Monday, 1 June 2026

(10.00 am)

THE CHAIR: Good morning, Ms Langdale.

MS LANGDALE: Chair, may I please call Dr Lade Smith.

DR SHUBULADE SMITH (affirmed)

Questioned by MS LANGDALE

MS LANGDALE: Dr Lade Smith, before we begin your evidence, I understand you'd like to say something.

A. Yes, if that's okay.

THE CHAIR: Yes, certainly.

THE WITNESS: I want to begin by acknowledging the families and the loved ones of those who died, alongside the survivors, who continue to live with the impact of this event.

These tragic attacks should never have happened and nothing I can say can lessen what you've lost or the impact on your lives, but I am truly sorry for your loss. I wanted to thank you again for your determination and perseverance in making sure this that Inquiry took place.

Mental health services need to be good, but they can fail, and when they fail, the consequences are devastating for the patients and for the public, and I'm glad that this Inquiry is taking place, and that it's looking carefully at not just how people in crisis are

understood, but how they're cared for, but also how the risks are recognised and where the system falls short.

Myself and all my colleagues hope that this Inquiry will lead to practical change, better commissioning decisions, clearer coordination, and more effective and properly resourced care.

THE CHAIR: Thank you.

MS LANGDALE: You have prepared two statements, one 15 January 2026 and the second, the 28 May 2026; can you confirm the contents are true and accurate as far as you're concerned?

A. Yes.

Q. Can we have on the screen, please, your first statement which is WITN0320001, and have pages 2 and 3, which tell you something -- tell us something about you, while at the same time you tell us something about your background and your experience.

A. So I'm a Consultant Psychiatrist, I trained in General Adult Psychiatry and subsequently worked in the ward, in the general adult ward in the community, and also then in Psychiatric Intensive Care, and then finally in forensic mental health care, and I have been the Clinical Director for Forensic Mental Health Services at the South London and Maudsley NHS Foundation Trust, as well as being a visiting senior lecturer at the

Institute of Psychiatrists, Psychiatry and Neuroscience. I have specialist expertise in the assessment diagnosis and management of mental illness. I teach and train trainees, medical students, other professionals, consultants.

I've organised training. I've been a risk management assessor and trainer. I've also developed training and have developed -- do research and developed various approaches that have won awards in psychiatry and, as a result of that, was awarded a CBE in the Queen's Birthday Honours in 2019.

Q. Can we have, please, pages 4 and 5 of your statement on the screen and there you set out the role and function of the Royal College of Psychiatrists, and you set out at paragraph 13:

"Representing over 22,000 members and ... approximately 1,600 mental health services signed up to [your] quality networks ... [you] connected ... members and support ... work in [this] area ..."

Is that right?

A. Yes, that's right.

Q. Is membership compulsory?

A. Membership of the peer networks isn't compulsory, no, that's something that is voluntary. It is something that the Trusts, the hospital Trusts, pay for but it's

around £3,000 a year.

Q. We see, on page 5, the function of the College:

"Develop[ing] and maintain[ing] ... - approved curricula for core and ... psychiatric training ...

"... produces clinical, ethical and service-level guidance, including College Reports ...

"... [and] supports quality improvement and accreditation of services ..."

A. Yes, that's correct.

Q. You explain there's no regulatory function that you have?

A. No. I wish that the College had a regulatory function. We don't have a regulatory function, we have an advisory function. We provide guidance, we provide standards and we provide training to meet those standards, but what we aren't able to provide is implementation unless we are given that function by another regulatory body.

Q. And funding for implementation?

A. And funding as well would be needed to do that.

Q. Can we have, please, page 8 and 9 on the screen. You set out before page 8 and 9 the role and function of the Royal College of Psychiatrists patient safety expert guidance working group ... looking at page 8, you say at paragraph 25:

"In 2008 the College published 'Rethinking risk to

1 others in mental health services'. This report was
2 aimed at addressing issues of risk to others and was
3 prioritised due to media and political highlighting of
4 high-profile incidents implying failure of risk
5 management in mental health services."
6 You say at paragraph 26:
7 "The College established the Patient Safety Working
8 Group, comprising of a broad range of psychiatrists from
9 different specialities with additional input from
10 patient and carer representatives, to revise CR150
11 seven years on in the context of a considerably altered
12 commissioning environment."
13 We're going to go to the guidance shortly, Dr Lade
14 Smith, but you set out at paragraph 28 that:
15 "CR150 was described as a good, concise document
16 which was politically challenging and difficult to
17 finalise due to differing views on risk assessments. It
18 was agreed ... [the] document should be modestly
19 redrafted and updated and not completely revised."
20 Why was it politically challenging and difficult to
21 finalise?
22 A. One of the problems that we've had in psychiatry is that
23 it's a very -- people have lots of views about
24 psychiatry and they're often very polarised. So we'll
25 have people who think that psychiatry is

1 overly-coercive. In and of itself it's a restrictive
2 specialty -- that, in fact, there's a whole movement
3 that's anti-psychiatry and don't think it should exist
4 at all, and that we shouldn't be treating people with
5 mental illness at all.
6 Q. That's in outlier?
7 A. An outlier.
8 Q. An extreme outlier, is it?
9 A. Well, those attitudes do influence other people's
10 attitudes who are perhaps more moderate, but then, on
11 the other hand, there are people who feel that what
12 should happen with people with mental illness is that
13 they should all just be locked up. So that we've got
14 these two polar opposites. One saying psychiatry
15 shouldn't exist and shouldn't provide any kind of
16 support, you know, at all, because we don't really
17 believe in mental illness, and another side saying: what
18 are you doing? You should be locking these people up,
19 and that's a tension that exists.
20 In fact, most psychiatrists will balance those
21 concerns, actually. And that's what we do in
22 psychiatry, you balance the concerns that are around
23 trying to treat people with mental illness versus trying
24 to -- and the risks that they might pose to themselves
25 and others.

1 **THE CHAIR:** Can I just switch off this fan. *(Pause)*
2 **MS LANGDALE:** The minutes of this meeting, Patient Safety
3 Expert Working Group, September 2013, we see at
4 paragraph 29, state:
5 "We should bear in mind that there is hostility in
6 the media towards psychiatry and that ... public's
7 perception is an issue."
8 "... hostility in the media towards psychiatry ..."
9 This was 2013. What do you understand that to refer to?
10 A. So it's not unusual for there to be stories in the media
11 about, for example, the historical abuses at that time
12 that had happened in mental health units; and again,
13 it's that feeling that psychiatrists were being overly
14 restrictive, that, you know, perhaps people were being
15 overly restrained, and certainly there were some
16 high-profile cases that had happened in which people
17 unfortunately had died as a result of going into
18 a mental health crisis and being restrained or overly
19 medicated.
20 Q. That can come down, please, and can we have WITN0320004,
21 page 1, and this is the "Rethinking risk to others in
22 mental health services" guidance.
23 It was revised in 2017, I think came about 2016, and
24 this is the 2017 version. And if we can go to page 5,
25 please, for the "Executive summary". We see this sets

1 out on the left:
2 "There is no conflict between patient and public
3 interest. The College has established the Patient
4 Safety Working Group, comprising a broad range of
5 psychiatrists from different specialities with
6 additional input from patient and carer representatives
7 to revise CR150 in the context of a considerably altered
8 commissioning environment".
9 What was "considerably altered" by the environment?
10 A. So around this time, there's no doubt that there was
11 a reduction in funding. There was a difference in who
12 was providing funding at that time. So in 2013 -- in
13 fact a bit later, but prior to 2005 there was a change
14 in the way in which psychiatry was delivered.
15 So it used to be that we had a situation whereby, as
16 a consultant, you would look after patients in the ward
17 and you would continue to look after them in the
18 communities. There was continuity of care.
19 So when I became a consultant -- I was first
20 consultant in 1999, I looked after patients in my ward,
21 followed them through to the community. If they started
22 becoming unwell I could bring them back again into the
23 ward. And so you looked after -- you know, this
24 consultant was this continuous person the whole time.
25 2005, as a result of, well, frankly partly to do

1 with the Working Time Directive, also to do with the
2 fact that psychiatrists were very overwhelmed and burned
3 out, but I think primarily to do with the Working Time
4 Directive, new ways of working -- a new ways of working
5 model was brought in and that new ways of working model
6 brought in an approach that, actually, also with the
7 development of new evidence around what are called
8 functional specialist teams.
9 So this functional model was brought in, which was
10 about saying that: look, you will be a doctor that
11 looks -- a consultant who looks after patients in the
12 inpatient service, or you'll look after them in the
13 community, or you might look after a specialist team.
14 And so that approach, which we now recognise as
15 being quite a fragmented approach, was a different
16 approach to how psychiatric services were commissioned.
17 So there was much more focus on commissioning specialist
18 teams such as Early Intervention teams, Assertive
19 Outreach teams, you know, specialist eating disorder
20 teams, specialist rehabilitation teams. And there were
21 also the generic Community Mental Health Teams and then
22 there was the obviously generic ward teams as well.
23 **Q.** Understood. You say, in the executive summary, sorry,
24 we see:
25 "Public concern about risk has not changed.

1 However, the significance of risk as a public issue is
2 subjective as well as objective. The public perception
3 of risk includes not only the probable frequency and
4 magnitude of a future event but also the culture in
5 which the perception of risk operates. In public
6 debate, some psychiatrists have argued that the emphasis
7 on risk in psychiatric patients is inappropriate or
8 excessive. Meanwhile, statutory bodies see a role for
9 mental health services to address public safety by
10 better risk management in the general population."
11 Is there a tension between individual psychiatrists
12 and statutory bodies do you think?
13 **A.** I'm not sure, I have to say, this is of its time, and
14 the -- I think if this foreword was being an
15 introduction was written now, it would be written in
16 a different way. So we have a lot more evidence around
17 violence and risk management now that perhaps wasn't
18 available then. Also, the College takes a much more
19 evidence-based approach to everything now.
20 So I'm not sure that I'd say that there's a tension
21 between individual -- there's always -- an individual
22 psychiatrist is like any individual. They'll have their
23 own particular views and political views, but the
24 emphasis now is much more on what's the evidence and how
25 do we implement that evidence into our practice?

1 **Q.** We see at page 6, please, the "Key findings and
2 recommendations":
3 "Risk management is a core function of all medical
4 practitioners and some negative outcomes, including
5 violence, can be avoided or reduced in frequency by
6 sensible contingency planning. However, adverse
7 outcomes cannot be eliminated. Accurate predictions is
8 challenging for individual patients."
9 And we see at paragraph 2:
10 "... clinical assessment of the risk of harm to
11 others should be based on the same principles as any
12 other clinical assessment of the patient's mental
13 health. These include a detailed history and mental
14 state examination."
15 And indeed in your statement, Dr Lade Smith, you
16 refer to, effectively, accurate prediction:
17 "In routine practice ... [depends upon]:
18 "identifying historical ... clinical ... and
19 contextual ... factors"; is that right?
20 **A.** Yes.
21 **Q.** Do you want to expand on that? What do you mean by
22 historical, clinical and contextual, to establish risk?
23 **A.** We know that the biggest risk factors for behaving in
24 a violent way in the future include a past history of
25 violence, a history of early violence, a history of

1 violence/criminality in the family, a history of
2 substance use.
3 So there are certain risk factors that we know
4 increase the likelihood of someone behaving violently in
5 the future. We know that certain mental illnesses are
6 associated with a higher risk of violence as well.
7 So they might be historical factors that are
8 important. The clinical factors will be about, as
9 I said, the illness that a person might be suffering
10 from but not simply suffering from an illness like
11 schizophrenia, which we know confers a higher risk, but
12 it's more about the symptoms that that person is
13 suffering from at the time.
14 So schizophrenia is characterised it's -- a type of
15 psychosis. It's characterised by delusions and
16 hallucinations of a particular type.
17 If a person has delusions or hallucinations that
18 make them feel particularly angry, and upset and
19 threatened, then that has been associated with
20 an increased risk of violence. So it's not simply
21 having the delusion or the hallucination; it's actually
22 the emotion that it evokes.
23 **Q.** If we go to page 26, please, the key principles are set
24 out, including at the top:
25 "Risk assessments should inform risk management and

1 contribute to clinical care and meeting the needs of
2 patients."
3 We see about halfway down:
4 "Risk is dynamic, can alter over time, and must be
5 regularly reviewed."
6 What does that mean, in practice?
7 **A.** So what that means is that the risk that a person might
8 pose can change over time, and so -- and particularly in
9 serious violence incidents. Serious violence is a rare
10 event, but it doesn't happen very often. But when it
11 happens, it's devastating. So what it means is that
12 a person might not behave in a violent way at all for
13 well over, you know, a year or two, and so during that
14 time, the risk to others is low but at some point it
15 might be much higher.
16 The problem is, if you make a static judgement -- if
17 you make a judgement based on the time that the way they
18 presented at one particular time a year before the
19 violence happens, then you might mistakenly just think
20 this is a person who is low risk. It doesn't take into
21 account all the different factors that might impact and
22 increase the likelihood of them behaving in a violent
23 way.
24 So when you are thinking about a person's risk, you
25 need to think about it in terms of something that can

1 change, and when you're thinking about it in terms of
2 something that can change, ie, it's a dynamic thing,
3 then you should be thinking about what are the ways,
4 what are the strategies that we can mitigate that risk?
5 And so then that helps you, and that's why it's
6 important to recognise it can alter over time and that's
7 why it's got to be regularly reviewed, so you can
8 understand, have we been able to mitigate that risk?
9 Have we reduced that risk? Or is it increasing, or is
10 there a new risk that has now come about that we were
11 unaware of?
12 So for example, I had a patient who has, you know,
13 has a cat, you know, he is someone who had perpetrated
14 very serious violence in the past. We'd managed to
15 treat him, he'd got very, very much better but he was
16 now a very isolated individual. His cat was incredibly
17 important to him. Everything was fine as long as that
18 cat was alive. If anything happened to that cat, then
19 that -- we knew that then his risk profile would change
20 and we would have to do something about that.
21 **Q.** Can we have please WITN0320005, which is the Good
22 Practice Guide, "Assessment and management of risk to
23 others". College report. If we go to page 5, sets out
24 in terms, the penultimate bullet point:
25 "A formulation and plan should specifically describe

1 the current situation and say what could be done to
2 mitigate the risk in [the] future."
3 As you've just described why that's important.
4 Then we see:
5 "Patient-identifying information may be shared:
6 "with the patient's explicit consent; or
7 "on a need-to-know basis when the recipient needs
8 the information because they will be involved with the
9 patient's care (where staff from more than one agency
10 are involved, the patient needs to be told that some
11 sharing of information is likely) ..."
12 You refer in your statement to the confidence of
13 staff or rather a lack of confidence around psychiatry
14 around when information can be shared. First of all, in
15 what circumstances can it be shared? If you have
16 a patient, for example, in our case -- I'm not asking
17 you to comment on the specifics -- but who was at
18 university, also had been seen by the police on a number
19 of occasions and also mental health. What kind of
20 information sharing would you expect across agencies?
21 **A.** So first and foremost it's just to say that
22 confidentiality does have limitations; it's not
23 absolute. You can share information when people give
24 their consent. You can share information if it's
25 lawful, if there is thought to be a risk to others,

1 certainly, and you can -- and it's also that a person --
2 you can -- you should ideally tell the person that
3 you're going to do this, unless you think that that in
4 of itself is going to create harm. And certainly when
5 it comes to -- there are inter-agency working panels.
6 So for example, the multi-agency protection arrangement
7 and Multi-agency Protection Panel Arrangement, that's
8 MAPPA, and that will involve a number of different
9 agencies. It can be determined there that actually
10 there is some crucial information that needs to be
11 shared. Good practice is you let the patient know. As
12 I said, if the patient is -- it might cause problems,
13 then you may not share that information.
14 **Q.** We don't see, in the case we're examining, in any of the
15 notes detailed documentation about a conversation with
16 VC, the patient, about what would need to be shared and
17 why. You know, there's periods when you have seen
18 earlier where he may have been more receptive to that
19 than later, but just that very conversation that you're
20 describing as good practice.
21 Is it not only permissible but good practice for
22 a psychiatrist at the outset, to set the parameters,
23 when we meet someone to just explain what your role is,
24 what their role is. Would that be seen as challenging
25 to the therapeutic relationship, or is that just helpful

1 to the patient to know what your role is, as the
2 psychiatrist, to keep them safe, other people safe and
3 to help them?
4 A. Well, what we'd normally do, it would be good practice
5 to explain to people what a psychiatrist is, what you
6 do, what the plan for treatment is. Just as you would
7 with any patient, actually, it's not just about
8 psychiatrists; this is about medicine full stop. You
9 know, we've all been patients and we want to know who's
10 looking after us and what it is that they're going to do
11 and what our part is to play in that. And it's very
12 important when it comes to psychiatric illness because
13 it's likely, especially if someone has a chronic
14 relapsing remitting illness, that you're going to have
15 a long relationship with them.
16 Actually, that very first interaction and the first,
17 especially the first admission, is crucial to how the
18 person may engage with you later on.
19 So transparency is a really important thing.
20 Q. Can we go to page 7, please, of the guidance. Tips for
21 psychiatrists. Helpfully put together. The third one:
22 "Be curious and look beyond face value."
23 The fifth one:
24 "Explore implications of the patient's emotions and
25 beliefs."

1 Again, we know in this case that VC's family
2 provided to the first psychiatrist a series of messages
3 and communications which reflected beliefs, thoughts, at
4 various times. We also know that wasn't uploaded at all
5 onto the RiO notes. Is it difficult to upload
6 a document like that onto RiO notes for other people to
7 see it?
8 A. I -- just to say that unfortunately different hospital
9 Trusts use different electronic patient records. So RiO
10 is one form of electronic record. Where I work with use
11 a different form of electronic records, it's -- RiO is
12 said to be easier than where I work, but where I work,
13 frankly, sometimes it can be quite difficult to upload
14 the documents, and sometimes you have to get the admin
15 staff to help you to do it.
16 But you do have -- if there are concerns about where
17 the information is kept, there is a third party bit to
18 most electronic records where it can be kept so it's
19 more confidential, but you put an alert to say there's
20 information in third party that people need to see.
21 So, for example, families may want to share
22 information with you that they don't want their relative
23 to know they've shared, and so you can put that into
24 third party.
25 Q. But you could still, as another or subsequent Consultant

1 Psychiatrist, see it because it's relevant as it states
2 here, to understand a patient's emotions and beliefs,
3 isn't it, when assessing risk?
4 A. Yes, of course.
5 Q. And it's right up there in these tips, isn't it?
6 A. Yes.
7 Q. Work out what you can and presumably family members or
8 carers or people around the patient will have insight
9 and information to contribute to that in many cases,
10 presumably?
11 A. Yes.
12 Q. Also, four points down from that:
13 "Look for patterns and escalations."
14 And:
15 "Don't be frightened to discuss your thoughts with
16 colleagues."
17 Discussing thoughts, a Multi-Disciplinary Team
18 meetings are obviously one place for that, and an
19 important place for that and everything should be
20 documented. Do you find, in your role people, will more
21 informally consult you or want your opinion on
22 something? Again, you've seen evidence here of the
23 first consultant being contacted over email by
24 subsequent professionals treating or working with VC.
25 Does that happen? Is that something you'd expect to

1 happen if you've got greater knowledge of a patient or
2 just because of your experience, people want to know
3 what you think?
4 A. Yes, obviously, you know, as doctors we'll often talk to
5 each other about patients that we know, sometimes you
6 might talk to a colleague because, you know, you want
7 a second opinion about a person's treatment. They may
8 have a bit more knowledge about a particular form of
9 treatment, a particular type of condition. So yes,
10 that's very common.
11 Q. You'd expect that in your role and with your experience?
12 A. Yeah, I mean, people will often come to me and ask me
13 about, you know, a particular patient that they've got
14 because they know that I've looked after the patient
15 before or because they know I've got particular
16 expertise in that area.
17 Q. You tell us in your statement that rethinking risk to
18 others in mental health services, the report was drawn
19 to everyone's attention, but there was no formal
20 implementation. That's paragraph 41. We don't need to
21 go to it. But what do you mean by "no formal
22 implementation"?
23 A. So, as I said earlier, the Royal College of
24 Psychiatrists provides guidance, we set the standards,
25 we provide training. But we can only provide, you know,

1 advise people to use this guidance, and we are,
2 certainly at the moment, we're usually reliant on NHS
3 England to disseminate guidance and to let people know
4 about it, but they are the ones who would, you know,
5 they're the main commissioners and they are the ones
6 who, if there's something that needs to be implemented,
7 you'd expect that NHS England would, you know, support
8 the implementation of that. And they could, for
9 example, they can ask other bodies, like the Royal
10 College, to, you know, develop an implementation plan
11 and help implement it, but it's actually NHS England
12 that would have to get people to use it.
13 **Q.** You tell us there's no unified guidance by NHS England
14 on risk assessment. You say that at paragraph 40.
15 Should there be? If so, what do you think it should
16 say?
17 **A.** Yeah, I mean, ideally there would be unified guidance
18 and that everyone would be using a similar approach.
19 One of the difficulties with, certainly in general adult
20 services, has been that there's an expectation that
21 there's a risk assessment done on everybody and, you
22 know, that's a requirement from the commissioners.
23 Unfortunately, there isn't standardisation about what
24 that risk assessment should look like, and so sometimes
25 what's happened is that different hospital trusts have

1 developed their own risk assessment form, and
2 unfortunately that's not necessarily evidence -- it's
3 not evidence based, it's not, you know, necessarily
4 reliable. It's often a very static tool, meaning it's
5 just at that point in time.
6 And people have often been encouraged just to say:
7 is this person low, medium or high risk? And that only
8 tells you about that person when you were seeing them
9 just then, and that's not a good approach to risk
10 assessment and risk management.
11 **Q.** When you referred to the fact of unified guidance, you
12 also say, "It shouldn't be framed defensively"; what do
13 you mean, it shouldn't be framed defensively?
14 **A.** So, in fact, in the -- the Department of Health provides
15 some guidance around risk assessment and risk management
16 around 2009 and they describe very well, actually, the
17 thing about defensive risk management, and the
18 difficulty is that if you don't feel confident about
19 risk management, then what you might do is say, "Well,
20 I --" here it says, "I've looked in the notes, someone
21 has designated this person as being low risk, therefore
22 they're low risk and I don't have -- I don't then have
23 to do anything other than manage that person as a low
24 risk person because it's been done".
25 It's not been helped by -- so what would happen is

1 that people would go to -- you know, something awful
2 happens, a person dies, often by suicide, usually.
3 They'll go to the coroner's court and oftentimes the
4 Coroner will ask "Was a risk assessment done?" So
5 there's been a focus on people saying, "Yes, I did the
6 risk assessment" or "I didn't" rather than thinking
7 about, you know, so making a determination of risk
8 rather than thinking about how do you manage this
9 person's risk? And really, a risk, dynamic risk
10 assessments should be about formulation and it really
11 needs to be about understanding what factors might make
12 this person more likely to behave violently towards
13 others, or, in the case of suicide, more likely to harm
14 themselves.
15 And you develop a risk formulation that helps you to
16 develop a risk management strategy for that person.
17 **Q.** Is it your view that the Principles of Best Practice set
18 out in the guide and the report are not well integrated
19 into psychiatric clinical practice?
20 **A.** I'm not sure I would say that. It depends on -- I mean
21 one of the problems we have in psychiatry is that
22 there's been such under-resourcing over such a long
23 period of time, that there's been a gradual erosion of
24 standards.
25 What that means is that in some places you'll get

1 excellent care, some of the time, but in many places you
2 get okay care some of the time, and in some places the
3 care isn't good enough, and is significant variation.
4 And that variation isn't simply by -- to do with which
5 hospital you're under; that variation could be by ward
6 or team.
7 **Q.** Is that about individuals, then, rather than resources?
8 Because presumably everywhere is affected by resources
9 but some places are providing excellence in some cases
10 and others aren't good enough?
11 **A.** Well, it's often -- it's actually probably more --
12 resources are important because it's actually often to
13 do with experience and training. And so what will
14 happen is this: for example, it's a bit like being -- so
15 I've been doing psychiatry now for 33 years, and when
16 I started, you know, I was lucky, I trained at
17 a world-class psychiatric hospital, fantastic trainers,
18 in a very deprived area with lots and lots of people
19 with severe mental illness, and so I got experience of
20 looking after people with serious mental illness, plus
21 I was trained by people who were the experts in the
22 field.
23 So I have a very good understanding of how best to
24 look after people. And I've had 30-odd years of --
25 **Q.** Continuing to meet --

1 **A.** -- of continuing to do that. And in the time I've been
2 working there have been changes in the way psychiatric
3 care has been delivered that means that, so for example
4 we've gone from, you know, a continuity of care approach
5 to this fragmented approach.
6 What that means is that I know what "good" looks
7 like more than, say, a colleague who has only recently
8 come in to services. So that colleague might be
9 brilliant, but, so for example, I understand in, you
10 know, in this case, if, you know, this man was
11 discharged after, you know, when he didn't turn up to
12 services, he was discharged. I, you know, certainly in
13 my experience, somebody who has a severe mental illness
14 that's relapsing and remitting, that is associated with
15 risk to self or others, if they stop coming, that's
16 usually a bad sign, not a sign of health. And often in
17 medical terms, if someone doesn't need to come and see
18 you any more it's because they're well. But actually
19 when it comes to psychosis --
20 **Q.** It's the reverse?
21 **A.** It can be, because, depending on the person's insight,
22 it can be that that person doesn't realise they're
23 unwell, and that's why they're not coming to see you.
24 So what we would have done, what we would do is
25 ensure that we've gone to see that person to make sure

25

1 they're well before we would discharge them. And -- but
2 if you are working -- that's because I've been working
3 for a long time and I know what the service is meant to
4 be like.
5 Over the years, when there has been a reduction in
6 resources, in funding, we've gone from having -- we used
7 to have, you know, 20% of the disease burden; we get
8 8.4% of the funding, and next year that funding won't be
9 ringfenced so it's likely to reduce even further.
10 As I said, if you can't, if you can't look after
11 everybody when you've only got -- when you haven't quite
12 got enough resources, plus we've got 15-20% staff
13 vacancies. So I might know what "good" looks like, but
14 what tends to happen is that we make do and mend, and we
15 cut our cloth according to what we have. It means,
16 then, that the services become, if you like, the
17 threshold for getting into the services get higher, so
18 people end up becoming -- only being able to get into
19 services when they're in crisis.
20 If you are a new consultant coming into that, or not
21 just consultants, but any new mental health staff, you
22 would begin to think that well -- especially for certain
23 staff who learn a lot on the job, then you would think:
24 well, this the norm, that actually you don't admit
25 people or you don't start to -- you don't bring people

26

1 into your service unless they are so unwell that they
2 are a risk to themselves or others.
3 And the problem with that is that it means that you
4 don't necessarily know what "good" looks like. So you
5 can still be good at your job but you are working
6 according to what the policies and procedures are of
7 your system -- *(overspeaking)* --
8 **Q.** Well, the policies in that system were actually very
9 clear about discharge and seeing people et cetera, so
10 I don't think the policies were wrong. But anyway, I'm
11 not asking you to comment on the specific case.
12 But as far as risk formulation tools are concerned,
13 you say, I think it's at paragraph 54, there's a need
14 for national standardised practical and concise risk
15 formulation tool. Is there a particular tool or model
16 which you think should be adopted?
17 **A.** Well, what -- this is difficult because a structured
18 professional risk judgement is the model that works
19 best. It can take a while, so for example in forensic
20 services, you know, commonly the HCR-20 is used,
21 sometimes a tool called the DUNDRUM is used, but they
22 can take quite a few hours, they require everyone in the
23 multi-disciplinary team, plus the patient, plus you
24 might want to involve, you know, their family if they're
25 still around. I mean they can take hours and hours to

27

1 do. And in general adult services, frankly they don't
2 have the luxury of that.
3 And so there isn't an actual tool that is, if you
4 like, quick enough. However, the principles of, you
5 know, the HCR-20 and that structured professional risk
6 judgement are something you can train people to do. And
7 we know, I think you've heard from Professor Seena Fazel
8 and he has developed the OxRisk tool which is
9 specifically for people with schizophrenia and
10 schizophreniform disorders, and in fact I was --
11 actually I think I'm allowed to say this -- I was one of
12 the reviewers for his paper when he first, you know,
13 developed it. And actually that's a very useful tool
14 for being able to say actually it has what's called
15 a very good negative predictive value, ie it can tell
16 you who is likely not to behave in a violent way and
17 that's quite useful, which means that you can then
18 concentrate more of your efforts on those people who you
19 think are more likely to behave in a violent way.
20 But what it does is it takes the risk factors that
21 we should be aware of anyway, and so there's something
22 about ensuring that people have better understanding and
23 training in violence risk assessment just generally
24 anyway. And depending on where you work in the country,
25 you're more likely to have better understanding of that.

28

1 So if you work in south London or inner city Manchester,
2 inner city Birmingham, you probably have a -- are more
3 cognisant of that because you -- because the base rates
4 of violence and crime are higher than they are, maybe,
5 in a more affluent -- *(overspeaking)* --
6 **Q.** Whatever the tool you're using, the structured tool, how
7 important is it not simply to rely on self-report. So
8 for example, substance misuse, history, alcohol. If
9 you're relying on a patient, those tools are only as
10 useful as the accuracy of the information that has gone
11 in, isn't it?
12 **A.** Yeah, that's correct and you should really make efforts
13 to get collateral information.
14 **Q.** We don't see much of that in the case we're examining.
15 Do you think psychiatrists are too ready to accept what
16 a patient says in the so-called desire to build that
17 therapeutic relationship and trust, and they don't want
18 to contradict or confront patients with factors or facts
19 that suggest otherwise?
20 **A.** I'm not sure I'd agree with that exactly, because one of
21 the ways you can develop a therapeutic relationship with
22 someone is actually getting to know them and their
23 families, and the families will often see that person
24 much more than you do, and because we are so stretched
25 you can use the families as part of the team, if you

1 like, so everyone is working together. And there are
2 approaches that really are very much about including the
3 person and their families, and sometimes people are
4 estranged from their families, often because of their
5 illness but they'll have, if you like, proxy families,
6 other people who support them. So, you know, we'd try
7 and include them as well.
8 So this is a way of, you know, enhancing and
9 supporting your team, really.
10 **Q.** Can we have on the screen WITN0401001, page 33. It's an
11 extract from Dr Fazel's report which I'd like your
12 comments on, please. Paragraph 15 on page 33. When
13 asked what recommendations did he think the Chair of
14 this Inquiry should make, he says at the second point:
15 "The Royal College of Psychiatrists should
16 strengthen the curriculum on violence risk assessment
17 and management as part of their Membership examination."
18 What do you say about that?
19 **A.** Well, we do actually have, you know, questions and
20 training -- well, we have questions on the -- what are
21 called high-level outcomes. So there's an expectation
22 that psychiatrists are cognisant of, and understand,
23 risk and understand risk management. We don't provide
24 specific training to each specific trainee, because the
25 trainees get their training via the deaneries which will

1 be the rotations they are attached to, and there's an
2 expectation that the deaneries provide that training.
3 What we can do and what we would like to do is to
4 provide, you know, more training for people. However,
5 they will have to either pay for that training
6 themselves or, and given what's happened, I think a more
7 sensible approach, because I think -- I think everyone
8 is agreed that there needs to be a national
9 standardised --
10 **Q.** Unified national clinical training?
11 **A.** Yes, it would be. You know, we would be very happy to
12 support that training. But it would need to be --
13 unfortunately, it would need to be funded by somebody.
14 I think the employers would find it difficult to support
15 that funding because frankly employers are required to
16 find 5%, 6% cost improvement savings every year.
17 **Q.** But the College has the expertise, the guidance, and
18 it's about embedding it; is that fair?
19 **A.** Yeah, I mean, we've got the guidance, we've got the
20 expertise. That's not a problem. The problem is the
21 implementation.
22 **Q.** Just at the bottom of this page from Professor Fazel,
23 paragraph 16, please:
24 "Discharge to primary care should not be considered
25 unless risks of violence and suicide have been

1 considered by the multidisciplinary team."
2 Who would you expect to be present in
3 a multi-disciplinary Team meeting discharging someone
4 from community services to primary care?
5 **A.** So when there's a discharge meeting, it's usually the
6 Responsible Clinician, often, you know, the Consultant,
7 the person's care coordinator. If there's -- if -- the
8 care coordinator may be, you know, it could be a --
9 well, a nurse, it might be a social worker, it might be
10 a psychologist, but if it isn't it any of those, then
11 the psychologists -- social workers are really important
12 in terms of thinking about where the person is going to
13 be living, et cetera.
14 Although, unfortunately, it used to be the case that
15 every general adult team would have a social worker, but
16 that's no longer the case. And there's been
17 a significant reduction in social workers. Likewise, it
18 used to be the case that every team would have
19 a psychologist. Again, we've got a shortage of
20 psychologists, so that's often not the case.
21 And then as well -- and you might have an
22 occupational therapist, again, you'd be lucky if you got
23 an occupational therapist, and you would invite -- we
24 always invite the GP, but the GPs don't have time to
25 come. But you would --

1 **Q.** But they're effectively notified at the very least that
2 --
3 **A.** Yeah, you send them -- obviously you send them
4 information about the CPA and the family, of course, so
5 any of the supporters.
6 **Q.** You say "obviously", but is it obvious? It sounds
7 obvious that you'd let the GP know, if they couldn't be
8 there, that they'd know and they'd have details about
9 arrangements or discharges, is that --
10 **A.** That's usual. The whole point about the CPA process or
11 the discharge process is that anybody who you think
12 needs to be aware of what might happen in this person's
13 life.
14 "Because part of the discharge process is that
15 you'll go through crisis and contingency management, so:
16 what's a person's relapse indicators? If they start to
17 go into crisis, what you need to do, what the
18 contingencies that will be taken. So it might be that
19 family member recognises that they're going to crisis,
20 so they will phone the care coordinator, say this is the
21 care coordinator's number, the care coordinator will do
22 this. So everybody knows what's meant to happen
23 including the patient.
24 **Q.** Would you expect the Responsible Clinician to sign the
25 discharge letter to the GP or would it be an admin

1 function?
2 **A.** It might be the -- I mean, it might be the Responsible
3 Clinician or it might be a delegate. Usually, you know,
4 the ward doctor, for example.
5 **Q.** But a medical person?
6 **A.** It might be a medical person, but sometimes it'll say
7 something like, you know, "Dictated by" but, you know,
8 "signed in their are absence", but you'd sign it off.
9 **Q.** Can we have on the screen now WITN0320001, page s 20 and
10 21, and this is your first statement, Dr Lade Smith,
11 dealing with the role of intervention in psychosis
12 teams. So that can be on while I ask you about the need
13 for early and effective treatment. Pages 20 and 21,
14 please.
15 To what extent does prompt and effective treatment
16 for schizophrenia improve outcomes and reduce risk?
17 **A.** So we know that the duration of untreated psychosis has
18 a significant impact, negative impact, on people's
19 outcome. And it negatively impacts their social
20 functioning; it negatively impacts their personality.
21 It can actually negatively impact a person's IQ. So the
22 longer you remain untreated for, the more likely it is
23 that -- especially in young men, actually -- the more
24 likely it is it's going to affect every single aspect of
25 your life. And, in fact, when -- when schizophrenia was

1 first recognised, this is, you know, in the 1800s, there
2 are two people who recognised it in different places
3 around the same time. One of whom noticed that there
4 were all these young men that he was seeing, this is
5 Emil Kraepelin, all these young men who were presenting
6 with this odd disorder that they seemed to have these
7 very acute symptoms, and then it would seem that they
8 would burn out and that they would lose their
9 intellectual function, they would lose their motivation,
10 they were unable to function in the way that they could
11 before. He actually called it dementia praecox,
12 precocious dementia, and of course these were in the
13 days when there weren't available treatments for this
14 disorder.
15 So when -- the longer you're not treated for, the
16 worse the outcome.
17 **Q.** The most effective way of reducing the likelihood of
18 serious harm is timely and guideline concordant
19 treatment of psychosis, isn't it?
20 **A.** Yes, absolutely.
21 **Q.** Depot reduces relapse risk and helps with
22 non-concordance; is that right?
23 **A.** Yeah, it has to be said that depot medication means
24 long-acting injection. Depots not just in psychiatry,
25 you can get depot contraceptives and so on. Just to say

1 that it's not just simply that taking a depot improves
2 concordance; taking medication is the best thing but
3 it's hard to take medication, not simply because
4 a person refuses to take medication or because they
5 don't believe they've got an illness and "why should
6 I therefore take it". Sometimes people just forget.
7 We know that in the rest of medicine, that, you
8 know, compliance with medication isn't it always
9 perfect. For example, with antibiotic medications,
10 people often take part of a course and forget to take
11 the rest of it. But certainly there's evidence that if
12 you take a depot medication, then rates of -- if you
13 have a severe mental illness like schizophrenia or some
14 other kind of psychosis, that rates of hospitalisation
15 are reduced.
16 **Q.** You say at paragraph 83, we don't need to put it up, but
17 the majority of psychotic disorders can be treated.
18 That's a key message, isn't it?
19 **A.** Yes.
20 **Q.** The fact that if people are hearing voices or they are
21 experiencing psychosis, it is so important to get early
22 treatment. Do you think that's a message that's
23 adequately communicated more widely?
24 **A.** I have to say that the Royal College of Psychiatrists,
25 we have been saying this again and again and again, but

we have to bear in mind that historically, you know, for 700-plus years, people thought that there was nothing to be done about severe mental illness and mental illness and it was only since, you know, the early 1900s that it was recognised at all that a mental illness could be treated in any way. And it was only in 1955 that the first antipsychotic medications became available and it became clear that, guess what, these illnesses can be treated.

I have to say that medication is not the only thing, but it is one of the mainstays and we now know that people benefit from medication, plus certain types of psychological therapy, psychoeducation is really important to understand your illness. Family intervention is really important. That can really help. Having meaningful day-time activity. Attention to your diet and there's more evidence now that ketogenic diets might be useful. Also, definitely really importantly, refraining from recreational substance use, particularly drugs like cannabis and stimulants like cocaine and amphetamines which are, for want of a better word, psychotogenic, and there are certain tells that we know are going to increase the likelihood of a person developing a psychotic illness, like a person not being able to sleep. It doesn't matter who you are, if you

don't sleep for four or five days, you're going to start to hear voices.

So we know what works and we know what works very effectively. However, unfortunately, as I was saying before, there's a whole heap of people who don't believe in mental illness or don't believe that mental illness should be treated by psychiatrists; they think that medication shouldn't be used at all, and that's not the patients, this is often very senior people, some psychiatrists even go around the world and tell people this. You know, they advise governments to say that you shouldn't be using medications, and clearly that influences what people think.

There's a lot of stigma attached to having this illness, and I think the stigma is partly because people think it can't be treated. But 80% of mental illnesses can be very effectively treated and that includes psychosis. 25% of people have one episode, it never happens again. 25% of people have an episode, they get better, it might happen again but each time they get back to their normal functioning, and they'll learn how to manage themselves and look after themselves so they stay well. 25% of people have a relapse. They get better but not quite to where they were before, so there's a slight deterioration every time; they have

a relapse. So the aim is to stop having relapses.

15% of people unfortunately have an illness and they have progressive deterioration. Again it's about trying to stop the deterioration from becoming so severe that they're very disabled by the illness, and unfortunately 10% of people die by suicide as a result of the illness.

Q. Can we have on the screen, please, NHFT0006464. This is the "Information sharing and suicide prevention Consensus" document. While we're getting that up, would it be useful, do you think, to have a Consensus Statement in effect of preventing violence against others?

A. Sorry, could you just --

Q. Would it be useful to have a similar document for information sharing to prevent violence against others?

A. Yes, yeah.

Q. We see it here, bringing different organisations together, that the same would be important in respect of violence towards others?

A. Yes, it would, and it could be that it's in the same document. One of the reasons I say that is just for practical reasons, that people are so busy that if you have too many documents you have to read, it's likely that you might look at one and not the other, and what you would want is for people to look at, just to look

at it.

Q. Page 4, please. We see clearly and this is where it would overlap:

"The statement does not change practitioners' current legal duties of confidentiality in respect of the people they are caring for. It is designed to promote greater sharing of information within the context of the relevant law, and to clarify that this is a matter of professional judgement for an individual practitioner providing care to an individual person."

And we see page 5, fourth paragraph:

"... professional judgement [would] ... need to be made, based on an understanding of the person and what would be in their best interest. ... should take into account ... person's previously expressed wishes and views in relation to sharing information with families, and, where practical, include consultation with colleagues. The judgement may be that it is right to share critical information. If the purpose of the disclosure is to prevent a person who lacks capacity from serious harm, there is an expectation ... practitioners will disclose relevant confidential information, if it is considered to be in the person's best interest to do so".

In the terms of any patient in mental health

1 services, do you consider compelling treatment in
2 a patient with a view to preventing them committing
3 serious criminal offences, thereafter being hospitalised
4 or incarcerated or whatever? Do you think that is in
5 their best interests or could be in their best
6 interests?
7 A. Yes, of course. I mean that's what the Mental Health
8 Act is all about, actually. Because you have to
9 remember when we're detaining someone, we're detaining
10 them for reasons of their health, first and foremost.
11 They have a mental disorder, and that mental disorder is
12 impacting their health and it is potentially a risk to
13 themselves or others. So at the very least, it's
14 harmful to their health.
15 And it's -- it has to be remembered that oftentimes,
16 the patients that we see, they are so unwell and
17 unfortunately because we are so under-resourced,
18 overwhelmed, it means they have to wait a long time
19 before we can actually -- even then when we detain them,
20 they have to wait a long time before they can get
21 admitted sometimes because there are no beds. There
22 just aren't enough beds in the right places.
23 Q. In terms of information sharing to prevent the risk of
24 harm to the public it requires information sharing with
25 housing, social care; do you agree? You need to know

1 where patients are living, how they're coping in their
2 community environment. That needs strengthening,
3 doesn't it, information sharing with local authorities?
4 A. Yeah, I mean people will do this as a matter of good
5 practice. Again, it's -- because people are very
6 overstretched and overwhelmed, there often isn't --
7 because you won't necessarily have the details of that
8 person's housing, you have to find out who their housing
9 officer is -- that can take a while to do -- which is
10 one of the reasons why, when everyone in a general adult
11 team had a social worker it was really helpful, because
12 the social workers would often have those relationships
13 already, they would know who to contact and so on. But
14 clearly, information sharing is really important.
15 Q. Can we have, please, your statement back on the screen
16 WITN0320001, page 34.
17 Different topic. "Digital/online risks". Page 34,
18 please. The Inquiry has heard evidence about VC viewing
19 and engaging with violent and extreme content online,
20 and it appears no monitoring of his Internet use was
21 considered when he was an inpatient. Is that just
22 something that never would happen?
23 A. So certainly it depends on what kind of environment
24 you're in. So if you are in a secure forensic unit,
25 then there will be monitoring of your online behaviour.

1 If you're in a general adult unit, there wouldn't
2 necessarily be monitoring of your online behaviour
3 unless there was a particular reason why there was
4 a concern. But if there was a particular reason why
5 there was a concern, then it's more likely you would be
6 under forensic services because people would know that
7 this is a concern, and we're kind of worried about this.
8 And also the other thing is that sometimes what
9 people will do, if they are in general adult services
10 and they -- so, you know, in our Trust and they learn
11 about this, they would take advice from the forensic,
12 from us, the forensic colleagues, and we would say, "You
13 need to try and limit their access to forensic -- to,
14 you know, to online content."
15 Q. And do you say, at paragraph 104:
16 "Risks associated with online behaviour (...
17 stalking ... violent or extremist content) are not yet
18 consistently addressed in traditional risk frameworks.
19 This is an area where new guidance is likely to be
20 needed as evidence and practice evolve."
21 And it is about a certain generation keeping up as
22 well, isn't it?
23 A. *(The witness nodded)*.
24 Q. The more experienced people understanding what is out
25 there and how accessible it is?

1 A. Yes, and as we know, digital harms, it's really becoming
2 apparent now that, you know, the online world can be
3 really quite harmful, as well as, you know, being -- the
4 Internet being a fantastic invention and it can be
5 really useful. But there are harms associated with it
6 as well.
7 And to some extent, not just psychiatry, but I think
8 all the world is playing catch-up, including security
9 services and so on. So -- but it is something that we
10 would, we certainly would -- we're actually starting to
11 do work on now. We have a faculty of clinical
12 informatics and a special interest group that is
13 a digital special interest group, and the good news is
14 that we've got these very able, digitally savvy
15 psychiatrists who are recognising this and are starting
16 to recognise that there are -- not just recognising it
17 but actually starting to develop a better understanding,
18 particularly for our children and young people, and how
19 we might be able to manage those risks.
20 So there's work going on, there's evidence being
21 gathered. One of the things that frankly that will be
22 extremely useful will be if we could get -- if the tech
23 companies would share their data, so that we had better
24 understanding of what the benefits might be but also any
25 potential harms and who might be more likely to be

1 harmed by digital online content.
2 Q. Can we have page 119 -- sorry, paragraph 119, page 38 of
3 your statement on the screen. And while we do, a
4 separate question, please, Dr Lade Smith, about
5 capacity. The Inquiry has heard evidence from Mr Ruck
6 Keene regarding a proposed statutory duty to consider
7 capacity, because he considers professionals can hide
8 behind the presumption of capacity.
9 Do you agree that assessment of capacity, how
10 frequently it's done, when it's done, is an issue that
11 needs to be addressed? And what do you think about
12 a proposed statutory duty to consider capacity?
13 A. I have to say that usually the concern, certainly
14 from -- when CQC do their assessments, they, until
15 recently often the concern is that people haven't
16 assessed capacity sufficiently well. The -- just to say
17 first and foremost, the Mental Health Act, and, you
18 know, Alex Ruck Keene won't like me saying this but the
19 Mental Health Act essentially does trump the Mental
20 Capacity Act. When someone is severely unwell, you use
21 the Mental Health Act. Then what you use the Mental
22 Capacity Act for, the guide, you know, the principles of
23 the Mental Capacity Act are this person's understanding
24 of a particular decision: will they take their
25 treatment? Where might they -- you know, you might

1 think: this person is unwell, I think they need to come
2 in and I think they need to come in now, to this
3 hospital.
4 The person themselves might say, "I don't want to
5 come into hospital." And then you have to -- then you
6 would think: well, what capacity do they have? And
7 you -- if they have capacity, then, you know, you
8 explain why they need to come in. If they don't have
9 capacity, you explain still why they need to come in,
10 but they are still going to need to come in, but you
11 might document their capacity at that time. But
12 actually you make the decision about -- you make the
13 decision first and foremost, and you would use the
14 Mental Health Act to admit them.
15 Q. Do you think a person who is convinced they're not
16 mentally unwell, and they have schizophrenia, they are
17 convinced they are not mentally unwell, and think mental
18 health services are deliberately harming them, in your
19 view does that person have the capacity to assess and
20 understand the benefits of treatment?
21 A. Well, actually it would depend on the reason why they
22 don't think they are ill and why they think that mental
23 health services are harming them. So back to what
24 I said before: there is significant -- there's
25 significant influence from the anti-psychiatry movement

1 and people who are critical of psychiatry who say:
2 "Actually, this illness, schizophrenia, doesn't exist,
3 you are making it up and, by the way, psychiatric,
4 mental health services harm people."
5 There is evidence that psychiatric services have
6 harmed people in the past. So if they were to say:
7 "Well, hold on a minute, look at all this work from, you
8 know, Thomas Szasz or RD Laing, or certain, you know,
9 modern day psychiatrists", or from certain
10 organisations, "It says here..."
11 You don't have to look very far on social media to
12 see that there are lots of people who don't believe in
13 schizophrenia as a disorder or psychosis as a disorder,
14 and don't believe in psychiatric treatment, some of whom
15 are health professionals.
16 So if they were to give those same views, that
17 wouldn't necessarily mean they lacked capacity. If,
18 however, they said, "I don't believe I'm ill, I am
19 absolutely sure that the devil is inside me looking out
20 through my eyes and the devil is telling me that
21 I shouldn't come anywhere near you because you are
22 against me and you're going to hurt me", then that would
23 mean that they were making a decision that was not
24 a capacitous decision.
25 Q. Can we have a look on the screen, please, paragraph 119,

1 and you set out where the College is aware of variation
2 in policies, different levels of mandatory training,
3 refresher training and risk assessment, and even
4 provisional training on the Mental Health Act and the
5 Mental Capacity Act.
6 Whose responsibility is it, do you think, to ensure
7 that there isn't this variation? Because I'm assuming
8 within it comes the poor practice you've referred to and
9 excellent practice in other environments. So who is
10 responsible for overseeing this and seeing that this
11 does not happen, this uneven provision?
12 A. That would be NHS England.
13 Q. Do you think they do enough to ensure that this isn't
14 the case, or have done enough?
15 A. I think that in the last few months, probably year or
16 so, we've seen a change in leadership, and I think that
17 we will see -- start to see change, but in my
18 experience, I don't think -- NHS England will get the
19 guidance, but they're not very good at making sure
20 there's implementation of it.
21 Q. So practical. It would be practical about how you
22 implement it?
23 A. Yeah.
24 Q. Culture, change culture in some cases?
25 A. Well, I mean, you know, in order to change culture, you

know, it's often done by changing some policies and procedures and expectations of what the practice will be. That can be done at a national commissioning level or a local commissioning level, but the local -- and this is very important, there's going to be a change or there is a change happening now about how commissioning is delivered. So before, it was at the level of NHS England. NHS England is being abolished, and it will now be at the ICB level, that's the Integrated Care Board level. They'll have new names.

In --

Q. New acronyms?

A. New names, new acronyms, new structures. All the ICBs have been shrunk from, you know, 50-odd down to 26 or 28 or something like that and those ICBs, they're basically responsible for the health of a particular region.

What you would want to see, because they're the commissioners, you would want to see that there is someone in that ICB, or whatever it's going to be called, who is responsible for mental health care delivery and understands -- not just responsible for it, because they are, obviously, but understands what's needed.

In this new structure, there aren't any -- we've only heard of, I think, one what's called OPIC, Office

for I don't know -- Implementation, Commissioning, sorry -- there's only one senior mental health person in these seven -- the kind of ICBs together. It's pan-ICBs, and there's only going to be one and I've only heard about that, I think they're starting today, a Medical Director in the Midlands area. But all the others don't have a senior person in charge of mental health who understands about mental health care, which means that, if we're lucky -- if we are lucky -- there will be somebody in the, you know, commissioning, the new commissioning structure, who understands about mental health care, understands population need, understands the evidence, understands the importance of this being clinically driven and understands that the care needs to be delivered in a way that people will actually access the services. Because if they don't, then nothing is going to change.

Q. Page 43, please, of your witness statement, alongside page 44. You set out the international perspective on page 43, and set out on page 44, please, the College consideration of the main lessons for the UK.

If you can take us through, please, page 44, the bullet points at the top, what do you say is required in the UK?

A. So we do need further strengthening of community

provision. In 1974, it was decided that the asylums, which, you know, would be, you know, dissolved, there was deinstitutionalisation.

At that point 40% of NHS beds were for mental health and learning disability patients. Since then, our beds have reduced by 85%. The expectation was that the money that was saved, because asylum care is expensive, the money that was saved from the asylums would be pumped into and ploughed into community services.

Unfortunately, as ever, the money didn't really follow, which has meant that community services have been -- there were occasionally there's injections of money and funding and resources, but generally, they are, you know, they're just not properly resourced, and because they're not properly resourced, it means that they've got thinner and thinner and they can produce a crisis response, but often not good enough in certain places.

There's no doubt that we need to have better supported housing because people will come into hospital and then they can't leave hospital, accounting for 10% of our beds being filled with people who are ready for discharge but can't be discharged because there's nowhere for them to go to.

There certainly needs to be better integration

between mental health and primary care, housing, social care, criminal justice agencies, because these are all agencies that will be involved in the person's care at times.

I've mentioned about beds. In some places, like Somerset, there is only 70% bed occupancy and they've got lots of beds. But in many places across the country, particularly in inner city areas, we are literally -- since 2022, 95%-plus bed occupancy and in many cases 100%-plus bed occupancy. So in Northampton it's 116% bed occupancy, which means that if someone needs to come into hospital, they either have to go into a -- you know, they can't get into their local area hospital, they have to go to a placement far away from where they might live, which affects their ability to integrate back into the community, it affects their ability to continue, have that continuity of care.

There will be things that happen in the out-of-area placement that you don't get the same information about as you would know if you had seen the person and looked after them. So there's stuff that you'll miss, and so that erodes information and understanding.

And, frankly, it also means that because there aren't enough beds then, you know, as I think I said before, people end up -- the thresholds just get higher

1 and higher and higher, and when people are in crisis,
2 that's when they are most likely to pose a risk to
3 themselves and others. And the whole thing about mental
4 health services is that we need to be seeing people
5 early, as early as possible, into treatment. Not only
6 is that better for them clinically, it also reduces the
7 risk of them going into crisis.
8 And then the final thing, really, is -- I mean
9 basically we just need to -- one of the big problems is
10 that when people do get into our services, we actually
11 aren't able to offer them the effective interventions
12 that we know work because they haven't been implemented,
13 we're not tested against them, we're not asked to
14 provide that care. We're just asked to -- we're
15 actually measured against our bed occupancy and our
16 length of stay; we're not actually measured against
17 whether we get people well.
18 **Q.** Can we go, please, to page 67 and you refer here to the
19 new -- the detention criteria, in the Mental Health Act,
20 set out at paragraph 209.
21 "serious harm may be caused to the health or safety
22 of the patient or of another person unless the patient
23 receives medical treatment/is so detained".
24 In terms of that as a criteria for detention, what
25 are your concerns about that?

1 **A.** So at the College we have concerns about this because
2 there is this idea that somehow -- the psychiatrists at
3 the time doing the assessment will -- and also the
4 social workers, the social worker will have something to
5 do with this or, sorry, the Approved Mental Health
6 Professional, who is often a social worker, have to
7 decide about whether or not that person's illness, and
8 that person, as a result of their illness, might call --
9 you know, that might be the cause of someone being
10 harmed. But that idea of causation is not something
11 that was pre- -- you were previously required to think
12 about, actually, and although it may seem obvious, you
13 think: yeah of course it would, but it's not always
14 clear. And it also goes away from the idea that we are
15 trying our hardest to see people as early as possible.
16 We don't want to wait until they're so unwell that there
17 is no choice, which is the situation we're in now, that
18 we have no choice but to bring somebody in because
19 they're very unwell and it's obvious because they've
20 just hit somebody. It would be better to be able to
21 bring people in at a much earlier stage because you
22 think: well, actually, this is -- they're starting to
23 get unwell, they really lack capacity, they don't
24 understand that they're -- you know, that -- they really
25 need to get treatment, we could actually bring them in

1 now, give them treatment, they'll get better, and that's
2 about, you know, their health which is being harmed, and
3 it's harmful to them, before it might become a risk to
4 anybody else.
5 **Q.** And previously, it was "He ought to be so detained in
6 interest of his own health or safety or with a view to
7 protection of other persons."
8 Is your concern surrounding the difficulty of
9 predicting serious harms and psychiatrists getting
10 caught up in that and what it means -- *(overspeaking)* --
11 **A.** Well, there's no doubt that people would end up being
12 caught up anyway. What counts as serious harm? You
13 know, some people will say: well actually, you know,
14 someone said something to me at work, I didn't like it,
15 it affected me psychologically, I'm having, you know,
16 a day off or something. Another person might think --
17 I mean, you know, I look after patients with forensic
18 issues who have come from families where, you know,
19 there's been a lot of violence, and I remember one of my
20 patients saying, "You don't understand, Dr Smith,"
21 because they'd just hit another patient on the ward, he
22 said -- "I'm not a violent man, there was no blood."
23 So his understanding of what it meant to be violent
24 was --
25 **Q.** Drawing blood?

1 **A.** Yeah.
2 **Q.** Can we look at page 70, please, and have the whole page,
3 220 and 221. To address your concerns about the
4 detention criteria, the College suggests the following.
5 Can you set out, please, what you say here?
6 **A.** So a person needs to be suffering from a mental disorder
7 of the nature or degree, and:
8 "there is a significant risk of serious harm to the
9 health or safety of the patient or [that] of another
10 person.
11 "it is necessary, given the nature or degree of the
12 harm, for [the person] the patient to receive medical
13 treatment (or assessment)
14 "the necessary treatment (or assessment) cannot be
15 provided unless the patient is detained under this Act;
16 "[And] the appropriate treatment (or assessment) is
17 available for the patient."
18 And that was based on amendments by a Member of
19 Parliament, actually.
20 **Q.** Why do you say it enables "holistic, straightforward
21 clinical assessment"?
22 **A.** So this is because you need to be able to provide
23 a person with -- a holistic assessment, essentially it's
24 a biopsychosocial assessment, and that means taking into
25 account their biological state, their psychological

1 situation, their social situation and environment. It's
2 just what we do as psychiatrists. That's it.
3 **Q.** Did you contribute to the focus groups and Sir Simon
4 Wessely's review?
5 **A.** So I was in the core working group and I also was the
6 deputy chair for the African Caribbean working group,
7 the tribunal's group, and rising rates of detentions.
8 **Q.** And what's your view of the Act generally, where it's
9 landed on a number of issues?
10 **A.** There were some good bits, some bad bits and some ugly
11 bits, I think. And there were some good bits which
12 are -- and I have to say that when the review was done,
13 and it was a cast of thousands involved, when the review
14 was done, there was consensus and everyone agreed, and
15 it seemed to get the balance between -- because the
16 aim -- you know, we were tasked with trying to address
17 the increasing rates of detention, addressing the racial
18 disparities in detention, and also trying to bring it
19 more in line with modern, human rights thinking.
20 And at the end of the review I think we managed to
21 do that in a sensible way. There was a lot of
22 discussion and give and take, and bearing in mind that
23 there were a group of people who said, "There shouldn't
24 be a Mental Health Act at all", and that was quite
25 a strong push, actually, particularly because the

1 UN Convention on the Rights of Persons with Disabilities
2 had complained that the UK's approach to psychiatric,
3 you know, mental health care, and the Mental Health Act,
4 was actually amounted to torture. And that was -- so
5 that was the milieu that we were working in.
6 So we -- you know, there was -- we went from people
7 saying there shouldn't be a Mental Health Act, people
8 saying there should be fusion and it should be a Mental
9 Capacity Act, and in fact the review came out with what
10 looked like the best Bill that you could get that
11 satisfied, you know, the majority of people.
12 Then there were -- I don't know what happened, but
13 there were probably people who influenced the Bill, you
14 know, the actual Bill from outside who hadn't gone
15 through -- you know, done the same level of scrutiny,
16 et cetera, and things changed, actually. And it meant
17 that we end up with the Bill -- the Act now, some parts
18 of which are good, some parts of which are problematic.
19 **Q.** What do you think is problematic?
20 **A.** Well, it's problematic that, you know, we've outlined
21 the detention criteria. That's a bit problematic
22 because it's open to confusion.
23 **Q.** Do you think it's going to be important what the mental
24 health Codes say about that?
25 **A.** Yeah, and actually it needs to be operationalised, and

1 what that means is: how are we going to make this work
2 in practice? And right now the Department of Health and
3 Social Care are working with various stakeholders to
4 develop the Code of Practice around the new, you know,
5 the new amendments to the Mental Health Act.
6 **Q.** What sort of thing would you like to see in the Code of
7 Practice?
8 **A.** Well, certainly when it comes to detention criteria,
9 making it very clear about what it is that we mean by
10 "serious harm"; that it might also relate to a person's
11 health, actually, not just to the likelihood of them
12 being violent to somebody else.
13 So because that's important, and, you know, what
14 often gets forgotten is these are people who are very,
15 very, very unwell at times, but can get better.
16 **Q.** With treatment?
17 **A.** With treatment, people can live very healthy, you know,
18 normal lives. Just like someone with diabetes, you just
19 have to remember to look after yourself a bit more than
20 you might do if you didn't have the diabetes or you
21 didn't have the psychosis.
22 **Q.** Can we have, please, WITN0320036, page 3. This is your
23 second statement, Dr Lade Smith, and you refer to
24 coercion and coercive practices. The Inquiry has heard
25 a lot of evidence from different practitioners of what

1 they consider "least restrictive" practice to mean.
2 First of all, before we go to what you say at
3 paragraph 9, what do you say about that principle? What
4 does it mean?
5 **A.** Well, "least restrictive" principle essentially means
6 that we are, particularly when you are -- if you are
7 detaining someone under the Mental Health Act, you are
8 depriving them of their liberty. And if you are going
9 to do that, not only do there need to be safeguards
10 around that, that's, you know, right back to the
11 beginning of, you know, UK law.
12 There have to be safeguards around that, but also,
13 you have to do it in a proportionate way, and you have
14 to do it in a proportionate way that is safe and lawful.
15 **Q.** And that involves as you say in paragraph 18:
16 "... consideration of [the] risk they pose to
17 themselves and others, balanced alongside the type of
18 treatment that is going to keep [the] ... person well."
19 **A.** Yeah, absolutely.
20 **Q.** Going back to page 9, what do you say to the comment
21 that the College or the government or generally
22 psychiatrists may be under pressure for being considered
23 to be overly coercive, that that impacts in some way on
24 their day-to-day decision making? Do you think there is
25 that pressure?

A. You do have to remember that we are bound by law to pay attention to inappropriate restrictive practice, and actually quite right too, because there have been very high profile, inappropriate use of restriction that has resulted in people being significantly harmed and even dying. And that's something that, over the years, certainly mental health services have got better at managing.

That doesn't mean that we don't use restrictive practice, however. But you have to use it in a way that is proportionate and we have to think about it carefully. Those two things are not incompatible and certainly, I'm slightly concerned that there's an idea that somehow, asking us to be careful about how we manage people's -- manage people when they're severely unwell amounts to us not being able to do that work. We do it, but we do it with safeguards and we do it in a careful way. It's not always easy and sometimes it can be quite complex. And we know it has to be done, but you just do it carefully.

Q. You set out at paragraph 51, page 13, the role of race in decision making, and tell us what you say about that at paragraph 51?

A. So this, actually, there's quite a lot of history to this and so for -- about 50 years ago, it was recognised

that there was an increase detention rates for people from minoritised ethnic groups, not just black people, but people who were not from the white, British majority. And particularly for black people. And in fact rates -- when people started looking at this -- rates of detention were two-and-a-half times more than in the white population for black people, particularly people from black Caribbean backgrounds and actually that's continued and last year or the year before it was three and a half times, this year, it's four times the rates.

Q. Was that linked to failure to access early intervention, early services and the like?

A. So what people also realised is that 40% of black people were coming into mental health services in crisis and of course if you have a health problem, what you do is you go to your GP, and you tell your GP you have a problem and the GP refers you, or now you can phone 112, and can, you know -- you actually phone up and get mental health support almost directly. But for some reason, black people, particularly black men, were much more likely to come in in crisis and come in either with the help of the police because they have been picked up in the street very unwell, or via the criminal justice system because they'd posed a risk when they were

unwell.

The difficulty has been that over that 40, 50 years, there have been these, again, very polarised arguments with one group of people saying this is simply because black people are inherently prone to psychosis, and another group of people saying, actually, you're simply -- that's just racism, full stop. And these two factions would argue, argue, argue.

The problem with that is it precluded people from doing the thinking that needed to be done and, you know, looking at the evidence. A bit like we get polarised, very binary arguments now, stop people from thinking and, you know, having any balanced thought.

In the last kind of 15 years or so, there's been -- people have done that thinking and that evidence, and what's become clear is a number of things: one, that if you look at the countries of origin of, you know, the black populations in the UK, the rates of mental illness, particularly severe mental illness, are not that dissimilar to the rates you see in the white population in the UK, except for some unusual places like Trinidad, because -- and that's related to use of cannabis in Trinidad.

But rates of mental disorder full stop, anxiety, depression, PTSD, bipolar illness, schizophrenia, other

psychosis, are higher in the black population in the UK, and in other white majority countries, than they are in the white population. So rates of anxiety and depression are two to four times higher. Rates of PTSD are higher, rates of psychosis are higher too.

When you then start to look at: well, why might this be? Interestingly, the first generation black people have rates of disorder that are similar to -- more similar to the, you know, the countries of origin than the white British population, but their descendants, second, third, fourth generation, have much higher rates.

Also very recent study, the INTREPID study -- and that shows -- it was looking at cannabis and psychosis and it looked at cannabis and psychosis in different countries -- found that rates of psychosis were low in Nigeria, India, against, actually lower than they were in -- almost lower than they were in the white British population. Rates were much higher in Trinidad where there was much higher cannabis use.

So this is -- then research has found that actually, the excess rates that you see of mental illness in black people are not simply about some genetic problem; it's there's more going on here. We know what the risk factors are for mental illness. So yes, the

1 genetics are important, but beyond that perinatal
2 factors are important.
3 What happens to you when you are in the womb is
4 really important. So we know that being exposed to
5 toxins, being exposed to viruses, being small for dates,
6 being born prematurely -- so a fascinating finding is
7 that if you are born in the winter months, the
8 likelihood of you developing schizophrenia 20 years
9 later is much higher than if you're not born in the
10 winter months. It doesn't matter if you're in the
11 northern hemisphere or southern hemisphere. That's
12 thought to be related to exposure to things like flu
13 viruses. So, you know, we're all wondering what's going
14 to happen 20 years after Covid? Is there going to be
15 a spike in schizophrenia which is what you see after flu
16 epidemics. So the Spanish flu epidemic, the Japanese
17 flu epidemic, there are spikes of schizophrenia.
18 We also know early life trauma is important. So
19 adverse childhood experiences. We also know that, you
20 know, if you do use drugs and you start using cannabis
21 from when you are in your mid-teens, then that
22 significantly increases your risk of developing a
23 psychotic illness by 11 times.
24 Migration is important, but, of course, that's not
25 really an impact on the second, third, fourth

1 generation.
2 So it's now been recognised that the social
3 risk factors and social risk factors drive most mental
4 illness, a good 50%-plus of mental illness, they're just
5 much higher. Those social risk factors occur much more
6 in black people than they do, in the UK, than they do in
7 the white people in the UK and that explains why you get
8 higher rates of --
9 **Q.** But looking at what you say at paragraph 51:
10 "The College has consistently raised concerns about
11 ... disproportionate detention of Black and minoritised
12 ethnic communities, not to advise that Black people, or
13 anyone, shouldn't be detained when necessary, rather to
14 highlight ... timely access to appropriate treatment
15 ..."
16 So it's not the suggestion that a black person
17 should not be detained, that's not --
18 **A.** No, not at all, actually. In fact, what the College has
19 said very clearly, and College has supported and helped
20 to develop the Patient and Carer Race Equality
21 Framework, which is about trying to get people seen
22 earlier. Because what's very clear from the evidence is
23 that black people aren't able to access the services
24 when they need them, and this is a group of people who
25 really need these services, which is why, you know, the

1 old psychiatrists who, you know, have been shouting and,
2 you know, with these polarised arguments, have actually
3 created a problem in themselves because it stops
4 people -- also because, frankly, I have to say that
5 there have been some very high-profile problems with
6 psychiatry, and there were deaths, you know, very
7 high-profile deaths of four black men: David "Rocky"
8 Bennett, Sean Rigg, Kevin Clarke, Seni Lewis. And in
9 1998, when David "Rocky" Bennett died, and he was in
10 a mental health unit and he died after being restrained,
11 and given very inappropriately high doses of medication.
12 There was an Inquiry after that and I think it was
13 Sir John Blofeld said, actually, and this is 1998, he
14 said his death -- concluded that the death of David
15 "Rocky" Bennett was contributed to by institutional
16 racism in the NHS and private sector and something
17 needed to be done.
18 More recently, as a result of the death of
19 Seni Lewis, the government brought in the use of force
20 in mental health units Act, it's called Seni's Law. So
21 we are bound by law to do something about restrictive
22 practice. That doesn't mean that black people shouldn't
23 be detained, and in fact what it means is that this is
24 a group of people we need to make sure get the help they
25 need, and ideally they would get that help early rather

1 than waiting until they're in crisis. So we have to
2 change the services so we are more responsive, more
3 accessible, better able to meet the needs of that
4 population.
5 **MS LANGDALE:** I think that's time for a break, actually.
6 **THE CHAIR:** Yes. Shall we start again at 11.55, thank you.
7 **(11.35 am)**
8 **(A short break)**
9 **(11.55 am)**
10 **THE CHAIR:** Yes.
11 **MS LANGDALE:** Can we have on screen, please, WITN0320036,
12 page 7. Just a few more questions from me, please,
13 Dr Lade Smith.
14 We see at paragraph 26 that:
15 "The College has recently appointed a new Chair to
16 the Ethics Committee [to] ... oversee any updates to
17 Good Psychiatric Practice: Confidentiality and
18 Information Sharing, [and] they will set out a timeline
19 in the coming months."
20 What's envisaged with that role and the impact
21 of it?
22 **A.** So as we know, there are a number of Inquiries going on
23 at the moment. There are likely to be recommendations
24 that come out of those Inquiries that are going to
25 perhaps have an impact on our -- not just the advice

1 that we give and the guidance, but also the training
2 that we deliver. And so the role of the Chair will be
3 to gather the latest evidence, compare it to what exists
4 at the moment, check it against existing good practice
5 guidance, for example from the GMC, and then work --
6 they don't just do this by themselves, they work with
7 various stakeholders within and external to the College,
8 and then update that guidance.
9 **Q.** You mention Inquiries. Of course how recommendations
10 from Inquiries are implemented, particularly in the NHS,
11 is a cause for concern, isn't it?
12 **A.** Yes.
13 **Q.** Inquiries happen, recommendations are made and nothing
14 changes. So this a role that's anticipated to assist
15 with that, as far as the Royal College of Psychiatrists
16 is concerned?
17 **A.** Yeah, although it has to be remembered that the Royal
18 College acts -- as with other medical Royal Colleges, we
19 have an advisory function to government and they can
20 take our advice or not, and it would be very good if,
21 because we -- when it comes to mental health care,
22 particularly clinical care, we do have lots of evidence.
23 And if we don't have the evidence, we know where the
24 best evidence is available and so it would be useful for
25 people to come to us as a first port of call and then we

1 can direct them accordingly.
2 **Q.** Paragraph 27, you refer to the "lack of interoperability
3 in respect of digital patient records [being a] ... main
4 barrier to information sharing between agencies".
5 If we can have page 8, paragraph 28:
6 "The College has repeatedly asked the UK Government
7 to support the interoperability of digital patient
8 records."
9 How is that progressing? Any indication that that
10 will ever happen?
11 **A.** Not so far. I have asked personally myself the previous
12 Health Secretary, about this, and actually, myself and
13 other medical Royal Colleges, you know, the presence of
14 other medical Royal Colleges have said: look, you know,
15 the NHS is a really large customer and so, as a large
16 customer, it should be able to ask digital providers to
17 get their systems to talk to each other.
18 **Q.** Can we have on screen, please, RLIT0000031, page 1. And
19 this "The Royal College of Psychiatrists: Membership
20 Survey on local capacity".
21 We see, if we can have page 4 and 5, please, on the
22 screen, questions asked of those who participated:
23 "Do you ever feel you have to make a decision on
24 admission or discharge which is based on anything other
25 than the patient's clinical need and best interests?"

1 If we can have pages page 4, please, and page 5
2 alongside each other. And:
3 "If 'yes' ... where [is the] ... pressure coming
4 from"?
5 Tell us what the results of this were, in
6 a nutshell, please.
7 **A.** So essentially one of the main issues was insufficient
8 or unsuitable local inpatient provision, which means not
9 enough beds or not the right kind of bed to meet the
10 needs of that patient.
11 And so it has to be said that it's not simply
12 psychiatrists who decide, you know, it used to be the
13 case that psychiatrists would have more control over the
14 beds, but now there are bed management teams, and those
15 bed management teams are trying to do their very best.
16 Their job is to manage the scarce resource --
17 **Q.** Beds that they have.
18 **A.** -- that they have, and so bed management -- bed managers
19 will come to a ward and say to the psychiatrist on the
20 ward, "All right, who are you discharging, because I've
21 got 20 people waiting in A&E and I've got the Acute
22 ward, you know, the acute Trust shouting at my Chief
23 Exec and the Chief Exec is shouting at me and I need you
24 to move someone out."
25 So the pressure then is that you're trying to --

1 it's a bit like a Japanese, you know, tube train, you
2 have to squeeze someone out to get somebody else in.
3 **Q.** That can come down, please, and can we have WITN0075009.
4 You referred earlier to workforce strains in psychiatry.
5 I don't know if we can make that larger. If we can't,
6 it's going to be quite difficult.
7 Referring as you did earlier to:
8 "... feedback from College members suggests that
9 chronic workforce shortages, burnout from excessive
10 workloads, and poor work-life balance are contributing
11 to many consultants considering early retirement or
12 leaving the profession entirely."
13 This suggests at the bottom, there should be:
14 "... robust workforce planning, years of
15 understaffing has left the psychiatric workforce on life
16 support. ... minimal increases in consultant
17 psychiatrists numbers since 2012, while other
18 specialities have had far more workforce growth."
19 Is that your experience over the years?
20 **A.** Oh yes, for sure and, you know, we have, I think,
21 something like one in six consultant vacancies, which
22 means that sometimes they're filled by locums. There
23 are people who live abroad who come and do a locum in
24 the UK for a bit, then go. They're great. The problem
25 is, that that impacts service development. It means

1 that you can't, you know, bring new in treatments and in
2 fat there've been, you know, in the last ten years or
3 so, there have been a good ten or 15 new innovations in
4 psychiatry, but they're not implemented, they're not
5 implemented.
6 It's really difficult, I think, because I think it's
7 probably about three or four years ago there was
8 a statistic that 20% of the consultant psychiatry
9 workforce was over the age of 55. The reason that's
10 important is because if you were of a certain age you
11 were able to retire at that point, and it's not just
12 consultant psychiatrists, but nursing staff and mental
13 health social workers, who had a thing called "mental
14 health officer status" and, when asked, a significant
15 proportion of them were deciding that: "yeah, I'm going
16 to retire because I can't do this anymore".
17 **Q.** Can we have, please, WITN0207013, page 1: "Mental health
18 pressures in England". This is a BMA document, is it?
19 **A.** Yeah.
20 **Q.** If we go to page 15:
21 "Indexed NHS expenditure on mental health in England
22 in comparison to total NHS England expenditure."
23 Can you tell us what that represents?
24 **A.** Essentially, what it's showing is the spending on mental
25 health care has reduced and reduced and reduced and

1 continues to do so and what tells us is that mental
2 health care is just not prioritised. As I said before,
3 we are 20% of the disease burden and we get 8.4% of the
4 funding and in the time that I've been president, it's
5 gone from over 9%, to 8.7%, to 8.4%.
6 At the moment, there is a requirement for ICBs, the
7 commissioners, to ring-fence that mental health funding,
8 but it was a fight to get that ring-fencing to remain
9 this year. The expectation is that ring-fencing next
10 year will be gone.
11 Which means that we will have people who may not
12 have -- well, may have -- may have limited understanding
13 of the mental health need and what's required, how to
14 deliver it, who just may think: "well, what's the
15 point?" And I've got, you know, to spend this money
16 elsewhere. So unfortunately that situation may get
17 worse.
18 **Q.** Page 17, please. Can you tell us what this says?
19 **A.** So this is the -- this is actually to do with the number
20 of mental health beds that are occupied. If you have
21 80% bed occupancy and 85% -- sorry, 85% risk threshold
22 is literally the point at which you can properly manage
23 your beds. You can manage patient flow. You can get
24 people in when they need to get brought in. You're
25 better able to actually do all the thinking that you

1 might need to do. You'll have time enough to look after
2 the patients. Having a bed isn't it just about the bed,
3 it's about the staff that go with it and all the
4 interventions that go with that.
5 Anything above that, it means that you are not going
6 to be able to provide a safer level of care and you're
7 certainly not going to be able to manage your beds so
8 well, you're going to have difficulty getting people in
9 and of course that causes risks in the community to that
10 individual and potentially to others.
11 It also means it's harder to do the thinking and the
12 time to sort out getting people out of hospital, because
13 a person might come in from their flat, but when they
14 come in, that's when you discover that there have been
15 real problems with them being able to manage in that
16 flat and actually they're going to need new
17 accommodation, and so you need to have time to sort that
18 out.
19 Anything over 85% just stymies your ability to
20 provide effective and safe care.
21 **Q.** Page 19, please: "Inappropriate out of area mental
22 health placements". What's happened to those?
23 **A.** Unfortunately, you can see the thing to look at is at
24 the end of the graph, particularly the top line, you can
25 see that there's an incline, there's an increase in the

1 number of inappropriate placements, inappropriate
2 out-of-area placements.
3 What was meant -- some years ago, there was
4 a review, and the Government said, actually, you're
5 actually -- you know, the review found that there were
6 too many inappropriate out-of-area placements.
7 Sometimes it's correct that a person goes to a placement
8 that's outside their area because they have a very
9 specialised need and the only place that provides that
10 specialised need might be, you know, a couple of
11 hundreds miles from where they live. But most of the
12 time people are sent to out-of-area placements because
13 there just isn't capacity in their local area. That's
14 an inappropriate out-of-area placement.
15 And what the Government committed to was eliminating
16 out-of-area placements. Unfortunately, that hasn't
17 happened, and that just hasn't happened at all. And
18 when someone is sent out of area, it means that it's
19 harder for them to maintain contact with their local
20 community. It might be hard for them to recover because
21 their family, who might want to be involved, can't get
22 to visit them, and that can affect people. They'll be
23 looked after by people who don't know them quite so well
24 and don't necessarily understand how best to look after
25 them. Sometimes, obviously there can be problems with

1 information sharing with the local Trust.
2 **MS LANGDALE:** Thank you. Those are my questions.
3 **THE CHAIR:** Yes, thank you. Ms Eastwood.
4 **Questioned by MS EASTWOOD**
5 **MS EASTWOOD:** Good afternoon, Dr Lade Smith. I ask
6 questions on behalf of the bereaved families.
7 I'd like to ask you first about the College's
8 approach to the assessment of risk to others. You were
9 taken by Ms Langdale at the outset of your evidence to
10 the executive summary of the guidance, it is CR201,
11 Rethinking risk to others to in mental health services.
12 You told us it was revised in 2017, and you
13 described it as being of its time and you explained that
14 the foreword would be different now because the emphasis
15 now is much more on what's the evidence and how do we
16 implement that into our practice; is that right?
17 **A.** Yes.
18 **Q.** Do you agree that one of the pieces of evidence that the
19 College had before 2017 was the findings of the 1994
20 Ritchie Report following the death of Jonathan Zito?
21 **A.** Yes.
22 **Q.** Are you aware that the Ritchie report made
23 evidence-based, concrete recommendations for the
24 management of risk of a small, identified class of
25 patients who are known to pose a particular risk to

1 public safety?
2 **A.** Yes.
3 **Q.** Do you agree it was the responsibility of leaders within
4 the College to ensure that learning from that report was
5 not lost?
6 **A.** I think the difficulty is that there's an assumption
7 that medical Royal Colleges have -- because we can
8 provide guidance, and but what we have -- what we can't
9 do in the same way is actually implement that guidance.
10 And we can provide advice and we can provide training.
11 There is no doubt at all that -- and I was training
12 around the time that the -- you know, the incident
13 happened with Christopher Clunis. I was, you know,
14 coming to -- I was training when the Ritchie report came
15 out, and actually, there was huge amounts of -- there
16 was a great deal of change, actually, and I think back
17 now, and it's terrible that such a thing should have
18 happened again, and I think back now, 30 years ago, and
19 I think what -- that we were flooded with information.
20 We were supported with lots of information at that
21 point.
22 **Q.** But that was available in 2017 and do you accept, then,
23 that the failure to take an evidence-based approach to
24 the College guidance tends to suggest a loss of learning
25 from that report?

1 **A.** Actually, I disagree that there was a failure to take an
2 evidence-based approach. What I said was that the
3 foreword, the foreword, wouldn't be written in this way
4 now.
5 In fact, when -- if you're -- as a jobbing
6 psychiatrist and if you're thinking about: oh what do
7 I do about assessing risk and managing risk? What does
8 the College say? If you were to look on the College
9 website, what you actually get first and foremost --
10 anyone can do this right now actually, you can actually
11 look up assessing risk RCPsych and there will be a list
12 of -- in fact, it shows you the principles, the tips for
13 psychiatrists, et cetera, it doesn't really go into --
14 it doesn't actually go into the principles and the
15 practice in the guidance.
16 You would then have to -- and if you want, you can
17 then click on that, but actually what it provides you
18 with is an outline of jobbing psychiatrists, this is the
19 kind of thing you should be doing. And to be perfectly
20 honest with you, jobbing psychiatrists it's really
21 unlikely right now, they're not going to be reading the
22 whole guidance. What they're going to be doing is
23 looking at the tips, et cetera, which are evidence
24 based.
25 **Q.** Can I ask you then, you've told the Inquiry you've

1 recently appointed a new chair to the Ethics Committee
2 to ensure that learnings from this and others inquiries
3 is not lost. Was that not responsibility that had
4 previously been allocated within the College?
5 **A.** That's something we do all the time but this is about
6 this specific case and we happen to need -- you know,
7 there's a -- just say that everybody who works at the
8 College, all the psychiatrists are volunteers, and they
9 will have a tenure that they will work to, and then
10 sometimes they say, "It's time for me to move on", and
11 it happens to be that there's -- this Inquiry and other
12 Inquiries are going to provide new recommendations, the
13 Chair is moving on, so this is a good time to have a new
14 Chair and actually -- but that's not to say that the
15 previous Chair -- the previous Chair is fantastic,
16 actually.
17 **Q.** Can I ask you about the integration of your recommended
18 standards into psychiatric clinical practice, because
19 you've identified that because the Royal College is
20 neither commissioner nor regulator of services there is
21 variable implementation of standards nationally, and
22 you've spoken in particular of the uneven levels of
23 mandatory training on the Mental Health Act and the
24 Mental Capacity Act.
25 Who do you think should take over the mantle of

1 ensuring mandatory training, with the abolishment of NHS
2 England?
3 **A.** Well, that will probably be the Department of Health and
4 Social Care, but I think, I don't know whether it's
5 going to be them or whether it's going to be devolved to
6 ICBs, but there will, you know, there is -- there is
7 mandatory training, we all have to do mandatory
8 training.
9 **Q.** Is there a role for the College in ensuring uniformity
10 of such training?
11 **A.** We would love to do that. We would be very happy to do
12 that and if people want to make that the recommendation
13 that would be brilliant.
14 **Q.** In terms of another practical aspect, I think you agree
15 that nationally recommended practicable, scalable
16 operational tools, such as risk formulation templates,
17 MDT, risk handover summaries, could help to ensure that
18 high-level guidance is translated more consistently into
19 practical effect?
20 **A.** Yes, that would be helpful.
21 **Q.** Is the drafting of such operational tools something the
22 Royal College could do to assist with the --
23 **A.** We can certainly help with that but, you know, it would
24 have to be commissioned and funded. Because, as I said,
25 it takes -- actually I'm not sure I have said this but

1 it takes about 18 months to develop this kind of work.
2 **Q.** Where your guidance or your standards touched on issues
3 relevant to other agencies, do you agree it would be
4 helpful for the other agencies to be made aware of your
5 recommendations?
6 **A.** We always do. So when we have recommendations we will
7 send them around to other agencies. We will say --
8 I mean that's what all the different organisations will
9 do, and say, "By the way we've done this, you might be
10 interested. Hope, you know, you will have a look.
11 Please share with your constituency."
12 **Q.** So if we look at practical example, the Inquiry heard
13 that in your report relating to the responsibility of
14 psychiatrists to provide expert evidence to courts and
15 tribunals, that the College recommended that forensic
16 psychiatrists should resist commenting on the level of
17 culpability, which is a matter for the court.
18 Using that as an example, do you think that's
19 something that would have been helpful to send to, for
20 example, the CPS and courts to make them aware of your
21 recommendations?
22 **A.** So it has to be said that we usually send our guidance
23 around to our doctors, and mainly because what we don't
24 like to do is to tell lawyers what to do.
25 **Q.** Can I ask you, then, a third topic: resource

1 constraints. Because you've identified that the mental
2 health services nationally are operating under severe
3 resource constraints.
4 Do you agree, however, that that's a problem across
5 the whole health service? For example, there are
6 currently 8,000 GP posts that are vacant.
7 **A.** So there's no doubt at all that there are pressures
8 across the whole service, and it's interesting you
9 mention GPs because I think GPs are in a very similar
10 situation to psychiatry. There are certain specialities
11 that are much more -- that people -- that are basically
12 just sexier and more interesting and there's more -- and
13 people understand them more. And so -- and it's easy
14 for them to get the money.
15 So if you're saying, "Look at this brilliant robotic
16 surgery thing. Give us, you know, a couple of million
17 for this and, guess what: it's going to help take your
18 gallbladder out far more quickly, and look, there's only
19 a little tiny hole."
20 And you can see it and it's easier, and it's easier
21 to understand what it is you're spending your money on
22 and what you're going to get from that. It's actually
23 much harder with primary care with GPs than with mental
24 health care. And, as I've said before, for us in mental
25 health care, there has been this quite erroneous idea

1 that there's not much that you're going to get out of it
2 if you put money in. Whereas in fact what we know is
3 that -- and especially now there's really good
4 understanding that, you know, mental health problems are
5 problems of youth. You know, 75% happen before the age
6 of 24. So if you do not -- you know, once you've
7 survived childhood infectious diseases, the most common
8 disorder you're going to suffer from is a mental
9 illness, and the problem is that if you do not resource
10 that properly, then it's not just that it has an impact
11 on that individual's health and their productivity, it
12 affects the productivity of the country and, as we've
13 seen, it can significantly affect risk to other people
14 as well as-- *(overspeaking)* --
15 **Q.** Has the Royal College raised concerns with the
16 government --
17 **A.** Yes, oh yes.
18 **Q.** -- that there's *(unclear)* investment in NHS mental
19 health services?
20 **A.** All the time. I think that they are sick of me nagging
21 them, to be perfectly honest with you, yes.
22 **Q.** And if an individual clinician believes they can't keep
23 patients safe with the resources or skills that they
24 have, do they have a duty to speak up?
25 **A.** And they do speak up. What they do is you will have --

1 there's a whole whistleblowing or kind of procedure,
2 there's a Freedom to Speak Up.
3 **Q.** Do they have a duty to speak up?
4 **A.** Well, they do have a duty to speak up and they say that,
5 but it's very difficult because you're making it sound
6 as though it's somehow the individual clinician versus
7 their managers et cetera, but actually you have to
8 remember that everybody working in that health
9 organisation is in -- under similar pressure.
10 So the Chief Executive has a budget that is, you
11 know, to -- and they've worked out their budget to
12 deliver care to their local population. The income that
13 they get from their Commissioners, every single year, is
14 5-10% less than they need. Every single year, I think
15 nearly every single Mental Health Trust is required to
16 deliver the same care, if not more care but on less
17 budget. So every single mental health Trust is spending
18 their whole time looking for what's called "cost
19 improvement savings": how can you deliver more for less?
20 **MS EASTWOOD:** Thank you.
21 **THE CHAIR:** Yes, Ms Cartwright.
22 **Questioned by MS CARTWRIGHT**
23 **MS CARTWRIGHT:** Good afternoon, Dr Smith. I ask questions
24 on behalf of the survivors.
25 Can we please just go back to the amended law that

1 now changes the statutory criteria, when it is
2 implemented, for Section 2 and Section 3, and you've
3 been taken to one aspect of the new test by
4 Ms Langdale KC at paragraph 209, please, in your first
5 witness statement.
6 Thank you. So if we could go, please, to page 67,
7 please. Thank you.
8 So you've already identified the change to the
9 statutory criteria for Section 2 and Section 3, which
10 was essentially this received Royal Assent in December
11 of last year but essentially it's just waiting it's
12 implementation date. Obviously other provisions have
13 come in, and so you've already identified the "serious
14 harm may be caused to the health or safety of the
15 patient or of another person unless the patient receives
16 medical treatment is so detained."
17 And I think you identified, would you agree, that
18 that essentially indicates a higher threshold than the
19 current test?
20 **A.** That's a concern, yes.
21 **Q.** If we look at the second aspect, because it's not just
22 serious harm, if we move down please to 214, there's the
23 further layer that's now added by the new law in the
24 Mental Health Act of 2025 also, the likelihood
25 requirement that:

1 "it is necessary, given the nature, degree and
2 likelihood of the harm, for the patient to receive
3 medical treatment, or given the nature, degree and
4 likelihood of the harm, the patient ought to be so
5 detained."
6 And so would you agree again further layering to the
7 statutory criteria that used to exist?
8 **A.** Yeah.
9 **Q.** And I think you said in evidence, and I think perhaps if
10 we contextualise that with 33-years' experience in
11 psychiatry, that it's your concern that these new
12 statutory criteria are open to confusion?
13 **A.** Yeah, that's not simply my concern. I'm here
14 representing, you know, the Royal College of
15 Psychiatrists, and we have looked at this, at the new
16 Bill, we've been involved in developing it and, as I've
17 said before, there were some changes that were made that
18 were -- we expressed concerns about at the beginning, as
19 a result of lots of psychiatrists looking at that is
20 carefully and this is one we're still a bit concerned
21 about.
22 **Q.** And obviously we have reference to your 33-years'
23 experience but we appreciate also you're giving evidence
24 as the President of the Royal College of Psychiatrists,
25 and so you're saying this the considered view of a body

1 of opinion about the concerns?
2 **A.** Yeah, I mean that it will cause confusion. And because
3 of that it means that we have to be very careful to
4 ensure that we operationalise this very well.
5 **Q.** Yes, so cause confusion but also, would you agree, it's
6 another thing that you've talked about, that essentially
7 is highering the threshold for assessment and treatment
8 in hospital?
9 **A.** Potentially it might be. I mean, I have to say we do
10 have to be realistic. For many places, as I've said
11 before, you don't get into hospital unless you're
12 really, really unwell and you are already posing a risk.
13 So by this criteria it's not going to make any
14 difference.
15 **Q.** I think you've already identified that what's going to
16 be key to it is how that's operationalised, and you
17 talked about now there's the consultation between the
18 Department of Health and Social Care and stakeholders.
19 Is the Royal College of Psychiatrists part of that
20 ongoing discussion as to how it's going to be
21 operationalised in the Code of Practice?
22 **A.** Yeah, and actually I think the Department of Health are
23 doing this very carefully.
24 **Q.** Can I then go back to something you said at the outset,
25 before you commenced your evidence. You talked about

how you hoped this Inquiry brings practical change, better commissioning decisions, clear coordination, and more effective and properly resourced care. And you went on, I think, to give an example, in your practice when you used to be both a treating consultant when a patient was in hospital, but also you'd have that continuity of care when they were in community. Is that something you were alluding to when you were talking about more effective commissioning and continuity of care?

A. So we know that continuity of care is one of the best ways to deliver mental health care because the therapeutic relationship -- you know, when you get to know someone over time you're better able to develop a good therapeutic relationship with them. We know that's associated with a reduction in hospital utilisation, which means -- and this is from large studies -- which means that people are less likely to become so unwell that they end up in hospital. It's associated with a reduction in emergency department usage, again, because people are less likely to become so unwell that they end up in hospital because, when you get to know someone, they're better able to tell you when there are difficulties in their lives, when they're more stressed; it means that you're able to say to them

"Actually maybe we need to think about tweaking this, that, you know, you need to make sure you get some sleep, take a couple of days off work, take a bit of extra medication", whatever it is that works for that person to reduce the likelihood of them getting so unwell that they end up in crisis.

When you improve continuity of care, you improve the therapeutic relationship, things are just so much better. And unfortunately the way in which our services are commissioned currently are actually structurally work against that. It's very difficult to have that continuity of care. And at the time when this functional model was brought in, what was said is that the skill would be in how good your handover was and how good your, you know, basically information sharing was with other services.

What I think wasn't quite appreciated was that actually, necessarily when you are in a team and you are busy, and you've got loads to do, someone else tells you about someone else that they want you to see and it's like: we are full.

And so what we found when we did some work some years later, we were looking at community services and introducing a new community model, was that 30-40% of the Community Team's time was spent batting off

referrals, which is just a waste of time when that time could have been spent with, you know, patients and looking after patients.

Q. And so is what you're recommending as part of consideration of the Inquiry, a model that has the oversight of the psychiatrists, both of the patient in hospital but also in the community?

A. Yes.

Q. Then finally, please, can I just pick up one aspect that you deal with: The efficacy of antipsychotics, please. Can we briefly look at paragraph 85 of your first witness statement at page 28.

Thank you. You deal with antipsychotic medication being the mainstay of psychosis treatment, being associated with reduction in symptoms, reduction in relapse and associated reduction in violence in the 5% of people with psychosis who are at risk of behaving violently. Then you go on to deal with clozapine having superior efficacy compared with other antipsychotic medications.

So would you agree that, if the patient is in that cohort of 5% with psychosis at risk of behaving violently, there really should be careful thought given to the clozapine?

A. That's a good question, actually. It actually depends

on whether or not the person is treatment responsive. The main thing is that they need to get treatment. They need to be able to access treatment. And if a different antipsychotic works for them, fine. But if they have tried two, they've had a good trial of two different antipsychotics and that hasn't helped their symptoms sufficiently, then that's in indication for clozapine.

MS CARTWRIGHT: Thank you very much indeed.

THE CHAIR: Thank you.

Mr Straw.

Questioned by MR STRAW

MR STRAW: I represent VC's family.

Earlier on, when you were being questioned by Ms Langdale, you mentioned that sometimes people with mental illness are estranged from their families, often because of their illness.

I'd like to ask you about schizophrenia, please. Can schizophrenia lead a patient to have difficulties in their relationships with family members. For example, if it causes them to disengage or distance themselves from family members?

A. Yes, yes, it can. So schizophrenia's a type of psychosis. It just needs to be said very clearly that psychosis just means being detached from reality. There are different types of psychosis that you -- there are

1 about five main times: organic psychosis, when someone
2 has, say, a tumour sitting in a particular bit of the
3 brain and causes them to have delusions and
4 hallucinations; manic psychosis, people get very high;
5 depressive psychosis, people get very, very depressed
6 and they have mood congruent delusions and
7 hallucinations; and then the schizophrenia-type
8 psychosis; and then there's drug-induced psychosis.
9 The thing about delusions -- you get different types
10 of delusions and hallucinations in different types of
11 psychosis. So if someone is manic, they might think --
12 and just say a delusion is a false idea. It doesn't
13 matter what you say, what evidence there is, the person
14 believes it anyway and they believe it with really
15 strong conviction and it's out of keeping with what
16 their family, personal, educational beliefs are.
17 Hallucination is when there's a perception, so you
18 hear something but there's no one talking to you. You
19 get different types of hallucinations and delusions in
20 different illnesses and in schizophrenia, sometimes the
21 delusions are a bit bizarre, sometimes. There can often
22 be a lot of paranoia. Oftentimes people will direct it
23 around to the people who are closest to them, so you,
24 you know, it might be that the person closest to you
25 gets involved in your delusional system; either you

1 think they're being attacked or someone is attacking
2 them, or you think you look like my mum, but I'm not
3 sure you are my mum because there are people who are
4 able to disguise themselves really, really well. So you
5 might not always trust your family. And sometimes, and
6 usually it's the case, that it's people that are closest
7 to each other who have the problems.
8 **Q.** And is that someone with schizophrenia, difficulties
9 with family relationships, is that something that is
10 relatively common?
11 **A.** It's not uncommon. It's not uncommon and, also, you
12 have to remember that when people have severe mental
13 illnesses, there's such limited understanding of
14 illnesses that sometimes family members -- you know,
15 family members are usually the ones who, you know, if
16 there's a risk, it's usually the family members that are
17 the ones who get -- who are unfortunately the victims,
18 and it can mean that that means that people in the
19 family don't necessarily want to be involved with the
20 person, because they worry about, even if they've not
21 been a victim of any kind of risk, but the stigma that's
22 associated with having a severe mental illness might
23 mean that they think: well, this person has got a severe
24 mental illness, what does that mean they're going to do
25 to me?

1 So sometimes family members will distance
2 themselves. Sometimes it's the individual who will
3 distance themselves from the family member.
4 **Q.** Do you think that sufficient support is provided to the
5 family to cope with what may be a traumatic experience
6 of their loved one being struck down by schizophrenia
7 and potentially disengaging, distancing themselves from
8 their family?
9 **A.** It's really -- it can be really quite difficult. As
10 I said, mental health services are very, very stretched.
11 You do have to be able to find the time to meet with
12 families and often what happens in General Adult
13 Psychiatry is that families will be invited to, say, the
14 ward round or a discharge planning meeting or a CPA
15 meeting, but that's, you know, the time that you might
16 have to actually discuss with the family is not that
17 much.
18 I mean, I think about when I moved to -- from, you
19 know, really pressed general adult service, you know, to
20 the intensive care service and then to forensic
21 services, and I started what I called the Family Clinic
22 because I realised that coming to the ward round,
23 hearing about the person, there's loads of other people
24 there, you might get five minutes to talk or to ask, and
25 you might not really hear what's going on.

1 And I had the time, the luxury of time, when I moved
2 to these more specialised services to spend, to have an
3 hour each week where I would say to the family member:
4 do you want to come and we'll talk about what's going on
5 here? So that person got the -- or the family got the
6 opportunity to learn about what the condition was, what
7 it meant, what it might mean for them, what it might
8 mean in terms of longer-term prognosis for their loved
9 one and how best to manage it.
10 What was striking is the number of people I'd met
11 who had, you know -- and I have to say particularly when
12 I got into forensic services -- who have -- who -- the
13 fact who's relative had been involved with services for
14 quite a long time who had never been told what the
15 actual illness was, or who had never understood what the
16 illness was.
17 **Q.** Looking at it a slightly different way, do you think
18 that psychiatrists, staff, sufficiently understand and
19 sympathise with the difficulties families may face? So
20 in particular when their loved one with schizophrenia
21 distances themselves or disengages with their family?
22 **A.** It's difficult because, of course, especially in general
23 adults -- I mean, in general adult services, most people
24 the risk that they pose is to themselves and most people
25 don't pose a risk to others.

1 So the focus is actually about: how do we support
2 this person to get well? And if you have time, you will
3 try and engage the family and usually there will be
4 somebody in the family that you are able to have some
5 kind of -- get information from, try and get -- because
6 they, as I said before, the family can be really
7 supportive, but if the person is adamant that they don't
8 want to have anything to do with their family, if
9 they've got capacity, it's very hard to involve the
10 family in those discussions.
11 **Q.** One final issue, then could we have the witness
12 statement on screen, please WITN0320001. Thank you.
13 Page 33, please.
14 Here you discuss the GMC Guidance on confidentiality
15 and set out four pretty straightforward rules about when
16 information can be shared. So:
17 "A) The patient consents ...
18 "B) The disclosure is of overall benefit to a
19 patient who lacks capacity ...
20 "C) ... required by law ...[and]
21 "D) ... justified in the public interest."
22 You also say in your witness statement at 107 that
23 staff often feel uncertain about what can be shared.
24 How can we change that? What is needed to ensure that
25 staff do understand what may be relatively simple

97

1 guidelines?
2 **A.** So it has to be said, actually, that I think the doctors
3 are generally pretty good at this, actually. So when we
4 say staff, it's -- I think the staff who have the
5 hardest time with this are the nursing staff. I don't
6 really know about the nursing training, but it's often
7 that the nurses aren't exactly sure.
8 Having said that, every NHS staff member is required
9 to undertake mandatory training in information
10 governance every year, actually, and it does go through
11 this stuff. But when you are doing it all the way, so
12 as a doctor, I'm having to balance that all the time, so
13 I'm more cognisant of what's needed and what needs to
14 be -- you know, what's okay and what's not. And also,
15 it's much easier for me to check with a colleague. I
16 will contact, if I've got a concern -- you know, a real
17 concern, then I know to contact our Caldicott Guardian
18 and I'm lucky where I work there are people who are --
19 you know, there's international experts in this field.
20 I think it's much harder for, you know, if you're
21 a nurse, and it might be that you might ask your nurse
22 colleague, who also isn't it too sure, and then
23 eventually you might ask the consultant. But sometimes
24 I think people feel that it's -- I mean, it's difficult,
25 and they're not quite sure what to do.

98

1 **MR STRAW:** Okay, thank you very much.
2 **THE CHAIR:** Yes, thank you.
3 Mr Stein is here; do you want to ask?
4 **MR STEIN:** No questions.
5 **Questioned by THE CHAIR**
6 **THE CHAIR:** If I can ask you a couple of questions.
7 You've referred to a body of opinion that thinks
8 psychiatry shouldn't exist at all and certainly there
9 should be no interference with those who have severe
10 mental illness.
11 Does the College put out a message to those people
12 about the number of people who are killed a year?
13 **A.** I have to say that it's generally not that helpful to
14 try and -- what we try to say to people is this: that
15 mental illness, particularly severe mental illness, does
16 exist, number 1. Number 2, it can be treated and it can
17 be treated very effectively. And that treatment is
18 a holistic treatment that takes into account the
19 person's biology, psychology, social and environmental
20 state. So we try and put out a positive message because
21 in truth, if you try to get into arguments with people
22 who have very entrenched positions, it doesn't really
23 get you very far.
24 **THE CHAIR:** As far as just that point that I'm raising is
25 concerned -- and you've mentioned the ICBs and the

99

1 amount of money that they have to distribute and the
2 fact that, in fact, you said only one of the new ICBs
3 had a Medical Director.
4 **A.** One of the new -- the pan-ICB commissioning arrangements
5 so there are seven of them.
6 **THE CHAIR:** Thank you. Again, there is a repeated message
7 that homicides by severely mentally ill patients are
8 very rare, and it may be that in terms of numbers of
9 people with mental illness, that may be a small
10 statistic. But in terms of annual numbers, it's not, is
11 it?
12 **A.** Well, I mean, look, one is too many.
13 **THE CHAIR:** Yes.
14 **A.** The thing is that we do have solutions. We have things
15 that work. It's not that we have to invent a new
16 approach. We know what works, we know what is effective
17 for the treatment of -- of most mental illnesses,
18 including severe mental illness. In fact, you can treat
19 psychosis really, really effectively. The problem is
20 that less than one-third of people who need mental
21 health treatment can actually access it.
22 As I said before, it can take up to nine years to
23 get a diagnosis and therefore into treatment if you have
24 a severe mental illness. And once you are getting that
25 treatment, you know, people are so stretched that it

100

1 kind of depends on where you are in the country as to
2 whether you'll get good enough treatment.
3 **THE CHAIR:** Yes, but I think what I'm really asking about is
4 the message, because obviously there's a fear of
5 stigmatisation, but you yourself referred back to the
6 Ritchie Report and the Clunis Inquiry, but there have
7 been many other, similar incidents with similar deaths
8 that have not had public Inquiries over the last
9 30 years. And the Wessely Report, for example, doesn't
10 really mention homicides at all, in dealing with the
11 issues.
12 So is the fact that this is not referred to in order
13 to avoid stigmatisation in fact counter-productive in
14 the sense that the funding, perhaps, might follow and
15 that people's understanding of, both the numbers and
16 also the effects in society, would change?
17 **A.** Mm. It's an interesting question. I think there is
18 balance amongst psychiatrists who understand this.
19 I think the difficulty is that external to psychiatry,
20 there are lots of stakeholders who don't like to think
21 about the violence that can be perpetrated by the small
22 number of people, but it is part of what we have to
23 think about all the time.
24 **THE CHAIR:** Yes. It's just a question of whether that's,
25 I think we heard from Professor Appleby about how the

1 homicide element of the National Confidential Inquiry
2 was dropped.
3 **A.** Yeah.
4 **THE CHAIR:** And how learning was lost, and that there is
5 an arc of memory.
6 **A.** Yeah.
7 **THE CHAIR:** We're now 30 years on from Clunis, but in that
8 time, many other people have lost their lives as well,
9 but that's somehow not been acknowledged.
10 **A.** So I think, you know, I think it was a mistake that the
11 funding was withdrawn from the homicide bit. We were
12 all a bit surprised as to why that happened. I think
13 that, frankly, that's about the leadership in the people
14 who commissioned at the time. That leadership, I think,
15 has changed recently.
16 Unfortunately, I would love it if people listened to
17 psychiatrists all the time, but they don't. We can say
18 these things but it's important that -- there are lots
19 of other stakeholders in the mental health field, and
20 it's important for those stakeholders to also speak
21 about this, because it used to be the case that there
22 was a thinking that you couldn't do anything about
23 violence, and you couldn't do anything about violence in
24 society and you certainly couldn't do anything about the
25 violence that might be perpetrated by people with severe

1 mental illness, so better not to look at it.
2 We know now that that's not the case. It is
3 possible to reduce violence generally in society using
4 public health measures and it is possible to mitigate
5 the violence that might be perpetrated by that small
6 number of people with severe mental illness.
7 **THE CHAIR:** And just finally, you've referred to
8 fragmentation, and the importance of continuity. But
9 I just wanted to ask you about Assertive Outreach for
10 that particular group of patients, and it appears to be
11 potentially in contradistinction to the neighbourhood
12 hubs. What's your view about that?
13 **A.** I'm not sure it is, actually, if you think about the
14 neighbourhood hubs. There's 24/7 neighbourhood hubs.
15 They -- I mean, they're all working in slightly
16 different ways. They are an enhanced version of a thing
17 called the Community Mental Health Framework. The
18 Community Mental Health Framework was about trying to
19 make sure that the model of community care was much
20 more -- much more in the prime -- you know, the earlier
21 stage of someone being unwell, much more accessible to
22 people and could provide them with everything that they
23 needed.
24 The 24/7 model, you know, says, "Okay, everybody who
25 has got severe mental illness can come here".

1 I think that you could have -- they're not -- you
2 can't -- you're not going to be able to look after
3 everybody, you know, they're actually -- the number of
4 people they can look after in a particular area is not
5 everybody.
6 You could also have an Assertive Outreach Team.
7 Usually the Assertive Outreach Team would be for a whole
8 borough, and you can have an Assertive Outreach Team
9 that sits in the co-location -- you know, sits in the
10 same space, actually. So I don't think it's
11 incompatible at all, actually, because there will be
12 some people who feel really comfortable about coming to
13 see you and there will be others who don't. Your
14 Assertive Outreach Team would go off and look after
15 those people.
16 And then, you know, all -- but all the rest of it,
17 we really need to have proper implementation of the
18 Community Mental Health Framework, we need to test the
19 24/7 models to see if they're working and then make sure
20 that there's funding available to continue the
21 resourcing of those and to spread them out if they work
22 well, and we can have Assertive Outreach teams too.
23 **THE CHAIR:** Thank you.
24 We'll stop there and we'll start again at 1.45.
25 **(12.45 pm)**

1 **(The short adjournment)**
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5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

105

1 **I N D E X**
2 Page
3 DR SHUBULADE SMITH (affirmed) 1
4 Questioned by MS LANGDALE 1
5 Questioned by MS EASTWOOD 77
6 Questioned by MS CARTWRIGHT 85
7 Questioned by MR STRAW 92
8 Questioned by THE CHAIR 99
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

106

MR STEIN: [1] 99/4
MR STRAW: [2] 92/12 99/1
MS CARTWRIGHT: [2] 85/23 92/8
MS EASTWOOD: [2] 77/5 85/20
MS LANGDALE: [7] 1/4 1/7 2/8 7/2 68/5 68/11 77/2
THE CHAIR: [20] 1/3 1/10 2/7 7/1 68/6 68/10 77/3 85/21 92/9 99/2 99/6 99/24 100/6 100/13 101/3 101/24 102/4 102/7 103/7 104/23
THE WITNESS: [1] 1/11

'

'Rethinking [1] 4/25
'yes' [1] 71/3

-

-- and [1] 63/22
-- it [1] 64/14

.

... [1] 70/3
... main [1] 70/3

1

1,600 [1] 3/17
1.45 [1] 104/24
10 [3] 39/6 51/21 85/14
10.00 [1] 1/2
100%-plus [1] 52/10
104 [1] 43/15
107 [1] 97/22
11 [1] 65/23
11.35 [1] 68/7
11.55 [2] 68/6 68/9
112 [1] 62/18
116 [1] 52/11
119 [3] 45/2 45/2 47/25
12.45 [1] 104/25
13 [2] 3/15 61/21
15 [4] 30/12 39/2 73/3 73/20
15 January 2026 [1] 2/9
15 years [1] 63/14
15-20 [1] 26/12
16 [1] 31/23
17 [1] 74/18
18 [1] 60/15
18 months [1] 82/1
1800s [1] 35/1
19 [1] 75/21
1900s [1] 37/4
1955 [1] 37/6
1974 [1] 51/1
1994 [1] 77/19
1998 [2] 67/9 67/13
1999 [1] 8/20

2

20 [8] 26/7 26/12 27/20 28/5 34/9 34/13 73/8 74/3
20 people [1] 71/21
20 years [2] 65/8 65/14
2005 [2] 8/13 8/25
2008 [1] 4/25
2009 [1] 22/16
2012 [1] 72/17
2013 [3] 7/3 7/9 8/12
2016 [1] 7/23
2017 [5] 7/23 7/24 77/12 77/19 78/22
2019 [1] 3/11
2022 [1] 52/9
2025 [1] 86/24
2026 [3] 1/1 2/9 2/9
209 [2] 53/20 86/4
21 [2] 34/10 34/13
214 [1] 86/22
22,000 [1] 3/16
220 [1] 56/3
221 [1] 56/3
24 [1] 84/6
24/7 [3] 103/14 103/24 104/19
25 [4] 4/24 38/18 38/19 38/23
26 [4] 5/6 12/23 49/14 68/14
27 [1] 70/2
28 [4] 5/14 49/14 70/5 91/12
28 May 2026 [1] 2/9
29 [1] 7/4

3

3,000 [1] 4/1
30 years [3] 78/18 101/9 102/7
30-40 [1] 90/24
30-odd [1] 24/24
33 [3] 30/10 30/12 97/13
33 years [1] 24/15
33-years' [2] 87/10 87/22
34 [2] 42/16 42/17
38 [1] 45/2

4

40 [5] 21/14 51/4 62/14 63/2 90/24
41 [1] 20/20
43 [2] 50/18 50/20
44 [3] 50/19 50/20 50/22

5

5-10 [1] 85/14
50 years [2] 61/25 63/2
50%-plus [1] 66/4
50-odd [1] 49/14
51 [3] 61/21 61/23 66/9
54 [1] 27/13
55 [1] 73/9

6

67 [2] 53/18 86/6

7

70 [2] 52/6 56/2
700-plus [1] 37/2
75 [1] 84/5

8

8,000 [1] 83/6
8.4 [3] 26/8 74/3 74/5
8.7 [1] 74/5
80 [2] 38/16 74/21
83 [1] 36/16
85 [5] 51/6 74/21 74/21 75/19 91/11

9

95%-plus [1] 52/9

A

ability [3] 52/15 52/17 75/19
able [27] 4/16 14/8 26/18 28/14 37/25 44/14 44/19 53/11 54/20 56/22 61/16 66/23 68/3 70/16 73/11 74/25 75/6 75/7 75/15 89/14 89/23 89/25 92/3 94/4 95/11 97/4 104/2
abolished [1] 49/8
abolishment [1] 81/1
about [126]
above [1] 75/5
abroad [1] 72/23
absence [1] 34/8
absolute [1] 15/23
absolutely [3] 35/20 47/19 60/19
abuses [1] 7/11
accept [2] 29/15 78/22
access [7] 43/13 50/16 62/12 66/14 66/23 92/3 100/21
accessible [3] 43/25 68/3 103/21
accommodation [1] 75/17
according [2] 26/15 27/6
accordingly [1] 70/1
account [4] 13/21 40/15 56/25 99/18
accounting [1] 51/21
accreditation [1] 4/8
accuracy [1] 29/10
accurate [3] 2/10 11/7 11/16
acknowledged [1] 102/9
acknowledging [1] 1/11
acronyms [2] 49/12 49/13
across [4] 15/20 52/7 83/4 83/8
Act [24] 41/8 45/17 45/19 45/20 45/21 45/22 45/23 46/14 48/4 48/5 53/19 56/15 57/8 57/24 58/3 58/7 58/9 58/17 59/5 60/7 67/20 80/23 80/24 86/24
acting [1] 35/24
activity [1] 37/16
acts [1] 69/18
actual [3] 28/3 58/14 96/15
actually [89] 6/21 9/6 12/21 16/9 17/7 17/16 21/11 22/16 24/11 24/12 25/18 26/24 27/8 28/11 28/13 28/14 29/22 30/19 34/21 34/23 35/11 41/8 41/19 44/10 44/17 46/12 46/21 47/2 50/16 53/10 53/15 53/16 54/12 54/22 54/25 55/13 56/19 57/25 58/4 58/16 58/25 59/11 61/3 61/24 62/8 62/19 63/6 64/17 64/21 66/18 67/2 67/13 68/5 70/12 74/19 74/25 75/16 76/4 76/5 78/9 78/15 78/16 79/1 79/9 79/10 79/10 79/14 79/17 80/14 80/16 81/25 83/22 85/7 88/22 90/1 90/10 90/18 91/25 91/25 95/16 97/1 98/2 98/3 98/10 100/21 103/13 104/3 104/10 104/11
acute [3] 35/7 71/21 71/22
adamant [1] 97/7
added [1] 86/23
additional [2] 5/9 8/6
address [3] 10/9 56/3 57/16
addressed [2] 43/18 45/11
addressing [2] 5/2 57/17
adequately [1] 36/23
adjournment [1] 105/1
admin [2] 18/14 33/25
admission [2] 17/17 70/24
admit [2] 26/24 46/14
admitted [1] 41/21
adopted [1] 27/16
adult [11] 2/19 2/20 21/19 28/1 32/15 42/10 43/1 43/9 95/12 95/19 96/23
adults [1] 96/23
adverse [2] 11/6 65/19
advice [4] 43/11 68/25 69/20 78/10
advise [3] 21/1 38/11 66/12
advisory [2] 4/13 69/19
affect [3] 34/24 76/22 84/13
affected [2] 24/8 55/15
affects [3] 52/15 52/16 84/12
affirmed [2] 1/5 106/3
affluent [1] 29/5
African [1] 57/6
after [28] 8/16 8/17 8/20 8/23 9/11 9/12 9/13 17/10 20/14 24/20 24/24 25/11 26/10 38/22 52/21 55/17 59/19 65/14 65/15 67/10 67/12 75/1 76/23 76/24 91/3 104/2 104/4 104/14
afternoon [2] 77/5 85/23
again [21] 1/18 7/12 8/22 18/1 19/22 32/19 32/22 36/25 36/25 36/25 38/19 38/20 39/3 42/5 63/3 68/6 78/18 87/6 89/21 100/6 104/24
against [9] 39/11 39/15 47/22 53/13 53/15 53/16 64/17 69/4 90/11
age [3] 73/9 73/10 84/5
agencies [8] 15/20 16/9 52/2 52/3 70/4 82/3 82/4 82/7
agency [4] 15/9 16/5 16/6 16/7
ago [4] 61/25 73/7 76/3 78/18
agree [12] 29/20 41/25 45/9 77/18 78/3 81/14 82/3 83/4 86/17 87/6 88/5 91/21

A

agreed [3] 5/18 31/8 57/14
aim [2] 39/1 57/16
aimed [1] 5/2
alcohol [1] 29/8
alert [1] 18/19
Alex [1] 45/18
alive [1] 14/18
all [47] 2/3 6/4 6/5 6/13 6/16 11/3 13/12 13/21 15/14 17/9 18/4 35/4 35/5 37/5 38/8 41/8 44/8 47/7 49/13 50/6 52/2 57/24 60/2 65/13 66/18 71/20 74/25 75/3 76/17 78/11 80/5 80/8 81/7 82/8 83/7 84/20 98/11 98/12 99/8 101/10 101/23 102/12 102/17 103/15 104/11 104/16 104/16
allocated [1] 80/4
allowed [1] 28/11
alluding [1] 89/8
almost [2] 62/20 64/18
alongside [4] 1/12 50/18 60/17 71/2
already [5] 42/13 86/8 86/13 88/12 88/15
also [44] 2/1 2/20 3/7 9/1 9/6 9/21 10/4 10/18 15/18 15/19 16/1 18/4 19/12 22/12 37/18 43/8 44/24 52/23 53/6 54/3 54/14 57/5 57/18 59/10 60/12 62/14 64/13 65/18 65/19 67/4 69/1 75/11 86/24 87/23 88/5 89/6 91/7 94/11 97/22 98/14 98/22 101/16 102/20 104/6
alter [2] 13/4 14/6
altered [3] 5/11 8/7 8/9
although [3] 32/14 54/12 69/17
always [7] 10/21 32/24 36/8 54/13 61/18 82/6 94/5
am [5] 1/2 1/17 47/18 68/7 68/9
amended [1] 85/25
amendments [2] 56/18 59/5
amongst [1] 101/18
amount [1] 100/1
amounted [1] 58/4
amounts [2] 61/16 78/15
amphetamines [1] 37/21
angry [1] 12/18
annual [1] 100/10
another [11] 4/17 6/17 18/25 53/22 55/16 55/21 56/9 63/6 81/14 86/15 88/6
anti [2] 6/3 46/25
anti-psychiatry [2] 6/3 46/25
antibiotic [1] 36/9
anticipated [1] 69/14
antipsychotic [4] 37/7 91/13 91/19 92/4
antipsychotics [2] 91/10 92/6
anxiety [2] 63/24 64/3
any [18] 6/15 10/22 11/11 16/14 17/7 25/18 26/21 32/10 33/5 37/6 40/25 44/24 49/24 63/13 68/16 70/9 88/13 94/21
anybody [2] 33/11 55/4
anymore [1] 73/16
anyone [2] 66/13 79/10
anything [9] 14/18 22/23 70/24 75/5 75/19 97/8 102/22 102/23 102/24
anyway [5] 27/10 28/21 28/24 55/12 93/14
anywhere [1] 47/21
apparent [1] 44/2
appears [2] 42/20 103/10
Appleby [1] 101/25
appointed [2] 68/15 80/1
appreciate [1] 87/23
appreciated [1] 90/17
approach [15] 9/6 9/14 9/15 9/16 10/19 21/18 22/9 25/4 25/5 31/7 58/2 77/8 78/23 79/2 100/16
approaches [2] 3/9 30/2
appropriate [2] 56/16 66/14
approved [2] 4/3 54/5
approximately [1] 3/17
arc [1] 102/5
are [199]
area [17] 3/19 20/16 24/18 43/19 50/6 52/13 52/18 75/21 76/2 76/6 76/8 76/12 76/13 76/14 76/16 76/18 104/4
areas [1] 52/8
aren't [8] 4/16 24/10 41/22 49/24 52/24 53/11 66/23 98/7
argue [3] 63/8 63/8 63/8
argued [1] 10/6
arguments [4] 63/3 63/12 67/2 99/21
around [20] 4/1 6/22 8/10 9/7 10/16 15/13 15/14 19/8 22/15 22/16 27/25 35/3 38/10 59/4 60/10 60/12 78/12 82/7 82/23 93/23
arrangement [2] 16/6 16/7
arrangements [2] 33/9 100/4
as [99] 2/10 2/10 2/24 2/25 3/10 4/19 5/15 7/17 8/15 8/25 9/14 9/18 9/22 10/1 10/2 10/2 11/11 12/6 12/8 14/17 14/17 15/3 16/11 16/20 16/24 17/1 17/6 18/25 19/1 20/4 20/23 22/21 22/23 26/10 27/12 27/12 29/9 29/10 29/25 30/7 30/17 32/21 38/4 39/6 42/4 43/20 43/21 44/1 44/3 44/3 44/6 47/13 47/13 51/10 52/20 52/24 53/5 53/5 53/24 54/8 54/15 54/15 55/12 57/2 60/15 67/18 68/22 69/15 69/15 69/18 69/25 70/15 72/7 74/2 77/13 79/5 81/16 81/24 82/18 83/24 84/12 84/14 84/14 85/6 87/16 87/18 87/24 88/10 88/20 91/4 95/9 97/6 98/12 99/24 99/24 100/22 101/1 102/8 102/12
ask [18] 20/12 21/9 23/4 34/12 70/16 77/5 77/7 79/25 80/17 82/25 85/23 92/17 95/24 98/21 98/23 99/3 99/6 103/9
asked [7] 30/13 53/13 53/14 70/6 70/11 70/22 73/14
asking [4] 15/16 27/11 61/14 101/3
aspect [5] 34/24 81/14 86/3 86/21 91/9
Assent [1] 86/10
Assertive [7] 9/18 103/9 104/6 104/7 104/8 104/14 104/22
assess [1] 46/19
assessed [1] 45/16
assessing [3] 19/3 79/7 79/11
assessment [25] 3/2 11/10 11/12 14/22 21/14 21/21 21/24 22/1 22/10 22/15 23/4 23/6 28/23 30/16 45/9 48/3 54/3 56/13 56/14 56/16 56/21 56/23 56/24 77/8 88/7
assessments [4] 5/17 12/25 23/10 45/14
assessor [1] 3/7
assist [2] 69/14 81/22
associated [10] 12/6 12/19 25/14 43/16 44/5 89/16 89/20 91/15 91/16 94/22
assuming [1] 48/7
assumption [1] 78/6
asylum [1] 51/7
asylums [2] 51/1 51/8
at [118]
at it [1] 40/1
at page 6 [1] 11/1
at page 8 [1] 4/23
attached [2] 31/1 38/14
attacked [1] 94/1
attacking [1] 94/1
attacks [1] 1/15
attention [3] 20/19 37/16 61/2
attitudes [2] 6/9 6/10
authorities [1] 42/3
available [7] 10/18 35/13 37/7 56/17 69/24 78/22 104/20
avoid [1] 101/13
avoided [1] 11/5
awarded [1] 3/10
awards [1] 3/9
aware [6] 28/21 33/12 48/1 77/22 82/4 82/20
away [2] 52/14 54/14
awful [1] 23/1

B

back [12] 8/22 38/21 42/15 46/23 52/16 60/10 60/20 78/16 78/18 85/25 88/24 101/5
background [1] 2/17
backgrounds [1] 62/8
bad [2] 25/16 57/10
balance [6] 6/20 6/22 57/15 72/10 98/12 101/18
balanced [2] 60/17 63/13
barrier [1] 70/4
base [1] 29/3
based [11] 10/19 11/11 13/17 22/3 40/13 56/18 70/24 77/23 78/23 79/2 79/24
basically [4] 49/15 53/9 83/11 90/15
basis [1] 15/7
batting [1] 90/25
be [241]
bear [2] 7/5 37/1
bearing [1] 57/22
became [3] 8/19 37/7 37/8
because [98] 6/16 15/8 17/12 19/1 20/2 20/6 20/14 20/15 22/24 24/8 24/12 25/18 25/21 26/2 27/17 29/3 29/3 29/20 29/24 30/4 30/24 31/7 31/15 33/14 36/3 36/4 38/15 41/8 41/17 41/21 42/5 42/7 42/11 43/6 45/7 47/21 48/7 49/17 49/22 50/16 51/7 51/15 51/20 51/23 52/2 52/23 53/12 54/1 54/18 54/19 54/21 55/21 56/22 57/15 57/25 58/22 59/13 61/3 62/23 62/25 63/4 63/22 66/22 67/3 67/4 69/21 71/20 73/6 73/10 73/16 75/12 76/8 76/12 76/20 77/14 78/7 80/18 80/19 81/24 82/23 83/1 83/9 85/5 86/21 88/2 89/12 89/21 89/22 92/16 94/3 94/20 95/22 96/22 97/5 99/20 101/4 102/21 104/11
become [5] 26/16 55/3 63/16 89/19 89/21
becoming [4] 8/22 26/18 39/4 44/1
bed [13] 52/6 52/9 52/10 52/11 53/15 71/9 71/14 71/15 71/18 71/18 74/21 75/2 75/2
beds [14] 41/21 41/22 51/4 51/5 51/22 52/5 52/7 52/24 71/9 71/14 71/17 74/20 74/23 75/7

B

been [50] 2/22 3/6 12/19 14/8 15/18 16/18 17/9 21/20 22/6 22/24 22/25 23/5 23/22 23/23 24/15 25/1 25/2 25/3 26/2 26/5 31/25 32/16 36/25 49/14 51/12 53/12 55/19 61/3 62/23 63/2 63/3 63/14 66/2 67/1 67/5 73/2 73/3 74/4 75/14 80/4 82/19 83/25 86/3 87/16 91/2 94/21 96/13 96/14 101/7 102/9
before [25] 1/7 4/21 13/18 20/15 26/1 35/11 38/5 38/24 41/19 41/20 46/24 49/7 52/25 55/3 60/2 62/9 74/2 77/19 83/24 84/5 87/17 88/11 88/25 97/6 100/22
begin [3] 1/7 1/11 26/22
beginning [2] 60/11 87/18
behalf [2] 77/6 85/24
behave [4] 13/12 23/12 28/16 28/19
behaving [5] 11/23 12/4 13/22 91/17 91/22
behaviour [3] 42/25 43/2 43/16
behind [1] 45/8
being [41] 2/25 7/13 7/14 7/18 9/15 10/14 19/23 22/21 24/14 26/18 28/14 37/24 41/3 44/3 44/4 44/20 49/8 50/14 51/22 54/9 55/2 55/11 59/12 60/22 61/5 61/16 65/4 65/5 65/5 65/6 67/10 70/3 75/15 77/13 91/14 91/14 92/13 92/24 94/1 95/6 103/21
beliefs [4] 17/25 18/3 19/2 93/16
believe [8] 6/17 36/5 38/5 38/6 47/12 47/14 47/18 93/14
believes [2] 84/22 93/14
benefit [2] 37/12 97/18
benefits [2] 44/24 46/20
Bennett [3] 67/8 67/9 67/15
bereaved [1] 77/6
best [15] 23/17 24/23 27/19 36/2 40/14 40/24 41/5 41/5 58/10 69/24 70/25 71/15 76/24 89/11 96/9
better [24] 2/4 10/10 14/15 28/22 28/25 37/21 38/20 38/24 44/17 44/23 51/19 51/25 53/6 54/20 55/1 59/15 61/7 68/3 74/25 89/2 89/14 89/23 90/9 103/1
between [7] 8/2 10/11 10/21 52/1 57/15 70/4 88/17
beyond [2] 17/22 65/1
big [1] 53/9
biggest [1] 11/23
Bill [5] 58/10 58/13 58/14 58/17 87/16
binary [1] 63/12
biological [1] 56/25
biology [1] 99/19
biopsychosocial [1] 56/24
bipolar [1] 63/25
Birmingham [1] 29/2
Birthday [1] 3/11
bit [15] 8/13 18/17 20/8 24/14 58/21 59/19 63/11 72/1 72/24 87/20 90/3 93/2 93/21 102/11 102/12
bits [4] 57/10 57/10 57/11 57/11
bizarre [1] 93/21
black [19] 62/2 62/4 62/7 62/8 62/14 62/21 62/21 63/5 63/18 64/1 64/7 64/22 66/6 66/11 66/12 66/16 66/23 67/7 67/22
Blofeld [1] 67/13
blood [2] 55/22 55/25
BMA [1] 73/18
Board [1] 49/10
bodies [3] 10/8 10/12 21/9
body [3] 4/17 87/25 99/7
born [3] 65/6 65/7 65/9
borough [1] 104/8
both [3] 89/5 91/6 101/15
bottom [2] 31/22 72/13
bound [2] 61/1 67/21
brain [1] 93/3
break [2] 68/5 68/8
briefly [1] 91/11
brilliant [3] 25/9 81/13 83/15
bring [7] 8/22 26/25 54/18 54/21 54/25 57/18 73/1
bringing [1] 39/17
brings [1] 89/1
British [3] 62/3 64/10 64/18
broad [2] 5/8 8/4
brought [6] 9/5 9/6 9/9 67/19 74/24 90/13
budget [3] 85/10 85/11 85/17
build [1] 29/16
bullet [2] 14/24 50/23
burden [2] 26/7 74/3
burn [1] 35/8
burned [1] 9/2
burnout [1] 72/9
busy [2] 39/22 90/19
but [143]

C

Caldicott [1] 98/17
call [3] 1/4 54/8 69/25
called [13] 9/7 27/21 28/14 29/16 30/21 35/11 49/20 49/25 67/20 73/13 85/18 95/21 103/17
came [3] 7/23 58/9 78/14
can [135]
can't [13] 26/10 26/10 38/16 51/21 51/23 52/13 72/5 73/1 73/16 76/21 78/8 84/22 104/2
cannabis [6] 37/20 63/23 64/14 64/15 64/20 65/20
cannot [2] 11/7 56/14
capacitous [1] 47/24
capacity [24] 40/20 45/5 45/7 45/8 45/9 45/12 45/16 45/20 45/22 45/23 46/6 46/7 46/9 46/11 46/19 47/17 48/5 54/23 58/9 70/20 76/13 80/24 97/9 97/19
care [56] 2/6 2/21 2/22 8/18 13/1 15/9 24/1 24/2 24/3 25/3 25/4 31/24 32/4 32/7 32/8 33/20 33/21 33/21 40/10 41/25 49/9 49/20 50/8 50/12 50/15 51/7 52/1 52/2 52/3 52/17 53/14 58/3 59/3 69/21 69/22 73/25 74/2 75/6 75/20 81/4 83/23 83/24 83/25 85/12 85/16 85/16 88/18 89/3 89/7 89/10 89/11 89/12 90/7 90/12 95/20 103/19
cared [1] 2/1
careful [4] 61/14 61/18 88/3 91/23
carefully [5] 1/25 61/12 61/20 87/20 88/23
carer [3] 5/10 8/6 66/20
carers [1] 19/8
Caribbean [2] 57/6 62/8
caring [1] 40/6
Cartwright [3] 85/21 85/22 106/6
case [17] 15/16 16/14 18/1 23/13 25/10 27/11 29/14 32/14 32/16 32/18 32/20 48/14 71/13 80/6 94/6 102/21 103/2
cases [5] 7/16 19/9 24/9 48/24 52/10
cast [1] 57/13
cat [4] 14/13 14/16 14/18 14/18
catch [1] 44/8
catch-up [1] 44/8
caught [2] 55/10 55/12
causation [1] 54/10
cause [5] 16/12 54/9 69/11 88/2 88/5
caused [2] 53/21 86/14
causes [3] 75/9 92/20 93/3
CBE [1] 3/10
certain [11] 12/3 12/5 26/22 37/12 37/22 43/21 47/8 47/9 51/17 73/10 83/10
certainly [19] 1/10 7/15 16/1 16/4 21/2 21/19 25/12 36/11 42/23 44/10 45/13 51/25 59/8 61/7 61/13 75/7 81/23 99/8 102/24
cetera [6] 27/9 32/13 58/16 79/13 79/23 85/7
chair [12] 1/4 30/13 57/6 68/15 69/2 80/1 80/13 80/14 80/15 80/15 99/5 106/8
challenging [4] 5/16 5/20 11/8 16/24
change [20] 2/4 8/13 13/8 14/1 14/2 14/19 40/4 48/16 48/17 48/24 48/25 49/5 49/6 50/17 68/2 78/16 86/8 89/1 97/24 101/16
changed [3] 9/25 58/16 102/15
changes [4] 25/2 69/14 86/1 87/17
changing [1] 49/1
characterised [2] 12/14 12/15
charge [1] 50/7
check [2] 69/4 98/15
Chief [3] 71/22 71/23 85/10
childhood [2] 65/19 84/7
children [1] 44/18
choice [2] 54/17 54/18
Christopher [1] 78/13
chronic [2] 17/13 72/9
circumstances [1] 15/15
city [3] 29/1 29/2 52/8
clarify [1] 40/8
Clarke [1] 67/8
class [2] 24/17 77/24
clear [7] 27/9 37/8 54/14 59/9 63/16 66/22 89/2
clearer [1] 2/5
clearly [5] 38/12 40/2 42/14 66/19 92/23
click [1] 79/17
Clinic [1] 95/21
clinical [15] 2/23 4/5 11/10 11/12 11/18 11/22 12/8 13/1 23/19 31/10 44/11 56/21 69/22 70/25 80/18
clinically [2] 50/14 53/6
clinician [5] 32/6 33/24 34/3 84/22 85/6
closest [3] 93/23 93/24 94/6
cloth [1] 26/15
clozapine [3] 91/18 91/24 92/7
Clunis [3] 78/13 101/6 102/7
co [1] 104/9
co-location [1] 104/9
cocaine [1] 37/20
Code [3] 59/4 59/6 88/21
Codes [1] 58/24
coercion [1] 59/24
coercive [3] 6/1 59/24 60/23
cognisant [3] 29/3 30/22 98/13
cohort [1] 91/22
collateral [1] 29/13
colleague [5] 20/6 25/7 25/8 98/15 98/22
colleagues [4] 2/3

C

colleagues... [3] 19/16 40/18 43/12
College [46] 3/14 4/2 4/6 4/12 4/22 4/25 5/7 8/3 10/18 14/23 20/23 21/10 30/15 31/17 36/24 48/1 50/20 54/1 56/4 60/21 66/10 66/18 66/19 68/15 69/7 69/15 69/18 70/6 70/19 72/8 77/19 78/4 78/24 79/8 79/8 80/4 80/8 80/19 81/9 81/22 82/15 84/15 87/14 87/24 88/19 99/11
College's [1] 77/7
Colleges [4] 69/18 70/13 70/14 78/7
come [28] 7/20 14/10 20/12 25/8 25/17 32/25 46/1 46/2 46/5 46/8 46/9 46/10 47/21 51/20 52/12 55/18 62/22 62/22 68/24 69/25 71/19 72/3 72/23 75/13 75/14 86/13 96/4 103/25
comes [6] 16/5 17/12 25/19 48/8 59/8 69/21
comfortable [1] 104/12
coming [9] 25/15 25/23 26/20 62/15 68/19 71/3 78/14 95/22 104/12
commenced [1] 88/25
comment [3] 15/17 27/11 60/20
commenting [1] 82/16
comments [1] 30/12
commissioned [4] 9/16 81/24 90/10 102/14
commissioner [1] 80/20
commissioners [5] 21/5 21/22 49/18 74/7 85/13
commissioning [13] 2/4 5/12 8/8 9/17 49/3 49/4 49/6 50/1 50/10 50/11 89/2 89/9 100/4
committed [1] 76/15
Committee [2] 68/16 80/1
committing [1] 41/2
common [3] 20/10 84/7 94/10
commonly [1] 27/20
communicated [1] 36/23
communications [1] 18/3
communities [2] 8/18 66/12
community [21] 2/20 8/21 9/13 9/21 32/4 42/2 50/25 51/9 51/11 52/16 75/9 76/20 89/7 90/23 90/24 90/25 91/7 103/17 103/18 103/19 104/18
companies [1] 44/23
compare [1] 69/3
compared [1] 91/19
comparison [1] 73/22
compelling [1] 41/1
complained [1] 58/2
completely [1] 5/19
complex [1] 61/19
compliance [1] 36/8
comprising [2] 5/8 8/4
compulsory [2] 3/22 3/23
concentrate [1] 28/18
concern [13] 9/25 43/4 43/5 43/7 45/13 45/15 55/8 69/11 86/20 87/11 87/13 98/16 98/17
concerned [6] 2/11 27/12 61/13 69/16 87/20 99/25
concerns [10] 6/21 6/22 18/16 53/25 54/1 56/3 66/10 84/15 87/18 88/1
concise [2] 5/15 27/14
concluded [1] 67/14
concordance [2] 35/22 36/2
concordant [1] 35/18
concrete [1] 77/23
condition [2] 20/9 96/6
confers [1] 12/11
confidence [2] 15/12 15/13
confident [1] 22/18
confidential [3] 18/19 40/22 102/1
confidentiality [4] 15/22 40/5 68/17 97/14
confirm [1] 2/10
conflict [1] 8/2
confront [1] 29/18
confusion [4] 58/22 87/12 88/2 88/5
congruent [1] 93/6
connected [1] 3/18
consensus [3] 39/9 39/10 57/14
consent [2] 15/6 15/24
consents [1] 97/17
consequences [1] 1/22
consider [4] 41/1 45/6 45/12 60/1
considerably [3] 5/11 8/7 8/9
consideration [3] 50/21 60/16 91/5
considered [6] 31/24 32/1 40/23 42/21 60/22 87/25
considering [1] 72/11
considers [1] 45/7
consistently [3] 43/18 66/10 81/18
constituency [1] 82/11
constraints [2] 83/1 83/3
consult [1] 19/21
consultant [16] 2/18 8/16 8/19 8/20 8/24 9/11 18/25 19/23 26/20 32/6 72/16 72/21 73/8 73/12 89/5 98/23
consultants [3] 3/5 26/21 72/11
consultation [2] 40/17 88/17
contact [4] 42/13 76/19 98/16 98/17
contacted [1] 19/23
content [4] 42/19 43/14 43/17 45/1
contents [1] 2/10
context [3] 5/11 8/7 40/8
contextual [2] 11/19 11/22
contextualise [1] 87/10
contingencies [1] 33/18
contingency [2] 11/6 33/15
continue [4] 1/13 8/17 52/17 104/20
continued [1] 62/9
continues [1] 74/1
continuing [2] 24/25 25/1
continuity [9] 8/18 25/4 52/17 89/7 89/9 89/11 90/7 90/12 103/8
continuous [1] 8/24
contraceptives [1] 35/25
contradict [1] 29/18
contradistinction [1] 103/11
contribute [3] 13/1 19/9 57/3
contributed [1] 67/15
contributing [1] 72/10
control [1] 71/13
Convention [1] 58/1
conversation [2] 16/15 16/19
conviction [1] 93/15
convinced [2] 46/15 46/17
coordination [2] 2/5 89/2
coordinator [4] 32/7 32/8 33/20 33/21
coordinator's [1] 33/21
cope [1] 95/5
coping [1] 42/1
core [3] 4/4 11/3 57/5
Coroner [1] 23/4
coroner's [1] 23/3
correct [3] 4/9 29/12 76/7
cost [2] 31/16 85/18
could [22] 8/22 15/1 18/25 21/8 24/5 32/8 35/10 37/5 39/13 39/20 41/5 44/22 54/25 58/10 81/17 81/22 86/6 91/2 97/11 103/22 104/1 104/6
couldn't [4] 33/7 102/22 102/23 102/24
counter [1] 101/13
counter-productive [1] 101/13
countries [4] 63/17 64/2 64/9 64/16
country [4] 28/24 52/8 84/12 101/1
counts [1] 55/12
couple [4] 76/10 83/16 90/3 99/6
course [11] 19/4 33/4 35/12 36/10 41/7 54/13 62/16 65/24 69/9 75/9 96/22
court [2] 23/3 82/17
courts [2] 82/14 82/20
Covid [1] 65/14
CPA [3] 33/4 33/10 95/14
CPS [1] 82/20
CQC [1] 45/14
CR150 [3] 5/10 5/15 8/7
CR201 [1] 77/10
create [1] 16/4
created [1] 67/3
crime [1] 29/4
criminal [3] 41/3 52/2 62/24
criminality [1] 12/1
crisis [13] 1/25 7/18 26/19 33/15 33/17 33/19 51/17 53/1 53/7 62/15 62/22 68/1 90/6
criteria [10] 53/19 53/24 56/4 58/21 59/8 86/1 86/9 87/7 87/12 88/13
critical [2] 40/19 47/1
crucial [2] 16/10 17/17
culpability [1] 82/17
culture [4] 10/4 48/24 48/24 48/25
curious [1] 17/22
current [3] 15/1 40/5 86/19
currently [2] 83/6 90/10
curricula [1] 4/4
curriculum [1] 30/16
customer [2] 70/15 70/16
cut [1] 26/15

D

data [1] 44/23
date [1] 86/12
dates [1] 65/5
David [3] 67/7 67/9 67/14
day [5] 37/16 47/9 55/16 60/24 60/24
day-time [1] 37/16
days [3] 35/13 38/1 90/3
deal [4] 78/16 91/10 91/13 91/18
dealing [2] 34/11 101/10
deaneries [2] 30/25 31/2
death [4] 67/14 67/14 67/18 77/20
deaths [3] 67/6 67/7 101/7
debate [1] 10/6
December [1] 86/10
decide [2] 54/7 71/12
decided [1] 51/1
deciding [1] 73/15
decision [8] 45/24 46/12 46/13 47/23 47/24 60/24 61/22 70/23
decisions [2] 2/5 89/2
defensive [1] 22/17
defensively [2] 22/12 22/13
definitely [1] 37/18
degree [4] 56/7 56/11 87/1 87/3
deinstitutionalisation [1] 51/3
delegate [1] 34/3
deliberately [1] 46/18

D

deliver [6] 69/2 74/14 85/12 85/16 85/19 89/12
delivered [4] 8/14 25/3 49/7 50/15
delivery [1] 49/21
delusion [2] 12/21 93/12
delusional [1] 93/25
delusions [8] 12/15 12/17 93/3 93/6 93/9 93/10 93/19 93/21
dementia [2] 35/11 35/12
department [6] 22/14 59/2 81/3 88/18 88/22 89/20
depend [1] 46/21
depending [2] 25/21 28/24
depends [5] 11/17 23/20 42/23 91/25 101/1
depot [5] 35/21 35/23 35/25 36/1 36/12
Depots [1] 35/24
depressed [1] 93/5
depression [2] 63/25 64/4
depressive [1] 93/5
deprived [1] 24/18
depriving [1] 60/8
deputy [1] 57/6
descendants [1] 64/10
describe [2] 14/25 22/16
described [3] 5/15 15/3 77/13
describing [1] 16/20
designated [1] 22/21
designed [1] 40/6
desire [1] 29/16
detached [1] 92/24
detailed [2] 11/13 16/15
details [2] 33/8 42/7
detain [1] 41/19
detained [8] 53/23 55/5 56/15 66/13 66/17 67/23 86/16 87/5
detaining [3] 41/9 41/9 60/7
detention [10] 53/19 53/24 56/4 57/17 57/18 58/21 59/8 62/1 62/6 66/11
detentions [1] 57/7
deterioration [3] 38/25 39/3 39/4
determination [2] 1/19 23/7
determined [1] 16/9
devastating [2] 1/23 13/11
develop [10] 4/3 21/10 23/15 23/16 29/21 44/17 59/4 66/20 82/1 89/14
developed [6] 3/7 3/8 3/8 22/1 28/8 28/13
developing [4] 37/24 65/8 65/22 87/16
development [2] 9/7 72/25
devil [2] 47/19 47/20
devolved [1] 81/5
diabetes [2] 59/18 59/20
diagnosis [2] 3/2 100/23
Dictated [1] 34/7
did [5] 23/5 30/13 57/3 72/7 90/22
didn't [6] 23/6 25/11 51/10 55/14 59/20 59/21
die [1] 39/6
died [4] 1/12 7/17 67/9 67/10
dies [1] 23/2
diet [1] 37/17
diets [1] 37/17
difference [2] 8/11 88/14
different [27] 5/9 8/5 9/15 10/16 13/21 16/8 18/8 18/9 18/11 21/25 35/2 39/17 42/17 48/2 59/25 64/15 77/14 82/8 92/3 92/5 92/25 93/9 93/10 93/19 93/20 96/17 103/16
differing [1] 5/17
difficult [13] 5/16 5/20 18/5 18/13 27/17 31/14 72/6 73/6 85/5 90/11 95/9 96/22 98/24
difficulties [5] 21/19 89/24 92/18 94/8 96/19
difficulty [6] 22/18 55/8 63/2 75/8 78/6 101/19
digital [7] 42/17 44/1 44/13 45/1 70/3 70/7 70/16
Digital/online [1] 42/17
digitally [1] 44/14
direct [2] 70/1 93/22
Directive [2] 9/1 9/4
directly [1] 62/20
Director [3] 2/23 50/6 100/3
Disabilities [1] 58/1
disability [1] 51/5
disabled [1] 39/5
disagree [1] 79/1
discharge [10] 26/1 27/9 31/24 32/5 33/11 33/14 33/25 51/23 70/24 95/14
discharged [3] 25/11 25/12 51/23
discharges [1] 33/9
discharging [2] 32/3 71/20
disciplinary [3] 19/17 27/23 32/3
disclose [1] 40/22
disclosure [2] 40/20 97/18
discover [1] 75/14
discuss [3] 19/15 95/16 97/14
Discussing [1] 19/17
discussion [2] 57/22 88/20
discussions [1] 97/10
disease [2] 26/7 74/3
diseases [1] 84/7
disengage [1] 92/20
disengages [1] 96/21
disengaging [1] 95/7
disguise [1] 94/4
disorder [11] 9/19 35/6 35/14 41/11 41/11 47/13 47/13 56/6 63/24 64/8 84/8
disorders [2] 28/10 36/17
disparities [1] 57/18
disproportionate [1] 66/11
disseminate [1] 21/3
dissimilar [1] 63/20
dissolved [1] 51/2
distance [3] 92/20 95/1 95/3
distances [1] 96/21
distancing [1] 95/7
distribute [1] 100/1
do [144]
doctor [3] 9/10 34/4 98/12
doctors [3] 20/4 82/23 98/2
document [8] 5/15 5/18 18/6 39/9 39/14 39/21 46/11 73/18
documentation [1] 16/15
documented [1] 19/20
documents [2] 18/14 39/23
does [15] 13/6 15/22 19/25 28/20 34/15 40/4 45/19 46/19 48/11 60/4 79/7 94/24 98/10 99/11 99/15
does it [1] 60/4
doesn't [15] 13/10 13/20 25/17 25/22 37/25 42/3 47/2 61/9 65/10 67/22 79/13 79/14 93/12 99/22 101/9
doing [8] 6/18 24/15 54/3 63/10 79/19 79/22 88/23 98/11
don't [58] 4/13 6/3 6/16 16/14 18/22 19/15 20/20 22/18 22/22 22/22 26/24 26/25 26/25 27/4 27/10 28/1 29/14 29/17 30/23 32/24 36/5 36/16 38/1 38/5 38/6 46/4 46/8 46/22 47/11 47/12 47/14 47/18 48/18 50/1 50/7 50/16 52/19 54/16 54/23 55/20 58/12 61/9 69/6 69/23 72/5 76/23 76/24 81/4 82/23 88/11 94/19 96/25 97/7 98/5 101/20 102/17 104/10 104/13
done [19] 15/1 21/21 22/24 23/4 25/24 37/3 45/10 45/10 48/14 49/1 49/3 57/12 57/14 58/15 61/19 63/10 63/15 67/17 82/9
doses [1] 67/11
doubt [5] 8/10 51/19 55/11 78/11 83/7
down [7] 7/20 13/3 19/12 49/14 72/3 86/22 95/6
Dr [14] 1/4 1/5 1/7 5/13 11/15 30/11 34/10 45/4 55/20 59/23 68/13 77/5 85/23 106/3
Dr Fazel's [1] 30/11
Dr Lade [9] 1/4 1/7 5/13 11/15 34/10 45/4 59/23 68/13 77/5
Dr Smith [2] 55/20 85/23
drafting [1] 81/21
Drawing [1] 55/25
drawn [1] 20/18
drive [1] 66/3
driven [1] 50/14
dropped [1] 102/2
drug [1] 93/8
drug-induced [1] 93/8
drugs [2] 37/20 65/20
due [2] 5/3 5/17
DUNDRUM [1] 27/21
duration [1] 34/17
during [1] 13/13
duties [1] 40/5
duty [5] 45/6 45/12 84/24 85/3 85/4
dying [1] 61/6
dynamic [3] 13/4 14/2 23/9

E

each [7] 20/5 30/24 38/20 70/17 71/2 94/7 96/3
earlier [8] 16/18 20/23 54/21 66/22 72/4 72/7 92/13 103/20
early [13] 9/18 11/25 34/13 36/21 37/4 53/5 53/5 54/15 62/12 62/13 65/18 67/25 72/11
easier [4] 18/12 83/20 83/20 98/15
Eastwood [3] 77/3 77/4 106/5
easy [2] 61/18 83/13
eating [1] 9/19
educational [1] 93/16
effect [2] 39/11 81/19
effective [9] 2/5 34/13 34/15 35/17 53/11 75/20 89/3 89/9 100/16
effectively [6] 11/16 33/1 38/4 38/17 99/17 100/19
effects [1] 101/16
efficacy [2] 91/10 91/19
efforts [2] 28/18 29/12
either [4] 31/5 52/12 62/22 93/25
electronic [4] 18/9 18/10 18/11 18/18
element [1] 102/1
eliminated [1] 11/7
eliminating [1] 76/15
else [5] 55/4 59/12 72/2 90/19 90/20
elsewhere [1] 74/16
email [1] 19/23
embedding [1] 31/18
emergency [1] 89/20
Emil [1] 35/5
emotion [1] 12/22
emotions [2] 17/24 19/2
emphasis [3] 10/6 10/24 77/14
employers [2] 31/14 31/15
enables [1] 56/20
encouraged [1] 22/6
end [9] 26/18 52/25 55/11 57/20 58/17 75/24 89/19 89/22

E

end... [1] 90/6
engage [2] 17/18 97/3
engaging [1] 42/19
England [12] 21/3 21/7 21/11 21/13 48/12 48/18 49/8 49/8 73/18 73/21 73/22 81/2
enhanced [1] 103/16
enhancing [1] 30/8
enough [12] 24/3 24/10 26/12 28/4 41/22 48/13 48/14 51/17 52/24 71/9 75/1 101/2
ensure [8] 25/25 48/6 48/13 78/4 80/2 81/17 88/4 97/24
ensuring [3] 28/22 81/1 81/9
entirely [1] 72/12
entrenched [1] 99/22
environment [6] 5/12 8/8 8/9 42/2 42/23 57/1
environmental [1] 99/19
environments [1] 48/9
envisaged [1] 68/20
epidemic [2] 65/16 65/17
epidemics [1] 65/16
episode [2] 38/18 38/19
Equality [1] 66/20
erodes [1] 52/22
erosion [1] 23/23
erroneous [1] 83/25
escalations [1] 19/13
especially [6] 17/13 17/17 26/22 34/23 84/3 96/22
essentially [9] 45/19 56/23 60/5 71/7 73/24 86/10 86/11 86/18 88/6
establish [1] 11/22
established [2] 5/7 8/3
estranged [2] 30/4 92/15
et [6] 27/9 32/13 58/16 79/13 79/23 85/7
et cetera [6] 27/9 32/13 58/16 79/13 79/23 85/7
ethical [1] 4/5
Ethics [2] 68/16 80/1
ethnic [2] 62/2 66/12
even [6] 26/9 38/10 41/19 48/3 61/5 94/20
event [3] 1/14 10/4 13/10
eventually [1] 98/23
ever [3] 51/10 70/10 70/23
every [11] 31/16 32/15 32/18 34/24 38/25 85/13 85/14 85/15 85/17 98/8 98/10
everybody [8] 21/21 26/11 33/22 80/7 85/8 103/24 104/3 104/5
everyone [6] 21/18 27/22 30/1 31/7 42/10 57/14
everyone's [1] 20/19
everything [4] 10/19 14/17 19/19 103/22
everywhere [1] 24/8
evidence [37] 1/7 9/7 10/16 10/19 10/24 10/25 19/22 22/2 22/3 36/11 37/17 42/18 43/20 44/20 45/5 47/5 50/13 59/25 63/11 63/15 66/22 69/3 69/22 69/23 69/24 77/9 77/15 77/18 77/23 78/23 79/2 79/23 82/14 87/9 87/23 88/25 93/13
evidence-based [4] 10/19 77/23 78/23 79/2
evokes [1] 12/22
evolve [1] 43/20
exactly [2] 29/20 98/7
examination [2] 11/14 30/17
examining [2] 16/14 29/14
example [21] 7/11 14/12 15/16 16/6 18/21 21/9 24/14 25/3 25/9 27/19 29/8 34/4 36/9 69/5 82/12 82/18 82/20 83/5 89/4 92/19 101/9
excellence [1] 24/9
excellent [2] 24/1 48/9
except [1] 63/21
excess [1] 64/22
excessive [2] 10/8 72/9
Exec [2] 71/23 71/23
executive [4] 7/25 9/23 77/10 85/10
exist [6] 6/3 6/15 47/2 87/7 99/8 99/16
existing [1] 69/4
exists [2] 6/19 69/3
expand [1] 11/21
expect [6] 15/20 19/25 20/11 21/7 32/2 33/24
expectation [6] 21/20 30/21 31/2 40/21 51/6 74/9
expectations [1] 49/2
expenditure [2] 73/21 73/22
expensive [1] 51/7
experience [11] 2/17 20/2 20/11 24/13 24/19 25/13 48/18 72/19 87/10 87/23 95/5
experienced [1] 43/24
experiences [1] 65/19
experiencing [1] 36/21
expert [3] 4/22 7/3 82/14
expertise [4] 3/2 20/16 31/17 31/20
experts [2] 24/21 98/19
explain [5] 4/10 16/23 17/5 46/8 46/9
explained [1] 77/13
explains [1] 66/7
explicit [1] 15/6
Explore [1] 17/24
exposed [2] 65/4 65/5
exposure [1] 65/12
expressed [2] 40/15 87/18
extent [2] 34/15 44/7
external [2] 69/7 101/19
extra [1] 90/4
extract [1] 30/11
extreme [2] 6/8 42/19
extremely [1] 44/22
extremist [1] 43/17
eyes [1] 47/20

F

face [2] 17/22 96/19
fact [22] 6/2 6/20 8/13 9/2 22/11 22/14 28/10 34/25 36/20 58/9 62/5 66/18 67/23 79/5 79/12 84/2 96/13 100/2 100/2 100/18 101/12 101/13
factions [1] 63/8
factors [14] 11/19 11/23 12/3 12/7 12/8 13/21 23/11 28/20 29/18 64/25 65/2 66/3 66/3 66/5
facts [1] 29/18
faculty [1] 44/11
fail [2] 1/22 1/22
failure [4] 5/4 62/12 78/23 79/1
fair [1] 31/18
falls [1] 2/2
false [1] 93/12
families [15] 1/11 18/21 29/23 29/23 29/25 30/3 30/4 30/5 40/16 55/18 77/6 92/15 95/12 95/13 96/19
family [32] 12/1 18/1 19/7 27/24 33/4 33/19 37/14 76/21 92/12 92/19 92/21 93/16 94/5 94/9 94/14 94/15 94/16 94/19 95/1 95/3 95/5 95/8 95/16 95/21 96/3 96/5 96/21 97/3 97/4 97/6 97/8 97/10
fan [1] 7/1
fantastic [3] 24/17 44/4 80/15
far [10] 2/10 27/12 47/11 52/14 69/15 70/11 72/18 83/18 99/23 99/24
fascinating [1] 65/6
fat [1] 73/2
Fazel [2] 28/7 31/22
Fazel's [1] 30/11
fear [1] 101/4
feedback [1] 72/8
feel [7] 6/11 12/18 22/18 70/23 97/23 98/24 104/12
feeling [1] 7/13
fence [1] 74/7
fencing [2] 74/8 74/9
few [3] 27/22 48/15 68/12
field [3] 24/22 98/19 102/19
fifth [1] 17/23
fight [1] 74/8
filled [2] 51/22 72/22
final [2] 53/8 97/11
finalise [2] 5/17 5/21
finally [3] 2/21 91/9 103/7
find [5] 19/20 31/14 31/16 42/8 95/11
finding [1] 65/6
findings [2] 11/1 77/19
fine [2] 14/17 92/4
first [23] 2/13 8/19 15/14 15/21 17/16 17/16 17/17 18/2 19/23 28/12 34/10 35/1 37/7 41/10 45/17 46/13 60/2 64/7 69/25 77/7 79/9 86/4 91/11
five [3] 38/1 93/1 95/24
five days [1] 38/1
flat [2] 75/13 75/16
flooded [1] 78/19
flow [1] 74/23
flu [4] 65/12 65/15 65/16 65/17
focus [4] 9/17 23/5 57/3 97/1
follow [2] 51/11 101/14
followed [1] 8/21
following [2] 56/4 77/20
force [1] 67/19
foremost [5] 15/21 41/10 45/17 46/13 79/9
forensic [12] 2/22 2/23 27/19 42/24 43/6 43/11 43/12 43/13 55/17 82/15 95/20 96/12
foreword [4] 10/14 77/14 79/3 79/3
forget [2] 36/6 36/10
forgotten [1] 59/14
form [4] 18/10 18/11 20/8 22/1
formal [2] 20/19 20/21
formulation [6] 14/25 23/10 23/15 27/12 27/15 81/16
found [4] 64/16 64/21 76/5 90/22
Foundation [1] 2/24
four [7] 19/12 38/1 62/10 64/4 67/7 73/7 97/15
four years [1] 73/7
fourth [3] 40/11 64/11 65/25
fragmentation [1] 103/8
fragmented [2] 9/15 25/5
framed [2] 22/12 22/13
Framework [4] 66/21 103/17 103/18 104/18
frameworks [1] 43/18
frankly [8] 8/25 18/13 28/1 31/15 44/21 52/23 67/4 102/13
Freedom [1] 85/2
frequency [2] 10/3 11/5
frequently [1] 45/10
frightened [1] 19/15
full [4] 17/8 63/7 63/24 90/21
function [13] 3/13 4/2 4/10 4/12 4/13 4/14 4/17 4/21 11/3 34/1 35/9 35/10 69/19
functional [3] 9/8 9/9

F

functional... [1] 90/13
functioning [2] 34/20 38/21
funded [2] 31/13 81/24
funding [14] 4/18 4/19 8/11 8/12 26/6 26/8 26/8 31/15 51/13 74/4 74/7 101/14 102/11 104/20
further [4] 26/9 50/25 86/23 87/6
fusion [1] 58/8
future [4] 10/4 11/24 12/5 15/2

G

gallbladder [1] 83/18
gather [1] 69/3
gathered [1] 44/21
general [13] 2/18 2/20 10/10 21/19 28/1 32/15 42/10 43/1 43/9 95/12 95/19 96/22 96/23
generally [7] 28/23 51/13 57/8 60/21 98/3 99/13 103/3
generation [4] 43/21 64/7 64/11 66/1
generic [2] 9/21 9/22
genetic [1] 64/23
genetics [1] 65/1
get [65] 18/14 21/12 23/25 24/2 26/7 26/17 26/18 29/13 30/25 35/25 36/21 38/19 38/20 38/23 41/20 44/22 48/18 52/13 52/19 52/25 53/10 53/17 54/23 54/25 55/1 57/15 58/10 59/15 62/19 63/11 66/7 66/21 67/24 67/25 70/17 72/2 74/3 74/8 74/16 74/23 74/24 76/21 79/9 83/14 83/22 84/1 85/13 88/11 89/13 89/23 90/2 92/2 93/4 93/5 93/9 93/19 94/17 95/24 97/2 97/5 97/5 99/21 99/23 100/23 101/2
gets [2] 59/14 93/25
getting [8] 26/17 29/22 39/9 55/9 75/8 75/12 90/5 100/24
give [7] 15/23 47/16 55/1 57/22 69/1 83/16 89/4
given [7] 4/17 31/6 56/11 67/11 87/1 87/3 91/23
giving [1] 87/23
glad [1] 1/24
GMC [2] 69/5 97/14
go [29] 5/13 7/24 12/23 14/23 17/20 20/21 23/1 23/3 33/15 33/17 38/10 51/24 52/12 52/14 53/18 60/2 62/17 72/24 73/20 75/3 75/4 79/13 79/14 85/25 86/6 88/24 91/18 98/10 104/14
goes [2] 54/14 76/7
going [51] 5/13 7/17 16/3 16/4 17/10 17/14 32/12 33/19 34/24 37/23 38/1 44/20 46/10 47/22 49/5 49/19 50/4 50/17 53/7 58/23 59/1 60/8 60/18 60/20 64/24 65/13 65/14 68/22 68/24 72/6 73/15 75/5 75/7 75/8 75/16 79/21 79/22 80/12 81/5 81/5 83/17 83/22 84/1 84/8 88/13 88/15 88/20 94/24 95/25 96/4 104/2
gone [7] 25/4 25/25 26/6 29/10 58/14 74/5 74/10
good [40] 1/3 1/21 5/15 14/21 16/11 16/20 16/21 17/4 22/9 24/3 24/10 24/23 25/6 26/13 27/4 27/5 28/15 42/4 44/13 48/19 51/17 57/10 57/11 58/18 66/4 68/17 69/4 69/20 73/3 77/5 80/13 84/3 85/23 89/15 90/14 90/15 91/25 92/5 98/3 101/2
got [30] 6/13 14/7 14/15 20/1 20/13 20/15 24/19 26/11 26/12 26/12 31/19 31/19 32/19 32/22 36/5 44/14 51/16 52/7 61/7 71/21 71/21 74/15 90/19 94/23 96/5 96/5 96/12 97/9 98/16 103/25
governance [1] 98/10
government [7] 60/21 67/19 69/19 70/6 76/4 76/15 84/16
governments [1] 38/11
GP [7] 32/24 33/7 33/25 62/17 62/17 62/18 83/6
GPs [4] 32/24 83/9 83/9 83/23
gradual [1] 23/23
graph [1] 75/24
great [2] 72/24 78/16
greater [2] 20/1 40/7
group [15] 4/23 5/8 7/3 8/4 44/12 44/13 57/5 57/6 57/7 57/23 63/4 63/6 66/24 67/24 103/10
groups [2] 57/3 62/2
growth [1] 72/18
Guardian [1] 98/17
guess [2] 37/8 83/17
guidance [30] 4/6 4/14 4/23 5/13 7/22 17/20 20/24 21/1 21/3 21/13 21/17 22/11 22/15 31/17 31/19 43/19 48/19 69/1 69/5 69/8 77/10 78/8 78/9 78/24 79/15 79/22 81/18 82/2 82/22 97/14
guide [3] 14/22 23/18 45/22
guideline [1] 35/18
guidelines [1] 98/1

H

had [26] 4/12 5/22 7/12 7/16 7/17 8/15 14/12 14/13 15/18 24/24 42/11 44/23 52/20 58/2 72/18 73/13 77/19 80/3 92/5 96/1 96/11 96/13 96/14 96/15 100/3 101/8
hadn't [1] 58/14
half [2] 62/6 62/10
halfway [1] 13/3
hallucination [2] 12/21 93/17
hallucinations [6] 12/16 12/17 93/4 93/7 93/10 93/19
hand [1] 6/11
handover [2] 81/17 90/14
happen [18] 6/12 13/10 19/25 20/1 22/25 24/14 26/14 33/12 33/22 38/20 42/22 48/11 52/18 65/14 69/13 70/10 80/6 84/5
happened [13] 1/15 7/12 7/16 14/18 21/25 31/6 58/12 75/22 76/17 76/17 78/13 78/18 102/12
happening [1] 49/6
happens [7] 13/11 13/19 23/2 38/19 65/3 80/11 95/12
happy [2] 31/11 81/11
hard [3] 36/3 76/20 97/9
harder [4] 75/11 76/19 83/23 98/20
hardest [2] 54/15 98/5
harm [16] 11/10 16/4 23/13 35/18 40/21 41/24 47/4 53/21 55/12 56/8 56/12 59/10 86/14 86/22 87/2 87/4
harmed [5] 45/1 47/6 54/10 55/2 61/5
harmful [3] 41/14 44/3 55/3
harming [2] 46/18 46/23
harms [4] 44/1 44/5 44/25 55/9
has [49] 8/3 9/25 12/17 12/19 14/10 14/12 14/13 17/13 21/20 22/21 25/3 25/7 25/13 26/5 28/8 28/14 29/10 31/17 34/17 35/23 41/15 42/18 45/5 51/11 59/24 61/4 61/19 63/2 64/21 66/10 66/18 66/19 68/15 69/17 70/6 71/11 72/15 73/25 82/22 83/25 84/10 84/15 85/10 91/5 93/2 94/23 98/2 102/15 103/25
hasn't [3] 76/16 76/17 92/6
have [230]
haven't [3] 26/11 45/15 53/12
having [12] 12/21 26/6 37/16 38/14 39/1 55/15 63/13 75/2 91/18 94/22 98/8 98/12
HCR [2] 27/20 28/5
HCR-20 [2] 27/20 28/5
he [18] 14/13 14/15 16/18 25/11 25/12 28/8 28/12 30/13 30/14 35/4 35/11 42/21 45/7 55/5 55/21 67/9 67/10 67/13
he'd [1] 14/15
health [98] 1/21 2/22 2/23 3/17 5/1 5/5 7/12 7/18 7/22 9/21 10/9 11/13 15/19 20/18 22/14 25/16 26/21 40/25 41/7 41/10 41/12 41/14 45/17 45/19 45/21 46/14 46/18 46/23 47/4 47/15 48/4 49/16 49/20 50/2 50/8 50/8 50/12 51/4 52/1 53/4 53/19 53/21 54/5 55/2 55/6 56/9 57/24 58/3 58/3 58/7 58/24 59/2 59/5 59/11 60/7 61/7 62/15 62/16 62/20 67/10 67/20 69/21 70/12 73/13 73/14 73/17 73/21 73/25 74/2 74/7 74/13 74/20 75/22 77/11 80/23 81/3 83/2 83/5 83/24 83/25 84/4 84/11 84/19 85/8 85/15 85/17 86/14 86/24 88/18 88/22 89/12 95/10 100/21 102/19 103/4 103/17 103/18 104/18
Health Secretary [1] 70/12
healthy [1] 59/17
heap [1] 38/5
hear [3] 38/2 93/18 95/25
heard [8] 28/7 42/18 45/5 49/25 50/5 59/24 82/12 101/25
hearing [2] 36/20 95/23
help [10] 17/3 18/15 21/11 37/15 62/23 67/24 67/25 81/17 81/23 83/17
helped [3] 22/25 66/19 92/6
helpful [6] 16/25 42/11 81/20 82/4 82/19 99/13
Helpfully [1] 17/21
helps [3] 14/5 23/15 35/21
hemisphere [2] 65/11 65/11
here [13] 19/2 19/22 22/20 39/17 47/10 53/18 56/5 64/24 87/13 96/5 97/14 99/3 103/25
hide [1] 45/7
high [10] 5/4 7/16 22/7 30/21 61/4 67/5 67/7 67/11 81/18 93/4
high-level [2] 30/21 81/18
high-profile [4] 5/4 7/16 67/5 67/7
higher [19] 12/6 12/11 13/15 26/17 29/4 52/25 53/1 53/1 64/1 64/4 64/5 64/5 64/11 64/19 64/20

H

higher... [4] 65/9 66/5 66/8 86/18
highering [1] 88/7
highlight [1] 66/14
highlighting [1] 5/3
him [2] 14/15 14/17
his [7] 14/16 14/19 28/12 42/20 55/6 55/23 67/14
historical [4] 7/11 11/18 11/22 12/7
historically [1] 37/1
history [7] 11/13 11/24 11/25 11/25 12/1 29/8 61/24
hit [2] 54/20 55/21
hold [1] 47/7
hole [1] 83/19
holistic [3] 56/20 56/23 99/18
homicide [2] 102/1 102/11
homicides [2] 100/7 101/10
honest [2] 79/20 84/21
Honours [1] 3/11
hope [2] 2/3 82/10
hoped [1] 89/1
hospital [19] 3/25 18/8 21/25 24/5 24/17 46/3 46/5 51/20 51/21 52/12 52/14 75/12 88/8 88/11 89/6 89/16 89/19 89/22 91/7
hospitalisation [1] 36/14
hospitalised [1] 41/3
hostility [2] 7/5 7/8
hour [1] 96/3
hours [3] 27/22 27/25 27/25
housing [5] 41/25 42/8 42/8 51/20 52/1
how [34] 1/25 2/1 2/1 9/16 10/24 17/17 23/8 24/23 29/6 38/21 42/1 43/25 44/18 45/9 48/21 49/6 59/1 61/14 69/9 70/9 74/13 76/24 77/15 85/19 88/16 88/20 89/1 90/14 90/14 96/9 97/1 97/24 101/25 102/4
however [8] 10/1 11/6 28/4 31/4 38/4 47/18 61/10 83/4
hubs [3] 103/12 103/14 103/14
huge [1] 78/15
human [1] 57/19
hundreds [1] 76/11
hurt [1] 47/22

I

I also [1] 57/5
I am [1] 47/18
I ask [5] 34/12 77/5 79/25 80/17 85/23
I became [1] 8/19
I can [2] 1/16 99/6
I can't [1] 73/16
I could [1] 8/22
I did [1] 23/5
I didn't [1] 23/6
I disagree [1] 79/1
I do [1] 79/7
I don't [10] 22/22 22/22 27/10 46/4 48/18 50/1 58/12 72/5 81/4 104/10
I got [2] 24/19 96/12
I had [2] 14/12 96/1
I have [13] 2/22 3/2 10/13 24/23 36/24 37/10 45/13 57/12 67/4 70/11 81/25 96/11 99/13
I just [3] 7/1 91/9 103/9
I know [3] 25/6 26/3 98/17
I look [1] 55/17
I looked [1] 8/20
I mean [14] 20/12 21/17 23/20 27/25 42/4 48/25 53/8 55/17 82/8 88/2 95/18 98/24 100/12 103/15
I might [1] 26/13
I moved [2] 95/18 96/1
I need [1] 71/23
I please [1] 1/4
I realised [1] 95/22
I remember [1] 55/19
I represent [1] 92/12
I said [12] 12/9 16/12 20/23 26/10 46/24 52/24 74/2 79/2 81/24 95/10 97/6 100/22
I say [1] 39/21
I shouldn't [1] 47/21
I started [2] 24/16 95/21
I teach [1] 3/3
I then [1] 88/24
I therefore [1] 36/6
I think [48] 7/23 9/3 10/14 27/13 28/7 28/11 31/6 31/7 31/14 38/15 44/7 46/1 48/15 48/16 49/25 50/5 52/24 57/11 57/20 67/12 68/5 72/20 73/6 78/6 78/16 78/18 78/19 81/4 83/9 84/20 85/14 86/17 87/9 87/9 88/22 95/18 98/2 98/4 98/20 98/24 101/3 101/17 101/19 101/25 102/10 102/10 102/12 104/1
I trained [2] 2/18 24/16
I understand [2] 1/8 25/9
I want [1] 1/11
I wanted [1] 1/18
I was [10] 8/19 24/16 24/21 28/10 28/11 38/4 57/5 78/11 78/13 78/14
I wish [1] 4/12
I work [4] 18/10 18/12 18/12 98/18
I would [3] 23/20 96/3 102/16
I'd [6] 10/20 29/20 30/11 77/7 92/17 96/10
I'm [24] 1/23 2/18 10/13 10/20 15/16 23/20 27/10 28/11 29/20 47/18 48/7 55/15 55/22 61/13 73/15 81/25 87/13 94/2 98/12 98/13 98/18 99/24 101/3 103/13
I've [20] 3/6 3/6 3/7 20/14 20/15 22/20 24/15 24/24 25/1 26/2 50/4 52/5 71/20 71/21 74/4 74/15 83/24 87/16 88/10 98/16
ICB [3] 49/9 49/19 100/4
ICBs [8] 49/13 49/15 50/3 50/4 74/6 81/6 99/25 100/2
idea [6] 54/2 54/10 54/14 61/13 83/25 93/12
ideally [3] 16/2 21/17 67/25
identified [7] 77/24 80/19 83/1 86/8 86/13 86/17 88/15
identifying [2] 11/18 15/5
ie [2] 14/2 28/15
if [119]
ill [3] 46/22 47/18 100/7
illness [53] 3/3 6/5 6/12 6/17 6/23 12/9 12/10 17/12 17/14 24/19 24/20 25/13 30/5 36/5 36/13 37/3 37/3 37/5 37/14 37/24 38/6 38/6 38/15 39/2 39/5 39/6 47/2 54/7 54/8 63/19 63/19 63/25 64/22 64/25 65/23 66/4 66/4 84/9 92/15 92/16 94/22 94/24 96/15 96/16 99/10 99/15 99/15 100/9 100/18 100/24 103/1 103/6 103/25
illnesses [7] 12/5 37/8 38/16 93/20 94/13 94/14 100/17
impact [10] 1/13 1/17 13/21 34/18 34/18 34/21 65/25 68/20 68/25 84/10
impacting [1] 41/12
impacts [4] 34/19 34/20 60/23 72/25
implement [5] 10/25 21/11 48/22 77/16 78/9
implementation [12] 4/16 4/18 20/20 20/22 21/8 21/10 31/21 48/20 50/1 80/21 86/12 104/17
implemented [6] 21/6 53/12 69/10 73/4 73/5 86/2
implications [1] 17/24
implying [1] 5/4
importance [2] 50/13 103/8
important [26] 12/8 14/6 14/17 15/3 17/12 17/19 19/19 24/12 29/7 32/11 36/21 37/14 37/15 39/18 42/14 49/5 58/23 59/13 65/1 65/2 65/4 65/18 65/24 73/10 102/18 102/20
importantly [1] 37/18
improve [3] 34/16 90/7 90/7
improvement [3] 4/7 31/16 85/19
improves [1] 36/1
inappropriate [8] 10/7 61/2 61/4 75/21 76/1 76/1 76/6 76/14
inappropriately [1] 67/11
incarcerated [1] 41/4
incident [1] 78/12
incidents [3] 5/4 13/9 101/7
incline [1] 75/25
include [4] 11/13 11/24 30/7 40/17
includes [2] 10/3 38/17
including [7] 4/6 11/4 12/24 30/2 33/23 44/8 100/18
income [1] 85/12
incompatible [2] 61/12 104/11
increase [5] 12/4 13/22 37/23 62/1 75/25
increased [1] 12/20
increases [2] 65/22 72/16
increasing [2] 14/9 57/17
incredibly [1] 14/16
indeed [2] 11/15 92/8
Indexed [1] 73/21
India [1] 64/17
indicates [1] 86/18
indication [2] 70/9 92/7
indicators [1] 33/16
individual [12] 10/11 10/21 10/21 10/22 11/8 14/16 40/9 40/10 75/10 84/22 85/6 95/2
individual's [1] 84/11
individuals [1] 24/7
induced [1] 93/8
infectious [1] 84/7
influence [2] 6/9 46/25
influenced [1] 58/13
influences [1] 38/13
inform [1] 12/25
informally [1] 19/21
informatics [1] 44/12
information [37] 15/5 15/8 15/11 15/14 15/20 15/23 15/24 16/10 16/13 18/17 18/20 18/22 19/9 29/10 29/13 33/4 39/8 39/15 40/7 40/16 40/19 40/23 41/23 41/24 42/3 42/14 52/19 52/22 68/18 70/4 77/1 78/19 78/20 90/15 97/5 97/16 98/9
ing [2] 4/3 4/3
inherently [1] 63/5
injection [1] 35/24
injections [1] 51/12
inner [3] 29/1 29/2 52/8
innovations [1] 73/3
inpatient [3] 9/12 42/21 71/8
input [2] 5/9 8/6
inquiries [8] 68/22 68/24 69/9 69/10 69/13 80/2 80/12 101/8
Inquiry [15] 1/20 1/24 2/3 30/14 42/18 45/5 59/24 67/12 79/25 80/11 82/12 89/1 91/5 101/6 102/1
inside [1] 47/19
insight [2] 19/8 25/21
Institute [1] 3/1

I

institutional [1] 67/15
insufficient [1] 71/7
integrate [1] 52/16
integrated [2] 23/18 49/9
integration [2] 51/25 80/17
intellectual [1] 35/9
intensive [2] 2/21 95/20
inter [1] 16/5
inter-agency [1] 16/5
interaction [1] 17/16
interest [7] 8/3 40/14 40/24 44/12 44/13 55/6 97/21
interested [1] 82/10
interesting [3] 83/8 83/12 101/17
Interestingly [1] 64/7
interests [3] 41/5 41/6 70/25
interference [1] 99/9
international [2] 50/19 98/19
Internet [2] 42/20 44/4
interoperability [2] 70/2 70/7
intervention [4] 9/18 34/11 37/15 62/12
interventions [2] 53/11 75/4
into [35] 7/17 8/22 10/25 13/20 18/23 23/19 26/17 26/18 26/20 27/1 33/17 40/14 46/5 51/9 51/9 51/20 52/12 52/12 52/13 52/16 53/5 53/7 53/10 56/24 62/15 77/16 79/13 79/14 80/18 81/18 88/11 96/12 99/18 99/21 100/23
INTREPID [1] 64/13
introducing [1] 90/24
introduction [1] 10/15
invent [1] 100/15
invention [1] 44/4
investment [1] 84/18
invite [2] 32/23 32/24
invited [1] 95/13
involve [3] 16/8 27/24 97/9
involved [9] 15/8 15/10 52/3 57/13 76/21 87/16 93/25 94/19 96/13
involves [1] 60/15
IQ [1] 34/21
is [332]
is: [1] 59/1
is: how [1] 59/1
isn't [20] 3/23 19/3 19/5 21/23 24/3 24/4 28/3 29/11 32/10 35/19 36/8 36/18 42/6 43/22 48/7 48/13 69/11 75/2 76/13 98/22
isn't standardisation [1] 21/23
isolated [1] 14/16
issue [4] 7/7 10/1 45/10 97/11
issues [6] 5/2 55/18 57/9 71/7 82/2 101/11
it [279]
it'll [1] 34/6
it's [136]
its [2] 10/13 77/13
itself [2] 6/1 16/4

J

January [1] 2/9
Japanese [2] 65/16 72/1
job [3] 26/23 27/5 71/16
jobbing [3] 79/5 79/18 79/20
John [1] 67/13
Jonathan [1] 77/20
judgement [7] 13/16 13/17 27/18 28/6 40/9 40/12 40/18
June [1] 1/1
June 2026 [1] 1/1
just [72] 1/25 6/13 7/1 13/19 15/3 15/21 16/19 16/23 16/25 17/6 17/7 18/8 20/2 22/5 22/6 22/9 26/21 28/23 31/22 35/24 35/25 36/1 36/6 39/13 39/21 39/25 41/22 42/21 44/7 44/16 45/16 49/21 51/14 52/25 53/9 53/14 54/20 55/21 57/2 59/11 59/18 59/18 61/20 62/2 63/7 66/4 68/12 68/25 69/6 73/11 74/2 74/14 75/2 75/19 76/13 76/17 80/7 83/12 84/10 85/25 86/11 86/21 90/8 91/1 91/9 92/23 92/24 93/12 99/24 101/24 103/7 103/9
justice [2] 52/2 62/24
justified [1] 97/21

K

KC [1] 86/4
Keene [2] 45/6 45/18
keep [3] 17/2 60/18 84/22
keeping [2] 43/21 93/15
kept [2] 18/17 18/18
ketogenic [1] 37/17
Kevin [1] 67/8
key [4] 11/1 12/23 36/18 88/16
killed [1] 99/12
kind [14] 6/15 15/19 36/14 42/23 43/7 50/3 63/14 71/9 79/19 82/1 85/1 94/21 97/5 101/1
knew [1] 14/19
know [199]
know confers [1] 12/11
knowledge [2] 20/1 20/8
known [1] 77/25
knows [1] 33/22
Kraepelin [1] 35/5

L

lack [3] 15/13 54/23 70/2
lacked [1] 47/17
lacks [2] 40/20 97/19
Lade [9] 1/4 1/7 5/13 11/15 34/10 45/4 59/23 68/13 77/5
Laing [1] 47/8
landed [1] 57/9
Langdale [6] 1/3 1/6 77/9 86/4 92/14 106/4
large [3] 70/15 70/15 89/17
larger [1] 72/5
last [6] 48/15 62/9 63/14 73/2 86/11 101/8
later [5] 8/13 16/19 17/18 65/9 90/23
latest [1] 69/3
law [8] 40/8 60/11 61/1 67/20 67/21 85/25 86/23 97/20
lawful [2] 15/25 60/14
lawyers [1] 82/24
layer [1] 86/23
layering [1] 87/6
lead [2] 2/4 92/18
leaders [1] 78/3
leadership [3] 48/16 102/13 102/14
learn [4] 26/23 38/21 43/10 96/6
learning [4] 51/5 78/4 78/24 102/4
learnings [1] 80/2
least [4] 33/1 41/13 60/1 60/5
leave [1] 51/21
leaving [1] 72/12
lecturer [1] 2/25
left [2] 8/1 72/15
legal [1] 40/5
length [1] 53/16
less [6] 85/14 85/16 85/19 89/18 89/21 100/20
lessen [1] 1/16
lessons [1] 50/21
let [3] 16/11 21/3 33/7
letter [1] 33/25
level [11] 4/5 30/21 49/3 49/4 49/7 49/9 49/10 58/15 75/6 81/18 82/16
levels [2] 48/2 80/22
Lewis [2] 67/8 67/19
liberty [1] 60/8
life [5] 33/13 34/25 65/18 72/10 72/15
like [41] 1/8 10/22 12/10 18/6 21/9 21/24 24/14 25/7 26/4 26/13 26/16 27/4 28/4 30/1 30/5 30/11 31/3 34/7 36/13 37/20 37/20 37/24 45/18 49/15 52/5 55/14 58/10 59/6 59/18 62/13 63/11 63/22 65/12 72/1 72/21 77/7 82/24 90/21 92/17 94/2 101/20
likelihood [10] 12/4 13/22 35/17 37/23 59/11 65/8 86/24 87/2 87/4 90/5
likely [19] 15/11 17/13 23/12 23/13 26/9 28/16 28/19 28/25 34/22 34/24 39/23 43/5 43/19 44/25 53/2 62/22 68/23 89/18 89/21
Likewise [1] 32/17
limit [1] 43/13
limitations [1] 15/22
limited [2] 74/12 94/13
line [2] 57/19 75/24
linked [1] 62/12
list [1] 79/11
listened [1] 102/16
literally [2] 52/9 74/22
little [1] 83/19
live [5] 1/13 52/15 59/17 72/23 76/11
lives [4] 1/17 59/18 89/24 102/8
living [2] 32/13 42/1
loads [2] 90/19 95/23
local [10] 42/3 49/4 49/4 52/13 70/20 71/8 76/13 76/19 77/1 85/12
location [1] 104/9
locked [1] 6/13
locking [1] 6/18
locum [1] 72/23
locums [1] 72/22
London [2] 2/24 29/1
long [8] 14/17 17/15 23/22 26/3 35/24 41/18 41/20 96/14
long-acting [1] 35/24
longer [4] 32/16 34/22 35/15 96/8
longer-term [1] 96/8
look [40] 8/16 8/17 9/10 9/12 9/13 17/22 19/13 21/24 24/24 26/10 38/22 39/24 39/25 39/25 47/7 47/11 47/25 55/17 56/2 59/19 63/17 64/6 70/14 75/1 75/23 76/24 79/8 79/11 82/10 82/12 83/15 83/18 86/21 91/11 94/2 100/12 103/1 104/2 104/4 104/14
looked [9] 8/20 8/23 20/14 22/20 52/20 58/10 64/15 76/23 87/15
looking [15] 1/25 4/23 17/10 24/20 47/19 62/5 63/11 64/14 66/9 79/23 85/18 87/19 90/23 91/3 96/17
looks [5] 9/11 9/11 25/6 26/13 27/4
lose [2] 35/8 35/9
loss [2] 1/18 78/24
lost [5] 1/16 78/5 80/3 102/4 102/8
lot [8] 10/16 26/23 38/14 55/19 57/21 59/25 61/24 93/22
lots [10] 5/23 24/18 24/18 47/12 52/7 69/22 78/20 87/19 101/20 102/18
love [2] 81/11 102/16
loved [4] 1/12 95/6 96/8 96/20
low [7] 13/14 13/20 22/7 22/21 22/22 22/23 64/16
lower [2] 64/17 64/18
lucky [5] 24/16 32/22 50/9 50/9 98/18
luxury [2] 28/2 96/1

M

made [5] 40/13 69/13 77/22 82/4 87/17
magnitude [1] 10/4
main [6] 21/5 50/21 70/3 71/7 92/2 93/1

M

mainly [1] 82/23
mainstay [1] 91/14
mainstays [1] 37/11
maintain [2] 4/3 76/19
majority [4] 36/17 58/11 62/4 64/2
make [20] 12/18 13/16 13/17 23/11 25/25 26/14 29/12 30/14 46/12 46/12 59/1 67/24 70/23 72/5 81/12 82/20 88/13 90/2 103/19 104/19
making [9] 1/19 23/7 47/3 47/23 48/19 59/9 60/24 61/22 85/5
man [2] 25/10 55/22
manage [12] 22/23 23/8 38/22 44/19 61/15 61/15 71/16 74/22 74/23 75/7 75/15 96/9
managed [2] 14/14 57/20
management [20] 3/3 3/7 5/5 10/10 10/17 11/3 12/25 14/22 22/10 22/15 22/17 22/19 23/16 30/17 30/23 33/15 71/14 71/15 71/18 77/24
managers [2] 71/18 85/7
managing [2] 61/8 79/7
Manchester [1] 29/1
mandatory [6] 48/2 80/23 81/1 81/7 81/7 98/9
manic [2] 93/4 93/11
mantle [1] 80/25
many [11] 19/9 24/1 39/23 52/7 52/10 72/11 76/6 88/10 100/12 101/7 102/8
MAPPA [1] 16/8
matter [6] 37/25 40/9 42/4 65/10 82/17 93/13
Maudsley [1] 2/24
may [24] 1/4 2/9 15/5 16/13 16/18 17/18 18/21 20/7 32/8 40/18 53/21 54/12 60/22 74/11 74/12 74/12 74/14 74/16 86/14 95/5 96/19 97/25 100/8 100/9
maybe [2] 29/4 90/1
MDT [1] 81/17
me [15] 20/12 20/12 45/18 47/19 47/20 47/22 47/22 55/14 55/15 68/12 71/23 80/10 84/20 94/25 98/15
mean [35] 11/21 13/6 20/12 20/21 21/17 22/13 23/20 27/25 31/19 34/2 41/7 42/4 47/17 47/23 48/25 53/8 55/17 59/9 60/1 60/4 61/9 67/22 82/8 88/2 88/9 94/18 94/23 94/24 95/18 96/7 96/8 96/23 98/24 100/12 103/15
meaning [1] 22/4
meaningful [1] 37/16
means [32] 13/7 13/11 23/25 25/3 25/6 26/15 27/3 28/17 35/23 41/18 50/9 51/15 52/11 52/23 55/10 56/24 59/1 60/5 67/23 71/8 72/22 72/25 74/11 75/5 75/11 76/18 88/3 89/17 89/18 89/25 92/24 94/18
meant [7] 26/3 33/22 51/11 55/23 58/16 76/3 96/7
Meanwhile [1] 10/8
measured [2] 53/15 53/16
measures [1] 103/4
media [5] 5/3 7/6 7/8 7/10 47/11
medical [15] 3/4 11/3 25/17 34/5 34/6 50/6 53/23 56/12 69/18 70/13 70/14 78/7 86/16 87/3 100/3
medicated [1] 7/19
medication [12] 35/23 36/2 36/3 36/4 36/8 36/12 37/10 37/12 38/8 67/11 90/4 91/13
medications [4] 36/9 37/7 38/12 91/20
medicine [2] 17/8 36/7
medium [1] 22/7
meet [6] 4/15 16/23 24/25 68/3 71/9 95/11
meeting [6] 7/2 13/1 32/3 32/5 95/14 95/15
meetings [1] 19/18
member [5] 33/19 56/18 95/3 96/3 98/8
members [10] 3/16 3/18 19/7 72/8 92/19 92/21 94/14 94/15 94/16 95/1
membership [4] 3/22 3/23 30/17 70/19
memory [1] 102/5
men [5] 34/23 35/4 35/5 62/21 67/7
mend [1] 26/14
mental [123]
mentally [3] 46/16 46/17 100/7
mention [3] 69/9 83/9 101/10
mentioned [3] 52/5 92/14 99/25
message [6] 36/18 36/22 99/11 99/20 100/6 101/4
messages [1] 18/2
met [1] 96/10
mid [1] 65/21
mid-teens [1] 65/21
Midlands [1] 50/6
might [65] 6/24 9/13 12/7 12/9 13/7 13/12 13/15 13/19 13/21 16/12 20/6 22/19 23/11 25/8 26/13 27/24 32/9 32/9 32/21 33/12 33/18 34/2 34/2 34/3 34/6 37/18 38/20 39/24 44/19 44/24 44/25 45/25 45/25 46/4 46/11 52/15 54/8 54/9 55/3 55/16 59/10 59/20 64/6 75/1 75/13 76/10 76/20 76/21 82/9 88/9 93/11 93/24 94/5 94/22 95/15 95/24 95/25 96/7 96/7 98/21 98/21 98/23 101/14 102/25 103/5
Migration [1] 65/24
miles [1] 76/11
milieu [1] 58/5
million [1] 83/16
mind [3] 7/5 37/1 57/22
minimal [1] 72/16
minoritised [2] 62/2 66/11
minute [1] 47/7
minutes [2] 7/2 95/24
miss [1] 52/21
mistake [1] 102/10
mistakenly [1] 13/19
misuse [1] 29/8
mitigate [4] 14/4 14/8 15/2 103/4
Mm [1] 101/17
model [10] 9/5 9/5 9/9 27/15 27/18 90/13 90/24 91/5 103/19 103/24
models [1] 104/19
moderate [1] 6/10
modern [2] 47/9 57/19
modestly [1] 5/18
moment [4] 21/2 68/23 69/4 74/6
Monday [1] 1/1
money [9] 51/6 51/8 51/10 51/13 74/15 83/14 83/21 84/2 100/1
monitoring [3] 42/20 42/25 43/2
months [5] 48/15 65/7 65/10 68/19 82/1
mood [1] 93/6
more [62] 2/5 6/10 9/17 10/16 10/18 10/24 12/12 15/9 16/18 18/19 19/20 20/8 23/12 23/13 24/11 25/7 25/18 28/18 28/19 28/25 29/2 29/5 29/24 31/4 31/6 34/22 34/23 36/23 37/17 43/5 43/24 44/25 57/19 59/19 62/6 62/21 64/8 64/24 66/5 67/18 68/2 68/2 68/12 71/13 72/18 77/15 81/18 83/11 83/12 83/12 83/13 83/18 85/16 85/19 89/3 89/9 89/25 96/2 98/13 103/20 103/20 103/21
morning [1] 1/3
most [10] 6/20 18/18 35/17 53/2 66/3 76/11 84/7 96/23 96/24 100/17
motivation [1] 35/9
move [3] 71/24 80/10 86/22
moved [2] 95/18 96/1
movement [2] 6/2 46/25
moving [1] 80/13
Mr [5] 45/5 92/10 92/11 99/3 106/7
Mr Ruck [1] 45/5
Mr Stein [1] 99/3
Mr Straw [3] 92/10 92/11 106/7
Ms [12] 1/3 1/6 77/3 77/4 77/9 85/21 85/22 86/4 92/14 106/4 106/5 106/6
Ms Cartwright [3] 85/21 85/22 106/6
Ms Eastwood [3] 77/3 77/4 106/5
Ms Langdale [5] 1/3 1/6 77/9 92/14 106/4
Ms Langdale KC [1] 86/4
much [29] 9/17 10/18 10/24 13/15 14/15 29/14 29/24 30/2 54/21 62/21 64/11 64/19 64/20 65/9 66/5 66/5 77/15 83/11 83/23 84/1 90/8 92/8 95/17 98/15 98/20 99/1 103/19 103/20 103/21
multi [5] 16/6 16/7 19/17 27/23 32/3
multi-agency [2] 16/6 16/7
multi-disciplinary [1] 27/23
multidisciplinary [1] 32/1
mum [2] 94/2 94/3
must [1] 13/4
my [11] 2/3 8/20 25/13 47/20 48/17 55/19 71/22 77/2 87/13 94/2 94/3
myself [3] 2/3 70/11 70/12

N

nagging [1] 84/20
names [2] 49/10 49/13
national [5] 27/14 31/8 31/10 49/3 102/1
nationally [3] 80/21 81/15 83/2
nature [4] 56/7 56/11 87/1 87/3
near [1] 47/21
nearly [1] 85/15
necessarily [9] 22/2 22/3 27/4 42/7 43/2 47/17 76/24 90/18 94/19
necessary [4] 56/11 56/14 66/13 87/1
need [51] 1/21 13/25 15/7 16/16 18/20 20/20 25/17 27/13 31/12 31/13 33/17 34/12 36/16 40/12 41/25 43/13 46/1 46/2 46/8 46/9 46/10 50/12 50/25 51/19 53/4 53/9 54/25 56/22 60/9 66/24 66/25 67/24 67/25 70/25 71/23 74/13 74/24 75/1 75/16 75/17 76/9 76/10 80/6 85/14 90/1 90/2 92/2 92/3 100/20 104/17 104/18
need -- you [1] 80/6
needed [8] 4/19 43/20 49/23 63/10 67/17 97/24 98/13 103/23
needs [19] 13/1 15/7 15/10 16/10 21/6 23/11 31/8 33/12 42/2 45/11 50/15 51/25 52/12 56/6 58/25 68/3

N

needs... [3] 71/10 92/23 98/13
negative [3] 11/4 28/15 34/18
negatively [3] 34/19 34/20 34/21
neighbourhood [3] 103/11 103/14 103/14
neither [1] 80/20
networks [2] 3/18 3/23
Neuroscience [1] 3/1
never [5] 1/15 38/18 42/22 96/14 96/15
new [33] 9/4 9/4 9/5 9/7 14/10 26/20 26/21 43/19 49/10 49/12 49/13 49/13 49/13 49/24 50/11 53/19 59/4 59/5 68/15 73/1 73/3 75/16 80/1 80/12 80/13 86/3 86/23 87/11 87/15 90/24 100/2 100/4 100/15
news [1] 44/13
next [2] 26/8 74/9
NHFT0006464 [1] 39/7
NHS [18] 2/24 21/2 21/7 21/11 21/13 48/12 48/18 49/7 49/8 51/4 67/16 69/10 70/15 73/21 73/22 81/1 84/18 98/8
NHS England [1] 73/22
Nigeria [1] 64/17
nine [1] 100/22
nine years [1] 100/22
no [22] 3/23 4/10 4/12 8/2 8/10 20/19 20/21 21/13 32/16 41/21 42/20 51/19 54/17 54/18 55/11 55/22 66/18 78/11 83/7 93/18 99/4 99/9
nodded [1] 43/23
non [1] 35/22
non-concordance [1] 35/22
nor [1] 80/20
norm [1] 26/24
normal [2] 38/21 59/18
normally [1] 17/4
Northampton [1] 52/10
northern [1] 65/11
not [127]
notes [4] 16/15 18/5 18/6 22/20
nothing [4] 1/16 37/2 50/17 69/13
noticed [1] 35/3
notified [1] 33/1
now [37] 9/14 10/15 10/17 10/19 10/24 14/10 14/16 24/15 34/9 37/11 37/17 44/2 44/11 46/2 49/6 49/9 54/17 55/1 58/17 59/2 62/18 63/12 66/2 71/14 77/14 77/15 78/17 78/18 79/4 79/10 79/21 84/3 86/1 86/23 88/17 102/7 103/2
nowhere [1] 51/24
number [15] 15/18 16/8 33/21 57/9 63/16 68/22 74/19 76/1 96/10 99/12 99/16 99/16 101/22 103/6 104/3
number 1 [1] 99/16
Number 2 [1] 99/16
numbers [4] 72/17 100/8 100/10 101/15
nurse [3] 32/9 98/21 98/21
nurses [1] 98/7
nursing [3] 73/12 98/5 98/6
nutshell [1] 71/6

O

objective [1] 10/2
obvious [4] 33/6 33/7 54/12 54/19
obviously [10] 9/22 19/18 20/4 33/3 33/6 49/22 76/25 86/12 87/22 101/4
occasionally [1] 51/12
occasions [1] 15/19
occupancy [6] 52/6 52/9 52/10 52/11 53/15 74/21
occupational [2] 32/22 32/23
occupied [1] 74/20
occur [1] 66/5
odd [3] 24/24 35/6 49/14
off [6] 7/1 34/8 55/16 90/3 90/25 104/14
offences [1] 41/3
offer [1] 53/11
Office [1] 49/25
officer [2] 42/9 73/14
often [28] 5/24 13/10 20/4 20/12 22/4 22/6 23/2 24/11 24/12 25/16 29/23 30/4 32/6 32/20 36/10 38/9 42/6 42/12 45/15 49/1 51/17 54/6 59/14 92/15 93/21 95/12 97/23 98/6
oftentimes [3] 23/3 41/15 93/22
oh [3] 72/20 79/6 84/17
okay [5] 1/9 24/2 98/14 99/1 103/24
old [1] 67/1
on [99] 1/17 2/13 3/12 4/2 4/20 5/11 5/17 6/10 8/1 9/17 10/7 10/24 11/11 11/21 13/17 15/7 15/17 15/18 17/18 19/21 21/2 21/14 21/21 23/5 23/20 25/21 26/23 27/11 28/18 28/24 29/7 29/9 30/10 30/12 30/12 30/16 30/20 34/9 34/12 34/18 35/25 39/7 40/13 42/13 42/15 42/23 44/9 44/11 44/20 45/3 46/21 47/7 47/11 47/25 48/4 50/19 50/20 55/21 56/18 57/9 58/1 60/23 64/24 65/25 68/11 68/22 68/25 70/18 70/20 70/21 70/23 70/24 71/19 72/15 73/21 73/24 77/6 77/15 79/8 79/17 80/10 80/13 80/23 82/2 82/16 83/21 84/11 85/16 85/24 89/4 91/18 92/1 92/13 95/25 96/4 97/12 97/14 101/1 102/7
once [2] 84/6 100/24
one [43] 2/8 5/22 6/14 13/18 15/9 17/21 17/23 18/10 19/18 21/19 23/21 28/11 29/20 35/3 37/11 38/18 39/21 39/24 42/10 44/21 49/25 50/2 50/4 53/9 55/19 63/4 63/16 71/7 72/21 77/18 86/3 87/20 89/11 91/9 93/18 95/6 96/9 96/20 97/11 100/2 100/4 100/12 100/20
one-third [1] 100/20
ones [5] 1/12 21/4 21/5 94/15 94/17
ongoing [1] 88/20
online [8] 42/17 42/19 42/25 43/2 43/14 43/16 44/2 45/1
only [21] 10/3 16/21 20/25 22/7 25/7 26/11 26/18 29/9 37/4 37/6 37/10 49/25 50/2 50/4 50/4 52/6 53/5 60/9 76/9 83/18 100/2
onto [2] 18/5 18/6
open [2] 58/22 87/12
operates [1] 10/5
operating [1] 83/2
operational [2] 81/16 81/21
operationalise [1] 88/4
operationalised [3] 58/25 88/16 88/21
OPIC [1] 49/25
opinion [4] 19/21 20/7 88/1 99/7
opportunity [1] 96/6
opposites [1] 6/14
or [107]
order [2] 48/25 101/12
organic [1] 93/1
organisation [1] 85/9
organisations [3] 39/17 47/10 82/8
organised [1] 3/6
origin [2] 63/17 64/9
other [37] 3/4 6/9 6/11 11/12 17/2 18/6 20/5 21/9 22/23 30/6 36/14 39/24 43/8 48/9 55/7 63/25 64/2 69/18 70/13 70/14 70/17 70/24 71/2 72/17 80/11 82/3 82/4 82/7 84/13 86/12 90/16 91/19 94/7 95/23 101/7 102/8 102/19
others [26] 5/1 5/2 6/25 7/21 11/11 13/14 14/23 15/25 20/18 23/13 24/10 25/15 27/2 39/12 39/15 39/19 41/13 50/7 53/3 60/17 75/10 77/8 77/11 80/2 96/25 104/13
otherwise [1] 29/19
ought [2] 55/5 87/4
our [19] 10/25 15/16 17/11 26/15 43/10 44/18 51/5 51/22 53/10 53/15 53/15 54/15 68/25 69/20 77/16 82/22 82/23 90/9 98/17
out [45] 3/13 3/14 4/21 5/14 8/1 9/3 12/24 14/23 19/7 23/18 35/8 42/8 43/24 47/19 48/1 50/19 50/20 52/18 53/20 56/5 58/9 61/21 68/18 68/24 71/24 72/2 75/12 75/12 75/18 75/21 76/2 76/6 76/12 76/14 76/16 76/18 78/15 83/18 84/1 85/11 93/15 97/15 99/11 99/20 104/21
outcome [2] 34/19 35/16
outcomes [4] 11/4 11/7 30/21 34/16
outlier [3] 6/6 6/7 6/8
outline [1] 79/18
outlined [1] 58/20
Outreach [7] 9/19 103/9 104/6 104/7 104/8 104/14 104/22
outset [3] 16/22 77/9 88/24
outside [2] 58/14 76/8
over [18] 3/16 13/4 13/8 13/13 14/6 19/23 23/22 26/5 61/6 63/2 71/13 72/19 73/9 74/5 75/19 80/25 89/14 101/8
overall [1] 97/18
overlap [1] 40/3
overly [5] 6/1 7/13 7/15 7/18 60/23
overly-coercive [1] 6/1
oversee [1] 68/16
overseeing [1] 48/10
oversight [1] 91/6
overspeaking [4] 27/7 29/5 55/10 84/14
overstretched [1] 42/6
overwhelmed [3] 9/2 41/18 42/6
own [3] 10/23 22/1 55/6
OxRisk [1] 28/8

P

page [44] 4/2 4/20 4/21 4/23 7/21 7/24 11/1 12/23 14/23 17/20 30/10 30/12 31/22 40/2 40/11 42/16 42/17 45/2 45/2 50/18 50/19 50/20 50/20 50/22 53/18 56/2 56/2 59/22 60/20 61/21 68/12 70/5 70/18 70/21 71/1 71/1 73/17 73/20 74/18 75/21 86/6 91/12 97/13 106/2
page 1 [3] 7/21 70/18 73/17
page 119 [1] 45/2
page 13 [1] 61/21
page 15 [1] 73/20
Page 17 [1] 74/18
Page 19 [1] 75/21
page 26 [1] 12/23
page 28 [1] 91/12
page 3 [1] 59/22

P

page 33 [3] 30/10 30/12 97/13
page 34 [2] 42/16 42/17
page 38 [1] 45/2
page 4 [3] 40/2 70/21 71/1
page 43 [2] 50/18 50/20
page 44 [3] 50/19 50/20 50/22
page 5 [5] 4/2 7/24 14/23 40/11 71/1
page 67 [2] 53/18 86/6
page 7 [2] 17/20 68/12
page 70 [1] 56/2
page 8 [3] 4/20 4/21 70/5
page 9 [1] 60/20
pages [5] 2/14 3/12 34/9 34/13 71/1
pages 2 [1] 2/14
pages 20 [2] 34/9 34/13
pages 4 [1] 3/12
pan [2] 50/4 100/4
pan-ICB [1] 100/4
pan-ICBs [1] 50/4
Panel [1] 16/7
panels [1] 16/5
paper [1] 28/12
paragraph [27] 3/15 4/24 5/6 5/14 7/4 11/9 20/20 21/14 27/13 30/12 31/23 36/16 40/11 43/15 45/2 47/25 53/20 60/3 60/15 61/21 61/23 66/9 68/14 70/2 70/5 86/4 91/11
paragraph 104 [1] 43/15
paragraph 119 [2] 45/2 47/25
paragraph 13 [1] 3/15
Paragraph 15 [1] 30/12
paragraph 16 [1] 31/23
paragraph 18 [1] 60/15
paragraph 2 [1] 11/9
paragraph 209 [2] 53/20 86/4
paragraph 25 [1] 4/24
paragraph 26 [2] 5/6 68/14
Paragraph 27 [1] 70/2
paragraph 28 [2] 5/14 70/5
paragraph 29 [1] 7/4
paragraph 40 [1] 21/14
paragraph 41 [1] 20/20
paragraph 51 [3] 61/21 61/23 66/9
paragraph 54 [1] 27/13
paragraph 83 [1] 36/16
paragraph 85 [1] 91/11
paragraph 9 [1] 60/3
parameters [1] 16/22
paranoia [1] 93/22
Parliament [1] 56/19
part [8] 17/11 29/25 30/17 33/14 36/10 88/19 91/4 101/22
participated [1] 70/22
particular [18] 10/23 12/16 13/18 20/8 20/9 20/13 20/15 27/15 43/3 43/4 45/24 49/16 77/25 80/22 93/2 96/20 103/10 104/4
particularly [16] 12/18 13/8 37/19 44/18 52/8 57/25 60/6 62/4 62/7 62/21 63/19 69/10 69/22 75/24 96/11 99/15
partly [2] 8/25 38/15
parts [2] 58/17 58/18
party [3] 18/17 18/20 18/24
past [3] 11/24 14/14 47/6
patient [49] 4/22 5/7 5/10 7/2 8/2 8/3 8/6 14/12 15/5 15/10 15/16 16/11 16/12 16/16 17/1 17/7 18/9 19/8 20/1 20/13 20/14 27/23 29/9 29/16 33/23 40/25 41/2 53/22 53/22 55/21 56/9 56/12 56/15 56/17 66/20 70/3 70/7 71/10 74/23 86/15 86/15 87/2 87/4 89/6 91/6 91/21 92/18 97/17 97/19
patient's [6] 11/12 15/6 15/9 17/24 19/2 70/25
Patient-identifying [1] 15/5
patients [23] 1/23 8/16 8/20 9/11 10/7 11/8 13/2 17/9 20/5 29/18 38/9 41/16 42/1 51/5 55/17 55/20 75/2 77/25 84/23 91/2 91/3 100/7 103/10
patterns [1] 19/13
Pause [1] 7/1
pay [3] 3/25 31/5 61/1
peer [1] 3/23
penultimate [1] 14/24
people [167]
people's [4] 6/9 34/18 61/15 101/15
perception [4] 7/7 10/2 10/5 93/17
perfect [1] 36/9
perfectly [2] 79/19 84/21
perhaps [6] 6/10 7/14 10/17 68/25 87/9 101/14
perinatal [1] 65/1
period [1] 23/23
periods [1] 16/17
permissible [1] 16/21
perpetrated [4] 14/13 101/21 102/25 103/5
perseverance [1] 1/19
person [60] 8/24 12/9 12/12 12/17 13/7 13/12 13/20 16/1 16/2 17/18 22/7 22/8 22/21 22/23 22/24 23/2 23/12 23/16 25/22 25/25 29/23 30/3 32/12 34/5 34/6 36/4 37/23 37/24 40/10 40/13 40/20 46/1 46/4 46/15 46/19 50/2 50/7 52/20 53/22 54/8 55/16 56/6 56/10 56/12 56/23 60/18 66/16 75/13 76/7 86/15 90/5 92/1 93/13 93/24 94/20 94/23 95/23 96/5 97/2 97/7
person's [16] 13/24 20/7 23/9 25/21 32/7 33/12 33/16 34/21 40/15 40/23 42/8 45/23 52/3 54/7 59/10 99/19
personal [1] 93/16
personality [1] 34/20
personally [1] 70/11
persons [2] 55/7 58/1
perspective [1] 50/19
phone [3] 33/20 62/18 62/19
pick [1] 91/9
picked [1] 62/23
pieces [1] 77/18
place [5] 1/20 1/24 19/18 19/19 76/9
placement [4] 52/14 52/19 76/7 76/14
placements [6] 75/22 76/1 76/2 76/6 76/12 76/16
places [11] 23/25 24/1 24/2 24/9 35/2 41/22 51/18 52/5 52/7 63/21 88/10
plan [3] 14/25 17/6 21/10
planning [3] 11/6 72/14 95/14
play [1] 17/11
playing [1] 44/8
please [47] 1/4 2/13 3/12 4/20 7/20 7/25 11/1 12/23 14/21 17/20 30/12 31/23 34/14 39/7 40/2 42/15 42/18 45/4 47/25 50/18 50/20 50/22 53/18 56/2 56/5 59/22 68/11 68/12 70/18 70/21 71/1 71/6 72/3 73/17 74/18 75/21 82/11 85/25 86/4 86/6 86/7 86/22 91/9 91/10 92/17 97/12 97/13
ploughed [1] 51/9
plus [9] 24/20 26/12 27/23 27/23 37/2 37/12 52/9 52/10 66/4
pm [1] 104/25
point [11] 13/14 14/24 22/5 30/14 33/10 51/4 73/11 74/15 74/22 78/21 99/24
points [2] 19/12 50/23
polar [1] 6/14
polarised [4] 5/24 63/3 63/11 67/2
police [2] 15/18 62/23
policies [5] 27/6 27/8 27/10 48/2 49/1
political [2] 5/3 10/23
politically [2] 5/16 5/20
poor [2] 48/8 72/10
population [10] 10/10 50/12 62/7 63/21 64/1 64/3 64/10 64/19 68/4 85/12
populations [1] 63/18
port [1] 69/25
pose [7] 6/24 13/8 53/2 60/16 77/25 96/24 96/25
posed [1] 62/25
posing [1] 88/12
positions [1] 99/22
positive [1] 99/20
possible [4] 53/5 54/15 103/3 103/4
posts [1] 83/6
potential [1] 44/25
potentially [5] 41/12 75/10 88/9 95/7 103/11
practicable [1] 81/15
practical [10] 2/4 27/14 39/22 40/17 48/21 48/21 81/14 81/19 82/12 89/1
practice [29] 10/25 11/17 13/6 14/22 16/11 16/20 16/21 17/4 23/17 23/19 42/5 43/20 48/8 48/9 49/2 59/2 59/4 59/7 60/1 61/2 61/10 67/22 68/17 69/4 77/16 79/15 80/18 88/21 89/4
practices [1] 59/24
practitioner [1] 40/10
practitioners [3] 11/4 40/22 59/25
practitioners' [1] 40/4
praecox [1] 35/11
pre [1] 54/11
precluded [1] 63/9
precocious [1] 35/12
predicting [1] 55/9
prediction [1] 11/16
predictions [1] 11/7
predictive [1] 28/15
prematurely [1] 65/6
prepared [1] 2/8
presence [1] 70/13
present [1] 32/2
presented [1] 13/18
presenting [1] 35/5
president [2] 74/4 87/24
pressed [1] 95/19
pressure [5] 60/22 60/25 71/3 71/25 85/9
pressures [2] 73/18 83/7
presumably [3] 19/7 19/10 24/8
presumption [1] 45/8
pretty [2] 97/15 98/3
prevent [3] 39/15 40/20 41/23
preventing [2] 39/11 41/2
prevention [1] 39/8
previous [3] 70/11 80/15 80/15
previously [4] 40/15 54/11 55/5 80/4
primarily [1] 9/3
primary [4] 31/24 32/4 52/1 83/23

P

prime [1] 103/20
principle [2] 60/3 60/5
principles [7] 11/11 12/23 23/17 28/4 45/22 79/12 79/14
prior [1] 8/13
prioritised [2] 5/3 74/2
private [1] 67/16
probable [1] 10/3
probably [6] 24/11 29/2 48/15 58/13 73/7 81/3
problem [13] 13/16 27/3 31/20 31/20 62/16 62/17 63/9 64/23 67/3 72/24 83/4 84/9 100/19
problematic [4] 58/18 58/19 58/20 58/21
problems [10] 5/22 16/12 23/21 53/9 67/5 75/15 76/25 84/4 84/5 94/7
procedure [1] 85/1
procedures [2] 27/6 49/2
process [3] 33/10 33/11 33/14
produce [1] 51/16
produces [1] 4/5
productive [1] 101/13
productivity [2] 84/11 84/12
profession [1] 72/12
professional [5] 27/18 28/5 40/9 40/12 54/6
professionals [4] 3/4 19/24 45/7 47/15
Professor [3] 28/7 31/22 101/25
Professor Appleby [1] 101/25
Professor Fazel [1] 31/22
Professor Seena [1] 28/7
profile [6] 5/4 7/16 14/19 61/4 67/5 67/7
prognosis [1] 96/8
progressing [1] 70/9
progressive [1] 39/3
promote [1] 40/7
prompt [1] 34/15
prone [1] 63/5
proper [1] 104/17
properly [6] 2/6 51/14 51/15 74/22 84/10 89/3
proportion [1] 73/15
proportionate [3] 60/13 60/14 61/11
proposed [2] 45/6 45/12
protection [3] 16/6 16/7 55/7
provide [20] 4/14 4/14 4/15 4/16 6/15 20/25 20/25 30/23 31/2 31/4 53/14 56/22 75/6 75/20 78/8 78/10 78/10 80/12 82/14 103/22
provided [3] 18/2 56/15 95/4
providers [1] 70/16
provides [4] 20/24 22/14 76/9 79/17
providing [3] 8/12 24/9 40/10
provision [3] 48/11 51/1 71/8
provisional [1] 48/4
provisions [1] 86/12
proxy [1] 30/5
psychiatric [15] 2/21 4/4 9/16 10/7 17/12 23/19 24/17 25/2 47/3 47/5 47/14 58/2 68/17 72/15 80/18
psychiatrist [9] 2/18 10/22 16/22 17/2 17/5 18/2 19/1 71/19 79/6
psychiatrists [46] 3/1 3/14 4/22 5/8 6/20 7/13 8/5 9/2 10/6 10/11 17/8 17/21 20/24 29/15 30/15 30/22 36/24 38/7 38/10 44/15 47/9 54/2 55/9 57/2 60/22 67/1 69/15 70/19 71/12 71/13 72/17 73/12 79/13 79/18 79/20 80/8 82/14 82/16 87/15 87/19 87/24 88/19 91/6 96/18 101/18 102/17
psychiatry [28] 2/19 3/1 3/9 5/22 5/24 5/25 6/3 6/14 6/22 7/6 7/8 8/14 15/13 23/21 24/15 35/24 44/7 46/25 47/1 67/6 72/4 73/4 73/8 83/10 87/11 95/13 99/8 101/19
psychoeducation [1] 37/13
psychological [2] 37/13 56/25
psychologically [1] 55/15
psychologist [2] 32/10 32/19
psychologists [2] 32/11 32/20
psychology [1] 99/19
psychosis [29] 12/15 25/19 34/11 34/17 35/19 36/14 36/21 38/18 47/13 59/21 63/5 64/1 64/5 64/14 64/15 64/16 91/14 91/17 91/22 92/23 92/24 92/25 93/1 93/4 93/5 93/8 93/8 93/11 100/19
psychotic [3] 36/17 37/24 65/23
psychotogenic [1] 37/22
PTSD [2] 63/25 64/4
public [12] 1/23 8/2 9/25 10/1 10/2 10/5 10/9 41/24 78/1 97/21 101/8 103/4
public's [1] 7/6
published [1] 4/25
pumped [1] 51/8
purpose [1] 40/19
push [1] 57/25
put [7] 17/21 18/19 18/23 36/16 84/2 99/11 99/20

Q

quality [2] 3/18 4/7
Queen's [1] 3/11
question [4] 45/4 91/25 101/17 101/24
questioned [11] 1/6 77/4 85/22 92/11 92/13 99/5 106/4 106/5 106/6 106/7 106/8
questions [9] 30/19 30/20 68/12 70/22 77/2 77/6 85/23 99/4 99/6
quick [1] 28/4
quickly [1] 83/18
quite [18] 9/15 18/13 26/11 27/22 28/17 38/24 44/3 57/24 61/3 61/19 61/24 72/6 76/23 83/25 90/17 95/9 96/14 98/25

R

race [2] 61/21 66/20
racial [1] 57/17
racism [2] 63/7 67/16
raised [2] 66/10 84/15
raising [1] 99/24
range [2] 5/8 8/4
rare [2] 13/9 100/8
rates [21] 29/3 36/12 36/14 57/7 57/17 62/1 62/5 62/6 62/11 63/18 63/20 63/24 64/3 64/4 64/5 64/8 64/12 64/16 64/19 64/22 66/8
rather [6] 15/13 23/6 23/8 24/7 66/13 67/25
RCPsych [1] 79/11
RD [1] 47/8
read [1] 39/23
reading [1] 79/21
ready [2] 29/15 51/22
real [2] 75/15 98/16
realise [1] 25/22
realised [2] 62/14 95/22
realistic [1] 88/10
reality [1] 92/24
really [48] 6/16 17/19 23/9 23/10 29/12 30/2 30/9 32/11 37/13 37/15 37/15 37/18 42/11 42/14 44/1 44/3 44/5 51/10 53/8 54/23 54/24 65/4 65/25 66/25 70/15 73/6 79/13 79/20 84/3 88/12 88/12 91/23 93/14 94/4 94/4 95/9 95/9 95/19 95/25 97/6 98/6 99/22 100/19 100/19 101/3 101/10 104/12 104/17
reason [5] 43/3 43/4 46/21 62/20 73/9
reasons [4] 39/21 39/22 41/10 42/10
receive [2] 56/12 87/2
received [1] 86/10
receives [2] 53/23 86/15
recent [1] 64/13
recently [6] 25/7 45/15 67/18 68/15 80/1 102/15
receptive [1] 16/18
recipient [1] 15/7
recognise [3] 9/14 14/6 44/16
recognised [6] 2/2 35/1 35/2 37/5 61/25 66/2
recognises [1] 33/19
recognising [2] 44/15 44/16
recommendation [1] 81/12
recommendations [10] 11/2 30/13 68/23 69/9 69/13 77/23 80/12 82/5 82/6 82/21
recommended [3] 80/17 81/15 82/15
recommending [1] 91/4
record [1] 18/10
records [5] 18/9 18/11 18/18 70/3 70/8
recover [1] 76/20
recreational [1] 37/19
redrafted [1] 5/19
reduce [4] 26/9 34/16 90/5 103/3
reduced [7] 11/5 14/9 36/15 51/6 73/25 73/25 73/25
reduces [2] 35/21 53/6
reducing [1] 35/17
reduction [8] 8/11 26/5 32/17 89/16 89/20 91/15 91/15 91/16
refer [6] 7/9 11/16 15/12 53/18 59/23 70/2
reference [1] 87/22
referrals [1] 91/1
referred [7] 22/11 48/8 72/4 99/7 101/5 101/12 103/7
Referring [1] 72/7
refers [1] 62/18
reflected [1] 18/3
refraining [1] 37/19
refresher [1] 48/3
refuses [1] 36/4
regarding [1] 45/6
region [1] 49/16
regularly [2] 13/5 14/7
regulator [1] 80/20
regulatory [4] 4/10 4/12 4/13 4/17
rehabilitation [1] 9/20
relapse [5] 33/16 35/21 38/23 39/1 91/16
relapses [1] 39/1
relapsing [2] 17/14 25/14
relate [1] 59/10
related [2] 63/22 65/12
relating [1] 82/13
relation [1] 40/16
relationship [7] 16/25 17/15 29/17 29/21 89/13 89/15 90/8
relationships [3] 42/12 92/19 94/9
relative [2] 18/22 96/13
relatively [2] 94/10 97/25
relevant [4] 19/1 40/8 40/22 82/3
reliable [1] 22/4
reliant [1] 21/2
rely [1] 29/7
relying [1] 29/9

R

remain [2] 34/22 74/8
remember [6] 41/9 55/19 59/19 61/1 85/8 94/12
remembered [2] 41/15 69/17
remitting [2] 17/14 25/14
repeated [1] 100/6
repeatedly [1] 70/6
report [14] 5/1 14/23 20/18 23/18 29/7 30/11 77/20 77/22 78/4 78/14 78/25 82/13 101/6 101/9
Reports [1] 4/6
represent [1] 92/12
representatives [2] 5/10 8/6
representing [2] 3/16 87/14
represents [1] 73/23
require [1] 27/22
required [7] 31/15 50/23 54/11 74/13 85/15 97/20 98/8
requirement [3] 21/22 74/6 86/25
requires [1] 41/24
research [2] 3/8 64/21
resist [1] 82/16
resource [4] 71/16 82/25 83/3 84/9
resourced [5] 2/6 41/17 51/14 51/15 89/3
resources [7] 24/7 24/8 24/12 26/6 26/12 51/13 84/23
resourcing [2] 23/22 104/21
respect [3] 39/18 40/5 70/3
response [1] 51/17
responsibility [4] 48/6 78/3 80/3 82/13
responsible [7] 32/6 33/24 34/2 48/10 49/16 49/20 49/21
responsive [2] 68/2 92/1
rest [3] 36/7 36/11 104/16
restrained [3] 7/15 7/18 67/10
restriction [1] 61/4
restrictive [7] 6/1 7/14 60/1 60/5 61/2 61/9 67/21
result [7] 3/10 7/17 8/25 39/6 54/8 67/18 87/19
resulted [1] 61/5
results [1] 71/5
rethinking [3] 7/21 20/17 77/11
retire [2] 73/11 73/16
retirement [1] 72/11
reverse [1] 25/20
review [7] 57/4 57/12 57/13 57/20 58/9 76/4 76/5
reviewed [2] 13/5 14/7
reviewers [1] 28/12
revise [2] 5/10 8/7
revised [3] 5/19 7/23 77/12
Rigg [1] 67/8
right [15] 3/20 3/21 11/19 19/5 35/22 40/18 41/22 59/2 60/10 61/3 71/9 71/20 77/16 79/10 79/21
rights [2] 57/19 58/1
ring [3] 74/7 74/8 74/9
ring-fence [1] 74/7
ring-fencing [2] 74/8 74/9
ringfenced [1] 26/9
RiO [4] 18/5 18/6 18/9 18/11
rising [1] 57/7
risk [106] 3/6 4/25 5/2 5/4 5/17 7/21 9/25 10/1 10/3 10/5 10/7 10/10 10/17 11/3 11/10 11/22 11/23 12/3 12/6 12/11 12/20 12/25 12/25 13/4 13/7 13/14 13/20 13/24 14/4 14/8 14/9 14/10 14/19 14/22 15/2 15/25 19/3 20/17 21/14 21/21 21/24 22/1 22/7 22/9 22/10 22/15 22/15 22/17 22/19 22/21 22/22 22/24 23/4 23/6 23/7 23/9 23/9 23/9 23/15 23/16 25/15 27/2 27/12 27/14 27/18 28/5 28/20 28/23 30/16 30/23 30/23 34/16 35/21 41/12 41/23 43/18 48/3 53/2 53/7 55/3 56/8 60/16 62/25 64/25 65/22 66/3 66/3 66/5 74/21 77/8 77/11 77/24 77/25 79/7 79/7 79/11 81/16 81/17 84/13 88/12 91/17 91/22 94/16 94/21 96/24 96/25
risk factors [7] 11/23 12/3 28/20 64/25 66/3 66/3 66/5
risks [7] 2/2 6/24 31/25 42/17 43/16 44/19 75/9
Ritchie [4] 77/20 77/22 78/14 101/6
RLIT0000031 [1] 70/18
robotic [1] 83/15
robust [1] 72/14
Rocky [3] 67/7 67/9 67/15
role [14] 3/13 4/21 10/8 16/23 16/24 17/1 19/20 20/11 34/11 61/21 68/20 69/2 69/14 81/9
rotations [1] 31/1
round [2] 95/14 95/22
routine [1] 11/17
Royal [20] 3/14 4/22 20/23 21/9 30/15 36/24 69/15 69/17 69/18 70/13 70/14 70/19 78/7 80/19 81/22 84/15 86/10 87/14 87/24 88/19
Ruck [2] 45/5 45/18
rules [1] 97/15

S

safe [5] 17/2 17/2 60/14 75/20 84/23
safeguards [3] 60/9 60/12 61/17
safer [1] 75/6
safety [10] 4/22 5/7 7/2 8/4 10/9 53/21 55/6 56/9 78/1 86/14
said [36] 12/9 16/12 18/12 20/23 26/10 35/23 46/24 47/18 52/24 55/14 55/22 57/23 66/19 67/13 67/14 70/14 71/11 74/2 76/4 79/2 81/24 81/25 82/22 83/24 87/9 87/17 88/10 88/24 90/13 92/23 95/10 97/6 98/2 98/8 100/2 100/22
same [11] 2/16 11/11 35/3 39/18 39/20 47/16 52/19 58/15 78/9 85/16 104/10
satisfied [1] 58/11
saved [2] 51/7 51/8
savings [2] 31/16 85/19
savvy [1] 44/14
say [71] 1/8 1/16 4/23 5/6 9/23 10/13 10/20 15/1 15/21 18/8 18/19 21/14 21/16 22/6 22/12 22/19 23/20 25/7 27/13 28/11 28/14 30/18 33/6 33/20 34/6 35/25 36/16 36/24 37/10 38/11 39/21 43/12 43/15 45/13 45/16 46/4 47/1 47/6 50/23 56/5 56/20 57/12 58/24 60/2 60/3 60/15 60/20 61/22 66/9 67/4 71/19 79/8 80/7 80/10 80/14 82/7 82/9 85/4 88/9 89/25 93/2 93/12 93/13 95/13 96/3 96/11 97/22 98/4 99/13 99/14 102/17
say: [1] 55/13
say: well [1] 55/13
saying [14] 6/14 6/17 9/10 23/5 36/25 38/4 45/18 55/20 58/7 58/8 63/4 63/6 83/15 87/25
says [6] 22/20 29/16 30/14 47/10 74/18 103/24
scalable [1] 81/15
scarce [1] 71/16
schizophrenia [20] 12/11 12/14 28/9 34/16 34/25 36/13 46/16 47/2 47/13 63/25 65/8 65/15 65/17 92/17 92/18 93/7 93/20 94/8 95/6 96/20
schizophrenia's [1] 92/22
schizophrenia-type [1] 93/7
schizophreniform [1] 28/10
screen [13] 2/13 3/13 4/20 30/10 34/9 39/7 42/15 45/3 47/25 68/11 70/18 70/22 97/12
scrutiny [1] 58/15
Sean [1] 67/8
second [7] 2/9 20/7 30/14 59/23 64/11 65/25 86/21
Secretary [1] 70/12
Section [4] 86/2 86/2 86/9 86/9
Section 2 [2] 86/2 86/9
Section 3 [2] 86/2 86/9
sector [1] 67/16
secure [1] 42/24
security [1] 44/8
see [40] 4/2 7/3 7/25 9/24 10/8 11/1 11/9 13/3 15/4 16/14 18/7 18/20 19/1 25/17 25/23 25/25 29/14 29/23 39/17 40/2 40/11 41/16 47/12 48/17 48/17 49/17 49/18 54/15 59/6 63/20 64/22 65/15 68/14 70/21 75/23 75/25 83/20 90/20 104/13 104/19
seeing [5] 22/8 27/9 35/4 48/10 53/4
seem [2] 35/7 54/12
seemed [2] 35/6 57/15
seen [8] 15/18 16/17 16/24 19/22 48/16 52/20 66/21 84/13
Seena [1] 28/7
self [2] 25/15 29/7
self-report [1] 29/7
send [5] 33/3 33/3 82/7 82/19 82/22
Seni [2] 67/8 67/19
Seni Lewis [1] 67/19
Seni's [1] 67/20
senior [4] 2/25 38/9 50/2 50/7
sense [1] 101/14
sensible [3] 11/6 31/7 57/21
sent [2] 76/12 76/18
separate [1] 45/4
September [1] 7/3
September 2013 [1] 7/3
series [1] 18/2
serious [14] 13/9 13/9 14/14 24/20 35/18 40/21 41/3 53/21 55/9 55/12 56/8 59/10 86/13 86/22
service [9] 4/5 9/12 26/3 27/1 72/25 83/5 83/8 95/19 95/20
service-level [1] 4/5
services [50] 1/21 2/23 3/17 4/8 5/5 7/22 9/16 10/9 20/18 21/20 25/8 25/12 26/16 26/17 26/19 27/20 28/1 32/4 41/1 43/6 43/9 44/9 46/18 46/23 47/4 47/5 50/16 51/9 51/11 53/4 53/10 61/7 62/13 62/15 66/23 66/25 68/2 77/11 80/20 83/2 84/19 90/9 90/16 90/23 95/10 95/21 96/2 96/12 96/13 96/23
services' [1] 5/1
set [16] 3/13 3/14 4/21 5/14 12/23 16/22 20/24 23/17 48/1 50/19 50/20 53/20 56/5 61/21 68/18 97/15
sets [2] 7/25 14/23

S

seven [3] 5/11 50/3 100/5
seven years [1] 5/11
severe [17] 24/19 25/13 36/13 37/3 39/4 63/19 83/2 94/12 94/22 94/23 99/9 99/15 100/18 100/24 102/25 103/6 103/25
severely [3] 45/20 61/15 100/7
sexier [1] 83/12
Shall [1] 68/6
share [7] 15/23 15/24 16/13 18/21 40/19 44/23 82/11
shared [8] 15/5 15/14 15/15 16/11 16/16 18/23 97/16 97/23
sharing [14] 15/11 15/20 39/8 39/15 40/7 40/16 41/23 41/24 42/3 42/14 68/18 70/4 77/1 90/15
short [3] 2/2 68/8 105/1
shortage [1] 32/19
shortages [1] 72/9
shortly [1] 5/13
should [37] 1/15 5/18 6/3 6/12 6/13 6/18 7/5 11/11 12/25 14/3 14/25 16/2 19/19 21/15 21/15 21/24 23/10 27/16 28/21 29/12 30/14 30/15 31/24 36/5 38/7 40/14 58/8 58/8 66/17 70/16 72/13 78/17 79/19 80/25 82/16 91/23 99/9
shouldn't [13] 6/4 6/15 6/15 22/12 22/13 38/8 38/12 47/21 57/23 58/7 66/13 67/22 99/8
shouting [3] 67/1 71/22 71/23
showing [1] 73/24
shows [2] 64/14 79/12
shrunk [1] 49/14
SHUBULADE [2] 1/5 106/3
sick [1] 84/20
side [1] 6/17
sign [4] 25/16 25/16 33/24 34/8
signed [2] 3/17 34/8
significance [1] 10/1
significant [7] 24/3 32/17 34/18 46/24 46/25 56/8 73/14
significantly [3] 61/5 65/22 84/13
similar [8] 21/18 39/14 64/8 64/9 83/9 85/9 101/7 101/7
Simon [1] 57/3
simple [1] 97/25
simply [11] 12/10 12/20 24/4 29/7 36/1 36/3 63/4 63/7 64/23 71/11 87/13
since [4] 37/4 51/5 52/9 72/17
single [5] 34/24 85/13 85/14 85/15 85/17
Sir [2] 57/3 67/13
Sir John [1] 67/13
Sir Simon [1] 57/3
sits [2] 104/9 104/9
sitting [1] 93/2
situation [7] 8/15 15/1 54/17 57/1 57/1 74/16 83/10
six [1] 72/21
skill [1] 90/14
skills [1] 84/23
sleep [3] 37/25 38/1 90/3
slight [1] 38/25
slightly [3] 61/13 96/17 103/15
small [5] 65/5 77/24 100/9 101/21 103/5
Smith [13] 1/4 1/5 1/7 5/14 11/15 34/10 45/4 55/20 59/23 68/13 77/5 85/23 106/3
so [201]
so-called [1] 29/16
social [22] 32/9 32/11 32/15 32/17 34/19 41/25 42/11 42/12 47/11 52/1 54/4 54/4 54/6 57/1 59/3 66/2 66/3 66/5 73/13 81/4 88/18 99/19
society [3] 101/16 102/24 103/3
solutions [1] 100/14
some [39] 7/15 10/6 11/4 13/14 15/10 16/10 22/15 23/25 24/1 24/2 24/2 24/9 24/9 36/13 38/9 44/7 47/14 48/24 49/1 52/5 55/13 57/10 57/10 57/10 57/11 58/17 58/18 60/23 62/20 63/21 64/23 67/5 76/3 87/17 90/2 90/22 90/22 97/4 104/12
somebody [8] 25/13 31/13 50/10 54/18 54/20 59/12 72/2 97/4
somehow [4] 54/2 61/14 85/6 102/9
someone [28] 12/4 14/13 16/23 17/13 22/20 25/17 29/22 32/3 41/9 45/20 49/19 52/11 54/9 55/14 59/18 60/7 71/24 72/2 76/18 89/14 89/23 90/19 90/20 93/1 93/11 94/1 94/8 103/21
Somerset [1] 52/6
something [34] 1/8 2/15 2/15 2/16 3/24 3/24 13/25 14/2 14/20 19/22 19/25 21/6 23/1 28/6 28/21 34/7 42/22 44/9 49/15 54/4 54/10 55/14 55/16 61/6 67/16 67/21 72/21 80/5 81/21 82/19 88/24 89/8 93/18 94/9
sometimes [23] 18/13 18/14 20/5 21/24 27/21 30/3 34/6 36/6 41/21 43/8 61/18 72/22 76/7 76/25 80/10 92/14 93/20 93/21 94/5 94/14 95/1 95/2 98/23
sorry [7] 1/17 9/23 39/13 45/2 50/2 54/5 74/21
sort [3] 59/6 75/12 75/17
sound [1] 85/5
sounds [1] 33/6
south [2] 2/24 29/1
southern [1] 65/11
space [1] 104/10
Spanish [1] 65/16
speak [6] 84/24 84/25 85/2 85/3 85/4 102/20
special [2] 44/12 44/13
specialised [3] 76/9 76/10 96/2
specialist [6] 3/2 9/8 9/13 9/17 9/19 9/20
specialities [4] 5/9 8/5 72/18 83/10
specialty [1] 6/2
specific [4] 27/11 30/24 30/24 80/6
specifically [2] 14/25 28/9
specifics [1] 15/17
spend [2] 74/15 96/2
spending [3] 73/24 83/21 85/17
spent [2] 90/25 91/2
spike [1] 65/15
spikes [1] 65/17
spoken [1] 80/22
spread [1] 104/21
squeeze [1] 72/2
staff [15] 15/9 15/13 18/15 26/12 26/21 26/23 73/12 75/3 96/18 97/23 97/25 98/4 98/4 98/5 98/8
stage [2] 54/21 103/21
stakeholders [6] 59/3 69/7 88/18 101/20 102/19 102/20
stalking [1] 43/17
standardisation [1] 21/23
standardised [2] 27/14 31/9
standards [7] 4/14 4/15 20/24 23/24 80/18 80/21 82/2
start [8] 26/25 33/16 38/1 48/17 64/6 65/20 68/6 104/24
started [4] 8/21 24/16 62/5 95/21
starting [5] 44/10 44/15 44/17 50/5 54/22
state [4] 7/4 11/14 56/25 99/20
statement [16] 2/13 3/12 11/15 15/12 20/17 34/10 39/11 40/4 42/15 45/3 50/18 59/23 86/5 91/12 97/12 97/22
statements [1] 2/8
states [1] 19/1
static [2] 13/16 22/4
statistic [2] 73/8 100/10
status [1] 73/14
statutory [8] 10/8 10/12 45/6 45/12 86/1 86/9 87/7 87/12
stay [2] 38/23 53/16
Stein [1] 99/3
stigma [3] 38/14 38/15 94/21
stigmatisation [2] 101/5 101/13
still [6] 18/25 27/5 27/25 46/9 46/10 87/20
stimulants [1] 37/20
stop [8] 17/8 25/15 39/1 39/4 63/7 63/12 63/24 104/24
stops [1] 67/3
stories [1] 7/10
straightforward [2] 56/20 97/15
strains [1] 72/4
strategies [1] 14/4
strategy [1] 23/16
Straw [3] 92/10 92/11 106/7
street [1] 62/24
strengthen [1] 30/16
strengthening [2] 42/2 50/25
stressed [1] 89/25
stretched [3] 29/24 95/10 100/25
striking [1] 96/10
strong [2] 57/25 93/15
struck [1] 95/6
structurally [1] 90/10
structure [2] 49/24 50/11
structured [3] 27/17 28/5 29/6
structures [1] 49/13
students [1] 3/4
studies [1] 89/18
study [2] 64/13 64/13
stuff [2] 52/21 98/11
stymies [1] 75/19
subjective [1] 10/2
subsequent [2] 18/25 19/24
subsequently [1] 2/19
substance [3] 12/2 29/8 37/19
such [8] 9/18 23/22 23/22 78/17 81/10 81/16 81/21 94/13
suffer [1] 84/8
suffering [4] 12/9 12/10 12/13 56/6
sufficient [1] 95/4
sufficiently [3] 45/16 92/7 96/18
suggest [2] 29/19 78/24
suggestion [1] 66/16
suggests [3] 56/4 72/8 72/13
suicide [5] 23/2 23/13 31/25 39/6 39/8
summaries [1] 81/17
summary [3] 7/25 9/23 77/10
superior [1] 91/19
support [11] 3/19 6/16 21/7 30/6 31/12 31/14 62/20 70/7 72/16 95/4 97/1
supported [3] 51/20 66/19 78/20
supporters [1] 33/5
supporting [1] 30/9
supportive [1] 97/7
supports [1] 4/7
sure [19] 1/19 10/13 10/20 23/20 25/25 29/20 47/19 48/19 67/24 72/20 81/25 90/2 94/3 98/7 98/22 98/25 103/13 103/19 104/19
surgery [1] 83/16

S

surprised [1] 102/12
surrounding [1] 55/8
Survey [1] 70/20
survived [1] 84/7
survivors [2] 1/13 85/24
switch [1] 7/1
sympathise [1] 96/19
symptoms [4] 12/12 35/7 91/15 92/6
system [5] 2/2 27/7 27/8 62/25 93/25
systems [1] 70/17
Szasz [1] 47/8

T

take [24] 13/20 27/19 27/22 27/25 36/3 36/4 36/6 36/10 36/10 36/12 40/14 42/9 43/11 45/24 50/22 57/22 69/20 78/23 79/1 80/25 83/17 90/3 90/3 100/22
taken [3] 33/18 77/9 86/3
takes [5] 10/18 28/20 81/25 82/1 99/18
taking [4] 1/24 36/1 36/2 56/24
talk [5] 20/4 20/6 70/17 95/24 96/4
talked [3] 88/6 88/17 88/25
talking [2] 89/8 93/18
tasked [1] 57/16
teach [1] 3/3
team [16] 9/13 19/17 24/6 27/23 29/25 30/9 32/1 32/3 32/15 32/18 42/11 90/18 104/6 104/7 104/8 104/14
Team's [1] 90/25
teams [12] 9/8 9/18 9/18 9/19 9/20 9/20 9/21 9/22 34/12 71/14 71/15 104/22
tech [1] 44/22
teens [1] 65/21
tell [15] 2/14 2/15 2/16 16/2 20/17 21/13 28/15 38/10 61/22 62/17 71/5 73/23 74/18 82/24 89/23
telling [1] 47/20
tells [4] 22/8 37/22 74/1 90/19
templates [1] 81/16
ten [2] 73/2 73/3
tends [2] 26/14 78/24
tension [3] 6/19 10/11 10/20
tenure [1] 80/9
term [1] 96/8
terms [12] 13/25 14/1 14/24 25/17 32/12 40/25 41/23 53/24 81/14 96/8 100/8 100/10
terrible [1] 78/17
test [3] 86/3 86/19 104/18
tested [1] 53/13
than [25] 15/9 16/19 18/12 22/23 23/6 23/8 24/7 25/7 29/4 29/24 59/19 62/6 64/2 64/9 64/17 64/18 65/9 66/6 66/6 68/1 70/25 83/23 85/14 86/18 100/20
thank [16] 1/18 2/7 68/6 77/2 77/3 85/20 86/6 86/7 91/13 92/8 92/9 97/12 99/1 99/2 100/6 104/23
that [660]
that's [71] 1/9 3/21 3/24 4/9 6/3 6/6 6/19 6/21 14/5 14/6 15/3 16/7 20/10 20/20 21/22 22/2 22/9 25/14 25/15 25/23 26/2 28/13 28/17 29/12 31/20 32/16 32/20 33/10 36/18 36/22 36/22 38/8 41/7 49/9 53/2 55/1 57/2 58/21 59/13 60/10 61/6 62/9 63/7 63/22 65/11 65/24 66/17 68/5 69/14 73/9 75/14 76/8 76/13 80/5 80/14 82/8 82/18 83/4 86/20 86/23 87/13 88/16 89/16 91/25 92/7 94/21 95/15 101/24 102/9 102/13 103/2
that: [1] 9/10
that: look [1] 9/10
their [69] 10/22 15/24 16/24 18/22 22/1 27/24 29/22 30/3 30/4 30/4 30/17 30/25 34/8 34/19 34/20 35/8 35/9 38/21 40/14 41/5 41/5 41/10 41/12 41/14 42/1 42/8 43/13 44/23 45/14 45/24 46/11 52/13 52/15 52/16 54/8 55/2 56/25 56/25 57/1 60/8 60/24 64/10 70/17 71/15 71/16 75/13 76/8 76/13 76/19 76/21 84/11 85/7 85/11 85/12 85/13 85/18 89/24 92/6 92/15 92/16 92/19 93/16 95/6 95/8 96/8 96/20 96/21 97/8 102/8
them [60] 8/17 8/21 8/22 9/12 12/18 13/22 17/2 17/3 17/15 22/8 26/1 29/22 30/6 30/7 33/3 33/3 41/2 41/10 41/19 46/14 46/18 46/23 51/24 52/21 53/6 53/7 53/11 53/13 54/25 55/1 55/3 59/11 60/8 66/24 70/1 73/15 75/15 76/19 76/20 76/22 76/23 76/25 81/5 82/7 82/20 83/13 83/14 84/21 89/15 89/25 90/5 92/4 92/20 93/3 93/23 94/2 96/7 100/5 103/22 104/21
themselves [19] 6/24 23/14 27/2 31/6 38/22 38/22 41/13 46/4 53/3 60/17 67/3 69/6 92/20 94/4 95/2 95/3 95/7 96/21 96/24
then [65] 2/20 2/21 6/10 9/21 10/18 12/19 13/19 14/3 14/5 14/18 14/19 15/4 16/13 22/9 22/19 22/22 24/7 26/16 26/23 28/17 32/10 32/21 35/7 36/12 41/19 42/25 43/5 45/21 46/5 46/5 46/7 47/22 50/17 51/5 51/21 52/24 53/8 58/12 64/6 64/21 65/21 69/5 69/8 69/25 71/25 72/24 78/22 79/16 79/17 79/25 80/9 82/25 84/10 88/24 91/9 91/18 92/7 93/7 93/8 95/20 97/11 98/17 98/22 104/16 104/19
therapeutic [6] 16/25 29/17 29/21 89/13 89/15 90/8
therapist [2] 32/22 32/23
therapy [1] 37/13
there [143]
there's [68] 4/10 6/2 8/10 10/20 10/21 16/17 18/19 21/6 21/13 21/20 21/21 23/5 23/22 23/23 27/13 28/21 30/21 31/1 32/5 32/7 32/16 36/11 37/17 38/5 38/14 38/25 44/20 44/20 46/24 48/20 49/5 50/2 50/4 51/12 51/19 51/23 52/21 55/11 55/19 61/13 61/24 63/14 64/24 75/25 75/25 78/6 80/7 80/11 83/7 83/12 83/18 84/1 84/3 84/18 85/1 85/2 86/22 88/17 93/8 93/17 93/18 94/13 94/16 95/23 98/19 101/4 103/14 104/20
there've [1] 73/2
thereafter [1] 41/3
therefore [3] 22/21 36/6 100/23
these [21] 1/15 6/14 6/18 11/13 19/5 35/4 35/5 35/6 35/12 37/8 44/14 50/3 52/2 59/14 63/3 63/7 66/25 67/2 87/11 96/2 102/18
they [155]
they'd [4] 33/8 33/8 55/21 62/25
they'll [7] 10/22 23/3 30/5 38/21 49/10 55/1 76/22
they're [45] 2/1 5/24 17/10 21/5 22/22 25/18 25/22 25/23 26/1 26/19 27/24 33/1 33/19 39/5 42/1 46/15 48/19 49/15 49/17 50/5 51/14 51/15 54/16 54/19 54/22 54/24 61/15 66/4 68/1 72/22 72/24 73/4 73/4 75/16 79/21 79/22 89/23 89/24 94/1 94/24 98/25 103/15 104/1 104/3 104/19
they've [10] 18/23 20/13 36/5 51/16 52/6 54/19 85/11 92/5 94/20 97/9
thing [19] 14/2 17/19 22/17 36/2 37/10 43/8 53/3 53/8 59/6 73/13 75/23 78/17 79/19 83/16 88/6 92/2 93/9 100/14 103/16
things [9] 44/21 52/18 58/16 61/12 63/16 65/12 90/8 100/14 102/18
think [109]
think: [1] 46/1
think: this [1] 46/1
thinking [14] 13/24 14/1 14/3 23/6 23/8 32/12 57/19 63/10 63/12 63/15 74/25 75/11 79/6 102/22
thinks [1] 99/7
thinner [2] 51/16 51/16
third [8] 17/21 18/17 18/20 18/24 64/11 65/25 82/25 100/20
this [138]
Thomas [1] 47/8
those [24] 1/12 4/15 6/9 6/20 28/18 29/9 32/10 42/12 44/19 47/16 49/15 61/12 66/5 68/24 70/22 71/14 75/22 77/2 97/10 99/9 99/11 102/20 104/15 104/21
though [1] 85/6
thought [5] 15/25 37/2 63/13 65/12 91/23
thoughts [3] 18/3 19/15 19/17
thousands [1] 57/13
threatened [1] 12/19
three [2] 62/10 73/7
threshold [4] 26/17 74/21 86/18 88/7
thresholds [1] 52/25
through [6] 8/21 33/15 47/20 50/22 58/15 98/10
time [60] 2/16 7/11 8/10 8/12 8/24 9/1 9/3 10/13 12/13 13/4 13/8 13/14 13/17 13/18 14/6 22/5 23/23 24/1 24/2 25/1 26/3 32/24 35/3 37/16 38/20 38/25 41/18 41/20 46/11 54/3 68/5 74/4 75/1 75/12 75/17 76/12 77/13 78/12 80/5 80/10 80/13 84/20 85/18 89/14 90/12 90/25 91/1 91/1 95/11 95/15 96/1 96/1 96/14 97/2 98/5 98/12 101/23 102/8 102/14 102/17
timeline [1] 68/18
timely [2] 35/18 66/14
times [9] 18/4 52/4 59/15 62/6 62/10 62/10 64/4 65/23 93/1
tiny [1] 83/19
tips [4] 17/20 19/5 79/12 79/23
today [1] 50/5
together [4] 17/21 30/1 39/18 50/3
told [4] 15/10 77/12 79/25 96/14
too [8] 29/15 39/23 61/3 64/5 76/6 98/22 100/12 104/22
took [1] 1/20
tool [9] 22/4 27/15 27/15 27/21 28/3 28/8 28/13 29/6 29/6
tools [4] 27/12 29/9 81/16 81/21
top [3] 12/24 50/23 75/24

T

topic [2] 42/17 82/25
torture [1] 58/4
total [1] 73/22
touched [1] 82/2
towards [4] 7/6 7/8 23/12 39/19
toxins [1] 65/5
traditional [1] 43/18
tragic [1] 1/15
train [3] 3/3 28/6 72/1
trained [3] 2/18 24/16 24/21
trainee [1] 30/24
trainees [2] 3/4 30/25
trainer [1] 3/7
trainers [1] 24/17
training [29] 3/6 3/8 4/4 4/15 20/25 24/13 28/23 30/20 30/24 30/25 31/2 31/4 31/5 31/10 31/12 48/2 48/3 48/4 69/1 78/10 78/11 78/14 80/23 81/1 81/7 81/8 81/10 98/6 98/9
translated [1] 81/18
transparency [1] 17/19
trauma [1] 65/18
traumatic [1] 95/5
treat [3] 6/23 14/15 100/18
treated [9] 35/15 36/17 37/6 37/9 38/7 38/16 38/17 99/16 99/17
treating [3] 6/4 19/24 89/5
treatment [36] 17/6 20/7 20/9 34/13 34/15 35/19 36/22 41/1 45/25 46/20 47/14 53/5 53/23 54/25 55/1 56/13 56/14 56/16 59/16 59/17 60/18 66/14 86/16 87/3 88/7 91/14 92/1 92/2 92/3 99/17 99/18 100/17 100/21 100/23 100/25 101/2
treatment/is [1] 53/23
treatments [2] 35/13 73/1
trial [1] 92/5
tribunal's [1] 57/7
tribunals [1] 82/15
tried [1] 92/5
Trinidad [3] 63/22 63/23 64/19
true [1] 2/10
truly [1] 1/17
trump [1] 45/19
trust [8] 2/24 29/17 43/10 71/22 77/1 85/15 85/17 94/5
trusts [4] 3/25 3/25 18/9 21/25
truth [1] 99/21
try [8] 30/6 43/13 97/3 97/5 99/14 99/14 99/20 99/21
trying [10] 6/23 6/23 39/3 54/15 57/16 57/18 66/21 71/15 71/25 103/18
tube [1] 72/1
tumour [1] 93/2
turn [1] 25/11
tweaking [1] 90/1
two [10] 2/8 6/14 13/13 35/2 61/12 62/6 63/7 64/4 92/5 92/5
type [6] 12/14 12/16 20/9 60/17 92/22 93/7
types [5] 37/12 92/25 93/9 93/10 93/19

U

ugly [1] 57/10
UK [10] 50/21 50/24 60/11 63/18 63/21 64/1 66/6 66/7 70/6 72/24
UK Government [1] 70/6
UK's [1] 58/2
UN [1] 58/1
UN Convention [1] 58/1
unable [1] 35/10
unaware [1] 14/11
uncertain [1] 97/23
unclear [1] 84/18
uncommon [2] 94/11 94/11
under [9] 23/22 24/5 41/17 43/6 56/15 60/7 60/22 83/2 85/9
under-resourced [1] 41/17
under-resourcing [1] 23/22
understaffing [1] 72/15
understand [17] 1/8 7/9 14/8 19/2 25/9 30/22 30/23 37/14 46/20 54/24 55/20 76/24 83/13 83/21 96/18 97/25 101/18
understanding [15] 23/11 24/23 28/22 28/25 40/13 43/24 44/17 44/24 45/23 52/22 55/23 74/12 84/4 94/13 101/15
understands [8] 49/21 49/22 50/8 50/11 50/12 50/13 50/13 50/14
understood [3] 2/1 9/23 96/15
undertake [1] 98/9
uneven [2] 48/11 80/22
unfortunately [17] 7/17 18/8 21/23 22/2 31/13 32/14 38/4 39/2 39/5 41/17 51/10 74/16 75/23 76/16 90/9 94/17 102/16
unified [4] 21/13 21/17 22/11 31/10
uniformity [1] 81/9
unit [3] 42/24 43/1 67/10
units [2] 7/12 67/20
university [1] 15/18
unless [9] 4/16 16/3 27/1 31/25 43/3 53/22 56/15 86/15 88/11
unlikely [1] 79/21
unsuitable [1] 71/8
until [3] 45/14 54/16 68/1
untreated [2] 34/17 34/22
unusual [2] 7/10 63/21
unwell [20] 8/22 25/23 27/1 41/16 45/20 46/1 46/16 46/17 54/16 54/19 54/23 59/15 61/16 62/24 63/1 88/12 89/19 89/22 90/6 103/21
up [29] 3/17 6/13 6/18 19/5 25/11 26/18 36/16 39/9 43/21 44/8 47/3 52/25 55/10 55/11 55/12 58/17 62/19 62/23 79/11 84/24 84/25 85/2 85/3 85/4 89/19 89/22 90/6 91/9 100/22
update [1] 69/8
updated [1] 5/19
updates [1] 68/16
upload [2] 18/5 18/13
uploaded [1] 18/4
upon [1] 11/17
upset [1] 12/18
us [18] 2/15 2/16 17/10 20/17 21/13 43/12 50/22 61/14 61/16 61/22 69/25 71/5 73/23 74/1 74/18 77/12 83/16 83/24
us to [1] 61/14
usage [1] 89/21
use [18] 12/2 18/9 18/10 21/1 21/12 29/25 37/19 42/20 45/20 45/21 46/13 61/4 61/9 61/10 63/22 64/20 65/20 67/19
used [11] 8/15 26/6 27/20 27/21 32/14 32/18 38/8 71/12 87/7 89/5 102/21
useful [9] 28/13 28/17 29/10 37/18 39/10 39/14 44/5 44/22 69/24
using [6] 21/18 29/6 38/12 65/20 82/18 103/3
usual [1] 33/10
usually [12] 21/2 23/2 25/16 32/5 34/3 45/13 82/22 94/6 94/15 94/16 97/3 104/7
utilisation [1] 89/17

V

vacancies [2] 26/13 72/21
vacant [1] 83/6
value [2] 17/22 28/15
variable [1] 80/21
variation [5] 24/3 24/4 24/5 48/1 48/7
various [4] 3/9 18/4 59/3 69/7
VC [3] 16/16 19/24 42/18
VC's [2] 18/1 92/12
version [2] 7/24 103/16
versus [2] 6/23 85/6
very [72] 5/23 5/24 9/2 13/10 14/14 14/15 14/15 14/16 16/19 17/11 17/16 20/10 22/4 22/16 24/18 24/23 27/8 28/13 28/15 30/2 31/11 33/1 35/7 38/3 38/9 38/17 39/5 41/13 42/5 44/14 47/11 48/19 49/5 54/19 59/9 59/14 59/15 59/15 59/17 61/3 62/24 63/3 63/12 64/13 66/19 66/22 67/5 67/6 67/11 69/20 71/15 76/8 81/11 83/9 85/5 88/3 88/4 88/23 90/11 92/8 92/23 93/4 93/5 93/5 95/10 95/10 97/9 99/1 99/17 99/22 99/23 100/8
via [2] 30/25 62/24
victim [1] 94/21
victims [1] 94/17
view [7] 23/17 41/2 46/19 55/6 57/8 87/25 103/12
viewing [1] 42/18
views [6] 5/17 5/23 10/23 10/23 40/16 47/16
violence [26] 10/17 11/5 11/25 11/25 12/1 12/6 12/20 13/9 13/9 13/19 14/14 28/23 29/4 30/16 31/25 39/11 39/15 39/19 55/19 91/16 101/21 102/23 102/23 102/25 103/3 103/5
violence/criminality [1] 12/1
violent [10] 11/24 13/12 13/22 28/16 28/19 42/19 43/17 55/22 55/23 59/12
violently [4] 12/4 23/12 91/18 91/23
viruses [2] 65/5 65/13
visit [1] 76/22
visiting [1] 2/25
voices [2] 36/20 38/2
voluntary [1] 3/24
volunteers [1] 80/8

W

wait [3] 41/18 41/20 54/16
waiting [3] 68/1 71/21 86/11
want [24] 1/11 11/21 17/9 18/21 18/22 19/21 20/2 20/6 27/24 29/17 37/21 39/25 46/4 49/17 49/18 54/16 76/21 79/16 81/12 90/20 94/19 96/4 97/8 99/3
wanted [2] 1/18 103/9
ward [14] 2/19 2/20 8/16 8/20 8/23 9/22 24/5 34/4 55/21 71/19 71/20 71/22 95/14 95/22
was [128]
wasn't [3] 10/17 18/4 90/17
waste [1] 91/1
way [27] 8/14 10/16 11/24 13/12 13/17 13/23 25/2 28/16 28/19 30/8 35/10 35/17 37/6 47/3 50/15 57/21 60/13 60/14 60/23 61/10 61/18 78/9 79/3 82/9 90/9 96/17 98/11
ways [7] 9/4 9/4 9/5 14/3 29/21 89/12 103/16
we [238]
we'd [3] 14/14 17/4 30/6
we'll [5] 5/24 20/4

W

we'll... [3] 96/4 104/24 104/24
we're [19] 5/13 16/14 21/2 29/14 39/9 41/9 41/9 43/7 44/10 50/9 53/13 53/13 53/14 53/14 53/16 54/17 65/13 87/20 102/7
we've [17] 5/22 6/13 17/9 25/4 25/25 26/6 26/12 31/19 31/19 32/19 44/14 48/16 49/24 58/20 82/9 84/12 87/16
website [1] 79/9
week [1] 96/3
well [56] 2/25 4/19 6/9 8/25 9/22 10/2 12/6 13/13 17/4 22/16 22/19 23/18 24/11 25/18 26/1 26/22 26/24 27/8 27/17 30/7 30/19 30/20 32/9 32/21 38/23 43/22 44/3 44/6 45/16 46/6 46/21 47/7 48/25 53/17 54/22 55/11 55/13 58/20 59/8 60/5 60/18 64/6 74/12 74/14 75/8 76/23 81/3 84/14 85/4 88/4 94/4 94/23 97/2 100/12 102/8 104/22
went [2] 58/6 89/4
were [57] 7/13 7/14 7/15 9/2 9/16 9/20 14/10 22/8 24/21 27/8 27/10 35/4 35/5 35/10 35/12 38/24 47/6 47/16 47/23 51/4 51/12 54/11 57/10 57/11 57/16 57/23 58/5 58/12 58/13 62/3 62/6 62/15 62/21 62/25 64/16 64/17 64/18 64/19 67/6 71/5 73/10 73/11 73/15 76/5 77/8 78/19 78/20 79/8 87/17 87/17 87/18 89/7 89/8 89/8 90/23 92/13 102/11
weren't [1] 35/13
Wessely [1] 101/9
Wessely's [1] 57/4
what [159]
what's [25] 10/24 21/25 28/14 31/6 33/16 33/22 49/22 49/25 57/8 63/16 65/13 66/22 68/20 74/13 74/14 75/22 77/15 85/18 88/15 95/25 96/4 98/13 98/14 98/14 103/12
whatever [4] 29/6 41/4 49/19 90/4
when [86] 1/22 8/19 13/10 13/24 14/1 15/7 15/14 15/23 16/4 16/17 16/23 17/12 19/3 22/8 22/11 24/15 25/11 25/19 26/5 26/11 26/11 26/19 28/12 30/12 32/5 34/25 34/25 35/13 35/15 41/9 41/19 42/10 42/21 45/10 45/14 45/20 53/1 53/2 53/10 57/12 57/13 59/8 60/6 61/15 62/5 62/25 64/6 65/3 65/21 66/13 66/24 67/9 69/21 73/14 74/24 75/13 75/14 76/18 78/14 79/5 82/6 86/1 89/5 89/5 89/7 89/8 89/13 89/22 89/24 89/24 90/7 90/12 90/18 90/22 91/1 92/13 93/1 93/17 94/12 95/18 96/1 96/11 96/20 97/15 98/3 98/11
when everyone [1] 42/10
where [28] 2/2 15/9 16/18 18/10 18/12 18/12 18/16 18/18 28/24 32/12 38/24 40/2 40/17 42/1 43/19 45/25 48/1 52/15 55/18 57/8 64/19 69/23 71/3 76/11 82/2 96/3 98/18 101/1
Whereas [1] 84/2
whereby [1] 8/15
whether [7] 53/17 54/7 81/4 81/5 92/1 101/2 101/24
which [44] 2/14 2/14 5/16 7/16 8/14 9/9 9/14 10/5 12/11 14/21 18/3 24/4 27/16 28/8 28/17 30/11 30/25 37/21 42/9 50/8 51/2 51/11 52/11 52/15 54/17 55/2 57/11 58/18 58/18 65/15 66/21 66/25 70/24 71/8 72/21 74/11 74/22 79/23 82/17 86/9 89/17 89/18 90/9 91/1
while [7] 2/15 27/19 34/12 39/9 42/9 45/3 72/17
whistleblowing [1] 85/1
white [8] 62/3 62/7 63/20 64/2 64/3 64/10 64/18 66/7
who [89] 1/12 1/13 5/25 6/10 6/11 8/11 9/11 13/20 14/12 14/13 15/17 21/4 21/6 24/21 25/7 25/13 26/23 28/16 28/18 30/6 32/2 33/11 35/2 35/5 37/25 38/5 40/20 42/8 42/13 44/15 44/25 46/15 47/1 47/1 47/12 48/9 49/20 50/8 50/11 51/22 54/6 55/18 57/23 58/13 58/14 59/14 62/3 66/24 67/1 70/22 71/12 71/20 72/23 72/23 73/13 74/11 74/14 76/21 76/23 77/25 80/7 80/25 91/17 93/23 94/3 94/7 94/15 94/17 94/17 95/2 96/11 96/12 96/12 96/14 96/15 97/19 98/4 98/18 98/22 99/9 99/12 99/22 100/20 101/18 101/20 102/14 103/24 104/12 104/13
who's [2] 17/9 96/13
whole [12] 6/2 8/24 33/10 38/5 53/3 56/2 79/22 83/5 83/8 85/1 85/18 104/7
whom [2] 35/3 47/14
Whose [1] 48/6
why [19] 5/20 14/5 14/7 15/3 16/17 25/23 36/5 42/10 43/3 43/4 46/8 46/9 46/21 46/22 56/20 64/6 66/7 66/25 102/12
widely [1] 36/23
will [62] 2/4 6/20 9/10 12/8 15/8 16/8 19/8 19/20 20/12 23/4 24/13 29/23 30/25 31/5 33/18 33/20 33/21 40/22 42/4 42/25 43/9 44/21 44/22 45/24 48/17 48/18 49/2 49/8 50/10 50/15 51/20 52/3 52/18 54/3 54/4 55/13 68/18 69/2 70/10 71/19 74/10 74/11 79/11 80/9 80/9 81/3 81/6 82/6 82/7 82/8 82/10 84/25 88/2 93/22 95/1 95/2 95/13 97/2 97/3 98/16 104/11 104/13
winter [2] 65/7 65/10
wish [1] 4/12
wishes [1] 40/15
withdrawn [1] 102/11
within [5] 40/7 48/8 69/7 78/3 80/4
WITN0075009 [1] 72/3
WITN0207013 [1] 73/17
WITN0320001 [4] 2/14 34/9 42/16 97/12
WITN0320004 [1] 7/20
WITN0320005 [1] 14/21
WITN0320036 [2] 59/22 68/11
WITN0401001 [1] 30/10
witness [6] 43/23 50/18 86/5 91/12 97/11 97/22
womb [1] 65/3
won [1] 3/9
won't [3] 26/8 42/7 45/18
wondering [1] 65/13
word [1] 37/21
work [25] 3/19 18/10 18/12 18/12 19/7 28/24 29/1 44/11 44/20 47/7 53/12 55/14 59/1 61/16 69/5 69/6 72/10 80/9 82/1 90/3 90/11 90/22 98/18 100/15 104/21
work-life [1] 72/10
worked [2] 2/19 85/11
worker [5] 32/9 32/15 42/11 54/4 54/6
workers [5] 32/11 32/17 42/12 54/4 73/13
workforce [6] 72/4 72/9 72/14 72/15 72/18 73/9
working [23] 4/23 5/7 7/3 8/4 9/1 9/3 9/4 9/4 9/5 16/5 19/24 25/2 26/2 26/2 27/5 30/1 57/5 57/6 58/5 59/3 85/8 103/15 104/19
workloads [1] 72/10
works [7] 27/18 38/3 38/3 80/7 90/4 92/4 100/16
world [4] 24/17 38/10 44/2 44/8
worried [1] 43/7
worry [1] 94/20
worse [2] 35/16 74/17
would [98] 4/19 8/16 8/17 10/15 14/19 14/20 15/20 16/16 16/24 17/4 17/6 21/4 21/7 21/12 21/17 21/18 22/25 23/1 23/20 25/24 25/24 26/1 26/22 26/23 31/3 31/11 31/11 31/12 31/13 31/14 32/2 32/15 32/18 32/23 32/25 33/24 33/25 35/7 35/8 35/8 35/9 39/9 39/14 39/18 39/20 39/25 40/3 40/12 40/14 42/12 42/13 42/22 43/5 43/6 43/11 43/12 44/10 44/10 44/23 46/6 46/13 46/21 47/22 48/12 48/21 49/17 49/18 51/2 51/8 52/20 54/13 54/20 55/11 59/6 63/8 67/25 69/20 69/24 71/13 77/14 79/16 81/11 81/11 81/13 81/20 81/23 82/3 82/19 86/17 87/6 88/5 90/14 91/21 96/3 101/16 102/16 104/7 104/14
wouldn't [3] 43/1 47/17 79/3
written [3] 10/15 10/15 79/3
wrong [1] 27/10

Y

yeah [22] 20/12 21/17 29/12 31/19 33/3 35/23 39/16 42/4 48/23 54/13 56/1 58/25 60/19 69/17 73/15 73/19 87/8 87/13 88/2 88/22 102/3 102/6
year [16] 4/1 13/13 13/18 26/8 31/16 48/15 62/9 62/9 62/10 74/9 74/10 85/13 85/14 86/11 98/10 99/12
years [21] 5/11 24/15 24/24 26/5 37/2 61/6 61/25 63/2 63/14 65/8 65/14 72/14 72/19 73/2 73/7 76/3 78/18 90/23 100/22 101/9 102/7
years' [2] 87/10 87/22
yes [42] 1/9 1/10 2/12 3/21 4/9 11/20 19/4 19/6 19/11 20/4 20/9 23/5 31/11 35/20 36/19 39/16 39/20 41/7 44/1 64/25 68/6 68/10 69/12 72/20 77/3 77/17 77/21 78/2 81/20 84/17 84/17 84/21 85/21 86/20

Y

yes... [8] 88/5 91/8 92/22 92/22 99/2 100/13 101/3 101/24
yet [1] 43/17
you [546]
you'd [8] 1/8 19/25 20/11 21/7 32/22 33/7 34/8 89/6
you'll [6] 9/12 23/25 33/15 52/21 75/1 101/2
you're [38] 2/11 14/1 16/3 16/19 17/14 24/5 28/25 29/6 29/9 35/15 38/1 42/24 43/1 47/22 63/6 65/9 65/10 71/25 74/24 75/6 75/8 76/4 79/5 79/6 83/15 83/21 83/22 84/1 84/8 85/5 87/23 87/25 88/11 89/14 89/25 91/4 98/20 104/2
you've [22] 1/16 15/3 19/22 20/1 26/11 28/7 48/8 79/25 79/25 80/19 80/22 83/1 84/6 86/2 86/8 86/13 88/6 88/15 90/19 99/7 99/25 103/7
young [4] 34/23 35/4 35/5 44/18
your [74] 1/7 1/17 1/17 1/18 2/13 2/16 2/17 3/12 3/18 11/15 15/12 16/23 17/1 19/15 19/20 19/21 20/2 20/11 20/11 20/17 23/17 27/1 27/5 27/7 28/18 30/9 30/11 34/10 34/25 37/14 37/16 42/15 42/25 43/2 45/3 46/18 50/18 53/25 55/8 56/3 57/8 59/22 62/17 62/17 65/21 65/22 72/19 74/23 75/7 75/19 77/9 80/17 82/2 82/2 82/4 82/11 82/13 82/20 83/17 83/21 86/4 87/11 87/22 88/25 89/4 90/14 90/15 91/11 93/25 94/5 97/22 98/21 103/12 104/13
yourself [2] 59/19 101/5
youth [1] 84/5

Z

Zito [1] 77/20