

# CONFIDENTIAL PSYCHIATRIC REPORT

## Nottingham Inquiry

---

### **Introduction**

I have been instructed by the Nottingham Inquiry, in a letter dated 23 September 2025, to assist with providing my opinion on certain key issues faced by the psychiatrists in the case of Valdo Calocane, including risk assessment. I note that, in relation to good practice, I have been asked to consider the period from 2019 to the present day. I can confirm that I have not worked in Nottingham and do not have any conflicts of interest with mental or other healthcare trusts in Nottingham.

I have been asked to briefly summarise my career and expertise.

### **Qualifications**

I am a medical graduate of the University of Edinburgh, where I obtained a Bachelor of Medicine (Honours) degree in medical pathology in 1990 and qualified with Bachelor of Medicine and Bachelor of Surgery in 1993. I obtained Membership of the Royal College of Psychiatrists in 1997. I obtained a Doctor of Medicine research degree in 2002 and received my Certificate for the Completion of Specialist Training in Forensic Psychiatry in 2003. I was elected Fellow of the Royal College of Psychiatrists in 2011. I am approved under Section 12(2) of the Mental Health Act 1983.

### **Career and experience**

My general professional training in psychiatry was in Oxford from 1995 to 1998, including as a junior doctor at Broadmoor Hospital. My higher training was as a clinical research fellow at Oxford University on a project where I interviewed 203 older prisoners to examine psychiatric morbidity and received one year's higher training in old age psychiatry. Subsequently I trained in forensic psychiatry in Oxfordshire and Berkshire from 2000 to 2003. Since 2003, I have been a consultant forensic psychiatrist in Oxford and have worked in medium and low secure settings, and as a visiting psychiatrist to a local prison from 2010 to 2023. I was awarded the Professorship of Forensic Psychiatry at the University of Oxford in 2014.

I have been instructed by both the prosecution and defence in more than 50 homicide cases to provide psychiatric evidence, and also by the GMC in relation to evidence

provided by a psychiatrist in a homicide case. I was the sole forensic psychiatrist appointed by the UN-backed court as an expert witness for the Khmer Rouge Tribunal over 2012-2014, where I gave oral evidence on three occasions. I was the Government Legal Department's appointed expert in the Julian Assange extradition case (2020), and the CPS-instructed expert in the Court of Appeal case of R v Sanjay Nijhawan (2022). I was appointed by the Belize Supreme Court to provide expert advice on four homicide cases in 2022.

### **Current role and research interests**

I currently work as a clinical academic, with clinical work as a community forensic psychiatrist liaising with general adult psychiatric teams on people on their caseload that they require advice on risk assessment and management. I lead a research group at the University of Oxford investigating violence risk assessment, violence prevention, and suicide assessment and management in high-risk populations. I have also conducted research on the psychiatric morbidity of homicide offenders, and written chapters and reviews on psychiatric assessment, the assessment of capacity, risk assessment, and the epidemiology of mental illness and violence. I am co-lead of the Data Science theme of the Oxford Health Biomedical Research Centre.

### **Other relevant appointments and memberships**

I have provided evidence to Parliamentary Select Committees (including the Justice Committee), advised the UK's Chief Medical Officer and Chief Scientific Officer, and currently serve as an expert panel member for the Independent Advisory Panel on Deaths in Custody, a public advisory body co-sponsored by three government departments. I am section editor for forensic psychiatry for *BMJ Mental Health*, an academic editor for *PLoS Medicine*, and on the international advisory board of the *Lancet Psychiatry*.

I have been asked to provide my opinion on the following questions/issues:

**Item 1: Mental illness and violence**

There is a clear relationship between mental illness and various adverse outcomes. These outcomes include the perpetration of violence and criminal offending, being victimised, and premature mortality, including deaths from accidents and suicide. The relationship differs, to some extent, by the specific diagnostic category of mental illness, as some mental illnesses have stronger associations with these adverse outcomes than other illnesses. When referring to mental illness, I am considering schizophrenia spectrum disorders, bipolar disorder, depression, and anxiety disorders. Neurodevelopmental disorders and personality disorders are not typically considered mental illnesses, although they are included within the broader category of psychiatric disorders/conditions (and classified as 'mental disorders' according to the Mental Health Act 1983 [amended 2007]).

This relationship between mental illness and adverse outcomes is supported by a triangulation of research designs. Such triangulation is a powerful method for establishing causal relationships between exposures (such as mental illness) and outcomes (such as violence). In the particular case of mental illness and violence, research designs and replicated findings that support a clear relationship include randomised controlled trials, in which individuals treated for symptoms of mental illness are followed up for these adverse outcomes and compared with those who receive placebo medications or treatments for the same illnesses. These trials inherently account for socio-economic and other background differences, as participants are randomly assigned active treatment (such as an oral antipsychotic medication) or placebo treatment (such as a dummy tablet). Other research designs that are consistent with a causal inference include pharmaco-epidemiological studies. These types of studies use real-world evidence on large numbers of people who are being treated with medication, examining groups who have received different medications and following them over time for adverse outcomes. Using pharmaco-epidemiological designs, it is possible to account for important background confounding factors such as socio-economic status. In a variant of this approach, known as a within-individual or self-controlled design, the same person acts as their own control. This makes it possible to account for all background factors that remain stable within an individual, including their childhood experiences and genetic vulnerabilities. Here, the same person is studied for violent outcomes when they are taking medication and when they are not (which can be captured reliably using population registers in Nordic countries, where medication that is prescribed and collected ('dispensed') is recorded).

Another important research design that is consistent with the clear association between mental illness and adverse outcomes is epidemiological (or observational) research, where people diagnosed with mental illness are followed up over time for adverse outcome rates and compared with people without mental illness. In this context, there is now robust and replicated evidence using sibling control designs. These sibling designs compare two individuals for an adverse outcome: one with a mental illness and their sibling of the same sex at birth who does not have a mental illness. This method accounts for shared genetic vulnerability and likely similar childhood experiences, including growing up in comparable socio-economic circumstances.

There are now a range of high-quality studies that have used these population-based designs that are consistent with causal inference in the relationship between mental illness and adverse outcomes, and in particular for the perpetration of violence. The strongest evidence is for schizophrenia spectrum disorders, but there is robust evidence for bipolar disorder and depression. Most of the evidence has been drawn from epidemiological studies that have explored the major categories of psychiatric disorders and investigated whether mental illness is associated with increased risks of the perpetration of violent crime, and elevated risks of being severely victimized (which leads to hospital admission for treatment of an injury). The strength of nationwide epidemiological studies is that they are comprehensive and, unlike trials, do not exclude participants for specific reasons (such as being too unwell or having comorbidities).

I have been involved in two reviews of the evidence, and one nationwide study that has investigated all major mental illnesses and links with violence perpetration and victimization. The reviews are from 2018 (Fazel, *Br J Psychiatry* 2018, which was an umbrella review of all replicated risk factors with violence including neuropsychiatric disorders: WITN0401002); Whiting, *Lancet Psychiatry* 2021, which was a structured review that included the available sibling control studies and neurodevelopmental disorders: WITN0401003; and Sariaslan, *JAMA Psychiatry* 2020, which is a nationwide study of links between the major psychiatric categories and violent crime perpetration and victimization: WITN0401004 - see Figure 4 for sibling control estimates for the main diagnostic categories).

The first of these reviews investigates modifiable risk factors for violence from a population perspective, and brings together systematic reviews of different neuropsychiatric diagnoses and their associations with violent outcomes. It shows that people with schizophrenia-spectrum disorders account for 5-10% of all violent incidents

in countries such as the UK (which is less than the impact of people with substance use disorders that account for around 15%).

The second of these reviews provides more detail on the evidence on schizophrenia-spectrum disorders and summarises the epidemiology, including sibling-control studies, and guidelines on risk assessment. One other novel feature of this review is that it presents the research findings on the absolute rates of violent crime for different time periods. Over a lifetime, 23% of individuals with a schizophrenia diagnosis in the whole Swedish population had a violent conviction and the 5-year incidence of violent conviction after first diagnosis was 11% in men and 3% in women. This type of research is only possible in some Nordic countries due to the availability of high-quality registers that can be accurately linked across health and criminal justice records. The findings of this review underscore the overall picture that, although violence is perpetrated by a minority of people with schizophrenia-spectrum disorders, the population impact is large enough for public health and policy to address. Furthermore, in some patient groups, such as men, any adverse event over 10% is important to prevent and should be a key clinical area for prognosis and treatment. The review also outlined that there was very little detail on risk assessment and management in guidelines for schizophrenia-spectrum disorder in England and the US. In England, NICE refers to a comprehensive multidisciplinary assessment and suggest crisis resolution to manage risk.

The third paper is primary empirical research using the total Swedish population to investigate links between schizophrenia-spectrum disorders with violent crime and being violently victimized. The novel feature of this investigation is that it uses sibling controls to robustly account for socio-economic factors that might explain any associations; in other words, by comparing people with schizophrenia and their same-sex siblings without schizophrenia, after adjusting for age, this design can help separate out the effect of the illness from socio-economic and childhood factors (as they are mostly shared between siblings). The study found 7-fold increased risk of violent crime convictions in people with schizophrenia in statistical models that used sibling designs. In addition, contrary to much expert opinion, the risk of being violently victimized was not increased in people with schizophrenia compared with their non-affected siblings (after adjustment for age and comorbidities). One explanation for this is that people with schizophrenia without comorbid conditions are more socially isolated and therefore less likely to be in environments that put them at risk of being victimized. Being victimized remains another important adverse event to prevent, but the notion that violent victimization risks are higher than being a violent perpetrator in schizophrenia is not supported in this high-quality population study.

- a. I have also been asked to comment on risk factors for psychosis and the likely age of onset for psychosis. This is not an area of specific expertise on my part.
  
- b. I have been asked to comment on the relationship between schizophrenia and violence. I understand this to refer to the perpetration of violence. There is strong triangulated evidence to suggest that schizophrenia is a causative factor for violence. First, a meta-analysis of randomised controlled trials of antipsychotic treatment has shown a strong effect of antipsychotics (with around a 60% reduction in violent outcomes) (WITN0401031). This is considered a robust marker of causality because the treatment of symptoms has led to a reduction in violent outcomes. In these trials, the control group comprised individuals with schizophrenia who did not receive active treatment but instead received a placebo medication. Second, there are nationwide pharmaco-epidemiological studies using within-individual designs that show similarly substantial reductions in violent crime among people with schizophrenia. The outcomes in these investigations are violent crime and violent arrest, and these studies have been conducted in Sweden (which is the largest country worldwide with registers linked between health and crime, which means that this type of research can be conducted). Third, in the most recent review of the international evidence, there are 24 epidemiological studies, which have consistently shown that schizophrenia is associated with increased risk of violent outcomes (NHSE0002731). These studies have included different violent outcomes, not only criminal offending but also self-reported and informant-reported measures of violence. The overall findings of this research are that the increased risk of violence perpetration in men with schizophrenia and other psychoses was increased 4-6 times (with a pooled odds of violence of 4.5) compared with general population comparisons. The risk was also elevated in women with schizophrenia (7-15 times). The evidence also clearly showed that the odds of violence remained substantially elevated in people without co-occurring substance use disorder. Further, there was increased risk of perpetrating sexual offenses (of similar magnitude). In homicide, the increased odds were considerably higher (as reported in the pooled odds ratio of 18; with 95% confidence intervals between 14 and 23). The absolute risk, though, is very low – somewhere in the range of 1 homicide per 10,000 people per year. The National Confidential Inquiry reports around 50 homicides committed by patients per year, which represent 11% of all homicides, although this will likely be an underestimate as it includes people who were in contact with mental health services in only the previous 12 months and relies on ascertainment of diagnostic

information from court reports and the responsible clinician completing a survey retrospectively. These approaches are not as accurate as using lifetime clinical records and linking them with conviction information as has been done using Nordic country data.

A small number have been conducted in low- and middle-income countries (which have not used crime as the outcome) although most evidence has been generated in high-income countries (including the UK), and also investigations with different ways of diagnosing schizophrenia. Importantly, many of the epidemiological investigations are prospective (where the diagnosis was clearly made before the outcome) and many use comprehensive and careful adjustment for factors that could confound any relationship between schizophrenia and violence.

One good example is the Dunedin study, where over 1000 children were followed from birth up until the age of 21 and where high quality diagnostic approaches and ascertainment of outcomes (self-report and official court information) were used (WITN0401005). In this study, the association with schizophrenia was statistically significantly associated with violence (as reported in an odds ratio of 2.5, with 95% confidence intervals of 1.1-5.7) after carefully accounting for socio-economic status and other comorbid disorders, including cannabis and alcohol use disorder. This underscores another consistent finding – that the association between schizophrenia and violence is present even when co-occurring substance use disorders are taken into account. In addition, there are sibling control studies from two countries—Sweden and Israel—that have demonstrated that the sibling with schizophrenia has a higher risk of violent crime than the sibling without schizophrenia. This is further evidence of an association consistent with a causal inference.

For an overview of the triangulated research evidence of schizophrenia and violence, I was involved in a short summary for the journal *World Psychiatry* in 2024 (WITN0401006). There is a related piece in 2022 as a letter to *JAMA Psychiatry* with this information in a tabular form (WITN0401007).

These two pieces outline the consistent, replicated and robust findings that schizophrenia is associated with violence perpetration. They present the findings from randomized controlled trials and other treatment studies and the epidemiology that link schizophrenia to violence. The articles argue that reducing

stigma can be most effectively done by preventing violence rather than ignoring or minimizing these links.

Further support for a causal relationship between schizophrenia and violence is based on plausible mechanisms that can explain the association. The aforementioned research letters briefly summarise this – which is based on certain psychotic symptoms (e.g. anger arising from paranoid delusions [see WITN0378026]). There is also new evidence on plausible mechanisms from a comprehensive qualitative study conducted in the UK (WITN0401008). This study, which involved in-depth interviews with 20 patients with psychosis, identified seven psychological processes that can explain the link, including violence being a response to being sensitive to disrespect, threats of physical harm and, for inpatients unfair treatment, whether real or imagined. It also found violence being used to regulate difficult internal emotional states.

- c. I have been asked to comment on modifiable factors to manage the risk of violence in patients with mental illness/schizophrenia. There is a replicated evidence base linking certain risk factors and markers with an elevated violence risk ('risk markers' is preferred by some researchers as it does not imply causality). These have been classified into similar overall domains, such as psychopathological factors (which include symptoms), substance misuse problems, and treatment-related ones. There is greater uncertainty regarding overall symptom scores, partly because symptom checklists do not account for heterogeneity in the effects of individual symptoms. One finding is that there is elevated risk of violence in people with schizophrenia with a history of self-harm, which may indicate underlying impulsivity as part of the individual's personality profile.

A recent systematic review of longitudinal studies reported that co-occurring substance misuse (including any misuse [any illegal drug and/or alcohol], and drug misuse and alcohol misuse separately), co-occurring personality disorder, and a diagnosis of schizophrenia (vs other psychotic disorders) increase violence risk in people with psychosis. In relation to treatment factors, the evidence is clearest for non-adherence to medication being a risk factor, and for antipsychotic treatment acting as a protective factor. Psychological treatment has not been shown to associated with reducing risk one way or the other.

This information on risk factors is based on a 2025 systematic review of longitudinal studies, that synthesized the data from 47 separate investigations; I was the senior author: WITN0320014 (see especially table 2). The review found that there were 30 different risk factors replicated in three or more independent samples. It tested whether, in people with schizophrenia, the effect of a risk factor (and thus differs from the epidemiological studies cited above, which test the risk of violence in people diagnosed with schizophrenia compared to people in the general population). Criminal history factors were associated with the greatest risk of violent outcomes (increasing risk by 3-5 fold in people with schizophrenia), followed by substance misuse factors (increasing risk 2-3 fold). Many treatment-related factors were protective (with around halving of violence risk).

I am not aware of any robust evidence regarding social integration or other social or policy issues. These factors would be difficult to study, partly because of the influence of other variables that often occur at the same time as any changes in policy. I was involved in an ecological study of 179 countries that examined whether societal factors were associated with violence at a population level (WITN0401009), although this will not be tested specifically in people with mental illness. The effect of total alcohol consumption on assault rates was significant (reported as p value of 0.038 [where p values below 0.05 are typically considered statistically significant]). This study reported that alcohol consumption, in high income countries, was associated with violence rates as measured using four outcomes (official and self-report). These findings further strengthened the case for restricting alcohol supply by pricing, reducing availability and limiting marketing to children, and other measures to reduce societal violence.

## **Item 2: Risk Assessment**

I have been asked to comment on good practice. My view is that good practice in assessing the risk of violence posed by mental health patients involves three main areas. First, taking a comprehensive personal and clinical history that includes information about previous violence towards others, a history of substance misuse, and triggers for any psychotic relapses. Such a history should aim for corroboration from informants and other sources where possible (see below). Second, this should be followed by a clinical examination that covers the main areas of mental state (appearance and behaviour, speech, mood, thought and perception, cognition, and insight), and investigates the presence of delusions and their impact on mood and anger. Finally, a structured

violence assessment tool should be administered to provide a baseline risk evaluation and yesa means to communicate risk consistently within and between services.

I will now address specific questions that have been put to me.

a When should risk assessments be undertaken?

In my view, risk assessments should be undertaken in general adult psychiatry when individuals are first taken on by mental health services. In addition, they should be conducted when there has been a clear change or escalation in risk, such as when someone has been arrested by the police or expressing new or specific thoughts of harming others. Risk assessments should also be undertaken when there is uncertainty about violence risk, as it provides an opportunity for the clinical team to consider it in a more structured way.

b Who should undertake them?

Risk assessments should be undertaken by clinical staff, including medical doctors, clinical psychologists, or nursing staff. Such assessments should be reviewed by the multidisciplinary clinical team, and any uncertainties discussed. The experience of clinical staff should be considered, and less experienced clinicians should have their risk assessments reviewed. Establishing simple rules for when this is appropriate is difficult and will depend on professional group. In the case of medical doctors, foundation doctors and core psychiatric trainees should have risk assessments reviewed by a more senior member of the clinical team.

c How and from where should information be gathered?

Information should be gathered from third parties, such as the patient's family, whenever possible. This is important because some individuals with psychosis may be guarded about their background histories or, if they are acutely unwell, may not remember or may be unwilling to share details relevant to risk assessment. Liaison with official third parties, such as the police, should also be routinely considered in individuals where there is reasonable suspicion (e.g. self-reported previous arrests, informants, or previous arrests/crimes reported in their medical records). Routinely collecting information from police may not be necessary in certain groups, such as older women, where the risk is very low, and doing so may unnecessarily consume clinical

time and resources. Many psychiatrists may not decide to request information from third parties based on concerns about patient confidentiality, which, in my view, represents a misunderstanding of the guidance on this issue.

d How is violence defined by clinicians and risk tools?

I am not certain about all the definitions used or whether they are consistent. There are many such tools in practice. Some risk tools do not clearly specify what they mean by violence, and I note that one published criticism of the outcome for the HCR-20 is that it is “so broad (including verbal threats) as to be meaningless in the services we work in” (WITN0401010). In contrast, clinicians are generally more concerned with serious outcomes, such as violent arrests or convictions, which also reflect wider societal costs, including health effects for victims.

I have been asked about the indicators of risk of violence used by clinicians and in risk assessment tools. I understand this to mean the factors that clinicians and risk tools use to indicate an elevated risk of violence in people with mental illness. I am not aware of many UK-based studies that have investigated this, but a recent qualitative investigation of 18 clinicians is informative (WITN0320015; I am one of the authors). In the context of first-episode psychosis, the study reports that clinicians consider psychotic symptoms, past violence, and some weighed up substance misuse comorbidity (see section 3.1.1 in the paper). I note that this study reported, “Several [clinicians] stated that the relevance of past violence depended on its context”, which I understand to mean that clinicians consider risk more seriously if previous violence occurred in the context of a psychotic relapse or a clearly deteriorating mental state.

I have been asked whether the definition of violence includes acts that lead to injury without the direct use of force. I am not certain about how clinicians define this, although in my clinical experience, it is defined inconsistently. Some clinicians focus on criminal charges, while others will consider a broader definition of violence perpetration that includes inpatient interpersonal violence towards staff and other patients, as well as violent threats to others. However, it is my understanding that risk tools do typically consider this definition of violence that includes injury. Some risk tools do this explicitly because such acts of violence are recorded in police records (e.g. as ‘harassment’, ‘threats to kill’, or ‘racially or religiously aggravated’ offences) and their outcomes include criminal offences. Other tools also consider threatening behaviour and other acts of violence that have not resulted in criminal charges as part of their definition of violence.

e Key risk factors that should be analysed in a risk assessment

Key risk factors that should be considered include the individual's sex at birth, chronological age, and past history of violence or violent crime—these are the strongest and most consistent risk factors for any violent outcome, and in all mental illnesses. The choice of other key risk factors should be informed by high quality research evidence. Typically, these can be investigated in statistical models, where the various candidate risk factors are adjusted (or accounted for) by each other. These are described as multivariable (statistical) models, and have the clear advantage of avoiding redundancy and inflated associations, as some factors are inter-related.

Across diagnostic groups, risk factors and their effects may be different. In other words, a risk tool developed for people with psychosis may not be accurate for someone with a personality disorder or anxiety disorder, although these are empirical questions that, to my knowledge, have not been examined.

I have been asked to consider some other specific factors. Lack of compliance with treatment plans and medication is an important clinical consideration, and some risk tools have an item for this. In my view, however, it is difficult to operationalize for a tool (e.g. how many medications can be missed, and whether non-engagement can be reliably measured) and can be part of a comprehensive clinical assessment that complements a risk tool. 'Relapse when not taking medication' is important for violence risk, particularly if a past relapse was associated with an escalation in risk. Lack of insight is also difficult to measure in reliably, as insight exists on different levels. I am not aware of research that has investigated whether partial insight (e.g. agreeing to treatment but refusing medication) is associated with risk.

My overall view is that risk tools developed for people with psychosis and schizophrenia should be used in both general and specialist services (e.g. Early Intervention in Psychosis services).

Co-occurring substance misuse is a strong risk factor in people with schizophrenia, and should be included in risk assessments for this patient population. This has been studied in the UK (WITN0401011), showing increased risk associated with daily use of cannabis, stimulants, other illegal drugs (hallucinogens), and multiple drugs. The magnitude of the increased risk was between 2-4 times in the UK first episode psychosis sample, and 2-3 times in the previously cited systematic review of longitudinal studies. It is also a strong risk factor for people with other psychotic disorders, such as bipolar disorder. Regarding histories of antisocial behaviour, I consider this a key risk factor, particularly when

antisocial behaviour occurred in the context of a psychotic relapse and the severity of acts escalated. In one study we conducted, different ways of categorising criminal history were examined. We found that a history of violent crime was the strongest predictor of subsequent violent crime in people with schizophrenia. Other measures, such as a history of a non-violent offence or specific criminal histories (e.g. for weapon use), were less predictive (WITN0401012). This study tested their relative predictive effects – all were associated with increased violence risk (apart from age of first conviction for a violent offence in women, which is a risk marker in the HCR-20 tool).

f        What tools should be used in risk assessment?

Risk assessment tools should be those that have been developed and validated in the population being assessed. Other key considerations are the tool's predictive performance, their feasibility and acceptability for clinical use, and any research investigating their impact on outcomes.

In general psychiatry, external validation is the gold standard to assess a tool's performance in real-world settings. However, in forensic psychiatry, external validation is too high a threshold due to the small numbers of patients discharged per year, and internal validation can reasonably be expected.

Most existing tools were developed for forensic psychiatric populations—that is, individuals with serious offending histories—and will not be accurate for general adult psychiatry. This is because most tools incorporate the base rate of the outcome (i.e. the average likelihood of the outcome) and model the effects of risk markers on this base rate. The base rate is considerably higher in forensic than in general psychiatric populations. In addition, the magnitude of risk factors is different between general and forensic populations. For example, the effects of previous violent crime and comorbid substance misuse are weaker in forensic populations (partly because there less variation in these factors and they are more common). Thus, tools used in general psychiatric settings should be specifically developed and validated for those populations. A limitation of older risk tools, such as the HCR-20 and VRAG, is that they have been developed on small sample sizes, typically on forensic populations, but not for individuals in general adult psychiatric services.

I have been asked to consider the different types of risk assessment available. In my view, their differences between them are overstated. Structured professional judgment approaches use a list of unweighted risk markers—mostly based on dated evidence—and ask clinicians to assign an overall rating of high, medium, or low risk after

considering these risk markers. This approach lacks consistency, as clinicians may interpret and weigh factors differently, and individual clinicians may provide different overall ratings for the same patient. Unstructured clinical judgement, which uses no formal tools, has been shown to perform worse in terms of accuracy compared with risk tools. A recent and well-conducted systematic review demonstrated this clearly in head-to-head comparisons (WITN0401013), which was based on 31 studies and more than 45,000 risk judgements. The statistic used to test differences was the area under the curve (AUC) – which measures how well a model or approach separates out those who are violent compared with those who are not violent. For unstructured (i.e. subjective) judgement, the AUC was reported as 0.62, and for approaches using risk scores from tools, it was 0.69. This represents a substantial difference, as AUC statistics are relatively insensitive to small changes.

However, clinical judgement has a role, as it can consider risk markers not captured by tools (such as symptoms), factors unique to an individual (e.g. triggers), and the imminence of risk. The actuarial approach assigns numerical weights to individual risk factors, producing an overall probability of violence over a specified time period (or a risk score, which is a numerical value on a scale). In practice, the difference between structured professional judgment and actuarial approaches is not clear-cut.

The most evidence-based approach, in my view, is to combine actuarial-type instruments with clinical judgment. The actuarial component provides consistency and transparency, while clinical expertise ensures appropriate interpretation, unique triggers and factors, and how to link assessment to treatment and management. This aligns psychiatric practice more closely with the rest of medicine, where structured tools routinely complement clinical judgment. This combined approach also allows for clinical override, which will be necessary for some individuals based on their risk history (e.g. where there are known triggers).

I have been asked to comment on the risks and benefits of using these tools. Importantly, there is empirical evidence on this based on a mixed methods study based in England published in 2025 (WITN0401014). Difficulties with the use of tools include the potential to exacerbate stigma and cause distress by asking patients about their violent histories, as well as the lack of clinical time to conduct another type of assessment. One other problem is that clinical teams may not have the resources or treatments to address an elevated violence risk in one of their patients. Denial of care (for individuals deemed at 'low' risk) and loss of clinical skills are other potential difficulties if clinicians rely on tools without combining them with clinical judgement.

In my view, all these potential difficulties can be addressed with appropriate training and information. Importantly, empirical findings in the 2025 study showed that stigma was not a problem: “Inadvertent stigmatisation or labelling was not found to be a concern. Many clinicians felt that whether risk was assessed formally with a tool or in the standard unstructured manner made no difference to such issues. The intended purpose of the tool for positive input and support was highlighted”. Furthermore, in this qualitative investigation, patients and carers thought that a structured approach could improve openness and therapeutic rapport. It can enable a more collaborative approach to risk management.

At the same time, I do not think that current structured professional judgement tools are appropriate in general adult psychiatry for two principal reasons. First, they were not developed for such populations, and, to my knowledge, have not been externally validated in UK general psychiatry using adequate methods (e.g. at least 100 outcome events, clear prediction horizons, and reporting calibration and discrimination statistics). To my understanding, the research on these tools has been in forensic populations. Second, they are resource-intensive, being time-consuming and requiring training to use (which needs to be paid for and periodically updated). For general psychiatry, risk tools should be scalable, have easy to score predictors, and not require extensive training to use.

(i) Short-term risk assessment tools

Some tools are designed specifically for short-term risk, typically over a 24-hour period in inpatient settings (e.g., DASA or BVC). These tools are not appropriate for community settings or for individuals being discharged from hospital. High-quality risk tools should specify a prediction horizon (e.g., 12 months).

(ii) Magnitude of harms

To my knowledge, risk tools developed for psychiatric populations typically do not consider the magnitude of harms separately from overall risk. This differs from the criminal justice system, where some tools provide information of the risk of any recidivism and the risk of violent recidivism. Some tools also consider more serious violent offending.

g The OxMIV tool

OxMIV is a novel risk assessment tool that I was involved in developing with colleagues

in the UK and Sweden. It is unique for several reasons – (i) it was specifically developed for people with psychosis, (ii) used data on more than 75,000 individuals in its original development and validation study, which is many orders of magnitude larger in terms of sample size than previous tools combined (e.g., a 2023 systematic review identified 36 forensic tools validated in a total of 10,460 participants). This means that OxMIV's external validation, based on 16,387 people, was larger than all these previous validations combined, (iii) it reported a full range of performance measures, including calibration, (iv) it used reliable and replicated risk factors that are mostly routinely collected (and therefore do not consume staff resources), (v) it transparently published the effects of the included risk factors, the risk formula that provides the probability score, and the research protocol (which was written before the study was conducted), and (vi) it has been translated into a freely available online tool, featuring visualizations of outputs and information on the baseline risk level in populations of individuals diagnosed with psychosis (i.e. schizophrenia-spectrum disorders and bipolar disorder). OxMIV uses 16 risk markers across three domains—socio-demographic, historical, and clinical—and takes approximately 10-15 minutes to complete per individual. The tool was intentionally designed to be practical and easy to score. A short video guide on the tool was published online: [https://oxrisk.com/oxmiv\\_user\\_video\\_guide/oxmiv-full-video-2-0-25-6-20/](https://oxrisk.com/oxmiv_user_video_guide/oxmiv-full-video-2-0-25-6-20/)

The tool was first published in 2017, and in a geographical external validation in Sweden showed a very high level of accuracy (c-index = 0.89) and excellent calibration between expected and observed probabilities. The discrimination performance (as measured by the c-index, which can be interpreted similarly to an area under the curve statistic or AUC) was considerably higher than tools studied in general psychiatric patients with psychosis (where the AUCs ranged from 0.60 to 0.77 were reported in a previous systematic review: WITN0401015; cf. the pooled AUC for HCR-20 and VRAG in forensic populations was 0.69: WITN0388002).

#### (i) External validations of OxMIV

A subsequent validation in England, among individuals presenting to early intervention in psychosis (EIP) services also showed strong performance using routinely collected real-world data (WITN0401016) and a broader outcome (defined as either a police occurrence of violent offence or an incident documented in electronic health records involving interpersonal violence with a weapon or causing injury, regardless of whether it resulted in police involvement). I was one of the senior authors on this study. Overall, the OxMIV model, slightly adapted for the EIP population, showed good discrimination (AUC 0.75) and good calibration using a range of performance measures. An important

component of this English study was that it investigated a measure of impact—net benefit— which models the use of OxMIV compared with unstructured clinical assessment. This impact analysis showed that the net benefit was higher for OxMIV using all clinically realistic thresholds for violence risk.

A further aspect of this English validation is that it compared OxMIV with unstructured clinical assessment. The paper concluded: ‘we found that unstructured clinical judgement alone in assessing violence risk was suboptimal. The specificity of clinical judgement was 89%, but sensitivity was 40%; that is, the majority (60%) of individuals who went on to perpetrate violence did not have any risk in this domain identified by the assessing clinician. Among these individuals, risk factors for violence were objectively present. Thus, a key need is to improve the sensitivity of clinical assessments, and, to do so, using a 10% cut-off for classifying increased risk with OxMIV provides a good balance of over and under-identifying risk.’ In contrast, using OxMIV with a 10% cut-off for 1-year risk of violence, sensitivity was 71% and specificity 66%. The improvement in sensitivity (from 40% to 71%) exemplifies the potential of OxMIV to complement clinical assessment.

The other two external validations used different outcomes and are not directly relevant to general adult psychiatry. One external validation in Germany was conducted in a prison hospital setting and used institutional violence as the outcome, rather than community violence (WITN0401017). The study authors reported good evidence of predictive performance when comparing scores between violent and non-violent groups (i.e. statistical discrimination). I was not involved in this study. The study authors concluded: “the risk assessment tool OxMIV succeeded in predicting violent behavior in imprisoned psychiatric patients. As a result, it may be applicable for identification of patients with special needs in a prison environment and, thus, improving prison safety.” In a related study, the authors concluded that OxMIV is “applicable as an adjunct to clinical decision making in prison psychiatry” (WITN0401018). A further external validation in the Netherlands (WITN0401019) involved research participants (collected primarily for a genetic project, i.e. not a real-world study), a different time horizon (3 years) and outcome (any violence). As expected, this led to shrinkage in discrimination (AUC 0.67), although calibration was acceptable after recalibration. This research cohort had less severe illness and less violence than a real-world sample as participants needed to be recruited for a genetic study. Nevertheless, this suggests that, with recalibration, the OxMIV model can be adapted for research cohorts and different outcomes. Recalibration is necessary, which adapts the base rates of the model to the new population and outcomes.

(ii) Feasibility and acceptability studies of OxMIV

A further set of investigations has tested OxMIV's feasibility and acceptability to clinicians and patients. The most comprehensive was a mixed-methods study in England involving 141 first-episode psychosis patients, complemented by qualitative interviews with 20 clinicians, and additional interviews with 12 patients and carers (WITN0401014; I was a co-author).

This study reported that OxMIV was broadly acceptable from a service perspective, with a favourable balance between effects on resource and benefits. Patients and carers thought that the tool could help make risk assessment more transparent and promote a more collaborative approach to risk management. Two areas where clinicians were uncertain about OxMIV's usefulness was for patients were: first, for patients whose risk was already known to be low; and second, when asking about some background risk markers in the tool (e.g. family history of criminality). Some clinicians felt that the tool needed to link to risk management suggestions (which it currently does not) to have a more direct impact, and that its role in complementing clinical judgement required clearer emphasis.

Another feasibility study was conducted in two university hospitals in Spain and one in China (WITN0401020; I was a co-author). This study interviewed 12 Spanish clinicians, who reported clinical benefits, including being able to discuss risk factors with the wider clinical team and increased awareness of violence risk. They noted that some risk factors were difficult to obtain, and certain risk markers were not included in the tool (such as relationships with others). This investigation also included interviews with 26 Chinese psychiatrists, and a thematic analysis of their views is reported in the published paper.

I was recently commissioned to write a brief overview of OxMIV for *Psychiatric Times*: WITN0401021.

h HCR-20 Version 3

The HCR-20, originally developed in the mid-1990s in a Canadian sample of mostly male forensic psychiatric patients, is a structured clinical judgment tool. It has 20 items, which can be scored 0 (absent), 1 (partially or possibly present) and 2 (present). On completing these 20 items, it asks for clinical judgement to rate someone as low, medium and high, but these are not linked to the score (out of 40) or probabilities of future violent outcome. Thus, it has been criticized for lacking clinical utility. For example, in one systematic review, it was shown that individuals rated as 'high' risk had subsequent risks

of violence ranging from 5 per cent to 95 per cent (WITN0401022). This means that the tool has serious limitations if used to communicate risk levels between services. The tool can be time-consuming—one study found that version 2 required approximately 16 person-hours to complete. Other limitations are that the underlying evidence base is dated – the 20 items making up the version 3 of the tool are very similar to those from 1995 version. The tool does not include age and gender, which are powerful risk factors and this means that predictive performance will be constrained. There is no weighting of individual items, which is not consistent with the risk factor evidence, and may give the impression that they are of similar importance when coming to an overall risk category.

(i) Real world evidence on performance

When tested in real-world forensic populations in the UK and northern Europe, the HCR-20 tool has shown mixed and occasionally poor predictive accuracy (see e.g. WITN0401023, where it performed no better than chance to predict reoffending in discharges from medium secure units in Belgium; and also WITN0401024, where the 10 historical items performed poorly in a real-world Scottish medium secure sample with AUCs of 0.54 for serious offending – see table 5). In a prospective study from high security in the UK, which used all 20 items of the tool, it performed poorly (WITN0401025).

One key consideration in the evidence about HCR-20 is the financial and non-financial conflicts of interest, which are inconsistently reported by developers and translators of the tool. Another is the analytic approaches show a high risk of bias (WITN0388002). A good critique of the HCR-20 has been published in *Evidence-Based Mental Health*: WITN0401026.

At the same time, the HCR-20 has certain strengths in that it provides a framework for assessment and can be linked to management. In forensic mental health services, psychologists often use it to help with risk management planning (and it allows for scenario planning, which divides clinical opinion on its usefulness or relevance, but will have a role in some forensic patients).

i The Royal College of Psychiatrists' Report c201

This is a very wide-ranging report, and dealing with all aspects of it is not possible. In my view, however, some parts of it require updating. It is now nearly ten years old, and the evidence base has advanced since then, particularly in relation to scalable, probabilistic tools that can support clinical decision-making and the information on risk factors should be updated.

j (i) Standardisation between NHS Trusts

I have been asked about whether the use of risk assessment tools should be standardised across NHS Trusts. I would recommend this as it would improve risk communication between services, which in turn would support risk management for patients who move between services, and allow for national evaluations of practice. The latter is often missed as part of any policy response but is crucial – research evaluating any changes should be explicitly part of any new service-level changes. Funding needs to be allocated for this research (as part of an open competition administered by National Institute for Health and Care Research, for example).

(ii) I have been asked whether the use of risk assessment tools should be mandated, or more strongly encouraged, in clinical practice. Although most electronic health record systems require completion of a risk assessment field, these are typically free text boxes and not linked to validated tools. Clinicians can enter unstructured text such as ‘high’ or ‘low’ without further explanation. In my view, the use of risk tools should be recommended as part of good quality clinical practice – and consideration can be given to mandating it as part of first assessment for people with psychotic illnesses who are taken on by mental health services (e.g. in Early Intervention in Psychosis services or community mental health services for adults), and in individuals where there are clear risk markers (e.g. previous interpersonal violence or criminality). Furthermore, in referrals or patients where there is uncertainty, risk assessment tools should be used to assist with a more team-based approach to consider risk.

**Item 3. Practice on the ground**

There is less research evidence on some of these issues.

a. Training and guidance.

My opinion is that training should be strengthened, and national training and guidance are best delivered by the Royal College of Psychiatrists. I have been a member of the College since 1997, and my impression is that specific training programmes for College members and associate members (who are typically doctors in training posts) on risk assessment are not common or regular. I organised a one-day training event in 2025 (‘Risk Assessment in Psychiatry’), and more than 600 psychiatrists attended, which suggests an unmet need. Participant feedback received was very positive. The Royal College of Psychiatrists would be able to provide information on other training initiatives. I have commented on guidance below.

There is one annual international and several national conferences that the College organises which are often well-attended, and the programme can include talks on risk assessment. But these conferences rely on organisers inviting speakers to speak on risk issues for plenary sessions. Notably, none of the keynote lectures at the 2025 International Congress were on risk assessment or violence risk/prevention (<https://www.rcpsych.ac.uk/events/congress/programme>). There are separate faculties of the College by subspecialty, and the forensic faculty organizes annual conferences, but this is almost entirely attended by forensic psychiatrists (rather than general adult psychiatrists) and hence focuses on different issues that are specific to forensic services.

There is College guidance from 2016 on their website, Good Practice Guide Report 201: (NHFT0015099). The guidance is not based on a review of the research literature but on the views of a consensus expert clinical panel. It is brief and primarily framed as questions rather than providing an overview of the evidence base. The principles outlined on assessment, formulation and management are reasonable and not controversial. The guidance on risk management is limited to four generic principles – there are no explicit evidence-based recommendations. In the section on risk assessment, there is a heading about ‘Information from other sources’ in ‘factors to consider’, where it states: ‘Has everyone with relevant information been consulted? This includes carers, criminal records, Police National Computer markers and probation reports.’ In the same section on factors to consider, it states in relation to risk assessment: “A structured professional judgement approach to assessing risk is preferred to actuarial or unstructured assessments. It involves combining clinical judgement and use of a structured pro forma (e.g. Historical Clinical Risk Management Version 3).” This is no longer consistent with the current evidence base.

Training is also provided in one online CPD module (from 2019: WITN0401027), which as with all college CPD modules, requires payment to complete. It is not clear how many people use this or whether it is widely known among members and fellows of the College. I have not reviewed its contents.

There is potentially relevant guidance from NICE on the short-term management of violence (NHFT0004025), but this is focused on inpatients and responding to violent incidents. In relation to community settings, it states: “Health and social care provider organisations, including ambulance trusts, should consider training staff working in community and primary care settings in methods of avoiding violence, including anticipation, prevention, de-escalation and breakaway techniques, depending on the frequency of violence and aggression in each setting and the extent to which staff move between settings.” These recommendations about de-escalation and breakaway

techniques relate to responding to current violence and/or immediate threats, so this guidance is not directly relevant to the broader issues of risk assessment and management.

b. The practice of NHS Trusts. This is likely to vary considerably. I am not aware of any national surveys of risk assessment tools used in general psychiatry. I have been working with Oxford Health NHS Foundation Trust to implement OxMIV into its electronic health record platform, which was included in 2020-22, and recently re-introduced (after a change to electronic health records systems). Any implementation will require the support of senior clinical leaders. I do not know the situation in Nottingham Healthcare NHS Trust.

c. Regularity of risk assessment. I am not aware of any recent national surveys of this. In a regional survey in Oxfordshire and Buckinghamshire, this was done as a minor part of a baseline assessment in the Early Intervention in Psychosis service (WITN0320015).

d. How risk assessment is done in practice. My impression is that there is no consistent approach. There are risk tabs in structured fields in electronic health records in which free text can be added. In the above cited regional survey, clinicians used 'flags' in the records to identify concerns – no structured risk assessment was conducted.

e. Disparity between Trusts and/or between general and forensic settings. I do not know whether there is disparity between Trusts. There is a difference, however, between general and forensic settings in how risk assessment is conducted. In forensic settings, structured risk assessments, particularly the HCR-20 which benefits from first-mover advantage, are widely used, and usually repeated every 6 months in keeping with Care Programme Approach review meetings. Some forensic services supplement the HCR-20 with other risk tools, such as the START (Short-Term Assessment of Risk and Treatability). The START assesses other adverse outcomes, such as self-harm, over weeks to months but with insufficient evidence of its predictive accuracy (with no validations that met the threshold for inclusion in this recent review: WITN0388002). There is also poor evidence of its clinical impact - a cluster randomised controlled trial showed that it did not improve outcomes on discharge in the forensic units where it was added to usual practice (WITN0401028), perhaps because the extra resources required to use the START tool did not lead to improvements in risk management.

f. Importance of certain factors. I have been asked to consider the impact of various factors in risk assessment and management. Some of these are addressed above (4e). In general terms, these factors listed need to be considered as part of comprehensive clinical assessment. The factors include age, sex at birth, previous violence, family

history of violence/crime/antisocial behaviour, past and present drug misuse, past and present alcohol misuse, previous self-harm episode, not completing standard secondary school, and adherence to medication and other treatments. Other clinical factors should be considered, including the severity of the current episode, whether delusions are present, in particular persecutory ones, and if these delusions are associated with anger or other affective responses. Non-specific symptoms such as hostility should be considered. Co-occurring personality difficulties, particularly if reported or apparent before the illness onset, also need to be assessed. Balancing the benefits (to reducing risk and improving health and wellbeing) and potential harms (to therapeutic rapport and engagement) involves difficult and finely balanced decisions, which require the involvement of trained psychiatrists and, in more complex cases, the involvement of more senior psychiatrists and a multidisciplinary team.

The principle of treatment in accordance with the least restrictive option is a key part of good clinical care, and should be considered alongside comprehensively assessed risks to health, safety and others when decisions about admission to hospital and discharge are made. The reluctance to use diagnostic labels is highly problematic, in my opinion, as evidence clearly shows that diagnosis is a key consideration and prognostic factor in violence risk assessment and management. Risk factors for violence in schizophrenia and their effective management are very different to that of someone with, for example, an anxiety disorder. In relation to management, we have shown that certain antipsychotics are associated with greater reductions in violent crime risk in schizophrenia (WITN0401029), which includes clozapine and long-acting injectable antipsychotics, which would not be considered in anxiety disorders.

Questions about the implementation of the Mental Health Act are outside my particular expertise. In relation to resourcing of mental health provision, we conducted an economic analysis of the costs of violence perpetration in severe mental illness in England and Wales. This could be considered as part of policy initiatives. During 2015-16, societal costs were estimated to be £2.5 billion (which would be around £3.5 billion in today's money), with £1.4 billion costs of physical and emotional harm to victims, and around £500 million in costs to secure forensic care (WITN0075014). One key finding was the importance of reducing repeat offending (or recidivism) in people with severe mental illness on societal economic costs. Based on 2015-16 costs, 'we found that if the recidivism rate of individuals with severe mental illness was reduced to that of people without severe mental illness, the total annual cost to society from violent crime perpetrated by people with severe mental illness would be reduced from £2.5 to £1.8 billion, or a saving of £0.7 billion. This reduction underlines the importance of forensic and prison mental health services to decrease the impact of violence by reducing

recidivism among the estimated 3200 prisoners with severe mental illness at any point in England and Wales'. This saving would now be around £1 billion (after accounting for inflation).

4. Recommendations on ensuring best practice can be better disseminated and embedded. I have no specific expertise on how to disseminate best practice. Based on my clinical experience in forensic psychiatric services, a monetary incentive for services has been one driver to regularise risk assessment. Expert guidelines can assist with disseminating and embedding best practice, but developing clinical guidelines can take considerable time and often involves compromise among expert members that dilute the clarity or robustness of the recommendations. Nevertheless, in my view, the current focus in forensic services on using HCR-20 (and related tools like START) requires change, as it is based on a dated approach and, as explained above, can no longer be described as evidence-based. Newer higher quality tools should replace and/or complement structured clinical judgement instruments.

5. I have been asked to consider areas relating to assessment of risk to others in which you consider that there is a need for: (a) National training and/or guidance where there is none; (b) Greater training and/or guidance than already exists? (c) Changes to the current structures, training, or guidance to reduce the risks posed by psychiatric patients to others.

Training for clinicians working in general adult psychiatry in violence risk assessment is currently limited and should be improved. This could include regular training events on violence risk that outline the background evidence on risk factors, and how to assess and manage risk clinically, which can include clinical scenarios to consider. What currently exists are a series of ad-hoc arrangements that are not sufficient or regular. As all doctors who are in higher psychiatric training and consultant psychiatrists are members of the Royal College of Psychiatrists, this would be the best body to organise training events. Trainee psychiatrists often attend College events as they are usually affiliate members of the College. In the past few years, the College has hosted one or two national training events, but this relies on experts (who are expected to give up their time to arrange, prepare and speak at these events without remuneration) to organize and run these training events.

Thus, strengthening training nationally should be considered and the College is best placed to deliver this. This would include reviewing the curriculum for the Membership examination, also organised by the College, to strengthen knowledge and skills for the next generation of consultant psychiatrists.

6. I have been asked to consider the powers under which mental health clinicians can provide clinically indicated mental health treatment on a non-voluntary basis, and specifically consider admission for assessment and/or treatment under the MHA 1983 (s2 and s.3), the general authority under s.5 MCA 2005 and the interplay of these powers. This is not an area that I have particular expertise.

7. I have been asked to comment on the assessment of a patient's capacity to make a decision as to mental health treatment - (i) treatment generally; and (ii) depot medication in particular and when should the assessment be done and repeated, who should do the assessment and the principles that apply.

In general, it is my understanding that the principles that apply are based on the Mental Capacity Act 2005. There is a presumption of capacity, and capacity should be relevant to the decision being made. The principles in the Act around determining lack of capacity include: a person is unable to make a decision for themselves if they are unable "(a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision (whether by talking, using sign language or any other means)."

The accompanying Code of Practice provides more detailed information about how and when these capacity assessments should be made. It outlines that the Responsible Clinician (typically a consultant psychiatrist) should make the decision, which can involve discussion with the multidisciplinary clinical team. Section 4.35 outlines the times when capacity should be considered: "the person's behaviour or circumstances cause doubt as to whether they have the capacity to make a decision; somebody else says they are concerned about the person's capacity, or the person has previously been diagnosed with an impairment or disturbance that affects the way their mind or brain works (see paragraphs 4.11–4.12 above [which include mental illnesses]), and it has already been shown they lack capacity to make other decisions in their life" (NHSE0000343). I agree with the Code's recommendations about these issues and think that they are applicable to long-acting injectable antipsychotic (depot) medication, where the same principles apply as they would for any other medications. Thus, an understanding of the benefits and risks of depot medication, alternatives (i.e. oral medications and possibly clozapine in treatment-resistant persons), and the reason why depot is recommended would be part of a capacity assessment.

In relation to timing, applying the Code suggests that a capacity assessment would be done on first assessment, when there is a clear change in mental state (e.g. deterioration or relapse, including leading to hospitalization) or circumstances. Being arrested by the police or becoming homeless would constitute a change in circumstances in my view.

8. I have been asked to the implications of treatment capacity in relation to four scenarios: (a) a patient with a diagnosis of schizophrenia does not recognise that they have a mental illness.

The assessment of capacity would need to consider other aspects of their mental state apart from insight. However, insight on its own would likely impair a person's understanding of the information relevant to the decision. If they thought that they had a physical illness (e.g. a brain disease) and that depot medication would treat this, it is possible that someone could have the relevant capacity.

b. a patient with a diagnosis of schizophrenia that does not recognise that depot medication would be of any benefit to them;

In my view, if they felt that the medication would harm them, this patient would not understand the rationale for treatment, and hence would not have capacity. If this individual felt that there were no harms or benefits with having depot medication, then other aspects of their mental state would need to inform capacity decisions.

c. a patient that declines depot medication because they have paranoid delusions as to what the purpose and outcome of taking the medication would be;

In this scenario, it is my opinion that this person does not have capacity. Capacity requires an understanding (that is not delusional) of the rationale for treatment.

d. a patient declines depot medication with insight into their condition.

Insight into their condition on its own is not sufficient for capacity. There needs to be insight into the need for treatment, understanding of the risks and benefits of the

recommended treatment, and being able to communicate that decision. I consider the latter criterion to include consistency in their communication of a decision; in other words, that someone does not change their decision over a short period of time (such as every few hours) without a change in circumstances.

9. I have been asked to provide an opinion from a psychiatric perspective as regards the use of relevant powers in the following scenarios:

a. A patient with schizophrenia in the community, without capacity as regards mental health treatment, declines to (i) engage with mental health services; or (ii) take depot medication, and who poses a risk of imminent harm to the public or themselves if they do not take the medication.

In my view, this person should be assessed under the provisions of the Mental Health Act. They are suffering from a mental disorder (schizophrenia) of a nature (chronicity if there is information about the course of illness) and degree (lack of insight, and possibly other symptoms) which warrants detention for assessment or treatment, in the interests of their health and safety (imminent risk to the public or themselves). It is likely that detention will be necessary for assessment or treatment, and that community-based measures will not succeed (particularly if they refuse to take medication).

b. A patient with schizophrenia in the community, without capacity as regards mental health treatment, declines to (i) engage with mental health services; or (ii) take depot medication, and who poses a risk of future but not imminent harm (ie: a number of weeks or months away) to the public or themselves if they do not take the medication now or consistently.

More information is required to make an informed decision in this scenario. This would include whether this person has previously relapsed when they have not taken medication, and, if so, how quickly, and whether any deterioration/relapse was associated with increased risks. If a previous episode of non-adherence was associated with a clear deterioration, and this led to risks to the public or themselves, then it is my view that they should be assessed under the provisions of the Mental Health Act. Imminence is not explicitly part of the Act's criteria, but the more imminent the risk is, the easier it is to justify detention if challenged. There are emergency alternatives if there is an 'urgent and immediate' need (see Code of Practice), which can be used when

inpatients wish to leave hospital (Section 5(2) or Section 5(4) holding powers) and by the police in community settings (Section 136). However, Section 4 (emergency admission, requiring two assessors, one doctor and one approved mental health professional) is very rarely used in my experience. Furthermore, part of the consideration of risk to themselves include self-neglect, victimization, and exploitation by others.

c. A patient with schizophrenia in the community, with capacity as regards mental health treatment, that declines to (i) engage with mental health services; or (ii) take depot medication, and who poses a risk of imminent harm to the public or themselves if they do not take the medication.

I think this person should be considered as per (a) above despite having capacity to consent to treatment. The criteria for consideration under the provisions of the Mental Health Act remain – they have a mental condition of a nature or degree, detention is necessary for their safety or that of others, and necessary for further assessment or treatment. Further assessment needs to consider if their refusal to take medication is driven in part by an abnormal mental state and the need for treatment should consider if other symptoms are present or partially treated. Further, alternatives in the community may not be available if the risks are imminent.

d. A patient with schizophrenia in the community, with capacity as regards mental health treatment, that declines to (i) engage with mental health services; or (ii) take depot medication, and who poses a risk of future but not imminent harm (ie: a number of weeks or months away) to the public or themselves if they do not take their medication now or consistently.

With more information, this person should be considered for detention under the provisions of the Mental Health Act as they may meet criteria. In my view, non-imminence is not as relevant as the effects of non-adherence on their mental state and risk (see b above).

10. I have been asked to consider the above four scenarios but in circumstances where a patient is being detained whether for assessment or treatment under the MHA 1983 and discharge is being considered. In addition, I have been asked to comment upon the powers and use of a Community Treatment Order.

It is my view that a Community Treatment Order (CTO) would be appropriate for (a) and (c). The core criteria appear to be met – in relation to mental disorder of a nature or degree, and necessity in the interests of health, their safety or that of others. There is an implicit least-restrictive alternative consideration.

In addition, a CTO should be considered for scenario (b), although more information is required to inform the decision. Scenario (d) is the most difficult to consider as this will apply to many patients, and there are resource implications that will inevitably come into a decision to consider a CTO. It is my view that evidence-based risk assessment tools can inform resource allocation. Otherwise, such decisions are made by clinicians in ways lacking transparency (i.e. subjective judgement), consistency (potentially exacerbating inequalities), and liable to cognitive biases (such as availability and recency bias). In such patients, a history of violence should be a more important consideration of risk than recent inpatient behaviour. But clinicians, if relying on subjective judgement, will likely weigh inpatient behaviour and insight highly. In relation to consistency, a qualitative study that examined the responses of 18 clinicians to two clinical risk scenarios found poor consistency in violence risk estimation (WITN0320015): “Clinicians found evaluating risk difficult, saying it felt subjective and lacked a formal basis, relying upon pattern-recognition and clinical instinct. This subjectivity was reflected in responses to the clinical vignettes... There was no consistent view on which scenario was more concerning, which varied according to whether more weight was placed on resistance to input from services, or history of violence.”

11. I have been asked to comment on the following scenario: “If a patient who suffers from psychosis is concerned about taking depot medication because of a general fear of injections, are there any other lawful powers or approaches that could be taken to ensure that the medication is given in circumstances where clinicians are concerned that the patient, without the medication poses (i) a risk of imminent harm to the public or themselves if they do not take the medication; or (ii) the patient poses a risk of future but not imminent harm to the public or themselves if they do not take the medication now or consistently.”

This is a complex scenario that requires the involvement of an experienced clinician. More information should be sought about severity of the fear, previous evidence about injections, and whether the fear has been mitigated in the past and how. My clinical experience is that, for some people, these fears can be addressed with psychoeducation, in others with additional short-term anti-anxiety medications, and in

some individuals, their reported fear is not consistent with previous documented injections. More formal treatments, such as exposure therapy or an adapted form of cognitive behaviour therapy, can be considered for those with a clear-cut needle phobia. Such treatments are administered by clinical psychologists.

12. I have been asked to comment on, in situations where clinicians are concerned about risk to others or themselves, whether clinicians can inform third parties, such as the police, probation, family of the patient, or potential victims of violence.

It is my view that all these third parties can be informed, and it is not different if the patient is in detention or in the community. The principle of best interests would apply for the patient. This is clear if the risks are primarily towards themselves. But they also apply in relation to others in that prevention of future violence is highly relevant to prognosis, and being arrested or detained in custody will disrupt care and support in the community, and thus increase risks of further deterioration to mental health. I do not think that this differs if the patient is subject to a CTO or it is suspected that the patient lacks capacity to take decisions about their healthcare or medication. I do not consider that this would differ if it were known that the patient's capacity has not been assessed for some time. However, I think that the threshold to inform third parties will be lower if the patient has previously been reported to the police for alleged offences arising from acts of aggression, intimidation or violence. The principle of public interest (see below) also applies when the risks are primarily towards others.

I have also been asked to comment on whether clinicians have any legal or regulatory duty to do so, or whether the same indicated by any guidance or best practice that you are aware of.

It is my understanding that it is considered best practice and covered in guidance, including GMC guidance on confidentiality that explicitly permits disclosure to the police and other agencies even if a patient refuses consent. The underlying principle is that of public interest. The latest GMC guidance (published in 2017, updated in 2024) states: "Confidential medical care is recognised in law as being in the public interest. The fact that people are encouraged to seek advice and treatment benefits society as a whole as well as the individual. But there can be a public interest in disclosing information if the benefits to an individual or society outweigh both the public and the patient's interest in keeping the information confidential. For example, disclosure may be justified to protect individuals or society from risks of serious harm, such as from serious communicable diseases or serious crime." (NUHT0000044). The relevant section reads: "If it is not

practicable or appropriate to seek consent, and in exceptional cases where a patient has refused consent, disclosing personal information may be justified in the public interest if failure to do so may expose others to a risk of death or serious harm. The benefits to an individual or to society of the disclosure must outweigh both the patient's and the public interest in keeping the information confidential. Such a situation might arise, for example, if a disclosure would be likely to be necessary for the prevention, detection or prosecution of serious crime, especially crimes against the person. When victims of violence refuse police assistance, disclosure may still be justified if others remain at risk, for example from someone who is prepared to use weapons, or from domestic violence when children or others may be at risk."

I am not an expert in the common law position, which I do not think is considered by medical doctors in the scenario outlined.

13. What is the position as regards sharing medical or other personal information with the nearest relative and/or family where a patient withdraws consent for this information to be shared? What is the position if a patient withdraws consent but (i) is deemed to lack capacity as regards that issue at the time of the purported withdrawal; (ii) has capacity at the time of withdrawal but is later assessed to lack capacity to determine their mental health treatment?

It is my view that the same principle of public interest applies here, and the above guidance covers relatives and/or family. It is my understanding that the public interest duty overrides patient consent, and thus this guidance applies even if a patient does not provide or withdraws consent. If a person lacks consent, and asks a doctor not to share information, it is possible that an independent mental health advocate has been appointed, who can represent them. In practice, I am not sure that this is feasible due to resource constraints.

The GMC guidance (op. cit.) also covers a different aspect in relation to gathering information about a patient as part of their care: "You might need to share personal information with a patient's relatives, friends or carers to enable you to assess the overall benefit to the patient. But that does not mean they have a general right of access to the patient's records or to be given irrelevant information about, for example, the patient's past healthcare."

14. I have been asked to set out, and compare and contrast, the legal processes, powers and obligations as regards the discharge of patients that are (i) detained under Part II of the Act; and (ii) are detained under Part III of the Act?

In brief, those detained under Part II of the Act can be discharged informally or with conditions set in a CTO (which can include attending appointments with community mental health services, taking prescribed medication, residing at an approved address, or other specified conditions such as abstaining from illegal drugs). Failure to comply with CTO conditions can lead to recall to hospital and possible re-admission under Section 3 if criteria are met. A patient can refuse treatment if informal, and has the right to apply for a tribunal to review conditions.

In those detained under Part III of the Act, this partly depends if they are subject to a Restriction Order or not. If they are not, discharge is absolute and the patient becomes informal. There are no recall powers once discharge occurs, and engagement with community mental health services is voluntary. If a patient is a restricted patient, then there are patient obligations which are legally enforceable. These can include residence at an approved address, attending mental health appointments in the community, adherence to treatment (which can include depot medication), restrictions to travel or people to contact, and reporting requirements. The Ministry of Justice can recall someone to hospital at any time, without new medical recommendations, when there are concerns about mental health, risk, or a breach of conditions. Patients have a right to appeal a recall. It is my understanding that the Tribunal cannot revoke a Restriction Order once it has been imposed at sentencing, which can only be done by the Secretary of State.

One important piece of evidence, not widely known, in relation to powers relates to reoffending rates in those detained under Part III. In Part III, there are official statistics from the Ministry of Justice, which indicate a very low rate of reoffending – over a 6-year period from 2016/17, this is around 0.4% reoffending risk (assuming a population of up to 400 restricted patients residing in the community. The official findings are: “In 2016/17, four restricted patients committed an indictable reoffence in the 12 months after discharge, equivalent to an indictable proven reoffending rate of 1.1%. In each of the following 2017/18, 2018/19, 2019/20 and 2021/22 annual cohorts, one restricted patient committed at least one indictable reoffence in the 12-month follow-up period. This equates to an indictable proven reoffending rate of 0.3% for each of these cohorts (note for 2020/21 no restricted patients committed an indictable reoffence)” (See

Annex A: WITN0401030). This has not been updated by the Ministry of Justice and should be in my view.

This is a substantially lower reoffending rate for indictable offences than any equivalent population, even accounting for age and offence type, and strongly suggests that supervisory framework associated with a Restriction Order reduces serious reoffending. Indictable offences are serious crimes, tried in the Crown Court, and typically involve violence towards other persons.

15. What recommendations do you think the Chair of this Inquiry should make to ensure lessons are learned and to prevent similar attacks in the future?

- i. Evidence-based, UK-validated, and scalable risk assessment tools should be incorporated as part of standard clinical care into general adult psychiatric assessment, at first assessment and when there is an escalation of risk.
- ii. The Royal College of Psychiatrists should strengthen the curriculum on violence risk assessment and management as part of their Membership examination.

16. What improvements could be made locally and nationally to multi agency working to increase effectiveness in preventing similar outcomes in the future?

- i. Discharge to primary care should not be considered unless risks of violence and suicide have been considered by the multidisciplinary team.
- ii. Information on previous violence and crime should be routinely requested by psychiatric teams of the police when there is reasonable suspicion.
- iii. When serious interpersonal violence has come to the attention of the police or clinical team, pursuing criminal charges should be considered the default approach (rather than dropping charges).

*I believe the content of this statement to be true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.*

**GRO-B**

Signed:

**Professor Seena Fazel BSc (Hons), MBChB, FRCPsych, MD  
Professor of Forensic Psychiatry and Honorary Consultant Forensic Psychiatrist  
University of Oxford and Oxford Health NHS Foundation Trust**

**Dated: 22 February 2026**

**Index to Expert Report of Professor Seena Fazel**

No.	Inquiry URN	Document Description
1	WITN0401002	Fazel et al, Risk factors for interpersonal violence: an umbrella review of meta-analyses, <i>Br J Psychiatry</i> 2018
2	WITN0401003	Whiting et al, Violence and mental disorders: a structured review of associations by individual diagnoses, risk factors, and risk assessment, <i>Lancet Psychiatry</i> 2021
3	WITN0401004	Sariaslan et al. Risk of Subjection to Violence and Perpetration of Violence in Persons With Psychiatric Disorders in Sweden, <i>JAMA Psychiatry</i> 2020
4	WITN0401031	Ceraso A, LIN JJ, Schneider-Thoma J, Sifakis S, Tardy M, Komossa K, Heres S, Kissling W, Davis JM, Leucht S. Maintenance treatment with antipsychotic drugs for schizophrenia. <i>Cochrane Database of Systematic Reviews</i> 2020, Issue 8. Art. No.: CD008016, pages 28 and 217
5	NHSE0002731	Daniel Whiting, BM, BCh; Gautam Gulati, MD; John R. Geddes, MD and others, Re: Association of Schizophrenia Spectrum Disorders and Violence Perpetration in Adults and Adolescents From 15 Countries A Systematic Review and Meta-analysis, <i>JAMA Psychiatry</i> 2022;79(2): 120-132
6	WITN0401005	Arseneault et al, Mental Disorders and Violence in a Total Birth Cohort Results From the Dunedin Study, <i>Arch Gen Psychiatry</i> , 2000;57;(10):979-986.
7	WITN0401006	Whiting, D., Gulati, G., Geddes, J.R., Dean, K. and Fazel, S. (2024), Violence in schizophrenia:

		triangulating the evidence on perpetration risk. <i>World Psychiatry</i> , 23: 158-160
8	WITN0401007	Whiting et al, Associating Violence With Schizophrenia—Risks and Biases—Reply, July 2022, <i>JAMA Psychiatry</i> 79(7):739-740
9	WITN0378026	Coid, J. W., Ullrich, S., Kallis, C., Keers, R., Barker, D., Cowden, F., & Stamps, R. (2013). The relationship between delusions and violence: Findings from the East London first episode psychosis study. <i>JAMA Psychiatry</i> , 70(5), 465–471. <i>JAMA Psychiatry</i> , 2013 May;70(5):465-71.
10	WITN0401008	Lambe S, Cooper K, Fazel S, Freeman D. Psychological framework to understand interpersonal violence by forensic patients with psychosis. <i>The British Journal of Psychiatry</i> . 2024;224(2):47-54
11	WITN0320014	Lagerberg et al. Systematic review of risk factors for violence in psychosis: 10-year update, <i>Br J Psychiatry</i> , 2025 Feb;226(2):100-107.
12	WITN0401009	Wolf A, Gray R, Fazel S. Violence as a public health problem: an ecological study of 169 countries. <i>Soc Sci Med</i> . 2014 Mar;104(100):220-7
13	WITN0401010	Edward Silva, The HCR-20 and violence risk assessment – will a peak of inflated expectations turn to a trough of disillusionment? <i>BJPsych Bull</i> . 2020 Dec;44(6):269–271
14	WITN0320015	Whiting et al., Approaches and challenges to assessing risk of violence in first episode psychosis: A qualitative interview study of clinicians, patients and carers, <i>Early Intervention in Psychiatry</i> . 2024;18:624–632.

15	WITN0401011	Lamsma et al., Use of illicit substances and violent behaviour in psychotic disorders: two nationwide case-control studies and meta-analyses, <i>Psychol Med.</i> 2020 Sep;50(12):2028-2033
16	WITN0401012	Witt et al, Improving risk assessment in schizophrenia: epidemiological investigation of criminal history factors, <i>Br J Psychiatry.</i> 2015 May; 206(5):424–430
17	WITN0401013	Viljoen et al. (2025). Are risk assessment tools more accurate than unstructured judgments in predicting violent, any, and sexual offending? A meta-analysis of direct comparison studies. <i>Behavioral Sciences &amp; the Law</i> , 43(1), 75–113
18	WITN0401014	Whiting et al, Use of a violence risk prediction tool (Oxford Mental Illness and Violence) in early intervention in psychosis services: mixed methods study of acceptability, feasibility and clinical role. <i>The British Journal of Psychiatry.</i> 2026;228(2):140-149
19	WITN0401015	Singh et al, Structured Assessment of Violence Risk in Schizophrenia and Other Psychiatric Disorders: A Systematic Review of the Validity, Reliability, and Item Content of 10 Available Instruments, <i>Schizophrenia Bulletin</i> , Volume 37, Issue 5, September 2011, Pages 899–912
20	WITN0388002	Ogonah et al. Violence risk assessment instruments in forensic psychiatric populations: a systematic review and meta-analysis. <i>Lancet Psychiatry.</i> 2023 Oct;10(10):780-789
21	WITN0401016	Whiting D, Mallett S, Lennox B, Fazel S. Assessing violence risk in first-episode psychosis: external validation, updating and net benefit of a prediction tool (OxMIV). <i>BMJ Mental Health.</i> 2023;26:e300634

22	WITN0401017	Negatsch V, Voulgaris A, Seidel P, Roehle R, Opitz-Welke A. Identifying Violent Behavior Using the Oxford Mental Illness and Violence Tool in a Psychiatric Ward of a German Prison Hospital. <i>Front Psychiatry</i> . 2019 Apr 23;10:264
23	WITN0401018	Krebs et al, Applicability of two violence risk assessment tools in a psychiatric prison hospital population, <i>Behavioral Sciences &amp; the Law</i> (2020) Pages 471-481
24	WITN0401019	Lamsma J, Yu R, Fazel S; Genetic Risk and Outcome of Psychosis (GROUP) investigators. Validation and recalibration of OxMIV in predicting violent behaviour in patients with schizophrenia spectrum disorders. <i>Sci Rep</i> . 2022 Jan 10;12(1):461
25	WITN0401020	Beaudry G, Canal-Rivero M, Ou J, Matharu J, Fazel S, Yu R. Evaluating the Risk of Suicide and Violence in Severe Mental Illness: A Feasibility Study of Two Risk Assessment Tools (OxMIS and OxMIV) in General Psychiatric Settings. <i>Front Psychiatry</i> . 2022 Jun 30;13:871213
26	WITN0401021	Seena Fazel, Giulio Scola, Violence Risk Assessment: Using the Oxford Mental Illness and Violence Tool, <i>Psychiatric Times</i> November 19, 2024 Vol 41, Issue 11
27	WITN0401022	Singh JP, Fazel S, Gueorguieva R, Buchanan A. Rates of violence in patients classified as high risk by structured risk assessment instruments. <i>Br J Psychiatry</i> . 2014 Mar;204(3):180-7
28	WITN0401023	Jeandarme, I., Pouls, C., De Laender, J., Oei, T. I., & Bogaerts, S. (2017). Field validity of the HCR-20 in forensic medium security units in

		Flanders. <i>Psychology, Crime &amp; Law</i> , 23(4), 305–322.
29	WITN0401024	Ho, H., Thomson, L., & Darjee, R. (2009). Violence risk assessment: the use of the PCL-SV, HCR-20, and VRAG to predict violence in mentally disordered offenders discharged from a medium secure unit in Scotland. <i>The Journal of Forensic Psychiatry &amp; Psychology</i> , 20(4), 523–541.
30	WITN0401025	Vojt, G., Thomson, L. D. G., & Marshall, L. A. (2013). The predictive validity of the HCR-20 following clinical implementation: does it work in practice? <i>The Journal of Forensic Psychiatry &amp; Psychology</i> , 24(3), 371–385. <a href="https://doi.org/10.1080/14789949.2013.800894">https://doi.org/10.1080/14789949.2013.800894</a>
31	WITN0401026	John Tully, HCR-20 shows poor field validity in clinical forensic psychiatry settings, <i>Evid Based Ment Health</i> . 2017 Jul 14;20(3):95–96
32	NHFT0015099	Assessment and management of risk to others, Royal College of Psychiatrists
33	WITN0401027	Training webpage on Risk assessment and management of violence in general adult psychiatry, Royal College of Psychiatrists Learning Hub
34	NHFT0004025	Violence and aggression: short-term management in mental health, health and community settings, National Institute for Health and Care Excellence (NICE)
35	WITN0401028	Troquete NAC, van den Brink RHS, Beintema H, et al. Risk assessment and shared care planning in out-patient forensic psychiatry: cluster randomised controlled trial. <i>British Journal of Psychiatry</i> . 2013;202(5):365-371
36	WITN0401029	Sariaslan A, Leucht S, Zetterqvist J, Lichtenstein P, Fazel S. Associations between

		individual antipsychotics and the risk of arrests and convictions of violent and other crime: a nationwide within-individual study of 74 925 persons. <i>Psychological Medicine</i> . 2022;52(16):3792-3800
37	WITN0075014	Senior M, Fazel S, Tsiachristas A. The economic impact of violence perpetration in severe mental illness: a retrospective, prevalence-based analysis in England and Wales. <i>Lancet Public Health</i> . 2020 Feb;5(2):e99-e106
38	NHSE0000343	Mental Capacity Act 2005 Code of Practice
39	NUHT0000044	Confidentiality: good practice in handling patient information, General Medical Council
40	WITN0401030	Ministry of Justice Statistics, Annex A: Proven reoffending rates for restricted patients statistics, 2016/17 to 2021/22