Royal College of Psychiatrists
Exhibits: **RCP/01 – RCP/10**
Dated: 7 August 2026

THE SOUTHPORT INQUIRY

FIRST WITNESS STATEMENT OF PROFESSOR SUBODH DAVE

ON BEHALF OF THE ROYAL COLLEGE OF PSYCHIATRISTS

I, **Professor Subodh Dave,** on behalf of the Royal College of Psychiatrists will say as follows: -

Introductory matters

1. I am the President of the Royal College of Psychiatrists (**RCPsych** or the **College**).

2. I am a Consultant Liaison Psychiatrist in the NHS in Derbyshire. I am Professor of Psychiatry and Head of the Centre of Mental Health at the University of Greater Manchester. I currently serve as President of the Royal College of Psychiatrists, having previously served as Dean.

3. I have held a number of leadership positions in healthcare and medical education, including National Clinical Adviser for the Community Mental Health Framework, which supported the development of the programme that secured £3.5 billion of investment for community mental health transformation.

4. My expertise in medical education has been sought internationally, and I have contributed to curriculum development, assessment design and educational evaluation in Hong Kong, Singapore, India, Sri Lanka, Australia and the United Kingdom.

5. Throughout my career I have developed a number of innovative educational initiatives, including one of the world's largest Expert Patient Teacher Programme,

the toolkit for which was launched in the House of Lords. During my time as Dean of the Royal College of Psychiatrists, I led the development of the College's first Diploma in Old Age Psychiatry, its first Certification Programme in Public Mental Health Leadership, its first Digital Literacy Framework for Psychiatrists and Dean's Grand Rounds, an initiative designed to bridge the gap between evidence and clinical practice that now attracts thousands of psychiatrists from around the world.

6. I have a longstanding interest in workforce development and health inequalities and have advised national organisations including the British Medical Association and the General Medical Council. I have authored more than fifty peer-reviewed publications and numerous educational programmes, and I serve on the Advisory Board of the Centre for Research Equity at the University of Oxford.

7. My work has been recognised through a number of awards, including Psychiatrist Educator of the Year and Doctor of the Year. I was also named a Rising Star in the Health Service Journal's list of the 50 most influential Black, Asian and Minority Ethnic leaders in health.

8. I am a Trustee of the charity Doctors in Distress and have raised thousands of pounds to support the prevention of suicide among healthcare professionals. I founded the 'Dr1in4' initiative, which brings to life doctors' lived experience of mental illness.

9. This witness statement is made to assist the Southport Inquiry (the **Inquiry**) with the matters set out in the Rule 9 request dated 10 July 2026 (the **Rule 9 request**) and with reference to the Terms of Reference.

10. This statement has been prepared with the assistance of RCPsych's legal representatives, Bates Wells and Braithwaite LLP. Some matters within this statement are within my own knowledge, and others prepared with the assistance of RCPsych's appointed members and staff. Where matters are not within my own knowledge, I have identified the source of my information or the basis for my belief.

Background – the Royal College of Psychiatrists

11. RCPsych is the professional medical body responsible for supporting psychiatrists. It works to secure the best outcomes for people with mental illness, intellectual disabilities and developmental disorders by promoting excellent mental health

services, supporting the prevention of mental illness, training outstanding psychiatrists, promoting quality and research, setting standards and being the voice of our members and the profession.

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

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

14. The College:

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

15. Through these functions, RCPsych seeks to ensure psychiatrists and multidisciplinary teams across NHS and independent services are equipped to deliver safe, effective and rights-based care.

16. RCPsych does not commission, regulate or inspect services; those responsibilities sit with commissioners, providers and regulators. Its role is to set and support professional and service standards and to provide education, guidance and quality improvement infrastructure.

17. While the College develops evidence-based guidance and quality standards, RCPsych does not have powers to mandate adherence to them or to monitor compliance across services. Implementation of professional guidance is influenced by local commissioning decisions, workforce capacity, service configuration and organisational priorities.

18. RCPsych plays an important leadership role in promoting evidence-based practice and supporting quality improvement, but the College's ability to influence clinical practice depends upon the wider health and care system providing the necessary workforce, infrastructure and resources to enable those standards to be consistently delivered in practice.

The role of the President of RCPsych

19. As President of RCPsych, my role is to set the vision for the College and lead on driving improvements in access, experience and outcomes for people with mental illness in the UK and across the world.

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

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

22. As President, I have the responsibility of chairing meetings of Council and the Board of Trustees, and ensuring that they follow the Charter, Bye-Laws, and regulations. I was elected in 2026 and hold this role until June 2029.

Violence Fixated Individuals

23. RCPsych is aware of the use of the relatively novel term Violence Fixated Individuals (**VFI**) within some policy, security and operational contexts. While the term VFI may have utility in other settings, the College does not recognise VFI as a clinically valid or reliable psychiatric term. It is neither a recognised psychiatric diagnosis nor a clinically validated definition, and there is currently no robust evidence to support its use as a distinct category of individuals. Diagnostic categories are not set by the College but by the World Health Organization as part of their International Statistical Classification of Diseases and Related Health Problems (**ICD**).

24. RCPsych is concerned that the term VFI may inadvertently be interpreted by non-health agencies as representing a recognised clinical condition or diagnosis. Our previous experience with similar terms, such as Dangerous and Severe Personality Disorder (**DSPD**), is that there are risks with creating labels that become widely adopted in practice despite lacking a sound clinical or diagnostic basis. Such terminology can lead to misunderstandings and the conflation of separate groups of people. For example, the introduction of the DSPD category led to a costly programme intended to prevent crime by a small number of people which showed negligible positive impact. It undermined principles of medical ethics by encouraging 'warehousing' of people rather than providing effective treatment. The term VFI has similarities with DSPD nomenclature, although it is worth noting that though DSPD had no clinical validity it was a classification of a mental disorder (personality disorder) whereas VFI is not.

25. The concept of VFI also appears to combine several overlapping but distinct phenomena, including grievance-fuelled violence, stalking, fixation, and interest in extreme violence or mass casualty events. These phenomena have different psychological, behavioural and clinical characteristics and should not be assumed to represent a single, coherent or evidence-based construct.

26. Where there is a need to describe an individual's apparent preoccupation with extreme violence or mass casualty events, the College considers it preferable to

refer to violence-fixated *behaviours* (**VFB**) rather than violence-fixated *individuals*.[1] This behavioural framing describes observable patterns of behaviour or presentation without implying the existence of a stable or enduring personal characteristic or diagnostic category. It also better reflects the fact that such behaviours may change over time and in response to circumstances or intervention, rather than representing an immutable trait. We also would like to emphasise that neither VFI nor VFB should be regarded as synonymous with any recognised psychiatric diagnosis or personality disorder. They should not be equated with antisocial personality disorder, as there is no evidence that violence-fixated behaviours are specific to, or define, that disorder.

27. Any use of this terminology should be clearly presented as descriptive and operational rather than clinical or diagnostic, and discussions of psychiatric risk assessment should continue to be grounded in established psychiatric assessment, formulation and the best available empirical evidence.

Identification and management of VFIs

28. As set out above, the College does not recognise VFIs as a clinically reliable psychiatric term. There have been no publications by RCPsych on this topic reflecting the fact there is no empirical validity to the term VFI.

29. The College has not undertaken any data-based or statistical analysis of the risk posed by VFIs, nor into the prevalence of VFB in individuals with certain characteristics or diagnoses, for the same reason.

The Mental Health Act 1983 and other legal powers

Mental Health Act 1983 (as amended by Mental Health Act 2025) and VFI

30. The Mental Health Act 1983 (**MHA**) creates provision for the reception, care and treatment (including powers of detention and assessment) of mentally disordered patients. "Mental disorder" means any disorder or disability of the mind and is defined according to statutory criteria.[2]

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[1] For clarity, the College does not use either term (VFI or VFB) in clinical practice at all. If fixation on mass casualty events is part of mental illness, the College refers to the mental illness diagnosis. Generally, RCPsych only uses recognised psychiatric terms from diagnostic manuals such as ICD. AR, in the absence of a mental illness, would have had his ASD diagnosis referred to in clinical notes.
[2] Section 1(2) Mental Health Act 1983.

31. The MHA applies to individuals on the basis of the presence of a mental disorder and the statutory criteria set out in the legislation, not on the basis of operational or descriptive labels such as VFI. As VFI is not a recognised clinical diagnosis or a recognised mental disorder, the term has no independent legal or clinical significance within the MHA.

32. The Mental Health Act 2025 amends the MHA framework for compulsory assessment / detention and related criminal justice powers. The amendments to section 1 of the MHA (not yet in force) include definitions of "autism", "learning disability", which are excluded from the definition of "psychiatric disorder".[3] The amendments are coming into force in phases through commencement regulations on dates to be appointed.

33. The Mental Health Act 2025 amendments describe a learning disability as having "serious behavioural consequences" if it is associated with "abnormally aggressive or seriously irresponsible conduct by the person". However, the Mental Health Act 2025 does not create any specific provisions relating to individuals described as VFI, nor does it alter the legal position for this group. The reforms apply generally to all individuals who may fall within the scope of the MHA and do not establish VFI as a recognised clinical or legal category.

34. Mental health services assess and treat people on the basis of identified mental health need. Individuals who do not have a mental disorder requiring assessment or treatment would not ordinarily come under the care of mental health services simply because they have been identified through security, policing or other operational processes.

35. Where an apparent fixation on extreme violence or mass casualty events forms part of the presentation of a recognised mental disorder, this should be assessed and managed within established psychiatric frameworks. If the statutory criteria for detention are met, the MHA provides the appropriate legal framework for assessment and treatment. However, the presence of violence-fixated behaviours alone does not constitute a mental disorder and cannot, in itself, justify the use of the MHA.

[3] See further paragraph 54 setting out the College's concerns in respect of these clinical definitions.

36. The College also notes that the presence of conditions such as autism spectrum disorder should not be conflated with violence-fixated behaviours. Autism is not synonymous with VFI or VFB, and where violence-fixated behaviours occur in an autistic person, they should not be assumed to arise from, or be explained by, the autism itself. As with any individual, decisions regarding assessment and treatment under the MHA must be based on the person's mental disorder, their clinical presentation, and whether the statutory criteria are met.

Management of individuals who pose a risk of harm

37. Mental health legislation is not designed to manage risk (for example because of an individual's known history or an identified fixation on violence) in the absence of mental disorder, and any intervention under the MHA must be based on the statutory criteria rather than concerns about dangerousness alone.

38. Where there is sufficient evidence to suspect that a mental disorder may be present, an MHA assessment can be requested, even where a formal psychiatric assessment has not previously been possible because the individual is unwilling to engage. A confirmed diagnosis is not required before an assessment is undertaken. Rather, the medical recommendations supporting an assessment to consider (i) detention or (ii) assessment once detained must provide reasonable evidence that a mental disorder may be present and that the statutory criteria warrant consideration. If, following assessment, the legal criteria are met, detention under section 2 of the MHA remains available to allow assessment and, where appropriate, the initiation of treatment under section 3. These provisions are not substantially altered by the Mental Health Act 2025.

39. Convening an MHA assessment can be valuable even where detention does not ultimately occur. The process provides an opportunity for information to be brought together from multiple agencies, enabling a more comprehensive understanding of the individual's presentation, level of risk, previous history and current circumstances. This multi-agency approach is often essential where individuals have withdrawn from services or where no single organisation has a complete picture of the concerns.

40. However, where there is insufficient evidence to suspect a mental disorder, or where the statutory criteria are not met, the MHA cannot and should not be used as a

mechanism for investigating or managing risk. In those circumstances community psychiatrists cannot act unilaterally. Instead, the response should be coordinated through the wider safeguarding and public protection systems. Depending on the circumstances, this may include safeguarding procedures, Multi-Agency Safeguarding Hubs (**MASH**), Multi-Agency Public Protection Arrangements (**MAPPA**), police involvement where appropriate, and close collaboration between health, social care and other statutory partners. Effective information sharing and joint risk management are often critical in these situations.

41. Particular challenges can arise during the transition from child and adolescent to adult services. Young people who are approaching their eighteenth birthday may remain the subject of significant multi-agency concerns despite the ending of many child protection processes. Careful transition planning and continuity of multi-agency communication are therefore crucial to ensure that emerging risks are appropriately managed and that responsibility does not become fragmented as legal and service frameworks change.

Current legislative framework

42. The legal powers available to manage an individual depend on the circumstances giving rise to concern and the relevant statutory framework. Where an individual has a mental disorder and the statutory criteria are met, the MHA provides the appropriate legal framework for assessment and, where necessary, detention and treatment. Where an individual has committed, or is suspected of having committed, a criminal offence, the appropriate response lies within the criminal justice system and the powers available to the police and courts.

43. Where neither the statutory criteria for detention under the MHA are met nor a criminal offence has been committed, there are generally no equivalent legal powers to detain adults solely on the basis of concerns about potential future risk. This reflects the principle that compulsory detention should only occur where there is a clear legal basis provided by Parliament.

44. For children and young people under the age of 18, there may, in limited circumstances, be powers available under the Children Act 1989 to support safeguarding and protection. However, these powers have a different purpose from the MHA and are not designed as substitutes for mental health legislation. Their

application will depend on the individual circumstances of the case and should be considered within the wider safeguarding framework (see paragraph 40 above).

45. The College considers that the existing legal frameworks governing mental health, criminal justice and safeguarding should continue to apply according to their established statutory purposes, rather than creating new powers linked to an operational or descriptive category such as VFI.

46. RCPsych would be concerned by any proposal to introduce legislation that could result in long-term preventative detention on the basis of an individual's perceived future risk or the commission of a criminal offence. Current methods of violence risk assessment cannot predict long-term individual risk with sufficient accuracy to justify such an approach, and legislation should continue to reflect the principles of necessity, proportionality and evidence-based decision-making.

47. We are particularly concerned that, if the term 'Violence Fixated Individuals' were to become widely used as though it represented a recognised clinical category, there is a risk that it could evolve into a quasi-diagnostic label. This could create pressure for legislative responses that are based on an unvalidated construct rather than established psychiatric knowledge. As previously noted, we do not recognise VFI as a clinically valid diagnosis or reliable clinical category and consider it important that operational terminology should not acquire unintended legal or clinical significance.

48. More broadly, the College has expressed concerns regarding aspects of the Mental Health Act 2025 reforms affecting people with learning disability, and autistic people, and will continue to engage with the UK Government on the implementation of those changes. Details of these concerns can be found below (from paragraph 54). However, those issues are distinct from the question of VFB and should not be conflated.

49. Overall, the College's view is that any future legislative developments should remain firmly grounded in established legal principles, recognised psychiatric practice and the best available evidence, rather than creating new statutory powers in response to an operational label that lacks clinical validation.

Mandatory detention and assessment

50. Where an individual does not have a mental disorder within the meaning of sections 2(2) or 3(2)(a) of the MHA, there is no legal power permitting a psychiatrist to detain or assess that person on a mandatory basis. This is irrespective of whether they may pose a risk of harm to others (for example because of a fixation on violence). Psychiatrists should not be involved in detaining those considered to be a risk where there is no mental disorder within the meaning of the mental health legislation (or where that mental disorder is not of the requisite nature or degree). That said, recommending an assessment under the MHA does not mean that the individual *will* meet the statutory criteria, but that in the clinician's view an assessment is required to determine whether the criteria is met. Similarly, not every case where an individual presents with a mental disorder and meets the criteria for detention will result in detention. It involves an assessment of the most appropriate method for managing and/or treating the needs of that individual.

51. The College does not consider there to be a gap in the mental health legislative framework in this respect, due to the risks set out above of creating long term preventive detention (paragraph 46). Mental health legislation should only allow for the detention of people with a mental disorder of the requisite nature or degree. The Children Act 1989, Mental Capacity Act 2005, and criminal justice legislation provide a broader framework supported by multi-agency working (which is of variable effectiveness, see further from paragraph 97).

52. The College considers that the question of legislative change is not primarily an issue for mental health services or psychiatrists. This is more a social policy question of whether we want to incarcerate people who are 'fixated' on mass casualty or extreme violence, in relation to which we imagine elected representatives might take into account factors including harm reduction, prevalence, length of incarceration, human rights complexities of indefinite detention for public protection, cost et cetera. It is unwise to think that psychiatry can predict long term very rare events. Making the MHA more robust would not necessarily address the risks which arose in this context. Any legislative changes that are perceived as necessary should not be mental health legislation changes.

Legislative treatment of Learning Disability and Autism

53. There are circumstances where detention for assessment can be on the basis of autism (as a mental disorder) under the MHA, in its current form and after

amendment by the Mental Health Act 2025, if the statutory criteria are met. However, after the Mental Health Act 2025 changes are implemented, this will not be the case under section 3 of Part 2 of the MHA. The College has substantial concerns, which it raised with the Department of Health and Social Care, regarding the reforms to the provisions on learning disability and autism in the Mental Health Act 2025, which are summarised below.

54. During the passage of the Mental Health Bill 2025,[4] the College submitted written evidence setting out its concerns in respect of the clinical definitions of Learning Disability and Autism introduced and their applicability in the context of admission and detention (**RCP/01**). **RCP000002**

55. The College also previously made a submission to the Joint Committee on the Draft Mental Health Bill which, in 2023, made the following recommendation:

"We recommend there should be provision by which detention can be continued after the 28-days allowed under Section 2 of the Mental Health Act for people with learning disabilities or autistic people in tightly defined exceptional circumstances. This should only be available if pre-authorised by a specialist Tribunal comprising individuals with an understanding of learning disabilities or autism. The time-period should be determined in the Tribunal and subject to regular review by the same Tribunal. The conditions which constitute "exceptional circumstances" should be defined in the Code of Practice; we envisage they might include particularly complex presentations where further assessment beyond 28 days is needed."

56. In the spirit of this recommendation, and in the hope of mitigating many of the concerns detailed above, the College proposed the following amendment to the Bill during its passage through the House of Lords (**RCP/02**): **RCP000003**

"After Clause 4

insert the following new Clause—

"Treatment for autism or learning disability

(1) The Mental Health Act 1983 is amended as follows.

[4] Now Mental Health Act 2025, amending the MHA.

(2) After section 3 (admission for treatment) insert—

"3A Admission for treatment: autism or learning disability

(1) An application for admission for treatment under section 3 may only be made in respect of a patient with autism or a learning disability with the approval of the appropriate tribunal.

(2) An application for approval may only be granted by the appropriate tribunal in exceptional circumstances.

(3) The appropriate tribunal may when granting an application for approval set a duration of authority to detain which is shorter than that provided for in section 20(1)."

(3) After section 20 (duration of authority) insert—

"20ZA Duration of detention: autism or learning disability

(1) A patient with autism or a learning disability admitted to hospital in pursuance of an application for admission for treatment may not be detained further in the absence of a further application for approval from the appropriate tribunal.

(2) An application for approval may only be granted by the appropriate tribunal in exceptional circumstances.

(3) The appropriate tribunal may when granting an application for approval set a duration of authority to detain shorter than that provided for in section 20(2)(a).

(4) Section 78 applies to the making of procedural rules by the Mental Health Review Tribunal for Wales for applications for approval under subsection (1)."

(4) In section 118 (code of practice), in subsection (1), at end insert—

"(c) for the guidance of the appropriate tribunal as to the meaning of "exceptional circumstance" for the purposes of section 3A and section 20ZA.""

Member's explanatory statement

The purpose of this amendment is to address concerns about the needs of some people with learning disabilities who pose a considerable risk in the community and require supervision and treatment but will not be managed safely in the community, and yet have no formal ancillary diagnosis."

57. This amendment was not moved, but it still reflects some of the College's existing concerns and thoughts on mitigating potential risks of the applicability of the legislative framework as amended by the Mental Health Act 2025.

Neurodevelopmental conditions (ASD) and assessment of risk

58. Neurodevelopmental conditions such as Autism Spectrum Disorder (**ASD**) form an important part of the overall clinical assessment and inform the formulation of an individual's presentation, vulnerabilities, communication needs, behaviours and risks by psychiatrists.

59. It is important to note that ASD is not an illness and therefore not treatable in itself. Treatment can include interventions for manifestations and ancillary presentations of the disorder, including intrusive thoughts, anxiety et cetera.

60. The principal challenge is not the recognition of neurodevelopmental conditions during MHA assessments, but the availability of appropriate services following assessment.

61. Waiting times for autism assessment are often unacceptably long, and post-diagnostic support for individuals and their families is frequently limited or absent. Many people experience a marked reduction in available support following diagnosis, with significant variation in the provision offered by health services, local authorities and social care. Addressing these gaps is important in its own right and may also improve opportunities for early intervention where individuals have complex or overlapping needs.

62. Where there are concerns about an individual with a diagnosed or suspected neurodevelopmental condition posing a risk of serious harm to others, effective management requires a coordinated multi-agency response. No single organisation is likely to hold all the relevant information or possess all the necessary powers to manage the risks involved. The College therefore supports a model in which agencies work together within established multi-agency frameworks, with a clearly identified lead agency responsible for coordinating assessment, information sharing, risk management and ongoing oversight. This will vary between cases and should be determined on an individual basis depending on various factors, such as severity of the diagnosed condition, rather than by applying a single model to all presentations. Existing arrangements, such as those used within Prevent and Multi-

Agency Public Protection Arrangements (**MAPPA**), provide well-established examples of how coordinated multi-agency working can support the management of complex cases while ensuring that each organisation acts within its statutory responsibilities. In AR's case, had a MHA assessment not resulted in detention, that would have been an opportunity to escalate and retain AR on the CAMHS caseload, or to discharge back to GP care, but with a referral to another identified agency to take the lead. It is important that in cases where a person is discharged back to the care of their GP, there is clear route to re-assessment and referral back into mental health specialist services if required.

Link between ASD and violence fixated behaviour

63. There is no evidence to support a causal relationship between ASD and susceptibility to violent extremism or VFB. Any apparent overrepresentation in Prevent referrals is more likely to reflect a range of interacting factors rather than autism itself increasing the risk of serious violence.

64. Possible explanations for an apparent overlap include improved recognition and diagnosis of autism across health, education and social care; increased awareness of neurodevelopmental conditions among professionals making referrals; and broader multi-agency training, leading to greater identification of autistic individuals who may be experiencing vulnerabilities. In addition, Prevent and Channel processes increasingly consider cases involving concerning behaviours without a clear ideological driver, which may contribute to changes in the profile of referrals.

65. The increasing prevalence of online harms is also likely to be relevant. Some autistic children and young people may be particularly vulnerable to exposure to harmful online content, including extremist material or graphic violent content without an ideological component.

66. It is therefore important that professionals avoid assuming that autism is a predictor of violence or extremism. Assessments should remain individualised, formulation-based and informed by the person's broader clinical, developmental and social context.

Striking a balance between protective practice and upholding patient rights

67. Under existing mental health legislation, there is no legal barrier to the assessment and detention of individuals with a mental disorder where the statutory criteria are met, including where this is necessary because of the risk of harm to others. At the same time, the MHA incorporates important safeguards, including independent medical recommendations, statutory oversight and rights of appeal, to ensure that compulsory powers of assessment and detention are exercised lawfully, proportionately and only where justified.

68. In the College's view, the principal challenges do not arise from deficiencies in the legislation itself but from the practical realities of implementation. Mental health services continue to face significant workforce shortages, increasing demand, pressures on inpatient capacity and variable access to community services. These operational pressures can affect the timely assessment and treatment of people with serious mental illness and are likely to have a greater impact on patient and public safety than the legal framework itself. We would therefore caution against assuming that legislative reform alone can address the issues highlighted by cases involving serious violence.

69. RCPsych also recognises that the application of the MHA is influenced by evolving professional practice and wider societal attitudes. The principle of using the least restrictive option is an important safeguard and should remain central to clinical decision-making. However, it should not be interpreted as meaning that all restrictive interventions are undesirable. The appropriate question is whether any restriction is proportionate to the individual's clinical needs and the risks identified through careful assessment and formulation. In some circumstances, timely use of compulsory powers may represent the least harmful and most clinically appropriate course of action for both the individual and the wider public. We therefore consider it helpful to emphasise the importance of proportionate restrictions rather than viewing restriction as something that should always be minimised irrespective of the circumstances.

70. The Mental Health Act 2025 introduces significant reforms, the full implications of which will depend on the accompanying Code of Practice (currently being developed) and how the revised detention criteria are interpreted and implemented in practice. It is therefore too early to draw firm conclusions about the operational impact of those changes. However, the College recognises that there are differing professional views regarding aspects of the reforms and that there is a need for

clear guidance to support consistent decision-making. Careful implementation will be essential to avoid unintended consequences, including variability in practice or an increase in defensive decision-making that does not necessarily improve patient care or public safety.

Identification, assessment and management of 'VFIs'

71. The MHA is designed to provide a legal framework for the assessment and treatment of people with a mental disorder where the statutory criteria are met. As we have previously stated, VFI is not a recognised clinical term, diagnosis or mental disorder, and we would not expect the legislation or supporting statutory guidance to create specific provisions for an operational or descriptive label.

72. Psychiatrists do not use specific tools to assess VFI because VFI is not a recognised psychiatric diagnosis or clinical condition. Psychiatric assessment tools are designed to identify and assess mental disorders and, where appropriate, to inform clinical judgement about risks associated with those disorders. They are not intended to assess an operational category such as VFI.

73. More broadly, no currently available risk assessment tool is capable of predicting serious interpersonal violence at an individual level with sufficient precision to support clinical or legal decision-making in isolation. Clinical judgement, informed by comprehensive assessment and formulation, therefore remains essential.

74. Where an individual presents with VFB, the psychiatrist's role is to assess whether those behaviours occur in the context of a mental disorder and, if so, to undertake a comprehensive clinical assessment, formulate the case, and consider the associated risks. Psychiatrists may use established approaches to the assessment of suicide risk, violence risk and other relevant clinical risks as part of that process. However, these assessments are undertaken within the context of recognised mental disorders and should not be regarded as tools for identifying or assessing VFI itself.

75. Where VFB occur in the context of a mental disorder, the existing provisions of the MHA are available where the statutory criteria for compulsory assessment or treatment are satisfied. In these circumstances, the focus of psychiatric care should be on the assessment and treatment of the underlying mental disorder, together with a comprehensive assessment and management of risk. Effective management of

any risk to others is also likely to require coordinated multi-agency working involving health, social care, policing and other relevant organisations.

76. Conversely, where an individual does not have a mental disorder, the MHA should not be used. Mental health legislation should not be extended to permit compulsory assessment or detention solely because an individual displays VFB or is considered to present a risk of future violence. The statutory threshold for intervention under the MHA is, and should remain, the presence of a mental disorder together with the legal criteria for compulsory powers.

77. It is also important to recognise that many individuals who display VFB will not have a mental disorder and may never come into contact with NHS mental health services. In such cases, psychiatric assessment tools are unlikely to be applicable, and mental health services may have no clinical role unless there is reason to suspect the presence of a mental disorder.

78. This does not mean that professionals are unable to act where serious concerns exist. Psychiatrists and mental health services can assess individuals where there is reason to suspect a mental disorder, even if that has not yet been formally diagnosed. Where no mental disorder is identified, or the statutory criteria are not met, other legal and professional responsibilities remain relevant.

79. Where concerns arise about VFB, effective assessment and management are therefore likely to require a coordinated multi-agency approach. Information relevant to risk may be held across health services, policing, education, social care, security agencies and other organisations, and no single agency is likely to possess a complete understanding of the individual's circumstances. Robust information sharing, joint assessment and coordinated risk management are therefore likely to be more effective than reliance on any single assessment tool or professional discipline. The management of such cases should be understood as a multi-agency responsibility rather than one that can or should be addressed solely through mental health legislation.

Mental health assessment and criminality

80. The fundamental considerations for mental health services do not change simply because an individual has committed a criminal offence. The determining factor for psychiatric assessment and intervention is whether the individual has a mental

disorder and whether there is a mental health need that falls within the remit of NHS mental health services. The commission of an offence, in itself, does not establish the presence of a mental disorder, nor does it alter the statutory criteria under the MHA.

81. Where an individual has committed a criminal offence and there is reason to suspect the presence of a mental disorder, psychiatrists will assess and manage that individual in accordance with established clinical and legal frameworks. If the statutory criteria are met, the MHA provides the appropriate powers for assessment and treatment. Conversely, where there is no mental disorder, responsibility for managing offending behaviour rests primarily within the criminal justice system rather than mental health services.

82. The commission of a violent offence may, however, have practical implications for how risk is managed. Offending behaviour is more likely to be identified, recorded and shared through criminal justice systems, and this can facilitate a more coordinated multi-agency response involving policing, probation, health and other relevant agencies. Such arrangements may provide a more comprehensive understanding of the individual's history and current risks, although effective information sharing and collaboration remain important irrespective of whether a criminal offence has occurred.

83. The College is not aware of any validated UK-based assessment tool that has been specifically developed to identify or assess individuals described as VFI or to predict risks associated with violence-fixated behaviours. Assessment of any associated risks should therefore continue to rely on comprehensive clinical assessment, formulation and, where appropriate, coordinated multi-agency risk management.

Identification of risk posed by VFIs

84. The College considers that identification of risk posed by individuals displaying VFB could be improved as follows:

    a. Develop a shared understanding across agencies of VFB and avoid over-reliance on terms such as VFIs which are not rooted in clinical diagnoses (see above from paragraph 24). There should be greater consistency in how

relevant behaviours are recognised and described across health, policing, education, social care and other agencies.

b. Use the term "violence-fixated behaviours" rather than "Violence Fixated Individuals". Referring to behaviours rather than individuals emphasises that these are observable presentations that may change over time, rather than stable or enduring personal characteristics.

c. Adopt a descriptive approach to behaviours. Any framework should describe patterns of behaviour rather than seek to define a new category of individuals. This will reduce the risk that an operational description is inadvertently interpreted as a psychiatric diagnosis or quasi-diagnostic label.

d. Develop a common multi-agency framework for assessment and risk management. Agencies should work from shared principles and processes for assessing concerns, sharing information and coordinating interventions. This should focus on structured professional judgement and multi-agency decision-making rather than reliance on any single assessment instrument.

e. Ensure that any assessment framework is evidence-based and validated for the UK population. We would caution against developing new assessment tools without a robust UK empirical evidence base, as such tools would lack appropriate validation. Equally, assessment instruments developed in other jurisdictions should not be adopted wholesale without demonstrating that they are valid and reliable in UK populations.

f. Avoid rigid thresholds within any assessment framework. If structured assessment tools are used, they should inform rather than determine professional judgement. Reliance on fixed cut-off scores may create artificial thresholds that exclude individuals who require intervention while giving a misleading impression of precision and consistency.

g. Identify a clear lead agency for each case. Responsibility for coordinating assessment and management should rest with the agency best placed to address the individual's primary needs and risks. This will vary between cases

and should be determined on an individual basis rather than by applying a single model to all presentations.[5]

h. Build on existing multi-agency arrangements. Wherever possible, existing frameworks such as MASH and other established partnership arrangements should be used rather than creating new structures. These mechanisms already support information sharing and coordinated decision-making, although it is important to recognise the limitations of individual frameworks.

i. Develop appropriate multi-agency training. Once there is greater consensus regarding the description and management of VFB, training should be developed across relevant sectors. This should reinforce the distinction between behavioural descriptions and psychiatric diagnoses, clarify the respective responsibilities of different agencies, and promote consistent approaches to assessment, information sharing and risk management.

Single, central accessible tool for risk assessment

85. We do not support the introduction of a single risk assessment tool for VFB. There is no agreed definition of VFB, nor is there a validated evidence base from which such a tool could be developed. We would therefore have concerns about introducing a tool that has not been developed and validated for the UK population.

86. Instead, we support the development of a shared multi-agency risk assessment framework that enables consistent information sharing, structured professional judgement and coordinated decision-making across agencies. Any future assessment tool should be developed from robust empirical evidence, validated in UK populations, and designed for a clearly defined purpose before being implemented.

87. Within healthcare, we continue to support evidence-based approaches to violence risk assessment based on structured professional judgement rather than unvalidated actuarial tools. RCPsych has established guidance which provides a framework for assessing and managing risk to others within mental health services (**RCP/03**). **RCP000004** However, the College recognises that there may be a requirement for updated, multi-sector/profession guidance and a shared framework in the near future.

[5] RCPsych agrees with Dr Irani's report (**DRI000001-2)** paragraph 3.8.4 in this respect.

88. A shared framework could improve consistency, communication and information sharing between agencies, reducing duplication and supporting more coordinated risk management. Conversely, a single tool risks oversimplifying complex presentations, creating false reassurance, and being applied outside the context for which it was developed. Without a robust evidence base and UK validation, it may also result in inaccurate or inconsistent assessments.

89. RCPsych therefore does not consider it practicable for a single assessment tool to be used across all organisations. Different agencies have distinct statutory responsibilities, legal powers and information available to them. For example, healthcare services require approaches that assess risk in the context of mental disorder and clinical management, while other agencies will focus on safeguarding, public protection or criminal justice considerations. A common multi-agency framework, supported by agency-specific assessment methods where appropriate, is likely to be more effective than a single universal tool.

Training for psychiatrists on VFIs

90. There is currently no specific training for psychiatrists on VFIs, and the College does not consider that there should be training based on VFI as though it were a recognised psychiatric diagnosis or clinical category. As previously stated, VFI is not a mental disorder or a clinically validated construct, and training should not reinforce the perception that it represents a distinct diagnostic entity.

91. Psychiatrists already receive training in the assessment and management of risk to others as part of their professional education and continuing clinical practice. This includes structured professional judgement approaches to violence risk assessment, undertaken in the context of recognised mental disorders and informed by comprehensive clinical assessment and formulation. The College's guidance on *Rethinking risk to others in mental health services* (**RCP/03)** provides the current **RCP000004** principal framework for the assessment and management of risk to others within mental health services. The College is in the process of establishing a process either for revision or for producing a new style of guidance and is in contact with NHSE regarding producing future guidance.

92. A range of validated assessment tools may also be used where clinically appropriate, including the Structured Assessment of Violence Risk in Youth (**SAVRY**) RCP000005 (**RCP/04**) and the Historical Clinical Risk Management-20 (HCR-20V3) (**RCP/05**). RCP000006 There is no version of SAVRY validated for ASD, but it can be used alongside other tools such as the Framework for Assessment of Risk and Protective Factors in Autism Spectrum (**FARAS**) (**RCP/09**). These approaches support clinical decision- RCP000010 making but are not designed specifically for VFB or the operational category of VFI, nor are they designed for use in the absence of a mental illness. Additionally, CAMHS services will not have training in, nor the time or resource to use specialised risk assessment tools necessitating referrals to Forensic Child and Adolescent Mental Health Services (**FCAMHS**) (see further paragraph 105 below).

93. There is, however, scope to strengthen existing training. We consider it would be more appropriate to strengthen education on the identification, assessment and management of violence-fixated *behaviours* within established clinical and multi-agency frameworks than a new category of VFI. This should include greater awareness of behavioural indicators, structured professional judgement, emerging patterns of concern, appropriate referral and escalation pathways, and effective information sharing and multi-agency working. Increased awareness of established arrangements such as Prevent, MAPPA, MASH and other public protection frameworks would help psychiatrists understand how mental health services contribute to wider societal risk management. Joint multi-agency training would help develop a shared understanding of roles and responsibilities and promote more consistent management across services. The College can play an important role in supporting and disseminating training in these areas.

Training for psychiatrists addressing the impact of neurodevelopmental conditions on risk

94. Current psychiatric training covers the assessment and management of neurodevelopmental conditions, including autism and attention deficit hyperactivity disorder (**ADHD**), and the importance of considering an individual's neurodevelopmental profile during clinical assessment and formulation. However, there would be value in strengthening training on how neurodevelopmental conditions may influence the presentation of VFB, communication, vulnerability, engagement with services and multi-agency risk management. Such training should reinforce that neurodevelopmental conditions are not, in themselves, predictors of violence or serious offending.

Multi-agency Arrangements

Information sharing

95. There exists already a framework for sharing concerns about risk of serious harm or death. Please refer to:
    a. NHS Code of Practice on confidentiality (**RCP/06**) RCP000007
    b. GMC Confidentiality: good practice in handling patient information (**RCP/07**) RCP000008
    c. RCPsych Good Psychiatric Practice: Confidentiality and Information Sharing (3rd edition) (CR209 Nov 2017) (**RCP/08**) RCP000009

96. As set out in evidence to other statutory public inquiries, RCPsych considers that the key barriers to the effective sharing of information about risk include a lack of interoperability in respect of digital patient records between agencies. At present, the agencies involved (such as different mental health trusts; physical health trusts; primary and secondary care; ambulance services; other non-health agencies, such as the Police, Local Authorities, Social Services, Voluntary Community and Social Enterprise services and Housing) do not have digital record systems that can 'speak to' each other. Understandably, this impacts the ability for these agencies to share information effectively, and corroborating information is vital to utilise risk assessment tools such as SAVRY effectively.

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

Multi Agency Public Protection Arrangements (MAPPA)

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

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

RCP000011

100. The MAPPA Guidance (April 2024) (**RCP/10)** is clear that confidentiality is limited and if there is thought to be a serious risk posed to others, confidentiality can be breached and the information shared in line with the MAPPA framework. This stipulates that consent is not needed where it is lawful, proportionate, required to protect the public and focused on managing identified, specific risks. While there is not a defined list, the type of risks include factors such as previous behaviour and offending history, current/recent presentation and behaviour, factors that increase risk (such as substance use or social isolation), information on compliance and engagement with services, specific threats or communications, and specific information held by agencies such as that relevant to risk of harm or concerning behaviour.

101. In the case of under 18s where parents withhold, withdraw or manipulate their consent to information sharing, this would be managed through the Children Act 1989 with referrals to social care and, if necessary, the child becoming a 'looked after child'. When a child is a 'looked after child', the information sharing processes are very robust. However, if the child does not meet this criteria, social worker shortages can lead to multi-agency meetings without all the right attendees. If parents or legal guardians refuse to consent to, or obstruct, a child's engagement with mental health or other services this can create a scenario where the child 'slips through the net'.

102. RCPsych has been asked to comment on the Counter Terrorism Clinical Consultancy Service **(CT CCS)** model, and whether it has improved co-working and information sharing between the NHS and counter-terrorism specialists. In the College's view the CT CCS model has limited reach. It has not improved co-working and information sharing outside the footprint of the model itself. It is a police (not health) led service and isn't involved in many/most cases that psychiatrists deal with. The College is not aware of any credible independent evaluation studies of the CT CCS model but would generally hesitate to confirm that there is evidence of its successful operation.

Role of Psychiatrists in multi-agency arrangements

103. Psychiatrists have an established role within multi-agency arrangements where VFB occur in the context of suspected or confirmed mental disorder. Their contribution is to assess and treat mental disorder, making an appropriate diagnosis or provisional diagnoses, provide clinical formulation, advise on risk, and share relevant information to support multi-agency decision-making.

104. Mental health services are well established participants in MAPPA and may contribute to Prevent where there is a relevant mental health need. Psychiatric involvement in MASH is generally more variable and depends on local arrangements and the presence of mental health concerns.

105. For children and young people, FCAMHS play an important multi-agency role by providing specialist assessment, consultation and clinical advice to partners including social care, education, youth justice and the police. FCAMHS support the assessment and management of complex cases where concerns about serious violence arise alongside possible mental disorder or neurodevelopmental conditions. However, there is a significant variation in what FCAMHS services do (paragraph 107). In some areas FCAMHS will see patients, while in others they only provide consultation to a referring agency. In evidence, Dr Irani was asked about specialist interventions which could have been considered around 'violence fascination' and suggested that "*this is a piece of work psychologists do but does not necessarily sit within the mental health domain. So it would be in some FCAMH services but… it's rather tricky about where it sits.*" In the absence of a mental disorder, it is hard to see in what context mental health services such as FCAMHS would take on a patient with 'violence fascination'. In most parts of the country there are youth offending services designed to provide support to young people at risk of offending outside the context of mental illness and these are more appropriately placed to provide support to young people with "violence fascination". For FCAMHS to undertake this work, the service would require significant additional funding and the Department of Health and Social Care would need to reduce the variation between services.

Assessment of multi-agency frameworks

106. As above, existing multi-agency frameworks, including MAPPA, MASH and Prevent, provide established mechanisms for information sharing, coordinated

decision-making and risk management. Their principal strength lies in bringing together agencies with different statutory responsibilities and expertise, enabling a more comprehensive assessment of complex cases (such as individuals displaying VFB) than any single organisation could achieve alone.

107. However, there are important limitations. The operation of FCAMHS varies considerably across England, with differences in service models, capacity and available resources. Many FCAMHS operate primarily as consultation services, providing specialist advice to partner agencies rather than delivering ongoing case management. This variability can lead to inconsistent access to specialist expertise and differing levels of support across the country.

108. There are also wider challenges within existing multi-agency arrangements. MAPPA is often perceived primarily as a framework for managing known offenders, which may limit its application in other contexts, while MASH arrangements can vary between local areas and are not always well understood by partner agencies. Improving consistency, clarity of roles and resourcing across these frameworks would strengthen their effectiveness in managing complex cases involving violence-fixated behaviours.

109. Psychiatrists and mental health services are well accustomed to working within arrangements such as MAPPA, MASH and Prevent, although these frameworks are not specific to VFB and mental health services will only be involved where there is a suspected or confirmed mental disorder. While psychiatrists make an important contribution to frameworks such as MAPPA, Prevent and Channel, this work is usually undertaken alongside existing clinical commitments rather than through dedicated, funded capacity.

110. The strengths of these frameworks lie in their established governance, defined leadership arrangements, clear case management processes and collaborative working between agencies. There is generally good understanding of which agency leads, how information is shared, and the respective responsibilities of health, policing, social care and other partners. While individual clinicians may vary in their familiarity with these arrangements, the role of mental health services within the frameworks is generally well established.

111. Referral pathways and escalation routes are strongest where they are supported by statutory duties and clearly defined responsibilities. Frameworks with a

statutory footing, such as MAPPA, are generally more consistent and effective than those that rely primarily on voluntary cooperation. Strengthening existing statutory multi-agency arrangements is therefore likely to be more beneficial than creating new structures specifically for VFB or VFI.

112. RCPsych recognises that statutory multi-agency arrangements are generally associated with clearer governance, greater accountability and more consistent engagement from partner organisations. Where agencies have clearly defined statutory responsibilities, there is often greater clarity regarding leadership, information sharing, case management and escalation, which can support more effective management of complex cases.

113. For this reason, there is merit in considering whether aspects of existing non-statutory multi-agency arrangements could benefit from a stronger statutory basis. Any such changes would require careful consideration of their practical implications, but a statutory footing may help to promote more consistent participation by relevant agencies and strengthen collaborative working.

114. RCPsych does not consider that a new multi-agency structure is required. Existing frameworks should be strengthened and used more effectively, rather than creating additional arrangements that risk duplication, uncertainty and the transfer of responsibility between agencies.

115. Where there are concerns about VFB, we consider that a coordinated multi-agency approach with a clearly identified lead agency is the most effective model. The lead agency should be determined by the individual's primary needs and the nature of the identified risks, rather than by a single model applied to all cases.[6]

116. Existing structures such as Prevent, MASH and MAPPA each have important roles. Prevent already has experience of managing cases where there are concerns about serious violence without a clear ideological driver. MAPPA provides a robust statutory framework but is generally limited to individuals who meet the relevant eligibility criteria, including many with criminal convictions, and therefore will not apply to all cases. MASH provides an important mechanism for information sharing

[6] The College agrees with Dr Irani's oral evidence that good practice for multi-agency working would include *"clear identification at every stage of who is the lead agency documented, and put into effect"*, and *"a pooling of information including in relation to risk information"* and that all agencies involved in the young person's care should have copies of all key risk documents.

and safeguarding but is unlikely to be sufficient as the sole framework for managing these complex presentations.

Lead agencies and lead 'duty holders'

117. As above, the College supports the principle that, in every case, there should be a clearly identified lead agency with responsibility for coordinating multi-agency assessment, information sharing and case management. Without clear leadership, there is a risk that responsibility becomes fragmented and that effective action is delayed. The lead agency should be determined on a case-by-case basis according to the individual's primary needs and statutory framework. This may include children's social care or the local authority for children and young people, probation services where an individual is subject to criminal justice supervision, or another statutory agency with primary responsibility for the case.

118. However, RCPsych does not consider that responsibility for managing risk should rest with a single individual or agency in every case. Individuals displaying VFB represent a highly heterogeneous group, only a minority of whom will have a diagnosable mental disorder. Regardless of which agency leads, risk management should remain a shared multi-agency responsibility, with the lead agency determined by the individual's primary needs and circumstances (see paragraph 84.g and 115).

119. Psychiatrists are well placed to lead where the individual's primary need is the assessment and treatment of a mental disorder, for example during detention under the MHA. However, VFB are not causally linked to mental illness and therefore mental health services will often not be required in those cases. In addition, current workforce and resource pressures mean that psychiatrists would not have the capacity to undertake a universal case management role. In most other cases, another agency is likely to be better placed to coordinate the response. For children and young people, this will often be children's social care or the local authority, while for individuals already subject to criminal justice supervision, probation services may be the most appropriate lead agency.

Integration of 'VFI-related process' into safeguarding and/or mental health frameworks

120. There are currently no formal or nationally consistent processes specifically for the management of VFB. As a result, there is considerable variation across England in how such cases are identified, assessed and managed.

121. There are also no evidence-based interventions specifically for VFIs that have been validated in the UK. This reflects the absence of a clear, agreed definition of VFI and the heterogeneity of the people to whom the term may be applied.

122. Where mental disorder is suspected or confirmed, existing multi-agency frameworks such as MASH and MAPPA are generally well established, and the role of mental health services within these arrangements is well understood. Prevent may provide a useful door for some cases because it supports multi-agency consideration of risk to others, including where ideology is not the principal driver. However, access is inconsistent and depends on local service capacity, eligibility criteria and referral pathways. Mental health interventions may be limited by long waiting times and workforce pressures, while individuals without a diagnosable mental disorder may not meet thresholds for specialist services. Multi-agency pathways also vary considerably between areas, creating uncertainty about where cases should be referred and who should coordinate them. Rather than creating new VFI-specific processes, we consider that the priority should be to strengthen and improve consistency within these existing frameworks, with clear referral pathways, defined agency responsibilities and effective multi-agency collaboration.[7]

123. RCPsych does not consider that a new standalone clinical treatment for 'VFIs' is necessarily required. Effective risk management of VFB is more likely to depend on coordinated multi-agency working, timely information sharing, clear case leadership and routes for referral and escalation where risk increases. There should also be strong information sharing, consistent access to specialised advice, and sufficient resources for agencies to participate effectively. Relevant interventions may include treatment of an identified mental disorder, psychological therapies, social care support, family work, educational or occupational support, and criminal justice or safeguarding measures. None of these interventions sits solely within health services, because VFB is not itself a mental illness.

[7] RCPsych agrees with Dr Irani's report (**DRI000001-2)** paragraph 3.7.2.1, 3.5.2.1 and 3.5.2. There is significant local variation, but each area should have a clearly articulated escalation route to strengthen existing processes.

International practice

124. The College is not aware of any international models, assessment tools or interventions that have been sufficiently validated to recommend for implementation in the UK specifically for VFB. The available evidence is limited, and approaches developed in other jurisdictions may not be directly applicable within the UK's legal, health and safeguarding systems.

125. Rather than importing unvalidated models, we recommend investment in a dedicated UK research programme to establish a clearer understanding of VFB, evaluate existing multi-agency approaches, and develop and validate assessment methods and interventions appropriate to the UK context. Building a robust domestic evidence base is likely to provide greater long-term benefit than adopting approaches whose effectiveness has not been demonstrated within UK services.

Improvements

126. RCPsych considers that the greatest improvements can be achieved by strengthening existing systems rather than creating new VFI-specific legislation, structures or clinical services. Priority should be given to developing a shared understanding of VFB across agencies, recognising that this is a behavioural description rather than a psychiatric diagnosis.

127. Practical improvements should include clearer referral and escalation pathways, a designated lead agency for each case, strengthened multi-agency information sharing, and consistent use of existing frameworks such as Prevent, MASH and MAPPA where appropriate. Mental health services should contribute where there is evidence of mental disorder, but responsibility for managing risk should remain shared across agencies.

128. The College also recommends investment in research to establish a stronger UK evidence base, including the development and validation of assessment approaches, evaluation of existing multi-agency practice, and identification of effective interventions.

129. Finally, these arrangements will require adequate investment to be effective. Existing multi-agency frameworks and mental health services are already operating under significant workforce and resource pressures. Additional funding should be

provided to support dedicated capacity for multi-agency working, timely access to specialist mental health assessment where indicated, workforce development and training, and the consistent implementation of existing frameworks across England. Strengthening the capacity of existing services is likely to deliver greater benefit than establishing new structures without the resources to support them.

Statement of Truth

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

Signed:

SIGNATURE

Subodh Dave

President of Royal College of Psychiatrists

Dated: 7 August 2026

Annex 1 – EXHIBIT INDEX

Exhibit No.	Inquiry Reference No.	Document Description.
RCP/01	RCP000002	Written evidence submitted by the Royal College of Psychiatrists (MHB76) to the Mental Health Bill 2025: Learning Disability and Autism.
RCP/02	RCP000003	Proposed amendment number 35 to the Mental Health Act 2025, after clause 4.
RCP/03	RCP000004	CR201 RCPsych Guidance (August 2016, corrected May 2017) – Rethinking risk to others in mental health services.
RCP/04	RCP000005	Structured Assessment of Violence Risk in Youth (SAVRY) 2006
RCP/05	RCP000006	Historical-Clinical-Risk Management-20, Version 3 (HCR-20V3)
RCP/06	RCP000007	NHS Code of Practice on confidentiality (Nov 2003)
RCP/07	RCP000008	General Medical Council Professional Standards. Confidentiality: good practice in handling patient information (April 2017)
RCP/08	RCP000009	RCPsych Good Psychiatric Practice: Confidentiality and Information Sharing (3rd edition) (CR209 Nov 2017)
RCP/09	RCP000010	Violent behaviour in adolescents: assessment and formulation using a structured risk assessment tool *BJPsych Advances* (2024)
RCP/10	RCP000011	HM Prison & Probation Service MAPPA Guidance (April 2024)