what is in between the
7 diagnosis and the violence that we're talking about? So
8 what about schizophrenia leads to violence?
9 So that's what that statement is saying, and that
10 requires much more detailed type of research where you
11 look at symptoms and you try and disentangle those
12 symptoms from each other, and identify the ones that are
13 most strongly linked to violent acts.
14 **Q.** That must be difficult with comorbidities, if you've got
15 psychosis, personality disorder, very difficult to
16 disentangle, presumably?
17 **A.** It can be, but there are groups of people in many of
18 these studies who don't have comorbidities, so they
19 represent one way of doing it. And -- but at the same
20 time it's important to address and to investigate
21 comorbidities, because we know that in the case of
22 schizophrenia, that comorbidities do increase the risk
23 and the question there is why? What are they doing?
24 Are they just making the symptoms worse or are there
25 something about, for example, the drugs and alcohol

1 themselves that increase the risk? Or do they, for
2 instance, lead to people to stop taking their
3 medication?
4 And so they are ways of looking at this question,
5 and in the case of schizophrenia, all those explanations
6 are likely. So they make the symptoms worse, they lead
7 people to stop taking their medication, or other
8 treatments, and there are direct effects of drugs and
9 alcohol to do with disinhibition and impulsivity that
10 also increase the risk.
11 **Q.** That article can come down now, please, and can we have
12 WITN0401003, page 1. This is an article in the Lancet
13 Psychiatry 2020:
14 "Violence and mental disorders: a structured review
15 of associations by individual diagnoses, risk factors,
16 and risk assessment."
17 If we go to page 2, please, the box on the right,
18 text at the bottom:
19 "Absolute rates of violence in schizophrenia
20 indicate the relevance of prevention and management of
21 risk to clinical services, particularly when treating
22 individuals in their first episode of illness. Over
23 a lifetime, 23% of individuals with a diagnosis of
24 schizophrenia in Sweden had a violent conviction."
25 23% is a higher proportion than those with other

1 mental illnesses, is that right, such as bipolar or
2 depression?
3 **A.** Yes, it is, yes.
4 **Q.** It sets out clearly, as well, that if an individual is
5 born male, there's a higher risk than if born female; is
6 that right?
7 **A.** That's right, yes, again, I would say it's substantially
8 higher risk if they're male at birth.
9 **Q.** Is there an age range assessment for the highest risk
10 for men? Young men higher risk than older men?
11 **A.** It is, yes. And I mean we've quite carefully modelled
12 the association with age, and it's very similar to the
13 pattern you'd seen in the general population, so it's
14 younger people have higher risk.
15 There's a slight delay, so it's probably more people
16 in their twenties that the risk is highest, partly
17 because the illness only really becomes present in late
18 adolescence, so you don't see a peak of violence in
19 teenage years like you would do in the general
20 population; you see it a bit later. But there is
21 a clear association with age, and actually age is one of
22 the strongest predictors of violence in all mental
23 illnesses, and in the general population. So it mirrors
24 what's happening in the general population.
25 It's worth saying that -- I mean 23% over a lifetime

1 is high. I mean that's a one in five, almost one in
2 four. At the same time, most people are not violent.
3 So there's another way of looking at that data and
4 saying: well, it's a minority of people. And
5 particularly if you take a five-year period, there we
6 found that after diagnosis, about 10% of men had
7 a violent conviction over the next five years, which
8 means that 90% of people do not.
9 So I think it's -- there's different ways of looking
10 at this data. Our view is that it's important to have
11 the data available and clearly presented. How you
12 interpret it will depend on particularly where you
13 work -- from a clinical perspective where you work in
14 services. But it's important to be aware that that data
15 is present.
16 We've also done studies in England and we've found
17 that after making contact with services, around 10% have
18 a violent incident in the next year. So this 10% rule
19 I think holds true also in England, as well.
20 Q. Are auditory command hallucinations to commit violence
21 associated with a heightened risk of violence?
22 Dr Farnham told the Inquiry you can't be in such
23 a mental state for a very long time without something
24 happening, often it involves the patient harming
25 themselves but it could be harming someone else. So, of

1 course, he's a forensic psychiatrist too and just
2 commenting on the impact of auditory command
3 hallucinations on an individual.
4 A. I think the evidence suggests that it's your response to
5 those hallucinations. So if those hallucinations lead
6 to a response such as anger or mood, your mood becomes
7 changed quite significantly, then I think there is
8 a link with violence. I think just on their own,
9 auditory hallucinations may or may not be associated
10 with violence, but I think where we know that they're
11 associated with violence is where they lead to a --
12 particularly anger or a strong mood element to do with
13 them. I think you're referring to command
14 hallucinations, so these are hallucinations where you're
15 being told to do something, and I think the difficulty
16 there is that they -- first of all they're quite rare,
17 and second of all they're often not particularly
18 reliable. So people say they have command
19 hallucinations but when you drill down into the details,
20 it's not actually a command hallucination in many cases.
21 I think probably easier just to think of a set of
22 symptoms, auditory hallucinations are one of them,
23 which, if they do elicit anger or mood responses, are
24 going to increase your risk.
25 There are other symptoms, as well, so hostility,

1 impulsivity are important symptoms, and they are part of
2 the wider picture in schizophrenia as well.
3 Q. Can we have WITN401012, please, page 1, a 2015 article:
4 "Improving risk assessment in schizophrenia:
5 epidemiological investigation of criminal history
6 factors".
7 If we can go to page 6, please:
8 "Implications
9 "This study suggests a conviction for a violent
10 crime prior to diagnosis may be the strongest predictor
11 of subsequent convictions for violence in those with
12 schizophrenia."
13 A. Yes, that's right, yes. And that's been validated
14 subsequently. So the work we've done, and other people
15 have done, has shown that a conviction prior to
16 diagnosis is the strongest predictor. That, at the same
17 time, all violent incidents, even if they don't lead to
18 a conviction, are predictive. This study is
19 a comparative study so it looks at all the possible
20 background risk factors in relation to violence and
21 non-violent offending, and we rank them in a sense,
22 looked at the relative strength of those. And if you do
23 it that way, you find that violent crime is the
24 strongest predictor, but actually all background history
25 of violence is a predictor and actually background

1 history of non-violent offending is a predictor as well.
2 So this is just a way of establishing which is the
3 most important of these risk factors in the past.
4 Q. That can come down, please, and can we have WITN320014:
5 "Symptomatic review of risk factors for violence in
6 psychosis: 10-year update".
7 In 2025, and can we go, please, to page 6, second
8 paragraph on the left, the role of antipsychotic
9 treatment.
10 Can you just expand for us on that, please?
11 A. This is the paragraph starting with "Antipsychotic
12 treatment", yes?
13 Q. Yes.
14 A. Well, what we did in this review is we looked at
15 different domains of risk factors, and one of the
16 domains was treatment-related factors. So what we tried
17 to do was bring together all the evidence in
18 longitudinal studies. So these are studies which look
19 forward, so they are slightly better designed, the
20 research design, because you're not looking backwards at
21 what happened; you're looking forwards. And here what
22 we did is we looked at treatment-related factors, as
23 I say, and antipsychotic treatment, so this is
24 medication, a group of treatments. They reduced the
25 risk of violence by about 50%, and we also looked at

1 other types of treatments, for example, antidepressants,
2 where there is a small protective effect, and that could
3 be explained by the effects of antidepressants on, for
4 example, impulsivity or mood, mood being disturbed.
5 We also looked at psychological treatments and
6 didn't find that psychological treatments reduced the
7 risk of violence in people with schizophrenia. And that
8 paragraph also discusses the possibility that the
9 antidepressants are working through anger. I mean I've
10 mentioned that just previously so that specifically
11 mentions that.
12 **Q.** Do you consider that it's sufficiently understood how
13 statistically significant it is, the antipsychotic
14 treatment, in managing and preventing violence?
15 **A.** I don't know the answer to that question. I think it is
16 understood. I think broadly speaking, a general --
17 the general view of psychiatrists would be that
18 antipsychotic treatment is important, and so I think
19 that's broadly understood. The extent of it, I don't
20 know. So this is quite a substantial decrease in risk,
21 and that's been found in randomised controlled trial
22 evidence, so the best quality evidence. And that
23 substantial decrease may not be fully -- people be fully
24 aware of that.
25 **Q.** That can come down, please, and can we have WITN401005.

1 This is the Dunedin Study, not one of yours; you refer
2 to it helpfully in your report.
3 **A.** Yes.
4 **Q.** "Mental Disorders and Violence in a Total Birth Cohort".
5 Can we have a look at page 6, please. And the
6 bottom paragraph, have 6 and 7 together:
7 "The tendency to see the world as a threatening
8 place, measured at 18 years of age, explained much of
9 the violence of individuals who endorsed the bizarre
10 symptoms of schizophrenia at 21 years of age."
11 Can you help us with this paragraph at the end of
12 that page and the next one, and also whether
13 schizophrenia does come out of the blue, as it were, or
14 for some people there are personality traits or existing
15 concerns that develop -- lead them to be more likely to
16 develop schizophrenia?
17 **A.** Yes. So the advantage of this particular study is they
18 take the thousand people born in one town and follow
19 them up very, very carefully with regular assessments
20 every few years. So it's very, very well described and
21 very carefully followed up, and what that enables you to
22 do is look at all the other possible explanations for
23 violence, try and account for them and see if -- what
24 makes mental illnesses independently associated with
25 violence. And broadly speaking what this study did is

1 they found that schizophrenia was associated with
2 violence; it's about a two to three-fold increased risk
3 in this particular cohort up to the age of 21.
4 And, as I say, the value is they were able to
5 account for childhood problems, socioeconomic
6 differences, drug problems, cannabis use, even
7 sub-threshold cannabis use. So they really were able to
8 do very careful accounting of all the possible
9 explanations.
10 So one of the reasons why it's often cited is it's
11 a very clear example of an epidemiological study that
12 finds this link with schizophrenia.
13 In terms of your question about these comorbidities,
14 I think the other value in this study is they do show
15 that the comorbidities further increase the risk, so
16 that they found that if someone had a childhood conduct
17 disorder, so this is a disorder that presents in
18 childhood and continues into adolescence where
19 essentially rule-breaking behaviours and impulsivity,
20 that they found that that was one of the factors
21 they've -- looking backwards, that people with
22 schizophrenia presented more commonly with.
23 That doesn't speak to the cause of the
24 schizophrenia; it just says that if people have conduct
25 disorder as well, it's like a co-morbidity, then that

1 does increase the risk.
2 That, I think, in adulthood would equate to people
3 having personality disorders, particularly antisocial.
4 So if you have a combination of the two, that will
5 further your risk.
6 The other thing that they found was the relevance of
7 the drug and alcohol problems which I have referred to
8 previously which does further increase the risk, and
9 I think in our systematic review as well we found that
10 drug disorders do at least double the increase, at least
11 double your risk of violence, if you have schizophrenia,
12 and that's also across a range of illegal drugs, it's
13 not just one, and alcohol also does increase your risk,
14 particularly if it's misused.
15 Cannabis does, if it's misused, and in studies we've
16 done using English data we've also shown that as well,
17 and that also applies to hallucinogens, stimulants and
18 other illegal drugs.
19 **Q.** That can come down, please, and can we have WITN0378026,
20 page 1. Not a study of yours, the relationship between
21 delusions and violence:
22 "Conclusions and relevance: Anger due to delusions
23 is a key factor that explains the relationship between
24 violence and acute psychosis. A subset of delusional
25 beliefs may be causally linked to violence, and certain

1 uncommon beliefs demonstrated a direct association with
2 minor violence. Highly prevalent delusional beliefs
3 implying threat were associated with serious violence,
4 but they were mediated by anger."
5 If we go, please, to page 4, the comment box, if we
6 can have 4 and 5 on the screen together, please:
7 "We confirmed strong associations between anger
8 related to delusions and both minor and serious
9 violence."
10 The bottom of that box on the left on page 4:
11 "The association was stronger for serious violence
12 than for minor violence, and the higher attributable
13 risk of anger due to delusions (particularly for serious
14 violence) has implications for preventative intervention
15 and treatment. If anger due to delusions could be
16 identified and treated, [the] substantial number of
17 violent incidents could potentially be prevented."
18 Do you agree with that?
19 A. I do, yes, and there's been work subsequently done that
20 has I think -- yeah, confirmed this, in other samples
21 also in the UK. So previously I was talking about
22 hallucinations leading to anger, but here this study
23 refers to delusions leading to anger, and I think
24 there's a broad pattern here which is if your symptoms
25 are associated with an affective -- "affective" is

1 a word we use to refer to a change in your mood or your
2 emotional response -- that that is an important target
3 for treatment.
4 Q. We see at paragraph 2, reference to the delusions.
5 These include being spied on, familiar people
6 impersonated, persecution conspiracy and
7 misidentification. And if we see under:
8 "Pathways from delusions to violent behaviour:
9 "Delusions of being spied on, persecutory delusions,
10 and delusions of conspiracy were strong predictors of
11 serious violence even after adjustments."
12 What does that mean, "even after adjustments"?
13 A. So taking into account other factors such as drugs or
14 personality problems. So it's trying to see whether
15 there's an independent association, and that's what they
16 found in this study.
17 Q. In consultations with a patient, would you expect
18 psychiatrists to explore, whether it's command
19 hallucinations, delusions, would you expect them to
20 explore the thinking if the patient was willing to tell
21 them and what those delusions might represent for them
22 and what they thought they were telling them to do, for
23 example?
24 A. Yes, I would. It's difficult to sort of talk broadly
25 about psychiatry. I mean, many assessments are done by

1 nursing colleagues, so I can't speak to what type of
2 detail goes into those assessments, but psychiatrists
3 I would expect them to look into more detail about the
4 nature of delusions, and it's often reported that they
5 write down persecutory delusions as often -- you often
6 see in the notes, because it's reported by the patient.
7 Q. What about -- that can come down, thank you -- we've not
8 asked you to comment on VC's case and I don't want to
9 comment or ask you too many questions about the details
10 of it. But just as a principle, if you were given, as
11 a psychiatrist, a plethora of notes or writings from
12 a patient, would you consider it necessary to have
13 a look at those to see what they said about their
14 delusions or otherwise? Or would there just not be time
15 for that, frankly, in general psychiatry? I mean,
16 what's the realistic answer and what's the optimal
17 answer.
18 A. I think you'd have to ask the general psychiatrist. I'm
19 not -- as a forensic psychiatrist, I think I would
20 because I'd want to know more, as much as I can about
21 the nature of the delusions and any specific threats.
22 Q. What do you mean by threats?
23 A. Well, any people identified or organisations identified.
24 I mean, they're the particular areas in -- that you're
25 concerned in people with elevated risk.

1 Q. Can we have, please, WITN0401008. This is one of yours:
2 "Psychological framework to understand interpersonal
3 violence by forensic patients with psychosis."
4 This was the first qualitative study to explore
5 psychological pressures for violence in psychosis,
6 wasn't it? The three themes emerged, if we go to
7 page 3, first of all:
8 "Theme one: violence of the dominant response mode."
9 So that's where people: all I know is violence,
10 effectively, from their background, experience?
11 A. Yes.
12 Q. "Theme 2: [page 4] Violence protects against a trio of
13 sensitivities."
14 Can you expand a bit more on that, please?
15 A. Yes, I think this is one of the novel aspects of this
16 study because I think it clarifies very usefully why
17 violence is used as a response by people, by some
18 people, and here what we identified was three types of
19 sensitivities that people are sensitive to being
20 disrespected, and violence is used as a response to
21 that.
22 They're worried about being harmed, and so they're
23 on guard, they're concerned about threats in the
24 vicinity, either where they live or in this case on the
25 ward. And, finally, they are sensitive to being treated

1 unfairly, and that can lead to frustrations and people
2 then reacting as a response to being frustrated.
3 So it provides a little bit more detail and, yeah,
4 targets, in a way, for treatment, psychological targets
5 for treatment. And that is novel and I think quite
6 helpful.
7 **Q.** In this study, and indeed any of the others you've
8 conducted, did you look at the influence or the impact
9 of social media on a cohort?
10 **A.** No. This is an important question, but not to my
11 knowledge, that's been looked at. I think it's -- the
12 reason partly is because most of these studies have been
13 done on inpatients, and there are quite strict rules
14 about what people are able to access. So I think that's
15 an important area for people to look at in community
16 samples.
17 **Q.** For psychiatry as a whole to keep up, as it were, where
18 people in the community may be being influenced or
19 engaging online, be it about conspiracy theories, about
20 violence, attacks -- understanding what's influencing
21 their mind at any time?
22 **A.** I agree.
23 **Q.** Do you think -- I mean, it's difficult, isn't it, to
24 enforce any of that? You can't require to see a phone
25 or access to what patients have had, and some may be

25

1 very guarded. How would you set about with a patient
2 trying to elicit what they had been disturbed by or what
3 they had watched? How would you manage or try to get
4 that information from them?
5 **A.** Well, I think -- I mean, experienced psychiatrists will
6 know how to approach these type of questions. I mean
7 usually you do it in a round-about way, so you would,
8 you know, raise a topic which may not be directly
9 related to what they're looking at online, but it's --
10 it may be something in the news, and then you'd start
11 asking some questions and I think a lot depends also on
12 developing a therapeutic rapport with an individual over
13 time and them willing to share things with you. But
14 I think an experienced psychiatrist will be able to ask
15 questions in a way that opens up these type of
16 conversations.
17 So I mean it's very common throughout our experience
18 dealing with people who are very guarded about their
19 symptoms. So there's a sort of skill set, it's sort of
20 soft skills that you learn to try and elicit these type
21 of more personal things.
22 And at the same time, I mean I think it is also an
23 opportunity to speak to carers or parents, if it's
24 relevant, sometimes in joint meetings, and that can also
25 be an opportunity for this type of information to come

26

1 out. So it could be done in a sort of collaborative way
2 with other people. And then sometimes it just takes
3 a bit of time. So it may be that you follow up in your
4 second or third appointment with a bit more direct
5 questioning about these issues but you don't do it
6 initially, so it's a process rather than something you
7 try and sort out in one go.
8 **Q.** When you say "soft skills", can you expand on those?
9 **A.** Well, it's picking up on social cues, it's picking up on
10 what you know about the person, their likes and
11 dislikes. It's building on those. So you may know
12 something about their interest and you use that as a way
13 in to a wider discussion. It's also being aware when
14 someone is guarded. I mean you can sort of pick up on
15 body language and that can tell you something that you
16 may wish to go back to at a later point, and just pause
17 at that point, but go back to the later point.
18 So there's a sort of range of things. It's to do
19 with body language, eye contact, things people say, the
20 type of language they use, their tone of their voice,
21 the volume of their voice. It's what broadly -- I mean
22 you've heard of the -- this thing called a mental state
23 examination. I mean, that's why that's so essential in
24 any assessment, because it's part of this wider clinical
25 examination that you're picking up on appearance and

27

1 behaviour, speech, the content of speech. And then you
2 will approach it in different ways at different times
3 during an interview.
4 **Q.** Mental health state examinations, at any point in time,
5 who is best able to conduct those, do you think? As
6 a category of professional?
7 **A.** Well, I think all professionals can conduct them.
8 I mean psychiatrists are trained quite extensively in
9 doing these assessments and it's part of the basic
10 training. I don't know enough about the other
11 professions but it is -- I mean you see in notes people
12 doing mental state examinations from all professional
13 backgrounds.
14 I think, I mean sometimes it's useful to do it --
15 I think -- I made the point about that it maybe needs to
16 be done on multiple occasions. I think there's value in
17 discussing it with colleagues if you're uncertain. So
18 there's a number of ways of trying to enhance its value.
19 **Q.** That can come down, please, and can we have WITN0401006,
20 page 1 and 2 alongside each other:
21 "Violence in schizophrenia: triangulating the
22 evidence on perpetration risk."
23 We see at page 2, if we have 1 and 2 together, can
24 you just set out for us what you conclude here as
25 authors?

28

1 A. Yeah, this is -- we felt was an important article to
2 write. It's a short article, and we wrote it in
3 a journal that is very widely distributed to
4 psychiatrists around the world, because --
5 Q. World Psychiatry, indeed.
6 A. World Psychiatry. And the reason is that we felt
7 there's still some -- quite a strong body of opinion in
8 psychiatry that doesn't think there's a link between
9 schizophrenia and elevated risk of violence. And we
10 thought it was important to set out what we think is
11 robust evidence that's triangulated, so it comes from
12 different sources, to show quite clearly that there is
13 a link and, you know, our view is that this question has
14 been settled some time ago, but there's still a body of
15 opinion within mental health that doesn't think that
16 there's a link, or that any link can be explained away
17 by, for example, socioeconomic differences or comorbid
18 drug problems. So this body of opinion is of the view
19 that any association that you find is not independent,
20 that it's explained by, for example, drug problems in
21 people with schizophrenia. It's not the schizophrenia;
22 it's the fact that people with schizophrenia are
23 vulnerable and have a higher rate of using illegal
24 drugs.
25 And what we tried to do in this article was present,

1 in a short piece, the evidence that we think is very
2 strong, strongly supports a causal link between
3 schizophrenia and risk of violence, and there are, as
4 I've mentioned, these trial -- the trial evidence is
5 probably the strongest evidence here, that trial data
6 shows that if you treat the symptoms, the risk of
7 violence is decreased by actually 63% in the
8 12 randomised controlled trials that have been
9 conducted.
10 But that is also supported by real world studies
11 which look at large numbers of people on medication and
12 compare them to people who are not on medication, and
13 there's even better designs where you compare the same
14 person when they take medication with when they don't
15 take medication, they're called "with individual"
16 studies, and we've done a couple of those. And that
17 shows a similar decrease in risk of about 60% when
18 people are taking their medication. So that's in the
19 same person, and that's very powerful, because it, in
20 a sense, accounts for the background factors of that
21 person.
22 And then there are these epidemiological studies, so
23 these population-based studies where you compare people
24 with schizophrenia to people without schizophrenia, and
25 there's been about 24 of those studies in different

1 countries using different outcomes, so not just crime,
2 but also interpersonal violence reported by family
3 members, self-reported as well and they all, every
4 single one of those studies finds an increased risk.
5 And some of those studies, like the Dunedin one, are
6 very carefully adjusted for background factors, and
7 despite that, they all find this association.
8 Then we also argue in this piece that there are also
9 plausible mechanisms. So you see an association: is
10 there a plausible mechanism and, for example, delusions
11 that lead to anger is a plausible mechanism; it's been
12 shown in good-quality studies.
13 So what we try and do here is just outline the
14 evidence because I think there is a body of opinion in
15 psychiatry that doesn't see there being a link, and
16 I think that's partly driven by their concern about
17 stigma, but we think that's a misunderstanding of the
18 evidence. You can't deny the evidence just because you
19 don't want to -- just because you're worried about
20 a risk of stigma.
21 Q. Let's come to stigma in a moment. In terms of the first
22 concern that some, you say, some colleagues or
23 psychiatric colleagues don't identify the risk, you
24 state at page 2 in the last paragraph:
25 "... we would argue that it is possible to recognize

1 the association between a psychotic illness and
2 increased risk of violence, and that this leads to
3 better preventative treatment. Improving prevention
4 requires clinicians and researchers to recognize this
5 link, however unpalatable, and endeavour toward reducing
6 it, whilst advocating ... and working with patients and
7 their families to ensure that it is seen in context and
8 not exaggerated."
9 You placed this article in World Psychiatry. What's
10 your sense of the feedback to that? Do you still think
11 there are people that can't or don't acknowledge the
12 associated risk at these points in time?
13 A. Yes, I do. I mean this has been something I've been
14 writing about for about 20 years, and you still --
15 there's still a number of pieces being written but also,
16 when I present the evidence in meetings, I often get
17 pushback, and the pushback is usually, as I say, because
18 it must be explained by other factors. It's almost that
19 people don't want to believe that there is a link, and
20 that's why we use the words "however unpalatable" in
21 that sentence.
22 But our view is that, you know, in order to do
23 something about this link, you have to face up to the,
24 I think, the really robust evidence now. I mean it's as
25 I say, I think it's settled. This is not really

1 a research question any more; the evidence is now
2 overwhelming and it's triangulated across many different
3 designs in many different countries using many different
4 outcomes, different ways of measuring violence, and
5 it's -- as I say, it's robust and strong and highly
6 replicated evidence. And denying the link is, I think,
7 a problem because it means you then don't address it.
8 If you don't think there's a link, you won't do anything
9 to prevent it or treat it.
10 **Q.** Even where some acknowledge the link, is this issue of
11 stigma a more concerning one, or equally concerning for
12 them? And what is the issue of stigma?
13 **A.** Yes, so this is, I think, the main issue why the link is
14 discounted or sometimes not -- ignored: that people are
15 worried by identifying this link, you increase stigma
16 for a group of people who are already very heavily
17 stigmatised. And so we know that people with
18 schizophrenia, you know, they don't get -- they are
19 stigmatised when it comes to things like accommodation,
20 work, physical health treatment. I mean these are
21 really serious problems that they are stigmatised.
22 And so the concern is, by identifying this, you make
23 that worse. And our view is -- is no. I mean the best
24 way to address stigma is to prevent these type of
25 outcomes, in this case violence, in people with

1 schizophrenia. That's the best way to address the
2 stigma; not by denying the link, which exists, but by
3 preventing it. And that's what we've argued.
4 When we've done some work with -- we've spoken to
5 psychiatrists in some of the work we've done, and
6 they've told us that it is a -- I mean it's one of the
7 reasons why they do back away from doing risk
8 assessments, is they're worried that it's stigmatising.
9 So we know that also in the qualitative work we've done
10 on the ground, that it is a concern people have, and
11 like I say, it's been written about on and off over the
12 last 20 years as well.
13 **Q.** Is that -- we'll come to information sharing later --
14 but is that something that's in respect of information
15 sharing as well, that there's concern if you share risk
16 about a patient, or risk of violence, that that's
17 stigmatising or making their life more difficult?
18 **A.** It might be. I don't know if that's the main issue.
19 I think it's more basic than that. I think it's just --
20 as a psychiatrist you want to, you know, you're focusing
21 on the best interests of your patients and you're, you
22 know, and you're then concerned that by identifying this
23 risk you're not serving the best interests. But I think
24 that's a misunderstanding, of that -- *(overspeaking)* --
25 **Q.** Where would you put the patient's interests in terms of

1 managing and providing them with treatment, even if it's
2 compulsory treatment; is that in the patient's best
3 interests, if it prevents them committing serious
4 violent offences, or do you not assess best interests in
5 that way?
6 **A.** No, it is definitely in people's best interests.
7 I mean, at the very basic level, I mean, you know,
8 committing a violent act will disrupt their care quite
9 severely. I mean, they may get arrested; they may get
10 remanded in custody; they may end up in prison. And we
11 know that prison is not a good place to have treatment
12 for mental illness, particularly acute mental illness.
13 So that is at a very basic level.
14 But there's more than that. I mean, there's the
15 effect of, of course, on the victims, which is
16 important, and on the services as well, which will be
17 highly disrupted by those type of incidents.
18 So there's a sort of wider effect --
19 **Q.** Public interest, best interests for patients --
20 **A.** Public interest and best interests, yes.
21 **Q.** That can come down, please. You refer in your report to
22 the Swedish research in the Nordic countries, and that
23 they're better able to have detailed research on this
24 topic in particular. Why is that? What is it about how
25 they keep and record information?

1 **A.** Well, there's a long tradition in Nordic countries of
2 transparently and openly people sharing health care and
3 other routinely collected information with published
4 agencies, which are entirely anonymised. I mean, it's
5 very confidential and it's very carefully managed, but
6 what it means is that you can then interrogate those
7 data in the real world.
8 And the other advantage in Nordic countries, which
9 is almost unique, is that you can link different types
10 of data. And so in this case you can link healthcare
11 data with crime data, and the reason you can link it is
12 because people have a unique identification number in
13 these countries, a ten-digit number, and so you can do
14 it accurately. And then you can link it with other
15 datasets such as education, people leaving the country
16 because there's an immigration dataset, so you can
17 account for when people leave.
18 These datasets also exist for other social factors,
19 where people live, their civil status. So these Nordic
20 countries have a tradition of these, and the other
21 advantage of them is that they routinely collect
22 information on diagnosis and treatment, so then you know
23 something about diagnosis and, you know, what medication
24 people are getting, for how long. And that's been the
25 basis of a lot of my research is interrogating that

1 data, because it's unique resource.
2 And Sweden is mentioned because it's the largest of
3 these Nordic countries with a population of about
4 10 million, and the other Nordic countries have also
5 excellent registers: Finland, Denmark, Norway, but
6 they're smaller populations.
7 **Q.** Is there evidence as to whether the likelihood of
8 violent conviction increases or decreases from first
9 diagnosis? In other words, the longer the illness,
10 especially untreated, the risk of violence increases?
11 **A.** Yes, there is. I mean, some of it is indirect because
12 we know that treatment reduces the risk, but there is
13 some other work that shows that the duration of
14 untreated psychosis is a risk factor.
15 Those studies are difficult to do, but there is, as
16 I say, I think it's from two sides. There's -- we know
17 the treatment works and we also have some information to
18 suggest that the longer the period of untreatedness is
19 linked to increased risk of violence.
20 **Q.** Can we have, please, page 9 of your statement,
21 WITN0401001, your report I should say. The top
22 paragraph. We touched on this earlier in the article,
23 the top paragraph:
24 "Many treatment related-factors were protected (with
25 around halving of violence risk)."

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1 Does that mean that medical management and treatment
2 is effectively provided for a schizophrenia patient the
3 risk of violence on average is roughly halved?
4 **A.** Yes.
5 **Q.** The evidence of an increase in risk is clearest when the
6 person with schizophrenia does not receive consistent
7 and appropriate medication?
8 **A.** Yes, that's right. I'm on page 9 here, but I think
9 you're reading -- is that the page you're referring to?
10 **Q.** Thank you for that. It is the same paragraph on the
11 screen.
12 **A.** Oh, is it?
13 **Q.** Yeah. It's the last sentence at the top:
14 "Many treatment-related factors were protective
15 (with around halving of violence risk)".
16 **A.** Yes, at the end of the paragraph. Sorry, I missed it.
17 **Q.** It is okay. You have set that out as you did earlier.
18 **A.** Yes.
19 **MS LANGDALE:** Chair, this is probably a convenient moment to
20 break for the morning break?
21 **THE CHAIR:** Right. Well, we'll start again at 11.20. Thank
22 you.
23 **(11.02 am)**
24 **(A short break)**
25 **(11.20 am)**

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1 **MS LANGDALE:** Professor, if we can move now, please, to the
2 issue of risk assessment, and you were invited to
3 comment on good practice, and you set out page 9 of your
4 report:
5 "First, taking a comprehensive personal and clinical
6 history that includes information about previous
7 violence towards others [is required] ..."
8 And you say:
9 "Such a history should aim for corroboration from
10 informants and other such sources where possible ..."
11 Why do you say that? In fact if we go -- if we have
12 your statement on the screen at page 10, you set out
13 these three issues separately. So firstly, when should
14 they be undertaken?
15 **A.** Well, my view is that when someone is first accepted by
16 a mental health service to provide a baseline -- as part
17 of a comprehensive, holistic, baseline assessment,
18 because at the first assessment you want to get a full
19 picture of someone's -- all their particular needs,
20 including their violence risk, suicide risk, and their
21 treatment needs as well.
22 So I think the assessment should be done when
23 someone is first accepted by a service, and then also
24 I think when there's a clear change or escalation in
25 risk, if something happens that you know about, that

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1 you've been told or they tell you, such as, for example,
2 someone's been arrested or expressing some new thinking,
3 new thoughts about harming others in this context. And
4 then I think the final area would be -- a final time
5 would be when there's uncertainty, and where there's
6 uncertainty among a team, then it's a good opportunity
7 to try to think about risk in a more structured way
8 rather than relying on people's subjective
9 decision-making.
10 **Q.** Whose role is it to identify: look, there's uncertainty,
11 time to do another risk assessment or review of risk?
12 **A.** Well, I mean, I think it would be the responsible
13 clinician, it would be the person leading the treatment,
14 because they have the overview of what's happening and
15 the information goes to them from different sources. So
16 they would be in a good position to do it.
17 **Q.** What if they haven't read the progress notes which had
18 comments or information that were relevant to
19 potentially escalation of risk? How would that be
20 captured? Who would spot that?
21 **A.** Well, in some -- for some patient groups every six
22 months there's a review, and in that review, some
23 multi-disciplinary review, that could be reviewed.
24 I mean, that's an opportunity to look at the care over
25 the last -- previous -- the last few months, and if

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1 there's a change, and uncertainty about how to proceed
2 going forward, then that would provide that opportunity.
3 **Q.** You say in your report that the person who first sees
4 the patient taking a comprehensive personal and clinical
5 history, what's the role of family, or those who know
6 the patient? What information would you like to get
7 from them?
8 **A.** Well, I think it's a very important role, because they
9 can provide background history, they can help
10 corroborate information, particularly if there's gaps,
11 and, you know, where you've noticed some guardedness, it
12 could be an opportunity to sort of clarify that
13 information.
14 But sometimes people themselves, patients themselves
15 can't remember what's happened. I mean, they may have
16 been unwell or it may have been a long time ago, so it's
17 important to try and address those gaps. And I've
18 highlighted that, you know, some of those gaps are about
19 a history of harm towards others, and I think that
20 that's an important area where you can get corroborative
21 information, informant history.
22 **Q.** You talk about informants, what do you mean by that
23 phrase in this context?
24 **A.** Well, it would be family usually, or if someone has
25 a carer or a partner. I mean, they would be the sort of

1 classic examples, but it could be beyond that. I mean,
2 if people have had contact with the police or Social
3 Services, that can be important providers of
4 information.
5 **Q.** Providers of information. What if the patient didn't
6 want you to speak to family members? Would you, as
7 a responsible clinician, have that conversation with the
8 patient and say you needed to receive information in any
9 event, or would you just consider that you couldn't
10 speak to a family member if they didn't want you to?
11 **A.** No, I mean I think the practice would be that you'd
12 explain to the patient why that's important, and do it
13 in -- but, I mean, the purpose of doing it is not just
14 to get information; it's also to sort of try and work
15 together and come up with a plan. So I think if it's
16 presented in that light, it's not just an exercise in
17 finding out information from the past, but it's also
18 about trying to plan -- people talk about safety
19 planning, I mean, broadly breaking, that's a form of
20 risk management, so: can we do this in
21 a more collaborative way with other people involved who
22 can assist you, particularly if you become unwell?
23 **Q.** Would you use the phrase "safety planning" with
24 a patient, a patient with schizophrenia?
25 **A.** You would do in relation to suicide risk. I mean,

1 that's something you would talk about.
2 **Q.** What about risk to others?
3 **A.** I mean, I use the term "risk management" -- I mean,
4 that's the familiar term. But I think some people don't
5 like the word "risk" and they prefer the word "safety",
6 and I think that's fine. I mean, I don't have a strong
7 view about that.
8 **Q.** If you assess best interests in the way you did earlier,
9 that it's also safer for the patient, it is safety
10 planning, isn't it, at least to the public and the
11 patient?
12 **A.** Yes, I agree.
13 **Q.** You refer to potentially getting information from the
14 family and also the police. Again, if you hit a brick
15 wall with a patient about getting information from the
16 police, assuming you share that you want to have
17 information from the police, would you still obtain that
18 information?
19 **A.** I would if there's a reasonable suspicion. I think that
20 that can be justified and I think it would be good
21 practice.
22 **Q.** In your experience, are there clear mechanisms for
23 obtaining information from the police? A form,
24 something that explains it very quickly, when you can
25 get the information, how? Have you seen anything like

1 that?
2 **A.** My experience is a bit limited in this respect because
3 I'm working at the forensic end of the spectrum, but my
4 understanding is that most police forces have a mental
5 health liaison person, and they would be the person to
6 approach, and develop links with services, and many
7 services have links with such individuals and good links
8 with such individuals. So that would be the most
9 obvious way to address that.
10 **Q.** Have you ever experienced barriers in obtaining
11 information that you've needed as a forensic
12 psychiatrist, or overall managed to get what you need?
13 **A.** Well, I have. I mean, I have in different settings. So
14 I've worked for many years in prison and that can be
15 a difficult place to get background history from, partly
16 because healthcare records are sometimes not joined up.
17 That's now improved, so now we are able to get hold of
18 general practice records, but for many years, that was
19 difficult.
20 So I think some of these problems have been
21 addressed, actually, over the last few years and that's
22 a good example. But that's in a prison setting, that's
23 a very specific setting.
24 In the general adult setting, I can't -- I'm not --
25 I'm not the best person to ask about that.

1 **Q.** Understood. Who should undertake assessments? Risk
2 assessments, you set out here:
3 "... undertaken by clinical staff, including medical
4 doctors ..."
5 What is it about their experience and expertise
6 that's important for the purposes of conducting risk
7 assessments?
8 **A.** Well, I think ... I mean, it's about integrating the
9 science of risk assessment with the art, and the art is
10 the soft skills that I was mentioning before and I think
11 you want clinical staff who have some experience of
12 both. I mean, they understand the science and they have
13 some training in the art of doing a risk assessment, and
14 it's about combining those two, really, to provide
15 comprehensive assessment.
16 And so, I think -- I mean, I've said that clinical
17 staff should do it and I think they can be reviewed by
18 a clinical team, a multi-disciplinary team, where you
19 can get different perspectives and uncertainties can be
20 discussed. And I've also highlighted the fact that
21 I think that experience of staff needs to be considered,
22 because, I mean, some of these assessments can be
23 difficult to do well, and it may well be that people who
24 are very early on in their career need supervision and
25 discuss these with more senior, experienced members of

1 a team.
2 So I think it's difficult to be very prescriptive.
3 I mean, I think there's some broad principles, and they
4 would be that, you know, it's people who are clinically
5 trained with some framework, supervisory framework,
6 multi-disciplinary team meeting or being able to discuss
7 it with a more senior member of the team.
8 **Q.** Does consistency of care and responsible clinician help
9 as well? You spoke earlier about how you might not
10 mention something the first time, but you'd go back to
11 it the second time. The therapeutic relationship, how
12 important is that for the purposes of risk assessment?
13 **A.** It's important. It's more important probably on the
14 management side than the assessment side. I mean, the
15 assessment side can be done, you know, in the one-off
16 meeting. A comprehensive assessment can be done. But
17 I think if you're going forward and trying to institute
18 the best treatments and the best management for
19 somebody, then consistency is important, and so
20 I think -- yeah, I would place the emphasis for
21 consistency more on the management of risk than the
22 assessment.
23 **Q.** Thank you, that can go down, please. Can we have
24 WITN0388002, page 1. We asked you how violence is
25 defined by clinicians and risk tools. Before we go back

1 to your report, can we look at some of the articles you
2 have helpfully provided to us. This one, "Violence risk
3 assessment instruments in forensic psychiatric
4 populations: a systematic review and meta-analysis."
5 If we go to page 2 in the box at the top:
6 "Although various risk assessment tools have been
7 developed to assist with risk prediction and management,
8 it is not known which tools are supported by high
9 quality evidence and which are most accurate."
10 That's what this article addresses. If we can go to
11 page 7, and perhaps have 7 and 8 on the screen at the
12 same time. You comment about the HCR-20, talk about
13 predictive performance of any assessment tool and the
14 overall implications for risk assessment.
15 Can you just set out your view about the HCR-20,
16 risk assessment tools.
17 **A.** Yes. So this particular review is a review in forensic
18 psychiatric settings, and because the HCR-20 was
19 developed for forensic psychiatric settings, and so it's
20 looking at the tools that have been tested out in those
21 particular populations.
22 And our view based on the evidence -- and this is
23 a review of how well the tool performs in terms of its
24 prediction, so how well does it identify risk going
25 forward? Our view was that -- I mean these tools,

1 broadly speaking, do reasonably well. I mean, they're
2 moderately predictive in a forensic setting, and -- but
3 we did highlight some problems, partly because many of
4 these tools were developed 30 years ago, and the
5 evidence has moved on on -- particularly on
6 risk factors, and these tools don't incorporate that
7 evidence.
8 So I think, in terms of forensic psychiatry, these
9 tools have a place, they're widely used, they add some
10 value because they provide a structure, but in terms of
11 forensic psychiatry we thought that the real problem is
12 that many of them are quite dated, including the HCR-20,
13 and that if you were to start from scratch, so if you
14 set up a new unit, you would want to use newer tools
15 which have incorporated the latest evidence, the latest
16 methods about how to develop them and actually involve
17 the views of patients, carers, clinicians, in the
18 development of the tool and how it's reported.
19 Back then, 30 years ago, people didn't do that. It
20 was -- the methods were much simpler and now, I think,
21 dated. But they remain to have a value. The value is
22 essentially providing a structure. It doesn't have to
23 be this particular structure.
24 **Q.** No, I understand. We'll come to other options. If we
25 look at the top of page 8:

1 "For forensic mental health services, the findings
2 suggest that, as a minimum, risk assessment tools should
3 be used to complement clinical decision making; they
4 should not be used to inform decisions about length of
5 stay without validations showing high sensitivity."
6 **A.** Yes, I think that's, broadly speaking, an overall
7 message of the research we've done. I mean, we've done
8 a number of reviews of risk assessment tools in
9 different settings, and the overall message is that they
10 shouldn't be used in isolation; they should be used with
11 clinical decision making, and the other overall message
12 is they shouldn't be used for harmful things. So
13 harmful things is, for instance, in this case length of
14 stay, extending length of stay. They're not accurate
15 enough that they should determine decisions about length
16 of stay or in the different context, they shouldn't
17 determine, for instance, sentence length, if it comes
18 to -- in criminal justice settings.
19 So that was our view: that they're part of
20 a decision-making process, they can inform it, they're
21 helpful, they provide some structure around that
22 decision-making process, some transparency, some
23 consistency, but their limitations mean that they
24 shouldn't be used solely to determine decisions such as
25 how long someone should stay in hospital.

1 **Q.** If we can have that off the screen, please, and
2 WITN0401010, page 1. So WITN0401010. Against the
3 screen, the author, Edward Silva:
4 "... HCR-20 and violence risk assessment - will
5 a peak of inflated expectations turn to a trough of
6 disillusionment?"
7 That's the wrong reference, can we have WITN0401010,
8 please. Thank you. We see on the left-hand side:
9 "... HCR-20 the most widely used violence risk
10 assessment tool ..."
11 But reference to how long it takes and the questions
12 and going through the notes, et cetera, and expressing
13 limitations of the tool.
14 One criticism, over the page, please, at page 2:
15 "... definition of violence used in the HCR-20 is so
16 broad (including verbal threats) as to be meaningless in
17 the services we work in."
18 **A.** Yes.
19 **Q.** Any comments on that, please?
20 **A.** Well, I think it's an important criticism, really.
21 I think my view is that the field has moved on, really,
22 since this type of tool was developed 30, 31 years ago.
23 And the people writing about it often have been strong
24 advocates, and there has been -- there hasn't been
25 a good, open discussion about its strength and

1 limitations. And this is one of the few pieces that
2 highlight some of the limitations and I think it makes
3 a number of useful points, one of them about the
4 definition of violence being meaningless.
5 I mean, there are some other criticisms as well
6 including the definition of how the word "high risk" is
7 used in these tools is so broad that it is also almost
8 meaningless because it refers to such a wide range of
9 risks. So this is one, I think, of a series of useful
10 pieces that's come out in the last 10 years to highlight
11 limitations.
12 The broader context is that, as I say, people
13 writing about this have been people who have been strong
14 advocates. They've either been the people who develop
15 the tool or people with other conflicts of interest who
16 make money out of training or publishing translations of
17 the tool. And that's just an important part of the
18 bigger picture here --
19 **Q.** Not necessarily a conflict if you think the product is
20 a good one, but -- (*overspeaking*) --
21 **A.** No, but it needs to just be part of the bigger picture,
22 that people are aware that there are conflicts of
23 interest and that has to be seen in the wider picture.
24 **Q.** If we can have that off the screen, please, and
25 WITN0401026, another observation about:

1 "HCR-20 [showing] ... poor field validity in
2 clinical forensic psychiatry settings".
3 So WITN0401026. If we go to page 2 we can have that
4 on the screen at the same time, paragraph 2:
5 "... many practical reasons why the HCR-20 may be of
6 limited benefit as a predictive tool in clinical
7 practice."
8 **A.** Yes.
9 **Q.** You see on the second page, second paragraph?
10 **A.** That's right, yes.
11 **Q.** And reference to it being "time-consuming (up to 14 on
12 average)."
13 **A.** That's right, yes. So, I mean, if you were to develop
14 a tool for general psychiatry, this wouldn't be the one
15 because I mean 14 hours is just not practical. And
16 I mean I think that's referring to a study that was done
17 where they looked at -- it's not one person, because the
18 HCR-20 often involves a multidisciplinary input, that's
19 the total number of person hours, but I think one of the
20 problems with it is it's not scalable, it's not
21 something that can be used in routine, busy services.
22 And the other problem with that is that if you do
23 insist on using tools that take a long time, you then
24 detract from other important elements of clinical care
25 like risk management, and so there's a price to be paid,

1 and I think that has to be considered in the discussion
2 about what tools are used, that there's a balance to be
3 had, and in a way I think the balance should be shifted
4 more towards the management and preventing violence in
5 people with mental illness and not spending a huge
6 amount of time doing the assessment. We know what
7 risk factors are important; a structure is good, having
8 some transparency and openness is good, it provides
9 consistency, but the focus should really be on
10 prevention.
11 **Q.** Can we have another article on the screen, please,
12 WITN0320015, a piece of your research, co-authored:
13 "Approaches and challenges to assessing risk of
14 violence in first episode psychosis: A qualitative
15 interview study of clinicians, patients and carers".
16 **A.** Yes.
17 **Q.** You set out under "Results" firstly, what were the
18 issues or themes that were identified?
19 **A.** Well, what we wanted to know was really what would
20 clinicians, patients and carers want? I mean, what do
21 they see as the best approaches and the most important
22 challenges to assessing risk of violence? And we were,
23 I mean, a little bit surprised actually, because the
24 patients and carers were quite positive around
25 structured risk assessment.

1 So carers said that they thought a structure is
2 important, it provided a way of talking about these
3 issues in a more neutral way, and patients also said to
4 us that they also liked the fact that this was something
5 that was done on everyone, they weren't being singled
6 out. So they liked the idea that this was an approach
7 that would be routinely done.
8 But also they liked the fact that you are asked
9 directly about questions and this again was something
10 that hadn't really come out in the literature, that
11 people were, you know, in many cases valued the
12 opportunity to talk about these risks; it hadn't been
13 addressed before, directly, with individuals.
14 And in terms of clinicians, clinicians express the
15 fact that there was a bit of uncertainty in what they
16 did. They relied mostly on three or four factors: age,
17 sex at birth, and history of violence, and they were
18 uncertain about what other factors to consider and how
19 to consider them. And clinicians also highlighted the
20 fact that they were worried about stigma, which
21 I mentioned before.
22 So it was quite a useful way of understanding what's
23 actually going on in the real world, in a busy service
24 with people with psychosis, and we came away thinking
25 that actually people would welcome a structured

1 assessment. It helped clinicians, because they were
2 a bit uncertain about how to do the assessment
3 thoroughly and comprehensively. In a way it freed them
4 up; they didn't have to worry so much, thinking are they
5 missing something? What exactly are they missing? It
6 provided them with a structure. And patients and carers
7 liked the fact it was transparent, open, provided
8 an opportunity to talk in a more neutral way about risk.
9 So that was our impression from this particular
10 piece of work in a service in England.
11 **Q.** Can we go to page 3 please, and 3.1.1 we see there:
12 "There was consensus that, after the first
13 assessment, violence risk is not usually reviewed unless
14 indicated, except for acute scenarios."
15 **A.** Yes.
16 **Q.** So what did you take from that?
17 **A.** Well, this was really just reporting what people did,
18 and I mean our takeaway from that is maybe that's too
19 high a threshold, acute scenarios, I mean it's a big
20 vague and maybe that having some guidelines around when
21 you would review the risk, such as someone has been
22 arrested or reported violence, like I said before or
23 there's some uncertainty because of an escalation of
24 risk.
25 So I think that that's what I take away from that:

1 that it may be that it would benefit from having some
2 guidelines around when risk could be reconsidered.
3 **Q.** Page 4 and 5, if we could have those two on the screen,
4 please, and looking at 3.1.2, "Stigma, sensitivity and
5 engagement":
6 "Concern about stigma was a barrier to clinicians
7 broaching the subject of violence. Further, for those
8 with a history of violence, clinicians were wary of
9 causing distress by enquiring about this, especially
10 during early engagement."
11 Now as difficult as that might be, what do you say
12 about that: the fact that they're worried about
13 distress, that they don't discuss this issue?
14 **A.** Well, I think -- I mean I think this is -- is a real
15 problem. And I think some clinicians, you know, do
16 avoid the subject because of concerns about stigma, and
17 then also wary of causing distress by enquiring about
18 it. What was important was that when we asked the
19 patients about this, they didn't say, "It would cause me
20 distress", and so that was useful, that we were able to
21 actually take that up in the subsequent work we did with
22 patients and carers.
23 I can see where people are coming from. I mean
24 sometimes when you do go back into people's histories,
25 you are very cautious about upsetting people,

1 re-traumatising them, and that may be, particularly
2 early on, you don't want to create barriers with
3 engagement. So I can see that's a reasonable concern,
4 but I think what we found is it's not actually something
5 that patients share.
6 **Q.** "Handover and inter-agency communication":
7 "Many underlined the challenge of handing over risk
8 information, especially when communicating to clinicians
9 outside of the usual care team, or other agencies
10 providing care. Liaising with the police was one
11 scenario with potentially different thresholds of
12 concern."
13 "Different thresholds of concern". What was being
14 suggested or how did you assess that to be the case?
15 **A.** Well, I think my reading of that is that the police may
16 have a higher threshold for concern than a clinician,
17 and there's a lack of clarity as to what is a reasonable
18 level to raise with the police. So it's about
19 uncertainty about when you would want to liaise with the
20 police.
21 And what we had was a scenario, a case a vignette,
22 a clinical vignette, and some people thought I would
23 raise this with the police and other people thought that
24 they wouldn't. And, again, I think that's in a way
25 that's okay. I mean, that may reflect the real world,

1 but if you've got better liaison with the police mental
2 health liaison person, you know, that may be
3 a conversation to have with them, and then it can help
4 clarify what thresholds of concern are appropriate.
5 **Q.** On page 5, at (c):
6 "Key was determining whether risk is directly linked
7 to symptoms of mental illness (rather than eg
8 personality factors)."
9 Why was that key? What was suggested there?
10 **A.** Yeah, the -- I think the key -- the key feature there
11 was that that was thought to be the responsibility of
12 mental health services, if it's symptoms of mental
13 illness. Because personality factors are long term
14 from -- have been present from adolescence, are not
15 really treatable, as far as we know. Many of them are
16 not treatable. And so that's why it's key: because
17 there's something that you are more responsible for, in
18 terms of treatment availability.
19 **Q.** What about sharing information with the police for the
20 purposes of public protection? Did you ask clinicians
21 in this context about that, that it might not be
22 pertinent to mental health services provided, but the
23 risk to the public, they may have information that's
24 relevant to that that they could pass on to the police?
25 **A.** We didn't ask that directly. I don't recall that being

1 asked directly. I think what we did is present a range
2 of scenarios and ask people when they would contact the
3 police, and we got different information back. So there
4 was inconsistency in who would -- you know, in what
5 situations you would contact the police.
6 **Q.** 4.3 on page 6, please, you refer to training:
7 "Training should ... address the need for a
8 straightforward approach to clinical enquiry and carer
9 involvement, and so should involve patients and carers
10 in its development and delivery to ensure
11 acceptability."
12 Anything else you'd like to say about training?
13 **A.** Well, I think -- I mean, my view is it should be
14 strengthened. I mean, there is some training and it's
15 part of all -- I can talk about psychiatry, and it is
16 part of one's psychiatric training, but I think it can
17 be strengthened. Sometimes people think about risk and
18 they combine it with all the risks, so suicide risk,
19 with violence risk, and premature maternity risk, and
20 I think they should be separated out. They are
21 different risk factors. There are different ways of
22 managing those risks.
23 **Q.** They were separated out, weren't they, in an NHS
24 collection of data, suicide --
25 **A.** That's right, yes.

1 **Q.** -- and mental health, homicides, and then it stopped in
2 respect of mental health homicides, collecting the data,
3 didn't it?
4 **A.** That's right, yes, but I'm talking about the training,
5 so the curriculum, for instance, the Royal College of
6 Psychiatrists curriculum, it's one item for assessing
7 risks for various adverse outcomes sort of put together.
8 And I think there's clear -- they should be
9 separated out. There's differences which would be
10 usefully separated out, because you sort of dilute the
11 information that you have, and the quality of the
12 information, the accuracy, if you mix them all together.
13 So that would be one thing about training, I would say.
14 And I think -- I wrote in my report that I think the
15 training is best managed, is best sort of run by the
16 Royal College of Psychiatrists, that's the body that
17 undertakes training for various other things as well,
18 and sets the curriculum, and that would be the body,
19 I think, most appropriate for providing national
20 training.
21 **Q.** Can we have the next article, please, which is
22 WITN0401014, and while we're getting that, Professor, do
23 you know why that data wasn't collected beyond 2016?
24 **A.** You mean the National Confidential Inquiry?
25 **Q.** Mm.

1 **A.** I think it was -- I don't know, for definite, but my
2 understanding was that it was to do with funding partly
3 and -- but I don't know.
4 **Q.** Can we have pages 1 and 3 on here:
5 "Use of a violence risk prediction tool (Oxford
6 Mental Illness and Violence) in early intervention in
7 psychosis services ..."
8 Can you tell us something about that, please,
9 Professor?
10 **A.** Yes, so this was a study I was involved in. What we did
11 was we developed a tool for violence risk prediction
12 specifically in people with psychosis, and specifically
13 in general psychiatry. So this is an example of the
14 tool that's developed for the population, a specific
15 population, which is unlike HCR-20, which was developed
16 for the forensic population, this is a tool developed
17 specifically for general psychiatry. And we developed
18 it in Sweden because in Sweden you've got the best
19 quality data to, in a sense, have a laboratory where you
20 can develop this tool.
21 I mean, it was developed in a very large number of
22 people, 75,000 people, which is more than all the other
23 risk prediction tools combined, so the numbers of
24 people -- and the importance of that is it gives you
25 precision, it means you can interrogate risk factors

1 more accurately with more precision.
2 The other thing about this particular tool is that
3 when we have studied it, we've looked at its
4 performance, so its accuracy, using a full range of
5 metrics, not just one, but the full range. And then
6 we've also involved -- in this particular study, we've
7 looked at its acceptability, because a tool may be very
8 accurate but it may not be acceptable or feasible or
9 have a clinical role. So you can imagine, you know, you
10 can develop a tool, let's say using machine learning,
11 which has hundreds of variables in, but no one is going
12 to use it, it takes too long or it's too complicated or
13 the NHS systems just can't cope with something that has
14 hundreds of variables.
15 So this particular study looks at this tool that we
16 developed. The tool that we developed is scalable, it's
17 short, it's about ten to 15 minutes, has 15-items --
18 **Q.** And you say -- sorry to interject there, but you say it
19 can be conducted with routinely available clinical
20 information.
21 **A.** That's right, yes.
22 **Q.** What do you mean by that? What's routinely available?
23 **A.** So this is -- part of any baseline assessment,
24 information will be collected as part of any baseline
25 assessment, and the tool draws on those pieces of

1 information. So you don't have to go back and
2 re-interview someone. So in a way it's kind of
3 an efficient way of doing things, because you're using
4 information that would be part of a good quality first
5 assessment, rather than going back and saying, "Oh I've
6 got an extra questionnaire I want to go back and spend
7 hours with a patient with." This tool doesn't do that;
8 it uses what's already collected. Some of the variables
9 may not be, but a good quality assessment would include
10 those variables.
11 And what this particular study does is it looks at
12 whether clinicians found it as something that was
13 acceptable, so they thought it was something that they
14 would use and they would find it helpful, whether it was
15 feasible, so, you know, whether it was practical,
16 whether it could be done in the service. And then its
17 clinical role. So how does it interact with my clinical
18 judgement? And these were the things that we looked at.
19 And overall, the picture that emerges is that you
20 really are talking about a tool to support
21 decision-making. So it complements decision making. It
22 does things, it fills in some gaps, it addresses some
23 limitations of clinical decision-making. For example,
24 some of the risk factors people aren't familiar with;
25 some of the risk factors you don't know how to weight

1 them, so how important they are.
2 You know, for example, I mean we talked about age.
3 Age is a very important risk factor, but how do you
4 weight it? How much emphasis do you put on age? And
5 a tool like this can help do that, you know, because as
6 a clinician, I find that difficult, to try to model
7 that, in my brain, with sex at birth, with previous
8 violence, if it exists.
9 So it provides a structure; it's a transparent
10 approach; it enables you to speak openly with patients
11 and carers about what to do next. So we found that
12 overall in this study, that it was acceptable, it was
13 feasible, and it did have a clinical role, essentially.
14 **Q.** Previous violent crime, if we look at 3 at the top:
15 "Any lifetime conviction for violence (assault with
16 or without injury. homicide, robbery, arson, [et cetera]
17 ...)"
18 What about events that actually haven't result in
19 a conviction? Because you'll know that those --
20 **A.** Yeah.
21 **Q.** -- with mental health disorders don't always progress
22 through the criminal justice system. Would that mean
23 they wouldn't be taking into account events or
24 information from the police where there's not
25 a conviction? Do you think that --

1 **A.** Yes.
2 **Q.** -- should be taken into account?
3 **A.** Yes. So, I mean, on the basis of this study we actually
4 changed the tool, so there's a version of the tool which
5 includes violence that hasn't led to a conviction but is
6 serious enough to have been recorded.
7 **Q.** Can you send us the up-to-date copy --
8 **A.** Yes, it's called OxMiv-EIP, so Early Intervention in
9 Psychosis. So it's the same tool, but it's got a dash
10 EIP. And that version of the tool we adapted on the
11 basis of the study, because this was something that
12 clinicians brought up with us and I think, you know,
13 that's the value of these type of instruments is that
14 you can update them regularly, you know, you're not sort
15 of stuck one way of doing things, but you're open to the
16 fact that they should change with feedback and
17 information.
18 I mean, one of the things, you know, that clinicians
19 also said to us was that: we're not quite sure how to
20 link information from this tool with what we do next,
21 and I think that's a work in -- I mean, that is also
22 a work in progress, because how you link information
23 from the tool to what you do next will partly depend on
24 your clinical setting, but also partly on actually other
25 pieces of work, research, where you can figure out how

1 best to link it.
2 So I think that's an important part of the picture.
3 I mean, the other element of this study is it's a study
4 done in England and it's important, you know, to
5 highlight that, you know, other tools like HCR-20
6 haven't been studied in general psychiatry in England,
7 so I mean, when people talk about HCR-20, they're
8 talking about them in forensic populations, but not in
9 general psychiatric populations. So HCR-20 was
10 developed for a forensic psychiatric population, it's
11 been studied a little bit in forensic psychiatric
12 populations in England, but it hasn't been -- wasn't
13 developed in general psychiatry and it hasn't been
14 tested out in general psychiatry.
15 So here you have an example of something that has
16 been, and as a consequence of it, you know, changes have
17 been made and it's been adapted.
18 **Q.** If we go to page 7, please: "Acceptability and
19 feasibility of the ... tool", you record as you stated
20 earlier:
21 "The tool was ... broadly acceptable from a service
22 perspective. The balance between resource and benefits
23 ..."
24 We've just lost that, I'm sure it'll come back
25 again, WITN0401014, page 7, thank you.

1 "The balance between resource and benefits was
2 thought to be favourable. There was also statistical
3 concordance between the tool and clinical judgement,
4 which was important for acceptability. Patients and
5 carers stated that using a structured approach to
6 improve assessments was acceptable, and could help with
7 the openness of risk assessment."
8 Page 8, please. You set out the limited impact on
9 what support clinicians offered. Do you see in the
10 left-hand side, the penultimate paragraph, can you just
11 tell us about that?
12 **A.** So I think this is really a pointing out a general
13 principle --
14 **Q.** With all structured tools?
15 **A.** -- with all structured tools, which is that if it's not
16 linked to a -- linked to therapeutic intervention, so
17 it's not linked to treatment, on its own it's not going
18 to have any impact. You can do as many assessments as
19 you want to, but if it's not linked to what you do next,
20 it will have a limited impact. And what we highlight is
21 that there's a clear example of that in the -- in
22 suicide research literature where they tested this out
23 with a screening tool and then the screening tool linked
24 to an intervention and they showed in a trial that you
25 really need to link it to some intervention to make

1 a difference for outcomes.
2 **Q.** Indeed, you set that out in a further piece of work.
3 That one can come down, please, and can we have
4 WITN0401016. It's:
5 "Assessing violence risk in first-episode psychosis:
6 external validation, updating and net benefit of
7 a prediction tool ..."
8 If we go to page 4, below the table on the left:
9 "Second, we found unstructured clinical judgment
10 alone in assessing violence risk was suboptimal."
11 So using a structured tool alone suboptimal, and
12 likewise, clinical judgement.
13 **A.** Yeah, I think the important thing there is using
14 unstructured clinical judgement meant that you missed
15 the majority of people who went on to perpetrate
16 violence. So there was a high rate of false negatives.
17 And in a way, from a service perspective, that's the
18 thing you want to avoid as much as possible: is missing
19 cases; your focus is about preventing violence in the
20 future and using the tool, that was a clear increase in
21 that performance. So improved that particular way of
22 looking at a tool quite substantially. So you don't
23 miss as many people who go on to commit violence.
24 So that's an important difference between having
25 a tool and unstructured tool, because judgement -- our

1 view is that in the end both should work together. So
2 actually, I'm -- I don't agree with a lot of people who
3 treat these things as very separate, you know, and
4 I think it's an artificial dichotomy that people make
5 between actuarial tools and structured clinical
6 judgement. These days, you should always use actuarial
7 tools with professional judgement, so it's a completely
8 artificial comparison.
9 It was made 20, 30 years ago and people still talk
10 about it, but no one says that anymore. It's both:
11 combining professional judgement with a structured
12 approach. You can call it what you want, but it's
13 always about combining the two.
14 Q. Not least because you need to assess the quality and
15 veracity of the information that is going into any
16 judgement. That's the professional judgement, isn't it?
17 A. That's partly it, but also there's lots of individual
18 factors that don't come up in these tools. So there's
19 individual triggers, there's individual items, there's
20 individual elements of somebody that a tool will never
21 be able to capture.
22 Q. Is unstructured clinical judgement even more suboptimal
23 where an individual is seen by many clinicians over
24 a period of time?
25 A. I don't know. I mean, some clinicians will be very good

1 at risk assessment, but the problem really is that in
2 a -- from a service perspective, from a more broader
3 perspective, it's too inconsistent. Some will be good,
4 some won't be good. And it's impossible to communicate
5 risk, also because people use different thresholds and
6 use different risk factors, weight them differently. So
7 I don't know. You're asking a question of having
8 multiple people do the assessment, does that improve the
9 assessment? I don't know the answer to that question.
10 It may well be that people make the same mistakes,
11 and we know that for instance in assessing risk, people
12 often look at the last piece of information, or how
13 someone was recently. So their presentation in the last
14 month, let's say, and they discount the past. And it
15 may be that people repeat that focus, in a sense that
16 recency bias, if you have multiple people doing a risk
17 assessment in an unstructured way.
18 Q. That can come down now, please, and if we can go to
19 page 11 of your report which is WITN0401001, page 11.
20 You point out that violence is defined inconsistently.
21 Do you think there needs to be a more consistent
22 definition of violence?
23 A. I don't know. I think that there needs to be a basic
24 threshold. So I think that obviously interpersonal
25 violence is -- should be included in the definition.

1 The bit where there's uncertainty is where what you do
2 with threats, and I think some threats are violent in
3 the sense that they're quite concerning and they are
4 actually in law considered violent offences. So I think
5 I would -- I think that it's clear where interpersonal
6 violence exists and I think there can be some
7 information or some guideline around if a threat is
8 worrying somebody, that would constitute violence, in my
9 opinion.
10 Q. Psychological harm?
11 A. Exactly.
12 Q. -- *(overspeaking)* -- psychological harm.
13 A. Exactly.
14 Q. You've already told us that the tool has adapted and you
15 would agree, no doubt, that it's important to take into
16 account behaviour that has not resulted in criminal
17 charges or prosecutions because it's the behaviour in
18 the context in which it arose which is crucial for risk
19 assessment, not whether charges have resulted.
20 A. I agree with that. And I mean I think that's also
21 another reason why tools can work well with clinical
22 decision-making in combination, because the clinical
23 decision-making can consider the context in more detail
24 than a tool can. A tool is just a snapshot usually.
25 The other thing to say is that people sometimes say

1 these actuarial tools rely on static factors. I mean
2 that's not the case any more. They don't only rely on
3 static or unchangeable factors; they have modifiable
4 factors in them. So OxMiv has a number of identifiable
5 factors including around treatment. So one of the
6 factors is "Have you been on an antipsychotic treatment
7 in the last six months?" which is a modifiable factor.
8 There's a lot said about these tools which reflect
9 the debates of 20 years ago, and I think the evidence
10 has moved on now and there are many modifiable
11 factors -- well, not many, there are some modifiable
12 factors in these new tools and I don't accept this
13 dichotomy that, you know, you have structured clinical
14 judgement and actuarial on the one hand. I think that's
15 just an old dichotomy.
16 Q. Does the level of violence recorded by the police, for
17 example, if they record something as an assault
18 occasioning actual bodily harm instead of grievous
19 bodily harm, does that impact on mental health
20 assessments? Will how the police have categorised
21 something have an impact?
22 A. Well, it has an impact in whether someone is a --
23 forensic psychiatry is involved or not. Because usually
24 the threshold for forensic psychiatry is grievous bodily
25 harm and above. So in that sense it has an impact. But

1 in terms of risk assessment, I don't think it does,
2 obviously. I mean I think here, you know, you have
3 a history of violence and it's a key risk factor and it
4 needs to be considered, and I would say then the next
5 step is to consider someone's mental health at the time,
6 what triggers there were, you know, comorbidities, and
7 so on, and look in more detail about the particular
8 context of that episode.
9 **Q.** Can I have page 12 on screen, please. You set out in
10 the second paragraph:
11 "Lack of compliance with treatment plans and
12 medication is an important clinical consideration ...
13 some risk tools have an item for this."
14 Given the importance of lack of compliance, and
15 particularly on outcomes, do you consider it's important
16 to recognise this as a factor in any tool?
17 **A.** Yes. I mean the thing about it is that it's -- it can
18 be recognised in different ways. For instance, it could
19 just be the question: "Have you been on an antipsychotic
20 treatment in the last six months?"
21 I think having -- you don't want to create
22 situations where you over-complicate the assessment and
23 prolong it. So I think it should be part of
24 a comprehensive assessment. How you operationalise it,
25 I think, you have to be careful about not

1 over-complicating the assessment. It's going to one
2 factor of many; it's an important factor but not the
3 only important factor.
4 **Q.** That can come down, please. Is the Oxford Mental
5 Illness and Violence tool widely used in the UK and, if
6 not, do you know why?
7 **A.** No, it's not. I mean part of the reason is that it's
8 only recently been -- we've only recently finished these
9 studies and I think for any a tool to be widely used,
10 you really need to show good evidence in the context, so
11 in the country you're working in, that it works, that
12 it's feasible, acceptable, and has a role. And that
13 information has only been really published in the last
14 year or two. And I think -- so that explains part of
15 the issue.
16 I mean the other part of the issue is that there
17 isn't really a culture in general psychiatry to use risk
18 tools. So this is a tool that's specifically aimed at
19 general psychiatry. In forensic psychiatry there is
20 a culture. There people use rules routinely, and there,
21 you know, HCR-20 is widely used but there are other
22 tools also used in forensic psychiatry. But in general
23 psychiatry there isn't this culture, and most of the
24 time you're asked to comment on risk but in a sort of
25 descriptive way, "Yes", "No", almost, and then write

1 some free text. So there isn't really a culture. This
2 requires something that would be quite --
3 **Q.** A sea change?
4 **A.** It would be quite -- yeah. It would be quite -- it
5 would be new. It would be very novel, I think very
6 welcome. The time is right for many reasons. I think,
7 you know, partly the time is right because we now have
8 quite strong evidence about these links between some
9 mental illnesses and crime. We know a lot more about
10 what the risk factors are and now we have methods to
11 develop scalable, simple tools that are moderately
12 accurate. They're not perfect but they're moderately
13 accurate, which can complement decision-making.
14 **Q.** And it is scalable, isn't it, for use in general
15 psychiatry?
16 **A.** Totally scalable. It takes about ten minutes to use
17 and, as I say, most of the information has already been
18 collected.
19 **Q.** Can the model also be used to help with risk management
20 planning?
21 **A.** Not directly. Indirectly, yes. So if you identify the
22 people at higher risk than you expect, that can lead to
23 a series of actions including, for example, gathering
24 more information about the context of, let's say,
25 previous violent incidents. It can lead to

1 more collaboration. So collaborative way of thinking
2 about risk with carers, for example, and patients. It
3 can lead to targeting modifiable factors, and we now
4 know more information about those. So we had
5 information for instance about anger, so that's
6 relatively new in the field. We know more now about
7 which antipsychotics have a more direct impact on
8 impulsivity and hostility. So there is an issue about
9 optimising treatment and that could be something that
10 would be a next step.
11 So I think there are number of things that now can
12 be done afterwards and there may well be inter-agency,
13 cross-agency working that also can come out of a risk
14 assessment.
15 What I don't think can come out of it is, as I said
16 before, you know, something that is like a -- prolong
17 someone's stay in hospital, or a change to the sort of
18 recommendations about sentencing. They're not developed
19 for that purpose, and that would be a misuse of those
20 tools.
21 **Q.** We asked you about whether the use of risk assessment
22 tools should be standardised across NHS Trusts. What do
23 you say about that?
24 **A.** I say that they should be. I think that there is a role
25 in the first assessment, the baseline assessment, in

1 people with severe mental illness to have, as part of
2 a comprehensive baseline assessment that -- not just
3 addresses violence risk but also suicide risk and other
4 risks, for example victimisation, physical health.
5 That's part of a good quality, comprehensive assessment.
6 And violence risk assessment should be part of that.
7 It's an important part of that comprehensive assessment.
8 **Q.** In terms of training, is there no compulsory training in
9 respect of risk assessment?
10 **A.** So part of the curriculum for -- I can talk about
11 psychiatrists here, but part of the curriculum includes
12 a section about risks and understanding risks. As
13 I said, I think that could be strengthened by separating
14 out the risks because I think we now know more
15 information that you can't just lump them all together
16 and the risk factors don't operate across all of them in
17 the same way.
18 So there is part of the curriculum, and that, then,
19 already is to some extent in the training, and my view
20 is it could be strengthened.
21 **Q.** We know of course that since the Ritchie report and the
22 Christopher Clunis case there was emphasis there on
23 recommended training. You've been a psychiatrist since
24 that time. Has there been a development and
25 strengthening in training in this area over the last

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1 couple of decades, or would you say not?
2 **A.** I don't know, to be honest. I've been a psychiatrist
3 over that period but I've been a forensic psychiatrist
4 and I think it's difficult for me to comment on general
5 psychiatry. I think there's always been a tension -- my
6 impression is there has been this tension with the
7 concern about increasing stigma, and that has been
8 a barrier, actually, to strengthening training.
9 **Q.** Has that become a developing concern, this issue about
10 stigma?
11 **A.** I think it's always been there and I think it goes in
12 waves, and I think stigma is talked about a lot in the
13 last 10 years in particular. And so I think there's
14 this tension and I think that that -- I think that has
15 held back strengthening this element, this focus on how
16 to improve our risk assessments and ultimately
17 prevention of violence in people with severe mental
18 illness.
19 **Q.** Do you think there's a lack of knowledge amongst
20 practitioners in respect of risks of violence to the
21 public, and this topic that you're obviously immersed
22 in, but do you think more generally?
23 **A.** I think, yes. I would say, broadly speaking, lack of
24 knowledge ... I mean, it's difficult to give a straight
25 answer to that. I mean, knowledge varies. Some people

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1 have very good knowledge about this, some people less
2 good. I mean, I give quite a lot of talks to trainee
3 psychiatrists and I think my impression is that the
4 knowledge varies, and it's difficult for me to be more
5 specific than that.
6 **Q.** We asked you to comment on guidance from the Royal
7 College, and can we have, please, NHFT0015099:
8 "Assessment and management of risk to others
9 "[The] Good Practice Guide."
10 We see at page 11 of that guide limited to the four
11 principles. What observation do you have about that?
12 What would you like to see here? You say there's no
13 explicit evidence-based recommendations, what would you
14 like to see included in risk management guidance?
15 **A.** Well, I think now we know more about the role of
16 medication, so I think optimising a review of medication
17 with a view of optimising medication. So, for example,
18 we know that there's some medications that, as I said
19 before, have a clearer effect on relapse prevention and
20 also on violence risk reduction and in particular one
21 medication called clozapine, but also intramuscular
22 injections, as well.
23 So that's changed.
24 The general principles, I think, you know, now
25 I think we're probably moving towards more collaboration

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1 with patients and carers about their risk management.
2 I think there is more information now about the
3 importance of addressing comorbidities. So in
4 particular, drug and alcohol misuse. So they would be
5 some just that come to mind.
6 **Q.** If we go, please, to page 9, you comment on the
7 structured professional judgement approach comment
8 there, and you say that's no longer consistent with the
9 current evidence base; does that need updating, as far
10 as you're concerned?
11 **A.** Yes, I mean, it's only a short paragraph at the end, and
12 I think that's -- maybe in 2016 that was reasonable,
13 because the -- I think people approached actuarial tools
14 as a thing separated from clinical decision making. But
15 now we don't look at it like that. We combine them, and
16 the actuarial tools in -- 10 years ago, some of them --
17 many of them were -- had a number of limitations.
18 **Q.** Do you agree with Dr Tully that any guidance in respect
19 violence risk assessment tools needs to be more nuanced
20 than requiring their incorporation as a matter of course
21 into general adult psychiatry?
22 **A.** It requires more nuance around -- can you just repeat
23 the second --
24 **Q.** Into how violence risk assessment tools are introduced
25 or implemented? In other words, as you've set out

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1 earlier, that it needs to involve clinical judgement as
2 well as -- *(overspeaking)* --
3 **A.** Absolutely, yes, I agree with that. And with a view to,
4 as I say, involving other pieces of information if
5 they're missing. So it's not just: here's the
6 information I have, but actually being open to the
7 possibility of gathering more information as well.
8 **Q.** Can we go to page 30 of your report, please, so
9 WITN0401001, page 25, actually.
10 Capacity. You were asked to consider capacity. Do
11 you agree that patients who are subject to Community
12 Treatment Orders and who have capacity to decide whether
13 or not to agree to the proposed medical treatment can
14 only be given treatment in the community with their
15 consent? They can't be forced to take it if they have
16 capacity?
17 **A.** I have to remind myself what I've written.
18 **Q.** So somebody in the community who has the capacity to
19 reject treatment can't be forced?
20 **A.** That's right.
21 **Q.** So community -- they can't turn up, knock on the door
22 and force them to take it, can they?
23 **A.** That's right, yes.
24 **Q.** What about the issue of oral medication as part of
25 a Community Treatment Order? Is it appropriate to have

1 oral medication in the context of a Community Treatment
2 Order or is that just simply impossible to verify, to
3 know that the person has taken the medication?
4 **A.** I'm of the view that it's not possible, and it's
5 a Community Treatment Order is appropriate for people on
6 depot or intramuscular medication.
7 **Q.** But not oral medication?
8 **A.** That's right.
9 **Q.** If a person lacks insight into their own condition, is
10 it possible for them to properly understand the benefits
11 of compliance with medication?
12 **A.** Well, I think my view about insight is that there are
13 different levels of insight, and so people can have
14 partial insight, and they may for instance think that
15 medication is of value, but for a physical health
16 problem rather than a mental health problem. And that's
17 a partial form of insight. So I don't think insight is
18 a sort of "yes/no" question, it requires a little bit of
19 clinical judgement as to how -- how much insight is
20 left.
21 **Q.** If a patient's illness deludes them to think that
22 medication is being prescribed by clinicians as part of
23 a plot against the patient, is the patient unlikely to
24 understand the rationale and benefits of treatment?
25 **A.** Yes.

1 **Q.** That can come down. Thank you.
2 If we have page 30 instead. We asked you about
3 information sharing, and at paragraph 12, so page 30,
4 paragraph 12, WITN0401001:
5 "... situations where clinicians are concerned about
6 risk to others or themselves, whether [they] ... can
7 inform third parties, such as police, probation, family
8 of the patient, or potential victims of violence."
9 I'm not going to take you to the GMC Guidance,
10 you've referred to it, we all know what it says. On the
11 ground, what's your broad answer to that?
12 **A.** So my answer is yes, it can be done based on the
13 principle of best interests but also on the principle of
14 public interest, and there's guidance from the GMC about
15 that.
16 **Q.** We asked you finally about recommendations, and can we
17 go to page 33, please. You set out paragraphs 15 and
18 16. Can you tell us what you're saying there and why?
19 **A.** Yes, I've been quite brief and I've made two
20 recommendations. One is that I think evidence-based
21 UK-validated and scalable risk assessment tools should
22 be part of standard clinical care in general psychiatry,
23 both at first assessment and when there's a clear
24 escalation of risk. So I think that should be
25 considered; that would be an important step change.

1 And the second is about strengthening the
2 curriculum. So I think the curriculum is the best
3 vehicle to do that for psychiatry, and some improvement,
4 more detail, really, about the type of -- what's
5 specific to violence risk assessment and management
6 should be part of the curriculum and separated out from
7 risks in general, which is where it exists now.
8 In terms of improvements locally and nationally,
9 I've made some general comments. I mean these aren't
10 driven by research, but just more an observation based
11 on my experience, and reading around some of the
12 research literature and other literature, and I've said
13 that I didn't -- I don't think discharge to primary care
14 should be considered "unless risks of violence and
15 suicide have been considered by the multidisciplinary
16 team."
17 I've also said that "Information on previous
18 violence and crime should be routinely requested by
19 mental health teams of the police when there is
20 a reasonable suspicion." And that's important just to
21 get a comprehensive picture of someone's background
22 history.
23 And then I've also pointed out, which I think other
24 people have, is that "When serious interpersonal
25 violence has come to the attention of the police or the

1 clinical team, pursuing criminal charges should be
2 considered the default approach (rather than dropping
3 charges)."
4 **Q.** Why is that?
5 **A.** For many reasons. One of them is that the very act of
6 pursuing criminal charges is quite important as a signal
7 to the individual that their actions have consequences,
8 and they have -- you know, and these people are taking
9 it seriously. This is a serious change.
10 Second reason is that pursuing criminal charges is
11 quite important in terms of record keeping as well,
12 because sometimes what happens, particularly if people
13 move services, is that's the only way you'll know if
14 someone has a history of any violence. They may not
15 tell you about it and this is the only way that you'll
16 know. And so it's actually, I think, an important part
17 of subsequent risk assessment. And actually it's a very
18 important part of their care as well, because it enables
19 the clinical team to have a accurate picture of their
20 risks going forward, and that will get lost if all these
21 charges are always dropped.
22 **Q.** And you told us earlier about how the Nordic countries
23 have high-quality registers. Do we have the ability in
24 the UK to effectively monitor and evaluate the number of
25 violent incidents associated with those presenting with

1 schizophrenia spectrum disorders?
2 **A.** No.
3 **Q.** Should we have?
4 **A.** Yes. It's been very difficult trying to link health and
5 crime records in the UK, and there's been some advances
6 made, particularly in Wales, where it's been done in
7 discrete cohorts, but in England it's been very
8 difficult, and there are various issues to do with --
9 a lot to do with confidentiality and concerns around
10 identifying people and also working across health and
11 justice systems, that there are also problems about
12 that.
13 But I know, I mean, before I started doing research,
14 I know that people had been trying to do this before me
15 for years, and had run into difficulties, and this
16 remains a challenge: to have an integrated dataset that
17 you can do this.
18 It's not enough, I think, only to have an integrated
19 dataset, I think -- and I mentioned this in my report --
20 to have dedicated funding streams as well is important,
21 and it may well be that if there is a dedicated funding
22 cause, then that actually promotes good-quality research
23 into this area because currently what happens is that
24 when you apply for funding usually you're going in with
25 everything else in the whole of medicine, and this area

1 by its very nature is a difficult area, so it's a high
2 risk area, so I can see why funders aren't necessarily
3 attracted to it because they may think: well, this may
4 not succeed. But it also has -- you know, it's very
5 important not just for public health but public safety,
6 so it's got wider implications which are important to
7 consider.
8 **Q.** It's got huge impact for individuals, hasn't it?
9 **A.** Absolutely.
10 **Q.** For health, safety, for bereaved individuals, and
11 economic implications, as well?
12 **A.** Absolutely. We did a study where we estimated that it
13 was about a billion pounds of savings if you could
14 reduce offending by people with severe mental illness,
15 so if you're able to stop and prevent offending with
16 people with severe mental illness, it would lead to
17 about a billion pounds' saving in today's money.
18 We published a piece about three or four years ago,
19 so in -- add inflation to that, it comes to about
20 a billion pounds.
21 **Q.** The Inquiry has heard some evidence that there is
22 tension between the role of patient autonomy, least
23 restrictive options, and this question of protection of
24 the public, do you consider whether there are those
25 tensions and, if so, whether they are appropriately

1 balanced in the UK at the moment?
2 **A.** That's a very broad question, and I think my comment in
3 relation to that would be that I don't think these
4 things stand apart from each other. Often the patient's
5 best interests are served by actually addressing
6 violence risk and addressing it thoroughly and
7 comprehensively.
8 So sometimes people think very short term about
9 patient autonomy in a very narrow way, but actually
10 patient autonomy would be served by preventing these
11 violent acts in people with mental illness. It would
12 be, you know -- and, you know, in the same way that
13 stigma would be best served by preventing violent acts
14 by people with severe mental illness.
15 So I think it's just the perspective, I think, maybe
16 should change in that some of these things really are
17 synergistic, I mean they work together. And, you know,
18 for example, detaining someone against their will to
19 treat their mental illness is in their best interests.
20 It will often lead to much better, longer-term outcomes,
21 and has the added benefit of public safety as well in
22 many cases -- in some cases, not many cases.
23 So there's a sort of wider picture, and I think
24 sometimes people look very narrowly just at the interest
25 group they're working with, in a sense. And I think if

1 you take a broader perspective and look at the societal
2 impact, you -- these things often can work together, and
3 serve each other quite well.
4 **MS LANGDALE:** Thank you, Professor. Those are my questions.
5 There may be some more within the room.
6 **THE CHAIR:** Yes, Mr Moloney. Thank you.
7 **Questioned by MR MOLONEY**
8 **MR MOLONEY:** Just one question of clarification, please,
9 Professor.
10 You were asked by Ms Langdale about the impact of
11 the accurate categorisation of offending by the police,
12 and part of your answer was that it has an impact in
13 whether forensic psychiatry has been involved or not,
14 because usually the threshold for forensic psychiatry is
15 grievous bodily harm and above.
16 Can I just ask you to clarify the practicalities of
17 that, please? Did you mean simply that usually forensic
18 psychiatrists are only instructed by the court or the
19 offence or prosecution in criminal cases where the level
20 of violence has reached that level of seriousness?
21 **A.** I mean it in -- across the board. So if a referral is
22 made from general psychiatry for advice, it's usually
23 accepted or taken on by forensic psychiatry, the
24 referral, if it reaches a certain threshold. So it
25 doesn't have to have a specific conviction associated

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1 with it, but you sort of look at it and see, does it --
2 would it be the equivalent of a grievous bodily harm
3 type incident?
4 **Q.** I see. So would that be essentially if someone is
5 treated for a disorder, not in a forensic setting but
6 say in a setting they were at times an inpatient, at
7 times in the community, then they would usually only be
8 referred to forensic psychiatry services if they'd
9 reached that level of really serious violence or GBH.
10 **A.** Yes. I mean people will refer at different levels.
11 It's more that forensic psychiatry would consider them
12 much more seriously if it's reached that threshold,
13 consider them as a patient, for example, that they would
14 admit to their unit, a forensic unit. So it's more that
15 it's the way that forensic psychiatrists consider the
16 threshold.
17 General psychiatry will refer across, I think, a
18 range of thresholds, but I think it's, broadly speaking,
19 services consider that as a threshold. It's obviously
20 going to be different because sexual offences will be
21 thought of differently, and so will arson be thought of
22 differently, but they would be considered very seriously
23 by forensic psychiatry as well. I mean any sexual
24 offence and any arson which endangers life and is
25 reckless would also be considered very seriously.

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1 So that would be -- it's more just I'm talking about
2 the way forensic psychiatrists looks at referrals that
3 come to them.
4 **Q.** Of course because they have to prioritise.
5 **A.** Exactly.
6 **Q.** So perhaps to make an obvious point, but if there is
7 inaccurate categorisation of offending that minimises
8 the offending, then of course that can have impact on
9 the extent to which the subject is able to access
10 services which might be beneficial to them?
11 **A.** Exactly.
12 **MR MOLONEY:** Thank you very much, professor.
13 **THE CHAIR:** Thank you. Yes, Mr Straw.
14 **Questioned by MR STRAW**
15 **MR STRAW:** Professor, I represent VC's family.
16 You mentioned earlier that prison is not a good
17 place to have treatment for mental illness, particularly
18 acute mental illness. For somebody with schizophrenia,
19 is secure hospital a better place to receive treatment
20 than prison?
21 **A.** So I think I should clarify. I mean, it's not a good
22 place for severe mental illness, and particularly when
23 someone is acutely unwell. And that's partly because
24 you can't treat someone against their will in prison,
25 and often people who are acutely unwell need treatment

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1 against their will.
2 And the law allows you to transfer people from
3 prison to hospital, partly for that reason: because
4 someone's treatment is not -- it cannot be instituted in
5 prison if they're refusing treatment.
6 So yes, people with severe mental illness,
7 particularly acutely, are much better served, they're
8 much better treated in forensic psychiatric units.
9 The other issue is that there is a risk to other
10 people in prison, because if someone is very unwell and
11 when they relapse they perpetrate violence towards
12 others, then there's a risk to prison staff and other
13 people in prison, and so that's the other issue, it's
14 not just the individual is not being treated for the
15 illness but then there's also a safety issue around
16 staff and other people in prison who could be assaulted.
17 **Q.** So looking at treatment, the availability of treatment,
18 and specifically about medication, is this right, that
19 in a secure hospital, medication, whether it's
20 injectable against the individual's will or another
21 type, clozapine, for example, it's more likely to be
22 available and applicable?
23 **A.** That's right, yes, because injectables can be
24 administered against someone's will in hospital. It's
25 more than that, because it's also -- often with these

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1 medications you need to balance, adjust a dose quite --
2 in a very fine way, particularly when you're starting
3 someone on medication, and you really need 24-hour
4 nursing support to do that. Because people can have
5 side effects and sometimes quite sudden side effects,
6 and therefore being in a hospital setting provides
7 the -- a better framework to do that and to change the
8 dose accordingly to reach the right balance between the
9 effect of the treatment and the side effects. Because
10 all these medications have side effects. So there's
11 always a balancing act between what's the optimal
12 treatment versus not having the side effects that are
13 impairing you doing things you want to do.
14 So there's that element to it, as well. It's the
15 ability to be able to supervise the medication, not just
16 administer it, but actually change it, adapt it,
17 supervise it, optimise it.
18 **Q.** You touch on this in your report. Could we have a look
19 at this, please. It's WITN0401001, page 32, please. In
20 the bottom paragraph there, you discuss those detained
21 under Part III of the Mental Health Act.
22 **A.** Yes.
23 **Q.** So note that:
24 "In Part III, there are official statistics from the
25 Ministry of Justice, which indicate a very low rate of

1 [offending *(sic)*] -- over a 6-year period from 2016/17,
2 this is around a 0.4% reoffending risk ... [for those]
3 residing in the community."
4 At the bottom of the page there you talk about the
5 "indictable of proven reoffending rate of 0.3%".
6 **A.** Yes.
7 **Q.** And then over the page, please, at the top there that
8 you know:
9 "This is a substantially lower reoffending rate for
10 indictable offences than any equivalent population, even
11 accounting for age and offence type, and strongly
12 suggests that supervisory framework associated with
13 a Restriction Order reduces serious [offending]..."
14 Just to be clear, this is a substantially lower
15 re-offending rate even as compared to someone who was
16 detaining in prison rather than in a hospital under the
17 Part III provisions; is that right?
18 **A.** That's right. I mean "substantially lower" is putting
19 it mildly. I mean it's hugely lower. It's really quite
20 stark. I mean a 0.3% re-offending rate. I mean the
21 average re-offending rate is, for one year offences,
22 usually in most countries of the world is about 40-50%.
23 That's for any re-offending. But for indictable
24 offences that might go down to about 20%. So you're
25 talking 0.3 and, you know, usually it's about 20% for

1 indictable offences.
2 Then if you account for age and offence type, that
3 might go down in a general prison population, so it
4 might go down lower but it's not going to be anywhere
5 close to 0.3%. So this is almost the lowest rate of
6 re-offending that I've ever seen, and we did a study
7 where we tried to use different prison cohorts and look
8 at their re-offending rates, and most of the prison
9 cohorts that we chose, you know, even if you pick very
10 severe offences, people who are in prison for very long
11 periods of time, I mean they don't really go lower than
12 5%.
13 So what this suggests is that a restriction order
14 is, you know, one of the most effective ways of reducing
15 the risk of repeat offences. Of course, they have to be
16 carefully managed, because it's quite a lot of --
17 there's quite a lot of resource implications, it's
18 a supervisory framework and it requires involvement with
19 the Ministry of Justice, so it's not something that can
20 done very widely; it has to be done in a careful and
21 targeted way. But what it suggests to me is that these
22 risks are modifiable.
23 I mean, here is one extreme way of doing it, but it
24 does suggest that with the supervisory framework, which
25 doesn't have to be with the restriction order, it can be

1 another supervisory framework, you can reduce risks.
2 **Q.** Why is it that the supervisory framework following
3 Part III of the Mental Health Act detention is so --
4 leads to such a dramatically lower risk than under
5 prison supervision?
6 **A.** Because I think it's -- what it's able to do is that,
7 because these are people with severe mental illness, and
8 usually these are people where their mental illness has
9 been driving the offending, and so what the supervisory
10 framework does is it sort of, once someone starts to
11 relapse, you can recall them back to hospital. And in
12 a way you're pre-empting, you're preventing people
13 re-offending, so it's the pre-emptive nature of the
14 fact -- and also, that it's associated -- it's specific
15 to people with -- people with severe mental illness
16 where you've got a clear, in a way, a clear risk factor
17 that you can manage and monitor and then address.
18 **Q.** One linked question. If someone is detained under
19 Part III of the Mental Health Act, very serious
20 offences, murder --
21 **A.** Yes.
22 **Q.** -- the same person being detained in prison, is there
23 any difference in the likely length of detention?
24 **A.** I think, when people have looked at it, they've found
25 that, on average, people who are detained in hospital

1 are detained for very long periods of time for serious
2 offences. I don't know a straight comparison,
3 straight -- but the overall picture is that people who
4 are -- who go to forensic hospitals on serious offences,
5 it's often longer than the equivalent prison sentence.
6 I can't talk about murder, because murder is complicated
7 because of -- for lots of reasons, but if you take other
8 offences and you look at the equivalent of what's
9 happening to people if they go to hospital, they usually
10 spend longer time in hospital.
11 So, for example, sexual offences or arson or
12 non-murder, violent offences.
13 **Q.** Very basic question about schizophrenia; how long
14 does it last?
15 **A.** It's a lifetime condition in most people, and it
16 presents usually in late adolescence, early twenties and
17 it's lifetime because it's thought to be
18 neurodevelopmental, so it's something that develops
19 either during late pregnancy or first few years of life,
20 or combination of the two. And in most people it's
21 lifetime. So although you present in your, let's say,
22 late teens, early twenties, it's something that remains
23 throughout your life.
24 There are a proportion of people -- it's not
25 entirely clear how many -- but it's somewhere between

1 ten and 20% -- who, after a first episode, they seem to
2 recover and live normal lives. Normal in the sense that
3 they never go back to hospital and never present again
4 to services.
5 So there is a proportion of people who seem to
6 recover from this first episode, but for most people
7 it's lifelong and it's a condition that relapses usually
8 if there's a stress or a trigger or, let's say, the use
9 of illegal drugs is a very classic trigger that leads to
10 relapse, or someone stopping taking their medication
11 would be another example of a trigger for someone
12 relapsing.
13 **Q.** Thank you. Then, finally, just briefly about risk
14 assessments. You mentioned earlier that a patient may
15 be very guarded. Again, looking specifically at someone
16 with schizophrenia or psychosis, can that condition
17 cause someone, so the symptom of the condition, cause
18 someone to be very guarded?
19 **A.** Yes, because part of the illness in many people is
20 paranoid thoughts. Some of those are delusions, so they
21 are unshakeable beliefs that, let's say, the clinician
22 is including with the police or some other agency, and
23 often it's some national agency, like MI5 or MI6, and so
24 you're guarded because of that reason.
25 So the illness itself, it leads you to withhold

1 information because of concerns you have.
2 **Q.** You also mentioned that it's important for risk
3 assessors to have experience and training. Presumably
4 in a situation where you're assessing someone who's very
5 guarded, and you need to look at perhaps more subtle
6 signs of their appearance and behaviour, would it be
7 right it's particularly important that the risk assessor
8 in that context has experience and training to spot
9 those more subtle signs?
10 **A.** Well, I think it's always important. I mean, I think
11 those subtle signs are part of psychiatry from day one.
12 I mean, this is -- most of the patient groups that we
13 deal with are -- you're going to have to use those
14 skills. So even mental illnesses like depression and
15 anxiety disorders, you know, you will acquire those
16 skills because people well also not be -- sometimes
17 they'll be withholding information or guarded, or
18 masking symptoms is a classic example, particularly in
19 some demographic groups like older men.
20 So I think it's just part of your training as
21 a psychiatrist, and I think it's incorporated. I mean,
22 I think it's there and, you know, most psychiatrists
23 train for three years, it's a core training, and then
24 another three years specialty training. I mean, it's
25 a long period -- and that's after medical school which

1 is often five to six years, and foundation years, which
2 are two years. So you have this quite long period of
3 training where you're developing these skills.
4 I'm not -- I mean, I think in response to counsel,
5 I mean, I wasn't particularly -- I'm not suggesting that
6 you need to go on a sort of two-day training course
7 about violence risk assessment. I don't think that's
8 what I'm saying here. I'm saying that it can be
9 incorporated already into the structures that we have,
10 and I think it's much more, actually, about a culture
11 shift and an awareness in general psychiatry that this
12 is part of what we do.
13 We sort of, 30 years ago, if I go back to when
14 I started, you know, suicide risk assessment was in
15 a way a little bit -- there was also some uncertainty
16 about whether this should be done routinely, and that
17 changed completely. Now it's routinely done. We ask
18 everyone about suicide risk. We're not worried by
19 asking someone that we're going to make them become
20 suicideal. We know that's not the case. We know that,
21 actually, it's therapeutic having that discussion.
22 And that's something that I think needs to happen
23 here: that, you know, this concern existed for one of
24 these risks, it doesn't exist anymore. It's routinely
25 asked on everybody, and now this is, I think, part of

1 the development of psychiatric practice that this should
2 now be part of what we do.
3 **MR STRAW:** Thank you very much.
4 Thank you, Chair.
5 **THE CHAIR:** Thank you. Mr Beggs.
6 **Questioned by MR BEGGS**
7 **MR BEGGS:** Professor, you emphasised, at page 14 of your
8 report, that clinical judgement has a role in risk
9 assessment because it can consider risk markers not
10 captured by tools, such as symptoms, factors unique to
11 an individual, triggers, and the imminence of risk.
12 **A.** *(No audible answer given)*.
13 **Q.** And it's obvious that the clinicians have to take the
14 decisions under Sections 2 and 3 of the Mental Health
15 Act.
16 **A.** *(The witness nodded)*.
17 **Q.** But is it equally obvious, in the context of potentially
18 dangerous paranoid schizophrenics, that the clinicians
19 should ideally proactively consult with the police, who
20 may have information?
21 **A.** I think it's a balance, isn't it. I mean my view is
22 that if there's a reasonable suspicion, which I put in
23 my report, reasonable suspicion intentionally vague,
24 because I think it has to be -- I can't be too
25 prescriptive. Then I think there is a role to consult

1 with police.
2 **Q.** And putting it simply, that's because it maximises the
3 available intelligence for the clinicians?
4 **A.** It does, but it also offers them an opportunity to find
5 out what happened at the time because those triggers and
6 individual factors, you may be at that point be able to
7 identify them, because otherwise you don't know what
8 they are.
9 **Q.** And sometimes they're quite nuanced.
10 **A.** *(The witness nodded)*.
11 **Q.** Better understood by psychiatrists than police officers,
12 for example?
13 **A.** Definitely.
14 **Q.** And does it logically follow from that answer that,
15 after completion of any such risk assessment, it might
16 be sensible for the clinicians to share that assessment
17 with the local police?
18 **A.** Yes. I mean I think it is, particularly if they're
19 individuals that are targeted. You know, there's
20 specific people mentioned.
21 I think, to make a general recommendation about that
22 is difficult, but I think where there are individuals
23 identified, yes.
24 **Q.** Thank you. And you also indicated in your report that
25 there should be another risk assessment after, to quote

1 you, "a clear change or escalation in risk".
2 **A.** *(The witness nodded)*.
3 **Q.** And you gave as an example, arrest.
4 **A.** Yes.
5 **Q.** I think from all that you have said, if that arrest is
6 linked to antisocial behaviour or violence, the call for
7 a renewed risk assessment is particularly strong.
8 **A.** I agree.
9 **Q.** And it follows, of course, that the clinicians need to
10 know about the arrest, don't they?
11 **A.** They do.
12 **Q.** And that requires, again, better communication systems,
13 platforms, as between the police and the clinicians;
14 you'd agree with that?
15 **A.** I'd agree.
16 **Q.** Again, does it follow that, after a renewed risk
17 assessment, you could understand why it might be thought
18 that the police ought to be provided by that with that
19 updated assessment?
20 **A.** Yes, I agree.
21 **Q.** My final question is, to go back to the point you dealt
22 with a moment ago when you identified reasonable
23 suspicions as the threshold, you said information on
24 previous violence and crime should be routinely
25 requested by psychiatric teams of the police?

1 **A.** Yes.
2 **Q.** So that necessarily requires, does it not, improved
3 communications between the two agencies?
4 **A.** It does.
5 **MR BEGGS:** Thank you very much.
6 **Questioned by THE CHAIR**
7 **THE CHAIR:** Yes, Professor, I just have a few questions of
8 things I wanted to clarify.
9 You've described how, as far as forensic psychiatry
10 is concerned, generally speaking, there are three routes
11 to being consulted. The first is where there is a risk,
12 as you've described, where, for example, a psychiatric
13 team, treating team, has been either threatened or
14 injured.
15 **A.** *(The witness nodded)*.
16 **THE CHAIR:** Or, secondly, at the time of arrest where the
17 courts want advice as the most appropriate place where
18 the then defendant should be kept.
19 And thirdly, finally, directly from prison.
20 But you've also referred to referral from a general
21 psychiatric team.
22 **A.** *(The witness nodded)*.
23 **THE CHAIR:** I think you've said that that would only be if
24 they thought it was a serious matter in cases of
25 violence; is that correct?

1 **A.** Yes. So I think I could clarify that. So I think the
2 first route from -- is from general psychiatry more
3 generally, and it comes out of general psychiatry being
4 concerned about the risk. So it may well be that there
5 has been an incident, or a threat, or some sort of
6 escalation, and it can also happen if someone is
7 a patient, is an inpatient, so is in hospital, and
8 there's a concern about their behaviour as an inpatient.
9 Or an outpatient. So it can come from general
10 psychiatry more generally.
11 In terms of from the courts, it can -- it's actually
12 more likely to happen at the time of sentencing. So
13 someone has already been convicted, but at the time of
14 sentencing the decision has to be made, does someone
15 goes to hospital --
16 **THE CHAIR:** If it helps you, I'm more interested in the
17 referral from the general psychiatry side of things.
18 **A.** Okay, yes, yes.
19 **THE CHAIR:** Because it's the idea that you've told us that
20 the forensic team would only accept a referral if they
21 thought that it was a serious, for serious violence?
22 **A.** That's right, yes.
23 **THE CHAIR:** So if you have a series of admissions or arrests
24 for lower-level violence if I can put it that way, would
25 that be taken into account as a cluster, as it were --

1 **A.** *(The witness nodded)*.
2 **THE CHAIR:** -- or would it have to be an individual, serious
3 act of violence?
4 **A.** No, I think the cluster would be considered,
5 particularly if there's an escalation in severity. So
6 if the cluster is -- remains probably the same level it
7 may not reach a threshold that forensic psychiatry would
8 consider taking this person on. But if there's an
9 escalation, a clear escalation, then I think it would be
10 considered more seriously.
11 **THE CHAIR:** But, generally speaking, practice varies.
12 **A.** It varies.
13 **THE CHAIR:** There's no, as you've said, definition of
14 what's -- what are the criteria?
15 **A.** No, because it depends on the local service and the
16 provision in the local services is different, and
17 practice also for various reasons is different in local
18 services.
19 **THE CHAIR:** Yes. Thank you.
20 Just to clarify a couple of points that you've
21 raised, when you were dealing with co-morbidity so, for
22 example, you said with childhood conduct disorder,
23 you've referred to rule-breaking behaviours and
24 impulsivity. What do you mean by that in lay terms?
25 **A.** So I think conduct disorder would be a sort of cluster

1 of behaviours which are about, for instance, breaking
2 rules at school, breaking rules at home. So it may be
3 you see a pattern of suspensions, even expulsions. You
4 may see some violence, some other antisocial behaviour,
5 maybe some minor offending like stealing things.
6 Someone who doesn't deal very well with rules,
7 essentially, and boundaries. That's one set of sort of
8 pattern of behaviours. And there's also -- people also
9 in conduct disorder they sometimes can't deal with their
10 own emotions very well. I mean there's outbursts,
11 there's sometimes quite large swings in mood. And some
12 people deal with that by harming themselves; some people
13 deal with that by harming others; some people deal with
14 that by being verbally very abusive.
15 Yeah.
16 **THE CHAIR:** Thank you, that's very helpful.
17 And just in relation to the recent research, which
18 I think you've referred us to some of it, but would I be
19 right in thinking that the majority of research in
20 relation to the support for the connection between
21 violence and schizophrenia is over the last few years?
22 You've referred us to various papers from, really, about
23 2020 onwards; is that correct?
24 **A.** I think, yes. But it has been, I think, in my view,
25 been pretty clear in the literature for over 10 years or

1 so. I think bringing it all together, different types
2 of research, that's probably become clearer in the last
3 few years but there's always been very clear
4 epidemiological evidence, so evidence from real-world
5 studies that there is a link.
6 And now what's happened is that there's -- that's
7 been triangulated with some treatment research, some
8 research about sort of psychological factors that can
9 explain the link between schizophrenia and crime. So
10 it's -- the triangulation has become stronger.
11 **THE CHAIR:** And would you say that even though there has
12 been that stronger triangulation, that hasn't filtered
13 through to the extent that there is still a real concern
14 about stigmatisation which seems to override that link?
15 **A.** Yes, I do. That's a strong impression I get, and I get
16 that impression not only by people writing in the
17 literature but also in psychiatric meetings I go to, in
18 conferences I attend. Also working with public
19 agencies, this comes across quite a lot so it's
20 understandable that advocacy organisations would push
21 back quite strongly against this view, but sometimes
22 I find the pushback too strong, actually. So that's
23 been a consistent pattern I've seen.
24 **THE CHAIR:** And that leads to, I think you've described,
25 people, perhaps clinicians, backing away from doing risk

1 assessment.
2 **A.** Yes, and one of the advantages of the work we did is we
3 actually asked the clinicians in a neutral way about
4 their experiences, and that's what they said to us: that
5 they were worried about stigma.
6 **THE CHAIR:** And just going back to the collection of data,
7 you've acknowledged that the confidential surveys
8 stopped collecting data on homicides by mental health
9 patients and I think you said you weren't able to help
10 us on the reasons for that but we are going to have some
11 evidence about it.
12 **A.** Okay.
13 **THE CHAIR:** But do you find that people are less willing to
14 accept this research because it's primarily on the basis
15 of the Nordic experience rather than, say, a British
16 experience?
17 **A.** No, I don't think so. I think the reason is more this
18 concern, and I think it's -- it's an area that as
19 a treating psychiatrist, I mean -- yeah, it's something
20 that you find difficult to address because it is -- it's
21 partly the unfamiliarity of it, but also the
22 stigmatisation of it.
23 I just want to make a little bit point about, I mean
24 the focus on -- the National Confidential Inquiry was
25 focused on homicides. I mean I think the lessons we can

1 learn that come from all violence perpetration, I
2 mean -- and that's the focus of my research, is not
3 looking at homicides but looking at the bigger picture
4 because I think it's often about what we can do to
5 prevent violence, which is going to have the biggest
6 impact.
7 **THE CHAIR:** Just in relation to that, because I haven't
8 picked that up from what you've said today, is do the
9 number of incidents of violence, does that increase the
10 risk in the future?
11 **A.** Yes, it does, so the --
12 **THE CHAIR:** -- *(overspeaking)* --
13 **A.** Yes, it does. It definitely does. So if you've got
14 more history of violence, that does increase your risk.
15 **THE CHAIR:** And that's whether or not it's reached the
16 courts?
17 **A.** Yes.
18 **THE CHAIR:** Just finally in relation to the point you've
19 made, which is that it's not only in the best interests
20 of the patient, but also in the public interest to risk
21 assess and to treat schizophrenia in this way. That was
22 described, looking at this as in the patient's
23 interests, as "Orwellian" by one of our witnesses; do
24 you agree with that? Somehow it's best for the
25 *(unclear)* considered interfering with the patient's own

1 will?
2 **A.** No, I don't really understand that. I mean, that's not
3 how we think of these illnesses in the rest of medicine.
4 You know, we don't see that in the same way. I can see
5 the parallels are not -- the analogy is not perfect with
6 the rest of medicine, but I do quite a lot of work on
7 suicide risk assessment and I think that there's very
8 clear parallels there that you, you know, the importance
9 of doing good quality risk assessment, good quality
10 safety planning is being -- has been shown to be
11 important there.
12 **THE CHAIR:** Thank you. I have no further questions. Thank
13 you very much.
14 Right, well we will rise now until 2.10. Thank you.
15 **(1.12 pm)**
16 **(The short adjournment)**
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