Editorial: Lessons from the clinical care of Valdo Calocane

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Schizophrenia affects around 1 in 150 adults in the UK and other high-income countries. It the 20th leading cause of years lived with disability [1], explained by the peak incidence of the illness occurring in the 20s. In the UK, around 220,000 people are being treated for schizophrenia by the NHS, who are at increased risk of adverse outcomes that can be mitigated with treatment. One of these is violence perpetration, where the supporting evidence is robust. This includes a recent Cochrane review of RCTs of maintenance antipsychotic treatment in people with schizophrenia [2], where treatment arms reported more than 50% reduction in violent outcomes compared with placebo, and longitudinal epidemiological investigations with crime and non-crime outcomes [3]. In addition, there are plausible mechanisms that explain how psychotic symptoms can lead to violence, such as pre-empting threats which are delusional in nature and misinterpreting social interactions. Incidence of violence perpetration is over 10% in 12 months in first episode psychosis [4]. Economic costs of schizophrenia are high – for violence perpetration, this is estimated at £2.5B annually in England and Wales [5]. Reducing risks of violence perpetration is therefore a key focus for mental health services.

Valco Calocane was diagnosed with schizophrenia during four psychiatric hospitalizations [6]. The review into his clinical care from Nottinghamshire Healthcare NHS Foundation Trust found serious failings that contributed to his relapse and the tragic events that subsequently unfolded. He was under the care of the Early Intervention Psychosis (EIP) service, who were assertive during Calocane's first two psychiatric admissions, which led to appropriate community supervision and monitoring. But failings were identified, particularly at the interface with other services. Inadequate and inconsistent risk assessments and poor links with the police and primary care. Discharge arrangements after Calocane's third admission, which was to a private hospital, were lacking. Other problems highlighted were a failure to enforce treatment and address treatment adherence, and specifically not using a long-acting injectable (depot) antipsychotic [7]. Admission also provided the opportunity to start a

Community Treatment Order (CTO), which allows for immediate recall to hospital when individuals refuse or disengage from treatment.

Assessing and managing these risks are complicated in patient management for individuals with schizophrenia. One of them, almost unique in healthcare, is that the illness itself is associated with loss of insight into the need for treatment. This was the case for Calocane, who is reported to have paranoid delusions about the clinical team colluding with criminal justice. The loss of insight leads in turn to poor treatment adherence, and balancing this with developing a therapeutic relationship underscores treatment challenges in this patient population. Mental health clinicians have to walk this tightrope continuously, balancing the need to engage with patients and families, respecting individual preferences, with the importance of assertive treatment and use of the Mental Health Act when necessary. EIP services were designed to have a low clinician to patient ratio and continuity of care, to enable that step up in intensity of care as required, including through crisis episodes and inpatient care, leading to improved patient outcomes and fewer hospital admissions. The current reality of EIP services though is that care coordinator to patient ratios (up to 1:35) do not allow the assertive outreach approach, as originally envisioned. Patients are transferred to crisis services or to out-of-area private providers, at the very time when they would most benefit from continuity of care. In Calocane's case, this had direct repercussions - the EIP team requested that depot medication be started and that a CTO was put in place whilst in hospital, but inpatient teams did not institute either.

What lessons can be drawn? One key implication is that people with severe mental illness and violence histories should have structured risk assessment to augment clinical decision-making [8]. In Calocane, the review highlights potential biases in decision-making, including recency bias (especially his clinical improvement as an inpatient). More structured risk assessment improves decision-making by reminding clinicians of background risk factors, their relative effects, and acts to slow down the assessment process so that clinicians consider all relevant factors rather than relying on recent and available information [9]. Another implication is to strengthen multi-agency working, in particular with the police, which includes information sharing. Calocane's first admission to hospital was triggered by a serious violent incident, which would usually lead to criminal charges. Charges should be pursued, partly as it leads to legal measures to enforce treatment and supervision, and because it signals that violence, even if driven by mental illness, have serious real-world consequences and should be considered in subsequent risk assessments. A further implication is how the community treatment in severe mental illness is managed. A clinical staging model [10], in line with other areas of medicine, has been proposed. The high likelihood of relapse and associated level of risk to others in Calocane would equate to a stage 4 illness requiring the most intensive and assertive of treatment packages.

Calocane missed 11 of 15 appointments to collect medication after last hospital discharge and the clinical team were unable to contact him by phone or on visits for many months before being discharged to his GP on 22 September 2022. There were no further healthcare contacts until his arrest in June 2023. The 'normalization' of discharges to GPs due to non-engagement is routine in mental health services and rightly criticised. If instead, his illness was recognised as most severe stage 4, discharge to GP would not be considered an option, and his care would remain the responsibility of mental health services, which require proper

resourcing to enable an effective assertive outreach in discharged patients. Continuity of care is central to high quality mental health care, and while transitions between services may be necessary, shared decision making between inpatient and outpatient clinical teams, between outpatient services and primary care, and ensuring family involvement throughout these transitions are key lessons to prevent similar tragic episodes.

983 words

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We have not used AI.

References

1 GBD 2019 Mental Disorders Collaborators. Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990-2019: a systematic analysis for the Global Burden of Disease Study 2019. *Lancet Psychiatry*. 2022;9:137–50. doi: 10.1016/S2215-0366(21)00395-3

2 Ceraso A, Lin JJ, Schneider-Thoma J, *et al*. Maintenance treatment with antipsychotic drugs for schizophrenia. *Cochrane Database Syst Rev*. 2020;8:CD008016. doi: 10.1002/14651858.CD008016.pub3

3 Whiting D, Gulati G, Geddes JR, *et al*. Association of Schizophrenia Spectrum Disorders and Violence Perpetration in Adults and Adolescents From 15 Countries: A Systematic Review and Meta-analysis. *JAMA Psychiatry*. 2022;79:120–32. doi: 10.1001/jamapsychiatry.2021.3721

4 Whiting D, Lennox BR, Fazel S. Violent outcomes in first-episode psychosis: A clinical cohort study. *Early Interv Psychiatry*. 2020;14:379–82. doi: 10.1111/eip.12901

5 Senior M, Fazel S, Tsiachristas A. The economic impact of violence perpetration in severe mental illness: a retrospective, prevalence-based analysis in England and Wales. *Lancet Public Health*. 2020;5:e99–106. doi: 10.1016/S2468-2667(19)30245-2

6 NHS England. Independent mental health homicide report into the treatment of Valdo Calocane. 2025. https://www.england.nhs.uk/2025/02/independent-mental-health-homicide-report-into-the-treatment-of-valdo-calocane/ (accessed 3 March 2025)

7 Wang D, Schneider-Thoma J, Siafis S, *et al*. Efficacy, acceptability and side-effects of oral versus long-acting- injectables antipsychotics: Systematic review and network meta-analysis. *Eur Neuropsychopharmacol*. 2024;83:11–8. doi: 10.1016/j.euroneuro.2024.03.003

8 Whiting D, Mallett S, Lennox B, *et al*. Assessing violence risk in first-episode psychosis: external validation, updating and net benefit of a prediction tool (OxMIV). *BMJ Ment Health*. 2023;26:e300634. doi: 10.1136/bmjment-2022-300634

9 Viljoen JL, Goossens I, Monjazeb S, *et al*. Are risk assessment tools more accurate than unstructured judgments in predicting violent, any, and sexual offending? A meta-analysis of direct comparison studies. *Behav Sci Law*. 2025;43:75–113. doi: 10.1002/bsl.2698

10 Nelson B, McGorry PD, Fernandez AV. Integrating clinical staging and phenomenological psychopathology to add depth, nuance, and utility to clinical phenotyping: a heuristic challenge. *Lancet Psychiatry*. 2021;8:162–8. doi: 10.1016/S2215-0366(20)30316-3