Witness Name: Dr Shubulade Smith

Statement No: WITN0320001

Dated: 15/01/2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DR SHUBULADE SMITH

Employing Organisation: The Royal College of Psychiatrists

I, Dr Shubulade Smith, will say as follows: -

1. I am a Consultant Psychiatrist and Visiting Senior Lecturer at the South London and Maudsley NHS Foundation Trust and the Institute of Psychiatry, Psychology and Neuroscience, King's College London. I am a Bachelor of Medicine and Surgery and I am a Fellow of the Royal College of Psychiatrists, a Fellow of the Royal College of Physicians of Edinburgh, and an Honorary Fellow of the Faculty of Public Health. I have a Certificate of Completion of Specialist training in General Adult Psychiatry and I have specialist training in Forensic psychiatry.

2. I have a higher research degree in the side effects of psychotropic medications. I have worked as a Consultant in Community Psychiatry, Intensive Care Psychiatry and Medium Security. I have over 33 years' experience in psychiatry.

3. I am currently Lead Clinician for the Acute Forensic Pathway for the South London Partnership between Oxleas NHS Foundation Trust, South London and Maudsley NHS Foundation Trust and Southwest London and St Georges NHS Foundation Trust. I am responsible for all the acute Forensic admissions for South London.

4. I was first appointed as a Consultant in 1999 and I have special expertise in the assessment, diagnosis and management of mental illness, including; common mental disorders, personality disorder, PTSD, neurodevelopmental conditions and more severe forms of mental illness such as psychosis. I am qualified to provide assessment and treatment of a range of psychiatric disorders and have specialist expertise in managing patients with serious and severe mental disorders.

5. I regularly teach medical students, resident doctors, consultants and psychologists. I am recognised by the Royal College as trainer of basic and higher trainees in psychiatry. I organise and teach on postgraduate training courses for senior psychiatrists for the Royal College of Psychiatrists. I was the co-Chair and organiser of the Royal College of Psychiatrists annual International Congress for 7 years. I have over 70 publications including articles in peer-reviewed scientific journals and book chapters. I regularly present at national and international scientific conferences. I have a number of awards in psychological medicine and for my work in psychiatry, which has changed psychiatric practice.

6. I have extensive experience of providing expert evidence in the form of written reports and oral evidence and I have formal training in providing expert opinion. I am approved by the Secretary of State UK under Section 12(2) of the Mental Health Act 1983 (Amended 2007).

7. In June 2019 I was awarded a CBE in the Queen's Birthday Honours list for services to Forensic Psychiatric Intensive Care. In November 2019, I was voted "Psychiatrist of the Year 2019" by the Royal College of Psychiatrists. I am currently President of the Royal College of Psychiatrists.

8. As President, my role is to set the vision for the College and lead on driving improvements in access, experience and outcomes for people with mental illness in the UK and across the world. My commitment to improving outcomes for people with mental illness is exemplified by pioneering the Prague Agreement, a coalition of all the 147 psychiatric associations together with mental health charities from across the world working with the World Bank and the WHO on global investment for mental health. I recently attended the United Nations Global Assembly 80 to discuss this.

9. The President also acts as the College's principal spokesperson to external organisations, the media, and the public. I serve as the primary contact between the College and central government, which includes leading discussions with the NHS and the Department of Health to voice the College's view on mental health care and psychiatry.

10. Additionally, the President also engages with the media by issuing statements and press releases on emerging issues relating to psychiatry. These communicate the College's policy positions and aim to maintain a unified message to the public.

11. As President, I have the responsibility of chairing meetings of Council and the Board of Trustees, and ensuring that they follow the Charter, Bye-Laws, and regulations. I was elected in 2023, and hold this role until June 2026.

Role and Function of The Royal College of Psychiatrists

12. The Royal College of Psychiatrists (RCPsych) is the professional medical body responsible for supporting psychiatrists. It works to secure the best outcomes for people with mental illness, intellectual disabilities and developmental disorders by promoting excellent mental health services, supporting the prevention of mental illness, training outstanding psychiatrists, promoting quality and research, setting standards and being the voice of our members and the profession.

13. Representing over 22,000 members and with approximately 1,600 mental health services signed up to our quality networks (a range of professional networks that connect our members and supports their work in areas such as Child and Adolescent Mental Health Inpatient Services, eating disorders, and psychiatric liaison services to work toward quality improvement in these fields), we work in all four nations of the UK, as well as supporting members internationally.

14. The RCPsych is a charity, with approximately 250 employees and more than 280 patient and carer representatives, registered in England and Wales (228636) and in Scotland (SC038369). Our core objectives are to support our members; deliver education, training and research in psychiatry; promote recruitment and retention in psychiatry; improve standards and quality across psychiatry and wider mental health services, to support the prevention of mental ill health; to be the voice for psychiatry; support psychiatrists to achieve their professional potential by providing an excellent member experience; and ensure effective management of our resources and deliver an excellent employee experience.

15. The College:

- develops and maintains General Medical Council–approved curricula for core and higher psychiatric training, including learning outcomes on risk assessment, risk management, and multi-agency working
- sets and quality-assures postgraduate examinations and supports psychiatrists' continuing professional development (CPD) through accredited events, e-learning and guidance
- produces clinical, ethical and service-level guidance, including College Reports on assessing and managing risk to others, confidentiality and information-sharing, and standards for community mental health services
- supports quality improvement and accreditation of services (for example, through the College Centre for Quality Improvement (CCQI) and programmes such as Accreditation for Community Mental Health Services (ACOMHS))
- advises government, arms-length bodies and regulators on mental health legislation, policy and service models.

16. Through these functions, the College seeks to ensure psychiatrists and multidisciplinary teams across NHS and independent services are equipped to deliver safe, effective and rights-based care. The College does not commission, regulate or inspect services; those responsibilities sit with commissioners, providers and regulators. Its role is to set and support professional and service standards and to provide education, guidance and quality improvement infrastructure.

Role and function of the Royal College of Psychiatrist's Patient Safety Expert Guidance Working Group

17. The RCPsych Patient Safety Expert Working Group was established in 2012 to ensure that the College's policy and advice in the field of patient safety and risk management remains consistent and up to date. The Patient Safety Expert Working Group was responsible for providing guidance on psychiatric risk assessment and management, including issues of patient safety and risk management policy, training, practice, confidentiality, safeguarding and probity.

18. The Patient Safety Expert Working Group was made up of individuals, who have knowledge of, and an interest and expertise in, risk assessment and risk management, patient safety, ethics, quality standards, safeguarding, and the relationship between policy and practice.

19. The Working Group was given the remit to liaise with other College Committees\Faculties\ Sections to engage in relevant risk activities of the College, especially the work of the Policy Committee, and undertake work with external stakeholders as appropriate for furthering College objectives in this area.

20. One of the key responsibilities of the group was to ensure that risk policy documents are kept up to date in particular CR150: Self-harm, Suicide and Risk: Helping People Who Self-harm (WITN0320002: CR150: Rethinking risk to others in mental health services) and CR158: Rethinking risk to others in mental health services (WITN0320003: CR158: Self-harm, Suicide and Risk: Helping People Who Self-harm).

21. In 2024, the College appointed a new Patient Safety Group Chair. This led to discussions regarding future structures of this work, including:
    - A desire to restructure the patient safety working – making it more of a specialist adviser role rather than focusing round a group such as the Patient Safety Group.
    - To make the work more direct and for it to focus on direct engagement with key stakeholders
    - To combine the current patient safety role and the proposed suicide prevention role into one role.

22. Following these discussions and following agreement from the College's Officers, the College made the decision to retire the Patient Safety Working Group and

replace with a new combined role focussing on patient safety and suicide which would be a specialist adviser role rather than a formal committee structure.

23. In light of the growing media interest around patient safety and the opportunities to influence afforded by the current reviews and investigations, it was agreed that the College should devise a formal influencing strategy with the aim of improving patient experience. Our approach covers the safety of staff and patients - therapeutic care cannot be delivered unless both staff and patients feel safe from violence, aggression and sexual abuse.

CR201 – *Assessment and Management of Risk to Other People: Good Practice Guidance and Good Practice Guide*

24. Please find the College Report CR201 – *Assessment and Management of Risk to Other People (WITN0320004: CR201: Rethinking risk to others in mental health services)* [hereinafter "the Report"] and the *Good Practice Guidance on Assessment and Management of Risk to Other People* [hereinafter] "the Guide"(WITN0320005: Assessment and Management of Risk to Other People: Good Practice Guidance) that accompanies it in the exhibits shared with the Inquiry.

25. In 2008 the College published "Rethinking risk to others in mental health services". This report was aimed at addressing issues of risk to others and was prioritised due to media and political highlighting of high-profile incidents implying failure of risk management in mental health services.

26. The College established the Patient Safety Working Group, comprising of a broad range of psychiatrists from different specialities with additional input from patient and carer representatives, to revise CR150 seven years on in the context of a considerably altered commissioning environment.

27. From the minutes of a meeting of the Patient Safety Expert Working Group on 24th September 2013:

28. *'[CR150] was described as a good, concise document which was politically challenging and difficult to finalise due to differing views on risk assessment. It was agreed that this document should be modestly redrafted and updated and not completely revised.*

29. *It was suggested that strength-based risk assessment and protective factors should be included. Positive risk-taking should be included and accurately defined as tightly controlled and well thought-out. There should also be a discussion about sharing the risk with patients and carers and the ethical issues associated with that. We should bear in mind that there is hostility in the media towards psychiatry and that the public's perception is an issue. It was also noted that the tiered approach in chapter 5 does not seem to have been picked up and should be developed more.*

30. *The Policy processes were discussed. The document should be sent out for everyone to update or comment on using track changes by the end of November,*

with the aim of bringing it to the next Policy Committee meeting for discussion on 11th December (this has since been rescheduled to 17th January 2014).

31. *It would be valuable for the Forensic Faculty to provide their expertise, particularly on the subject of probation services and also the General Adult faculty.'*

32. From a further meeting's minutes in February 2024:

33. *'There was a group consensus that the update of CR150 should include positive examples of good practice. The Chair John Morgan described CR150 as a focused and hard-hitting report but there was a clear need to make it more contemporaneous and for it to deal with changes in clinical practice. The report would focus on contributions from the General Adult and Forensic Faculties. Huw Stone was happy with the direction of revision and would contact Dr Nick Kosky, chair of the General Adult (GA) faculty about recruiting members to join the report's writing group. Huw Stone would also raise the issue at the next Forensic faculty meeting. According to HS, Dr Seena Fazel, Consultant Forensic Psychiatrist at Oxford Health NHS Foundation Trust, has agreed to become involved in the report's revision.'*

34. The report was written by the Patient Safety Expert Working Group as above. This was done by dividing work between the committee and editing through an iterative process. Further consultation and supervision was provided through the

Policy and Public Affairs Committee, which is made up of representatives of all the College's faculties and a number of key committees, leads and groups.

35. There was a review of CR201 due in 2021 but this was paused due to the pandemic. The College is in the process of establishing a process either for revision or for producing a new style of guidance and is in contact with NHSE regarding producing future guidance.

36. We are also aware that the next iteration of the Care Programme Approach (CPA) framework is due to be published soon and includes a section on risk management, including risk to others.

Dissemination, guidelines, training and clinical practice on the ground

37. CR201, Rethinking Risk to Others in Mental Health Services was published in August 2016. The original version is exhibited as: (WITN0320006: CR201 (First Published Version 2016). It was necessary to make a few changes and was updated slightly in 2017. This version is exhibited as (WITN0320004: CR201: Rethinking risk to others in mental health services).

38. The report would have been disseminated to clinicians through usual College communications with our members – through an electronic newsletter and through communication with faculties.

39. We are also aware of CR201 being drawn to the attention of all NHS mental health trusts in England via NHS Improvement's provider bulletin in October 2019

(WITN0320007: NHS England Response to Prevention of Future Deaths Report 2019 Letter from Stephen Powis to Lydia Brown).

Reflection of CR201 in guidance and practice

40. There is already a substantial national framework on clinical risk (for example, *Best Practice in Managing Risk* (DH, 2007) (WITN0320016: Best Practice in Managing Risk (DH, 2007)); subsequent Department of Health and Social Care (DHSC) guidance; the Mental Health Act (MHA) Code of Practice and relevant NICE guidance). College Reports on risk to others are consistent with this framework and emphasise structured professional judgement and formulation. However, there is no unified guidance provided by NHSE on this subject.
41. We are not aware of any evidence that specific recommendations in CR201 have been directly incorporated into other guidance provided by other organisations. We do not have any firm insight into why this might be, other than to speculate that this might be because they have their own processes in developing guidelines. This is a question for the cited organisations. However, CR201 has been widely distributed and discussed and formed part of the accepted best practice. Aside from dissemination, there was no substantial accompanying implementation strategy to ensure the incorporation of CR201 into wider guidance.

Reflection of best practice in CR201 in NHS Trusts

42. RCPsych sets the standards, but adherence to these is not mandatory. Trusts are most likely to work to the standards if they are commissioned to do so or if they are mandated to do so. RCPsych is neither commissioner nor regulator of services, however we do try and influence best practice in service delivery in the ways indicated below.

43. Seven of the 2022 RCPsych's CCQI core community standards (WITN0320033: CCQI Core Standards 2022) directly relate to risk management. However, because risk management is related to safe, timely and effective care - the standards as a whole seek to describe the structures, processes and aspects of clinical practice that support safe and effective care including risk management.

44. The current core standards are in the process of being refreshed and will be published in 2025 with an increased emphasis on aspects of care that relate to CR201. This includes management of co-occurring substance use, assertive engagement techniques, multiagency working and safety assessment, formulation and management with an emphasis on risk to self, from others, to others and from iatrogenic harm. These updates align with CR201 and NHS England's Personalised Care Framework.

45. The standards support implementation of ways of working and various service structures and processes associated with safe and effective care. The standards are not however clinical guidelines/ guidance and do not substitute for internal organization processes to monitor key clinical practice areas outlined in CR201.

46. Peer review and accreditation process utilized by the Quality Networks and Accreditation (QNAs) enable review of whether certain processes (such as risk formulation and safety management) are being routinely carried out but they are designed to explore quality at a service rather than practitioner level. Use of provider level internal processes such as clinical supervision and audit are key processes used to assess quality and effectiveness of risk management. The CCQI plays a role in reviewing that those processes are in place.

47. There is no current system through the College to monitor whether recommendations made by the College in outputs such as Occasional Papers are taken up. We encourage take up of these standards by influencing NHSE and other equivalent national bodies to be aware of them and take them into account when they are commissioning services. Various levers are used to try and reinforce changes in practice/ adoption of best practice but there are limitations to each. The peer accreditation networks are a method of quality assurance and improvement, which encourage take up of recommendations, but sign up to this process is voluntary. Those who are accredited by this process tend to also tend to be better rated by the CQC, however, some organisations sign up, but do not actively join the peer network and are not accredited. They receive information about good practice but we do not know if they utilise any of this.

48. Existing College related processes that support adoption of practices include:

a. National clinical audits- however there are only two of these commissioned by the Healthcare Quality Improvement Partnership (HQIP) that are focused on

mental health as part of their National Clinical Audit and Patient Outcomes Programme (NCAPOP).

b. Dissemination of information, provision of education and training, via courses (in person and online) and conferences and examination systems.

c. Reinforcement where relevant through the College's Core Service standards (CCQI) - with limitations as noted above. These cover the whole scope of service structure, process and delivery and are not able to cover all aspects of clinical practice/ effectiveness. Furthermore they are not mandated so coverage with respect to an improvement and assurance system is limited to those organisations which choose to become involved.

49. It is our view that the principles of best practice set out in the Guide and the Report are not well integrated into psychiatric clinical practice. The key difficulties preventing this are set out below:

- There is no national commissioning expectation to integrate this guidance into psychiatric clinical practice.
- There may be no local commissioning expectation to integrate this guidance into clinical practice.
- Related to the above, there are no clear outcome measures/metrics that are standardised across the UK.
- There is no mandated imperative to integrate this guidance into clinical practice.
- There are significant resource issues in mental health care in the UK, with the funding shortfall being over 50% of what is needed. Although mental illness

accounts for 20% of the disease burden in the UK, mental healthcare receives only 8.7% of the healthcare budget.

- There are significant workforce shortages – 1 in 6 consultant jobs are vacant, and on average, 20% of mental health nursing posts are vacant.
- In some areas, there are insufficient mental health beds. Since the 1980s, there has been a reduction in mental health beds by 85%. This was by design as mental health services moved from primarily inpatient-based services to predominantly community-based services (98% of mental health care is delivered in the community). The reduction in beds has not been systematic, however and has not been aligned to local population need. This means that some areas have a surplus, whilst the majority are under-resourced with respect to inpatient beds, such that when a bed is needed for someone in crisis, they are unable to access a bed. This results in patients being in the community for longer periods of time despite it being recognised that they would benefit from admission; long waits in emergency departments; patients being more likely to be sent to out of area placements (which are harder to rehabilitate from) and patients being more ill when they come into hospital and thus more likely to stay for longer as they take longer to get better. When patients are more unwell their safety is more likely to be compromised, towards themselves in particular, but also sometimes others.

Recommendations on how to ensure best practice as regards the risk of violence posed by patients to others can be better disseminated and embedded in clinical practice

50. The College’s view is that the main challenge is variable implementation, often caused by over-stretched services not absence of guidance. However, there is also a clear need for a national consensus on assessing and managing risk to others that is evidence-based, realistic and not framed defensively.

51. To improve dissemination and embedding of best practice on violence risk, the College would highlight:

Clearer national expectations for core competencies

52. ‘Risk to others’ competencies, including violence risk formulation and positive risk-taking, should remain explicit in training curricula for all professions, Annual Review of Competence Progression (ARCP) standards and consultant job planning and appraisal.

Linking risk standards to quality levers

53. The College Centre for Quality Improvement develops explicit, auditable quality standards which are used through the College's 29 quality and accreditation networks, such as the Accreditation for Community Mental Health Services network (ACOMHS). Services who participate in the networks are peer-review against the nationally agreed standards, rather than only local policies. However membership of most of the networks is voluntary and not mandated.

Practical, concise tools

54. Alongside College Reports and DHSC guidance, short, operational tools (e.g. one-page risk-formulation templates, standardised crisis/safety-planning formats, Multi-Disciplinary Team (MDT) risk-handover summaries) help translate

high-level principles into everyday practice. There is no standardised risk-formulation template used across all NHS mental health trusts in England. Instead, local NHS trusts and health boards develop their own clinical risk assessment and management policies. However, these locally developed forms typically incorporate shared, evidence-based principles and frameworks based on NICE, Government, NHS or College guidance. Though variable implementation is the primary issue, there is also a potential for a national guidance providing a greater degree of standardisation.

Multi-agency alignment

55. Training and guidance should explicitly connect clinical risk practice with Multi-Agency Public Protection Arrangements (MAPPA), safeguarding, Multi-Agency Risk Assessment Conference (MARAC) and other multi-agency arrangements, with clear triggers for joint work where there is a risk of serious harm to others.

Supervision and culture

56. Local systems should ensure regular supervision and MDT forums where complex risk-to-others decisions are discussed, documented and reviewed, fostering a culture in which staff can raise concerns and learn from difficult cases.

Statutory/Regulatory/Training Background

Assessment, detention, and discharge under the Mental Health Act 1983

57. The Mental Health Act 1983 (as amended 2007) provides the legal framework for compulsory admission and treatment of individuals with mental disorder on the basis of risk of harm to themselves and/or others.

58. The MHA Code of Practice (2015) sets out guiding principles: least restrictive option, empowerment and involvement, respect and dignity, purpose and effectiveness, and efficiency and equity. It emphasises careful assessment and documentation of risk, consideration of alternatives to detention, and robust discharge planning (including liaison with families and other services).

59. The College supports implementation through:

- curricula and examinations that require knowledge of the MHA, its Code of Practice and relevant case law
- training and CPD events on medico-legal practice, tribunals and the MHA/Mental Capacity Act (MCA) interface
- guidance that links legal frameworks with clinical risk practice and ethical principles.

60. Clinically, best practice includes thorough pre-MHA assessments (with collateral information and attention to history of risk to others), clear recording of rationale for detention or discharge, and structured discharge planning with identified risk-management strategies and contingencies.

Psychiatric treatment in the community

<u>The role of crisis teams:</u>

61. Crisis Resolution and Home Treatment Teams (CRHTT) provide intensive support at home for individuals experiencing an acute mental health crisis as an alternative to hospital admission. CRHTTs gatekeep all requests for acute in-patient beds. They serve to facilitate good flow through inpatient units by facilitating timely discharge and reducing the length of hospital admissions. Home treatment by definition is an appropriate alternative to hospital admission for working age and older adults suffering with an acute psychiatric crisis of such severity that, without the involvement of a CRHTT, hospitalisation would be necessary. Such patients should be willing to receive home treatment which can be safely provided in their home environment.

The role of early intervention in psychosis team:

62. Early Intervention in Psychosis (EIP) is a clinical approach to those experiencing symptoms of psychosis for the first time. Reducing delays and providing optimal treatment of early symptoms of psychosis has been shown to improve longer term outcomes (less impact on personality functioning, IQ, relationships, morbidity and mortality), reduce harm and save money.

63. EIP has been a national policy requirement since 2000. The Department of Health and Social Care and NHS England (NHSE) launched their 'Achieving Better Access to Mental Health Services' policy in 2014 which led to a national service specification for EIP in 2016, last updated in 2023: Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance (published by NHSE and prepared by NICE and CCQI).

64. This standard details a set of essential interventions and requires EIP teams to engage with people assertively when they are experiencing a first episode of

psychosis. The implementation of the standard has been supported by national and regional delivery programmes (including the Early Intervention in Psychosis Network, EIPN, set up and run by the Royal College of Psychiatrists and described further below) and a national audit of clinical quality – the National Clinical Audit of Psychosis (NCAP).

The role of care co-ordinators

65. The role of the care co-ordinator is to be the main keyworker for a patient, co-ordinating their care, in particular supporting them to develop and implement their care plan, which should be personalised and will likely span a number of areas of social need, such as housing, employment and welfare support, that the person has, in addition to their clinical need for medication; psychological therapy; family intervention; physical health care and so on.

66. There is no formal training to become a care co-ordinator, it is something that is learned on the job, although student health practitioners, particularly nurses, may undertake clinical placements during their training that require them to shadow care co-ordinators and they would learn about care co-ordination in an apprenticeship type model. However, there are short courses available that support people to develop their skills as a care coordinator.

67. There is no best practice available with regards to care co-ordination. There are courses available. We do not know whether the quality of these courses is good or if they are effective.

The role of primary care

68. The majority of people with severe mental illness receive their care from their GP and other primary care practitioners. Primary care serves as the entry point for mental health support, enabling early identification and assessment, initial management through medication or psychological interventions, monitoring of physical health, and timely referral to specialist services.

69. The role of primary care in mental health changes significantly depending on whether a person is actively receiving secondary care or has been discharged from it, particularly following non-engagement.

70. When a patient is under secondary mental health care, primary care has a supportive role. GPs typically:

- Manage the patient's general physical health needs, including monitoring the physical side effects of psychiatric medication
- Provide repeat prescriptions or medication monitoring under shared-care agreements
- Support continuity by reinforcing care plans developed by secondary services
- Act as an accessible point of contact for emerging concerns and liaise with mental health teams as needed

71. In this context, responsibility for specialist assessment, risk management, and intensive treatment primarily sits with secondary care.

72. When a patient is not receiving secondary care, especially following discharge due to non-engagement, primary care often becomes the main or sole provider of ongoing mental health support. The GP's role expands to include:

- Ongoing assessment of mental state and risk, including safeguarding concerns
- Managing and reviewing psychiatric medication without specialist oversight
- Providing brief psychological interventions and signposting to community or voluntary services
- Attempting to re-engage the patient with care and re-refer to secondary services if risk escalates
- Coordinating care in the absence of formal care plans or crisis pathways

73. Discharge for non-engagement can place additional pressure on primary care, as patients may have complex needs but limited access to specialist support. GPs must balance continuity of care and risk management with the constraints of time, resources, and limited mental health specialisation.

74. Overall, primary care shifts from a collaborative role to a central coordinating role when secondary care is absent, highlighting its importance as a safety net within the mental health system—particularly for individuals who disengage from specialist services.

RCPsych's standards for Community Mental Health Services

75. RCPsych's core standards for Community mental health services was revised by the Royal College of Psychiatrists' College Centre for Quality Improvement (CCQI) in 2022 (WITN0320033: CCQI Core Standards 2022). The Community standards cover access to the service and what good care looks like (which includes assessment, care, treatment and discharge planning). The core standards are used by the quality networks and accreditation programmes within the CCQI. Each project will adopt the relevant core standards which will be used alongside their own specialist standards that relate to the service type being reviewed. Despite their importance, use of these standards is not mandatory. Only those organisations that choose to opt into a quality network take up and benchmark themselves against these standards.

The new Community Mental Health Framework for Adults and Older Adults

76. The Community Mental Health Framework for Adults and Older Adults (2019) describes how the mental health ambitions of the NHS Long Term Plan should be implemented locally.

77. It promotes:

- integrated, multidisciplinary community mental health services, working closely with Primary Care Networks and voluntary/community sector partners, thus care and support can be provided early and social disadvantage (which drives a lot of mental illness) can be tackled more effectively.
- crisis resolution/home treatment teams able to provide intensive support at home as an alternative to hospital admission

- early intervention in psychosis teams that offer assertive outreach, family interventions and evidence-based treatments
- specialist input from teams that work with the main co-ordinating community mental health team
- seamless transitions from primary to secondary or tertiary care and back again
- care coordination that addresses mental health, physical health and social needs.

78. The College, via CCQI and ACOMHS, has produced standards for adult community mental health services aligned with this framework and supports services to benchmark themselves against these standards through accreditation and peer-review. Training is provided through College conferences, CPD modules and Faculty activities.

79. The intended benefits, from the College's perspective, include: reduced fragmentation; earlier intervention; improved continuity of care; and better integration of housing, employment and substance use support – all of which are relevant to reducing serious incidents in the community.

The nature and utility of Community Treatment Orders

80. The majority of patients who have been detained under a section of the MHA are discharged into the community after their section has been rescinded and therefore it is usual for most people to remain in the community informally, not subject to the MHA. For those patients for whom there are concerns about engagement with treatment services and about whom there may be concerns

about safety to self and or others, a CTO may be considered to support their engagement with treatment. CTOs are only applicable to patients who have previously been detained under section 3 and allow detained patients to be discharged subject to conditions (for example, on residence or treatment adherence), with powers of recall to hospital. Unlike conditional discharge under section 37/41 (Court-directed hospital order, part III of MHA), CTOs are not overseen by the Ministry of Justice and they do not have the same strength of legal power as a s37/41 conditional discharge.

81. The evidence base, including UK trials, has not demonstrated a consistent reduction in readmissions attributable to CTOs when compared with alternative forms of supervised community care with similar levels of contact. On that basis, the College would emphasise:

- CTOs cannot be regarded as a primary violence-prevention tool.
- Their use should be clearly justified, regularly reviewed, and demonstrably the least restrictive option available.
- Priority should remain on high-quality, relational community care and treatment, including assertive outreach and supported housing, rather than relying mainly on legal compulsion.

Management of Psychosis

82. Many people with psychosis will have chronic relapsing remitting conditions which require long-term input. The aim of management is full recovery from the first episode and then to reduce the likelihood, frequency and severity of relapse. NICE guidance on psychosis and schizophrenia in adults sets the core clinical

framework (WITN0320022: Psychosis and schizophrenia in adults prevention and management (NICE Guidance)). It recommends:

- early identification and intervention
- combined pharmacological and psychological treatment (antipsychotic medication, CBT for psychosis, family interventions)
- attention to physical health and social determinants (e.g. housing, employment, finances)
- proactive relapse-prevention and crisis planning.

Treatment of psychosis

83. Treatment aims to resolve symptoms and to reduce associated disability. Long periods of untreated psychosis are associated with deterioration in social functioning; personality and intellectual functioning, which are thought to be related to the neurotoxic effects of chronic untreated psychosis. The majority of psychotic disorders can be effectively treated such that remission from symptoms can be achieved, however some people do not fully recover their premorbid functioning. This can be related to the duration of untreated psychosis, which is known to be a poor prognostic factor (WITN0320008: Howes (2021)). Timely effective treatment is needed to ensure better long-term outcome.

84. Treatment is a combination of antipsychotic medication; other medications (to help with mood disturbance, sleep and side effects, including antidepressants, mood stabilisers, hypnotics and anticholinergic medications); cognitive behavioural therapy; family interventions; psychoeducation; occupational therapy and lifestyle interventions (diet, exercise, smoking cessation) and

treatment of any co-existing conditions (WITN0320009:INTEGRATE: international guidelines for the algorithmic treatment of schizophrenia).

Medication for psychosis

85. Antipsychotic medication is the mainstay of psychosis treatment. It is associated with a reduction in symptoms, a reduction in relapse and it is associated with a reduction in violence risk in the 5% of people with psychosis who are at risk of behaving violently. There are a number of antipsychotics available, all of which have differing side effects. Clozapine has superior efficacy compared with other antipsychotic medications. Clozapine and long-acting injections are associated with lower mortality, lower morbidity and reduced hospitalisation compared with oral antipsychotic medications. It is notable that mortality rates are reduced with clozapine and long-acting antipsychotic injections even when the side effects of these medications are taken into account (WITN0320010: Aymerich (2025)).

86. In addition, 40% of people with psychotic disorders develop comorbid depressive illness which is associated with a high risk of suicide. They may require antidepressant treatment for significant depressive disorder.

87. In people with significant affective (mood) fluctuation, mood stabilisers such as lithium or sodium valproate may be indicated.

Managing medication non-concordance and psychosis

88. In relation to non-concordance, NICE recommends:

- exploring reasons for non-adherence (side-effects, insight, stigma, practical barriers)
- shared decision-making about alternative medications, formulations or doses
- considering long-acting injectable (depot) antipsychotics where repeated relapse due to non-concordance has occurred.

89. Long-acting injectable (LAI) antipsychotics are useful for those who find it difficult to take oral medication regularly. They reduce relapse risk and reduce hospitalisation. Some LAIs are now available as 3 monthly and 6 monthly preparations in addition to traditional monthly injections. Simplifying medication by reducing the number of medications or reducing the frequency of dosage can help with non-concordance.

90. Side effects are a major reason for non-adherence to medication. Involving the person in the choice of medication and choosing a medication that has a side effect profile that is most acceptable to the patient. Monitor carefully, adjust the dose and manage any emergent side effects assertively.

<u>Therapeutic relationships</u>

91. A body of therapeutic alliance literature suggests that therapeutic relationships between staff and service users create positive outcomes (WITN0320035: Sweeney (2018)). Numerous studies have shown that the quality of the relationship between therapist and patient is a consistent and strong predictor of positive outcomes in mental health care (WITN0320011: Razzaque (2024)).

92. There is increasing evidence that a more positive therapeutic relationship also leads to better adherence to treatment and more favourable outcomes across a range of diagnoses and treatment settings (WITN0320012: Frank (1990)).

93. Given this, it is important for policy makers to remember that not placing unnecessary divides between patient and clinician, including unnecessary levels of bureaucracy or restriction is an important way of keeping patients well and therefore the public safe. One area of psychiatric practice where there is great potential for the disruption of therapeutic relationships, and subsequent erosion of the potential for positive outcomes, is the use of compulsory detention and treatment under the MHA (WITN0320013: Cant (2025)). Though detention is often essential and beneficial, the potential impact it has on a therapeutic relationship is important to bear in mind.

The use of injectable antipsychotics such as depot

94. See above. Injectable antipsychotic medications (depots) come in monthly, 3 monthly and 6 monthly preparations. LAIs are associated with a reduction in relapse; reduced hospitalisation; reduced morbidity and reduced mortality.

95. From a risk-management perspective, the most effective way of reducing the likelihood of serious harm to self and others is timely and guideline-concordant treatment of psychosis, comorbid substance misuse and physical health conditions. Treatment is most likely to adhered to and effective when patients have a good therapeutic relationship with their clinician and there is continuity of care. The College supports implementation through curricula, CPD and service standards.

Assessing and managing the risk of patients

96. National DH/DHSC guidance on best practice in managing risk, together with College Reports on risk to others, provide the main framework. Core principles include:

- risk cannot be eliminated but can be systematically assessed, mitigated and reviewed
- risk assessment should be a dynamic, formulation-based process, not a one-off scoring exercise
- structured professional judgement, informed by evidence-based risk factors and protective factors, is preferable to purely unstructured judgement or reliance on numerical scores
- risk management should be collaborative, involving patients and, where appropriate, families and carers.

97. In routine practice this means:

- identifying historical (e.g. past violence), clinical (e.g. active psychosis, substance use) and contextual (e.g. access to potential victims, stressors) factors
- understanding how these interact in this individual's life
- agreeing a plan with the patient and MDT to mitigate them, including early warning signs, crisis contacts and multi-agency input where needed.

<u>Positive risk assessments</u>

98. Positive risk management recognises that risk can never be entirely removed. As a result, management plans will always involve choices that carry some level of risk. These risks should be clearly acknowledged within the decision-making process and discussed openly with the patient. Clinicians are encouraged to support reasonable autonomy and community participation while putting proportionate safeguards in place, documenting the reasoning and review process while remaining aware of the safety needs of the service user, their carer and the public.

99. Risk management involves:

- working collaboratively with the patient to identify what approaches are likely to be effective and which are not;
- taking into account the perspectives of carers and others involved
- being prepared to make decisions that include a degree of risk when the potential benefits are greater than the risks;
- creating plans and actions that promote the patient's stated goals and strengths, while reducing risks to the patient and others;
- clearly communicating the possible benefits as well as the potential risks to everyone involved; and
- making sure that the service user, carers, and anyone else who may be affected understand the decision, the reasons behind it, and the plans that follow.

The interface between mental capacity, treatment, and management of mental health

100. While the legal frameworks remain separate, there needs to be clear guidance on decision-making at the interface of the Acts.

Multi-agency working and communication to manage and risk assess patients

101. Effective risk management often requires collaboration with primary care, housing, social care, substance misuse services, criminal justice agencies and safeguarding bodies. Statutory frameworks (e.g. MAPPA) and local protocols provide the structure for this. Good practice includes clear lines of responsibility, agreed communication channels and joint risk plans for higher-risk cases.

Support to be provided to, and communication with, families of those with serious mental health problems

102. Families and carers often provide crucial support and information. The College's guidance on confidentiality and information-sharing emphasises that information can and should be shared where this supports the patient's care and is lawful and ethical to do so. Services should have local policies and training to support staff in involving families appropriately and offering them support in their own right.

103. The General Medical Council's (GMC's) guidance on confidentiality states: 'Confidentiality is an important ethical and legal duty but it is not absolute. You may disclose personal information without breaching duties of confidentiality when any of the following circumstances applies. A) The patient consents, whether implicitly for the sake of their own care or for local audit, or explicitly for other purposes. B) The disclosure is of overall benefit to a patient who lacks the

capacity to consent. C) The disclosure is required by law, or the disclosure is permitted or has been approved under a statutory process that sets aside the common law duty of confidentiality. D) The disclosure can be justified in the public interest'.

Further national training and guidance required

Digital/online risks

104. Risks associated with online behaviour (e.g. stalking and harassment via social media, engagement with violent or extremist content) are not yet consistently addressed in traditional risk frameworks. This is an area where new guidance is likely to be needed as evidence and practice evolve.

105. Beyond the specific risk-assessment points above, the College sees wider needs that affect both risk to self and risk to others.

106. While some guidance exists, the College considers there are areas where additional or strengthened national training and/or structural support would be beneficial:

Information-sharing and working with families/carers

107. Existing guidance stresses that information can and should be shared with families and carers where this supports the patient's care and is lawful. Nonetheless, staff often feel uncertain, especially when there are concerns about risk to others. Additional national training and decision-support tools (e.g.

flowcharts, standard phrases) could improve confidence and reduce variability with regard to staff understanding about confidentiality and its limitations.

Consistency and capacity in crisis and home-treatment services

108. Implementation of 24/7 crisis care and intensive home treatment remains uneven. Inadequate crisis provision can contribute to people "bouncing" between services, with risks insufficiently managed.

Supported housing and step-down provision

109. There is a significant lack of appropriate supported accommodation and this leads to delayed discharges, revolving-door admissions and unstable community placements, all of which can increase risk. Integrated commissioning between NHS, local authorities and housing is critical.

Supervision and staff support

110. High caseloads, workforce shortages and limited supervision can reduce the quality of risk assessment and planning. Embedding routine case-based supervision focusing on complex risk across disciplines would support safer practice.

111. Include something on the forthcoming changes on likelihood/causality and what will be needed for the code of practice.

Information-sharing and interoperability of records

112. Fragmented IT systems across primary, secondary, independent, social care and criminal justice sectors hamper comprehensive risk assessment, especially at transitions. This deficiency in interoperability leads to clinicians:

- Access only to incomplete data, leading to potentially flawed assessments
- Duplication of effort whereby different agencies may collect the same information multiple times
- Delayed interventions, caused by the time required to manually request and share information between systems
- Difficulty gaining an holistic view across services, meaning it is difficult to identify patterns of risk or concern at an early stage, potentially missing opportunities for preventative action

113. National work on interoperability and standardised risk summaries would improve safety.

Structured professional judgement (SPJ) in general adult settings

114. The SPJ approach is intended as a framework for clinical risk assessment and management with a focus on harm prevention through an understanding of individual risk and what is required to address the risk and protective factors most relevant to mitigating adverse outcomes. The SPJ approach is embodied in evidence-based guidelines or frameworks that promote systematisation and consistency. They are intended to be flexible enough to account for case-specific influences and the contexts in which assessments are conducted

115. Nationally supported training packages, with clear indications for when such tools are appropriate, could support proportionate and consistent practice.

Early psychosis and comorbid risk factors

116. Some mental disorders are associated with an increased risk of physical violence to others (WITN0320014: Lagerberg (2025)). People with psychosis who have comorbid substance misuse and/or a history of violence may have a higher relative risk of causing harm to others.

117. The evidence on this shows:

- Elevated risk of violence in schizophrenia spectrum disorders
- The absolute level of risk is small
- Only a minority of people with severe mental illness will perpetrate serious violence over their lifetime
- Violence perpetration risk is further increased if other factors, such as substance misuse comorbidity and previous violence perpetration and victimization, are also present
- These risk factors are amenable to treatment so early, assertive intervention is recommended
- Evidence suggests that ignoring this link because of worry that it will worsen stigma makes things worse (WITN0320015: Whiting (2024)).

118. The College identifies several areas where the evidence is evolving, and further research would be valuable:

- the effectiveness and limitations of structured risk-assessment tools (including SPJ tools) outside forensic settings, with a focus on real-world outcomes (e.g.

reduction in serious harm, experience of patients and families, effects on restriction and stigma)

- the long-term impact of community-based models (including those aligned with the Community Mental Health Framework and international open-door, community-centred approaches) on serious incidents, compulsory treatment and quality of life
- best practice in co-produced safety-planning, including use of digital tools and early-warning systems, particularly for people with fluctuating risk
- understanding and managing digital/online behaviours that may be linked to harm to self or others.

Gaps and inconsistencies between national and local training and guidance

119. The College is aware of:

- Variation in local risk policies, in terms of structure, emphasis and the extent to which they reflect national principles
- different levels of mandatory training and refresher training in risk assessment, including risk to others, between organisations and staff groups
- uneven provision of training on the MHA/MCA interface, on multi-agency working, and on information-sharing with families.

120. The College would support the development of a more unified national framework for clinical risk (drawing together DHSC guidance, the MHA Code and College guidance), with clear minimum training expectations and core documentation elements, while allowing proportionate local adaptation.

Discrepancies between national and local guidance

Focus of risk policies

121. Many Trust policies prioritise *risk of self-harm* and inpatient safety, because of the greater risk of self-harm in people with mental illness (including those with severe mental illness) but provide relatively less guidance on *community-based risk of violence or harm to others*. This contrasts with *Best Practice in Managing Risk* (DH 2007), which explicitly includes "risk to others" alongside self-harm and neglect (p. 3–5). CQC thematic reviews (e.g. *CQC 2018 – The State of Care in Mental Health Services 2014–2017*) (WITN0206014: CQC 2018: The State of Care in Mental Health Services 2014–2017) likewise observed "variable attention to risk to others in community teams."

Structure and use of tools

122. Some Trusts mandate specific actuarial or checklist tools (e.g. Functional Analysis of Care Environments - FACE, or bespoke scoring systems), whereas national guidance emphasises *structured professional judgement* and *formulation* (DH 2007; RCPsych CR201 *Rethinking Risk to Others* 2016). Inconsistent formats can impede continuity of care when patients move between organisations.

Frequency and content of training

123. Mandatory training on risk is not consistently refreshed or multidisciplinary. This diverges from *Best Practice in Managing Risk* principle 6 ("training and competence must be ensured across all staff groups").

Inclusion of multi-agency frameworks

124. Local policies vary in how explicitly they reference statutory multi-agency arrangements such as *MAPPA* (Criminal Justice Act 2003 s.325; Ministry of Justice MAPPA Guidance 2023) and *MARAC* for domestic abuse. The national *MHA Code of Practice* (2015, chapter 30) and DHSC (2009) *Assessing and Managing Risk in Mental Health Services* expect proactive liaison with MAPPA where relevant, but not all Trust templates make this clear.

Documentation burden and quality

125. Local policies differ in the level of required documentation. Some require lengthy forms that can encourage defensive or "tick-box" practice, whereas DH (2007) and RCPsych (CR201) emphasise concise, analytical formulation focusing on dynamic and protective factors.

Scope of emerging risks

126. Few local policies address *digital and online risks* (e.g. cyberstalking, extremist content), though the DHSC (2022) *Online Safety Strategy for Health and Care Staff* and NCISH (2024) identify this as an emerging area of concern.

Family and carer involvement

127. CQC (2023) found inconsistency in how carers are involved in risk assessments, despite the *MHA Code of Practice* (2015, para 4.17–4.20) and RCPsych (2019) *Confidentiality and Information Sharing Good Practice Guidance* (WITN0320017: RCPsych (2019) Confidentiality and Information

Sharing Good Practice Guidance) requiring carers to be involved wherever possible.

Learning from incidents

128. Trusts differ in how they disseminate learning from serious incidents involving harm to others. The *Patient Safety Incident Response Framework (PSIRF)* (NHSE 2022) (WITN0320018: The Patient Safety Incident Response Framework (PSIRF) (NHSE 2022)) promotes system learning, but the NCISH (2024) annual report notes "variable adoption and feedback loops," with some organisations lacking mechanisms to integrate findings into revised risk policies.

RCPsych involvement with mental health services in Nottingham

129. The College does not commission or regulate services but may be involved with local mental health services through our work.

- participation of services in our work to support improvement in mental healthcare, e.g. national quality and accreditation networks and quality improvement collaboratives
- College-organised educational events, training and Faculty/Division activities
- invited service reviews or other advisory work where requested by organisations.

130. Through the College Centre for Quality Improvement (CCQI), the College has worked with EIP teams in NHFT through their participation in the National Clinical Audit of Psychosis (NCAP) and the Early Intervention in Psychosis Network

(EIPN). Further detail of their participation is outlined in the witness statement submitted to the inquiry by Stephen McGowan (WITN0319001 - Nottingham Inquiry First Witness Statement of Stephen McGowan).

131. The College is reviewing its records to identify any other specific engagements with mental health services in Nottingham during the relevant period, including participation in quality initiatives, or bespoke training, and will provide these details separately if that would assist the Inquiry.

132. Participation in quality and accreditation networks provides Trusts - and the College - with valuable insight into how well services are meeting these standards. However, there are important limitations. Participation is not mandatory for most networks, meaning the intelligence generated is restricted to those Trusts that opt in. As a result, national visibility of variation, areas of challenge, and examples of excellence is incomplete.

133. Furthermore, while CCQI generates rich surveillance intelligence on quality and safety, there is currently no formal mechanism linking these insights to the wider national quality system. This means that Boards, Integrated Care Boards (ICBs) and regional or national bodies do not access this information and are not fully able to use the data to inform oversight, policy development or improvement prioritisation. The absence of a clearly agreed role for the College within the national quality and safety architecture leads to avoidable missed opportunities for system-wide learning and action.

International perspective

134. UK practice is broadly aligned with World Health Organization guidance in pursuing human-rights-based, least-restrictive mental health care and continued development of community services. The legal framework (MHA, MCA, ECHR/Human Rights Act) and policy direction (e.g. towards community-based, integrated care) reflect this.

135. The UK is primarily in line with international norms of practice, including the move away from large-scale institutionalisation towards community-based care, which is one of the most significant shifts in modern psychiatry. Community-based services offer the advantage of reducing stigma, promoting social inclusion, and maintaining crucial connections with family and local support networks, all of which are essential for long-term recovery.

136. Internationally:

- Trieste-inspired approaches in parts of Italy operate highly developed community services with open-door policies and low reliance on coercion, emphasising social inclusion, housing and community supports
- others (particularly in the old Eastern European block and in low income countries), rely more heavily on psychiatric institutions or on coercive community treatment.

137. The College considers that the main lessons for the UK lie in:

- further strengthening community provision, crisis response and supported housing
- improving integration between mental health, primary care, housing, social care and criminal justice agencies
- ensuring that there is sufficient bed capacity to ensure timely admission when needed, coupled with effective community services so that patients can be discharged to services that support them to remain stable and reduce the risk of relapse.
- continuing to reduce unnecessary coercion while ensuring effective, timely treatment and risk management.

138. Comparative work on structured risk-assessment practices in different jurisdictions (for example, how SPJ tools and multi-agency arrangements are used) can also inform UK practice, but needs to be interpreted in light of differences in legal and service contexts.

Work undertaken, or to be undertaken, following the attacks on 13 June 2023

139. Work has been undertaken to review some of the key areas below – while this has not been as a direct related of the attacks by VC, the College recognises the impact this work will have on preventing similar attacks from taking place.

<u>A review (with NHSE/DHSC) into the Community mental health framework for adults.</u>

140. In response to the Government's commitment to move from hospital to community and from treatment to prevention, predominantly in the form of a

'neighbourhood' approach to mental health, the College has identified the opportunity to review and republish the Community Mental Health Framework. NHSE/DHSC have acknowledged that the Community Mental Health Framework underpins the key principles of the 24/7 neighbourhood mental health pilots - to support the national roll out of these pilots, the College has proposed to NHSE that the Framework should be updated and rebadged as the 'neighbourhood framework'.

Work on standardising pathways of care

141. There are geographical areas of best practice which the College is working closely with who have clearly standardised the different pathways of care available to patients. These are areas which fully implemented the Community Mental Health Framework as it was introduced. Working with NHSE and the College's own local networks, we aim to disseminate this best practice, while understanding the challenges local areas my face in implementation.

Updates to the guidance to clinicians relating to medicine management in a community setting

142. The College has signposted clinicians to shared decision-making tools that support medicine management, such as Psymatik which provides a digital version of the INTEGRATE guidelines for schizophrenia (WITN0320009 - INTEGRATE: international guidelines for the algorithmic treatment of schizophrenia).

How legislation is used in the community to deliver medication to those who are non-compliant

143. Though, it is for DHSC to review how legislation is used in the community to deliver medication to those who are non-compliant, the College's views are as follows:

144. Mental health legislation does not permit compulsory treatment in the community. Conditions (CTO and 37/41) do not allow for medication to be given forcibly - but that people who are liable to be recalled (CTO/Conditional discharge), could be recalled to hospital if they are refusing medication.

145. However, this would depend on individual circumstances and what is known about the nature of their mental health problems. The reality is that the reduction in hospital beds has meant that recall to hospital because of refusing medication, in the absence of clear deterioration, is rarely possible because of the lack of inpatient resource.

146. If someone is not liable to recall and is not taking medication and their mental state has deteriorated to the extent that their health, safety or that of others is compromised, then the only recourse if all attempts to engage them has failed, is detention. This then depends on the judgement of the clinicians at any MHA assessment. Again, lack of resources means that it is highly unlikely that someone would be detained unless there were clear signs of deterioration associated with their non-compliance. Detention is of course possible (nature rather than degree) but hospital beds are a limited resource and therefore

generally reserved for people who are already unwell, rather than those who might (or are even likely) to become unwell.

Recommendations to improve psychiatric care in order to reduce the risks posed by psychiatric patients to others

147. Drawing together the points above, the College would highlight the following recommendations:

Timely effective treatment is needed to ensure better long-term outcome.

148. The therapeutic benefit provided to patients undergoing mental health treatment is the most substantial contributor to improving the mental health of patients and therefore reducing the chance of their mental health condition causing harm to themselves and others.

149. Evidence of the importance of therapeutic treatment in reducing risks of offending can be found through examining restricted cases where offenders are treated in hospital rather than in prisons. Between 1998 and 2008, ~500 people/year who were subject to restriction orders were discharged to the community and the 2-year re-conviction rates were 7% for all offences and 1% for grave offences (WITN0320019: Ministry of Justice: Statistics of Mentally Disordered Offenders 2008). For context, the UK prison population in a similar period was around 85 000 (WITN0320020: National Offender Management Service: Prison Population Briefing 2010). Of 20 000 people who left prison in the first quarter of 2004, 65% were convicted again an offence(WITN0320021: Re-offending of adults - results

from the 2004 cohort). Treating people's mental illness rather than focusing purely on restriction or punishment is the best way to prevent future offending in those with mental illness.

Evidence-based treatments

150. There is a large amount of evidence of the benefits of evidence-based treatments for those with severe mental disorder. Antipsychotic medications are the gold-standard treatment for psychotic episodes and disorders and have been shown to be more efficacious in treating positive symptoms. NICE details the evidence on treating psychosis and the benefits of evidence-based psychiatric treatment (WITN0320022: Psychosis and schizophrenia in adults prevention and management (NICE Guidance)).

151. There is also increasing evidence on the benefits of relational and trauma-informed care and the importance of training staff in this (WITN0320023: Sweeney (2016)). Focusing on evidence-based treatments for mental disorder is the best way to maximise patient and public safety.

Consolidate and implement a national clinical risk framework

152. Bring together DHSC guidance, the MHA Code of Practice and professional guidance into a clear framework for assessing and managing risk (including risk to others), with defined training expectations, core documentation and supervision standards.

Strengthen and fully implement community and crisis services

153. Deliver the Community Mental Health Framework and NHS Long Term Plan commitments consistently, including crisis/home treatment, EIP and supported housing, recognising their central role in preventing serious harm and avoiding fragmented "revolving-door" care.

Improve training on the MHA/MCA interface and information-sharing

154. Provide practical national training and tools to support clinicians in choosing and documenting the appropriate legal framework in high-risk cases, and in sharing information lawfully and compassionately with families and other agencies. The forthcoming revised Mental Health Code of Practice is an opportunity to start this work.

Promote structured, formulation-based risk assessment and management

155. Encourage use of structured professional judgement and risk formulation (supported, where appropriate, by evidence-based tools), embedded in MDT practice and supervision, rather than solely form-based or numerical risk scores. This can be done through a combination of training, clear policies, a supportive organisational culture, and multidisciplinary collaboration.

Enhance multi-agency arrangements

156. Ensure mental health services are fully engaged in MAPPA and other multi-agency mechanisms, with clear triggers and pathways for joint work in higher-risk cases, and support for information-sharing and joint planning. This will require further clarity on procedures and a collaborative culture.

Strengthen national learning systems

157. Improve collection, analysis and dissemination of learning from serious incidents involving harm to others, including from inquiries, and ensure that learning is rapidly reflected in guidance, training and service standards. Full implementation of the Patient Safety Incident Response Framework (PSIRF), focusing on system-based analysis (not just blame) will help achieve this.

Apply consistent standards across sectors

158. Recognise that both NHS and independent providers care for people who may, in rare instances, pose risks to others, and promote consistent national standards, shared training and joint learning across all sectors through mandated frameworks, system-wide collaboration, and shared platforms for reporting and analysis of patient safety incidents.

Mandate participation in Quality and Accreditation Networks

159. This will ensure national consistency and improve the completeness of quality intelligence.

Establish a robust national surveillance function

160. This will allow intelligence from provider participation is systematically shared with statutory bodies to inform policy decisions, regulatory focus and quality improvement priorities.

Expand use of CCQI's established methodologies

161. This will strengthen both improvement efforts and oversight through expansion of National Clinical Audits which would enable better oversight of current clinical practice and patient outcomes

Formalise the College's role within the national quality and safety infrastructure

162. This should include defined interfaces with DHSC, NHS England and the CQC, to enable CCQI intelligence to drive improvements, uphold standards of care and highlight where action is needed.

Service pressures/capacity

163. As the King's Fund have recently shown, with the exception of the Covid-19 period, when many beds were closed due to infection control, the current numbers of mental health beds (17,836) are at their lowest level since data collection began in 2010/11. Bed occupancy has remained consistently over the recommended level of 85% - the point at which quality of care is at risk of being compromised. Adult acute bed occupancy has almost invariably been at 95% or more nationwide since spring 2022. Over that period London and North West has seen the most consistently high rates between regions. When considering all mental health bed types, Northamptonshire Healthcare NHSFT has reported occupancy at 116% or more every quarter since Q3 2021/22. As a consequence, people who need to be admitted can face considerable delays in Emergency Departments (ED) while they wait for an available bed, or may be

cared for in inappropriate environments, such as being admitted to a ward in an acute trust.

164. Across the country, Psychiatrists have reported that many areas are struggling to meet the demand for mental health care within the available bed and wider system capacity.

165. This has led to:

- Frequent and persistently high use of inappropriate out of area placements, where patients are sent out of their area for mental health care that should be provided locally.
- Delayed urgent admissions and the reliance on Mental Health Act (MHA) assessments and formal admissions as the only means of accessing inpatient services.
- People in a mental health crisis staying too long in ED or being admitted to a general and acute hospital bed, where there is often a lack of psychiatric expertise.
- Unrelenting pressure on the staff to provide care for inpatients and manage their discharge from hospital.
- High rates of patient readmission, with the pressure to discharge patients before they are clinically ready and the lack of community provision, including crisis care and supported housing, leading to their return.
- Despite the welcome commitments in the NHS Long Term Plan and NHS Urgent and Emergency Care Plan, as well as the development of the NHS 10 Year Health Plan, these problems continue to persist.

Exploring mental health inpatient capacity

166. A College membership survey was conducted in early 2025 to gather member experiences of local inpatient capacity pressures - across England, 860 members participated. The survey findings further compound the challenging conditions under which psychiatrists and mental health professionals are working to attempt to consistently deliver safe and therapeutic care.

167. Almost half of the respondents (47%) faced daily delays in timely admissions and/or provision of inpatient mental health treatment, due to a lack of local or specialist capacity.

168. 44% heard daily about patients staying in a place of safety or in General Hospital Emergency Departments while waiting to be transferred to a suitable inpatient bed.

169. Nearly three quarters (73%) felt they had to make a decision on admission or discharge as a result of external pressures, rather than the patient's best interests.

170. The majority (81%) have experienced of witnessed 'moral injury' (a strong cognitive and emotional response following an event that violates a person's ethical code, such as feeling they are delivering substandard care) when making decisions around patient admission or discharge.

Psychiatric Workforce

171. Every two years we undertake a workforce census of the non-training psychiatric workforce in the UK. The survey provides a detailed analysis of the consultant and specialty and specialist (SAS) doctor workforce in psychiatry across England, Scotland, Northern Ireland and Wales. The 2025 workforce census is currently being undertaken; key findings for England from the 2023 workforce census are as follows:

- There were 5,151 consultant psychiatrist posts across the trusts in England that responded to the 2023 RCPsych workforce census, 84.1% of which were filled by substantive or locum consultants.
- Almost 1 in 6 (15.9%, 821) consultant psychiatrist posts in England were vacant in 2023, 5.5 percentage points greater than 10.4% (1 in 10) in 2021 and 6.1 percentage points greater than 9.8% in 2019.
- The 'true vacancy' rate in the 2023 census was 29.1% - over a quarter of consultant psychiatrist posts across England were vacant or filled by locum consultants.
- At specialty level, the 'true vacancy' rates were highest for child and adolescent psychiatry (36.8%), general adult psychiatry (32.7%), and eating disorders psychiatry (30.0%). More than a third of child and adolescent psychiatry consultant posts were vacant or filled with locum psychiatrists
    - In total, 206 consultants were reported to have retired in England in 2022 and 2023 – 57.8% and 42.2% of whom were male and female consultants, respectively.

- In the quarter ending June 2025, the medical and nursing vacancy rates in mental health trusts were 12.6% and 10.2% respectively, compared to 5.7% and 5.0% in acute trusts.

Assertive outreach

172. The low number of beds detailed above has several potential negative impacts on patient care, particularly that of patients not being given the treatment they need until they reach a point of extreme crisis, at which point they have already reduced their chances of improving quickly and also at a point where they have likely become a risk to themselves and others.

173. Due to the lack of beds, patients are occasionally discharged before the time that would be ideal as there is a need to make room for someone in crisis. Assertive Outreach previously existed across mental health services to keep patients who have been discharged in touch with mental health services to manage their care and monitor their health. This was defunded because they were deemed to be expensive compared with standard CMHT care. There is substantial evidence that assertive outreach can help engage with 'hard to reach' patients (WITN0320024: Killapsy (2016)).

Consultation with RCPsych Members on MHA Reforms

174. The College has surveyed its members twice on the Mental Health Act. The first time was in the early stages of the Wessely Review. The results can be found

here. The second was to help answer the questions posed in the Government's White Paper. The results can be found here.

175. These surveys formed a part of the College's engagement with its membership to help the voice of Psychiatry shape the reform process. Both of these survey results formed the basis of papers that were taken to Council for discussion and decision and ultimately were key in shaping our submissions to both the Review and the Government.

176. Additionally, the College has established a number of working groups to help reflect College opinion from across the specialties.

RCPsych involvement with Independent Review of the Mental Health Act

177. During the Review, Dr Lade Smith was tasked with taking part in the Review by then President Professor Wendy Burn and was appointed to the Review Working Group.

<u>Proposals in the review to increase the bar for detention</u>

178. Dr Annabel Price, then Chair of the Liaison Faculty sat on the topic group on the detention criteria.

179. The remit of this group was to decide:

- Whether Section 2 (detention for assessment) and Section 3 (detention for treatment) of the Mental Health Act should be combined or reconfigured, with an initial shorter period for assessment and treatment
- Whether and how a person's decision-making ability should play a role in detention

- Whether current risk thresholds under the Mental Health Act are the right ones, and if not, what they should be
- How the Mental Health Act can support positive risk taking and standardised/operationalised risk assessment when making decisions for detention and renewal of detention
- Whether the requirement for appropriate treatment to be available is adequate to ensure a person really is receiving clinically effective help while being detained

180. The group identified four primary concerns regarding the existing detention criteria and decision process, though discussion moved beyond these through the process

- The criteria for detention are vague, sometimes to the point of circularity (e.g. the ground in s2 that a person is suffering from mental disorder of a nature or degree 'which warrants detention' – in other words, you need detention because you need detention), and over-reliant on the presence of mental disorder, in a way which is discriminatory and inconsistent with developing international human rights standards. As a consequence, it is difficult to test or challenge the justification for detention. This can particularly be a problem when people are detained on the basis of a purported risk to self or others, at a renewal or appeal: the onus lies on them to demonstrate that they are no longer a risk, which they cannot easily do
- The principles of respect for autonomy, reciprocity and least restrictive alternative are not upheld, in that the patient's perspective may not be fully

considered in justifying detention; and detention and forcible treatment can be authorised but the person may not receive the treatment and support which would allow them to recover, or live a meaningful life while on detention

- The provisions for detention for treatment (s3) and detention for assessment (s2) do not articulate well and are significantly different in the rights afforded patients. Professionals have differing views on which procedure is appropriate in similar cases
- The time limits for short term detention and before automatic review by a tribunal are too long, and increasingly out of step with international comparators

181. The changes proposed by the group were intended to strengthen the rights of patients, make decisions on detention more transparent and ethically justifiable, encourage greater patient agency and promote more consistent and thorough care planning throughout the detention process. These recommendations were:

    - The detention stages and timelines should be reformed, with a s2 type detention lasting 14 days, renewable for a further 14 days, and a s3 type detention requiring tribunal consideration at no later than three months
    - The criteria for detention should reflect the ethical justification for detention, with the inclusion of a test of significantly impaired decision making, a more detailed 'necessity' test and a clearer justification for the particular treatment to be delivered without consent

- Detention should require a comprehensive care and treatment plan, which should evolve through the process from initial assessment to treatment and discharge.

Therapeutic benefit

182. Regarding the reforms on therapeutic benefit, our response to the White Paper in 2021 set out:

183. *We agree that detention should be therapeutic, but it is important to have clarity over what exactly this means and how it is measured. For example, the idea of what is therapeutic may differ between the individual and the clinician. Also, the provision of a safe place may be what is needed for someone's mental health – so the definition of "therapeutic benefit" would need to be broad enough to include both care and containment. Therefore, the meaning of 'therapeutic benefit' will be argued in great detail in tribunals (assuming the amendments apply not only to the wording of sections 2 and 3, but also section 72 which sets out the criteria that tribunals must apply, which are very similar but not quite identical to those in sections 2 and 3). Does it mean that the intention behind detention is to provide a therapeutic benefit, or does it mean that there must be actual therapeutic benefit that arises as a result of the detention? The meaning of the term seems fairly clear for illnesses such as psychosis or depression, but is possibly much less clear for conditions such as dementia, Learning Disability (LD) or Autism Spectrum Disorder (ASD). Does it mean that detention must be likely to make the patient improve, or is it sufficient to demonstrate that it will help*

to reduce harm? How will this apply to personality disorders where the benefit is perhaps more likely to accrue to others than to the patient? In the past there was a 'treatability' clause to Sec 3 which meant that, in some circumstances, people could not be detained unless their condition was 'treatable'. Similarly, some other treatments may take a longer time to be of benefit e.g. in the case of brain injury rehabilitation – given more frequent tribunals the benefit may not be evident at a particular point in time. It is also not possible to be certain in advance that detention will provide a therapeutic benefit, since a proportion of patients may not benefit from detention. So there needs to be a wording along the lines of 'detention is likely to provide a therapeutic benefit'. It would also be very hard to understand why some very ill people were not admitted, on the basis that they wouldn't get any better.

184. Additionally, our submission to the Joint Committee Call for Evidence set out:

185. 'The introduction of a requirement of likely therapeutic benefit, when detention for treatment is recommended, is welcomed. "Reasonable prospect" may be open to interpretation and we recommend clarification in the subsequent Code of Practice where reference to 'evidence-based treatment' might help constrain arbitrary predictions about therapeutic benefit.'

Proposals in the review to change the criteria and reduce the use of CTOs

186. At the beginning of the Review process, the College responded to the Review's call for evidence and provided its views (among other things) on Community Treatment Orders.

187. This call for evidence response was partially based on a survey of members undertaken by the College and then a session in the College's Council were options for the College to take were set before leading members.

188. The survey of members found clear majority of respondents agreed that some conditions applied to discharge is an important part of keeping people safe and well. However, opinion was fairly divided on whether CTOs in the current form should be abolished.

189. We took a paper to the College's Council to gain opinions on what lines the College should be taking on potential reforms. The option decided by Council was:

190. *'Option 1. Take a limited and cautious view at this stage, emphasising the fact that more research is needed, and that the practice of CTOs can be amended to improve practice and outcomes.*

191. *The Royal College of Psychiatrists is aware of the concerns about the effectiveness of CTOs and encourages more research. RCPsych would particularly like to see more research into why CTOs don't lead to lower admissions and how effective CTOs are at reducing the risks involved with discharging some patients to the community. Conditional discharge to the community can be an important part of keeping people safe and well and it is*

important that CTOs are not just judged on numbers, but rather on the effect they have on patients' experience.

192. *RCPsych believes that changes in culture and practice can make CTOs part of a supportive process that helps patients disengage from medical care and get better, as well as allowing clinicians to control risk. It is important that clinicians get the best possible training on how to use CTOs, which will ensure that patients do not remain on them any longer than necessary, that the threshold and criteria is respected and that the principle of least restrictive option is adhered to.*

193. *CTOs are an important part of mental health treatment If they are reframed in a way that allows greater communication and agreement between patient and clinician, they could strengthen the therapeutic relationship, and potentially lower the levels of readmissions.*

194. *Pros: This would prevent the College from taking a misstep early in the proceedings. There are ongoing debates in the College on capacity, coercion and risk and it would be good if the College could take full stock before making a more committed step. Also, this is most in line with the College survey results on CTOs.*

195. *Cons: Research takes a long time – it may not be possible to do it in the timeframe of the review. As well as this, any subtle, cultural changes may be hard to implement and would be unlikely to lead to a change in admission rates.'*

196. Following this being agreed at Council, we submitted the following view to the Review in our response to the call for evidence:

197. *'Recommendation: CTOs should be retained within the MHA, with modifications.*
    - *The Review should, as an overall aim, focus on amending rather than abolishing CTOs as they can provide an essential therapeutic benefit when used correctly.*
    - *The remit of CTOs should be limited to make sure that they are only used when most beneficial. The Review should consider amending the criteria to reflect a history of non-compliance with treatment leading to subsequent compulsory admission(s) within a defined timeframe.*
    - *Where appropriate, Advance Care Plans should be used as an alternative to CTOs in patients where this is likely to be effective, and joint care planning should be incorporated into CTOs as much as possible.'*

<u>Proposed reduction in the review to reduce the initial period of detention</u>

198. Dr Bala Oruganti (Consultant Psychiatrist and Chair of RCPsych in Wales General Adult Faculty during the Review) sat on the topic group on tribunals for us and contributed to recommendations that periods of detention under s.3 should run for 3 months, 3 months, 6 months and then 1 year thereafter, renewable by the patient's RC (the group being told that AMHP involvement, whilst desirable would be unlikely to be achievable in practice). However, this group was primarily lead by legal experts rather than medical practitioners.

199. Following this and with the publication of a White Paper, the College ran another survey of College Members and asked them:

200. 'Patients subject to section 3 of the MHA 1983 will have an automatic referral to a tribunal after 4 months and then annually (currently 6 months and 3 yearly).'

- 53.28% of respondents agreed
- 36.5% disagreed (too frequent)
- 1.31% disagreed (not frequent enough)
- 8.91% were not sure

201. Our response to questions regarding proposed changes in timelines in the 2021 White Paper was as follows:

202. *'Though we agree that it may be beneficial for patients to have the opportunity to challenge their detention more frequently. We wonder if it would be better if the frequency with which they could request a tribunal should be increased, rather than being automatically referred for one. We also worry that such regular tribunals may challenge patients' sense of their secure base in hospital, as they may frequently become preoccupied with whether or not their placement will continue. Increasing the frequency of tribunals will also increase workload and would need to be matched with resources – the workforce implications of this would need to be carefully considered with a costed feasible delivery plan. We would hope that before any changes are made, a very careful calculation of expected increase in workload would be made. An increased number of tribunals would also require an increased number of specialists available to do these.*

Already, there is not always a child and adolescent psychiatrist on the panel for young people, or a Learning Disability (LD) psychiatrist on the panel for a young person with LD. These should be essential pre-requisites for a tribunal to take place when seeing a young person, or a person with LD.

203. *However, there is a significant shortage of these specialty psychiatrists already within the workforce, and particularly within inpatient settings (15% vacancy rates for CAPs). Increased workload for tribunals would mean that time would be removed from the daily duties which would impact on quality of care. We are concerned that if not matched with appropriate resources and if guidelines for essential panel members are not set out, then the increase in tribunals could lead to a reduction in the number of people on the panels and this could ultimately reduce, rather than increase, patient safeguards. Additionally, there are a great number of patient groups who could be let down by the automatic proposals as patients have often expressed concerns that there are already too many tribunals, often not optimally timed, with many patients finding them stressful. Similarly, many young people don't want to appeal against their detentions as they find the experience of the tribunal traumatic. This needs to be taken into consideration and they should be as child/young person friendly as possible. Ideally the young person should have peer created information about what a tribunal is and how it works before going in for one.*

204. *Also enhanced training is urgently required for tribunal panels and judges regarding how the process could be adapted to be more Children and Young People (CYP) friendly, with formal recommendations for amended procedures*

which should be coproduced with CYP. We note that in our survey of members, the majority of members were happy to see the proposed changes in timeframe. We approve providing more rights to patients but on a whole, our view is that focus should be on improvement of quality rather than quantity of tribunals. This would generally include more 7 involvement of carers. Patients should have the right to defer or even cancel a hearing providing they have access to legal advice.'

Variance between the Review and Draft Bill on detention criteria: likelihood and causality

205. The new Mental Health Act was given Royal Assent on 18th December 2025. Whilst it was still in draft, the College's submission to the 2021 White Paper set out:

206. *'We agree in principle but the use of the words "substantial" and "significant" are open to interpretation which will allow for discretion but also wide variation in interpretation and can have different meanings for lawyers and clinicians. We maintain that the decision about what constitutes a substantial likelihood and significant harm should be a clinical decision rather than a legal one. We are also concerned that this is in contravention of many risk management and relapse prevention plans which look to intervene at the earliest opportunity before risk becomes "substantial and significant" in the non-consenting patient who lacks insight. Current tools to measure/predict risk, especially in young people are not very robust and not always used – perhaps the code could include more*

guidance about how this is measured? Although we do not believe that detentions will be significantly changed as regards the decision to detain, given the vagueness and subjectivity of the wording, detentions will be more open to challenge

207. More recently, the College has made its objections to the recent changes to the detention criteria clear to the Government – both the introduction of 'likelihood' and 'may be caused'. These are detailed below:

<u>"May be caused'</u>

208. The causal requirement is set out in amended section 2, 3 and elsewhere (with due alteration of details) in part II:

209. *'serious harm <u>may be caused</u> to the health or safety of the patient or of another person unless the patient receives medical treatment/is so detained'*

210. This is a new concept in the MHA. Causation (i.e. mental disorder as a cause of serious harm) is complex and requires multiple background conditions. 'May be caused' obscures complex background conditions.

211. Furthermore, the wording of the requirement is ambiguous. It appears to have the meaning 'if the patient is not detained, there is a risk of serious harm to their own health or safety, or to that of another person'. This meaning has a very wide breadth of application for preventative detention because risk is never zero (i.e. there is always 'a risk'). 'May be' is a highly inclusive verb phrase.

212. Finally, we are concerned that the ‘may be caused’ term will be very prone to hindsight bias, outcome bias and the narrative fallacy that are retrospective biases well recognised after the occurrence of serious harms.

213. In our view, both the breadth of prospective application of the ‘may be caused’ phrase and its liability for retrospective bias will drive defensive (rather than clinically reasoned) practice. It is well recognised that defensive practice drives down quality of care overall.

‘Likelihood’

214. The likelihood requirement is:

> *‘it is necessary, given the nature, degree and* likelihood *of the harm, for the patient to receive medical treatment, or given the nature, degree and* likelihood *of the harm, the patient ought to be so detained.*

215. Research has repeatedly underlined the difficulty of predicting serious harms such as violence or suicide (WITN0320004: CR201: Rethinking risk to others in mental health services). Indeed prediction is of very limited scientific and clinical value at the individual level when the base rate of serous harms, particularly serious violence, in the population being tested is low. Prediction tools for serious violence, even with relevant clinical stratifications, generate probabilities that are very low (WITN0320034: OxRisk: Oxford Forensic Psychiatry Risk Tools).

216. The term likelihood means probability. The meaning of likely in case law is 'more likely than not' (i.e. > 50%). Our understanding is that government does not want a '>50% chance of serious harm' interpretation of detention criteria. We agree, for the reasons that a) quantifying chances in individual cases is not practicable and b) even it were practicable, some serious harms are so serious that a 50% cut off is not appropriate.

217. Our view is that it is not realistic to expect MHA assessors, ACs etc. to provide probabilities of harm or to expect tribunals or courts to know how to interpret them. Such probabilities are typically only available at aggregate, or group, levels and are not *directly* relevant to individual risk assessment. Our concern is that the wording will give rise to pseudo exact and unreliable statements about probabilities and a pressure on assessors and ACs to provide them and for tribunals to seek them.

218. As in our response to the Joint Committee (WITN0320025: Written evidence submitted by the RCPsych to Joint Committee (MHA)), the College recommends removing words from the Bill that are not in practice exact and could (falsely) give the impression of being so.

219. We would like to see a simplification of the detention criteria with a view to ensuring a straightforward, holistic assessment of individual risk in the context of significant mental disorder which can be applied by clinicians and scrutinised by tribunals, etc. without ambiguous and potentially confusing wording.

<u>Recommended changes to detention criteria</u>

220. To address these concerns, the College recommends that the detention criteria are amended to require the following:

(a)the patient is suffering from mental disorder of a nature or degree; and

(b) there is a significant risk of serious harm to the health or safety of the patient or of another person

(c) it is necessary, given the nature or degree of the harm, for the patient to receive medical treatment (or assessment)

(d) the necessary treatment (or assessment) cannot be provided unless the patient is detained under this Act, and

(e) appropriate treatment (or assessment) is available for the patient.

221. This allows psychiatrists to do holistic, straightforward clinical assessments of:

- The mental disorder in an individual patient (the kind, degree, history, current manifestations and potential course).
- The serious harms in an individual patient that are relevant.
- The kind, degree, history, current manifestations and potential course of the harm(s) in this patient.
- Whether detention/deprivation of liberty is a necessary requirement for the treatment or assessment for the individual patient
- Whether appropriate treatment or assessment is available for this individual patient (the inpatient care and treatment plan)

222. Psychiatrists are familiar with these assessments and they align with best existing practice. In our view they are assessments which a well-trained psychiatric workforce can provide.

Proposal of extension of police powers under Sections 135 and 136

223. During the Report Stage of the passage of the Mental Health Act through the House of Lords, a series of amendments were passed that would introduce a new category of "authorised person" who can carry out detentions hitherto only performed by the police under s135 and s136. The intention of the amendments is to lessen the police's responsibility to attend mental health crises (both in people's residences and in public spaces).

224. However, extending police powers to a 'medical practitioner, approved mental health professional, mental health nurse or doctor, or a person of description specified in regulations made by the Secretary of State', is a radical proposal with a number of serious and potentially dangerous consequences and should not be pushed through without proper consideration of the potential consequences.

225. Responding for the government, Baroness Merron stated,

226. *'Extending these legal powers currently held by the police to other professionals would represent a major shift in roles and responsibilities for health and care professionals. It would place significant additional pressures on the NHS and potentially lead to staff, patient and public safety issues which mental health and*

urgent and emergency care leads have already raised significant concerns about.'

227. Though the Government have not chosen to include these changes to the Mental Health Act, there is an ongoing consultation on police powers which may include some of the proposals made.

228. While we recognise the immense pressures faced by Police services, we also acknowledge that mental health crises in the community are becoming increasingly acute and almost never occur without some level of risk. The expertise, skills and equipment of the police remain essential for safely reaching individuals in crisis – especially where they may be in immediate danger to themselves, pose a risk to others, or face a threat from others.

Community Treatment Orders and their dipropionate application to racialised communities

229. The use of CTOs, following their introduction in 2007, was significantly higher than predicted and their use is associated with marked racial/ethnic disparities. The changes proposed in the Draft Mental Health Act are very limited and offer no serious prospect of their use being restricted (which was the Wessely Review recommendation after hearing the evidence supporting their use).

230. The evidence of the disproportionate use of CTOs on Black people is well established. Recent statistics show that while black people are 4 times more

likely than white people to be detained under the MHA, they are 8 times more likely to be placed on a community treatment order (CTO).

231. As detailed above, the College has not at any time called for the abolition of Community Treatment Orders and has instead worked with Government to improve them to make sure they are achieving what they were stablished to do.

232. Although, there are aspects of care and service structure that contribute to disproportionate use of CTOs on Black people, it is primarily societal-wide factors that cause this.

233. Our 2017 survey of members found the top five factors that respondents believed explain why the Mental Health Act is applied to more people from BME (terminology used at the time) communities compared to the rest of the population in England and Wales were:

1. More barriers to those in the BME community accessing services – 79.8% cited this as one of the causes of this disproportion
2. Discrimination within wider society – 58.1% cited this as one of the causes
3. Insufficient access to wider public services (including housing, benefits social care, police – 57.6% cited this as one of the causes
4. Higher rates of severe mental illnesses within some BME communities – 56.3% cited this as one of the causes

5. Insufficient access to community mental health services – 55.3% cited this as one of the causes The College accepts this and tried to deal with the racism aspect.

234. The College recognises the issues with Community Treatment Orders and has put in place a number of methods to improve the practice surrounding them.

Elearning

235. Our Elearning hub provides a module on Community Treatment Orders which focuses on their implementation within the principles of the MHA Code of Practice.

Patient and Carer Race Equality Framework

236. The Patient and Carer Race Equality Framework (PCREF) is an organisational competency framework. It asks that organisations partner with the local community to coproduce services that better meet the needs of the local population.

237. The College played a key part in this work and contributed to a large number of the recommendations including on inequalities and the development of PCREF.

238. It suggests using QI approaches and asks for appropriate data collection and analysis. Staff and community partners develop change ideas designed to improve local services.

239. We urge that PCREF considerations underpin revisions to the Code of Practice and we support the CQC/Health Inspectorate Wales monitoring compliance with the PCREF as it evolves.

Advance Choice Documents

240. There is substantial evidence that Advance Choice Documents are the only intervention proven to reduce involuntary detention (by up to 25%). They help to improve the therapeutic relationship, can provide patients with choice and autonomy over their care and therefore improve their outcomes and reduce the need for detentions under mental health legislation. This reduced need for detention is related to people not becoming so unwell and going into mental health crisis that they require detention.

241. They resolve a fundamental inequality between physical and mental healthcare. While there is provision for those with physical health problems to use the Mental Capacity Act (MCA) to make advance decisions about their care (e.g. to refuse medical treatment), the same provisions are not legally binding for mental illness if the individual is admitted to a mental health hospital under the Mental Health Act 1983 (MHA).

242. Studies from the United States and United Kingdom have shown that Advance Choice Documents may be most effective among service users of Black ethnicity compared to those of other ethnic backgrounds. ACDs resulted in Black service users being more likely to have an increased sense of autonomy and including

them was more likely to be cost-effective for this group compared to those of other ethnic backgrounds.

243. Empirical research on ACDs has so far established the following:

244. People living with severe mental illness consistently say they would like to make ACD. Surveys in the US and UK concur that the majority (74%-88%) of respondents would like to make ACDs (WITN0320026: Swanson (2006)) (WITN0320027: Morriss (2017)).

245. ACDs can reduce the amount of involuntary treatment a person living with severe mental illness receives. Several RCTs evaluating the outcome of interventions to create documents which functioned as ACDs (with names such as Joint Crisis Plans and Psychiatric Advance Directives) have assessed the impact of these documents on involuntary hospital admissions (WITN0320028: Thornicroft (2013)).

246. Although results of individual trials varied, meta-analyses suggest that overall there is a significant reduction in compulsory admissions (WITN0320029: Molyneaux (2019)).

247. A multi-site RCT of ACDs in the UK established that this is an intervention that can significantly improve therapeutic alliance (WITN0320028: Thornicroft (2013)), (WITN0320026: Swanson (2006)).

248. It is of note that in a multicentre UK trial of an ACD equivalent (Joint Crisis Plans) it was shown that ACDs had the highest cost effectiveness for services when used with Black Service users (WITN0320030: Barrett (2013)).

249. In contrast to this evidence, there is limited evidence of the efficacy of CTOs – showing how engaging with patients can sometimes be achieved better when done in ways that are not restrictive (WITN0320031: Burns (2013)), (WITN0320032: Swartz (1999)).

Improving engagement with services

250. As detailed above, keeping patients engaged with their treatment while in the community is one of the most important ways of reducing risk to patients and the public. Rather than looking to achieve this through restriction, there are many ways (detailed above) that can do this through genuine engagement with patients, including:

- Positive therapeutic relationships
- Involving patients in decisions relating to their care
- Undertaking assertive outreach to engage hard-to-reach patients
- Providing good continuity of care

251. All of the above requires good mental health services that are well funded and staffed and with proper training and culture. These, rather than any individual legislative changes (excepting a statutory right to an ACD) will make the difference to keeping patients well and the public safe.

252. The College are not aware of any evidence to suggest that concerns about the disproportionate use of restrictive measures in respect of those of African and Caribbean heritage impacts the approach taken by practitioners when considering whether to use restrictive measures on black African or Caribbean mental health patients.

253. This should not be a consideration for clinicians who should base decision-making on apparent clinical risks. There is no evidence that psychiatrists are not admitting patients because they are Black. People of Black African or Caribbean heritage are over eight times more likely to be subjected to Community Treatment Orders than those of white heritage. This is the same as at the time of publication of the Independent Review of the Mental Health Act and recent evidence shows that detention rates in Black people are going up.

254. The main reason for people arriving in crisis and psychiatrists not admitting patients to hospital remains poor access to mental health services; poor community mental health service provision and a lack of appropriate beds when needed, regardless of ethnicity.

Statement of Truth

I believe that the facts stated in this witness statement are 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: 15/01/2026

Index to First Witness Statement of Dr Shubulade Smith

No.	Inquiry URN	Document Description
1	WITN0206014	CQC 2018 – The State of Care in Mental Health Services 2014– 2017.
2	WITN0319001	First Witness Statement of Stephen McGowan
3	WITN0320002	CR150: Self-harm, Suicide and Risk: Helping People Who Self-harm.
4	WITN0320003	CR158: Rethinking risk to others in mental health services.
5	WITN0320004	College Report CR201 – Rethinking risk to others in mental health services.
6	WITN0320005	Assessment and Management of Risk to Other People: Good Practice Guidance
7	WITN0320006	CR201 Rethinking Risk to Others in Menal Health Services
8	WITN0320007	NHS England Response to Prevention of Future Deaths Report 2019 Letter from Stephen Powis to Lydia Brown.
9	WITN0320008	Howes OD, Whitehurst T, Shatalina E, Townsend L, Onwordi EC, Mak TLA, Arumuham A, O'Brien O, Lobo M, Vano L, Zahid U, Butler E, Osugo M. The clinical significance of duration of untreated psychosis: an umbrella review and random-effects meta-analysis. World Psychiatry. 2021 Feb;20(1):75-95.

10	WITN0320009	INTEGRATE: international guidelines for the algorithmic treatment of schizophrenia.
11	WITN0320010	Aymerich C, Salazar de Pablo G, Pacho M, Pérez-Rodríguez V, Bilbao A, Andrés L, Pedruzo B, Castillo-Sintes I, Aranguren N, Fusar-Poli P, Zorrilla I, González-Pinto A, González-Torres MÁ, Catalán A. All-cause mortality risk in long-acting injectable versus oral antipsychotics in schizophrenia: a systematic review and meta-analysis. Mol Psychiatry. 2025 Jan;30(1):263-271.
12	WITN0320011	Razzaque, R., Mckenzie, E. Introducing Compassionate and Relational Enquiry (CARE): A Three-Day Training for Mental Health Clinicians on Relational Ways of Working. Community Ment Health J 60, 1037–1041 (2024). https://doi.org/10.1007/ s10597-024-01272-9
13	WITN0320012	Frank, A. F., & Gunderson, J. G. (1990). The role of the therapeutic alliance in the treatment of schizophrenia. Archives of General Psychiatry, 47, 228– 236
14	WITN0320013	Cant, T, A Suitable Manner? Developing a dialogical approach to a Mental Health Act Assessment. Could these be the seven key elements of a dialogical Mental Health Act assessment?

15	WITN0320014	Lagerberg T, Lambe S, Paulino A, Yu R, Fazel S. Systematic review of risk factors for violence in psychosis: 10-year update. Br J Psychiatry. 2025 Feb;226(2):100-107 doi: 10.1192/bjp.2024.120. Epub 2025 Mar 17. PMID: 40091674; PMCID: PMC7617503
16	WITN0320015	Whiting, D., Glogowska, M., Fazel, S., & Lennox, B. (2024). Approaches and challenges to assessing risk of violence in first episode psychosis: A qualitative interview study of clinicians, patients and carers. Early Intervention in Psychiatry, 18(8), 624– 632. https://doi.org/10.1111/ eip.13502
17	WITN0320016	Best Practice in Managing Risk (DH, 2007).
18	WITN0320017	RCPsych (2019) Confidentiality and Information Sharing Good Practice Guidance.
19	WITN0320018	The Patient Safety Incident Response Framework (PSIRF) (NHSE 2022)
20	WITN0320019	Ministry of Justice. Statistics of Mentally Disordered Offenders 2008: England and Wales. Ministry of Justice, 2010.
21	WITN0320020	National Offender Management Service. Prison Population and Accommodation Briefing for 8 October 2010. Ministry of Justice, 2010.
22	WITN0320021	Ministry of Justice. Reoffending of Adults. Results from the 2004 Cohort. Ministry of Justice, 2007.

23	WITN0320022	Psychosis and schizophrenia in adults prevention and management (NICE Guidance).
24	WITN0320023	Sweeney, A., Clement, S., Filson, B. and Kennedy, A. (2016), "Trauma-informed mental healthcare in the UK: what is it and how can we further its development?", Mental Health Review Journal, Vol. 21 No. 3, pp. 174- 192. https://doi.org/10. 1108/MHRJ-01-2015- 0006
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28	WITN0320027	Morriss R, Mudigonda M, Bartlett P, Chopra A, Jones S. National survey and analysis of barriers to the utilisation of the 2005 mental capacity act by people with bipolar disorder in England and Wales. Journal of Mental Health. 2017.
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30	WITN0320029	Molyneaux E, Turner A, Candy B, Landau S, Johnson S, Lloyd-Evans B. Crisis-planning interventions for people with psychotic illness or bipolar disorder: systematic review and meta-analyses. BJPsych Open. 2019;5(4).
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33	WITN0320032	Swartz MS, Swanson JW, Wagner HR, Burns BJ, Hiday VA, Borum R. Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial with severely mentally ill individuals. Am J Psychiatry 1999; 156: 1968–75. [PubMed].
34	WITN0320033	RCPsych's CCQI core community standards CCQI Core Standards 2022.
35	WITN0320034	https://oxrisk.com
36	WITN0320035	Sweeney A, Filson B, Kennedy A, Collinson L, Gillard S. A paradigm shift: relationships in trauma-informed mental health services. BJPsych Adv. 2018 Sep;24(5):319-333. doi: 10.1192/bja.2018.29. PMID: 30174829; PMCID: PMC6088388.