Witness Name: Christopher Hart
Statement No: WITN0075001
Dated: 30 January 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF CHRISTOPHER DAVID HART

I, **Christopher David Hart**, will say as follows:

Introduction

1. My qualifications are: RGN (Registered General Nurse), RMN (Registered Mental Nurse) and MA (Social Policy).

2. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 Request dated 26 August 2025 (the "**Request**").

My Career

3. Prior to completing my training as a mental health nurse (1983 – 1985), I worked as a general nurse, mainly in ITU and A&E. After qualifying as a mental health nurse, I worked at the Maudsley Hospital from 1985 - 1989, starting as a staff nurse and finishing as ward manager. I then managed St Luke's Hospital and all acute mental health services (including inpatient and community settings) in what is now Camden & Islington NHS Foundation Trust. In 1995 I returned to clinical work as a team leader for the Assessment and Treatment Community Mental Health Team in Lambeth, which merged to form SLAM NHS Foundation Trust.

4. I left the community team to take up a role as a Nurse Consultant in Liaison Psychiatry, based at St George's Hospital, in 2001. This was a joint role. Half my working week was in the Nurse Consultant position, with the other half spent at St George's and Kingston University of London as a Principal Lecturer (see below).

5. In 2009, I moved into the forensic service, working within the Medium Secure Unit at Springfield Hospital. My role subsequently incorporated clinical responsibility for nursing within the hospital's Psychiatric Intensive Care Unit from 2012-2013 when I left the NHS.

6. I remained within the university, taking on the position of senior lecturer on a part time basis from 2013 – 2016.

Current clinical roles

7. Since 2013 I have been working as an Independent Nurse Consultant. This initially involved educational work but has evolved to include clinical work in a number of prisons' inpatient units, supporting Oxleas NHS Foundation Trust. In this role, I risk assess and contribute to the risk management of the highest risk prisoners, both in terms of risk to self, e.g. suicide and self-harm, and risk to others e.g. violence. I did this for almost three years at HMP Belmarsh, which involved regular face to face contact with prisoners, attendance at ward rounds, liaising with the prison, writing reports for the prison and outside hospitals. I now do this to support the clinical teams at HMP Wandsworth and prisons in Kent.

Academic positions and roles

8. From 2001 - 2013, in my joint role, I was a principal lecturer at St George's and Kingston University of London, mainly teaching in the mental health field but also working with the communication skills and management and leadership teams.

9. I devised and led the University's Clinical Simulations Programme for mental health students. This won two awards for educational innovation at the annual

Student Nursing Times Awards. I also led on modules on Assessing the Risk of Suicide and Self Harm, and Mental Health for paramedics.

10. When I retired from my joint post as nurse consultant and principal lecturer in 2013, I rejoined the University as senior lecturer but, essentially, carried on in my previous role, continuing to lead and further develop the Clinical Simulations Programme and the same modules.

11. I left the University in 2016 to focus on the growing demands of the prison work I was being asked to do. This involved devising and leading an educational programme aimed at helping prisons and healthcare teams reduce deaths in custody, particularly those that are self-inflicted, funded by and run for the London Division of the Health and Justice Team in NHS England.

12. This became the Reducing Deaths in Custody Programme and I am still director for this programme, though it is now exclusively provided for Oxleas NHS Foundation Trust. The programme comprises modules on Assessing the Risk of Suicide and Self Harm, Mental Health First Aid, Advanced Communication Skills, Assessing the Risk of Violence and Dangerousness to Others, Challenging Behaviours and De-escalation Skills, and a range of other modules linked to understanding the causes of risk to self and/or others and ways of reducing and managing that risk.

13. This programme was another winner of a Nursing Times educational award.

14. Myself and the small team of independent nurse consultants who work with me have also provided similar programmes for community based health workers, school nurses and staff working in inpatient mental health units, as well as a yearlong programme on risk assessment and mental health for all clinicians working in the St Thomas' Hospital Emergency Department.

15. In the last five years we have also provided risk assessment programmes for different NHS Trusts and private sector organisations and have facilitated 'Train the Trainers' programmes for them.

Publications – clinical

16. In 2014, Routledge published my book, *A Pocket Guide to Risk Assessment and Management in Mental Health*. Although it provided a theoretical base and drew on existing literature it was, as the title suggests, a practical, skills-based work that covered all aspects of risk assessment, risk formulation and risk management specific to people with mental health conditions.

17. In 2024, a second, expanded text (*A Pocket Guide to Risk Assessment and Management in Mental Health, Second Edition*) was published. This included more information about the circumstances that increase risk in specific groups, e.g. young people, those misusing substances, people with specific mental disorders, as well as an entirely new section that focused on prison and forensic settings, specifically the assessment and risk management of violence to others.

18. I co-edited and authored a number of chapters in *Mental Health Care for Nurses: Applying mental health skills in the general hospital*, published in 2006 by Blackwell.

19. I have also provided chapters on mental health nursing and risk assessment in various books, including *Psychiatric and Mental Health Nursing: The craft of caring*, edited by Phil Barker and *Emergency Nursing at a Glance,* (Edited by Holberry and Newcombe).

Publications – mental health history

20. I have written two books that extensively cover the history of mental health nursing and mental health services: Behind the Mask (1994) and Politics and Nursing (2004).

21. I have had over 100 articles published, mainly in the nursing press, in respect of the history of mental health services, nursing and other topics, as well as clinical articles related to mental and adult nursing.

Relevant appointments and memberships

22. I am a member of the Royal College of Nursing and have held the following positions:

    - Chair of the Association of Nurse Consultants 2002 – 2009;
    - President of the International Chapter of the American Psychiatric Nurses Association 2004 – 2011;
    - Chair of the London Liaison Psychiatry Forum 2002 – 2009
    - Board Member of the United Kingdom Association of the History of Nursing 2011 - 2012.
    - Advisor for the Department of Health in different capacities, including:
        a. Member of the working party for the CNO Review of Mental Health Nursing in 2006;
        b. Advisor to The Emergency Care Collaborative;
        c. Member of the working group for the Development of the Responsible Clinician;
        d. Member of the Nursing Advisory Group on Research and Education;
    - Acted as advisor to the British Army in the re-organisation of its mental health services in Germany;
    - Advisor on the redesign of mental health services for the Welsh Office;
    - External investigator/advisor and carried out staff support work to mental health trusts in the wake of suicides and homicides by patients with a mental disorder, including acting as a clinical advisor to the Ombudsman.

23. As well as speaking at conferences throughout the UK, I have presented my work in various countries, including the United States, Canada, Denmark, Germany, Belgium, and the Netherlands.

Mental health nursing

The difference in training, competencies and roles between a general nurse and a mental health nurse.

24. Mental health nurses, as is the case for 'general' or 'adult' nurses, must complete a training that is approved by the Nursing and Midwifery Council (NMC), at which point they are recommended to the NMC register as a registered nurse (with a number of names used to describe this group of nurses, I will use the term 'adult' nurses, which is that commonly used within the profession). There are now a number of routes to registration, but the main one remains a three-year university based programme, resulting in a BSc(hons). It combines an educational programme alongside clinical placements in a variety of settings relevant to their field, where the student is supernumerary to the clinical team but should experience opportunities to learn about clinical practice, participating in patient care in a supervised role.

25. The most important thing to state at the outset is that there is no national curriculum for mental health nursing. Each university devises its own programmes although these are within guidelines from the NMC and will have been approved by the NMC. While the core of the programme will be consistent across universities there will inevitably be variations from institution to institution.

26. There are some similarities between the adult and mental health BSc courses but also distinct differences. Mental health nurses will be expected to be competent in the following:

    a Mental health theory;

    b Therapeutic relationships;

    c Psychosocial interventions;

    d Recovery focused practice and integrated practice (incorporating managing and coordinating care with the wider healthcare system);

e Risk management;

f Bioscience;

g Pharmacology.

27. The curriculum for adult nurses will focus on:

    a. Anatomy and physiology;
    b. Pharmacology (though looking at different drug groupings from mental health students);
    c. Individual health and wellbeing;
    d. Foundations of nursing practice (focused on physical health nursing).

28. Common modules include subjects such as:

    a. Communication skills;
    b. Academic skills development;
    c. Evidence based practice;
    d. Understanding and utilising research methodology;
    e. The law and ethics (though, again, mental health nurses will be exploring different aspects of these topics such as the Mental Health Act (1983));
    f. Documentation;
    g. Preparing for professional practice.

29. Although, in theory, all nurses should adopt a holistic approach to their patient care, with an emphasis on promoting wellbeing and health promotion, adult nursing focuses primarily on physical illness with mental health nurses focusing on mental disorder and illness.

30. Adult nurses will be addressing injuries, diseases and other conditions e.g. cancer, cardiovascular disease, gastrointestinal disorders, respiratory diseases and sepsis that affect the person's physical wellbeing. The work of mental health nurses is to provide care for patients whose psychological and emotional wellbeing has been affected by conditions such as psychotic disorders e.g. schizophrenia or bipolar affective disorder; affective disorders such as

depression or anxiety; personality disorders and substance misuse. However, it is well established that physical health problems impact on the individual's mental health and vice versa and it is a weakness of each training that they do not place sufficient emphasis on this.

31. Adult nurses will be expected to be competent in a range of tasks and activities e.g. assessment of healthcare needs (which should include psychological and emotional needs), communication skills, recognising and assessing signs of worsening physical health, nursing care related to nutrition and hydration, bladder and bowel health, skin integrity, pain management, managing long term conditions e.g. diabetes mellitus, end of life and palliative care. They should also be competent in identifying, assessing and managing risk in its widest form.

32. The core competency for mental health nurses centres on communication skills. This involves engaging with people whose mental health is impaired and developing what is termed a therapeutic relationship. This has been variously defined but can be said to be "A mutual learning experience and a corrective emotional experience for the patient," in which "the nurse uses herself and specified clinical techniques in working with the patient to bring about behavioural change" (Stuart and Sundeen, 1983, *Therapeutic nurse-patient relationship*) [WITN0075002] to "enable them to learn more satisfactory and productive patterns of behaviour" (Reynolds, 2009), *Developing therapeutic one-to-one relationships*) [WITN0075003]. This goes beyond the standard definition of a purposeful, professional relationship between nurse and patient, based on respect, mutual trust and empathy, with the aim of helping the patient achieve their health goals, all of which sound very good but do not offer the student the opportunity to really explore what this will look like in practice and *how* they might achieve this.

33. Communication skills also cover a variety of competencies e.g. motivational interviewing, using a range of questioning styles such as Socratic questioning, active listening, pacing, mirroring, using reflection, validation, funnelling in, summarising and knowing what type of question to use and when. The teaching

of them must get as close as possible to the experience the student will have when in clinical practice and is best achieved by using clinical simulation with actors taking the role of the patient. Trying to engage someone who is psychotic in a difficult conversation about their treatment is considerably different to what might be presented in a PowerPoint presentation or doing classroom exercises with members of their cohort.

34. Other competencies – which are, to an extent, also common to adult nursing – include clinical curiosity (not accepting behaviours or conversations at face value but trying to explore things in more depth); critical thinking; problem solving; risk assessment and risk management.

35. Undertaking the assessment of a patient's mental health, cognitive states, and complex behaviours, as well as recognising and addressing any significant deterioration in mental state are more specific to mental health nurses. Psychosocial interventions are a range of interventions aimed at helping with activities of daily living, including helping the patient access benefits, do their shopping, look for or maintain themselves in employment or education, make decisions about treatment and medication, all the time thinking about their cognitions, emotions and relationships, including those within their family.

36. While an adult nurse has a variety of equipment to assist them in their work e.g. when undertaking physical observations of temperature, blood pressure oxygen levels, or dressing packs etc, mental health nurses are themselves the therapeutic 'tool' and the efficacy of their individual work rests upon the relationship they establish with the patient, their thinking about the patient and decision making.

37. However, although each university will be slightly different in the detail of its curriculum content, it is arguable that few reflect the needs of the contemporary mental health nurse or those of service providers. Often, modules fail to dig into the practical detail of their subject matter. For example, care planning modules might explore the essential issue of collaborative approaches, the principles of planning the care for the individual but not how the patient may be engaged in

this, and the equally essential detail of how to write coherent, focused care plans, something that is a lot more difficult in mental health than might be imagined.

38. The often written about theory-practice gap is a reality. The academic content conceptually addresses 'mental health' and 'mental health problems' (though many universities could add more on trauma informed care, complex personality disorder, and provide more in-depth teaching on psychosis). But a sharper focus on the contemporary patient experience is needed, particularly in the areas of engaging the psychotic patient, the assessment of more complex mental health states, developing a collaborative relationship with the challenging patient, and dual diagnosis i.e. those suffering with a psychotic disorder and misusing illicit substances. More depth is required in advanced communication skills such as motivational interviewing (particularly looking at medication concordance), Cognitive Behavioural Therapy (CBT) techniques, de-escalation skills and engaging in long term therapeutic relationships with disturbed and distressed patients. The emotional labour required for this work is intense and extremely demanding, leading to some nurses complaining of 'compassion fatigue' and becoming avoidant of regular contact with their patient as required by their role of primary or 'named' nurse (see below). The teaching of risk assessment and risk management requires far more prominence.

39. There is also, very often, a lack of meaningful engagement and collaboration between service providers and universities. Not all lecturers will have current clinical contact with patients, and some will not have practised clinically in recent years. Away from clinical environments on university campuses, the realities of the clinical environment can often seem distant and students in some academic institutions will not find their experiences in clinical settings resonate with their teachers. Although academics are link lecturers – liaising with a specific clinical area and teams working there – the time devoted to this is limited and rarely involves the lecturer working alongside either students or their nurse mentors in the placement.

40. There are also limitations on students' opportunities to practice when they are out in clinical placements. Service reductions inevitably reduce the variety of placements available to students and many universities struggle to find a full range of suitable places for students across their three-year training. When students are on placement there is often a shortage of suitable mentors and appropriate mentorship. This can be because of a lack of regular substantive staff on a ward or in a community team, or possibly the experience or even attitude of the qualified staff responsible for providing mentorship. Faced with all their other responsibilities and tasks, some qualified nurses can find having to 'look after' a student a burden, particularly if that student is struggling. There is a considerable amount of work in being a student mentor, including having to work through a specific course to qualify as such. Students need their competencies observed and accredited, time has to be set aside for supervision, and they should be supported with all aspects of the placement. Faced with a poorly performing student, the mentor has to liaise with the university and possibly even go through a lengthy and stressful process should the student be deemed to have failed in the specific requirements of their placement.

41. It also has to be noted that chronic nurse shortages and inadequate post registration training provided by Trusts has resulted in cohorts of senior nurses who struggle in their role (see below), which in turn impacts upon the student experience in placement.

42. The result of these various factors is that many mental health student nurses, when admitted onto the register, have not received adequate training and preparation for the role ahead of them.

43. All of that notwithstanding, it has long been recognised that, even under the best of circumstances, it is difficult to be fully prepared to take on the complexities of the role of staff nurse (a term for a qualified nurse) and preceptorship programmes are well established in every NHS Trust, often in collaboration with a local university. These are programmes to limit their responsibilities and provide additional support for newly qualified nurses, usually lasting six months.

However, even here there are problems. The newly qualified nurse, or preceptee, is supposed to be introduced into their role in a graduated, managed way, with a mentor and support provided. Staffing shortages and lack of qualified mentors on the ward establishment can all render this effectively meaningless, with the newly qualified nurse expected to take on the full range of duties undertaken by their more experienced colleagues while receiving little supervision or support.

44. Working in environments where practice does not meet the necessary standards and is not evidence or theory based, it is difficult for the newly qualified nurse to carve out their own path and adapt the best principles of their training.

The role of mental health nurses in relation to the treatment of mental health patients in the period 2019 to 13 June 2023.

45. Little has changed in the overall role of the mental health nurse in the last 25 years, but the significant factor affecting the period 2019 to 2023 was the Covid-19 pandemic. During the lockdowns and restrictions of that era, face to face contact with patients in the community was limited. A lot of clinical contact was conducted online, which many patients found problematic. This also impacted upon students, who were unable to attend in person lectures. Being educated about a person-centred form of nursing, where relationships are fundamental, the lack of face-to-face contact with peers and lecturers was inevitably a huge loss, apart from all the now widely recognised problems of online learning. Students were also, for the most part, unable to go out into placement. This has led to what I have termed the 'Covid generation' of students who have missed out on significant parts of their education, which was made even worse when many universities were very slow to return to in person teaching after the restrictions were lifted. This generation required far more support from employers post Covid, post qualification, than previous cohorts, including specialised programmes to address both knowledge and skills deficits as a result of the restrictions placed upon them during the lockdowns and after. Sadly, this did not happen.

46. Some mental health NHS Trusts set up emergency services for patients to access (as I worked in during 2020 and 2021) rather than going to A&E in an acute hospital. These were largely nurse led, with nurses undertaking mental health assessments on patients not under the care of mental health services but presenting in crisis, as well as those known to mental health services. Following the assessment, dependent on a risk assessment about the patient's overall mental health and potential risk to self and others, the patient would be referred for inpatient care, to the appropriate community service, including counselling services, or discharged back to the care of their GP.

47. In inpatient units, although there were some restrictions in place, nursing carried on largely as it had pre Covid.

48. In most cases the mental health nurse is ostensibly 'in the frontline' of a patient's care, being the person who will have most contact with the patient. This should involve assessing their mental health state, drawing up a collaborative care plan aimed at assisting them in solving problems related to their mental health difficulties, everyday living and helping the patient maintain their own safety and minimising any potential risk to others. How this is done will vary according to the clinical setting.

49. In the most restrictive settings, forensic units and Psychiatric Intensive Care Units [PICUs], there is a much greater focus on security and risk assessment. This involves the nurse actively restricting the patient's freedom, both through the locking of doors and maintaining them within the clinical environment but behavioural interventions in the environment, such as enforcing rules and preventing access to certain items etc.

50. There will be an element of this in an acute inpatient ward, where security has become an increasingly pressing issue, partly because of the prevalence of illicit substances, partly because people being admitted to inpatient units are now far more acutely unwell than two decades ago, with the majority of patients being formally detained.

51. In many cases, nurses in inpatient settings do very good work that often goes unrecognised. However, they face an extremely challenging task. Often at an early stage in their career and relatively inexperienced, they are expected to admit new patients, assess their mental state, undertake a risk assessment and implement a risk management plan, draw up and implement a care plan that meets the individual needs of the patient, administer medication, spend time in regular face to face conversations with the patient, based on their care plan, and address the patients' physical care needs, all of which have to be documented on an electronic records system, requiring access to a computer, in an office away from the patients.

52. They also have to manage the physical environment, accommodate visits from other healthcare professionals, manage meetings such as ward rounds, Mental Health Act tribunals etc and fulfil a management function, supervising junior staff. The administrative role of ward managers largely takes them away from clinical contact with the patient as they try to meet the demands of the organisation in supplying statistical reports, complete audits and meet key performance indicators (KPIs). Given an acute inpatient ward can have several admissions in a day and there are only likely to be two registered nurses on duty, their time is often taken up with the administrative tasks associated with admissions and documentation. So, although they hold that aforementioned 'frontline' position, much of the more meaningful patient conversation and contact with patients lies with healthcare assistants (HCAs). These are 'nursing' staff who have not had the training of registered nurses and are not allowed to take the title of nurse. Their role is limited and there are a number of tasks they are not allowed to do, including completing formal risk assessments. Given these huge pressures, it is inevitable that significant numbers of patients won't have an up to date or meaningful, person centred care plan or risk assessment.

53. Most newly qualified nurses start their career in inpatient wards and find the opportunities to expand their clinical skill base limited due to the issues outlined above.

54. Thus, not fully competent nurses find themselves working in environments with, at best, limited opportunities to learn and expand their skill base, and build the necessary confidence and body of experience to make them better nurses working at the optimum level in helping their most disturbed patients. Moreover, they are working within 'models of practice' (I use the term lightly because very few organisations have a written, evidence based and coherent model for inpatient nursing) that are completely outdated, originating from work done in the 1980s. The Star Wards initiative, led by Marion Janner OBE, an ex service user, in 2004 brought together what was, essentially best practice and a range of initiatives to help improve the experience of patients, their carers/family and staff, often very successfully (*Star Wards: inspiring inpatient care* – WITN0075042). However, it takes a very broad approach and there is not very much about nursing practice. While it is strong on 'what to do' to make improvements e.g. shift the power from "nursing controlled care planning" (Janner M and Page J, 2008, *Star Wards 2: the sequel*) [WITN0075043], it doesn't set out to provide detail on *how* this should be done. Nor does it focus on how a nurse with three admissions and a ward round to manage in the course of one shift will sit down, negotiate and write up a care plan with a disturbed patient being detained against their will. With modern inpatient units now more closely resembling a cross between a PICU from the 1980s/90s and a mental health crisis centre, there is an urgent need to introduce a contemporary model that helps nurses address the needs of their patients more creatively, productively and effectively, but is sustainable and manageable for those providing the care, promotes their growth and skills set and will help inpatient units retain the best staff for longer periods.

55. There is one final point to be made about nursing in inpatient units. All wards will have a system for allocating nurses to specific patients. There is a long history to nursing care being organised in this way, going back to the early 1980s when Marie Manthey described how a registered nurse would be designated as a primary nurse for a set of patients for the duration of that patient's care, meeting with them to plan, implement and evaluate their nursing care in its entirety, with other nurses following that plan in the absence of the primary nurse (Ersser and Tutton, 1991, *Primary Nursing: a Second Look*) [WITN0075004]. Manthey was

referring to adult nursing, but this was later adapted for mental health nursing (Hart, 1991, *Close Enough To Touch*) [WITN0075005]. In this system, the primary nurse has authority to act and is both responsible and accountable for the nursing care they prescribe.

56. Other systems are used e.g. for a 'named nurse' or 'keyworker', with all following the fundamental principle that each patient will have a nurse allocated to their care throughout the span of their stay in the service, using an agreed care plan wherever possible as the basis of the conversations they have and activities they engage in, providing consistency and continuity, developing a therapeutic relationship. The same authority, responsibility and accountability lie at the heart of these systems. However, despite the wealth of literature that demonstrates the benefits of this to the patient, very few wards implement the system. Most have a board or some kind of official recognition where patients' names are allocated to a particular nurse. But the majority of teams then allocate a nurse to a patient quite randomly, and then a different nurse each shift, providing no continuity and no consistency.

57. Progressing their careers, most nurses leave inpatient wards. Some may take up posts in forensic units or PICUs, while others move into other areas of specialist work such as child and adolescent mental health, working with older adults or substance misuse patients. However, the majority will advance their career by taking a role in a community service. The early community teams were generic in nature and most bore the self-explanatory title of community mental health team, providing services to almost all patients within specified geographical areas. It is something of an anomaly, in healthcare organisation, that mental health services, and particularly those based in the community, are almost exclusively organised around geographical areas though some are linked to GP practices, accepting patients under the care of that practice. However, within mental health services this is the norm, with teams rigidly enforcing the practice of only accepting patients from within these boundaries, even if it creates what can seem like byzantine systems that referrers and patients have to navigate to access services.

58. In the mid-1990s newer, specialist services were developed, aimed at particular patient groups experiencing particular disorders or with specific needs. These included:

    a. Assessment and Treatment Teams, accepting referrals from any source but mainly GPs, undertaking initial assessments and then working on a time limited basis which might be session based e.g. seeing the person for a maximum of 20 sessions, or a period of time e.g. one year. After this, the expectation would be that the patient is either discharged from mental health services or referred on for longer term care.
    b. Case Management Teams, which worked with patients who were recognised as needing long term, specialised care which might last years or even for most of the person's life.
    c. Assertive Outreach Teams. These worked with a similar client group to Case Management Teams but would be the most challenging to engage and with whom it would be most difficult to maintain an ongoing clinical relationship. Again, it would be mostly nurses doing this work but would entail them building a profile of the patient that included the patient's habits, relationships, and where they might go when they were disengaging from services. They would develop a relapse profile and most up to date risk factors, with the team sufficiently resourced to go out and find the patient when they were actively trying to avoid contact.

59. These services were largely the result of initiatives resulting from the aftermath of the Christopher Clunis case. Mr Clunis had been diagnosed with paranoid schizophrenia, with a long history of violence when unwell, and had passed through numerous services across London, usually disengaging from treatment and not collaborating with treatment plans despite being under the care, at different times, of ten different consultant psychiatrists and having ten inpatient admissions. On 17th December 1992 he stabbed a complete stranger, Mr Jonathan Zito, in a London underground station. Mr Zito died of his wounds; Christopher Clunis was found guilty of manslaughter on the grounds of diminished responsibility and admitted to Rampton Hospital. A subsequent

Inquiry, headed by Jean Ritchie QC, released a report that revealed “a catalogue of failure" in its assessment of the care Mr Clunis had received and concluded community mental health teams were not fit to provide an adequate service to the thousands of seriously unwell patients discharged from psychiatric hospitals as part of sweeping closure programmes of the 1980s and early 1990s (Coid, 1994, *The Christopher Clunis Enquiry*) [WITN0075006]. Later that decade, National Service Frameworks (NSF) were established in the NHS, with funding available for specific targets. The mental health NSF recognised that ‘of the 15,000 people in England with severe and enduring mental illness, between 14 and 200 per 100,000 are difficult to engage. They are a diverse group, more likely to live in inner city areas, to be homeless, and to be over-represented in suicide, violence and homicide’ (DoH, 1999, *A National Service Framework for Mental Health*) [DHSC0000097].

60. The NSF legislated for assertive outreach as ‘a form of intensive case management’ to ensure ‘mental health services stay in contact with people with severe and enduring mental illness, especially individuals who are assessed as at risk of harm to themselves or of posing a risk to others’.

61. Within another decade, most NHS Trusts had seen further structural changes to their community mental health services as new research highlighted the benefits of other forms of specialised teams. However, with budgets shrinking this gradually came at the expense of other community services such as Assertive Outreach and Case Management teams. The new services included:

    a. Early Intervention Services (EIS) for people with first onset psychosis, usually within a younger age range;
    b. Crisis and Home Treatment Teams (though these functions were sometimes separated), aimed at working intensively with a patient in a crisis, initially requiring daily visits, or more, by nurses and other healthcare professionals, with the aim of preventing hospital admission and helping the person remain safely in the community;

c. 'Standard' community mental health teams – though these have a variety of names, such as Recovery Teams – which provide a service for a broader range of patients who do not meet the criteria for more specialist teams or whose care had been transferred from those teams.

62. This has led to the nursing role changing. All of these teams will see registered nurses as the majority staff group. Almost all those nurses will have previously worked in inpatient wards. The banding for these community posts will require experience at band 5, which is the starting point for RMNs, with the community posts usually being set at band 6 or 7.

63. At its core, community mental health nursing requires nurses to operate semi autonomously, going out to visit patients or see them in team bases which the patient will have travelled to from their own accommodation. However, the work the nurse will undertake during their contacts with patients is ill defined and significant parts of it will be outside the bounds of their training. It will encompass interpersonal counselling, motivational interviewing and other forms of communication skills such as using cognitive behavioural techniques (as opposed to CBT as a specific therapy), and psychosocial interventions. All of this becomes even harder as nurses' caseloads grow beyond safe limits, which they are in many Trusts.

64. Nurses may be the only person to see the person in their home environment, so their evaluation of that environment can be another crucial part of the overall risk assessment and other matters pertaining to the patient's mental health.

65. Risk assessment and risk management are expected to be a core activity for the nurse. Every patient's record has a template for this and must be completed after an initial assessment, which may well have been carried out by a nurse or combination of two clinicians together for the first contact. Reviews of that risk are expected at every further contact, particularly as the nurse regularly visiting the patient has the best opportunity to notice both external markers of any change in the patient's mental health and evaluate changes in their mental state.

66. There is, however, an aspect of the work of the vast majority of crisis and home treatment teams that runs contrary to a fundamental principle of mental health nursing and a lot of psychiatric practice. It is built into the model most Trusts use that visits are conducted by whoever is allocated for that day, rather than an allocated nurse or keyworker who follows the process of primary nursing etc discussed above. Even if there will be two visits in the same day, it is often different clinicians visiting. Inevitably, this impacts on consistency and continuity with many patients complaining of being asked the same questions again and again, with little reference to previous contacts, feeling frustrated at different people who do not seem to have a grasp of their situation or particularly interested. Although risk is an essential part of the interview, patients again complain that they feel as if they are being taken through a 'tick box exercise' rather than engaged in a meaningful, helpful process.

67. The Kings Fund report, *Mental Health 360: quality and patient experience* (Gilburt and Mallorie, 2024a, *Mental Health 360: quality and patient experience*) [WITN0075007], highlighted a deterioration across the board in mental health services between 2022 and 2023, with a decline in the number of services rated 'outstanding' or 'good'. Inpatient and PICU services received the worst rating, with only 56 percent meeting the 'outstanding' or 'good' threshold. The results from the annual community mental health survey for 2022 were even more depressing, revealing:

    a. 29% of respondents reported a good overall experience, down from 32% in 2014 when data was first collected;
    b. 40% of respondents felt they had 'definitely' seen services enough to meet their needs in the past 12 months, down from 47% in 2014;
    c. 55% felt there was definitely enough time to discuss their needs, down from 65% in 2014.

68. The authors' analysis of CQC reports identified, among other things, "A lack of person-centred or personalised care such that the care provided failed to recognise or meet people's needs (for example, generic care plans). The second

was around the culture of care, including a lack of dignity and respect for patients, or behaviour that was uncaring, discriminatory, or abusive."

69. But the same survey revealed nurses' satisfaction with the care provided by their organisation fell to its lowest level in five years. Nurses were aware of the shortcomings in the service they were providing and wanted to do better.

Community mental health service models

70. As has been described, specialist services can promote specialist skills and work effectively with specific patient groups e.g. EIS for people with a first episode of psychosis. But the development of so many different services mean the journey for a particularly unwell patient can be torturous, involve numerous clinicians and different approaches. For example, a psychotic patient already struggling to make sense of the world and their experience might find themselves being seen and assessed by a liaison psychiatry practitioner, who then has to refer them to a home treatment team for a further assessment if that practitioner thinks admission to hospital is warranted. If they are admitted, a further assessment takes place and they are then under the care of the ward team. Dependent on bed pressures, the patient may have to move wards during their admission. Discharge will often be to the home treatment team. As the patient's condition improves the next move will be to some form of local community team, who will provide care from then on. However, in many mental health Trusts, should the patient experience a 'crisis' they will then be seen by a crisis team (which may or may not be linked to the home treatment team). If all goes well, the patient's care will resume with their local community team. This means being seen and assessed by a minimum of five different teams, and having to get to know different nurses, psychiatrists. Even then, the cycle may start again.

71. One final problem with the multi service model: all these teams have exclusion criteria. In some cases, these are extensive and rigid, resulting in referrals being made and rejected, patients falling between services, delays and multiple referrals having to be made. For healthcare professionals such as GPs and

paramedics trying to find the right service for a patient they want to refer to, it can seem Kafkaesque.

The different roles of the mental health nurse, psychiatrist and other members of a multi-disciplinary mental health team

72. Nurses are the core of mental health service provision. They make up the vast majority of staff employed in almost any mental health setting and spend more time with the patient than any other clinical group. However, their role is the least defined, with the least boundaries but, in many respects, is the most demanding.

73. One important thing about the role of the nurse is that it is multi-faceted. They are expected to provide nursing care but will be involved in all parts of the patient's care and treatment. In inpatient units they are with the patient for the entirety of their shift, now often 11 - 12 hours, with a key part of that acting as custodians. Moving in and out of the different elements of their role can be challenging and requires both a flexible approach, an ability to maintain boundaries and a clear sense of what one is doing at any given point in time.

74. By contrast, most psychiatrists have a clearly defined role, related to assessing the patient's mental health, prescribing treatment, usually in the form of psychotropic medication and then reviewing the patient's overall care and symptomology periodically, most likely once a week at most and for a short period of time. Of course, psychiatrists in some teams will take on a more diverse role which may even encompass some aspects of their nursing colleagues' work, but this will be the exception.

75. However, an important component of the work of the consultant psychiatrist is that summarised in their job title: to be a consultant for the nurse and rest of the multi professional team, utilising their medical expertise but also supporting and guiding colleagues in their day to day work, using the distance they have from the patient in their consultant role to provide perspective and offer guidance and clinical leadership. This aspect of the role requires them to be able to facilitate clinical conversations where colleagues can talk not just about what they have

gleaned about 'symptoms', mental state and behaviours etc, but about their experience of being with the patient, their impression of the patient as a person and any potential risk(s). This requires an understanding of the work of the wider team e.g. the nurse, the limits of their responsibilities, their knowledge base and skills and what it is like for those clinicians, within their role, to try to work with the patient and the impact this has upon them. That is only part of the task. They then have to foster constructive conversation among colleagues about the patient, encouraging but 'containing' different perspectives and even potential conflict, all of which has to be formulated into a consensus that shapes the team's decision making. Of course, this is not solely the responsibility or even role of the consultant psychiatrist – team leaders (often nurses) and other senior clinicians will on occasions lead and always contribute to this process. Nonetheless, it is a key function of the consultant psychiatrist and requires a combination of experience, knowledge and skills acquired over time. Yet many mental health teams do not have a substantive consultant psychiatrist or, if they have, not for the designated number of sessions needed. The BMA has identified a current national vacancy rate for medical doctors in psychiatry of 12.6% across England, with London and the Midlands the most affected areas (BMA, 2025, *Mental Health Pressures in England*) [WITN0075008], while The Royal College of Psychiatrists identified a shortfall of 15% in the planned number of consultant psychiatrists in 2023 (RCP, 2023, *Royal College of Psychiatrists calls for urgent publication of NHS Workforce Plan as psychiatrist numbers stagnate*) [WITN0075009]. This means less experienced doctors taking on these roles, often as locums, with less time, more pressure and not having the grounding in this vital aspect of their work. Not only does this impact upon the team but is also likely to affect the individual clinical work of the consultant as an independent clinician and one area where this is likely to be seen is in risk assessment and risk management.

76. As responsible clinician, a role almost all psychiatrists inhabit, they have ultimate responsibility for the patient, and this involves a lot of background work in getting to know the patient and their circumstances. Comprehensive knowledge of the patient is not just expected but a necessity. However, much of that will be built

upon reading nursing entries in the patient record and hearing from the nurse about their ongoing contact with the patient. To a degree, a psychiatrist's decision making will be guided by this.

77. In addition to nurses and psychiatrists, strong multi professional teams will incorporate a number of different staff groups, most commonly psychologists, occupational therapists and social workers. Each should be able to provide a different perspective on the patient's care, as well as different skill sets, knowledge and experience in their interactions with the patient. In some community teams, these staff will have a generic role, but it is more likely their role and time with the patient will be prescribed e.g. the psychologist seeing the patient for one hour a week for an agreed number of sessions to talk about a specific issue, using a recognised clinical approach such as CBT.

78. Theoretically, nurses do not take instructions from psychiatrists and most mental health teams like to think of themselves as being egalitarian, with all members having a full say in the decision making about the patient and the treatment and care that will be offered. However, in truth, the consultant psychiatrist has the aforementioned role of responsible clinician, and, within the team, there are hierarchies that determine both how decisions are made and what those decisions are. It is my view that, with the deskilling of nurses, psychiatrists and possibly other disciplines have increased their influence in decision making.

79. Certainly, nurses rarely have any authority about admissions and never discharges. Although bed managers now play a hugely significant role in these matters, psychiatrists will inevitably carry a lot of influence, and discharge patients autonomously. In many Trusts, psychiatrists also dictate purely nursing duties and responsibilities for matters such as levels of observation, making decisions about when a patient should be placed on enhanced observation or have those observations stopped (various terms are used for this clinical activity, such as enhanced observation, close observation, 1:1 observation, therapeutic observation but they all refer to the same procedure). In some Trusts the decision to commence or discontinue enhanced observations is delegated to a junior

doctor who may never have seen the patient before, rather than a nurse who has been nursing the patient and knows them well.

80. A registered nurse, managing a ward for a shift, cannot refuse the proposed admission of a patient because it is their judgement that it would be unsafe to have that patient brought onto the ward, nor that someone's discharge would be premature and therefore should be delayed, or enhanced observation be commenced or discontinued. The time when a nurse could exert the clinical authority they derive from being a registered practitioner in their own right, whose ultimate responsibility is to their governing body, the NMC, is long gone.

The role of mental health nurses in the assessment of risk posed by patients to others

81. All clinicians are expected to risk assess every patient at every contact. This may be a very brief, informal 'scan' of the patient's current presentation. It may be more formal, detailed and even the explicit reason for seeing the patient. If it is not the first contact, the patient's risk assessment may need to be updated, or it may be sufficient to record that there has been no change in the risk.

82. The risk assessment would be documented in the patient's electronic record in a special template identified for this. The structure and organisation for recording the risk assessment will vary from Trust to Trust, according to which record system they use. However, each will have prompts and questions designed to help the clinician undertaking the assessment to both carry out that assessment and then document it. Most have free text boxes for specific information as well as a series of tick boxes, and many now have a free text box for a risk formulation. Some also have a definition of 'high' 'medium' and 'low' risk so the clinician can estimate, in their clinical opinion, the severity of the risk. However, what is missing from most record systems is a direct link that takes the practitioner to a template for a structured risk management plan that can be adapted to meet the individual needs of the patient, using the information that has been captured in the risk assessment and summarised in the risk formulation.

83. As already noted, however, nurses do not receive detailed, coherent training or education in assessing risk to others during their pre-registration training and few Trusts incorporate it in their post registration programmes beyond a mandatory one-day training, which allows only a cursory overview and rarely covers risk to others in any detail. Even fewer assess the competency of nurses to do this.

84. Other clinicians may have a specific role in assessing the risk the patient poses to others, particularly psychiatrists. It may be that this happens early in the contact with the patient because of factors identified in the referral or later, perhaps at the request of the nurses or as part of a Mental Health Act assessment.

85. Because of the nature and frequency of their contact with the patient, however, nurses are expected to assess the ongoing risk with the patient and note any changes in the patient's mental state, behaviour, or overall situation. This would include concordance with medication and attending appointments as well as how and what they communicate in any session with the nurse.

86. These conversations require another level of competence, however. Talking about suicide and/or self-harm can be a challenging conversation, but the vast majority of mental health nurses are reasonably confident in this. The challenge of talking with someone about their potential for violence requires additional skills. The patient may have all kinds of concerns: will the police be informed and what will be the consequences of that? Might it lead to being detained in hospital? How will the patient react to those anxieties? Might they minimise the risk, dissemble, try and distract or shut down? Talking about the emotions and thoughts that might fuel potential violence also carries its own challenge. There is the potential for those emotions to escalate during this type of conversation if the nurse probes the patient's perception of their situation. The nurse needs to be able to exert judgement about how to phrase questions and a range of sophisticated communication skills, how far to push, trying to read the patient's current state of mind as well as the issue under discussion. If this is in the community, the nurse has to be even more mindful of their own safety, particularly

if the patient is experiencing a paranoid psychosis or auditory hallucinations that are driving the risk.

87. In such circumstances, a nurse lacking the necessary confidence may opt not to ask difficult questions. If they report back to colleagues in the MDT that this is what they did, and perfectly valid reasons why, the team can decide about how to proceed to safely assess the patient. However, if the nurse reports that the patient did not report any thoughts of harming others etc, that conveys something entirely different. Although there is no hard evidence of this, there can be a feeling that nurses may opt, in certain situations, not to ask the question for fear of what they will hear if the patient answers honestly.

88. Another important aspect of the risk management process is that, having completed their risk assessment, nurses often have no authority in implementing a risk management plan. For example, a nurse in the community might conclude, with the support of their clinical team, that the patient would benefit from an informal hospital admission. However, this must then be agreed with a bed manager. This is a clinical role usually occupied by a nurse, with varying experience, designed to manage a patient's journey through the service, coordinating admissions with discharges, and transfers from one inpatient ward to another. Ostensibly, this is to ensure effective 'patient flow' and reduce patients' length of stay but, in essence, is a means of managing a very limited resource for which demand exceeds capacity.

89. Even if the bed manager concurs that an admission may be necessary, they will still require an assessment from the home treatment team to see if the patient can remain in the community with additional support. Should the home treatment team conclude admission is necessary that decision can still be overruled by the bed manager.

90. This can leave the nurse, who has assessed the patient as posing a level of risk that cannot safely be managed in their current setting, now having to do just that, their assessment having been second guessed by someone who has not even seen the patient. In these circumstances there is a risk not only of the nurse

feeling undermined but also their confidence in the system in which they work being damaged, with the further risk that this adversely affects future clinical decisions.

Risk of violence

Factors relevant to the risk of violence by mental health patients

91. It is widely recognised that people experiencing mental health problems are far more likely to be victims rather than perpetrators of violence. The majority of victims and perpetrators will be men. However, there are specific risks of violence being perpetrated by mental health patients and these will be discussed in some detail.

Risk of violence and sex of the patient

92. The key factor in violence is biological. As is the case with suicide, violence and homicide are intrinsically linked to the male gender. Analysis from 2016-17 highlights male involvement in violent crime and the proportionate increase associated with the severity of brutality. Males account for:

    a. 85% of assailants of common assault
    b. 88% of actual bodily harm
    c. 91% of grievous bodily harm (the latter resulting in serious injuries to the victim, such as broken bones or permanent disfigurement)
    d. 98% of sexual offending (Das, 2019, *How strong is the link between mental health and crime?*) [WITN0075010].

Risk of violence and mental disorder

93. The same is true of perpetrators of violence by people with a mental disorder: the vast majority will be male. "People with some types of mental disorder are more likely to be violent than others in the general population, a fact that is uncomfortable for many in the mental health sector" (Thornicroft, 2020, *People with severe mental illness as the perpetrators and victims of violence: time for a new public health approach*) [WITN0075011]. Schizophrenia and bipolar disorder

carry a slightly higher risk but people suffering with a combination of severe mental illness, substance misuse and anti-social personality disorder are significantly more likely to be violent than someone with severe mental illness alone (Putkonen et al, 2004, *Comorbid personality disorders and substance use disorders of mentally ill homicide offenders: a structured clinical study on dual and triple diagnoses*) [WITN0075012].

Risk of violence and age of the patient

94. There are not many statistics about age and violence by mental health patients, but age is a highly relevant factor in violence, especially among men, in the general population. Violence is highest in adolescence and young adulthood. It peaks during this period and then declines as the person grows older. Significant factors in individuals becoming violent will be experiencing adverse childhood experiences (ACEs), including violence, in the home at an early age and/or experiencing community violence.

Risk of violence and lack of compliance with treatment plans and medication

95. Lack of compliance with treatment plans and medication and the non-attendance of appointments are well established as significant risk factors in relation to violence perpetrated by people experiencing mental health difficulties. In the National Confidential Inquiry into Suicide and Safety in Mental Health, Appleby et al (2018) [WITN0075013] recorded that 258 of 600 patients between 2006 – 2016 who perpetrated a homicide "were either non adherent or had missed their final contact with services."

96. Non-compliance is easy to assess. The patient is not attending appointments or away from their accommodation at the agreed time of an appointment and does not respond to reasonable attempts to re-arrange. There is either a direct refusal to take medication, prescriptions are not being collected or other indications that it is not being taken. Agreed parts of a plan are not being followed (and this is perhaps one of the most powerful arguments for the use of care plans, that they

can be audited and the patient's concordance/compliance assessed on this basis).

97. Compliance should not be confused with concordance, but gauging the patient's engagement is an essential part of a risk assessment. The best risk management plan in the world will not work if the patient is not going to follow it. In these circumstances, the clinician is forced down the road of more restrictive practices, but this emphasises the need for the clinician to be clear about the patient's commitment to working with them. In short, concordance is when the patient agrees with what is needed and is either actively asking for treatment or recognises the need for it when it is suggested and is willing to accept it. Compliance – often mistaken for the former – means that the patient is agreeing to what the clinician suggests, even if they do not want it or would not continue with that treatment were the clinician to stop insisting they accept it. Reasons for this will vary. It may be a deference to authority, or a recognition that the treatment is still better than the condition it is treating. More dangerous from a risk perspective, the patient may have decided that short term compliance will stop the clinical team from being more restrictive e.g. a concern they might be detained in hospital or placed under a Community Treatment Order (and the clinicians may have suggested this in one form or another).

98. Particularly in the community, compliance can lull a clinical team into complacency, believing the patient is accepting treatment and doing certain things as part of a care plan when, in fact, away from the gaze of the team, they are doing neither. This might involve collecting medication from a pharmacy but not then taking it. It might be the denial of active symptoms, not carrying out agreed activities that have been deemed helpful, or continuing to use illicit substances when they have agreed with the clinician they won't use.

99. Obviously, concordance is the aim of the nurse when working with the patient but, if compliance is the best that can be achieved, that needs to be monitored very closely, which is very difficult when the nurse essentially only sees a snapshot of the patient's life.

100. It is all the more important if the patient is experiencing a psychotic disorder, particularly if it is known that the patient has paranoid delusions (perhaps a contributory factor in non-compliance) and is misusing illicit substances and/or alcohol.

Risk of violence and relapse when not taking medication

101. There will be different reasons a patient is not taking medication. It may be they have recovered from their initial period of being unwell and are now asymptomatic. The clinical team may think it is no longer necessary to prescribe medication. The patient may have decided that, having recovered, they no longer want to take medication and the team, while disagreeing, have no means of enforcing it and want to keep a working relationship with the patient. Possibly the patient has unilaterally decided to stop collaborating with the team regardless of their mental state or even because of it.

102. The absence of medication does not mean the patient will automatically relapse. Changes in lifestyle, relationships, giving up alcohol and street drugs, seeing a therapist, all might help the patient function well without relapse. It is possible there may be lingering symptoms but the patient is now able to manage or tolerate them.

103. Relapse is likely to occur in the context of certain factors either re-emerging in the patient's life or being new in their experience.

104. Risk factors for this, as with any element of risk can be said to fall into four categories:

    a. Those factors known to both the nurse and patient;
    b. Factors known to the patient but which they have not communicated to the nurse;
    c. Factors known to the nurse but which the patient cannot understand or disagrees with and;
    d. Factors not yet known to either patient or nurse.

105. One of the first things a mental health clinician should do when working with any patient as the latter enters the recovery phase is to begin working on a relapse profile, systematically focusing on the factors listed above. This entails working with the patient to develop a chronology of events that previously led to them becoming unwell with a focus on risk behaviours, risk events or near misses. Stressors and early warning signs should be identified as well as the emergence of unwanted phenomena, in what order they were experienced, what made them worse and what lessened their impact. The fourth category, not yet known to either patient or nurse, can only be explored by looking at 'What if?' scenarios, that is walking the patient through potentially difficult situations and trying to think about how these might affect them, what they would do, what they would want the team to do and the role of medication in that.

Risk of violence and insight or lack of insight

106. 'Insight' is a medical term in its broadest sense but is not without its problems. It is generally used to denote how the patient views the clinician's diagnosis or a conclusion about the patient's mental state e.g. a diagnosis of paranoid schizophrenia is made, with which the patient disagrees and the view is then taken that the patient 'lacks insight', with the risk that this alienates the patient, leaves them feeling misunderstood or, worse, a victim of an injustice, conspiracy or something else that plays into their perspective or their current situation. There is another problem. A 'lack of insight' implies the clinician is right and the patient wrong.

107. A better approach is to acknowledge the patient has a different perspective and work with them about why there is this difference, why the clinician and clinical team think as they do and trying to develop an understanding of why the patient thinks as they do.

108. If the clinicians cannot help the patient understand why they have come to the view they have and sufficiently demonstrate evidence to the patient of their mental disorder that facilitates a change of perspective – or the patient continues to 'lack insight' - inevitably, the time arrives when that difference of opinion must

be addressed. Should the risk necessitate it, this will almost certainly require more restrictive measures than the team may have wished (see below).

Risk of violence and psychosis and schizophrenia, and factors that may lead to the onset of psychosis

109. Reasons for the onset of psychosis are not fully understood but are multi-faceted. There are strong genetic factors, but it is usually a combination of those with stressful life events, including ACEs and trauma. It is associated with changes in brain chemistry. Prescribed medications can induce psychosis, as can certain medical conditions and brain injury. There is a strong association with substance misuse, particularly cannabis, hallucinogenics, cocaine and amphetamines.

110. While the trend across the UK has been for an increase in violent crime over the last decade or so, there is no similar statistical database related to violence from people with a mental disorder. However, Senior et al (2020, *The economic impact of violence perpetration in severe mental illness: a retrospective, prevalence-based analysis in England and Wales*) [WITN0075014] calculated that 5.3 per cent of all violent incidents in England & Wales in 2015–16 were perpetrated by people with severe mental illness.

111. There is older evidence that the prevalence of violence of people diagnosed with schizophrenia is higher (8%) than that in the general population (2%), but with a far higher relationship between alcohol abuse and violence (24%), and of people who are drug dependent engaging in violent behaviour (34%) (Swanson et al 1997, *Violence and severe mental disorder in clinical and community populations: the effects of psychotic symptoms, comorbidity, and lack of treatment*) [WITN0075015].

112. The significance of the presence of psychotic symptoms is fully discussed by Allnutt et al (2010, *Clinical Risk Assessment & Management: A Practical Manual for Mental Health Clinicians*) [WITN0075016], who note that the risk of violence increases in cases where the person's symptoms are not being treated,

particularly if this is due to the patient refusing treatment. Violent offences are often linked to delusional beliefs.

113. According to Hodgins (2008, *Violent behaviour among people with schizophrenia: a framework for investigations of causes, and effective treatment, and prevention*) [WITN0075017], among violent offenders with schizophrenia there are three distinct types who are defined by the age of onset of antisocial and violent behaviour:

    a. **Type 1 -** 'Early starters' display a pattern of antisocial behaviour that emerges in childhood or early adolescence, well before the onset of any illness. Their violence tends to remain stable across their lifespan;
    b. **Type 2** – Constitutes the largest group of violent offenders with schizophrenia. They show no antisocial behaviour prior to the onset of the illness then repeatedly engage in aggressive behaviour towards others;
    c. **Type 3** – A small number display a chronic course of schizophrenia with no aggressive behaviour for 1 - 2 decades after illness onset then engage in serious violence, often killing those who care for them.

114. However, there is, generally, no close association between aggressive behaviour and positive symptoms of psychosis. Aggressive behaviour tends to reflect a lack of interpersonal skills and poor psychosocial functioning. Hodgins (2008) [WITN0075017] noted psychosocial functioning was associated with two static predictors: the person's level of education and past diagnoses of substance misuse disorders and three dynamic predictors or risk factors, these being the presence of depression, non-compliance with antipsychotic medication and experiences of physical victimisation.

Risk of violence and substance misuse

115. There are strong correlations between alcohol use, certain illicit drug use and violence, associated with impaired judgement, greater impulsivity, and less awareness of, or concern for, consequences. Although drugs and alcohol are

sometimes used to 'self medicate' by people experiencing distressing symptoms of a mental disorder, including psychosis, they will often exacerbate those symptoms.

116. Research on alcohol-related harm to others is well established in some other countries but is relatively new in the UK. However, alcohol misuse has been associated with one third of violent incidents and 60-70 percent of homicides. Kilian et al (2024, *National and regional prevalence of interpersonal violence from others' alcohol use: a systematic review and modelling study*) [WITN0075018] note:

    a. "Alcohol has a stronger relationship with aggression than any other psychoactive substance. Alcohol-induced decreases in the inhibitory control and impairments in decision-making processes and the processing of emotions are considered key neurobiological pathways to aggression. Conservative estimates of the alcohol-attributable fraction of violence-related injuries suggest a causal effect of alcohol in 14·9% of the incidents globally. In other words, one in six injuries from interpersonal violence could have been avoided if no alcohol were consumed." (Kilian et al, 2024).

117. Data from the Crime Survey for England and Wales show that in about half of all violent crimes the victim perceived the offender to be under the influence of alcohol (Beynon, 2019, *New evidence on alcohol-related harm to people other than the drinker*) [WITN0075019].

118. Impulsivity is exacerbated when alcohol and cocaine are used concurrently but also when the patient is experiencing symptoms of anxiety and depression. Antisocial personality disorder is another complicating factor, with both impulsivity and anti-social behaviours being exacerbated (Roncero, 2025, *Gender differences in ADHD and impulsivity among alcohol or alcohol- and cocaine-dependent patients*) [WITN0075020].

Risk of violence and history of offending

119. It is well known that the biggest predictor of future risk is past behaviour. Results from the Surveying Prisoner Crime Reduction Survey (Boorman and Hopkins, 2012, *Surveying Prisoner Crime Reduction Survey*) [WITN0075021] showed that only 6% of prisoners were recorded as having no previous convictions prior to the offence that had brought them into prison. 72% had previous convictions of 'non serious' violence e.g. common assault.

120. There are, essentially, two patterns of offending. The first involves what has been termed 'offence specialisation', with the offender repeatedly committing the same type of crime e.g. theft. 'Offence escalation' occurs when the offenders crimes increase in severity e.g. from sexual assault to rape or common assault to a more serious form of assault.

121. The key thing for a nurse or clinician assessing the risk of violence is to track the trajectory of an individual's offending. There are two factors that are important. The first is that every offence committed by a patient must be reported, even if this will not result in the patient being convicted or even formally charged, so that there is a record of their offending behaviour that can be assessed. This is particularly the case with violent offences. The second is then to look for patterns. For example, has the violence increased? Are there shorter periods between incidents? What were the circumstances? What factors were involved e.g. substance use, no longer taking medication? Who was the victim? Were they known to the patient or unknown?

122. It must be remembered that all incidents of violence may not be currently known. Asking a patient if they have ever been arrested may prompt the answer, "No." However, asking if they have even been involved in anything that might have drawn the attention of the police had they known about it could prompt a completely different answer.

Risk of violence and homicide

123. For the three-year period year ending March 2021, 995 (94%) of suspects convicted of homicide were male. 40% were aged 16 to 24 and 27% aged 25 to

34 years. This contrasts with female suspects convicted of homicide who had an older age profile, with over half (52%) being aged 35 years and over (Office for National Statistics 2022, *Homicide in England and Wales: year ending March 2021*) [WITN0075022].

124. McCallion and Farrimond (2018, *An independent review of the Independent Investigations for Mental Health Homicides in England (published and unpublished) from 2013 to the present day*) [WITN0075023] were commissioned by NHS England to undertake a review of the Independent Investigations for Mental Health Homicides in England from 2013 to 2017. They reviewed fifty-seven reports but were unable to discern whether or not the perpetrator outline in mental health related homicides they discovered through their review had previously been identified and disseminated. As a result of their review, they noted the emerging perpetrator outline demonstrates that the majority were:

    a. Male (80%)
    b. In the community (95%)
    c. Had a median age of 36 years
    d. Known to their victims (83%)
    e. Not held under the MHA (93%)
    f. Using legal or illegal substances (85%)
    g. Had a forensic history (58%) or a history of violence (16%)
    h. May have more than one diagnosis including substance misuse, paranoid schizophrenia, anxiety and depression, and personality disorder (64%).

Risk assessment

125. Each clinical team should have a model for risk assessment. There is now an established consensus that the most effective is the use of structured professional judgement, or structured clinical assessment. This is not a specific assessment instrument but combines:

    a. The evidence base for risk factors
    b. An individual, structured patient assessment

c. A formulation
d. A risk management plan

126. Using this approach the clinician's decision is informed by aspects of an actuarial approach and background information. However, the application of clinical judgement is also required, demonstrating:

a. The ability to weigh up the information gained through the assessment itself against any clinical risk factors identified;
b. Integrating this within any algorithms prescribed by the team's organisation;
c. Using this combination of tools and information to come to a reasoned decision that addresses the key issues in the patient's situation.

Undertaking a risk assessment

127. The assessment process starts with the referral. Not just the information in it but what might be missing. If there are concerns about that, further information should be sought to enable the assessing clinicians to start the process as well equipped as possible.

128. There may be potential barriers which need to be considered e.g.

a. Someone having a learning disability
b. Disruption to the person's perception
c. Language
d. Literacy
e. Culture and health beliefs
f. Culture and gender beliefs
g. Culture and lack of understanding

129. First impressions are important, taking note of what the patient is like and how that evolves during the assessment process. It is important then to try and establish a rapport, going on to clearly explain the purpose of the conversation and what will be happening as a consequence. The more conversational the

clinician can make their time together, the more likely the patient is to feel relaxed and willing to impart sensitive information. This is helped if, in the early stages, the clinician establishes a sense of psychological safety, asking questions that are relatively neutral and which the patient feels comfortable to answer, getting them in the habit of responding positively.

130. From the outset, it is important to be assessing the level of collaboration (see above). Does the patient volunteer information? Are they evasive or avoidant about some things? Is their account consistent? Is there any sense that they are 'editing' what they say, running through options, perhaps trying to weigh up what the clinician wants to hear? Is there congruence between what is said, facial expression and body language?

131. Aside from the questions asked and how they are asked there are other elements to a successful risk assessment:

    a. Showing courtesy and respect for the person, even if they are challenging or uncooperative;
    b. Demonstrating interest in the person's story and validating their experience;
    c. Being compassionate;
    d. Building trust by being:
        i. Honest
        ii. Genuine – with the clinician having their own 'voice' and avoiding jargon;
    e. 'Holding' the person in a psychological rather than physical sense;
    f. Offering understanding and, where appropriate, what might be termed insight;
    g. Being able to facilitate the person to talk about and then tolerate the feelings they find most difficult.

132. The nurse should have a structure for their assessment which is always followed and used by everyone in their team. This will be in a written format but, ideally,

the nurse should know it and not to have read it from a form or, even worse, their laptop or computer.

133. There is a careful balance to be maintained. It is essential not to run through lists of questions without allowing the patient to digress or talk about things that are important for them, yet essential questions must be covered. Sometimes letting the person talk leads to them answering a question that would have come up later. However, there may be times the nurse needs to bring the person back to the issue(s) that initially prompted the assessment.

134. Another key element of a risk assessment is knowing the types of question to ask and when to use them e.g. starting with more 'open' type questions, gradually funnelling in to more 'closed' questions.

135. It is possible to bring a solution focused approach, seeking information about what has worked for the person in the past, how they have kept themselves and others safe in similar situations, looking at strengths and protective factors.

136. Summarising is an important part of the process, not just to demonstrate active listening and establish the nurse has understood what the patient has been telling them, but also to check that the patient has retained the content of the conversation, given their ability to process and retain information may be impaired by psychosis, cognitive deficits or anxiety.

137. As much information as possible is gathered from the patient but, particularly in relation to the seriousness of the risk, corroborating information should be sought. This might come from the organisation's own records, other clinicians who know the patient, family members and/or carers and other agencies who may have been involved with the patient e.g. social services, the police or probations services.

138. The patient's summary care record can also be consulted. Under normal circumstances this can only be done with the patient's consent but risk overrides patient confidentiality and allows the nurse to gather information from that as well.

139. All of this should contribute to the risk assessment but then go through the prism of what the assessing clinician(s) think about the patient, what it was like conducting the assessment, their impression. This is inevitably subjective and there are risks associated with it, such as the clinician's own prejudices coming to the fore or looking for confirmation bias of an immediate impression. Experienced, confident, knowledgeable and skilled clinicians should be aware of such factors and, with the ongoing support of their team, reflective practice and supervision, be able to safeguard against these and use the process in a positive way.

140. Table 1 summarises the process when assessing the risk of violence, though the detail listed above still applies to the interview or discussion with the patient.

Table 1: Structured Clinical Assessment of Violence Risk (adapted from Maden, 2007, *Treating Violence: a guide to risk management in mental health* [WITN0075024])	
Stage 1	Gathering information, using patient records, court reports etc, interviewing the person and speaking with relatives/carers and other informants
Stage 2	Standardised assessment of static and dynamic risk factors
Stage 3	Consideration of idiosyncratic risk factors
Stage 4	Description of risk to others, including the specific nature of the risk e.g. physical assault, potential victims, factors that increase/decrease the risk
Stage 5	Develop a risk formulation

Stage 6	Risk management plan, including contingency plans
Stage 7	Prioritise actions of the team and who will do what

Definitions of violence used by clinicians

141. There is no consistent definition of violence that is used in mental health services that is readily available to clinicians. Risk assessment tools rarely define it and electronic records, while asking for information about episodes of violence and the potential risk of violence, do not provide a definition to assist the clinician.

142. Indeed, terms such as violence and aggression are often interchangeable in clinical conversations. Particularly among nurses, there can be a lack of understanding in the difference between the two.

143. Outside of forensic services, there is little discussion about the nature of violence and consequence of potential victims feeling threatened, intimidated or having to act to protect themselves or remove themselves from harm. Even in forensic settings, including prisons, many nurses would not have access to, or a full understanding of, a definition of violence or the types of violence a patient may use. For the purposes of discussion, I am including the definition used in the second edition of my book, *A Pocket Guide to Risk Assessment and Management in Mental Health* [WITN0075044].

144. **Violence:** attempts to use force to violate, inflict physical damage or harm. However, violence can then be further differentiated:

    a. Reactive/hostile aggression (sometimes referred to as affective aggression) is a reaction to perceived provocation and arousal of hostility, described as a relatively primitive response to a perceived threat as in a form of self-defence. This type of affective aggression tends to be impulsive and relatively uncontrolled;

b. Instrumental aggression or predatory violence, involves purposeful, deliberate goal directedness and planning to obtain an objective or goal where the violence or aggression is representative of more than causing physical injury and achieving an end other than threat alleviation.

Risk assessment tools and their predictive value

145. Risk assessment tools are not predictors of the future and cannot accurately predict what an individual will do. At best, they identify risk factors, potential risk(s) and things that *may* affect the likelihood of events occurring. It is widely known that the use of 'predictive' tools alone has poor accuracy. As outlined above, there is now considerable evidence to support the use of structured clinical judgement as the best way to assess risk.

146. There are organisational risks associated with risk assessment tools. Each presents a potential checklist for the clinician and can lead to a 'tick box' approach to the assessment, with patients complaining that they are undergoing a procedure that has nothing to do with them as an individual but involves the clinician fulfilling a necessary function for their own benefit. Another risk is that, dependent on the patient's responses, the clinician concludes they have an accurate representation of the patient's risk. This is fine if the patient has answered every question honestly but, even then, the clinician has to consider those risk factors unknown to the patient and possibly to both the patient and the clinician.

'Short term' and 'longer term' risks

147. Terminology such as short and long term are not helpful in trying to define the likelihood of risk behaviours being enacted. Immediately, one has to ask, when does 'short term' end and 'medium term' begin? How far away is 'longer term' risk? These are not questions anyone can answer and can actually prove dangerous if a clinician writes "short term risk low but long risk high." Even within this brief sentence there is an added risk, in that clinicians may have very

different views of what constitutes high, medium and low, unless these are clearly defined within risk templates and clearly understood.

148. It is more useful to describe risk in terms of risk factors, such as:

a **Static**: These are fixed, historical factors e.g. gender, family history of suicide, violence, previous hospital admissions, previous risk incidents. They are not anything that can be changed, therefore not something to 'treat' and do not provide an authoritative guide to risk or whether or not it has changed. However, they can provide a baseline or guide to how the person may behave in certain circumstances e.g. if they are making threats are they likely to carry them out? Have there been acts of violence in the past? What were the circumstances? Was it linked to substance misuse, increased stress, psychotic symptoms and feeling threatened?

b **Stable**: Factors such as diagnosis of personality disorder or mental health problems, which have been present for some time and are unlikely to change. Of course, in many cases, diagnosis can change, either as the person becomes better known to clinicians, or new information comes to light through the assessment and treatment process. It then becomes important to re-evaluate issues of risk. These factors are not liable to fluctuate in a short space of time or be as vulnerable to change as dynamic factors.

c **Dynamic**: These are present but fluctuate in duration and intensity e.g. hopelessness, stress, treatment adherence, substance misuse or the opportunity to act in a dangerous way. It is important to consider these *measurable* factors in terms of treatment precisely because it is these that are susceptible to treatment and risk management interventions. Reducing these risk factors and their impact on the patient and their behaviour is important for positive outcomes.

d **Future**: This involves trying to anticipate potential risk(s), particularly given any knowledge of past risks.

149. The nature of different elements of the patient's risk profile can then be identified more clearly and precisely, allowing the clinician to think about the focus of immediate and future risk management plans. For example:

> "John Smith has a history of attempting to physically assault staff both in the community and hospital settings in the context of paranoid delusions, believing he is being unfairly detained and given medication he does not need against his will (*Static risk factor*). He has a five-year history of a psychotic disorder and depression (*Stable risk factor*). He has been smoking cannabis for several weeks and stopped taking his prescribed medication (*Dynamic risk factors*). Last night, he told his mother he is being watched by his neighbours and they are conspiring with the police to lock him away and then kill him. He has said he will not attend any outpatient appointments and does not want anyone from the mental health team to come to his house *(Future risk factor)*."

Risk assessment tools and the relationship between the risk of an event occurring and potential magnitude of harm should the event occur

150. As noted above, caution needs to be exercised in using terms like 'low', 'medium' and 'high.' Given this, with clear definitions it is possible to consider the risk of an event occurring and the magnitude of harm should the event occur.

151. There are a range of risk assessment tools that try to identify the relationship between the likelihood of an event occurring and its severity should it happen. At its simplest, this is presented as a straightforward matrix. However, I am not aware of any service that uses this type of tool in individual risk assessment; more, it is used in organisational risk assessment, such as NHS England's Principles for assessing and managing risks across integrated care systems (see table 2) or in health and safety.

Table 2: Principles for assessing and managing risks across integrated care system**s:** A typical '5×5' risk matrix. NHS England **(2024).** www.england.nhs.uk**)** [WITN0075025]

Consequence \ Likelihood	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost certain 5
5 Severe	Medium 5	High 10	Very high 15	Extreme 20	Extreme 25
4 Major	Medium 4	Medium 8	High 12	Very high 16	Extreme 20
3 Moderate	Low 3	Medium 6	Medium 9	High 12	Very high 15
2 Minor	Very low 2	Low 4	Medium 6	Medium 8	High 10
1 Minimal	Very low 1	Very low 2	Low 3	Medium 4	Medium 5

152. The HCR-20, used in forensic settings, is the most well-known and widely used tool for exploring future risk but does not, in the way Table 2 demonstrates, link likelihood with consequence, though it does try to assess likelihood in a detailed way. Changes were introduced in Version 3, with 16 new sub items, but these focused on historic factors (Risk Management Authority, 2019, *Historical Clinical Risk-20 (HCR-20) - developed into HCR-20^{V3})* [WITN0075045].

Positive risk management principles.

153. Rather than thinking of 'positive' risk management principles, it is more helpful to consider risk management as occurring on a spectrum. At one end, it will be highly restrictive, with clinicians making decisions based on their assessment and risk formulation which they believe necessary but with which the patient may not agree. At the other end of the spectrum clinicians, in collaboration with the patient, will be looking to take proactive initiatives that, in essence, test out their assessment that the patient is safe enough to move from one phase of their treatment to the next and require less restriction or active treatment.

154. For example, it might involve the patient leaving a psychiatric intensive care unit to receive further care and treatment on an acute inpatient unit, being discharged from an inpatient ward back to their home after a successful period of leave from the ward, reducing anti-psychotic medication, or being seen every other day by a home treatment team rather than every day.

155. The fundamental principle of this element of risk management is that the clinicians involved must consider the risk *after* they have implemented this stage of their plan with the patient and give very careful consideration to protective factors.

156. For example, while on the ward, the patient's psychotic symptoms have decreased in intensity and frequency and are causing far less distress. They are feeling calmer, safer to interact with other people and no longer frightened others will harm them. They have been attending occupational therapy, taking medication orally and there have been no incidents when they have felt the need to protect themself and threaten others. Talking with their nurse, they say they are ready to go home and can point to successful nights when they returned home to their mother's house, took their medication, slept well and met with the home treatment team as arranged. Their mother reported they were more like their 'old self' and is happy for them to come home permanently. The patient has a very positive relationship with their mother and will also have access to supportive family members, all of which are protective factors.

157. What needs to be balanced against this is the patient's previously stated refusal to take medication when they are no longer under the constraints of the hospital, the perceived stigma of having mental health professionals come to the house and desire to meet up with friends all of whom are drug users, a significant factor in their relapse profile. The question then is what can be added to the risk management plan to mitigate against previous risk factors being re-enacted and what can be done to help the patient stay well and minimise the risk.

158. As hopefully illustrated in this example, while it might seem the 'positive' risk management decision would be to discharge the patient, this is absolutely

dependent on the latest risk assessment and has to be congruent with the conclusions of that assessment.

Diagnostic labels and potential adverse impact on the patient's long-term prospects

159. There are different schools of thought about the use of diagnostic labels among clinicians and very different views expressed by patients. Some patients will find receiving a diagnosis a positive as it helps them understand what has been happening to them, provide context and place their own experience within the parameters of the diagnosis. They may also find it helpful to know other people have been diagnosed with the same disorder and recovered and even receive peer support from that group. Some clinicians will also take the view that it is better to give the patient a diagnosis and utilise treatment options based on this. For example, the clinical approach of Dr Julian Leff was based on not only giving patients a diagnosis of schizophrenia, where warranted, but then using that as the basis for psychoeducation, relapse prevention and developing coping strategies, not just for the patient but also their family (Lefley, 2007, *Advanced Family Work for Schizophrenia – An Evidence-Based Approach*) [WITN0075026].

160. However, the counter argument to that is that it can have a detrimental impact on the patient, particularly if the diagnosis is one of schizophrenia, which can seem like a life sentence. There is also the risk of making an early diagnosis that proves incorrect or that the diagnosis changes over time as more information comes to light or the clinician simply gets to know the patient better.

161. It can be argued that, without confirming a diagnosis, it is difficult to undertake a full programme of psychoeducation and fully explore potential risk as there is a lot of information about risk associated with particular mental disorders, particularly depression and suicide, and also that it is disingenuous of clinicians to have a view about diagnosis but withhold that from the patient.

162. It also presents something of a challenge, albeit one that is not insurmountable, for a clinician to relate to someone who is psychotic without colluding in any way with their psychosis and having to try to convey that the patient appears to have lost contact with reality and is experiencing something that is unique to them and is likely to worsen without specified treatment.

163. There are other ways to identify the cause of psychosis e.g. the stress vulnerability model, which de-medicalises it and offers an explanation for what has happened to the person based on their known experience and, in so doing, what needs to happen to remedy the situation.

164. However, perhaps the best way forward is through dialogue with the patient, determining what they want, how they can best be helped and for the clinical team to tailor its approach accordingly.

The principle of treatment in accordance with the least restrictive option.

165. When thinking about the management of risk, Tony Maden, a psychiatrist at Broadmoor Hospital, wrote in his book *Treating Violence: a guide to risk management in mental health* (2007) [WITN0075027] "Hope for the best but prepare for the worst." To that, might be added, "Always aim for the least restrictive option when working with patients but balance that with consideration for the safety of the patient and/or others and be prepared to be as restrictive as is necessary" (Hart 2024) [WITN0075028]. This involves:

    a. Maximising potentially protective factors;
    b. Minimising exacerbating factors;
    c. Acknowledging potential outcomes – and being clear about the potentially best *and* worst.

166. Crucial to thinking about the degree of restrictive practice that might be required in a patient's care goes beyond the basic assessment of a specific risk. For example, a patient may be thinking they have to protect themselves because, as part of their psychotic, paranoid beliefs, they are convinced someone is going to harm them. However, digging into that risk means trying to find out the patient's

intent. Is there a specific person they are worried about or are they unsure who it is? Might they try to harm the person they think responsible, or would they see the best way of protecting themselves as staying away from them? And what would they do if, despite their best efforts, they encountered the person they believed meant to harm them?

167. If the patient thinks they must physically assault the person with a weapon that is very different from believing it will be enough to ignore them. Having thoughts about doing something potentially dangerous but with no intention to act is, again, not as serious as wanting or intending to act. It is also necessary to assess the person's level of collaboration with the team before deciding how coercive a treatment plan may need to be, or what level of restriction is going to be required.

168. This may be straightforward if the patient is concordant, volunteering information about their mental state, thinking and potential actions, as well as a demonstration of their willingness to work with the team to ensure they and others remain safe. This forms part of a risk formulation, which then leads to the patient's risk management plan.

169. It is a different matter if the patient is not concordant. If there are serious concerns about the ability of the patient to act safely and they are unwilling to share their thoughts and intentions or work with the clinical team, a more restrictive approach becomes necessary for as long as the risk remains, remembering that it is always essential to try and assess the potential risk when the next step, with less restrictions, will be enacted.

170. Conversely, every patient has a right to be treated, even when they are expressly refusing it. This may sound paradoxical but not if the clinician considers the patient and the relationship with the patient in its wider context. For a clinical team to allow concerns about patients generally having been mistreated in the past affect their judgement and not treat a patient who is refusing it in the context of lacking capacity through a mental disorder as defined in the Mental Health Act deprives them of a fundamental right referenced in the NHS Constitution (2023) [WITN0075029] and Human Rights Act (1998). It also fails to consider how the

patient may think about their situation at some point in the future or have thought about it in the past.

171. Would the person who is psychotic and goes on to seriously harm someone because of their psychosis, and then has to suffer the consequences of that, be pleased their clinical team had refrained from taking a restrictive approach because of their ethnicity?

172. If asked, when undisturbed by their psychosis, if they would want to be treated if in a crisis and likely to harm themselves or others, would that person opt for a less restrictive treatment option than necessary? Or might they say they would want whatever treatment and care available to help keep themselves and others safe?

173. The important, indeed overriding, factor in these hypothetical examples is the nature and seriousness of the risk.

174. There is one final consideration when assessing the risk of harm to others and that is the duty to protect the public. This does not suggest the clinician should be recklessly restrictive and certainly not use racial stereotypes to influence their clinical judgement. It means they must exercise extra caution and, as a consequence, be as thorough as they possibly can in their assessment, risk formulation and risk management plan, moving further up the scale of restrictive measures as their conclusions demand.

The expressed wishes of the patient.

175. Inevitably, in trying to work with the expressed wishes of the patient, one has to be open to the possibility that those wishes may change, particularly in the light of a changing mental state. This goes back to the point made in the previous section. When particularly unwell, or disturbed in their thinking, the patient may decline treatment and clinical contact they had been comfortable with earlier in their relationship with the clinician and team. Similarly, the patient declining treatment often shifts in their opinion when treatment – in whatever form that takes – begins to have an effect. This is how we see patients move to less

restrictive environments, achieve reductions in medication, and have less frequent contact with the clinical team.

176. This underlines the importance of having a relapse profile and crisis plan so that the expressed wishes of the patient are known and agreed when they are clear in their thinking, functioning at their optimum level and not suffering from the changes in their mental state that put them at risk of harming themselves or others. The crisis plan can then be acted upon at the earliest possible stage when there are indications that the patient is beginning to relapse or become unwell.

177. Even if the person does not agree to do the work that leads to a relapse profile or help with the agreement of a crisis plan, the clinicians involved in the patient's care can still create a timeline that tracks any known changes in behaviour and how they link to the patient's mental state. Inevitably there is the possibility of gaps with this, as there will be things only the patient may know. It is then even more important to work with family and those close to the patient to try and fill in any gaps and seek to identify as much about relapse and potential risk as possible.

178. This does not then mean that the team would be acting upon the wishes of the patient as expressed to the team. However, it would reflect conversations with those family members/carers etc and hopefully result in actions they would support.

Avoidance of restrictive practices in the context of concerns about the disproportionate overuse of Mental Health Act restrictive measures with Black African and Black Caribbean patients.

179. Every clinician working in mental health needs to be aware of the disproportionate restrictive practices with Black African and Black Caribbean patients in mental health services and the criminal justice system.

180. A 2003 National Institute for Mental Health Report by Professor S.P. Sashidharan, *Inside Outside: Improving mental health services for black and minority ethnic communities in England* [WITN0075030], showed that people

from minority ethnic groups were more likely to be diagnosed with mental health problems, more likely to be admitted to a psychiatric hospital, subjected to more coercive forms of treatment, experience poorer outcomes from treatment or disengage prematurely from treatment.

181. More recently, during the period pertinent to this report, Black or Black British people were:

    a. 50% more likely to be referred to mental health services by the police;
    b. 3 - 5 times more likely to be diagnosed with schizophrenia;
    c. Almost four times more likely to be detained under the Mental Health Act than their white counterparts;
    d. Eight times more likely to face excessive restrictions through Community Treatment Orders.

182. Contributing factors to these disparities include barriers to early access to services, cultural factors and discrimination, whether conscious or not. Clinicians and the teams in which they work should, as part of their normal practice, consider how they address these issues and work with minority groups in the community and how that affects their work and relationship with specific patients. Managers and leaders need to create a culture where clinicians can talk openly about the issues with the intention of positively addressing problems and helping teams focus on clinical decision making that acknowledges such disparities and the factors influencing them. At the same time, they must be supported in being clear about the actual risks in a specific patient's case, and how they will be sensitively but coherently addressed in a way that is consistent with the perceived needs of the patient at that time.

183. This involves assessing all actual and potential risks both to the patient and/or posed by the patient. It also has to be recognised that the negative issues faced by members of the Black African and Black Caribbean communities, including disparities such as those highlighted above, may increase the risk for an individual patient. It may be that, regardless of their own circumstances and the intentions of the team trying to work with them, they believe they are being

mistreated precisely because they are Black African or Black Caribbean and want to avoid treatment as a consequence. Such views may be reinforced by family members or others close to them in their community.

184. This should not deter the clinician from taking the necessary steps to address the risk, no matter how restrictive they may be, but reinforce the need to continue an open dialogue with the patient, relatives/carers and the wider community about the rationale for their clinical decisions and how these are based on the specific risks identified. It requires the ability to have difficult conversations, accept the possibility of being misunderstood as well as what may feel like unfair criticism and possible formal complaints. It also has to be acknowledged that there may be the longer-term risk that the patient feels alienated and resists further contact with the team as recovery progresses, restrictions are lifted and the patient has more options.

185. Therefore, ethnicity must be a crucial consideration for mental health clinicians when working with any person experiencing mental health problems. This is also the case with issues of gender, age and economic class. At its simplest, this is because they will have shaped the person's life experience, relationships and perception, attitudes, beliefs and everything about them.

186. But the clinician must also understand that they are involved in a journey with that patient which involves getting to know the patient, trying to understand their experience and 'world view', and how that fits with that of the clinician and clinical team. Talking about that relationship, and what it means to the clinician, hopefully allows them an opportunity to repair any damage done by imposing restrictions and enforcing treatment the patient did not want and possibly resents. As noted, this involves listening to criticism – and evaluating it carefully, no matter that it may feel overly harsh at the time – and tolerating a range of raw and difficult feelings while taking the time to explain the rationale for what happened, what options the patient thought there were at the time and, in retrospect, how they now view them. Most importantly, this can be the time to start a dialogue about how any future conflict about treatment can be avoided.

Resourcing of mental health provision including forensic assessment of risk.

187. In the late 1990s, there was a debate about the funding of mental health services in a coming era of likely restrictions on resources. Would it be better to put money into services aimed at preventing crises and help patients with serious mental health problems avoid restrictive practices in services that were extremely expensive to maintain? Or should the money flow into forensic and other services aimed at providing the necessary care for seriously mentally ill people who pose the greatest risk to themselves and others?

188. Of course, it is not an either/or dichotomy. An examination of the histories of many patients who come into forensic services offers examples of where an earlier intervention by 'mainstream' mental health services may have prevented a crisis, meaning the patient's consequential actions could have been averted. This may have involved using more restrictive practices earlier in the patient's journey e.g. an admission to an inpatient unit, or transfer from an inpatient unit to a PICU. However, it may equally have entailed spending more time engaging with the patient and, possibly, family/carers, undertaking psychoeducation, being more assertive in establishing and maintaining contact with the patient, or keeping them involved with services for longer at their own request.

189. The move from restrictive practice to a more engaged, collaborative relationship with patients, both philosophical and practical, started in earnest after the 1959 Mental Health Act, which led to the discharge of thousands of hospital patients detained under the previous legislation. The advent of the first anti-psychotic medicines such as Chlorpromazine, prompted a further shift towards community-based care. This gathered pace, prompted by 24 major inquiries into allegations of abuse and/or ill treatment in psychiatric hospitals between 1968 and 1981. Hospital closures followed. Of the 87,394 NHS psychiatric beds available in 1981, 50% had gone by 1994. Only 27,000 were available to clinical teams in 2012, although the NHS was routinely purchasing a quarter of the beds used for mental health patients by 2025 (Bowie, 2025, *NHS reliance on private mental health beds for routine care is "now the norm," report says*) [WITN0075031].

190. Between 2012 and 2021 a further 5,837 NHS beds were closed, leaving 17,610 beds available to clinicians. However, in 2022, it was revealed that the NHS was paying private health care providers £2bn annually, with more than 9,000 private sector beds occupied by NHS patients. This brought the total to somewhere in the region of 27,000 being used for the NHS. Given private sector companies operate a profit margin of 15-20%, the cost effectiveness of such an arrangement is questionable (Campbell and Bawden, 2022, *NHS paying £2bn a year to private hospitals for mental health patients*) [WITN0075032].

191. It was expected that all the monies saved by closing the large psychiatric hospitals in the 1980s would be used to fund the newly developing community-based services. This was not the case and community mental health provision failed to meet patient demand with tragic consequences.

192. Finally, a report commissioned by the NHS Confederation's Mental Health Network estimated that the cost of mental ill health in England in 2022 was £300 billion. The cost is comprised of three major elements:

    a. **Economic costs of £110bn:** Losses to the economy due to mental ill health. These include the business costs of sickness absence and 'presenteeism' at work, as well as staff turnover and unemployment among people with mental ill health.
    b. **Human costs of £130bn:** The value, expressed in monetary terms, of reduced quality of life and premature mortality among people living with mental health difficulties
    c. **Health and care costs of £60bn:** This includes support provided by public services and informal care provided by family and friends (Cardoso F and Mchayle Z (2024) *Mental Health Network, The Economic and Social Costs of Mental Ill Health, Review of Methodology and Update of Calculations*) [WITN0075033].

193. In this context it could be argued that it would not only be humane but cost effective to develop a strategy for a fully funded expansion of mental health services, with a broad focus across the spectrum of care, from preventative

measures, including helping people access better housing, employment and social support, through an improved provision of talking therapy services to a full range of secondary mental healthcare provision, including community based teams, inpatient services and forensic services.

Risk management

Best practice in devising a risk management plan, including the use of the Mental Health Act 1983

194. Best practice in devising a risk management plan starts with having a risk formulation. This is developed from the clinician's assessment and should answer the following questions:

    a. How serious is the risk?
    b. Is the risk specific or general?
    c. How immediate is the risk?
    d. How volatile is the risk?
    e. What specific treatment, and which management plan, can best reduce the risk?

195. The Six Point Risk Assessment Model (Hart 2024) [WITN0075034] builds upon this and asks a further six questions:

    1. Who is at risk?
    2. What, specifically, is the risk?
    3. How are they at risk?
    4. Where are they at risk?
    5. When are they at risk?
    6. Why are they at risk?

196. The importance of this structural approach following the identification of risk is that it then makes it easier to develop a risk management plan to address these different factors. The risk formulation can be discussed with the patient, and they can even be asked for their own formulation of their situation i.e. how do they

understand any potential or actual risk? Differences between the clinician and patient can be explored but also used as the basis of a collaborative plan where possible. If there is no agreement, at least the clinician has a clear understanding of the areas of difference and why the patient takes the view they do.

197. As noted above, the principle is "Always aim for the least restrictive option when working with patients but balance that with consideration for the safety of the patient and/or others and be prepared to be as restrictive as is necessary." This involves:

   a. Maximising potentially protective factors;
   b. Minimising exacerbating factors;
   c. Acknowledging potential outcomes – and being clear about the potentially best *and* worst;
   d. Ensuring that clinicians' given the responsibility for managing the risk also have the *authority* to manage risks identified e.g. make clinical decisions, including adjusting the risk management plan in response to – and ideally in anticipation of – dynamic change in relation to the person's risk:
      i. In community settings this means the staff who have risk assessed the patient should be able to admit if necessary, or utilise more intensive home visits, rather than decisions being made by clinicians or managers who have not seen the patient or been involved in the assessment.
      ii. In inpatient areas, this involves those directly managing the risk determining levels of 'observation' or available support and other issues necessary to help the patient and others remain safe, if there is a clear case for how they will be used and the benefits;
   e. Managing the environment around the person as much as is practical.

198. As noted above, each healthcare organisation has templates for care plans but these are often confused and confusing. The essence of a good care plan is that it is:

   a. Simple in its structure;

b. Easy for anyone to understand;
c. Addresses one problem only (in this case, risk);
d. Has an outcome or solution that directly addresses the identified problem or need;
e. Is patient driven i.e. unless the patient is non collaborative, they 'own' the problem and solution and it is thus written in the first person;
f. Contains a list of interventions to solve the problem, both for the patient and nurse(s) working with them, with both sets of interventions complementing one another so that there is a specific agreement about what both parties will be doing, and for how long e.g. meeting each day for 15 minutes to discuss how safe the patient feels, what is helping with that and what is making it harder.

199. Decisions about how restrictive any plan must be have to be governed by the specifics of the assessment of risk and risk formulation. An individual clinician does not have to make a decision in isolation. If the assessment was not conducted with a colleague, a second opinion can be sought from within the team and further discussion take place with the rest of the team. Obviously, there will be occasions when time is of the essence, but it is likely that if there is great urgency and the risk is of a serious nature, with a non-compliant patient who lacks capacity in the context of mental illness, a Mental Health Act assessment will be sought.

200. In this context, the Mental Health Act is both an extension of the risk assessment, though takes on an added dimension, and component of the risk management plan. It has the added benefit of bringing into the assessment process a clinician and Approved Mental Health Practitioner, usually from outside the clinical team working with the patient. Given detention under the Act is a last resort, they must be convinced that there is no alternative and that possible alternatives have been fully considered. Detention as part of a risk management plan is best practice if there is evidence of a mental disorder of a nature or degree that warrants detention for treatment or assessment or that detention is necessary for their own

health or safety or for the protection of others, and the patient is unwilling to collaborate with the team or accept treatment.

Community management and Community Treatment Orders

201. These are effectively an extension of the Mental Health Act into the community, being a legal order under the Act that allow a patient to remain out of hospital while being treated under supervision, with specific conditions in place, such as making themselves available for assessment by their Responsible Clinician (RC) and second opinion doctor if required, living at a specified address, attending appointments with clinicians as arranged and taking prescribed medication. Failure to comply with the Order leads to the patient being recalled to hospital. The patient essentially has the same rights as they have as a detained patient.

202. The practical problem with Community Treatment Orders (CTOs) is that the individual clinician carrying out visits is limited in what they can do. If the patient refuses their medication, all they can do is report that back to the team. Keeping track of what the patient does, where they go, who they see etc is intensive work and, unless the team is resourced to do this, virtually impossible. If the RC thinks re-admission to hospital is needed because the patient is non collaborative, it is likely to be a lengthy and challenging process, possibly needing police support.

203. Overall, CTOs might be a better option than keeping someone in hospital for a lengthy period but there is evidence of inconsistent use across the country. In 2021-22 there were 5,552 new CTOs issued but earlier evidence suggests some psychiatrists make frequent use of them while others rarely if ever did, with variations from Trust to Trust (NHS Digital, 2022, *Mental Health Act Statistics, Annual Figures, 2021-2* [WITN0075035] and Rugkasa, 2016, *Effectiveness of Community Treatment Orders: The International Evidence* [WITN0075036]).

The use of medication when patients are not concordant with the medication plan

204. Medication for people who have a psychotic disorder works on several levels. Firstly, it reduces symptoms. This is important in that the majority of people

experiencing a psychotic episode find it deeply distressing and can suffer terribly as a consequence, regardless of the secondary risks associated with it, such as harm to self and/or others. Secondly, as this takes effect it allows the person to function more effectively and engage with other therapeutic interventions being offered by the team. It also prevents relapse if treatment is continued beyond the acute phase of a psychotic episode.

205. The value of medication is demonstrated in research findings that long acting anti-psychotic injections, commonly referred to as depot injections, result in fewer relapses and fewer episodes of hospitalisation than oral anti-psychotics (Pierre, 2021, *Long-acting injectable antipsychotic medication/ more effective than oral medications at preventing hospitalisation and relapse in schizophrenia according to new review* [WITN0075037]). This is because people are more likely to discontinue their oral medication and, in its absence, more likely to become unwell again. There are significant risks to leaving psychosis untreated without medication. It can lead to loss of grey matter in the brain, with structural and functional changes. The longer psychosis is untreated the more significant the potential for the changes in the brain to be permanent and repeated episodes that are not treated or inadequately treated create a 'kindling' effect, with a progressive decline in cognitive functioning and an increased resistance to treatment.

206. If medication is seen as an essential part of a patient's treatment plan, every effort should be made to encourage them to take it. This is a task shared between the prescriber – usually but not exclusively a psychiatrist – and the rest of the team but, in reality is mostly work undertaken by nurses. Again, this is specialised work and requires particular skills around motivational interviewing and techniques such as Socratic questioning, as well as the time to do this work.

207. However, medication on its own will only achieve limited goals, as important as they are. Other treatments like CBT, helping the patient maintain social links and involvement in employment or education, psychoeducation and family work will all play an important part in recovery. For the non-compliant patient, treatment

can be given under the Mental Health Act but as this will normally be for a defined, and often limited, period, the need to build concordance is a priority.

Capacity assessment where patients decline medication or decline engagement with mental health services.

208. Assessing the patient's capacity is an essential part of a Mental Health Act assessment. The clinical team believe the person has a serious mental disorder of a nature or degree that warrants detention for treatment or assessment or that detention is necessary for their own health or safety or for the protection of others. The patient disagrees and does not want treatment, either in the community or hospital. This might be an unwise decision. There may be symptoms of a mental disorder likely to deteriorate if left untreated but they are not currently so serious that they merit detention in hospital, with the possibility of treatment against the patient's will. Equally, the team may feel a period in hospital is necessary but, while the patient is unwilling to agree to that, will accept treatment in the community. Again, this is possibly unwise, but the acceptance of treatment suggests the patient has capacity.

209. The starting point when considering mental capacity is that the person has the capacity to make decisions unless determined otherwise through a detailed assessment. In practice, assessing capacity in such cases is challenging and complex. It can be fluid, in that the patient may have capacity and then not. They may have capacity about some things and lack it when making decisions about accepting treatment. All aspects of the individual's capacity have to be explored in depth and clinical teams should arguably adopt the maxim of treating when in doubt on the basis that people have the right to be treated and, despite any potential difficulties it may create in the relationship with the individual, the safest option is often the wisest. Finally, it has to be remembered that assessing capacity is not as easy a task as is suggested by the standard checklist within the Act, particularly if someone has been assessed as having a psychotic disorder, and even more so if there is also an element of personality disorder in the person's clinical presentation. An apparently rational reason to decline the

help on offer might actually be a manifestation of the person feeling constrained in their choices, unable to accept that help even though they can recognise at a deeper level that it is necessary. This goes beyond the clinician needing to determine if the person can understand the information relevant to the decision, retain the information for long enough to make the decision, use or weigh up that information as part of the process of making the decision and clearly communicate their decision. Careful consideration needs to be given to how the person weighs up the information, how they view their options and choices, their thoughts about treatment, including hospitalisation, their previous experiences within the mental health system (or perception of it if they have not had previous contact) as well as perceptions of what lies ahead given their preferred option, particularly if this involves declining treatment, medication or engaging with services. This leads us back to clinicians considering best and worst possible outcomes and being willing to share their views with the person, then having an honest conversation about these, particularly seeking the person's opinion about the clinician's concerns about potential worst outcomes.

Assessing the level of risk and antecedents to look out for

210. Although I have covered this in different parts of this witness statement, at the risk of repetition, I shall try and summarise key aspects of assessing the level of risk here. Interviewing the patient and significant others offers the opportunity to gather key information. Past risk behaviours and risk history are good indicators of current risk. When looking at past incidents, the clinician should consider the nature of the incident specifically and accurately. For example, what harm was caused? What were the background circumstances of the incident? Who suffered harm? What risk factors were present at the time? It is also important to explore what was going on in the patient's life at the time.

211. In attempting to gauge potential current risk or that in the future, the clinician must identify what the patient might do, then weigh up the likelihood of that event occurring and its impact were it to happen. As noted earlier, recognising there are likely things the patient alone knows, the clinician alone knows, knowledge

shared by both but factors neither has yet considered or knows, there must be an element of 'What if?' scenario exploration, utilising the skills needed to do this.

212. Factors that will increase the risk have to be considered, as well as elements that will decrease it. It is essential to assess the likelihood of protective factors being employed by the patient and their willingness to do everything possible to minimise potentially harmful ones. Considering the level of collaboration at this stage is not just about what the patient will do to work with the clinical team. It is also how collaborative they are being in the conversation. Given the possible imposition of restrictions, including medication and even detention in hospital and/or police involvement, the clinician must ask themselves if they are hearing an honest account. This does not necessarily mean the patient is actively lying. It could be that they are trying to convince themselves they would not do anything dangerous, that the thoughts they are having are not their own and they would not act upon them. It is possible that, within the context of the conversation and being with the clinician, the thoughts of hurting someone else have diminished and, away from the stimuli that have contributed to the increased risk, they genuinely feel able to control both themselves and their situation. Of course, it is also possible that their mental state dictates that they conceal their intentions.

213. Not being a mind reader, the clinician needs to take the time to assess the accuracy of the patient's story, as well as its consistency, plausibility, and anything else that helps the clinician reach the best conclusion possible under the circumstances.

214. In attempting to identify current or future risk(s) to the person themselves and/or others, the clinician needs to weigh up the following from previous risk incidents:

    a. **Recentness:** How recent was the last risk event? Where multiple incidents have occurred, the current risk must be seen as greater than if it were isolated. However, it is vital to review the current situation in the context of the entire risk history for the patient, even if the last incident was a considerable time ago or the circumstances initially appear to be different.

b. **Immediacy**: It is vital to try to establish how immediate the current risk is. If there does not appear to be any current risk, what would change to make *potential* risks *actual* risks or, if recent risks are no longer current, what has changed to bring this about? This formula is to be used rather than short, medium, long-term terminology.

c. **Frequency**: The more frequent the incidents, the greater the risk and the more robust the clinician needs to be in addressing them. Is the intensity and dangerousness of the behaviours escalating? Are the gaps between incidents narrowing? If so, how will the risk management plan be adapted to this?

d. **Severity:** The more serious the potential consequences of an incident, the more robust the clinician will need to be in addressing it, even if the patient is reluctant to engage, tries to assure the clinician there is no longer any risk or other clinicians have not appeared concerned.

e. **Patterns**: When undertaking the assessment, the clinician should be looking for common patterns that lead to an incident occurring, including anything in the patient's relapse profile or risk history.

f. **Thinking**: The clinician should frame questions to explore the way in which the person thinks, looking for things like:

    i. Thought disorder;
    ii. Evidence of paranoia and/or delusions;
    iii. Other phenomena affecting the patient's mental state, including perceptual disturbance and command hallucinations;
    iv. Cognitive rigidity;
    v. Difficulty solving problems;
    vi. Ruminations, and their content.

g. **Emotions:** Among a range of emotions to explore, assessing the overall level of *distress* is important in thinking about how much control the patient can exercise in keeping themselves and others safe. This is not necessarily going to be visible or obvious but is about how the person feels.

h. **Intent:** Rather than accepting the actual consequences of the person's previous actions, which may not have been particularly harmful, it is essential to explore their intent. This is as important when considering risk to self as it is with risk to others. The patient may have intended to do something very dangerous but, for a variety of reasons, whatever they did was relatively safe. Equally, in intending to do something they believed to be relatively safe, they may have done something very dangerous.
i. **Warning signs:** It is important to explore how anyone would know things were getting worse. What would the patient be saying and/or doing? What would others see? Crucially, would they let people know if things were deteriorating?
j. **Impulsivity:** No matter how impulsive the actions seem to be, and the patient claims they were, it is almost certain that they will have imagined doing whatever it was they did, possibly picturing it, fantasising about it, thinking about how they might do it, the aftermath and what it would feel like. Even if, when they're talking about it after having acted, they say it was impulsive and nothing was planned this still needs to be explored further. This is often because the patient had not thought through *when* they would do anything even though they had already considered doing something – or even the specific thing they did – and the tipping point was the result of an apparently inconsequential event.
k. **Planning:** Although even thinking about doing something is the beginning of a plan, the level of planning by the patient prior to carrying out a behaviour is an indicator of both the intent and the broader elements of risk to be managed and should be explored thoroughly, including:
    i. Although there may have been something impulsive in the way the person acted 'in the moment', was there really no element of planning or thought about what they might do before they actually did it?
    ii. When did the person first start thinking about doing something harmful to themselves or others?

iii. What options did they consider for doing this?

iv. How did they rule things out and come to their final choice about what they would do?

v. When did this shift from being vague thoughts to a 'plan' that they knew they would act on?

vi. How many things had to be done to put the plan into action, for example, looking on internet sites for information about potential lethality, obtaining a specific weapon, waiting for the opportunity to be alone, luring a victim to a specific place?

vii. Had the person had to actively deceive others to carry out the plan e.g. concealing things, telling them they were not having the thoughts they were having, going somewhere else that would have appeared to be safe?

viii. How long was the plan in place before acted upon?

ix. Was there anything specific that led the person to initiate the plan at the time they did?

l. **Level of collaboration:** How likely is the person to work with any risk management plan? How is the individual's willingness to collaborate influenced by issues such as capacity, insight/awareness and attitude to treatment?

m. How robustly has the clinician been able to test out the person's willingness to collaborate e.g. by a mental capacity assessment, whether or not the person will attend appointments, give them access to their premises, keeping to agreed care plans, offering information, allowing the clinician opportunities to talk to family and/or carers?

n. **Antecedents:** Was there trauma or even toxic stress experienced by the person as a child that may have impacted on their resilience as an adult? Domestic violence and being a victim of community violence at a young age can be factors, as can different forms of abuse, mental illness in the family, substance misuse, impulsivity, interpersonal stressors and psychosis.

Provision of the risk and management plan to third parties, such as the police, probation, housing or the local authority.

215. A major concern of mental health professionals is the maintenance of confidentiality. However, risk overrides the patient's right to confidentiality and, if the patient is unwilling for information about their risk to be shared with others, that must be acknowledged but the information shared with whichever agencies are relevant. It is also important to ask for other agencies, or third parties, to share any information that may be relevant to the work of the clinicians and team. It may also be necessary to invite representatives of those agencies to attend risk management meetings or case conferences.

216. In certain situations, the patient may be subject to MAPPA or MARAC and then their multi agency processes will govern information sharing and inter-agency collaboration.

Training for mental health nurses in relation to undertaking assessment of the risk posed by patients to others

217. There are no national training standards, or training provided at a national level for nurses in anything, including risk assessment. Training is provided at a local Trust level, but this tends to be a one-day course provided every one or two years. It is usually generic and provided for all staff, with groups comprising clinical personnel from consultant psychiatrists to healthcare assistants. The main focus is on the risk of suicide and self-harm. Some Trusts will allocate new starters onto a risk assessment training day as part of their induction, but this will depend on when the nurse starts rather than being a strategic policy initiative. My impression is that, if consciously thought about, there is an expectation that nurses will learn about this type of risk through their work and from more experienced colleagues.

218. As noted earlier, in universities there is no standardised training for mental health nursing students and the study of risk assessment will most often be spread across different modules rather than as a discreet subject, explored in depth, with

a coherent schedule that runs across the spectrum of risk and includes the risk of violence and dangerousness to others.

219. There is also a lack of specialist training for nurses moving into services where the risk assessment and risk management of dangerousness to others is even more central to their role. For example, nurses employed to work in a PICU will not, for the most part, receive any specialist education and training about risk assessment and risk management or working with those patients who are among the most challenging of all those using their organisation's services. It will be the same for nurses working in most forensic units. Where once a Trust might have sponsored staff to attend specialist forensic courses, that would be far less common now.

220. It would be unimaginable for an Intensive Therapy Unit in an acute hospital to be staffed by adult nurses who had not done a specialist ITU course. Similarly, nurses working in a Coronary Care Unit would be provided specialist education and training. The importance of this goes beyond the knowledge and skills of the individual nurse. An organisation cannot improve the quality of its services unless it can improve the quality of its staff group. It is well established that nurses working in every sphere of mental health services are managing more complex patients with a more challenging risk profile but they are simply not being equipped to do so.

Local NHS Trusts and the adoption and implementation of best practice for risk assessment

221. Unfortunately, I can find few examples where NHS Trusts adopt and implement the best practice for risk assessment and risk management. I am aware of some Trusts that have actually reduced the amount of time devoted to risk assessment training for nurses and other clinical staff and senior clinicians have had to battle with managers to maintain what they already have. Staff designated to deliver the training often receive little support and are expected to keep themselves up to date with new developments and the latest statistics in their own time. Very often this comes down to funding, with Trusts trying to balance their books

making the decision that staff training is less of a priority than other pressure points.

222. Oxleas NHS Foundation Trust continues to invest heavily in providing risk assessment education programmes and there is a strategic commitment to improve the quality of clinical practice in this area among nursing staff primarily but also that of other practitioners. This has been heavily focused on prisons and was a contributory factor in three large London prisons experiencing no suicides in more than three years, a significant achievement unmatched anywhere else in the capital. This education programme was the recipient of a national award from the Nursing Times (I must make a declaration of interest as I was personally involved in providing the education programme). However, they have funded similar training for healthcare assistants, school nurses and other groups involved in enhanced risk assessment. Similarly, Guys and St Thomas' NHS Foundation Trust have provided extended training programmes in risk assessment for their Emergency Department nurses.

223. I cannot comment on the national picture because there has been no national research or audit of actual risk assessments and risk management plans. However, I have not come across an organisation in the last decade, either in the NHS or private sector, where the majority of staff are recording risk assessments and risk management plans that I would regard as best practice. In most cases I have looked at, they are adequate at best although there are obviously always exceptions to this, with some practitioners excelling both in the act of assessing and managing risk and documenting their actions.

224. Organisations seem to lack the technical skills in problem diagnosis, statistical process design, and qualitative and quantitative analysis that would enable them to identify the nature of the problems they have with risk assessment and risk management, despite the weight of evidence that emerges from serious incident reviews, inquiries and the gathering of evidence across mental health services, let alone devise a strategy to address them. This may, in part, be linked to the relative inexperience of many managers in mental health trusts. An often

overlooked consequence of staffing shortages is that people are often promoted into senior positions prematurely. They then manage and mentor inexperienced staff who, in turn, are promoted prematurely. Often they will not receive any management training or that which is available has the same theory-practice gap student nurses experience.

225. Each organisation will have centres of excellence and teams where practice is of a high standard. There will be very good practitioners in all disciplines. But little of this seems to be the result of high-level strategy. Rather, it appears to be the result of strong local management and leadership, skilled, motivated clinicians from different disciplines or combinations of both. Disappointingly, organisations seem to struggle to disseminate best practice from high achieving teams or services and, particularly, learn the lessons of what has enabled them to thrive and then use that to help other areas improve.

Integrating the principles of best practice into mental health nursing clinical practice

226. I hope that this report has made clear my concerns about how the principles of best practice are rarely integrated into mental health nursing clinical practice, and that there are significant challenges with training both pre and post registration. Resource is a huge issue but there are also problems with policy. Time constraints and service models all contribute to making integration a challenge.

227. It is difficult, as a nurse, to write about colleagues in what might be perceived as such a negative light. However, these problems are long standing, systemic and have been highlighted in individual investigations after patient suicides and homicides, through inspections of services and Trusts' internal investigations and reports.

228. The lack of resource available to mental health Trusts does have consequences. Research for Community Care revealed that between 2010 and 2015 mental health funding was reduced by 8.25%, with community teams overall losing 5% of their budgets as referrals increased by 20%. At the same time, local authority

spending on working age adults with mental health needs fell by 13.2% in real terms (McNicoll, 2015, *Mental health trust funding down 8% from 2010 despite coalition's drive for parity of esteem*) [WITN0075038]. Assertive outreach teams lost 56% of their budgets.

229. A mental health nursing workforce of 40,228 in 2010 had fallen to 35,942 by 2016, only returning to 2010 levels in 2023, though some Trusts are operating with nurse vacancies of up to 20%. It has been estimated that there will be a shortfall of over 15,800 full time equivalent mental health nurses by 2036/37 (Gilbert H and Mallorie S, 2024b, *Mental health 360: workforce* [WITN0075039] and Day, 2024, *Overview of funding for mental health services in England* [WITN0075040]).

230. The King's Fund have reported that while funding for mental health services has been increasing in recent years, it is not keeping pace with demand and is still a small percentage of the total NHS budget. In 2021-22 the NHS spent £12 billion on mental health services in England, accounting for around 8% of the NHS budget. Total spending on mental health services has increased by an average 2.7% per year between 2017-18 and 2022-23. However, the impact of the Covid-19 pandemic, increased demand for mental health care and higher than expected inflation have left Trusts struggling, with investment insufficient to address historical underfunding. Financial constraints are restricting the provision of core services, and some providers have constrained expansion of the workforce (Gilburt and Mallorie, 2024c, *Mental health 360: funding and costs*) [WITN0075041].

231. All of this results in mental health services employing nurses in what has been an increasingly complex and challenging role with insufficient preparation or ongoing support once they are in post. If it is clear that an individual nurse or team of nurses are struggling, it has to be incumbent on the organisation to analyse the problem and address it before there is a tragedy. It is unrealistic to imagine that services and nursing care can be improved without improving the knowledge, skills and experience of nurses.

232. There has been a dramatic loss of clinical leadership roles in mental health nursing. Nurse consultant and clinical specialist posts have been cut. This has limited the career development for nurses and means those with ambition are far more likely to pursue managerial posts. It has left nursing without a level of seniority, expertise, leadership and clinical authority that many other disciplines still have. There is now no Director Nursing for Mental Health within the Department of Health. The role was diluted in 2013 when it was merged with public health. After responsibility for public health was transferred to Public Health England in 2015, the most senior nursing position for mental health was lost entirely. The national mental health director is a nurse by background, but her role encompasses the whole gamut of service provision and she is also the chief executive of a large London NHS mental health Trust. The national clinical director for mental health is a consultant psychiatrist. In this vacuum, nursing has virtually no voice in national policy making.

233. The debates about an underpinning philosophy to guide mental health nursing of the late1990s and early 2000s have been replaced by a resounding silence about the nature and future of the profession. Within academia, the battle has been to preserve mental health nursing as a specialism and prevent it being submerged into a generic training.

234. In this context it is always going to be, at best, challenging for nurses in the frontline of mental health services to integrate best practice into mental health nursing in risk assessment and risk management. Given their crucial role in risk assessment and risk management, this suggests positive change will be slow in coming.

Recommendations

235. To introduce into the Mental Health Nursing curriculum a national standard for the teaching of a five-day competency-based module, incorporating clinical simulation, for the teaching of the risk assessment and risk management of self-harm and harm to others, including developing a risk formulation and the writing of risk management plans.

236. To introduce into the Mental Health Nursing curriculum clinical simulation-based modules on advanced communication skills and advanced psychosocial interventions for working with the challenging patient.

237. To introduce a four-day mandatory module for all Mental Health Nurses working in NHS mental health services, to be attended every three years, with a two-day refresher annually, incorporating clinical simulation, for the teaching of the risk assessment and risk management of self-harm and harm to others, including developing a risk formulation and the writing of risk management plans. This training should include the necessity to continue working with difficult to engage patients, and the skills to do this. Annual specialised risk assessment training should be available for staff working in highly specialised areas, such as forensic services, PICUs and crisis and home treatment teams, focused on the specific needs and risks facing their patient groups.

238. Standardise the risk assessment template for all electronic record systems used by NHS Trusts, linking risk assessment, risk formulation and risk management plans, with new prompts and more detailed guidance.

239. Introduce mandatory cultural awareness training for all staff in NHS mental health Trusts, focusing on the disparities experienced by patients from minority ethnic groups.

240. Funding for mental health services should be increased to match 2010 levels, with parity of esteem to be achieved by 2030, with monies specifically allocated to fund assertive outreach teams back to 2010 levels.

241. Increase the recruitment of student mental health students to offset the projected shortfall of 15,800 full time equivalent mental health nurses by 2036/37.

242. Re-establish the position of Director of Mental Health Nursing at a national level with a nursing directorate that can lead on the development of nursing policy, with an immediate focus on:

a Risk assessment, risk management and how Trusts and private healthcare organisations work with their most challenging and at risk patients;

b The development of a contemporary nursing model for mental health inpatient care, looking at how care planning, risk assessment and primary nursing can be adapted for the crisis work required of many patients being admitted, that takes account of many patients being detained against their will, distressed, disturbed, and in need of:

   i a crisis assessment, including an assessment of risk and provisional risk management;

   ii initial stabilisation;

   iii full assessment;

   iv a working phase, when the nursing team are working with the patient towards clearly defined goals while continually re-assessing risk and maintaining risk management;

   v beginning the preparation for discharge, ensuring a risk assessment has been carried out for all patients prior to discharge that considers both the risk while they are on the ward and risk once they have been discharged, involving the community service that will assume care of the patient wherever this is applicable and possible to do so.

c Where necessary, a risk management plan, agreed with the patient, should be recorded and passed on to appropriate healthcare professionals and agencies that are involved in the person's care and treatment before the patient leaves the care of the inpatient team.

d The nursing model should incorporate primary nursing, with RMNs holding the role of primary nurses, having responsibility and authority for the patients allocated to their care, prescribing that care in the form of

care plans and seeing their own patients on each shift when they're working, to promote continuity of care and consistency. They would be supported by associate nurses made up of RMNs and HCAs, also allocated to the patient's care for the duration of their stay on the ward, who will see the patient in the absence of the primary nurse;

e Revising the model for Crisis and Home Treatment Teams, to introduce key working, with a nominated clinician leading the work with the patient, having responsibility and authority for the patients allocated to their care, prescribing that care in the form of care plans and seeing them on every shift when they are working, to improve continuity and consistency, with named associate keyworkers who would see the patient in the keyworker's absence;

f Establishing a mechanism to ensure it is mandatory for organisations to provide regular, ongoing reflective practice and clinical supervision to all mental health nurses, no matter the setting, to support them in their work and the additional responsibilities that come with being primary nurses or keyworkers.

243. An independent project group to be established by the Department of Health and Social Care to review mental health nursing in England, including clinical career structures and giving consideration to how clinical leadership and development for nurses within organisations can be strengthened (acknowledging that Director Nursing and matron posts are largely subsumed within managerial responsibilities, and don't provide a semi autonomous voice and 'home' for nursing within the organisation) reporting directly to Maria Caulfield MP as the Parliamentary Under Secretary of State (Minister for Mental Health) and Minister for Women's Health Strategy.

244. To review the organisation and structure of community mental health services, to simplify access for patients and ease referral pathways, ensuring all patients have a single keyworker, supported by members of the clinical team, with caseloads held at nationally recognised limits.

245. Introduce specialist training that provides for a post registration qualification for nurses working in highly specialist services e.g. PICU, forensic services and home treatment teams,

246. To return to clinicians the authority to admit or take action relevant to their risk assessment without having to gain permission from managers, including bed managers, who have not assessed the patient.

Improvements that could be made locally and nationally to multi agency working to increase effectiveness in risk assessment and risk management

247. Adding in extra work for hugely stretched public services seems, in some respects, perverse, impractical and doomed to failure. However, it is known that a relatively small number of mental health patients in many communities absorb an inordinate amount of resource, in terms of the time of health, police, social services and others' time, which not only is a significant financial burden but creates an opportunity cost, with vital services diverted from other patients in need of care, treatment, help and support. The patients themselves are often experiencing great levels of distress, as is likely to be the case for family members and/or carers. In such cases, the risk to both the patient and others is extremely difficult to manage for community mental health teams on their own.

248. We already have a multi professional model that has been assessed as being effective, which is MAPPA and MARAC. It would seem appropriate to use this as a model for providing safer, more effective care for those patients in the community posing the most immediate and severe risk but who do not meet the criteria for either MAPPA or MARAC.

249. A multidisciplinary task force within geographical areas, led by senior mental health professionals could be trialled to see if it could replicate the efficacy of the MAPPA and MARAC with multidisciplinary teams established that would actually be able to carry out face to face work with what should be a relatively small cohort of patients.

Statement of Truth

I believe 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: 30th January 2026

Index to First Witness Statement of Christopher David Hart

No.	Inquiry URN	Document Description
1.	WITN0075002	Stuart G and Sundeen S (1983) Therapeutic nurse-patient relationship. In: Stuart G and Sundeen S (eds) Principles and Practice of Psychiatric Nursing (Second edition). St Louis: C. V. Mosby Company
2.	WITN0075003	Reynolds B (2009) Developing therapeutic one-to-one relationships. In: Psychiatric and Mental Health Nursing: The Craft of Caring (Second edition), Barker P (ed). London: Hodder Arnold
3.	WITN0075004	Ersser S and Tutton E (1991) Primary Nursing – A Second Look. In: Ersser S and Tutton E (eds) Primary Nursing in Perspective. Middlesex: Scutari Press
4.	WITN0075005	Hart C (1991) Close Enough To Touch. In: Ersser S and Tutton E (eds) Primary Nursing in Perspective. Middlesex: Scutari
5.	WITN0075006	Coid, J W (1994) 'The Christopher Clunis Inquiry', *Psychiatric Bulletin*, 18:449-452
6.	DHSC0000097	Department of Health (1999) A National Service Framework for Mental Health. London: HMSO
7.	WITN0075007	Gilburt H and Mallorie S (2024a) Mental Health 360: quality and patient experience. The Kings Fund
8.	WITN0075008	BMA (2025) Mental Health Pressures in England. British Medical Association: 28 October 2025
9.	WITN0075009	Royal College of Psychiatrists (2023) Royal College of Psychiatrists calls for urgent publication of NHS Workforce Plan as psychiatrist numbers stagnate. Press Release, The Royal College of Psychiatrists
10.	WITN0075010	Das S (2019) How strong is the link between mental health and crime? *GQ Magazine*. 22.6.2019
11.	WITN0075011	Thornicroft G (2020) People with severe mental illness as the perpetrators and victims of violence: time for a new public health approach. Thornicroft, Graham. The Lancet Public Health, Volume 5, Issue 2, e72 - e73

12.	WITN0075012	Putkonen A, Kotilainen I, Joyal CC, Tiihonen J (2004) Comorbid personality disorders and substance use disorders of mentally ill homicide offenders: a structured clinical study on dual and triple diagnoses. Schizophrenia Bulletin; 30: 59–72
13.	WITN0075013	Appleby et al (2018) National Confidential Inquiry into Suicide and Safety in Mental Health. Manchester: Manchester University
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