

Witness Name: Prof. Timothy Kendall

Statement No.: WITN0076001

Dated: 11 November 2025

NOTTINGHAM INQUIRY

**FIRST WITNESS STATEMENT OF
PROFESSOR TIMOTHY JAMES GREAVES KENDALL**

I, Professor Timothy James Greaves Kendall, National Clinical Lead for New Models of Mental Health in NHS England, 133-135 Waterloo Road, London, SE1 8UG, will say as follows:

I would like to emphasise that my thoughts and feelings go out to those affected by the tragic deaths and the injuries sustained, and for the loss and anguish of those affected by the events within this Inquiry.

STATEMENT OVERVIEW

1. I make this statement in response to the Nottingham Inquiry's Rule 9 request to me dated 26 August 2025.
2. This statement is structured as follows:
 - a. **Section 1** provides an overview of my professional background.
 - b. **Section 2** considers chronic schizophrenia and the risk to the public.
 - c. **Section 3** outlines the transformation of mental health including details of the 24/7 Neighbourhood Mental Health Centre Programme.
3. Throughout this statement I have set out my reflections.

SECTION 1: MY PROFESSIONAL BACKGROUND

4. I am NHS England's National Clinical Lead for New Models of Mental Health, a role that I have held since 2023. In this position I am an adviser to NHS England. I work with colleagues throughout NHS England and I report to NHS England's Deputy Director of Mental Health, Learning Disability and Autism Quality.

5. I have worked with people with psychosis, including people with chronic schizophrenia, throughout my career.
6. I have been a consultant psychiatrist in Sheffield since 1992, and was a consultant psychiatrist for the homeless at Sheffield Health and Social Care NHS Foundation Trust ("**SHSCFT**") until earlier this year. I am now a consultant to a neighbourhood mental health service in Gleadless and Heeley in Sheffield.
7. Between 2016 and 2023, I was the National Clinical Director for Mental Health ("**NCD for MH**") at NHS England. National Clinical Directors provide clinical leadership, advice and support to NHS England and advise government departments and ministers. I reported to NHS England's National Medical Director.
8. As the NCD for MH, I provided advice across the NHS, which led to the modernisation of mental health and increased funding for mental health services in England by £3.3 billion per year (£1 billion as part of the Five Year Forward View for Mental Health [**NHSE0000002**], and £2.3 billion a part of the NHS Long Term Plan [**NHSE0000014**]). This included (but was not limited to) investment into community mental health for adults and children with the full range of mental health problems. For example, the following services were transformed: eating disorders, early intervention in psychosis ("**EIP**"), perinatal mental health, crisis and home treatment teams, and liaison (accident and emergency) teams.
9. As Founding Director of the National Collaborating Centre for Mental Health ("**NCCMH**"), I led the development of more than 30 National Institute for Health and Care Excellence ("**NICE**") guidelines between 2001 and 2016.

10. I chaired the first NICE guideline on the management of Schizophrenia (2003) **[NHSE0002388]**, which was evaluated by the WHO as the world's best guideline on schizophrenia (2005) **[NHSE0002437]**.
11. I have also been the lead in respect of the:
 - a. first National Quality Standard (Dementia);
 - b. update and expansion of the Psychosis and Schizophrenia guideline twice **[NHSE0002619]** **[NHSE0000539]**;
 - c. development of the NICE guideline on the management of Psychosis and Schizophrenia in children and young people **[NHSE0002730]**; and
 - d. development of the NICE guideline on psychosis and coexisting substance misuse **[NHSE0002384]**.
12. In each case, my role has been to facilitate a guideline development group or committee and lead them through the NICE process. This included leading a team of research scientists to undertake the systematic review, meta-analysis and synthesis of evidence worldwide and to help the committee make recommendations based on the evidence we presented to them.
13. Now, as International Director at NCCMH, I have consulted to a diverse range of governments and institutions, including those in Turkey, Georgia, Qatar, South Korea, California, Finland, Sweden, Germany, Denmark, Netherlands and China.
14. I developed and hosted the first Global Ministerial Summit in Mental Health in London in 2018. I have been a member of the steering group at each

subsequent summit, including Amsterdam, Paris, Rome, Buenos Aires and, this year, in Qatar.

15. Other relevant roles include:
 - a. the chair of the board of Centre for ADHD Research & Excellence Ltd since April 2024; and
 - b. since October 2024, a member of the board of the Healthy Brains Global Initiative, an international mental health charity.

16. Between April 2003 and March 2016, I was the Medical Director at SHSCFT. During my time as Medical Director I:
 - a. set up a service user experience monitoring unit;
 - b. reconfigured acute care and rehabilitation leading to the elimination of all out of area placements for a period of 10 years;
 - c. led the modernisation of the acute and crisis care pathways;
 - d. commissioned the first crisis house in Sheffield; and
 - e. initiated the development of NICE recommended personality disorder services within the community.

17. I have also previously worked as a psychoanalytical psychotherapist, working with people with psychosis and other severe mental ill-health (1992 to 2012), and as a consultant psychiatrist in an acute day hospital as an alternative to hospital admission in Sheffield (Southern Acute Day Hospital) from 1992 to 2003.

18. I have been Visiting Professor at University College London for the last 15 years, and an Honorary Professor of Mental Health at the University of Sheffield since October 2022.
19. I am a fellow of the Royal College of Psychiatrists (elected 2008). Between 2001 and 2025, I was a co-opted member of the Council of the Royal College of Psychiatrists.
20. I am a medical doctor with a Bachelor of Medicine, a Bachelor of Surgery, and a Bachelor of Medical Science (Physiology and neurochemistry) having graduated from the University of Sheffield in 1983. I was conferred with two honorary doctorates (Open University 2019; University of Sheffield 2020). I was awarded a CBE in the New Year Honours list in 2024 for services to mental health.
21. I have published widely, and I was awarded the 2004 Lancet Paper of the Year Award for showing the impact of selective publishing by the drug industry about antidepressants in the treatment of childhood depression; and with others was awarded the Paper of the Year Award for the Health Economic Journal 'Value in Health' in 2012 for work on schizophrenia.

SECTION 2: CHRONIC SCHIZOPHRENIA

22. Without treatment, people who have been diagnosed with chronic schizophrenia struggle to govern their own behaviour in any consistent way. For example, they will find it challenging to form, or sustain, trusting relationships with professionals, or with their relatives and friends.

23. This typically means that many people with chronic schizophrenia have chaotic lives and are unable to care for themselves adequately or to comply with usual social rule governed processes and institutions, such as claiming benefits, paying rent and attending medical appointments. They are, instead, preoccupied by their inner mental life, including delusions (strongly held beliefs that no one else holds) and hallucinations (usually auditory, often insulting and may be multiple and often, but not always, experienced as omnipotent). They often believe they specifically, rather than anyone else, are being persecuted by other people or groups, and/or being controlled by outside forces that make them do things that they would not usually do if it was not for their illness.
24. When treated, and with the right support, people with chronic schizophrenia can live a relatively normal life. Long term follow up studies suggest that about 70% of people with schizophrenia do very well, with 50% achieving continuous remission and a further 20% having stable improvement **[NHSE0002726]**. Only about 10% of people with schizophrenia have continuous severe symptoms **[NHSE0002453] [NHSE0002726]**.
25. Recovery and improvement seem to be promoted best by long term engagement with modern community-based treatment programmes which promote independence, have access to talking therapies and encourage work. Prolonged hospitalisation, especially without an intensive treatment programme, appears to do the opposite.
26. However, many people with schizophrenia do not want to have drug treatment. This is because they do not like the side effects of antipsychotics **[NHSE0002393]**, which are common and sometimes quite debilitating in

themselves, especially in terms of obesity and movement disorders [NHSE0002729], including the symptoms of Parkinson's disease [NHSE0002439]. Therefore, it is especially important when working with people with schizophrenia that the use of medication is done carefully, as recommended in the NICE guidelines on psychosis and schizophrenia, to minimise the risk of discontinuation of treatment (i.e., as an individual therapeutic trial). All treatment should be subject to shared decision making.

27. People with chronic schizophrenia can also respond to psychological treatments, including family therapy, which reduces relapse rates. Cognitive behavioural therapy for psychosis also improves symptoms and functioning. These therapies are available in EIP services. Unfortunately, when patients are discharged from EIP services back to standard community mental health teams ("CMHT") at the end of three years, access to these therapies becomes more difficult. CMHTs do not have easy access to the above therapies, and as a result, people returning to standard CMHTs after three years in an EIP service may lose the improvements they gained within a year.
28. A key element of working with people with chronic schizophrenia is to develop trusted relationships with continuity of care. It is also important to work assertively with them when signs of relapse or disengagement develop. Working with their family and friends is also important, as families often do not understand schizophrenia or associated treatments.
29. Disengaged, untreated and previously violent patients need to be re-engaged quickly, and in my view, should not be discharged until they are adequately re-engaged, stable and taking treatment.

30. It is also my opinion, but this is not specified in the NICE guidelines, that it is very important to be encouraging, engaging, supportive, compassionate, kind and persuasive when needed. The trusted relationship built up over time becomes ever more important when people relapse or begin to disengage.

Risk of harm

31. A number of people with schizophrenia spectrum disorders ("**SSD**"), a broader diagnostic grouping of predominantly psychotic disorders, which includes schizophrenia and schizotypal personality disorder, may, as a result of their illness, hurt themselves or harm others.

Self harm and suicide

32. About 30% of people with SSD will harm themselves in their lifetime **[NHSE0002727] [NHSE0002410] [NHSE0002391]**. For people with schizophrenia/schizophrenia related conditions, estimates vary between about 11% and 49%, although studies of different sub-populations differ considerably. For example, studies of people with schizophrenia (about 11%), with schizophrenia spectrum disorder (about 30%), people in early psychosis (about 18%), people in the period before psychosis (At Risk or Ultra High Risk states may reach nearly 50%) will give different results.
33. There is general agreement that self-harming behaviour in people with schizophrenia are above rates in the general adult population, which is typically less than 5% **[NHSE0002724][NHSE0002472]**. Between 5% and 10% of people with schizophrenia will die by suicide **[NHSE0002390] [NHSE0002399]**.

34. It is impossible to reliably or accurately predict who amongst people with schizophrenia will go on to die by suicide. This equally applies to the general population. For example, if someone in the general population has self-harmed, they are around 50 times more likely to die by suicide in the year after having self-harmed than those who have not self-harmed [NHSE0002725]. The factors associated with going on to die by suicide are prior history of self-harm, being male, having a physical health problem and/or suicidal intent. These are all very common amongst people with schizophrenia. However, as many more people self-harm than die by suicide, and as there are no other factors we know of that will help us to easily identify which of those who have self-harmed will die by suicide, we cannot predict reliably.

Risk of harm to others

35. It is important to recognise that most people with schizophrenia do not pose any danger to the public. People with schizophrenia are far more likely to be subject to violence than to perpetrate violence against others.
36. However, people with schizophrenia appear to have a higher risk of violence towards others than in the general population [NHSE0002438]. The difficulty with the data in this area is that studies tend to be of much broader groups, such as people with SSD, rather than solely those with schizophrenia.
37. The risks of violence is increased if the person [NHSE0002413] [NHSE0002731]:
- a. is not taking appropriate medication;

- b. has a substance misuse problem including alcohol intoxication or excessive use of drugs/alcohol;
 - c. has disengaged from services;
 - d. is living in disadvantaged circumstances;
 - e. is male; and/or
 - f. if they have a history of violence.
38. People with schizophrenia are also more likely than people in the general population to kill someone [NHSE0000483]. However, the overall risk of being killed by someone with schizophrenia remains very low.
39. Studies estimate that less than 6% of homicides are by people with schizophrenia. Where a homicide is committed by a person with schizophrenia the victim is usually a relative or someone known to them; they are rarely a stranger [NHSE0002389]. It is, however, impossible to predict who will go on from being violent to others to becoming a killer. Even if any, or all, of the risk factors set out above exist; these are too common to have reliable predictive value [NHSE0002413] [NHSE0002731].
40. When people with schizophrenia are engaged with treatment in mental health services, and are not using drugs or alcohol, the risk of them killing someone is generally reduced.

SECTION 3: MENTAL HEALTH TRANSFORMATION

41. In 2022, when I was the NCD for MH, I was invited to appear before NHS England's board meeting in public, along with my colleague and the then

National Director of Mental Health, Claire Murdoch, following the airing of two documentaries about inpatient services in Manchester and in Essex [NHSE0002451]. In those documentaries, patients had been humiliated and abused by staff which, unknown to staff, had been recorded. There was a public outcry about how appallingly these very vulnerable patients had been treated in mental health services.

42. NHS England's board wanted to understand how, and why, these two hospitals had developed cultures which allowed this to happen, and whether we could assure the board that this would not happen again. We agreed to look at new models for caring for people, especially for those with serious mental illness, which includes schizophrenia, both in hospital and community settings.
43. We believed we had two major problems with services:
 - a. too much dependence on an institutional or hospital response, which is experienced negatively and tends not to be therapeutic to people with serious mental illness, especially people in crisis; and
 - b. a fragmented community response, in which people are excluded from community teams because they do not fit specific inclusion criteria and are passed around from team to team, preventing continuity of care and the creation of trusted relationships. They are often discharged if they fail to engage with services. For context, in any area in England there is likely to be around 13 separate community mental health teams: Primary Care Mental Health teams, NHS Talking therapies, CMHT, Home Treatment Teams, crisis teams, assertive community treatment teams, community rehabilitation teams, EIP teams, community eating disorder teams,

perinatal mental health teams and more. Each team will have its own inclusion and exclusion criteria.

44. We developed two programmes of work to begin to address these deep structural problems in mental health services:
 - a. the culture of care programme, a national quality improvement programme aimed at transforming the culture of inpatient services, specifically to reduce the use of force and coercion and to support a compassionate and respectful approach to care making the experience of inpatient care better [NHSE0000035]; and
 - b. the 24/7 Neighbourhood Mental Health Centres programme, described below.

The 24/7 Neighbourhood Mental Health Centre Programme

45. The 24/7 Neighbourhood Mental Health Centre Programme (the "**Programme**") aims to test a new way of supporting people experiencing mental illness, including serious mental illness such as schizophrenia.
46. The Programme is testing the 'Neighbourhood Mental Health Centre' ("**Mental Health Centres**") model which is recognised by the World Health Organisation as central to the most advanced, community-based mental health care systems in the world [NHSE0002421] [NHSE0002422]. The 24/7 Neighbourhood Mental Health Centres build upon the work of NHS England's Community Mental Health Framework for Adults and Older Adults [NHSE0000015].
47. The early implementers are at different stages of development, but they are all aiming to deliver, or are actually delivering, open access neighbourhood mental

health centres covering a population of 30,000 to 50,000. The services are/will be open 24 hours a day, 7 days a week.

48. The Programme is aligned with the reforms of mental health law: choice and autonomy, least restrictive approach, therapeutic benefit and treating the person as an individual before treating them as a patient.

Mental Health Centres

49. Mental Health Centres are rooted in local neighbourhoods. They represent a shift towards a single integrated neighbourhood team with a unified holistic care model, bridging the gap between primary and secondary care as well non-health services (such as those relating to housing and employment) in ways that promote choice, recovery and citizenship. Crucially, care is delivered over a time by the same service and people, and therefore continuity of care is established. Staff working in these centres will be able to direct the person and their family to appropriate support without the need for onward referral, which reduces the need for referrals for service users to navigate complicated networks, pathways or referral processes. Support will be coordinated through joint clinical management, clear lines of accountability and clinical oversight arranged on a neighbourhood basis, to ensure continuity of care between these functions.
50. International studies into similar service designs have demonstrated it is possible to deliver a rights-based, person centred model of care which reduces levels of detention, demonstrates improved outcomes and is more cost effective.

51. International exemplars who have implemented similar models have demonstrated:
- a. a 50% reduction in mental health emergency presentations at general hospitals (Trieste, Italy);
 - b. a 30%-40% reduced suicide rate (Trieste, Italy);
 - c. 17% fewer compulsory admissions (Lille, France); and
 - d. a halving of the amount of time spent on hospitalisation (Lille, France).
52. World Health Organisation evidence shows this model can reduce admissions by up to 19%, reduce lengths of stay in inpatient settings to 6.5 days (England averages around 50 days for adult acute care), deliver up to a 42% reduction in bed days and a 42% reduction in physical restraints per person **[NHSE0002412]** **[NHSE0002421]** **[NHSE0002422]** **[NHSE0002392]**.

Pilots in England

53. Using the international evidence, NHS England worked with a group of people with lived experience to co-produce 10 key principles that underpin the model to be tested in England (see Annex 1).
54. In Spring 2024, NHS England launched a selection process to identify sites to test this approach and how the 'ingredients' of the model might apply in the English landscape and subsequently received 37 applications for funding. The Programme worked with panels of experts to select six sites to pilot this approach, each of which was allocated up to £5 million funding across 2024/25 and 2025/26. These six neighbourhoods are:

- a. Whitehaven (Cumbria, Northumberland, Tyne, and Wear NHS Foundation Trust);
 - b. Acomb (York Mental Health Partnership);
 - c. Birmingham East Central (Birmingham and Solihull NHS Foundation Trust);
 - d. Tower Hamlets (East London Foundation Trust);
 - e. Lewisham (South London and Maudsley NHS Foundation Trust); and
 - f. Heeley (Sheffield Health and Social Care NHS Foundation Trust).
55. These sites include a mixture of rural and urban geographies and populations, as well as areas that serve ethnic minority populations and populations facing multiple disadvantages including poverty, homelessness and isolation.
56. Each Mental Health Centre, led by an NHS Trust, will work in partnership with people with lived experience, social care, primary care and other healthcare providers, the Local Government Association, faith-based organisations and voluntary charity and social enterprise ("VCSE") organisations, as well as other services that provide support to people, such as housing providers and employment services.
57. Mental Health Centres will also work with social care, the voluntary sector and primary care to ensure that support and treatment can reach people and families who are struggling to engage with services. Providing 24/7 open access support via a Mental Health Centre will mean it is easier for people and their families to

ask for help from people they know when support is needed, reducing the need for delays resulting from referrals and waiting lists to access support.

58. The next stage in the transformation of community care is to bring the different community teams and services (for example, primary mental health care team, community mental health care team, home treatment team, crisis team, EIP team) together to enable continuity of care across pathways. In other words, each neighbourhood will be serviced by a Mental Health Centre which will encompass one functionally and operationally integrated community team serving all people (between 30,000 to 50,000) in that neighbourhood, turning no one away. Anyone with a mental health problem can drop into the centre with or without an appointment to receive support from psychiatrists, mental health professionals, social workers, voluntary sector workers and peer support workers. This is variously described as “no wrong door” or “all means all”.
59. Mental Health Centres will test and evaluate the core components and ways of working drawn from the evidence of international models and relevant related evidence from the UK. This will include testing mechanisms that will enable a ‘whole team approach’ including collaborative planning of care and treatment, communication and engagement, single patient records and shared outcome measures.
60. The Programme includes the drive to address inequalities and for system partners to work together to create the conditions for people to flourish in their local community. Each pilot has identified underrepresented groups who are currently poorly served by mental health services.

61. I believe that creating Mental Health Centres will result in developing longer term trusted relationships with patients, more so than existing services. This will enable continuity of care and will minimise the loss of patients from services, including those hard to engage. It is my view that if a patient in a similar situation to Valdo Calocane (based on my understanding of his clinical history) had access to a Mental Health Centre, it would be unlikely that they would be discharged, rather they would be assertively engaged and may be offered a bed in the Mental Health Centre and persuaded to take a depot injection and even offered broader psychological and social support. If that were unsuccessful and/or they became threatening or violent, they could be admitted to an inpatient unit.
62. Mental Health Centres which merge the existing community teams are, in my opinion, a model backed by international evidence and common sense.
63. The NHS England team overseeing this work meets regularly with sites, undertakes site visits, and hosts national webinars [NHSE0002728]. All sites meet with each other and the external evaluators (discussed below) every two months to share learning.
64. In addition to the six funded sites, NHS England is working with 16 Associate Sites who submitted bids and have committed to be part of the national support offer which includes sharing learning, networking opportunities and support visits from the national team. A national programme of support has been established for any area that would like to access learning or consider how this could be rolled out locally. Associate sites do not have access to additional funding.

Evaluation and future of Mental Health Centres

65. An external evaluation of the pilots has been procured (led by Ipsos Mori but including the Centre for Mental Health and University College London) which includes early feedback to pilot sites to enable them to respond in a timely manner to early findings and learning (this is currently in the data collection phase).
66. The evaluation led by Ipsos Mori will examine and identify the key ingredients and practices that help centres deliver the 10 key principles. The evaluation will quantify the impact on both people's experience of care and quality of life, and the impact on admission/use of hospitals and other services, such as accident and emergency.
67. The funding for the Mental Health Centre pilots (£30 million over two years) will come to an end in 2026. After this, a locality will need to decide to fund these centres. Whether pilot sites will continue to be able to provide 24/7 services with beds will depend on securing additional funding from the relevant Integrated Care Board.
68. The 10-year plan ([NHSE0000524]) states that mental health will move towards a neighbourhood model of care, but no funding, so far as I am aware, has currently been identified to take this from the pilot stage to national roll-out.

Statement of Truth

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.

Signed:

GRO-B

Dated: 11/11/2025

ANNEX 1

The principles of the 24/7 Neighbourhood Mental Health Centres

1. **Trusting relationships:** Everyone feels safe and cared for by the people providing support. People are supported to have ongoing/longer term relationships with staff who work hard to get to know them, what matters to them and earn their trust.
2. **Continuity of care:** People are not passed from one team or service to another. The same people support you whether you are at home, in crisis or need to stay in a bed.
3. **Neighbourhood-based:** People can get the help and support they need close to where they live and in their own community.
4. **Open access:** People can get help when they need it, where they need it, there is no criteria or referrals needed. It is easy to get a bed when you need it, and easy to leave when want to.
5. **Close to primary care and system partners, collaborating with VCSE:** There will be good links between your mental health care with your GP and other organisations or charities that provide support. They will work together.
6. **Co-produced with community and people with lived experience:** People and families who use the services will be part of designing them and delivering them.
7. **Services actively promote belonging and citizenship for all:** People who use services are seen as a whole person, just as important as anyone else in

their community and are valued for who they are. Their human rights are upheld and protected, and they will be supported to do what matters to them.

8. **Promoting freedom autonomy and choice:** People are in control of their own care and make choices about what they do and do not want.
9. **Do no harm:** The services provided are aware that many people will have experienced difficult things in their lives and will ensure they cause no further harm.
10. **All means all (also known as “no wrong door”):** These services are for everyone. Nobody is excluded. We will work hard to respect and respond to the reasonable adjustments people need.

Index

<u>No.</u>	<u>Inquiry URN</u>	<u>Document Description</u>
1	NHSE0000002	Report compiled by the independent Mental Health Taskforce to the NHS in England Re: The five year forward view for mental health.
2	NHSE0000014	Report dated 20/08/2019, compiled by NHS Re: The NHS Long Term Plan v1.2
3	NHSE0002388	Policy Guidance, re: Schizophrenia - Core interventions in the treatment and management of schizophrenia in primary and secondary care - Clinical Guideline 1, National Collaborating Centre for Mental Health [NICE]
4	NHSE0002437	Report dated 01/09/2005, compiled by Wolfgang Gaebel, Stefan Weinmann, Norman Sartorius and others, Re: Schizophrenia practice guidelines: international and survey and comparison.
5	NHSE0002619	Policy Document, Re: Schizophrenia - Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care, NICE
6	NHSE0000539	Policy document RE: Psychosis and schizophrenia in adults, by National Institute for Health and Care Excellence
7	NHSE0002730	Report dated 26/10/2016, Compiled by NICE, Re: Psychosis and schizophrenia in children and young people: recognition and management
8	NHSE0002384	Guidance, Re: Coexisting severe mental illness and substance misuse: community health and social care services, NICE

9	NHSE0002726	Report dated 01/10/2023, Compiled by: World Psychiatry, Re: 20- year trajectories of positive and negative symptoms after the first psychotic episode in patients with schizophrenia spectrum disorder: results from the OPUS study
10	NHSE0002453	Report dated 30/03/2022, compiled by Ida-Marie Molstrom, Julie Nordgaard, Annick Urfer-Parnas and others, Re: The prognosis of schizophrenia: A systematic review and meta-analysis with meta-regression of 20-year follow studies.
11	NHSE0002393	Report, dated 03/03/2017, compiled by Dawin I Velligan, Martha Sajatovic, Ainslie Hatch, Pavel Kramata, and John P Docherty [Patient Preference and Adherence, Dovepress] Re: Why do psychiatric patients stop antipsychotic medication? A systemic review of reasons for nonadherence to medication in patients with serious mental illness.
12	NHSE0002729	Report dated 01/06/2023, Compiled by Agarwal SM, Stogios N, Ahsan ZA and others, Re: Pharmacological interventions for prevention of weight gain in people with schizophrenia (Review)
13	NHSE0002439	Report dated 01/01/2000, compiled by Maurice Gervin & Thomas R.E. Barnes, Re: Assessment of drug-related movement disorders in schizophrenia.
14	NHSE0002727	Report dated 22/09/2025, Compiled by Dr Peter James Taylor, Dr Paul Hutton and Dr Lisa Wood, Re: Are people at risk of psychosis also at risk of suicide and self harm? A systematic review and meta-analysis.
15	NHSE0002410	Report, dated 10/01/2020, compiled by Wenjia Wang, Yongjie Zhou, Jiesi Wang, Hang Xu, Shuochi Wei, Dongmei Wang, Li

		Wang, and Xiang Yang Zhang [Progress in Neuropsychopharmacology & Biological Psychiatry] re: Prevalence, clinical correlates of suicide attempt and its relationship with empathy in patients with schizophrenia
16	NHSE0002391	Report, dated 09/01/2013, compiled by S. Challis, O. Nielssen, A. Harris and M. Large [Acta Psychiatrica Scandinavica], re: Systematic meta-analysis of the risk factors for deliberate self-harm before and after treatment for first-episode psychosis
17	NHSE0002724	Report dated 01/02/2025, Compiled by NICE, Re: 'Self harm how common is it?'
18	NHSE0002472	Report dated 01/2023, compiled by Richard T. Liu, Re: The epidemiology of non-suicidal self-injury: Lifetime prevalence, sociodemographic and clinical correlates, and treatment use in a nationally representative sample of adults in England.
19	NHSE0002390	Report, date unknown, compiled by Kahyee Hor [Journal of Psychopharmacology] and Mark Taylor [Journal of Psychopharmacology], re: Suicide and schizophrenia: a systematic review of rates and risk factors
20	NHSE0002399	Report, dated 10/07/2019, compiled by Leo Sher and Rene S.Kahn [Medicina], Re: Suicide in Schizophrenia: An Educational Overview
21	NHSE0002725	Report dated 23/11/2021, Compiled by BMJ, Re: Longer term management of self harm: summary of NICE guidance
22	NHSE0002438	Report dated 01/06/2002, compiled by Elizabeth Walsh, Alec Buchanan and Thomas Fahy, Re: Violence and schizophrenia: examining the evidence.

23	NHSE0000483	Report undated, compiled by Louis Appleby, Nav Kapur, Pauline Turnbull and others re: National Confidential Inquiry into suicide and safety in mental health
24	NHSE0002389	Report, dated 04/04/2009, compiled by Matthew Large [School of Psychiatry, St Vincent's Hospital, Sydney], Glen Smith [School of Psychiatry, St Vincent's Hospital, Sydney], and Olav Nielssen [Psychological Medicine, University of Sydney], re: The relationship between the rate of homicide by those with schizophrenia and the overall homicide rate: A systematic review and meta-analysis
25	NHSE0002413	Report dated 16/11/2020, compiled by Alison Baird, Roger T. Webb, Isabelle M. Hunt and others, Re: Homicide by men diagnosed with schizophrenia: national case-control study.
26	NHSE0002731	Report dated 22/12/2021, Compiled by 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
27	NHSE0002451	Minutes of Meeting, Re: The NHS England Board, 06/10/2022.
28	NHSE0000035	Policy Document RE: Culture of care standards for mental health inpatient services, NHS England
29	NHSE0002421	Guidance, Re: Comprehensive mental health service networks, World Health Organisation
30	NHSE0002422	Guidance document, Re: Guidance on community mental health services, [WHO]

31	NHSE0000015	Report dated 02/09/2019, compiled by NHS Re: The Community Mental Health Framework for Adults and Older Adults
32	NHSE0002412	Report, dated 01/03/2014, compiled by Jean Luc Roelandt, Nicolas Daumerie, Laurent Defromont, Aude Caria, Paula Bastow and Jugal Kishore [Journal of Mental Health and Human Behaviour], re: Community Mental Health Service: An Experience from the East Lille, France
33	NHSE0002392	Report, dated 01/06/2014, compiled by Roberto Mezzina [The Journal of Nervous and Mental Disease], re: Community Mental Health Care in Trieste and Beyond - An "Open Door - No Restraint" System of Care for Recovery and Citizenship
34	NHSE0002728	Report dated 12/06/2025, Compiled by NHSE, Re: 24/7 Neighbourhood Mental Health Centres Bi-monthly Pilots Event
35	NHSE0000524	Policy Document RE: Fit for the Future: 10 Year Health Plan for England, UK Government, NHS