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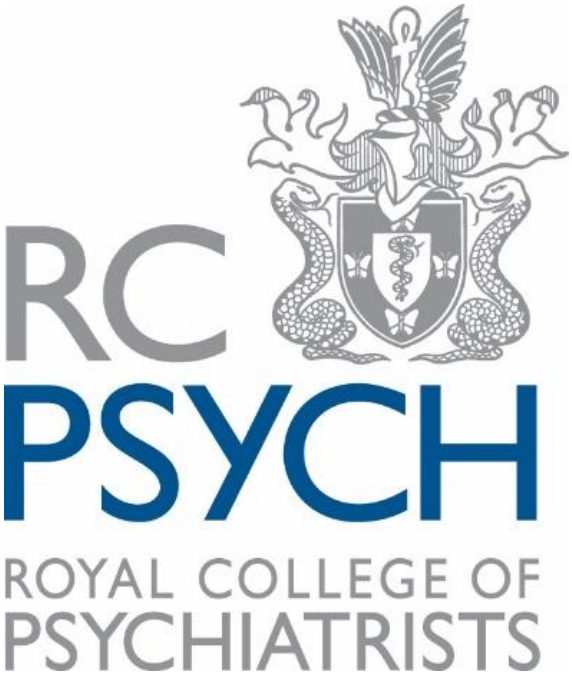


Faculty of Forensic Psychiatry Newsletter
January 2024

iForensic

Forensic Faculty Newsletter

In this issue

Welcome

News from the Faculty Chair

by

Dr Josanne Holloway

Chair of the Forensic Psychiatry Faculty

Very best wishes to everybody and welcome to 2024. 2023 has been a rather challenging year on many fronts for all of us both in our professional lives and as world citizens. The faculty executive committee in line with the college as a whole and other faculties has been working on a three-year strategy working within the framework of college priorities and shared strategic objectives with other college faculties.

All our strategic objectives come under our umbrella commitment to supporting the delivery of high quality person centred care, promoting excellent mental health services and embodying the voice of psychiatry. We also agreed that it would be important to have a limited number of strategic objectives which we could realistically work on, for each strategic objective to have a lead or co-lead and for progress on the actions and outcomes to be monitored at each executive committee meeting. At our most recent faculty executive meeting, we have finalised the leads and co-leads for each of our 8 strategic objectives as well as members of the exec team who will be supporting that work. Once the document has been updated, it will be uploaded onto the faculty webpage. We will inform you through Hayley Shaw our Faculty manager once the full document has been uploaded. Please access this and if you are interested in being involved in supporting these strategic priorities please do not hesitate to let us know through emailing Hayley Shaw on Hayley.Shaw@rcpsych.ac.uk

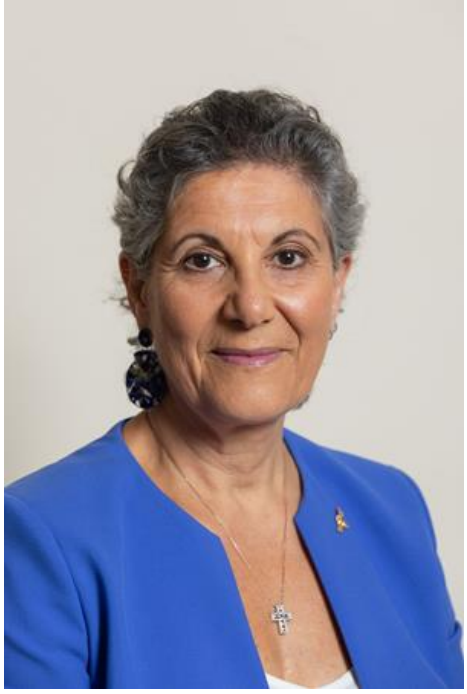
The 8 strategic priorities identified by the forensic faculty are:

1. **Support improved assessment and care planning to reduce harm**. This is to support and promote the use of formulation based risk assessment strategies and to support the move away from tick box risk assessments and to work in line with similar developments in relation to risk assessment and management strategies in relation to self harm.
2. **Enhancing patient and carer engagement and patient centred care**. We believe that patients (and carers as appropriate) should be at the heart of all we do and that patients and carers are equal partners.

3. **Enhance trainee and SAS experience**. Our trainees and SAS doctors are major contributors to the provision of mental health care and are the future of forensic mental health services so equipping them with the best opportunities for development are key in the sustainability of forensic services.
4. **Support the successful discharge/ release of individuals sentenced to IPPs.** As a faculty we have a small part in the bigger initiative, we see our role around ensuring that all prisoners entitled to S117 aftercare have this considered as part of their discharge package when they come before the parole board. This would mean us working with the probation services and prison in reach teams as well as the parole board to increase awareness and good practice. The other area is to support the statutory provision of aftercare services (which will mainly be around social care) for all IPP not only those entitled to S177 aftercare.
5. **Improve use of digital innovation to support Multi-disciplinary engagement in care, reduce administrative workload and improve rehabilitative experience for patients**. The outcome we wish to achieve is to support the use of smart digital solutions for example focussing first on digital commonly used forms in forensic psychiatry, to work with the college digital committee and working with our patient and carer rep to identify and progress one directly patient facing issue to reduce digital poverty amongst forensic in-patients.
6. **Support the review of the college document on Confidentiality and Information Sharing CR209**. This document is up for review. We believe that to provide safe, quality centred patient care there needs to be clarity around information sharing and confidentiality including when it comes to sharing information with carers.
7. **Support academic developments**. This is clearly a priority for the faculty and is an essential tool to ensure the sustainability of the specialty and continued improved care for our patients.
8. **Provide timely contributions to policy issues and maintain close working with the mental health unit at the MoJ**. We want to have a process where we can respond to government and other policies even when a quick response is required as is often the case. We have a wide range of experts in the faculty and would like to be in a position to utilise their expertise in our responses.

Once again please do contact Hayley if you would like to contribute to delivering our strategic objectives of have any queries. WE look forward to hearing from you.

Best wishes for 2024.



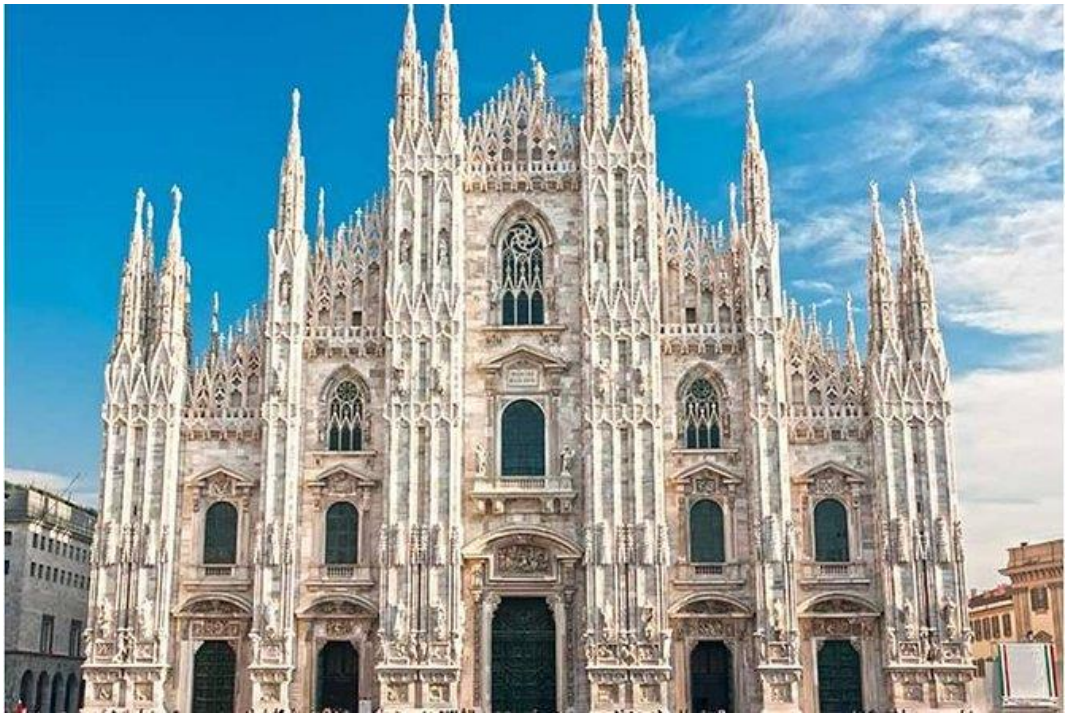
Josanne Holloway

Faculty of Forensic Psychiatry Conference 2024

Dr Callum Ross, Consultant Forensic Psychiatrist, Broadmoor Hospital

We are excited about our annual conference in Milan on 15, 16, and 17 May. Our venue will be the Meliá Milano.

Why is it happening in May? Well, that's a rather long story, but take heart – the planning is going well and the weather should be sunny.



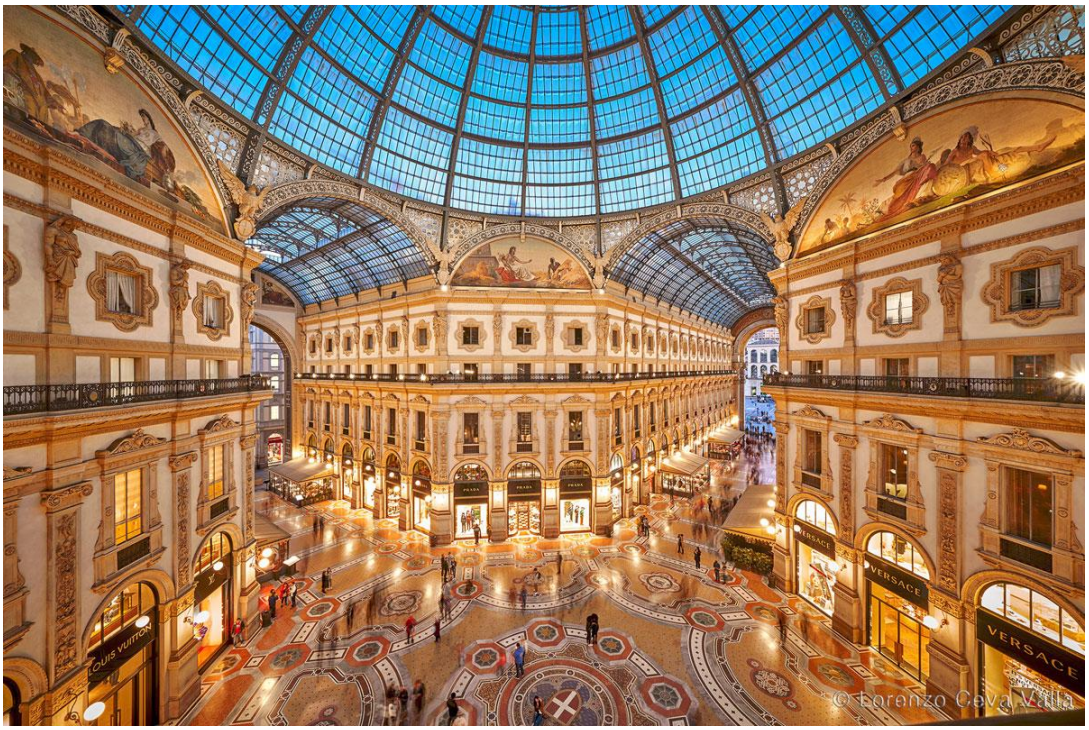
We are delighted that Dr Alan Mitchell - the President of The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) - will be a speaker. He will be joined by Dr Mauro Palma, Italy's Guarantor for the rights of persons deprived of liberty. Their talk will focus on the future of prison psychiatry in Europe.

Alan Mitchell will also take part in our debate, and the pencilled-in motion is this: *'This house believes that, except in a bona fide emergency, treatment for mental disorder must never be coerced in a prison or institution run by correctional services.'*

Our Italian colleagues in our host city are also playing a central role. Giovanni de Girolamo, Felice Carabellese, and Alessia Cicolini will all be speaking.

Thank you to everybody who has submitted proposals for seminars or plenary sessions. The number submitted far exceeded our expectations and we are presently rejigging the middle day to accommodate more. The request that talks be aligned with our Presidential themes proved to be a hit and it is really encouraging to organise a meeting with several talks considering the role of women in forensic mental health. Discussion about physical health will also feature prominently with one of our plenary sessions being given over to this topic.

The window for poster submissions remains open, so please do consider submitting something.



Our 2023 Brighton conference was a great success, and the debate we held, which considered the sentence of Imprisonment for Public Protection (IPP), has helped enable a lot of activity.

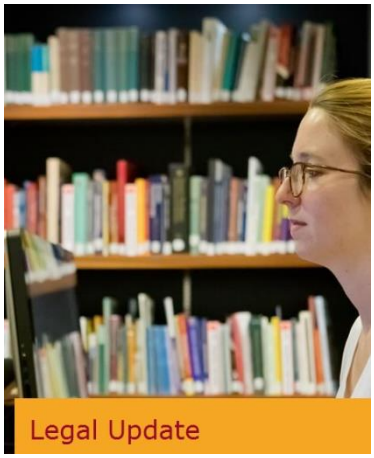
We look forward to seeing as many of you there as possible. Our venue is large and the more of you that can make it then the more interesting it will be!

For more information and to book:

Faculty of Forensic Psychiatry Conference 2024 (rcpsych.ac.uk)

Legal Update

Dr Richard Latham, Consultant Forensic Psychiatrist, South London and Maudsley NHS Trust



Reliability and credibility

There are some lines that the courts have drawn for mental health professionals when they give opinions about reliability and credibility of witnesses. Reliability as it relates to a mental disorder is probably territory on which we may tread, giving an opinion on whether someone is lying or not is generally out of bounds, and the credibility of a witness, whether the defendant or some other witness, is for the court to decide. These lines are not always straight or clear, however. The three cases are not new but all touch on the role of mental health experts in this area.

R v W 92 Cr App Rep 291

The defendant was charged with the murder of her daughter who was originally found to have died by accidental asphyxiation. The defendant later told her husband, a probation officer, and the police that she had killed her daughter. The main issue was whether her confessions were false. There was no mental health defence at her trial but there was an attempt to call mental health evidence because she had an abnormal personality (histrionic) and this was relevant to the question of whether her confessions were false. The mental health evidence was not allowed on the basis that the function of the jury would be usurped.

The Court of Appeal maintained this position and the psychiatric evidence was not allowed. The reasons given were that the actions of someone with an abnormal personality were likely to be within the experience of the jury, and they did not need an expert to explain how someone with an abnormal personality might react to the stresses and strains of life.

R v H [2014] EWCA Crim 1555

H was convicted of several offences including rape. The victim was his daughter, X, and at the age of fifteen she described that the offences had occurred from when she was 10 until 12. H denied all the offences and the issue for the jury was whether H or his daughter were telling the truth. The decision was informed by the reliability and credibility of X. H appealed based on mental health evidence about X's reliability and credibility.

X had a complicated medical history and had been detained on one occasion for treatment of mental disorder. A psychiatrist/psychotherapist provided evidence which was described as a "deconstruction, if not demolition, of the reliability" of X. This expert suggested that the memory of the abuse was 'recovered' during therapy, and that this was a case of false memory syndrome. The expert did not assess X in person.

The judge refused to allow the evidence and the Court of Appeal upheld this decision. The expert was found to have usurped the function of the jury when giving opinions on the credibility of the witness.

P v The Queen [2015] UKPC 9

P was convicted of rape and murder. Much of the basis of the conviction was confession evidence.

The responses in interview of P were described as strewn with inconsistencies, contradictions, implausibility and vagueness. The confessions he made were however of significant importance. He subsequently retracted his confessions when giving evidence at trial but was convicted, nevertheless. The conviction was quashed on appeal, and a retrial ordered, because of the possibility of him having falsely confessed. He did not give evidence at his second trial when the confession evidence was allowed but he was once again convicted. The final appeal introduced new mental health evidence about foetal alcohol spectrum disorder and the reliability of the confessions. Several experts provided evidence.

The court observed that the experts should be careful to avoid supplanting the court's role. It was noted that one of the experts had said specifically that the confession was unreliable and gave an explanation as to why Pora had confessed. The court observed that the expert could provide an opinion as to why P was disposed to make an unreliable confession but not to assert that the confession was in fact unreliable. This was an ultimate issue for the court, not the expert. P's convictions were nevertheless quashed.

Richard Latham
December 2023

Cultivating Reflective Spaces in Forensic Settings

by

Dr Adam Polnay, Consultant Psychiatrist in Psychotherapy

Those of us who work in forensic settings are involved in complicated and interesting clinical encounters. This may be partly what draws us to forensic psychiatry. Over time however, as we become more accustomed to forensic work, the following may end up seeming too obvious to say, but it needs to be said: this is emotionally demanding work.

Many patients we work with experience unsettling feelings such as fear, anger, shame, humiliation, aloneness, grievance, and abandonment. As with all people, our patients automatically communicate (unconsciously project) their feelings to others through their words, tone of voice, actions, facial expressions and body language. We, as their clinicians, will tune into our patients' inner emotional worlds. Broadly speaking, this happens in two ways. Firstly, through our more conscious observations of our patients and careful consideration of their history. And secondly, through the feelings and experiences that are evoked in us through interacting with those in our care (countertransference).

The neuroscience of this latter phenomenon is interesting. Gwen Adshead, forensic psychiatrist and psychotherapist explains, "An individual who experiences a strong emotion is able to transmit that experience to others (and vice versa)." (Adshead & Sarkar, 2012) A class of nerve cells in the brain, referred to as mirror neurons, "fire when another's emotional experience is witnessed." (Adshead & Sarkar, 2012) Mirror neurons activate in a comparable pattern either when we experience a particular emotion ourselves or if we observe someone else experience the same emotion. We may not always consciously observe the other person's emotional state; we may feel it as our own. Adshead continues, "The closer the emotional tie, the more pronounced the experience: we do feel the pain of others, especially those with whom we are in close relationships."

I think it is gradually returning to the mainstream that our countertransference experiences can – with some important considerations – provide valuable indicators as to the patient's experience and state of mind. Our countertransference might, for example, offer us a window into the patient's own warded-off feelings; or simply allow us to understand how those around the patient might feel or react to them, which is important for assessing therapeutic progress and risk. Making

use of the countertransference in these ways requires appropriate training and experience in interpersonal dynamics, such as gained through Balint groups during core and higher training, as well as ongoing opportunities to stop and reflect.

This is where Reflective Practice Groups play a part. Led by a psychotherapist, these groups offer the space to name, process and reflect on our experiences of working with patients. We take part in these groups to sustain interest in the clinical work, find containment and support, deepen our understanding of the interpersonal dynamics, and provide some protection against unhelpful enactments. If these groups are well attended by the various parts of clinical team, the sessions can help to piece together the shards of a fragmented clinical situation and provide a degree of protection against team splitting.

Personal therapy versus Reflective Practice Groups

Our inner responses to a patient will to some degree depend on our own personal lives. This aspect is too personal to tease out in staff Reflective Practice Groups – indeed, exploration of clinicians' personal lives explicitly does not fall within the frame of a staff Reflective Practice Group. Herein is one rationale why some clinicians interested in psychological dynamics (psychodynamics), alongside clinicians training in psychodynamic psychotherapy, seek out personal therapy for themselves during training or as fully qualified clinicians. Personal therapy for the clinician/therapist helps to try and disentangle where feelings are coming from – the patient, the clinician, or an interaction between the two. Personal therapy for a clinician is distinct from, and complements, staff Balint or Reflective Practice Groups.

The risks of not cultivating reflective spaces

Without reflective spaces to process our responses to patients, we will be more likely to act on our countertransference feelings, perhaps without realising it, in ways that may be unhelpful or even harmful to the patient's care. For example, we might end up avoiding a patient where the clinical work evokes in us a feeling of rejection and disinterest towards them – as opposed to being able to notice and make use of our feeling of rejection to wonder about what this might tell us about the patient's own state of mind. (It might be, perhaps, our interest is fading over time through being unconsciously 'invited' into a disinterested position by a patient who has experienced early neglect or rejection).

We are working with patients who have troubled inner and external worlds and who may have acted on their feelings in harmful and

disturbing ways. These dynamics bring possible pitfalls for us as clinicians and for the systems in which we work. There is a potential for us as clinicians to respond to provocation by taking up an overly restrictive or punitive position ourselves. Or perhaps we might experience a pull to go too far the other way in relation to someone who is acting in a threatening or demanding way, by overstepping a boundary or becoming overly placatory. There may also be the urge to withdraw into a hopeless or avoidant position in the face of incredibly slow change or the absence of apparent change.

Evaluating Reflective Practice Groups

So how do we know how or if Reflective Practice Groups are working? As part of a working group looking at Reflective Practice Groups, we undertook a literature review (see Patrick J, Kirkland J, Maclean C et al. 2018). We found a moderate body of qualitative research looking at Reflective Practice Groups. Qualitative studies in this area had largely positive outcomes, concluding that clinicians who come to groups tend to feel supported and may discover new perspectives through the group process. As with any active reflective process, when something meaningful is happening, this does not necessarily feel easy for participants; the sessions involve inviting clinicians to look closely at their own work and the role they play in clinical encounters, and this is not an anxiety-free process. As group facilitators, we find it useful to discuss all these dimensions before starting a group, so that participants are well informed.

Starting to address a gap in quantitative research – The Relational Aspects of CarE scale (TRACE)

We found that Reflective Practice Groups were poorly researched in terms of quantitative studies. Furthermore, the area lacked a suitable quantitative outcome measure to evaluate Reflective Practice Groups.

We therefore decided to develop a new quantitative outcome measure to tap into the kinds of processes that Reflective Practice Groups are intended to help with (Polnay, Walker and Gallacher 2021). A review of the literature led us to formulate five key areas:

1. personal awareness of common clinician emotional responses to patients (awareness of countertransference)
2. recognition that having such feelings is a normal aspect of clinical practice
3. ability and opportunity to discuss such responses

4. ability to utilise countertransference to help make sense of interpersonal dynamics
5. personal awareness of the risk of counterproductive enactments that may emerge from unprocessed or unrecognised feelings about patients.

From these areas, we drafted items for the outcome measure. Through consultation with colleagues and pilot-testing we refined this to a 20-item self-report scale, referred to as The Relational Aspects of CarE scale (TRACE).

The TRACE scale contains questions related to the five areas identified above. For example: "When working with patient(s) I am aware of sometimes feeling anxious" (awareness of common countertransference feelings); "Having feelings (e.g. anxiety, anger etc) in response to patients is unprofessional" (recognition that feelings about patients is a normal part of the work; note, scoring is reversed for this item).

The TRACE is distinctive from other existing questionnaires in that the scoring process considers that it is normal and self-aware for staff to experience a range of feelings in relation to clinical work. This contrasts with other existing questionnaires, such as the Attitudes towards Personality Disorder Questionnaire (APDQ), which regards a clinician as less reflective if they acknowledge having so-called negative feelings towards patients.

We evaluated the TRACE scale with a sample of 80 professionals. The factor structure of the questionnaire clustered items logically to the five areas used originally to generate the measure. The TRACE demonstrated good test–retest reliability (intra-class correlation = 0.94, 95% CI = 0.78–0.98) and face validity. Internal consistency demonstrated borderline acceptability. The TRACE showed a slight negative correlation with APDQ, which was expected as the two measures approach the issue of emotions in opposing ways, as discussed above.

The TRACE provides a straightforward, self-report tool that can be used by clinicians and researchers to evaluate Reflective Practice Groups. The TRACE is free to use and can be downloaded via the link in the references, below.

Additional resources to support Reflective Practice Groups

Members of clinical teams who are contemplating a Reflective Practice Group for themselves, as well as clinicians who are already in such groups, sometimes request background reading material. We have tried

to address a need for clear and relevant written material through a new textbook, Cambridge Guide to Psychodynamic Psychotherapy. The book covers core psychodynamic history, theory and practice, and goes on to apply psychodynamic principles to working in clinical settings where relationships are central – such as forensic settings. The book discusses the dynamics of anger and aggression, and explores how to approach Reflective Practice Groups from the perspectives of both facilitators and participants.

Summary

The interpersonal dynamics of forensic work are both fascinating and emotionally demanding, sometimes in unexpected ways. Reflective Practice Groups are but one element of a psychologically informed service. These groups can help to sustain our interest and curiosity in clinical work, and provide a space to consider how our patients relate to us and how we respond. This article describes the TRACE scale, which be used to evaluate Reflective Practice Groups at a local level or as part of research. A new textbook aims to provide accessible, relevant material about the psychodynamics of working in mental health settings, including Reflective Practice Groups.

References

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Patrick J, Kirkland J, Maclean C et al. Reflective practice paper and competency guidelines framework. Forensic Network Matrix Group; 2018. https://forensicnetwork.scot.nhs.uk/wp-content/uploads/2022/03/Matrix-Reflective-Practice-Framework.pdf

Polnay, A., Walker, H. and Gallacher, C. Developing a measure to assess clinicians' ability to reflect on key staff–patient dynamics in forensic settings. The Journal of Forensic Practice 2021;24(1):34-47. https://doi.org/10.1108/JFP-07-2021-0041

TRACE scale and scoring key downloads: https://www.research.ed.ac.uk/en/publications/developing-a-measure-to-assess-clinicians-ability-to-reflect-on-k

John Hamilton Travelling Fellowship – a report on my visit to Bolivia, 2023

by

Dr Anne Aboaja
Consultant Forensic Psychiatrist, Tees, Esk and Wear Valleys NHS Foundation Trust
Visiting Research Fellow, University of York
Clinician Research Fellow, NIHR ARC NENC

In my second year of SHO training (CT2) on the Trent programme, I volunteered for three weeks at a student counselling café in Bolivia with a faith-based NGO. Then, at the end of my SpR training in forensic psychiatry, I spent three months, initially as an Out of Programme Experience (OOPE), developing a mental health course at a project in Bolivia for women who had lived in prison as prisoners, wives of prisoners or children of prisoners. This was the start of my interest in prison mental health in Latin America. I was therefore delighted to be awarded the 2022 John Hamilton Travelling Fellowship to achieve the following objectives:

1. To raise awareness of prison psychiatry among clinicians and academics in Bolivia

2. To learn about current prison mental healthcare in Bolivia

3. To strengthen the UK-Latin America collaboration

In September 2023, I left the UK and began a 22-hour journey to Bolivia. Arriving the following day, I was met by my host and academic psychiatrist, Prof Guillermo Rivero. I was also met by a sunny climate with temperatures ranging from 26 to 40 degrees. I was ready to learn, teach, connect, be challenged, try new food, and be stretched linguistically.

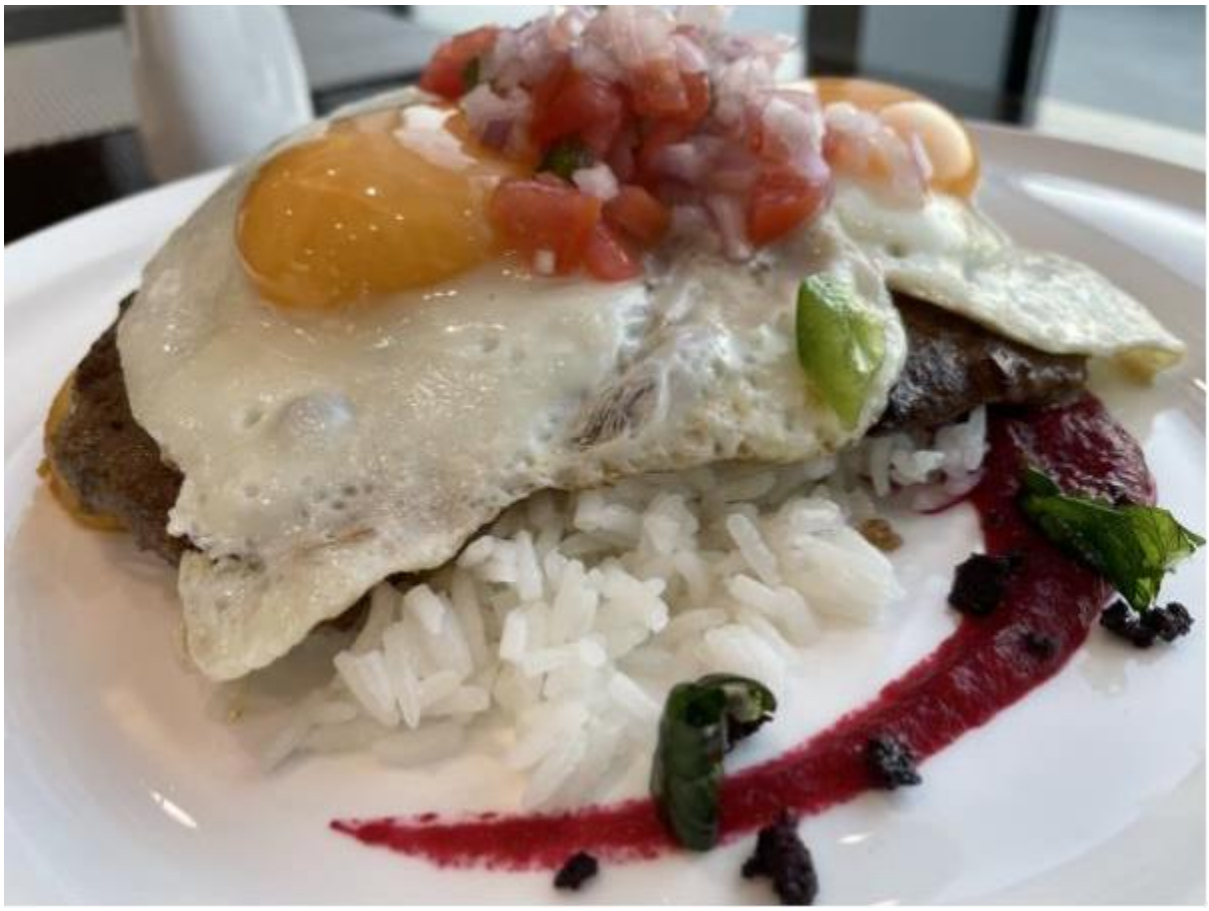

Photo: Silpancho, a traditional Bolivian dish comprising beef, rice, fried potatoes, fried egg, tomato, onion, and chilli.

I spent three days attending the SBP, Sociedad Boliviana de Psiquiatría (Bolivian Society of Psychiatry) conference, which is the equivalent of the RCPsych annual international congress. The opening ceremony was an impressive display of traditional music and dance. I gave a presentation in Spanish

on "Prison Psychiatry: a global perspective" which attracted a range of mental health clinicians and academics, as well as user/carer group representatives. During the congress, Guillermo and I recruited psychiatrists and psychiatry trainees to complete a survey about their perspectives on prison psychiatry.

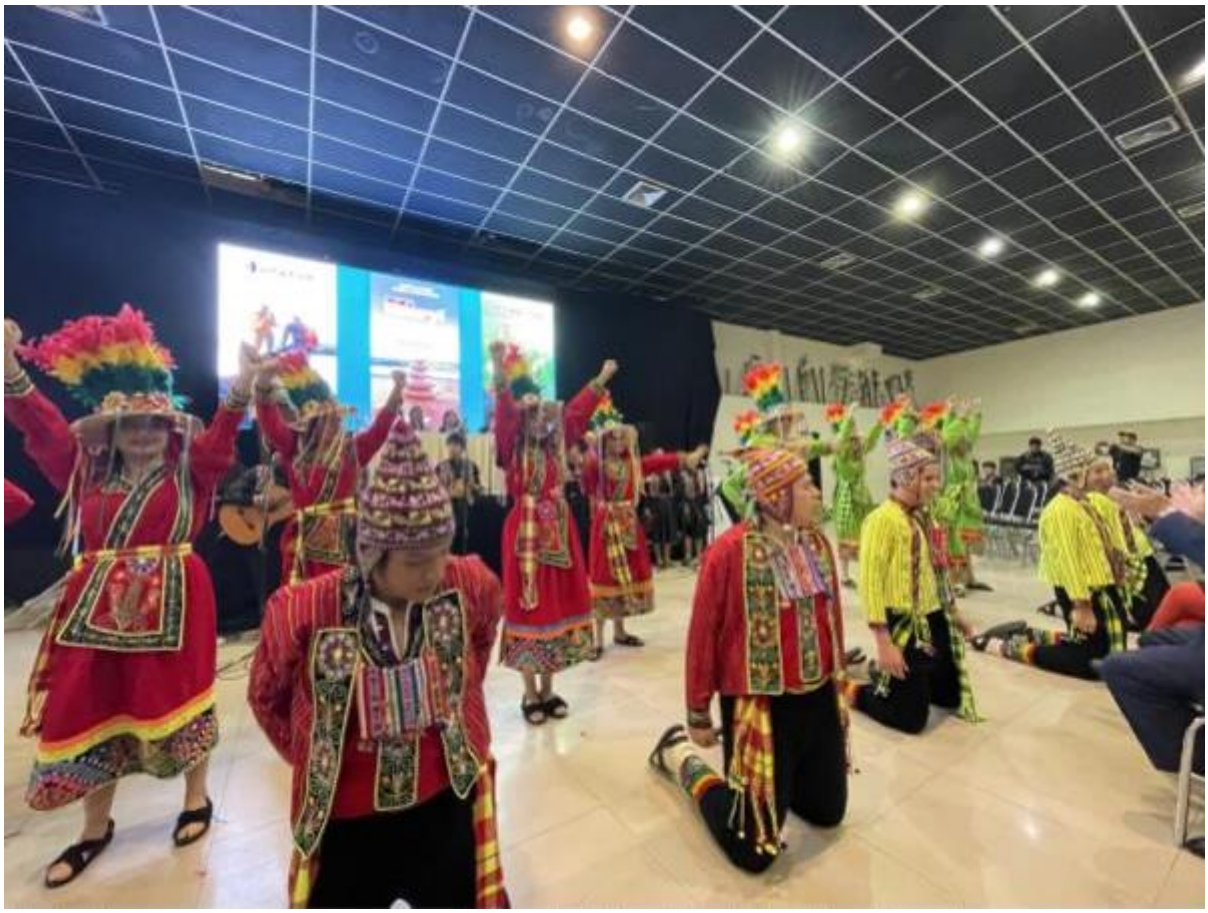

Photo: The opening ceremony of the Bolivian Society of Psychiatry biennial conference

On four occasions, I visited one of the largest prisons in the country. It was divided into separate areas, for example, women, men serving life sentences in closed conditions, men with substance misuse problem, and men in open conditions. The prison had a unique system in which the officers, "la policía", are situated outside the separate prison areas, intermittently making unannounced security visits to all areas. Each area had a degree of self-governance. In this way, the system reminded me of a school prefect system which allows appointed pupils to assume some responsibility usually assigned to teachers and to authorise discipline such as detentions. Each prison area had a prisoner-in-charge. This person was responsible for ensuring that various roles were filled by prisoners e.g., escorts, health centre assistants, food monitors, and was required to attend regular operational meetings with the prison senior leadership team. Each prison area was divided into several sections and each section was led by a "Number 1", a prisoner who reported directly to the prisoner-in-charge for the area.

My visits were accompanied by the prison psychiatrist. The prison was quite unlike any I had seen in the UK. I was pleased to see the extensive access to fresh air most prisoners enjoyed and the opportunities to participate in league football matches (I imagine this might appeal to UK

prisoners and patients in NHS secure settings). Walking through the crowded men's open area, I passed

prisoner-run shops, carpentry and crafts workshops, chapels, a library, a health centre, and an education centre. The prison psychiatrist visited several areas each day, reviewing patients and prescribing medication. I was impressed at how creatively he stewarded his resources. The absence of nursing staff was surprising. However, I met primary care doctors and allied health professionals who helped me understand the prison mental health system.

Outside of the prison, I spoke about forensic psychiatry topics to undergraduate students and psychiatry trainees. Through discussions, I learned that the full psychiatry training programme before reaching consultant level in Bolivia lasts only three years, in contrast to the six-year UK programme. Bolivian trainees have 15 days of annual leave, and some are part of on-call rotas with as few as three trainees.

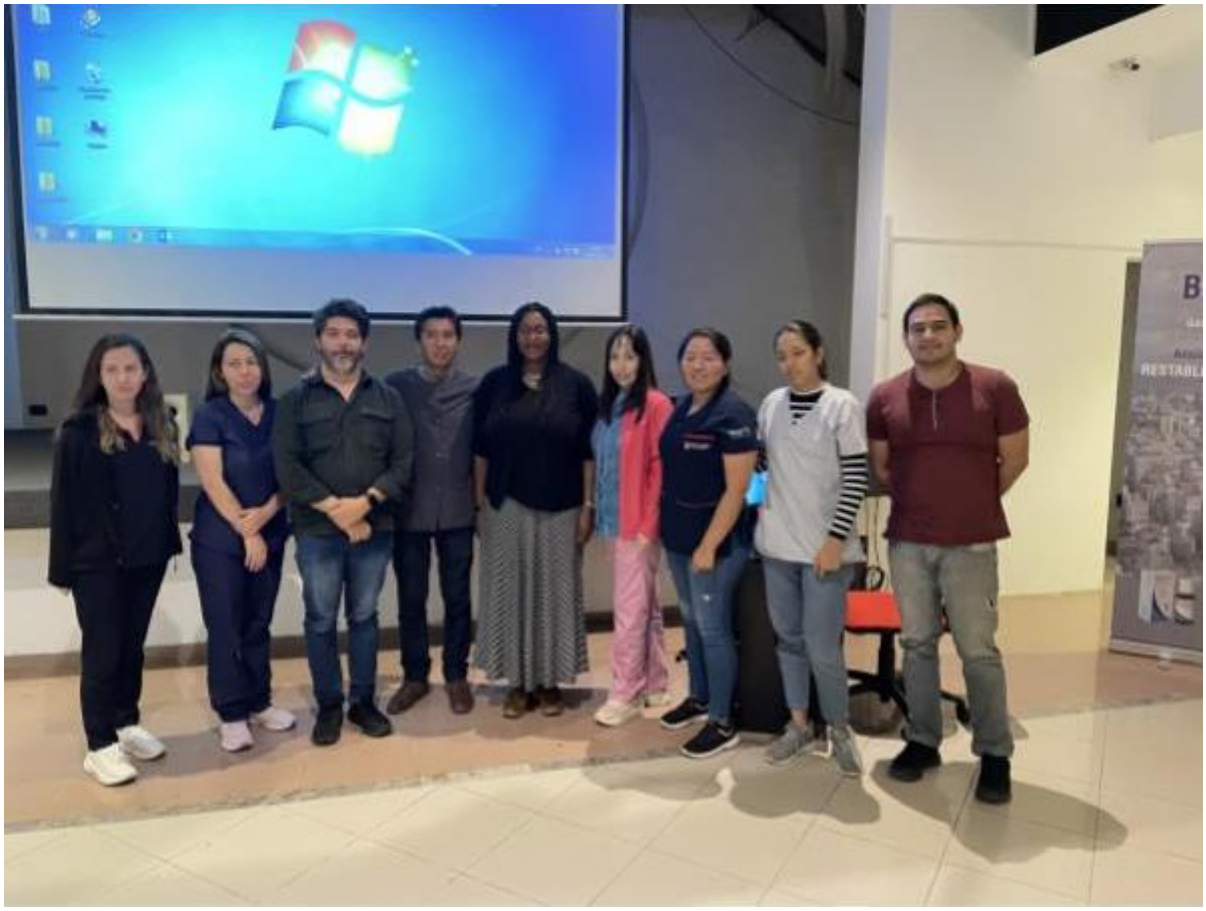

Photo: Evening speaking to psychiatric trainees about forensic psychiatry

Not all Bolivian cities have a public psychiatric hospital. I visited a private hospital run by a religious order. It was spacious with internal courtyards. The average stay was about two weeks. The hospital could usually choose whether to accept patients permitted to be transferred from prison for

treatment. However, there are no “secure” hospital beds in Bolivia. Part of the hospital had been converted into a permanent living area for about 12 patients with intellectual disability who did not have families to provide care in the community. This area was funded from profits of payments made by paying patients. In other areas of the hospital, a shared ensuite room for three people cost 35 Bolivianos per day whereas a private ensuite room with a television costs 70Bs/day. (35Bs converts directly to about £4.00; 35Bs is the cost of a Burger King chicken nugget meal in Bolivia.) Escorted leave in the hospital grounds involves walking through beautiful and extensive woodland with trees from which patients can freely pick and eat fruit, although they are advised to watch out for snakes!

My experiences and learning are too extensive to share fully in this report. I have returned with lessons and stories to share with colleagues in the UK. I would encourage trainees to consider spending time overseas and consultants to apply for the Fellowship. I am grateful to the Forensic Faculty for awarding the John Hamilton Travelling Fellowship. I also thank Eva, a pharmacy colleague from Tees, Esk and Wear NHS Foundation Trust, who kindly offered weekly lunchtime language practice prior to the visit.

MAP Mission - Bethlehem psychiatric hospital

by

Dr Hasanen Al-Taier, Consultant Forensic Psychiatrist

The Royal College of Psychiatrists in collaboration with the Medical Aid for Palestinians (MAP) organized a mission to train mental health professionals in Bethlehem psychiatric hospital in Palestine. The Team comprised of:

Dr Hasanen Al-Taiar, Consultant Forensic Psychiatrist, Oxford

Mr Tom McDade, Clinical trainer from Leicester Partnership Trust

Andy Robinson, Clinical trainer from Leicester Partnership Trust

Dr Sabina Bera, inpatient psychiatrist from New York, USA.

Below is a summary of the activities and observations from Sunday May 7th to Thursday May 11th, 2023.

The objective of this mission was to understand the challenges related to de-escalation and management of agitation on inpatient psychiatric wards at Bethlehem Psychiatric Hospital. The observations and data gathered during this mission will result in recommendations to improve safety for patients, family members, and staff, which in turn will lead to improved care and clinical outcomes for patients. Future recommendations will include a protocol for management of agitation and a needs assessment for inpatient psychiatric wards at Bethlehem Psychiatric Hospital.

Hearing from the staff (consisting of nurses, doctors, and their leadership) about the challenges faced regarding management of agitation. This included concerns about staffing shortages, challenging patient populations, and concern for their own safety and the safety of their patients.

There were challenges in managing patients who appeared to be verbally aggressive, especially in cases where patients made demeaning or offensive statements to staff. Staff had also concerns about physically intimidating patients who became agitated. They also described scenarios where one incident would lead to an increased level of agitation in the milieu. Staff reported that seclusion is used often in these scenarios.

Initial interventions would be piloted and monitored in the Women's and Men's Acute Wards, as this is where most incidents occur. Principles and protocols regarding de-escalation and management of agitation should be implemented hospital wide. Protocols may be posted in the form of posters or documents on inpatient wards. Operating within set standards may also address staff's concerns regarding retaliation after intervening with an agitated patients.

This has been a very interesting and rewarding training programme that aims to build professional capacity and teach the learners safe ways of managing their patients. We aim that this would be sustainable long term as the trainees will deliver the training to colleagues who have not attended it.

LSFU Placement as a GA Trainee

Dr. Sana Fatimaby, ST6 to Dr. Clare Stephenson, Newsam Centre, Seacroft Hospital, Leeds

During my 12-month ST6 placement in General Adult Psychiatry, I was assigned to a low secure Forensic Psychiatry unit. Despite my initial unfamiliarity with forensic psychiatry, the experience proved to be both inspiring and remarkably rewarding.

The convergence of General Adult Psychiatry, Social and Rehabilitation Psychiatry, and the specialised domain of Forensic Psychiatry was particularly fascinating. These diverse experiences significantly influenced my perspective on mental health care, facilitating the acquisition of valuable skills and knowledge that will shape my career moving forward. One of the initial impressions I grappled with was the heightened sense of security within the unit. The locked doors, restricted movements, and constant awareness of potential risks created an atmosphere quite distinct from the open wards I had previously encountered. It was a stark reminder of the delicate balance between providing therapeutic interventions and ensuring the safety of both patients and staff. This environment forced me to sharpen my risk assessment skills and taught me the importance of keen observation.

Interacting, on a daily basis, with service users with a significant forensic history challenged my preconceived notions, fostering a greater sense of empathy and open-mindedness. Recognising the interplay of mental illness, past trauma, and sociocultural factors became crucial in tailoring treatment plans, requiring patience and a willingness to acknowledge the complexities of their backgrounds, current presentation and forensic risk. Exploring the challenges of recovery and rehabilitation in the forensic setting revealed nuances comparable, if not more intricate, than those in a general adult setup. Dual diagnoses, reluctance to engage in treatment, and societal stigma added layers of complexity. Overcoming these challenges became integral to the rehabilitation process, emphasising the role of social inclusion and the obstacles posed by legal complexities and administrative hurdles.

Despite these challenges, moments of profound connection and growth were prevalent. Witnessing patients overcome obstacles and rebuild their lives underscored the transformative potential of psychiatric care. The multidisciplinary team in the low secure forensic unit played a pivotal role in shaping my understanding of collaborative care and co-production, emphasising the importance of teamwork in Psychiatry as a whole.

The emphasis on rehabilitation and risk management in forensic psychiatry prompted, for me, a reconsideration of traditional notions of 'recovery' in psychiatric treatment. I was fascinated how 'progress' was routinely measured not only in symptom reduction but also in the individual's ability to reintegrate into society safely, highlighting the broader societal implications of mental health care and the role psychiatrists play in public safety.

I hope to inspire more General Adult Trainees to consider choosing placements in Low Secure Forensic Units during the course of their higher training. This experience encouraged me to gain insights not only into Forensic Psychiatry and the intricate interplay between Mental Health Services and the Criminal Justice System but also to explore the nuanced aspects of Recovery and Rehabilitation. Additionally, it offered the opportunity to examine the challenges faced, particularly but not entirely exclusive to this service user group and gain experience and skills that can be readily transferrable to other clinical settings and subspecialties within the wider realms of Psychiatry.

The importance of reflective practice in forensic services

by

Dr Ioana Toma, Specialty Doctor in Forensic Psychiatry

Dr Alice Levee, Consultant Clinical Psychologist

Reflective Practice Groups in Forensic Settings represent a heterogenous group of mental health professionals, including occupational therapists, psychiatrists, psychologists and specialist mental health forensic nurses who meet within the confines of the secure service to think together about their work.

The Royal College of Psychiatry's Quality Network Standards for Forensic Mental Health
Services in medium security, low security and community settings all specify a requirement for workforce to have access to monthly formal reflective practice sessions.

The guidance goes on to say 'This forum provides staff members with the opportunity to reflect on their own actions and the actions of others. It can also be used to discuss concerns and issues of relational security'. Reflection is defined as 'a conscious effort to think about an activity or incident that allows the individual and/or the group to consider what was positive or challenging, and if appropriate, plan how it might be enhanced, improved or done differently in the future'. [1]

In a similar fashion, The General Medical Council supports this approach in their guidance for the reflective practitioner, stating 'Medicine is a lifelong journey, immensely rich, scientifically complex and constantly developing. It is characterized by positive, fulfilling experiences and feedback but also involves uncertainty and the emotional intensity of supporting colleagues and patients. Reflecting on these experiences is vital to personal wellbeing and development, and to improving the quality of patients care.' [2]

This collective thinking is a dynamic process designed to support and stimulate both intellectual and emotional responses which result from caring for disturbing and extremely challenging patients. It is usually facilitated by psychologists who are professionally equipped with the expertise to promote self-reflection, unearth unconscious mental processes and their impact on observable behaviour, tackle with

transference and countertransference and embed all of these into a culture of risk assessment and management.

Therapeutic relationships in secure settings are always dyadic relationships. This means there is a permanent interplay between the patient's history, psychopathology and experiences of previous relationships and staff's similar circumstances, both at a conscious and unconscious level. The chief task is to adopt a stance of receptiveness and create a safe space that has a transformative potential, which has enormous implication in the risk-reduction work. It is not uncommon that staff may re-enact attachment issues or personal traumatic experiences with patients and colleagues and find reminiscences of these mirrored in patients. Boundary maintenance, another core concept in forensic psychiatry is also easier to establish and maintain when there is time to think and reflect. In this way, reflective practice can be conceptualised as a provision of care for staff which may have incredible beneficial effects on patients' care. [3]

Mitigation of risk has been long-established as central in forensic psychiatry and psychotherapy. A key marker which differentiates it from other psychiatric disciplines is the involvement of a third party represented by the criminal justice system and by extension, public protection. Negotiating this triangular situation and tackling its competing demands underpins various lines of communication for which all staff are accountable. For this reason, duties of care can sometimes overlap, which creates the necessity of straight-forward communication and clear role delegation. All of these can be brought to the table in reflective practice sessions, and the diversity of group members is paramount due to their distinct skill set and experience, especially that of working with multiple external agencies and ramifications of the criminal justice system.

Another essential functional aspect in forensic psychiatry is containment. In psychoanalytic theory it was conceptualized as a process of holding emotions and feelings within the mind. Bion (1959) described social groups as a 'maternal container' where members offer and simultaneously receive overwhelming or burdensome projections and channel them back into a more palatable manner. Similarly, containment can be understood also pragmatically, as in physical and procedural institutional containment which enables safe provision of care.

The vast majority of patients lack robust internal structures that promote tolerance of conflicting and difficult emotions, and they will expel them from the mind through 'acting out' and eventually project them into staff's minds. When these projections become difficult to digest, they often require the presence of a 'buffer' which can relieve the tension within the

relationship and help metabolize the intensity of these experiences. The presence of the reflective group can be this buffer which will help self-regulate the clinician's emotional responses and allow for different perspectives to emerge in a particular context.

Coupled with a persistent mistrust of authority figures, violent attitudes are likely to elicit unconscious retaliatory responses from staff who can impose even stricter and more punitive regimes. In this way, the psychopathology of offender patients can be mirrored in the pathological culture and dynamics of the forensic institution. Early disrupted attachment relationships are recreated and relived with professionals for the sake of boundary-testing and affect regulation and are bound to trigger conflicts between offenders and staff, and between staff members, leading to splitting and erosion of nurturing relationships. 4 A containing environment is equally achieved by permanently attending to these communications and acknowledging the pressures and anxieties professionals are exposed to. This can ideally be elucidated within the protective confines of a reflective space and requires safe minds to come together and be fully honest with each other.

Countertransference is commonly understood as the therapist's cognitive-emotional responses to their client (Gabbard, 2004), however has expanded over the years into a more 'totalistic' definition such as 'all therapist reactions to a client, whether conscious or unconscious, conflict-based or reality-based, in response to transference or some other material' (Hayes, 2004). It is important to highlight that countertransference not just provides valuable understanding of what the patient induces in others but stems from unresolved conflicts and unconscious fantasies of the therapist. Functionally, it can be extended further into any relationship that involves two separate subjectivities which interact meaningfully and dynamically, a relationship that has the potential to nurture and stimulate growth for both parts.

In forensic services reflective practice received little empirical attention despite a very rich and diverse range of triggered emotional reactions, such as fear, anger, disgust, pity or shame. Even though a valuable therapeutic tool, can be a double-edged sword. It is both protective of the alliance with patients, but if not brought to the consciousness of those who engage with it, can be catastrophic and give rise to what can be perceived as 'alien feeling.' Recognizing our emotional reactions is not just diagnostically informative and prevents iatrogenesis, but essential to formulate a balanced risk assessment.

For example, sexual offences against children engender a 'by-default' negative counter-transferential process which has the potential to create more punitive measures and hostile states of mind in those who care for such offenders. This in turn will lead to increased distress for patients and staff who will be entrapped in a vicious cycle of burnout, despair, helplessness and eventually therapeutic nihilism – the belief that the patient is untreatable.

Risk-management wise, unmetabolized countertransference can distort the clinical picture. For example, patients who evoke in others negative and unpleasant feelings might be regarded as more prone to violence. Conversely, those who stimulate sympathy, pity or even physical attraction can be favoured and overlooked more easily, which can lead to blind spots in treatment through an underestimation of violence risk. 5

In light of the above, forensic settings can be seen as a theatrical scenery where the actors re-enact both conscious and unconscious phenomena, woven with compassion and care, for the sake of engendering safety to promote recovery. Reflective practice is a permanent rehearsal where staff should aim to maintain emotional wellbeing and an objective stance. A functional team is built upon both harmony and conflict, and the quality of clinical care ultimately depends on how willing the team is to nurture and value each member.

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WA mental health court model, 10 year anniversary

by

Adam Brett, Teri Ekanayake, Laura Found, Chris Hipwood, Daniel Cazangiu

The Western Australian therapeutic mental health court (Start court) was developed in 2013 in response to the overrepresentation of people with mental disorder in the criminal justice system. It is based in the magistrates court. It is a dedicated court program that has input from multiple agencies including the Department of Health, the Department of Justice, Western Australian police Department, legal aid WA, mental health Law Centre, drug and alcohol diversion (Cyrenian house), Outcare (non-government organisation) and court security (G4S). It is a voluntary, six-month program, which addresses the participants mental health, psychosocial needs and criminogenic factors. This report is a description of the program and how it has evolved over 10 years. We believe that the model of care is unique in Australia and one that could be easily replicated.

The initial target population was high prevalence mental disorders and low-level offending. This quickly evolved to include the spectrum of all mental disorders with a variation in severity and acuity. The main factor was that the individual wanted to address their mental health issues. Offending behaviour varied but the court could only manage people whose offending did not result in a term of imprisonment.

We looked to models used from the wide experience in the USA mental health courts and from experiences in the rest of Australia (1) which emphasised the need for therapeutic jurisprudence. Therapeutic jurisprudence provides the conceptual underpinning of the Start Court (2) and is solution focussed.

The aim of the court is to assess the client's mental health issues and put a plan in place. The goals were improving client's well being and quality of life, reduce their risk of reoffending, reduce their substance use, divert them away from the justice system and to save money.

The court operates without specific legislative backing, it relies on the grant of conditional bail under the provisions of the Bail Act.

The process

The Start Court resides in the Perth magistrate's court. Referral is usually made from other courts or by lawyers. Significant efforts have been made to promote the mental health court, including presentations to key stakeholders and advertising posters. The applicant is asked to bring information regarding their mental health issues. All mental health issues would be accepted, the only exclusions being antisocial, histrionic and narcissistic personality disorder as a primary diagnosis and if substances are the primary disorder, they would be referred to the drug court. Most criminal charges are accepted, if imprisonment is avoidable. Sex offenders are assessed on an individual basis, related to risk. If they are deemed legally and clinically suitable they are put through to an information session.

Information sessions were developed early in the program to ensure applicant's knowledge of the Start Court and improve retention in the program. Verbal and written information is provided to each applicant so they are aware of the expectations and that they enter the program with informed consent. They are told that the program is voluntary, that it runs for six months, and they will be asked to attend the court on a regular basis (usually each fortnight). They are informed of expectations regarding drug use and monitoring. They are asked to sign a release of information form so the clinical team can liaise with significant others. A paralegal goes through the form with the applicant. The applicant is then given an appointment for an initial assessment.

The initial assessment takes place with a clinician and a recovery and well-being officer. The purpose of this assessment is to ascertain suitability for the program and to develop a management plan. The management plan is developed with the participant to address mental health issues, AOD and psychosocial issues. Clinical suitability is discussed with the broader clinical team and a court report is developed. This is a comprehensive report that documents previous mental health and AOD contact and treatment, offending and current concerns, including risk issues. A plan is developed that outlines expectations of the participant. All draft reports are shared within the clinical team to ensure consistency and adoption of good practice.

The clinical team are not the primary carers for the participant but liaise with other services, which may include General Practitioners (GPs), psychologists, mental health services and non-government organisations. The clinical team may have to broker services and advocate for ongoing care for the participant. This could include letters to GPs to develop mental health care plans. Helping participants and their families navigate

the complex mental health system is a role for the team, including the carer support person.

The participant checks-in regularly to court for an update and to assess how they are progressing. A pre-court meeting is a multidisciplinary, interagency team meeting held before the participant appears in open court. A written handover of progress made in the adjournment period is provided to the court, which includes appointments attended and made, results of urinalysis and any other progress or challenges. In between appointments the clinical team, community corrections, AOD and the Outcare (non-government organisation) work together to ensure the participant is achieving their goals. There is a formal review at the halfway mark, after three months, to ensure that things are on track.

If a participant is doing particularly well they can be given an achievement certificate from the court. This is a formal process and the magistrate presents the certificate in open court. This can be a significant event for the participant and it is also helpful for new participants who are in the court to witness this.

If a participant is not reaching their goals or is not addressing their management plan goals they can be given an opportunity card. This occurs in open court and is given to the client. The card has questions on the back to address motivation and goals for the rest of the court program.

Participants can be terminated if they are non-compliant or if they reoffend on the program. They can also voluntarily terminate the program if they wish to do so, without any penalty and what they have achieved whilst on the program will be taken into consideration at their sentencing.

In line with the Bail Act participants are sentenced and discharged from the Start Court program after six months. Their participation in the program is taken into account at their sentencing. The court psychiatrist may provide a causal link, presentence report where necessary, which addresses their mental health at the time of the offending behaviour and any mitigating circumstances. The community corrections officer may provide the court with a pre-sentence report on request.

If the participant completes all of the goals outlined at the initial assessment they may graduate from the program. If they graduate, sentencing occurs in two parts: Initially the formal sentencing and handing down of the sentencing outcome occurs before an informal graduation.

On graduation, the participant is presented a recovery certificate. The magistrate also congratulates the participant and summarises the progress they have made on the program. The magistrate comes off the bar and personally presents the recovery certificate to the participant. The court stands and applauds the participant's achievement. The participant, their support people, the entire clinical team and the recovery and well-being team, community corrections officers and the police prosecutor may all say a few words.

The Start Court team comprises a dedicated magistrate, a dedicated judicial support officer, a dedicated police prosecutor, dedicated lawyers and court security. Start Court has had five magistrates over the years, with varying tenures. All of whom have brought something new to the table and have helped develop the program. Police prosecution liaise closely with the rest of the team and have learned to trust recommendations from the clinical team.

The clinical team has a nurse manager and an administrator. There are two full-time equivalent clinical nurse specialists, a senior social worker, a clinical psychologist and consultant psychiatrist. There is a drug and alcohol diversion officer, two community corrections officers and the Outcare team, consisting of a team leader, two recovery and wellbeing officers, a peer worker and a carer peer worker.

What works

We provide holistic care for the participants. We ensure that their basic needs are met, including food, accommodation and meaningful activity. We work as a team to assist the participants in fulfilling their goals.

We work under one roof in an open plan office, which facilitates easy communication, camaraderie and a team approach. The integration of peer workers, carer support workers and alcohol and drug officers within the clinical team makes a significant value add in the management of the participant. There is a flat hierarchy within the team enabling each member to have input into decisions from the team.

The court has access to expertise and receives regular feedback. Therapeutic jurisprudence is strengthened by timely feedback to the magistrate. The clinical team keeps in close contact with treating services to ensure the participants are receiving the optimal care and are attending appointments.

We have demonstrated an improvement in clients' mental health, a reduction in drug use, improved quality of life and a reduction in recidivism. It has been demonstrated that the court is cost effective.

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Let's talk about sex – promoting healthy attitudes and improved access to pornography in Wathwood Hospital by

Dr Rianne Parmar, Psychiatry CT3

As Psychiatrists, we aim to look at the patient as a whole person. We ask deeply personal and probing questions about so much of their experience of living. We often, however, overlook a person's needs to have a fulfilling sex life and healthy romantic relationships.

A person's identity as a sexual being does not stop when they become an inpatient. Whilst working as a CT3, I have learned from staff and patients at Wathwood Hospital, how patients' sexual needs are considered and addressed in a Male Medium Secure Inpatient Forensic setting.

Current policy allows patients to purchase pornography for private use in their own room. It must be material of equal nature to that available in a high street outlet. In practice, material is usually purchased in DVD format from the Amazon website and subsequently screened for suitability by Security staff. It also requires approval by the Responsible Clinician, which most commonly occurs in ward round in front of a multitude of professionals. In management meetings it became clear that there is a demand for adult materials, and this was demonstrated by the frequent issues caused by patients trading them.

With full Consultant support, a quality improvement project was born, with the goal of updating the policy to match modern standards. A key component of this has been seeking staff and patient views on the topic of access to pornography.

Two core trainee colleagues and I worked as a team to conduct qualitative, semi-structured interviews with patients in Wathwood Hospital. Participants were recruited from the fortnightly Patient Forum, with all inpatients welcome to contribute. Anonymised questionnaires involving Likert scales and free text response spaces were distributed at the Patient Forum and throughout the wards.

We investigated patients' awareness of the current procedure to access pornography, whether they felt it worked well, and what they thought the impact of facilitating easier access to pornographic material might be.

Staff were invited to complete a similar anonymised questionnaire, again considering their opinions on the positive or negative impacts of patients more readily having access to pornography. In addition, we gathered data to assess whether there was a difference in the degree of comfort asking staff for opposite-sex or same-sex pornography. Both patient and staff surveys demonstrated a consensus that the policy does not work well, and this is demonstrated in practise by the alternative routes patients take at present to source adult material.

Of note is that a few members of staff members expressed increased discomfort with the concept of patients asking for pornography involving same-sex sexual activity, compared to heterosexual sexual activity. One can only speculate as to whether this discomfort may at times be noticed by patients, and if that would therefore act as a barrier to them accessing material which best suits their individual sexuality.

Patients themselves expressed a desire to have access to LGBTQ+ pornographic content that is equal to cis- and heterosexual content. In the focus group, one participant considered how some patients may not be comfortable with, or fully understanding of, their own sexuality yet. If a person is currently unable to say to themselves what their needs are, can they be confident in expressing them to the people they must request porn from? His comment highlighted the importance of encouraging an environment which acknowledges the variety of patients' sexual needs and sexuality in a respectful manner.

As a woman in the room, I felt privileged to have participants share their personal views within the focus group. I recall a previous ward round where a patient appeared uncomfortable asking for a pornographic DVD, as 'there are ladies in the room!'. A focus group comment of 'it's porn, it's what men do' further demonstrated there may be some assumptions that viewing pornography is a male-only activity. I suspect these thoughts may exacerbate feelings of discomfort for our male patients, when having to bring a DVD/magazine title to ward round. In the focus group, multiple people described the process as embarrassing, particularly when a large proportion of our Multi-Disciplinary Team staff are female.

We also explored areas of concern. Patients were insightful in suggesting that individuals with historical sexual offences may need a more thorough risk assessment or care plan surrounding their pornography access. Some felt that accessing pornography may increase incidents of sexual assaults

towards staff and peers. I compare this to previous fears that violent video games might cause people to become more violent themselves and wonder if there is a way to prove a causative link. One participant was concerned that pornography, which is often made to appeal to the male gaze, would encourage patients to objectify women.

We have considered the idea of building a library of pre-approved DVDs from a local business. There is a hope that instead of fuelling misogyny and false expectations of sex, the opposite can be achieved by carefully selecting content. Pornography could be used for its primary purpose of addressing sexual needs whilst also demonstrating healthy, consenting, adult relationships. For people who have been detained for years – since their adolescence for some - this could provide education on real life sex and relationship skills on which they have missed out.

Not everyone will be interested in viewing porn. The average person will make a personal choice to access it or not, privately and in their own time. Whether solo or shared with others, we can seek to fulfil something high on most people's hierarchy of needs, if we consider Maslow's work. Our patients at Wathwood Hospital do not currently have the luxury of this choice. It is something I feel we should keep in mind, when providing the means to address sexual needs safely and appropriately, with as much dignity and privacy as possible.

Psychiatry on Trial: A Forensic Expert's Experience in two nations

Dr Ahmed Abouelghit, Consultant Forensic Psychiatrist and Acting Head of Forensic Mental Health Services, Hamad Medical Corporation, Qatar
Dr Mariem Baccar, Acting Consultant, Forensic Psychiatrist, Hamad Medical Corporation, Qatar

As forensic psychiatrists with experience in both the UK and Qatar criminal justice systems, we have come to appreciate the unique and often complex role we play as expert witnesses. Reflecting on these experiences, we see a tapestry of challenges that are remarkably similar in both contexts, yet delicately distinguished by the cultural and legal differences of each system.

We see the task of translating the intricate and often abstract concepts of mental health into concrete, understandable terms for the court as both a profound responsibility and a significant challenge. Mental health is a world filled with nuances and subtleties, where each patient's experience is unique and deeply personal. The conditions we diagnose, and treat are often complex, with symptoms and manifestations that can vary widely from one individual to another. This complexity is at the heart of psychiatric practice, yet it poses a unique challenge in the legal setting, where clarity and precision are paramount.

When we stand as expert witnesses, we are acutely aware of the need to bridge these two worlds. The depth of psychiatric knowledge we have acquired over the years must be conveyed in a way that is not only accurate but also comprehensible to those who do not share this background. It is a balancing act – ensuring that the richness and depth of psychiatric understanding are not lost, while also adapting this knowledge to the structured, often black-and-white world of legal discourse. This requires not just a deep understanding of psychiatry but also an ability to communicate effectively, to simplify without oversimplifying, and to illuminate without losing the essence of the subject matter.

The inherent subjectivity in psychiatric assessment adds another layer of complexity to this role. Psychiatry, in many ways, is an art as much as it is a science. It relies heavily on the interpretation of symptoms, behaviours, and patient narratives. This interpretive nature stands in

contrast to the objective certainty sought in the legal system. In the courtroom, our assessments, which are grounded in years of clinical experience and a deep understanding of human behaviour, are often scrutinised through a lens that seeks definitive answers. This scrutiny can be particularly intense during cross-examination, where every aspect of our evaluation can be questioned or challenged. We have found ourselves in situations where we had to defend not just the conclusions of the assessment but the very methodologies and principles that underpin psychiatric practice. These moments can be challenging, as they require us to not only stand firm in our expertise but also to explain and justify the inherently subjective nature of psychiatric assessment in a context that favours objective, tangible evidence.

Delving more into the task of determining an individual's competence or criminal responsibility, we find ourselves confronted with a multifaceted challenge that extends far beyond the bounds of current clinical assessment. This aspect of our role requires us to step into the past, to reconstruct and understand an individual's mental state at a specific moment in time – often during the commission of an alleged offence. This retrospective analysis is not just about applying psychiatric principles; it is about piecing together a mental puzzle without having all the pieces readily available. It is a daunting task, as mental states are fluid and can be influenced by a myriad of factors, both internal and external. The complexity is compounded by the fact that we are not just assessing a static condition, but attempting to reconstruct a dynamic and perhaps transient state of mind, one that could have been markedly different from the individual's usual mental state.

Giving an opinion on the ultimate issue is another major challenge. The inconsistent application of the ultimate issue rule across different jurisdictions is a significant concern, as it creates uncertainty about the extent and nature of our professional input in court. This inconsistency requires careful navigation to ensure that our testimony remains within professional boundaries. An additional significant challenge is the potential influence of our testimony on jury decision-making in the UK system - the Qatari judicial system does not apply the jury system. It is crucial to maintain a delicate balance between providing necessary clinical insights and avoiding any direct or indirect influence on the jury's legal judgments. Our testimony must be clinically sound, impartial, and free from the sway of the legal context. These challenges underscore the critical and complex role we play in the courtroom, striving to offer clear, unbiased, and clinically informed opinions that assist the judicial process while upholding the integrity of our profession.

Furthermore, working within the criminal justice systems in the UK and Qatar has highlighted the importance of cultural sensitivity and legal astuteness. Each system, with its unique legal definitions and cultural nuances, frames mental health and criminal responsibility in its own way. Navigating these differences requires an appreciation of the cultural contexts that shape how mental health is perceived and how responsibility is adjudicated. In the UK, where mental health awareness is more advanced, there is a certain framework and language that we use. However, in Qatar, where cultural factors play a more significant role in the interpretation of behaviour and responsibility, we must adapt our approach accordingly. This cultural and legal dexterity is crucial in ensuring that our assessments are not only clinically sound but also resonate with the legal and cultural ethos of the jurisdiction we are operating in. This aspect of our work serves as a constant reminder of the need to be both a clinician and a cultural interpreter, bridging the gap between the universal principles of psychiatry and the specific realities of different legal and cultural landscapes.

Lastly, the role of a forensic psychiatrist can significantly influence public perception of mental health. Each time we provide testimony in high-profile cases, we are not just speaking to a courtroom; we are also addressing a wider audience through the media and public discourse. Our words and interpretations carry weight far beyond the legal confines, influencing how society at large views mental illness and criminal behaviour. This realisation brings with it a profound sense of responsibility and duty. We find ourselves constantly mindful of the language we use and the conclusions we draw, knowing that they have the potential to either reinforce stigmas or contribute to a more compassionate understanding of mental health. This aspect of our work requires a careful balancing act – staying true to the scientific and ethical foundations of psychiatry while also being acutely aware of the societal implications of our testimony. It is a role that we approach with a deep sense of commitment and care, always striving to contribute positively to the ongoing dialogue around mental health and justice.

Net Zero Mental Health

Dawn Washington, Faculty of Forensic Psychiatry Sustainability Officer

As we will now all no doubt be familiar, the Royal College declared a climate and ecological emergency and published a position statement in May 2021 (https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/position-statement-ps03-21-climate-and-ecological-emergencies-2021.pdf) in which it was made clear that psychiatrists should be informed about and actively engaged in these issues. Over more recent months there have been numerous emotive stories in the main stream media highlighting events which are directly affected by global warming including storms, flooding and wildfires, making the crisis increasingly difficult to ignore. Climate change poses a major threat to both physical and mental health through mechanisms such as heatwaves, pollution, food insecurity and displacement and the world is not making changes fast enough. Despite this, the government have announced a 'watering-down' of net zero policies and given the go-ahead to develop the UK's biggest untapped oilfield. It is hard to know what to do or where to start but it is clear that doing nothing is not an option.

It is in this context that the National Collaborating Centre for Mental Health (NCCMH) and the College Centre for Quality Improvement (CCQI) at the College have released a report and educational resources on delivering greener, more sustainable and net zero mental health care (https://www.rcpsych.ac.uk/improving-care/net-zero-mental-health-care-guidance-education). This accessible, user-friendly report effectively summarises what we need to do and why, outlining four principles of low carbon care and setting out 33 recommendations aimed at policy makers, professional bodies, system leads, service leads and clinicians/professionals/staff.

Reaching Net Zero in the NHS is a massive undertaking and forensic services will present unique challenges for example due to risk issues, long average length of stay and use of out of area placements. All Trusts are in different places on the journey but there are pockets of innovative and inspiring practice, which can be shared and help to guide further action. I would urge everyone, regardless of their role or seniority to familiarise themselves with the document and resources and seek to introduce and role-model greener, more environmentally-friendly actions into both their individual and professional lives. To this end it was proposed that the Newsletter begins to incorporate a 'Sustainability Corner' in which specific actions could be suggested that may be easy for us to implement in our daily lives and practice. I would also like this to

invite submissions showing examples of different approaches and interventions from across the UK that could potentially be replicated in other Trusts.

My top tip for reducing your personal carbon footprint would be reviewing your banking habits. Not all banks were created equally and there are a number of websites available which will be able to tell you how sustainably and ethically banks and pension providers may be investing your money. A simple switch can reduce your carbon footprint dramatically with very minimal effort. One of the worst offenders is Barclays and as such there have been efforts from groups such as Psych Declares to urge the College itself to change banking provider. It is also worth considering any other groups you engage with – PTAs, charities, social clubs etc. – and speaking to them about who they bank with. The more money that is moved away from banks investing in fossil fuels, the less likely they are to continue to do so!

RCPsych Library - Forensic Faculty

Fiona Watson
Library and Archives Manager
Royal College of Psychiatrists

The College Library provides OpenAthens accounts to members, to help them support and develop their practice. The accounts allow access to a wide range of databases, ebooks and journals.

The collection is built completely on member recommendations, so if you can't find something you need, just let us know.

Databases – the College provides access for members to Medline, PsycINFO and Embase.

Journals – some examples include: Lancet Psychiatry, the American Journal of Psychiatry and European Psychiatry.

Books - We have a physical library and members are welcome to borrow books, which we will send out in the post for free. We also provide access to online version of the **Maudsley Prescribing Guidelines**.

For articles not available through our own subscriptions, we offer inter-library loans, finding what you need in another library and sending it out to you by email.

We also offer a free and unlimited literature searching service for those who do not have the time or confidence to search through the databases. This can also be combined with training for anyone who wants to refresh their skills.

You can find all these resources on the College website: www.rcpsych.ac.uk/library

Or get in touch with us directly:

infoservices@rcpsych.ac.uk / 020 8618 4099

Quality Network for Forensic Mental Health Services Annual forum

Date: 2nd July 2024
Time: 10.00am-4.00pm
Location: RCPsych Head Office
Booking Link: https://forms.office.com/e/c5frp45Ywd
Presentation Proposal link: https://forms.office.com/e/3CpwAxjvWf

Contributions Welcome

Thank you to the contributors of this edition.

We would welcome contributions for the next e-newsletter by Friday 26th July 2024.

The newsletter is a means to keep you informed and updated on relevant topics and the Faculty of Forensic psychiatry's work.

If you would like to share your experiences in your area or write in the newsletter, please contact the iForensic Newsletter team:

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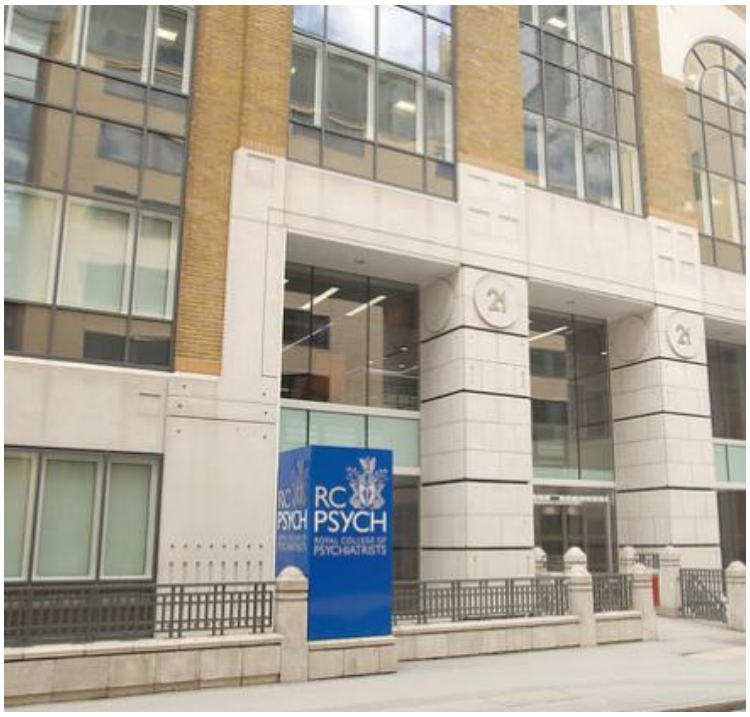

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