Witness Name: Dr Shubulade Smith

Statement No: WITN0320036

Dated: 28th May 2026

THE NOTTINGHAM INQUIRY

SECOND WITNESS STATEMENT OF DR SHUBULADE SMITH CBE

Employing Organisation: The Royal College of Psychiatrists

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

INTRODUCTION

1. My professional background is set out in my first witness statement to the Nottingham Inquiry (the "**Inquiry**") dated 15 January 2026 [WITN032001].
2. This witness statement is made to assist the Inquiry with the matters set out in the Rule 9 Request dated 22 May 2026.

"Least restrictive" principle

3. The Mental Health Act 1983: Code of Practice [WITN0320037] (the Code), published by the Department of The College is engaged with the DHSC on the development of an updated Code of Practice for the Mental Health Act 2025. Although the College provides training on the Mental Health Act, it is not the remit of the College to – and so the College does not – provide its own specific policy or guidance for practitioners to assist them in the guidance of the least restrictive principle.
4. Detention under the Mental Health Act is itself a restriction of liberty. No other medical specialty (other than rarely, Public Health medicine) has the power to restrict a person's liberty on health grounds. This is not a responsibility to take

lightly and must be done with careful thought. The legislation and the guidance clearly states that the primary factor to be taken into account when considering detention is the risk of harm to the patient or others, and this overrides the patient's autonomy.

5. The Mental Health Units (Use of Force) Act 2018 (UK) (commonly referred to as 'Seni's Law') [WITN0320038] and its statutory guidance provides a further legislative framework for restraint or isolation of a patient when it is necessary to prevent harm provided it is proportionate and applied in the least restrictive way possible.
6. For its own part, the College's National Collaborating Centre for Mental Health (NCCMH) previously ran a Reducing Restrictive Practice Collaborative that directly supported some mental health inpatient wards in NHS trusts across England to reduce the use of rapid tranquillisation, restraint, and seclusion. Teams that signed up to the Collaborative were supported by a quality improvement coach, a range of resources and regular peer-to-peer learning and knowledge sharing sessions. Between 2018 and 2020, 24 out of 38 wards saw reductions ranging from 25% to 100% in one or more measures of restrictive practice. Over 18 months, there was a 15% reduction in the overall use of restrictive practices among the 38 wards participating in the Collaborative.
7. Where required, it can be necessary to give treatment to people involuntarily – for their health, their safety and/or the safety of others. Psychiatrists acknowledge that patients subjected to restrictive practices are less likely to continue to engage with treatment following discharge, and therefore more likely to relapse – which increases the likelihood of harm to themselves and others.

Coercive treatment practices

8. There is a complex balance between a patient's autonomy with the duty to protect them or others from harm when there is impaired insight or capacity. Doing so requires careful review and decisions can be complex, so are often taken at a multi-professional team level and if needed, will involve input from the Caldicott Guardian and other ethical guidance. Decision-making is also guided by the Mental Capacity Act which, like other medical professions, psychiatrists are legally bound to work to. Psychiatrists must assess the patient's best interests, and

autonomy is one of the factors which must be taken into account rather than prioritised over managing the risk of harm. We know from data on detention rates and use of restrictive interventions from NHS Digital [WITN0320039] and the Care Quality Commission [WITN0320040] that coercive treatment is still being used but psychiatrists do this in the least restrictive way possible, as per guidance.

9. The College does not convey to the profession that psychiatrists are being overly coercive – whereby they are using coercive practices too readily, excessively, or without sufficient justification – and we do not recognise this as a message from the Government or the CQC. The College and other stakeholders advocate for good psychiatric practice which is appropriate and proportionate. In line with the legal framework, including the Mental Health Act, the College advises that coercive treatments should not be used when it is not appropriate to do so. However, we recognise that good practice sometimes includes coercive treatments.
10. This reflects the nature of some psychiatric illness in that people suffering from the condition lose insight and therefore do not believe they are unwell and do not see the need for treatment. Under these circumstances it may be necessary to give treatment to people involuntarily – for their health, their safety and/or the safety of others.
11. Through training and guidance, the College supports clinicians to manage the complexity involved in making decisions around coercive treatment; recognising when a treatment is coercive, how best to support someone when coercive treatment is required and how best to support staff to do this safely and in a way that will not unduly negatively impact the therapeutic relationship.
12. Coercive treatment can induce negative experiences of psychiatric care, which reduces the likelihood of patient engagement in the future. This in turn reduces the likelihood of adherence to treatment, thus increasing the likelihood of relapse into mental health crisis. This is associated with an increased risk to self and others. The College's experience over many years is that these issues are cyclical and that at times the press suggests that psychiatry is too coercive, and at other times, that psychiatrists place patient safety over public safety. This is why the College supports evidence-based and expert decision making through training and guidance.

The principle of patient autonomy

13. The 2007 amendments to the Mental Health Act focused more on risk to others than individual liberties, introducing extended powers of compulsion in the community and a widening of the professional groups that could apply to fulfil new roles that exercise power under the Act. Seni's Law (the Mental Health Units (Use of Force) Act 2018) is also an important national framework that supports the use of restraint and isolation of a patient in a proportionate and least restrictive way possible, while increasing transparency, accountability, and staff training around its use.
14. While we do not believe there has been an over-emphasis on patient autonomy at a national level, the College has repeatedly highlighted the sustained problem of NHS mental health services being over-stretched and under-resourced and how this impacts clinical decision-making. We know from responses to a 2025 RCPsych survey (primarily about general adult inpatient mental health capacity), that a large majority (73%) of respondents felt they had to decide on admission or discharge based on something other than the patient's clinical need and best interest. [WITN0320041] A substantial proportion of respondents described pressure coming from insufficient and unsuitable local inpatient provision, particularly bed availability and suitability. This is compounded by gaps in community services, leading to more people reaching crisis before they can access care; reducing patient's autonomy and increasing risk to others. However, this downward trend is reversible; continuity of care must be re-established as the model of care; avoiding readmission and staying well must be the focus of treatment (rather than reducing length of stay); the community treatment gap must be closed. All of which is achievable with clinical mental health expertise embedded at the heart of commissioning and decision-making.

Clinician training on least restrictive practice principle

15. The College publishes the Core Psychiatry Curriculum, which is the starting point for standards against which training is delivered across the UK to resident doctors. High Level Outcome 3.1 requires trainees to be able to balance the duty of care to the patient and the protection of others with the restriction of human rights within the legal and organisational frameworks in the UK. This training is required for

trainees to continue training in higher specialist posts. It is then repeated in the higher General Adult specialty curriculum.

16. The Mental Health Act is one of the legislative frameworks for implementing the least restrictive principle in the UK. The College provides training for Section 12 Doctors, which sets out the framework for detention under the Act, as well as Approved Clinician training. The training consists of eLearning modules with recorded presentations, interactive learning exercises, and end-of-module tests, along with a three-hour live online session with our expert panel. The courses are approved by the Department of Health and Social Care's National Reference Group. The College also offers employers access to these high-quality training sessions if they wish to deliver their own in-house training on these topics.

Application of least restrictive practice principle

17. The principle of least restrictive practice is a principle that is applied **after** a decision is made that a person is unwell and needs treatment. If it is thought that the person's illness poses a risk to themselves or others, then a decision will be made about the most proportionate (i.e. the least restrictive) way to manage them and their illness safely. To be clear, for an individual at a particular time, the least restrictive practice may well include being placed in seclusion in a secure environment.
18. Clinicians should apply the principle of least restrictive practice by making decisions based on the patient and their history, presentation, and their circumstances. Decisions regarding restrictive practices should always be proportionate and appropriate to the person – this should include a consideration of risk they pose to themselves and others, balanced alongside the type of treatment that is going to keep this person well. The NCCMH Reducing Restrictive Practice programme emphasises principles such as understanding the individual and the causes of their behaviour, and minimising harm. These can be understood in practice as considering factors such as immediacy of risk, availability of alternatives, individual needs, contributing factors, proportionality, and potential impact on the person.
19. If it is determined that the patient does not adhere to medication, then depot should be considered. However, this decision should be in communication with the patient

– for example, type of medication, where they could be injected, etc. should be discussed.

20. We do not believe that there is a range of understanding as the principles and best practice related to least restrictive practices are commonly understood and embedded in training and guidance. While overarching guidance is provided, clinicians will make decisions based on the patient and their history, presentation and their circumstances. Aside from natural variation in individual clinicians' implementation, we are not aware of systematic evidence of varied practice. It is important to recognise that psychiatrists work as part of a multi-disciplinary team where other professionals are involved in this decision making.

<u>Standards for Forensic Mental Health Services: Sixth Edition</u>

Considering the risk to others when discharging or transferring patients

21. This guidance focuses on people who are currently in forensic mental health services. Forensic mental health practitioners provide specialised assessment, treatment and care for those with a mental illness who have come into contact with the criminal justice system, or who pose a significant risk of harm to others and who cannot be managed in general adult services. The vast majority of mental health patients are treated in general adult services. Most patients in forensic services are there because of the risk they have posed to others and therefore the main focus of treatment and rehabilitation is reducing this risk. This guidance is solely directed to practitioners working with patients who pose, or have previously posed, a risk to others and this is at the forefront of their decision-making.
22. The Foreword states that patients must be enabled to progress to the community in 'safe and sustained ways', reiterating the need to mitigate against risks to others including risk posed to potential victims in the near vicinity of the individual (other patients, staff and visitors) as well as potential victims further away in geographical space and time – this includes those known to the individual patient and strangers. These are principles that are well understood to forensic mental health practitioners because of their training, engagement in peer networks and clinical experience. These practitioners inherently understand the need to consider risk to others in the clinical decisions they make, which the guidance makes clear throughout.

23. Standard number 29 specifically refers to the risk of suicide upon patient discharge or transfer. Forensic services are often so focused on the risk to others that risk to self can be overlooked. It therefore requires explicit reference in the guidance to ensure it is not neglected. The overshadowing of risk to self by the primary focus on risk to others is well-known to those who actively work in clinical forensic services.
24. The importance of risk to others is more explicitly mentioned at standard 31 which sets out that a risk assessment of the patient must be included in a discharge summary. Standard 57 advises that access to nature can be provided only according to a patient's risk assessment, standards 89 and 90 mention the need to consider victim issues and risks in care management. Standard 12 makes clear that risk assessment must consider risk to others (alongside risk to self and risk from others).
25. Any risks posed by a patient to others are very individually determined, hence the need for a structured professional risk judgement approach rather than actuarial measures which are inadequate in predicting whether a person in a particular group might pose a particular risk to others at a particular time and what that risk might be.

Royal College of Psychiatrists' Guidance on Information-sharing

26. The College has recently appointed a new Chair to the Ethics Committee which will oversee any updates to Good Psychiatric Practice: Confidentiality and Information Sharing, they will set out a timeline in the coming months. Any updates will take account of the Inquiry's recommendations.

Barriers to information sharing

27. A lack of interoperability in respect of digital patient records is the main barrier to information sharing between agencies. At present, the agencies involved (such as different mental health trusts; physical and mental health trusts; primary and secondary care; health trusts and ambulance services; health trusts and other non-health agencies, such as the Police, Local Authorities, Social Services, Voluntary Community and Social Enterprise services and Housing) do not have

digital record systems that can "speak to" each other. Understandably, this impacts the ability for these agencies to share information effectively.

28. The College has repeatedly asked the UK Government to support the interoperability of digital patient records. As a procurer of digital systems, the NHS could require digital providers to ensure their patient record systems "speak to" those of other digital providers in the UK. Having access to the records of a patient at any stage of their health journey would reduce the gaps in information flow that often occur.

29. Multi-Agency Public Protection Arrangements (MAPPA) is the statutory framework used to assess and manage the risks posed by violent offenders. [WITN0320042] The core function of MAPPA is to identify relevant offenders (adults or children) who may pose a risk to others; assess the risks posed and develop strategies to manage that risk. MAPPA confers a duty to cooperate on relevant agencies, such that police, probation (including youth offending teams), and prison services are required to collaborate with health, housing, local authority, and social care agencies to protect the public and reduce reoffending.

30. There are limitations to the MAPPA approach – often these are determined by resource constraints in all agencies. A patient might be referred to MAPPA but is not felt to be serious enough to warrant a MAPPA response at any level or may not be felt to require the level of risk that they were referred for by the clinical team.

31. The guidance is clear that confidentiality is limited and if there is thought to be a serious risk posed to others, then that confidentiality can be breached and the information shared in line with the MAPPA framework. This stipulates that consent is not needed where it is lawful, proportionate, required to protect the public and focused on managing identified, specific risks. While there is not a defined list, the type of risks include factors such as previous behaviour and offending history, current/recent presentation and behaviour, factors that increase risk (such as substance use or social isolation), information on compliance and engagement with services, specific threats or communications, and specific information held by agencies such as that relevant to risk of harm or concerning behaviour.

<u>NHS England Guidance to Integrated Care Boards on intensive and assertive community mental health care (February 2025)</u>

Static risk assessment tools vs risk formulation

32. The NHSE guidance is correct to advise that static risk assessment tools are not appropriate in predicting the long-term risk of violence towards others. NICE guidance addressing the use of risk formulation tools assessing risk to others currently does not exist, and therefore while the emphasis in the NHSE guidance could have been clearer, by explicitly speaking about best practice in violence risk assessment, the reference to risk formulation is correct.
33. Many risk assessment tools used by mental health trusts have been developed in-house and without an evidence base. They are often actuarial, with static determinations of low, medium, and high risk but inaccurate in predicting longer-term violence. This is because these tools don't consider the different situations a person may find themselves in for example, different environments, moods, interactions, etc that could impact a person's functions. The College suggests that there should be uniformity and application of risk tools across healthcare. The most appropriate guidance for managing risk to others is that provided by the College - CR201.
34. The Inquiry should be aware that there is a danger that risk assessment tools themselves can assess a person as having a low risk of harm to self or others when that is not the case. This has long been known for violence risk assessment and management and more recently this advice has been given by the National Confidential Inquiry into Suicide and Homicide (NCISH) for self-harm and suicide risk assessment. The best assessment of risk should be made through the provision of continuity of care and by the use of structured professional risk judgement which develops risk scenarios and uses risk formulation to develop strategies to manage the risks posed by a person.
35. The NICE guideline NG10 on "Violence and aggression" is mainly focused on the short-term assessment and management of imminent violence rather than the risk management of long-term violence risk – the latter of which, the NHSE guidance is seeking to support.
36. Both the need to determine short-term and long-term risk and means of determining short-term and longer-term risk management are different and therefore require different tools.

37. Short-term violence risk management is used for patients who are acutely unwell and display agitation and aggression towards others. In this circumstance professionals need to understand how to best manage such a level of aggression. This type of aggression usually occurs in an inpatient setting due to the acute nature of a person's illness and is of higher frequency but lower severity. The aim is usually to observe agitation levels and intervene before the level of agitation results in aggression towards others. Risk factors include how a person has behaved in the last 24 hours as well as levels of hunger; environmental noise; immediate interactions with staff and other patients and so on. Interventions include time out; early use of tranquillising medication (often taken by the patient themselves) and control of other factors, such as ensuring the person has eaten etc. Risk assessment tools, such as the Broset and DASA are used to support decision-making in these circumstances.
38. In contrast, long-term risk management is for patients who have histories of severe violence that is infrequent – usually low frequency, high severity violence. Predicting this violence is more difficult, because these events are rarer and requires risk formulation tools rather than actuarial risk assessment tools. This type of prediction primarily occurs in forensic settings with patients who have known histories of severe violence towards others. The risk management approach is different and based on structured professional judgement using risk formulation tools such as the HCR-20, which provide a framework that supports the team (often with the patient) to think through the circumstances in which there might be a repeat of prior violent behaviour; an escalation of that behaviour and whether and under what circumstances there might be a rapid change in behaviour. The aim is to develop strategies to mitigate and control the factors that might increase the risks that might be associated with each of these scenarios.
39. Even with structured professional risk formulation, it is known these tools cannot predict whether a person might perpetrate violence at a particular time, the type of violence and who might be the victim.
40. However, the effectiveness of the risk management approach can be seen when comparing when discharges of mentally disordered offenders from forensic mental health care services against the release of non-mentally disordered prisoners from prison custody. In 2021/22 298 people who were subject to restriction orders were

discharged from hospital across England and Wales and the number of proven reoffenders within one year was 15 (5.0%). By way of contrast the proven reoffending rate in the January - March 2022 period for adult offenders released from custody across England and Wales was 36.8% (55.5% for those who had received a custodial sentence of less than 12 months, 20.8% among those with sentences of 12 months or more).

41. NHSE's advocation of risk formulation rather than the use of risk assessment tools is in line with the College's guidance set out in CR201. There still needs to be a development of a risk assessment framework for general adult services.

43. While the College has not been commissioned by NHSE to develop any guidance and is not currently working with NHSE to do so, we should be involved in the development of any such guidance in respect of assessment of risk posed by patients towards others and would welcome the opportunity to contribute.
44. We are aware that NHSE commissioned research by the National Institute for Heath and Care Research on this topic, which is due to be published soon. In light of this ongoing work, the College has not updated its own guidance but will review it when research is available.

<u>The role of race and demographics in psychiatric care</u>

45. There is consistent evidence that people of Black Caribbean and Black African backgrounds in the UK experience higher rates of mental illness, compared to the White majority in the population, including common mental disorders like anxiety, depression and post-traumatic stress disorder (PTSD) [WITN0320043] [WITN0320044] as well as severe mental illnesses such as Bipolar illness, schizophrenia and other psychoses. [WITN0320045] [WITN0320046] There is compelling evidence that these increased rates of illness are not primarily explained by genetic factors, but closely associated with higher rates of social disadvantage, poverty, and in those Black people who use recreational substances, the early use of cannabis.[WITN0320047] [WITN0320048] This is further supported by studies of migrant populations showing that the risk of

psychotic disorders is higher among migrants and their descendants in Europe, particularly among those of African and Caribbean origin, compared with majority populations.[WITN0320049] [WITN0320050] Comparable increases are not consistently observed in populations of similar ethnic background in their countries of origin, suggesting that these differences are context-dependent and shaped by social conditions rather than ethnicity per se. [WITN0320051]

46. People of Black African and Caribbean heritage are more likely than White British people to have contact with mental health services through the criminal justice system, rather than GP referral or Talking Therapies self-referral.[WITN0320052] [WITN0320053] [WITN0320054] They are also significantly more likely to be detained under the Mental Health Act – around 2.5 times more likely than White British people – and more likely to be detained more than once (18.4% of all Black people detained in 2024-25), admitted to locked wards, psychiatric care and secure services, subjected to restrictive practices such as high dose antipsychotic medication, physical restraint and seclusion. [WITN0320055] [WITN0320056]
47. These disparities reflect a complex interplay of factors, including patterns of illness (particularly psychosis), social inequalities, barriers to early access to care, and differences in pathways and experiences within the mental health system.
48. Any decision regarding a patient's treatment is based on their health, their safety and/or the safety of others. There have been numerous studies into the disparities in mental healthcare, and psychiatry has examined its own practice to understand the nature of this inequity. Research shows that these disparities are not because of discriminatory practice by the profession, rather because of factors arising much earlier in a person's life.
49. 'By the time patients get to us [psychiatrists], they've often been failed many times over by institutions across education, health, social services, housing and the justice system'. [WITN0320057] It's well evidenced that mental health is dictated by social-economic determinants, alongside genetics. As a group who disproportionately experience poor housing, lower incomes, discrimination, etc. Black people are more vulnerable to poor mental health than their white peers.
50. This group then faces additional barriers of access to care; the Race and Health Observatory found that Black children are 10 times more likely to be referred to CAMHS via social services than via a GP (Smith and Mohan, 2022) highlighting

the barriers to accessing primary care that have gone unnoticed. [WITN0320057] In turn, Black people are more likely to engage with mental health services at crisis point, presenting with more acute symptoms and requiring more intensive treatment.

51. Rather than being influenced by a person's race in decision-making, psychiatrists have been required to respond to the consequences of institutional racism. The College has consistently raised concerns about the disproportionate detention of Black and minoritised ethnic communities, not to advise that Black people, or anyone, shouldn't be detained when necessary, rather to highlight that timely access to appropriate treatment must improve so that fewer Black people experience mental health crisis, thus reducing the need to detain.
52. In 2018 the College surveyed its members in anticipation of the Mental Health Act Review, to help inform the College's engagement. 1,835 members responded to the survey from across England and Wales. Members were asked their opinion on why the Mental Health Act applied to more people from minoritised ethnic communities compared to the rest of the population in England and Wales. The top factor was more barriers to those in the Black and Minority Ethnic community accessing services – 79.8% cited this as one of the causes of this disparity. Other factors can also give rise to a greater instance of mental health illnesses in the community, such as epidemics and pandemics.
53. The College's Advancing Mental Health Equality guidance supports commissioners and providers in producing population-led, culturally appropriate services but beyond the advice and expertise the College can provide, there must be a national drive to implement improved and more accessible services. Trusts are now required by NHSE to implement the Patient and Carer Race Equality Framework, developed by the College and arising from the Independent Review of the Mental Health Act.
54. Michael Marmot is clear that these problems will remain unless the government starts to tackle the 'causes of the causes'. The College welcomed the launch of a Call for Evidence to help shape a new cross-Government Mental Health Strategy for England. In fact, this is something we have been wanting to see introduced for quite some time.

55. Alongside a renewed focus on community mental healthcare, the Strategy provides the opportunity to turn the tide on worsening mental health but only if the Strategy focuses on support for the spectrum of mental illnesses, including those with more complex or serious needs, that are often overlooked.
56. It's well-established that improving mental health requires a whole society approach; from housing and social care to business and education in addition to healthcare and health research, and the Strategy needs to ensure there is collective responsibility. The Strategy must set out its governance structure and approach to reporting progress, to ensure real change is made.
57. To support other Government departments, Arm's Length Bodies, and regional bodies to make decisions which positively influence population mental health, a mental health policy test, akin to an equality impact assessment, should be rolled out.

Best practice guidance

58. Best practice guidance is clear that clinical decisions must be based on a person's health, their safety and/or the safety of others.
59. There are pieces of legislation, or legal requirements, which seek to reduce disparities in the health service - Public Sector Equality Duty [WITN0320058] Patient and Carer Race Equality Framework [WITN0320059] and the Mental Health Act. These however look at institutional practices rather than individual decision making.

Disparities in mental health care

60. The College and other stakeholders are not framing the profession as institutionally racist at an individual level, but have highlighted concerns around differential outcomes resulting from well-established disparities in access to and experiences of mental health services. This has emphasised their relationship with patterns of care at a system level, arising from structural factors (such as wider social conditions and differences in exposure to risk) or institutional factors (such as service design and pathways into care). The impact of this is to help clinicians recognise the need to actively examine and reduce inequalities through initiatives such as the Patient and Carer Race Equality Framework (PCREF) and broader

advancing mental health equalities (AMHE) work. [WITN0320060] These emphasise improving systems, data transparency, governance, accessible services and patient experience, with a focus on reducing inequalities and ensuring services better reflect and respond to the communities they serve.

61. The way this message is conveyed explicitly recognises that individual clinicians are not consciously or deliberately acting in a discriminatory way—for example, not routinely making clinical decisions, such as detentions or the use of restrictive practices, on the basis of a patient's race. There is no clear evidence that clinicians are routinely making decisions in this way, and this would be at odds with best practice, which requires decisions to be based on the individual's history, presentation, and circumstances.

Statement of Truth

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

Signed: GRO-B

Dated: 28th May 2026

Index to Second Witness Statement of Dr Shubulade Smith

No.	**URN**	**Document Description**	**Control Number**
1.	WITN0320037	Mental Health Act 1983: Code of Practice	
2.	WITN0320038	The Mental Health Units (Use of Force) Act 2018 (UK) Mental Health Units (Use of Force) Act 2018 - Statutory guidance for NHS organisations in England, and police forces in England and Wales	
3.	WITN0320039	NHS Digital (2025) *Mental Health Act Statistics, Annual Figures 2024–25: Detentions*. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2024-25-annual-figures/detentions	
4.	WITN0320040	Care Quality Commission (2026) *Monitoring the Mental Health Act 2024/25: Quality and safety of care*. Available at: https://www.cqc.org.uk/publications/monitoring-mental-health-act/2024-2025/safety	
5.	WITN0320041	RCPsych survey Royal College of Psychiatrists (2025) *Membership survey on local capacity: survey findings for England*. Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/policy/rcpsych-membership-survey-on-local-capacity---england.pdf	
6.	WITN0320042	People who have been given sentences over 12 months or who have been detained under hospital orders, sexual offenders and those deemed to be	

		dangerous who do not fulfil criteria but pose a serious risk to others.	
7.	WITN0320043	Morris, S., Hill, S., McManus, S. and Brugha, T. (2025) Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/24. London: NHS England.	
8.	WITN0320044	Hatch, S.L., Gazard, B., Williams, D.R., Frissa, S., Goodwin, L. and Hotopf, M. (2016) Discrimination and common mental disorder among migrant and ethnic groups: findings from a South East London community sample. Social Psychiatry and Psychiatric Epidemiology, 51(5), pp.689–701.	
9.	WITN0320045	Morgan C, Fearon P, Hutchinson G et al (2006) *Pathways to care and ethnicity. 1: Sample characteristics and compulsory admission. Report from the AESOP study.* Br J Psychiatry 188: 281–287.	
10.	WITN0320046	Kirkbride JB et al (2008) *Psychoses, ethnicity and socio-economic status.* Br J Psychiatry 193: 18–24.	
11.	WITN0320047	Kirkbride JB, Fearon P, Morgan C et al (2006) *Heterogeneity in incidence of schizophrenia and other psychotic syndromes.* Arch Gen Psychiatry 63: 250–258.	
12.	WITN0320048	Morgan C, Hutchinson G (2010) *The social determinants of psychosis in migrant and ethnic minority populations.* Int Rev Psychiatry 22: 207–215.	
13.	WITN0320049	Selten JP, van der Ven E, Termorshuizen F (2020) *Migration and psychosis: a meta-analysis of incidence studies*. Psychol Med 50: 303–313.	
14.	WITN0320050	Pignon B, Geoffroy PA, Thomas P, Roelandt JL, Rolland B, Amad A (2020) *Prevalence and correlates of anxiety disorders in the French general population: the Mental Health in General*	

		Population (MHGP) study. Journal of Affective Disorders, 277: 929–936.	
15.	WITN0320051	Morgan C, Cohen A, Esponda GM et al (2022) *Epidemiology of untreated psychoses in diverse settings (INTREPID II)*. JAMA Psychiatry 80: 40–48.	
16.	WITN0320052	Morgan C, Mallett R, Hutchinson G et al (2005) *Pathways to care and ethnicity. 2: Source of referral and help-seeking*. Br J Psychiatry 186: 290–296.	
17.	WITN0320053	Singh SP, Greenwood N, White S, Churchill R (2007) *Ethnicity and the Mental Health Act*. Br J Psychiatry 191: 99–105.	
18.	WITN0320054	Anderson KK, Flora N, Archie S, Morgan C, McKenzie K (2014) *A meta-analysis of ethnic differences in pathways to care at first episode psychosis.* Acta Psychiatr Scand 130: 257–268.	
19.	WITN0320055	Barnett P, Mackay E, Matthews H et al (2019) *Ethnic variations in compulsory detention under the Mental Health Act: a systematic review and meta-analysis*. Lancet Psychiatry 6: 305–317.	
20.	WITN0320056	NHS Digital (2025) *Mental Health Act Statistics, Annual Figures 2024–25*. Leeds: NHS Digital.	
21.	WITN0320057	Smith, S. and Mohan, R. (2022) The NHS is not an island—tackling racial disparities in healthcare. BMJ, 377, o944	
22.	WITN0320058	UK Government (2023) Public Sector Equality Duty: guidance for public authorities. Available at: https://www.gov.uk/government/publications/public-sector-equality-duty-guidance-for-public-authorities/public-sector-equality-duty-guidance-for-public-authorities	
23.	WITN0320059	NHS England (2023) *Patient and carer race equality framework*. Available at: https://www.england.nhs.uk/publication/patient-and-carer-race-equality-framework/	
24.	WITN0320060	Royal College of Psychiatrists (2023) Advancing mental health equity collaborative. Available at: https://www.rcpsych.ac.uk/about-us/equity-	

		diversity-and-inclusion/advancing-mental-health-equity-collaborative	