

# iForensic



Faculty of Forensic Psychiatry Newsletter  
Summer 2020

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# Welcome

## News from the Faculty Chair

by

Dr Josanne Holloway

Chair of the Forensic Psychiatry Faculty



This is my first contribution to the Forensic Faculty newsletter and I would like to start by thanking Pamela Taylor for her inspiring leadership over the last four years. It will be a hard act to follow but I will do my best. I am pleased to say that she has agreed to continue to serve on the Faculty executive committee so we will be able to benefit from her contribution for some time to come. I am due to chair the first executive meeting remotely in July and am very thankful to still have the support of Stella Galea without whom we would not be able to function. Some of the headline issues we will be addressing at future meeting include:

- It has been a strange few months during the COVID pandemic and there is a lot we have learnt in terms of innovative service delivery and use of digital platforms amongst other things. We also know that there are risks other than infection which we need to remain aware of and address, including raised suicide risks in our younger population and general disruption to previously well established clinical pathways.
- Equality, equity and diversity remain principles that we hold to dearly and tragic events continue to remind us that there is much work still to do in this regard.
- Workforce planning remains an important issue that we need to tackle more proactively and we will be working with colleagues in the College on this. Regional representatives and the devolved nation chairs will have an important role to play to inform this work. Recruitment and retention remain an essential arm of workforce planning. The Faculty's work with medical students and trainees, encouraging them into psychiatry in general and forensic psychiatry in particular are an important limb to our strategy. From a clinical perspective, neurodevelopmental psychiatry and forensic psychotherapy are important clinical areas that we need to

understand and protect. Forensic psychotherapy and research posts remain at risk and we need to be innovative and proactive in protecting these important areas of our clinical work.

- Communication and building relationships remains a priority, not only with Faculty members but also with organisations and departments which impact on our work. Our College communication lead, Minha Fayoom will be helping us update and review this area. We traditionally have good relationships with the Ministry of Justice and have collaborated with them on training, education and research. We hope to further develop similar effective working relationships with the Department of Health and Social Care.
- Much of our clinical work involves individuals in custodial and other secure settings and there are a number of work streams related to this. These include young people in custody, alternatives to custody, the contribution that the Faculty has made to sentencing, use of restrictive practices and a focus on victims including those of historical sexual abuse. Understanding the patient journey into and out of prison, and how this aligns to effective clinical pathways is a key priority.
- Mental health and substance misuse legislation are also issues that the Faculty has addressed.

For those of you who do not know me, I'd like to take this opportunity to tell you something about myself and what I may bring to the Faculty.

I am a Consultant Forensic Psychiatrist and Associate Medical Director for Specialist Services in the Northwest of England. I remain clinically active and have worked across all age groups and at all levels of security, in the community, prisons and on diversion projects. Some of my successes have been: developing comprehensive forensic patient pathways with continuity of care for patients; establishing the forensic deaf pathway and the Women's Enhanced Service; the championing and development of consultant and clinical leadership across specialist services; establishing meaningful patient engagement at all levels of decision making; establishing an ethos focusing on outcomes rather than process.

I have served on a number of RCPsych committees including the Forensic Faculty as Regional Representative and Treasurer (a long time ago now). As Northwest Division Chair I served on Council and the College Finance Committee. I led reviews on: The College in the context of other Royal Colleges; the College Education Centre which influenced the development of the current conference and continuing development structure; the work of Divisions within the College. I led a review and established the Quality Assurance Framework for the CASC examination. I am the Deputy Chief Examiner.

I see the role of the chair of the Faculty as ensuring that views of Faculty members and our patients are effectively represented within the wider College structures and nationally. It's important to keep the membership informed about relevant national and wider College business so we can be proactive and provide informed contributions to discussions and developments within the College, DoH, NHS, and MOJ. Transparency, and meaningful engagement is key. I hope to continue the great work that Professor Pamela Taylor has been doing.

I strongly believe that to sustain and further develop the role and expertise of members of our Faculty, we need to enthuse, train, mentor and retain the *best* medical students and psychiatric trainees. We have enormous potential to develop and support education, training and wellbeing of our members. Our conferences and training opportunities must be relevant, valid, up to date and new. We respect and honour the trail blazers of the past but we must provide a platform for our up and coming clinicians, academics and leaders of the future, supporting and showcasing evidence based new practice and innovation.

Acknowledging the real experiences and opinions of our front-line clinicians will keep us fresh and relevant. Our committee, especially through our national chairs and regional representatives, must engage actively with the wider membership in seeking views and in informing about work undertaken by the committee. The committee should provide opportunities for all members not just members of the executive to actively engage with committee business. We must continue to strive to develop and enhance our communication including effective use of our member's web page and developing more efficient and effective ways of communicating with members in a timely manner.

Someone wrote of me "*You challenge honestly, foster collaboration, genuinely care for things that matter (patients, and doctors who take care of them), and have a brazen edge which engages innovation*". I hope I continue to live up to that.

## Legal Update

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

Dr Nick Hallett, Consultant Forensic Psychiatrist, Essex Partnership University NHS Foundation Trust



We've tipped our hat to the theme of this issue with the first case. The capacity to consent to sexual relations case is already widely reported.

The two sentencing cases are worth reading because they reflect the different ways in which psychiatric evidence can be used for sentencing even when there is not a specific medico-legal question being asked.

### **R v Jones (Paul Anthony) [2020] EWCA Crim 764**

**Read it** if you're interested in the impact of the Coronavirus on sentencing

#### What was the issue?

The case concerned a 41-year old male convicted of attempted burglary and possession of Class A drugs. He had also stolen £485 worth of goods and had broken into a pub at night whilst the landlady and her partner were asleep. On 17<sup>th</sup> March, just six days before the Coronavirus lockdown, the Crown Court in Cardiff sentenced him to eight months imprisonment. He appealed on the basis that the sentence was manifestly excessive and that the Coronavirus lockdown made his time in custody more restrictive than it would otherwise have been.

#### What was the upshot?

In this case the sentence was not manifestly excessive especially as he had an extensive forensic history of 178 offences. Nevertheless, the impact of the Coronavirus lockdown which could not have been predicted by the sentencing judge should be taken into account. In the exceptional circumstances of the lockdown it was appropriate to consider the increased restrictions in prison as he only had 30 minutes out of his cell each day and no social visits were allowed. His sentence was reduced from eight months to six months.

## **A Local Authority v JB (Rev 1) [2020] EWCA Civ 735**

**Read it** because people under your care have sex

### What was the issue?

JB has autism spectrum disorder and complex cognitive deficits. The case considered the question of his mental capacity to decide to have sex and whether understanding that the other person must consent is necessary when considering the broader question. Prior to this judgement, the test had usually been considered in the form of *capacity to consent to sexual relations*.

### What was the upshot?

This case changed the basis of the test from capacity to *consent* to capacity to *engage* in sexual relations. This “recasting” of the decision means that the information relevant to the decision is:

1. the sexual nature and character of the act of sexual intercourse, including the mechanics of the act;
2. the fact that the other person must have the capacity to consent to the sexual activity and must in fact consent before and throughout the sexual activity;
3. the fact that P can say yes or no to having sexual relations and is able to decide whether to give or withhold consent;
4. that a reasonably foreseeable consequence of sexual intercourse between a man and woman is that the woman will become pregnant;
5. that there are health risks involved, particularly the acquisition of sexually transmitted and transmissible infections, and that the risk of sexually transmitted infection can be reduced by the taking of precautions such as the use of a condom.

## **R v MP & Waugh [2020] EWCA Crim 510**

## **R v Rezazadeh [2020] EWCA Crim 607**

**Read them** if you ever provide reports for sentencing

### What were the issues?

These cases are concerned with sentencing mentally disorder offenders. Arman Rezazadeh was convicted of five offences of racially aggravated damage to property and sentenced to prison. He appealed the sentence. He had psychosis and used cannabis. MP pleaded guilty to robbery and received a suspended sentence with a mental health treatment requirement. This sentence was appealed as being too lenient. She had a diagnosis of borderline personality disorder (BPD) and complex Post traumatic stress disorder (C-PTSD).

What was the upshot?

**Rezazedeh:** The Court agreed with the sentencing judge that culpability remained high: i) the psychosis was self-induced ii) they had stopped medication iii) they were drinking alcohol iv) the offending was premeditated. The Court agreed that he retained responsibility for his actions despite his mental health issues.

**MP:** The Court considered MP's background history and diagnosis of BPD/C-PTSD as well as the impact of a sentence of imprisonment from her treating psychiatrist. Her engagement with community mental health services was also taken into account. Although the sentence was considered to be unduly lenient the sentence remained.

Neither case relied on psychiatrists commenting directly on culpability.



# COVID-19: Medical concerns on a Forensic Psychiatric Unit

by

Dr Cornelia Beyers

ST4 Forensic Psychiatry

The Hatherton Centre, Midlands Partnership Foundation Trust

On 19 March 2020 I arrived at work feeling uneasy about COVID-19 developments. My psychology group had been cancelled; patients could not have visitors, leaves had been cancelled. Fevered discussions amongst staff took place alongside news bulletins as concerns about the outbreak grew. Discussions centred on how we would keep our patients safe without contracting the virus ourselves. On 20th March 2020, I was informed by my GP to work from home. This was a very stark realisation that things had changed: I was forced to become a witness from afar in the concerns for my patients. By Monday 23 March 2020 the whole medium secure unit was in lock down and plans were drawn up to rotate shifts to protect people from unnecessarily working on site whilst making sure patient safety was maintained.

Most of the emails I received in those hours included tasks handed to Nurse Practitioner colleagues. I noticed an increase in colleagues' anxiety and started to worry about overloading this group of RMNs helping us on the wards with "hands on" physical healthcare tasks. I decided to make a plan: combining my own skills as a doctor with my desire to help. By then, I had Microsoft Teams and was getting used to this method of communication. I was fully equipped with a headset, adept at hiding my coffee and slippers, and able to calmly lead a ward round whilst the dog was barking at the delivery driver.

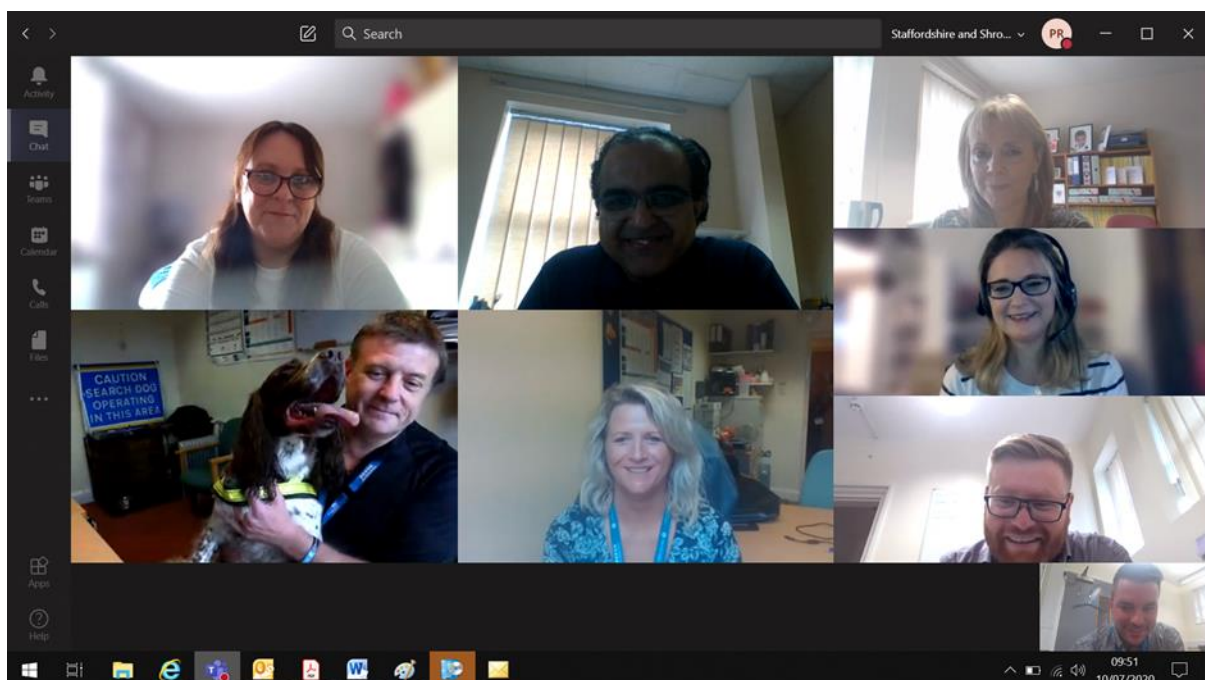
They say a good idea often gets somewhere because the first person hearing it shows excitement and enthusiasm. Here I have to compliment my clinical supervisor whose support was instrumental in getting the idea across the line. The 'COVID-19 medical ward round' was born: a virtual medical ward round overseeing and coordinating the medical management of our COVID-19 patients.

Twice daily ward rounds started on Wednesday 25 March 2020, comprising a virtual handover between the doctors on call, a nurse practitioner and a dietician. At times the wider leadership group joined when we needed to confirm urgent matters. Prior to each ward round, the

clinical progress, blood results and essential details were added to a spreadsheet and shared on Teams. We were then able to discuss issues arising, share protocols and agree actions. Everyone was updated as to the progress and comorbidities of our COVID-19 patients. We were able to reduce the amount of time spent by all clinicians on the ward, reducing unnecessary physical examinations and reducing the infection risk for staff and patients. We mobilised those working from home to gather information to inform policies and research. We sought advice from the wider Trust for issues relating to Oxygen and NEWS2 monitoring.

For most of us, the COVID ward round enabled us to share our fears, our worries and our hopes. We became a true unit; one where (almost!) everything could be said and a joke could be made in difficult times to see us through.

If you had asked me 20 years ago whether I would ever experience an online medical ward round fully equipped to make decisions with the help of one extra member of staff on the ward, I would have said "impossible". But it worked and we are all safe. We took our last patient out of isolation on 21st April 2020. The unit was safe, patients were safe, staff were safe and we were prepared for whatever came next.





## **COVID-19 Conspiracy Theories**

Conspiracy theories have been defined as “attempts to explain the ultimate causes of significant social and political events and circumstances with claims of secret plots by two or more powerful actors” (1). The COVID-19 world has given oxygen to conspiracy thinking. Indeed, a range of CTs have reached prominence in recent months. For example, the ‘pandemic’ conspiracy ‘documentary’ gained traction online and was shared widely on social media. This film attributed COVID-19 to the nefarious intentions of Bill Gates, The World Health Organisation and other public health institutions. Other examples include: COVID-19 as a rationale for a population control vaccine, 5G telephone masts, and the notion of bio-weaponry.

## **Why Believe Conspiracies?**

Those who endorse CTs are reported to be predominantly male, single, of ethnic minority background, of lower socioeconomic class, and socially isolated. They are more likely to have experienced adverse childhoods and psychiatric difficulties as adults (2). Notably, this is a similar demographic profile to those detained within secure care (3).

It is theorised that three broad psychological motivations underpin CT beliefs (4); epistemic (e.g. a lack of knowledge and understanding of events salient to an individual or group), existential (e.g. threatened, anxious, or powerless in the face of danger), and social (e.g. the perception that the in-group is at risk from the out-group). As such, conspiracy beliefs can be adaptive to achieve cognitive closure in the face of uncertainty, gain power when vulnerable or marginalised, and enhance in-group solidarity.

Such psychological mechanisms are pertinent to – and exaggerated within – psychiatric populations, where epistemic, existential and social challenges are frequently experienced by patients. Further, cognitive biases can make conspiracy thinking more likely. For example, a tendency to jump to conclusions (5) and hold schematic views of the world as dangerous (6) are a precipitant to delusional beliefs (5). Relatedly, subclinical delusional thinking (7) and schizotypy (8) have been associated with conspiracy thinking. These processes can be extrapolated to the impairing end of the psychosis continuum (9). There is a risk that conspiracy beliefs migrate to frank delusions.

## **Sequelae and Response**

Conspiracy theories can be benign within a resilient population. However, they can damage those who are psychologically fragile, marginalised, or unable to challenge attractive counter-narratives. Within psychiatric

inpatient settings, CTs present a challenge to the negotiated homeostasis of functioning wards. Dissatisfaction with hygiene-orientated restrictions – and theories that question the motivations or behaviour of healthcare professionals – can lead to discord, challenging behaviour, and splitting. The result of such processes might be disengagement from the physical health procedures that reduce the spread of COVID-19. If so, the virus might flare and further disrupt ward cohesion in a cyclical manner.

Within our secure mental health service, we have seen a range of reactions related to the change and associated pressures imposed by the pandemic. The contextual anxiety and low mood are understandable within the context of uncertainty and do not require direct intervention. Indeed, proactive strategies to maintain psychological safety and enhance coping can inoculate against adverse effects. Further, the mitigation of epistemic, existential, and social concerns (through empowerment, the dissemination of clear, consistent information, and therapeutic contact) are preventative. However, for some, there is a risk of profound distress, loss of functioning and psychopathology may develop and require treatment.

Notably, amongst this vulnerable group, CT have exacerbated – and been incorporated into – delusional beliefs, which have significantly affected functioning and caused high levels of distress. Without intervention, such phenomena could evolve into a psychotic episode. Should benign conspiracy beliefs migrate to psychopathology, it may be necessary to implement targeted psychosocial, pharmacological, and risk management strategies. Regular MDT monitoring, care-planning and pandemic-informed formulation will reduce the likelihood of mental health deterioration. Primary prevention is important, though clinicians must be prepared to react accordingly to the spread of COVID-19 conspiracies.

#### References

1. Douglas, K. M., Uscinski, J. E., Sutton, R. M., Cichocka, A., Nefes, T., Ang, C. S., & Deravi, F. (2019). Understanding conspiracy theories. *Political Psychology*, 40, 3-35.
2. Freeman, D., & Bentall, R.P. (2017). The concomitants of conspiracy concerns. *Social Psychiatry and Psychiatric Epidemiology*, 52 (5), 595-604.
3. Duke, L.H., Furtado, V., Guo, B., & Völlm, B.A. (2018). Long-stay in forensic-psychiatric care in the UK. *Social Psychiatry and Psychiatric Epidemiology*. 53 (3), 313-321.
4. Douglas, K.M., Sutton, R.M., & Cichocka, A. (2017). The psychology of conspiracy theories. *Current Directions in Psychological Science*, 26 (6), 538-542.

# **A lockdown within a lockdown: UK prison mental health care during the COVID-19 pandemic**

by

Dr Marcus Wade

Specialty Doctor in Forensic Psychiatry

HMP Brixton

When the Prime Minister announced on the 23<sup>rd</sup> of March that, due to the relentless surge of the COVID-19 pandemic, the UK must enter lockdown, that word struck a chord. Like the clang of a cell door as its bars collide on closure, it rang as I considered the immensity of this imposition. The entire population was to experience a form of what is daily reality for our patients in prison. The imperative to remain in an enclosed space, to venture out only when necessary or when compelled to, to fear those around you and the jeopardy that they may pose to your wellbeing. An effective, albeit blunt vehicle for empathy.

The lockdown restrictions were mirrored in the prison. Visits were halted and flow around the establishment was markedly curtailed. With no healthcare wing, our patients were suddenly placed at an even greater distance than usual. Given that most of them suffer comorbid if not primary personality difficulties, we anticipated manifold struggles with this open-ended 'lockdown within a lockdown'. Encased as Matryoshka dolls in the layered walls of their cells, their landings, their wings and the prison itself, access seemed nigh impossible. Cut off from our team, educational/vocational opportunities and their wider support networks, many of our patients were bereft of their productive outlets and carefully forged coping mechanisms. As a resettlement prison, such resources are crucial in maintaining momentum towards prosocial development and preparation for re-integration. We feared a spike in emotional dysregulation and consequent deliberate self-harm, acting out behaviours and even violence. We feared that those of a paranoid disposition would inevitably find their perceived persecution reinforced, without the means to reason through or challenge such notions. We feared that many would feel forgotten and hopeless.

The ensuing weeks were tinged with a pervasive sense of flux and uncertainty. Our usual ways of working had to change wholesale almost overnight. Clinics were cancelled, usual meetings were superseded by COVID-19 strategising, wing access was tightly restricted, group work

was thwarted by distancing requirements, staffing levels were slashed. Protocols and procedures seemed to shift and change all the time and the chain of information was not always fully linked. We had to work creatively to keep us and our patients afloat until the tide turned.

We first reviewed our entire caseload in order to stratify risk in a new light. We worked closely with Safer Custody to identify the most vulnerable and complex prisoners and prioritise them. All drug charts were reviewed to determine which patients could safely have medication in-possession rather than queueing at the hatch. We drafted letters to all our patients explaining the situation, offering reassurance and safety-netting advice and outlining their recourse to care. We developed and distributed in-cell packs containing wellbeing, self-help and activity materials. Once Personal Protective Equipment (PPE) was readily available, we conducted reviews through cell doors if appropriate or individually in listener suites with distancing maintained. At one stage reviews were conducted via telephone, but with limited telephony on the wings this proved difficult to facilitate safely and confidentially. Much of the time we were relying on our instincts and those of prison officers to sense and intervene when something was awry.

Many of our patients coped unexpectedly well with the new regime. Previously, we often found that inwardly or outwardly destructive behaviour was associated with perceived injustice or mistreatment: unfair adjudications, boons differentially granted, professional promises unkept. However, the blanket restrictions seemed to imbue many with a sense of unified tribulation; the notion that everyone was in the same imperilled boat. Similarly, our team developed a great sense of unity and purpose. We did not allow uncertainty and fear to develop into suspicion and resentment. Indeed we made efforts to be supportive and kind to one another. In line with the 2020 Mental Health Awareness Week theme of 'Kindness', our lead psychologist had the wonderful idea of erecting a 'Wall of Kindness' on which messages of admiration and gratitude could be posted to one another. It filled up quickly and has been a consistent source of warmth.

We are still some distance from normality. As we approach that point, there will be a need for much post-hoc contemplation on the events of these tumultuous months and how they impacted us and our patients. Indeed I hope that this can begin shortly – just as soon as our reflective practice workshop is permitted to re-convene!

# Management of COVID-19 within forensic deaf services

By

Dr Sodi Mann

Consultant Forensic Psychiatrist  
The John Denmark Unit

## Introduction

The John Denmark Unit is a specialist National Deaf Mental Health Unit in Manchester providing 18 specialist deaf open beds. It forms a network of nationally commissioned NHS England beds for the deaf; ranging from High Secure (Rampton), Medium & Low Secure (private sector) and open beds. Of the 3 NHS open deaf units (Manchester, Birmingham & London), Manchester is unique as it has 2 Forensic Psychiatrists providing an additional Forensic Stepdown pathway for secure deaf patients.

Staff working on the unit are a mixture of deaf and hearing, with the latter able to communicate in sign language.

## Preparations for COVID-19

Contingency plans in March 2020, took advantage of the flexibility afforded by some bed vacancies. The unit was split into 3 areas:

- i. 4 bedded female area was vacated & identified as the

"*Isolation Ward*" for future confirmed or suspected cases.

- ii. The 5 bedded male forensic stepdown ward was identified as the "*Shield Ward*". The unit had 2 shield patients and 3 further high-risk patients due to COPD and age.
- iii. The 9 bedded male area became mixed gender. This was risk assessed and the females were moved into one area of the ward with their own shared bathroom facilities.

## Management of the outbreak

An inpatient male presented with extreme lethargy, dehydration and diarrhoea (no pyrexia or persistent cough). COVID was not suspected. He required overnight transfer to a medical ward where he was swabbed. On his return, he was placed on the isolation ward as a precautionary measure. He swabbed positive for COVID-19. The medics advised the unit to swab all the patients (contrary to our Trust IPC protocol).

Subsequent swab results revealed 12/15 patients testing positive for COVID-19. The designated Isolation Ward was switched to become the Green Zone for the three COVID-19 negative cases. Emergency deep cleaning and patient movements took place at short notice. The timing was



unfortunate as both consultants were self-isolating and Government policy meant they could not attend work, even if they restricted themselves to the Red Zone.



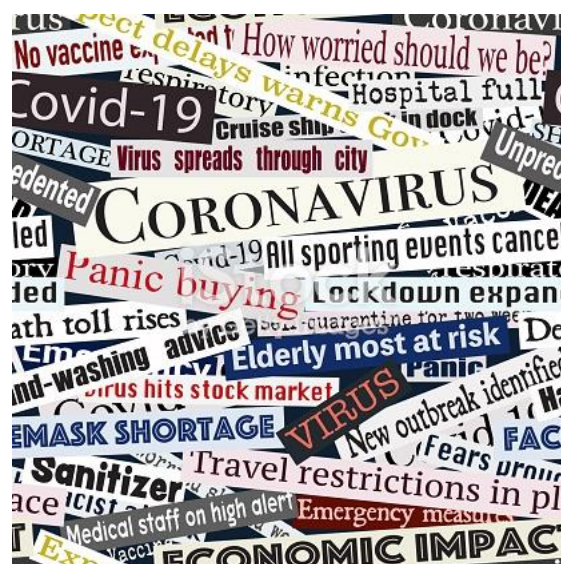
### Learning Points

1. This provided a unique spot prevalence of a ward where all patients were tested at a point in time. Only 4 patients were subsequently symptomatic; all 4 required oxygen and 2 needed transfer to a medical ward. 8 patients remained asymptomatic.
2. Had testing been restricted to symptomatic cases, only 4 patients would have been tested (we would have been unaware of 8 of the cases).
3. Wider testing informed management plans and the 3 negative patients remained negative. Similar testing could be applied to wards in other units (with static inpatient populations) in the event of one patient testing positive.
4. The predominant symptoms were lethargy, anorexia and GI symptoms. Cough was a late feature and most were apyrexial.
5. Interesting category of "COVID Recovered Shield Patients": both shield patients were asymptomatic positive cases. Shielding was reimplemented once they were negative to reduce the risk of reinfection.
6. Sister NHS units in London and Birmingham have not had similar large outbreaks but a secure deaf unit in the North West did. The latter suggests the possibility of a common vector for both
7. Despite preparatory training, staff initially lacked confidence in managing respiratory distress. Medical staff developed a simple 2-sided guidance sheet, which proved extremely helpful (see attached).
8. Two asymptomatic patients were outliers, taking over 3 weeks before testing negative. Both had a history of chemotherapy and immune conditions. The haematologist commented that delayed virus clearance in immunosuppressed patients is expected but anecdotally a degree of immunosuppression may protect patients from an excessive immune response (one of the causes of a severe disease course).

9. Deaf patients on the unit coped well and were remarkably compliant with self-isolation requirements. The authors suspect the self-isolating experience of being deaf made them more resilient

10. The unit has struggled with the adoption of face masks as they hinder communication with both deaf patients and staff. Masks prevent lip reading but also hinder signing, which relies heavily on facial expression and mouth movements. Unfortunately, the procurement of clear masks has been challenging as there are no European suppliers. FDA approved ones from the USA have not met European safety requirements.

11. If the UK adopts community mask wearing, this will impact negatively on the deaf community as a whole. The lack of deaf awareness by policymakers is demonstrated by the lack of interpreter presence at Government Daily Briefs in England (in contrast to Scotland and other countries).



# Embracing the challenges of a global pandemic in a high-secure setting

By

Dr Stephen Davidson  
ST5 Forensic Psychiatry  
Scotland Deanery

The State Hospital provides high secure psychiatric care to male patients in Scotland and Northern Ireland, with capacity of 140 beds.<sup>1</sup> General medical care has primarily been provided by three GP sessions per week, as a service level agreement with a local GP practice, supported by other practice staff. Medical care is provided by psychiatry trainees and consultants out-with these sessions. When patients require secondary general medical care, they receive this from a local district general hospital (DGH) or tertiary centre.

Since the beginning of the COVID-19 pandemic, it has been necessary to have contingency plans for the impact of varying severity of service disruption, to ensure that patients and staff remain safe. Psychiatry trainees have provided valuable input into this process.

In accordance with other health boards within NHS Scotland, a three tier Incident Command Structure (ICS) with support from a wide range of relevant disciplines, has been implemented by the State Hospital Board to respond appropriately to the pandemic – gold (strategic), silver (tactical) and bronze (operational).<sup>2</sup> Information was discussed and disseminated via daily teleconference briefings to medical staff, chaired by the medical management team, providing updates from the daily silver briefings and infection control matters for symptomatic patients, reducing in frequency, as necessary.

Temporary changes have been made to the operation of the State Hospital, including the provision of patient medical care, aspects of security, patient safety and infection control. These changes have been ratified rapidly through the ICS, including creation and implementation of novel clinical and operational guidance through our “Clinical Care Support Documentation”. New research information is being continuously reviewed through our STAG (Scientific & Technology Advisory Group) committee to keep this guidance current and valid, whilst supporting other colleagues working in the Forensic Network.<sup>3</sup>

Many of these changes relate to an expansion in the delivery of general medical care that may be

provided within the State Hospital, particularly in extremis, if capacity of nearby hospitals were to be overwhelmed. This includes detailed novel guidance on the prescription and administration of oxygen therapy and parenteral fluids, in addition to end of life care with guidance on anticipatory care planning, treatment escalation and limitation planning, and prescribing in palliative care. Implementation of these measures included overcoming associated practical challenges, for example, safe storage of oxygen cylinders and opening a dedicated ward area for providing attentive end of life care if required.

Due to obvious limitations of providing high standard, acute medical care at the State Hospital, there has been close liaison with acute services from the DGH. This includes establishing a direct contact number for on-call medical staff to discuss acute care matters, including thresholds for transfer to critical care, with a senior physician from the DGH. A key component of supporting this service, was completion of detailed medical summaries from the GP records of patients. This has supported decision making regarding patients being designated as high risk and those requiring shielding measures. In principle this allows remote consultation between acute services and duty doctor

regarding decisions for hospital transfers. They are therefore available to all duty medical staff via Microsoft Teams.



All patients have MDT completed individualised care plans related to anticipated increased periods of isolation. These care plans are subject to regular review and further detail is included for patients who would be unable to tolerate prolonged periods of isolation. Tailored security details for each patient has been updated to reflect escort requirements for emergency transfer to hospital. Again, this information is available to duty medical staff OOH to support remote decision making and avoid unnecessary delay to patient care.

There was an outbreak in the State Hospital where eight patients tested positive for COVID-19 over four weeks from the beginning of March. There was loss of approximately 25% of the workforce for reasons attributable to COVID-19. This has since settled, with no new positive cases since the beginning of April, and staff absence returning to baseline levels. This

was following rapid measures to contain transmission, including temporary hub-based working for senior staff, closure of our recreational facility and restrictions to patient movement. Following successful containment, in June we moved into the next phase, in line with Scottish Government guidance.<sup>4</sup> This involves embedding new practice for the next 12-18 months, accepting that we will be delivering care alongside the COVID-19 pandemic as the new normal. The focus of future changes will follow a QI approach to nurture innovation with focus on gradual loosening of restrictions to mitigate the negative impact to our patients.

References:

1. The State Hospital [Internet]. The State Hospitals Board for Scotland. Accessed June 2020. Available from: <https://www.tsh.scot.nhs.uk/>.
2. Preparing Scotland: Scottish guidance on resilience. Scottish Government; March 2012.
3. The State Hospital Scientific & Technology Advisory Group (STAG) [Internet]. Forensic Network. Accessed June 2020. Available from: <https://www.forensicnetwork.scot.nhs.uk/the-state-hospital-scientific-technology-advisory-group-stag/>.
4. COVID-19 – Framework for Decision-Making. Re-mobilise, Recover, Re-design: the framework for NHS Scotland; May 2020.

## Changing Chairs

By

Professor Pamela Taylor



Thank you all for all your support over the last four years. By the time you read this, my term in the chair of your Faculty will have ended – as will Amanda Taylor’s in the exotically named ‘vice-chair’. Everyone on your executive committee has been so committed either to changing things for the better or holding firmly to everything good. We have faced much threat to good practice, but it has generally been an inspiring period – in the Faculty and in the wider College. I am so pleased that the newsletter was relaunched, thanks to Helen Whitworth and her editorial team, to keep you in touch. I am immensely grateful

for all the support and guidance from College staff, and specifically for our Faculty from Stella Galea, about whom it is impossible to say too many good things.

Back in 2016, when I started in the chair, coincidentally, the College started a period of substantial change with the appointment of a new chief executive, Paul Rees. Part of that process has been to make us ever more mindful of underpinning values as well as skills. By now you will probably be familiar with the College’s explicit values, but here they are again: Courage, Innovation, Respect, Collaboration, Learning and Excellence. Joining in celebrating *Pride* and setting up *Black History Month* are just two of the steps on a path that saw the College become Charity of the Year in the 2019 European Diversity Awards. There is much still to do, and the willingness and spirit for action is ever more striking.

In more mundane but essential ways too the College enables through effective management and planning. Who would have predicted quite how essential the technology systems upgrade would be? Fiscal dangers are ever present, but the COVID crisis has particularly picked at weaknesses. The College has had a lot to face with loss of conferences and other key work, but management structures have safeguarded us and our work. In the longer term we may all be

asked to help more but, for now, we can continue forward in confidence.

An important way in which College structural reorganisation directly affected us was that the number of Faculty executive meetings was reduced from four to three a year. We continue with an informal meeting just before the annual conference but seized the opportunity of fewer official meetings to have some strategy time at every one, often inviting external experts. Our discussions have ranged through services for offenders with autism, victims of offenders with mental disorder, sentencing guidelines, parole board reform, decision making on use of handcuffs for our inpatients when outside their unit (no longer clinical enough), use of medication – or rather prohibitions on it – in therapeutic communities. When I took on the role of chairing the Faculty Chairs group, we had a session on inter-faculty co-operation. That was an exciting period when I learned so much from other Faculty Chairs.

There is always a regret – mine is the recent loss of our Forensic Psychotherapy Special Interest Group [FPSIG]. The College is in the awkward position of having in its constitution a cap on the number of SIGs, but constant pressure for new ones. Council voted to disband FPSIG. We are seeking to restore some of its important work with an inter-faculty group. This will require

your support to be effective. We must redouble support for the Adolescent Forensic Psychiatry SIG – currently very active, but nothing can be taken for granted! Other inter-faculty work is increasingly vital – with intellectual disability, with older age, and more.

Developing our workforce remains a priority. Difficulty in filling higher training posts has hit some specialties harder than others. Forensic psychiatry has not been as badly affected as some, but for the first time it has not filled all available posts. The College's *Choose Psychiatry* programme, with emphasis on attracting people to psychiatry even before they qualify as doctors, is exciting and does seem to be having some impact. The Forensic Psychiatry bursary scheme continues and it has been thrilling to see some of the people who we first met on that scheme become forensic psychiatrists. Psychiatry-wide there is major concern about falling numbers of academic posts, particularly at senior lecturer level – the professorial feeder posts. Research funding is hard enough to acquire in our field, reduced capacity to build academic leadership an even more serious problem. For forensic psychiatry, the Faculty has made some valuable links with *Crime in Mind* to map requirements in a way that could facilitate regrowth.

Related to all this has been the GMC's drive for curriculum revision. We have safeguarded forensic psychiatry as a full medical speciality. Tom Clark is leading our curriculum development. More consultations are imminent, so please be ready to help!

Inequalities in mental health care trouble us all. With the rest of the College we have spent a lot of time over the last four years advising on mental health legislative change for England and Wales. Notwithstanding concerns that proposed law reform was something of a distraction from raising resources to more realistic levels, eminently sensible proposals went forward. No government has yet delivered on this.

A key preoccupation since 2016 has been our overflowing and damaging prisons. While each part of the UK has its unique problems in this respect, in England and Wales austerity policies included slashing prison staff numbers by about 40% and heavily restricting legal aid, maximally disadvantaging the most vulnerable in the system. Death rates among prisoners – from all causes – self-harm and violence all escalated following this. Our constant lobbying has had some effect on restoring prison staff numbers. The College's *Quality Network for Prison Mental Health Services* has helped even otherwise failing

prisons to maintain acceptable mental health care delivery. We have also put substantial effort into increasing use of community sentences with treatment requirements as alternatives to custody. Government Departments have worked together and with us on stimulus programmes, with considerable success. A College position statement, which we have led, is pending.

Early in this four-year period, there were substantial concerns about stasis in the Ministry of Justice's mental health unit. There were unacceptable delays in all aspects of work with restricted patients in England and Wales. Thanks to Amanda Taylor's work with its remarkable former head, Natalya O'Prey, everything is back on track. We receive regular audit reports reflecting good practice and, most tellingly, we no longer receive frequent complaints about disruptions to clinical work with their potential for risking everyone's safety.

Who would have thought that our annual conference could become controversial? While colleagues across the psychiatry spectrum seemed more likely than not to oppose Brexit, we faced rigorous questioning on the right to hold conferences in mainland Europe as well as the UK. We defended that successfully – until a little virus intervened. My first



conference as Faculty chair was in Madrid. We got Spanish colleagues heavily involved with our programme. We learned in ways that cannot be achieved by reading alone about how they have developed their services. We were also told how much they welcomed our presence because their budgetary constraints prevent joining our conference otherwise. Then, snowed in in Nottingham, we had our first flavour of 'remote lectures'. They worked, but then we were mostly there in person and able to carry discussions forward long after a programmed session. At that meeting too, we took the important step of embracing the undergraduate essay prize winners as speakers. Their workshop proved so interesting that it has become a regular feature. In 2019, in Austria, at least some of us were able to visit services as well as hear about them and the international dialogue was strong. This year we nipped in and out of Liverpool just as we were beginning to confront the COVID crisis.

It is so good as we wade into a future which still looks very different from anything that we would have expected this time last year that people of the calibre of Josanne Holloway and Jeremy Kenney-Herbert are taking over as chair and vice-chair. Some of the work they have to do will be thrust on them, but somehow they will find their own unique themes and

variations too. My warmest wishes to them. There's a lot of responsibility involved, a lot of hard work but, perhaps whisper it, I expect them to really enjoy their time in the roles too. Do join me in making sure that they do!

# Contributions Welcome

Thank you to the contributors of this edition.

We would welcome contributions for the next e-newsletter by Friday 30<sup>th</sup> October 2020.

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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