iForensic

Faculty of Forensic Psychiatry Newsletter
Summer 2022

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Forensic Faculty Newsletter

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Welcome

News from the Faculty Chair

by Dr Josanne Holloway

Chair of the Forensic Psychiatry Faculty

It's that time of year again, getting to the end of the Summer holiday period, getting back to work, family members doing the same or getting ready for nursery, school, college or university. Hopefully this year to a more normal routine than the last couple of years.

We say good bye to another pioneer in the field of forensic psychiatry in the UK. It is with great sadness that we learn of the death of Professor Robert Bluglass CBE. Professor Bluglass was one of a handful of psychiatrists who have made and shaped forensic psychiatry in the UK. He was one of the co-editors and main contributors of the book Principles and Practice of Forensic Psychiatry, the first book I bought when I became interested in Forensic Psychiatry. He played a key part in the development of Forensic Services in the Midlands and beyond. He will be remembered and sadly missed by those who knew him and whose practice he influenced.

As a Faculty we are looking into using social media and the internet in a more effective way. We now have a Twitter account which Dr Kathleen Serracino-Inglott helps to keep active (Thank you Kathleen). If you have any information, you think should be shared through the Faculty Twitter account please email Kathleen, myself, or Catherine Langley. We are also in the process of updating our Faculty web page. Dr Elizabeth Masterson is taking the lead on this (Thank you Beth). If you have any ideas or suggestions on how to improve or enhance the webpage or want to be involved in its development, please contact Catherine Langley.

There has been significant discussion about College guidance on being an expert witness. The Faculty believe that this is an issue which all faculties need to contribute to. The College trustees have agreed to a revised version of the current College document on being an expert witness with wording to reflect that the College are not an accreditor of evidence given by individual psychiatrists in expert evidence but have acknowledged we have a role in providing general guidance on the issues that psychiatrists need to consider. The College is recruiting to a post to lead on expert evidence and we will be playing our role to contribute to a new document providing guidance on being an expert witness.

The Faculty has also contributed to College consultations including for example on trauma informed care and we continue to contribute to discussion on Prevent, the new Mental Health Act and its implementation. The College has appointed Dr Gareth Owen as Specialist Adviser on Mental health Law (England and Wales) and Richard Latham will serve as deputy. These are very important appointments in the light of the new Mental Health Act.

The Faculty is also funding one of the Psych Stars and Prof Pamela Taylor and Dr Aideen O'Halloran are supporting this.

Following our annual Faculty meeting we agreed to make a contribution in the light of the war in Ukraine. We have agreed to fund the translation of some of the College leaflets into Ukrainian and languages where Ukrainian refugees are likely to be living. We wanted our contribution to be something that was not already funded by the College and that it would be something that would have long term and a sustainable effect.
Finally I would like to invite you to consider becoming a CESR evaluator. This role is an extremely important role and though there is no fee for this role, the college does give a small honorarium in the form of College and Marks and Spencer vouchers. There is more information on the website CESR Evaluators (Rcpsych.ac.uk). Alternatively if you have any questions please feel free to email equivalence@rcpsych.ac.uk

Hope you all had a lovely summer break.

Josanne Holloway

Legal Update

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

Dr Fran Debell, Specialist Registrar in Forensic Psychiatry

UK terrorism laws provide for a range of means and sanctions to prevent and punish terrorism. Expert evidence may be relevant in a variety of legal contexts. In addition to criminal offences the following also exist:

- Registration and monitoring requirements imposed on convicted terrorists via a 'Notification Order', like provisions for sex offenders.
- Immigration powers to deport non-British citizens 'in the interests of national security', and to detain or bail with conditions in the interim.
- Terrorism Prevention and Investigation Measures (TPIM) which are restrictions imposed by the Home Office on individuals believed to be involved in terrorism-related activity, including travel restrictions, exclusion zones and electronic tag monitoring.

The Commissioner of the Police of the Metropolis v Ahsan [2015] EWHC 2354 (Admin)

<u>What was the issue?</u>

Ahsan was extradited to the US and convicted of conspiracy to assist terrorism through involvement in a website soliciting support for the Taliban. A Notification Order was sought for 15 years on his return to the UK. He argued this would breach his human rights (Articles 3 and 8 ECHR).

Psychiatric opinion concluded that the requirements would have a 'severe impact' on his mental health (depression, self-harm, suicidality, and Asperger's syndrome). Imposing an Order was considered likely to lead to severe depressive illness with a high risk of attempted suicide.

What was the upshot?

There were attempts to undermine the expert psychiatric report by criticising the expert's letter of instruction as implying that notification requirements were 'draconian'. However, the psychiatrist had outlined the notification requirements accurately, was not cross-examined on this issue and the evidence stood. The Order was refused because of this evidence. It was considered irrelevant that Ahsan lacked insight and had not sought treatment.

Takeaway for practice

Ensure accuracy in describing the measure/restriction you're asked to assess the impact of, to avoid accusations that you were influenced by 'misleading' instructions.

The Commissioner of Police for the Metropolis v Bary [2022] EWHC 405 (QB)

What was the issue?

Bary was extradited to the US for terrorist offences relating to US embassy bombings in Africa in 1998. Police sought a Notification Order for 30 years following his return to the UK in 2020. This was challenged as an unnecessary and disproportionate interference with his human rights (Article 8 ECHR).

Two psychiatrists provided evidence on the impact of notification requirements on Bary's mental health. They agreed on Bary's anxiety, moderate depression and symptoms directly associated with trauma (namely his past experiences of imprisonment and torture). They agreed that Bary's PTSD symptoms could worsen with the Order, that the risk of self-harm and suicide may increase, and that treatment may mitigate some risks of the Order.

What was the upshot?

The court found that in contrast to the 'stark' evidence in Ahsan, there was 'shading in the probability assessment' in Bary. The court noted that Bary was not currently suicidal, even though one expert had expressed

that worsening mental health symptoms would increase suicide risk. The court concluded that although psychiatric evidence on the risk of worsening mental health was accepted, the risk was not of sufficient magnitude or severity, or sufficiently unmanageable, to reject the Notification Order.

DD v Secretary of State for the Home Department [2015] EWHC 1681 (Admin)

What was the issue?

DD was linked to a terrorist organisation, Al-Shabaab but was acquitted of criminal charges in 2009. The security services continued to gather evidence of DD's links to terrorism, and a TPIM was imposed on him in 2012. DD asked that the TPIM (or at least some measures) be quashed, on the basis that its effect on his mental health breached Article 3 ECHR by amounting to inhuman or degrading treatment.

Psychiatric evidence was considered from two experts. A joint report acknowledged DD had experienced PTSD symptoms and a psychotic illness with auditory hallucinations and paranoid beliefs. The most damaging TPIM requirement (to DD's mental health) was electronic monitoring via a tag. Experts agreed that the tag exacerbated DD's paranoia. DD believed the tag contained a camera and bomb planted by MI5 and that voices emanated from it. He became distressed and suicidal after he thought his child may have damaged the tag. The experts agreed that the strain on DD's mental health could be eased by removing the tag.

What was the upshot?

The judge accepted that DD had PTSD symptoms and psychosis and that his mental state had deteriorated with an increased risk of suicide. It was accepted that an individual's mental state may increase his vulnerability so that article 3 may be breached even if it would not for a mentally healthy person. The court quashed the tag monitoring requirement, finding a breach of Article 3. Most of the other TPIM restrictions remained in place.

Takeaway for practice

Electronic tags are arguably inherently unsuitable for those with acute paranoia given the potential to worsen this condition.

Challenge and Change

by Dr Dan Cleall

Specialist Registrar in Forensic Psychiatry (ST6), South West London and St George's Mental Health NHS Trust

I am an ST6 higher trainee in Forensic Psychiatry on the South London Partnership Training Scheme and I recently completed a six-month rotation in prison psychiatry.

There are presently two fulltime prison rotations available to higher trainees in South London. The rotations are both popular and regularly receive positive feedback from trainees. I had been looking forward to a prison rotation since starting my higher training as I thoroughly enjoyed my liaison psychiatry rotation during core training and suspected that prison psychiatry may be a comparable job in a forensic field. I was particularly attracted to the pace and dynamism of the work, the range of different presentations, comorbidity, and complexity, the frequency of new assessments, and diagnostic uncertainty. Consequently, I was overjoyed when I received confirmation that I was allocated a rotation at HMP Wandsworth.

HMP Wandsworth is a category B reception and resettlement adult male prison originally built in 1851. As of 2021, the prison has an operational capacity of 1,368 making it the fifth largest prison in the UK by prisoner population and amongst the largest in Europe. The prison has an average intake of 4,615 prisoners each year (approximately 88 per week). Forty five percent of the prison population are foreign nationals. Nearly half the prison population are remand prisoners and nearly three quarters are unsentenced.

A few weeks before commencing my placement at HMP Wandsworth, I was informed that the prison was in the process of changing their mental health provider. As a result, the prison mental health team was in a state of flux and in the midst of a complicated TUPE (Transfer of Undertakings (Protection of Employment) Regulations 2006). I was warned that the changeover was due to occur during my placement and as a consequence, could disrupt or adversely impact my training experience. After speaking with my Trainee Programme Director, I decided to go ahead with the placement. I did not want to miss the opportunity of a prison rotation and I wanted to provide support to the prison mental health team during what was predicted to be a turbulent period.

My time at HMP Wandsworth can be described in three distinct chapters:

Chapter 1 – The Calm Before the Storm

When I started at HMP Wandsworth, the outgoing provider was still in position, albeit with a steadily decreasing number of staff. Although it was clearly a stressful time for the team, everyone was incredibly welcoming and supportive. As the outgoing provider had been in position for several years, there was a well-established mental health service in place which I found easy to integrate into.

During this initial two-month period, I learnt the ropes of prison psychiatry. I was given two weekly outpatient clinics, a general psychiatry clinic and a trauma clinic, I supported the mental health in-reach team (MHIRT) with medical assessment on the prison wings, and I provided cover for the prison in-patient mental health unit. As a result, I quickly gained experience and confidence assessing prisoners with a wide range of different mental health presentations and acuity. I also gained experience of referring prisoners to hospital, preparing court reports, and completing medical recommendations under part III of the Mental Health Act 1983 (MHA).

However, just as I was settling in and feeling comfortable in my new role, changeover day arrived.

Chapter 2 – Tempestuous Transition

After the outgoing provider departed, there was a temporary period of turbulence as the new provider established itself at the prison. A significant proportion of the outgoing mental health team chose not to transfer their employment to the new provider, consequently, there was a large changeover of staff within a short period of time. A new mental

health provider also meant a new set of policies and procedures to implement.

Given that there are on average 531 monthly referrals for mental health assessments at HMP Wandsworth (133 a week), the upheaval in the service and staffing changes resulted in an increased workload for everyone in the team. Nonetheless, the team coalesced to ensure that we continued to provide a high-quality service to the prisoners under our care. Although stressful at times, I received regular support from supervisors, senior staff, and colleagues.

As one of the few staff members who straddled the transition, I was able to assist with the handover process and provide continuity of care for many of the prisoners under the prison mental health team. As a result, I had a unique chance to develop my leader, teamworking, and management skills. During the transition period, I was encouraged to chair ward rounds on the inpatient unit, lead referral meetings, and represent the team at professionals' meetings. I was also invited to attend senior management meetings to discuss and devise strategies to develop the new mental health service at the prison. These opportunities and new responsibilities allowed me to work alongside colleagues from a variety of different clinical and non-clinical backgrounds.

Chapter 3 – Clear Blue Skies

As I approached the final two months of my rotation, many of the staffing issues had been resolved, the team was starting to take shape and find its footing, and the workload was stabilising. Consequently, the remainder of my placement sailed past almost effortlessly.

By the end of my rotation, I felt like a veteran prison psychiatrist. Although only a six-month placement, I had the opportunity to assess and manage countless prisoners in a range of different environments and scenarios.

On reflection, the challenges I faced during my rotation were easily overshadowed by invaluable learning experiences. It was particularly satisfying to have had an active role in the development of the new mental health service at the prison.

I was lucky to have had the opportunity to work with a brilliant complement of multidisciplinary colleagues who were all committed to providing mental health care to an often-overlooked, marginalised, and vulnerable population.

Although it was one of the busiest and demanding placements of my higher training, it was also one of the most rewarding. My experience at HMP Wandsworth has not only prepared me for a future career in prison psychiatry, but it has also inspired me.

Criminal Justice System and Deaf Offenders

By Dr Sodi Mann, Consultant in Forensic Psychiatry and Deaf Mental Health, Edenfield Centre & The John Denmark Unit, Manchester

Most people never consider the everyday challenges a deaf person in the community faces. How do they arrange a GP appointment by phone? Or speak to the GP receptionist without an interpreter? How do they manage the intercom at the hospital car park barrier? How did they cope with mask wearing if they rely on lip reading? How upsetting must it be when people think you are rude simply because you didn't hear them say "excuse me"?

The recent success of a legal case by Kate Rowley from Leeds, who is profoundly Deaf, illustrates how disaffected the Deaf community currently feels A High Court Judge ruled that Downing Street's failure to provide British Sign Language (BSL) interpreters during live Covid Briefings was discriminatory and breached equality legislation. Similar briefings in Wales, Scotland and Northern Ireland included BSL interpreters on screen.

We have had a situation where the government breached their obligations to ensure public health broadcasts are accessible to deaf people under the Equality Act. When this happens with a high-profile issue, it does not engender confidence that ministers leading various government departments, give the issue of accessibility the priority it deserves.

It is well recognised that the deaf community experiences major disadvantages in being able to access education, health, employment, social care, housing, and benefit entitlement (for a whole host of reasons related to accessibility).

Hearing Loss and d/Deafness

Statistics indicate that over 12 million (1 in 6) people in the UK have some form of hearing loss, with approximately 900,000 experiencing severe/profound deafness. Of these, over 24,000 declare that BSL is their preferred language. When it comes to BSL/sign language, inexperienced professionals working with deaf patients often have a poor grasp of language fluency, viewing BSL skills in the deaf as binary (either yes or no).

A hearing offender with a poor educational history associated with truancy, school exclusion and poor numeracy and literacy skills; will still have decent spoken English skills. This is because they will interact and socialise with hearing peers. They will still have a reasonable understanding of the external world from socialisation and incidental learning from the media. In comparison, a deaf person without education, without a deaf peer group, and an inability to access media, will exist in a '*communication bubble*'. They will struggle to develop fluency in any language and will have gaps in general knowledge.

There is a continuum of language fluency: At the very extreme end, this may only consist of '*home signs/gestures'* with little knowledge of BSL or English. At the other extreme, individuals can be fluent in both BSL and English. A common error is the assumption that a deaf person will always have reasonable literacy skills. Many deaf people struggle to watch TV (even with subtitles); struggle with official paperwork; and are unable to access online information.

Such language dysfluency in the deaf is referred to as Language Deprivation Syndrome and is associated with poor theory of mind, adjustment, and behavioural problems. Language Deprivation Syndrome in itself, without any impairment of intellectual functioning, can result in an offender being deemed unfit to plead in court. There are much higher rates of Language Deprivation Syndrome amongst deaf offenders in secure psychiatrist services. It is a challenge to deliver a CBT approach to offenders who do not possess the internal language for *'if this, then that'*, which is necessary for consequential thinking. Such offenders often require lengthy '*pre-therapy*' to develop the necessary internal language for CBT (alongside adaptations; such as role-play and visual information).

Lastly, it is worth pointing out the differences in the use of the terms: 'Deaf' vs 'deaf'.

Deaf (D) denotes persons who self-identify with the deaf cultural model, where they view themselves as a cultural and linguistic minority. They are often pre-lingually Deaf, fluent in sign language and immerse themselves into the Deaf community and culture.

At the other end of the continuum is the medical model, which perceives deafness (d) as a medical disability, which needs to be surmounted. People that align to this model are often not born deaf, use assistive technology, do not sign and prefer to social integrate into hearing culture.

Within the D/deaf community, the issue of Deaf v deaf is currently an active subject of debate. Some in the field recommend using 'deaf' in all

instances to reflect the non-binary nature of fluidity linked to identity. For the sake of simplicity, this article will use the term deaf.

Police and Courts

PLOD (Police Link Officer for the Deaf) exists in numerous English constabularies. PLOD consists of police officers with BSL skills that promote deaf awareness amongst police officers and improve the knowledge of the deaf community on how to access the police / PLOD to report crime.

BSL999 was launched throughout the UK on 17 June 2022, enabling the deaf community to make 999 calls using a video relay service.

The court system ensures interpreters are available for deaf witnesses whose first language is BSL. For witnesses who have a concurrent vulnerability such as a learning disability, mental illness, physical condition (e.g. stroke) or are under 18, the courts would arrange additional services of a Deaf Registered Intermediary. Unlike BSL interpreters (who are hearing), the first language of Deaf Intermediaries is usually BSL. They are communication specialists that provide advice on strategies to improve communication between all parties in the court room. They can also intervene in the interaction between the BSL interpreter and the witness, to rephrase questions to facilitate the witness's understanding.

Communication chains involving three or four people in the court can be time consuming. A court case involving multiple deaf co-accused witnesses can end up with multiple interpreters and intermediaries for each witness. This can cause the court process to being rather unwieldy (communication support professionals could even end up outnumbering everyone else in the court room).

It is also worth noting that there may be different biases at play when one compares the criminal records of deaf verses hearing offenders. Offenders may be more likely to get caught if they are deaf (not hearing alarms or anyone approaching). On the other hand, the Criminal Justice System may be more reluctant to proceed, viewing them as vulnerable (and therefore not in the public interest), as well as concerns about the additional time/cost involved with court proceedings.

Prison

There have been two important publications in this field:

i. The Howard League for Penal Reform – Not Hearing Us: An exploration of deaf prisoners in England and Wales.

ii. The British Deaf Association – Throw Away the Key? Highlighting how British prisons do not rehabilitate deaf people.

HMIP 2009 estimated there were around 400 prisoners in England and Wales with some form of hearing loss. However, NOMS research from 2014, estimated that there were around 1,600 prisoners with hearing difficulties. The reality is that we do not know the number of Deaf, deaf, or hard of hearing inmates in prison, as such data is not systematically captured.

Social and Ethical

The prevalence of mental disorder in the deaf community is twice that of the general population, highlighting how they would be a more vulnerable group in the prison setting.

Deaf inmates have been described as serving *"a sentence within a sentence"* due to the sense of isolation and stress experienced in custody. Such offenders are unable to communicate with others, struggle to understand the prison rules, are disadvantaged in seeking opportunities that are available to others, and are at higher risk of being the victim of bullying and discrimination.

Research has demonstrated that there is woeful provision of communication support in prison and patchy provision for making video calls to family.

Legal and Financial

The prison service is bound by The Equality Act 2010, which requires the prison establishment to make 'reasonable adjustments' for disabled inmates. Additionally, the establishments must be mindful of the provisions of the Human Rights Act; Article 3 (Degrading Punishment); Article 8 (Respect for Family Life); and Article 14 (Rights and Freedoms without Discrimination).

Research has consistently found that deaf inmates have struggled to complete sentence plans or access rehabilitation programmes because they are not adapted or deaf accessible. This is a major explanation as to why deaf prisoners serving indeterminate sentences are so often well over tariff. In some cases, Parole Boards will not accept completion of adapted interventions as they are not deemed to be accredited.

Successful litigation in the past by a deaf prisoner in a local prison resulted in the development of a Deaf Prison Inreach Service based at Rampton Hospital that inputs into prisons falling within a 70-mile radius. It seems surprising that further litigations have not occurred or that a further network of Deaf Prison Inreach Teams have not been developed nationally.

In terms of sex offenders, HMP Watton (Nottingham) provides a specialist adapted programme for deaf sex offenders.

Anecdotal experience suggests that the threshold for transfer to a specialist secure deaf mental health service is lower for deaf offenders compared to hearing offenders. This is due to the prison being subjectively a more stressful environment, and the fact that appropriate rehabilitation is often not available in accessible form within the prison establishment. Therefore, these offenders end up meeting the appropriate treatment test in hospital. The lengths of stay for deaf offenders is longer than hearing offenders in secure hospitals. This is due to multiple factors, such as: the need to conduct pre-therapy; lower thresholds for admitting sex offenders and personality disordered patients; the lack of specialist deaf supported accommodation placements in the community; as well as the lack of specialist deaf forensic community teams.

A recent NHS England Secure Deaf Services Review highlighted three priority areas:

i. Joint gatekeeping into secure deaf services by local forensic services alongside specialist Deaf services.

ii. Developing further Deaf Prison Inreach Teams nationally.

iii. Developing Deaf Community Forensic Outreach Teams.

Currently, there are three NHS Open Deaf Services in the UK based in Manchester, Birmingham and London, alongside 5 Secure Deaf Services. Rampton is the only High Secure Service. The remaining 4 secure services are all in the private sector.

Swimming Against The Tide: Reflections upon the Provision of Reflective Practice for Prison Mental Health Teams

By Dr Andrew Williams, Psychoanalyst in Private Practice, previously Consultant Psychiatrist in Forensic Psychotherapy, Portman Clinic, Tavistock and Portman NHS Foundation Trust

Having recently left the forensic world after fifteen years of active service as a psychiatrist specialising in forensic psychotherapy, I thought I would share some thoughts about the experience of providing reflective practice to mental health inreach teams based within prison settings.

The Portman Clinic is an NHS service that offers long-term individual and group psychodynamic psychotherapy to persons who have offended and live in the community. With the luxury of time and a comparatively calm setting in which to conduct this work, it is possible to develop a detailed understanding of the unconscious factors that help us understand why someone commits an offence. Using insights gained from this work, and drawing from psychoanalytic and group analytic principles, the clinic also provides reflective practice for secure mental health units and prison settings.

I distinctly remember, as a naïve specialist registrar in forensic psychotherapy, being sent off on my first assignment outside the clinic. This was to start a new reflective practice group for a mental health inreach team based within a busy and under-resourced London prison. In keeping with my rather idealistic and enthusiastic mindset, I had hoped that offering the team insights about their own and others' psyches would enable them to move into a more enlightened form of practice. Little did I know about the challenges I would encounter.

Forensic psychotherapists are trained to identify and work with the emotional impact of people who commit offences upon others. We are also trained in understanding the wider impact of people who offend upon the organisations that are tasked with managing them. I will never forget one of the first 'real' experiences of learning about what this actually meant during my first reflective practice assignment. I arrived at the

prison gate, explaining that I was there to run a group for mental health staff based in the Healthcare department. I was told to wait in the airlock; someone would soon come to collect me. I waited for over half an hour but nobody came. Prison staff walked past, moving in and out, often in cheery, boisterous moods. I felt invisible and helpless. My appeals to the gate staff were met gruffly with, "Just be patient Doc, someone is on their way". With the allocated time for the group having passed, I eventually made my way home, feeling rather despondent.

Later that evening, having had some time to reflect upon what had taken place, it dawned on me that I had been given a small taste of what it might feel like, deep down, to exist in a prison, whether as an inmate or a professional. Trapped, invisible, to some extent dehumanised, helplessly watching the world go about its business. A rather unpleasant, but also helpful, introduction to the emotional temperature of prison life.

The following week, when I did manage to get into the prison in order to run the group, I was met with a stony-faced team who seemed resentful at having to attend the group at all. I explained that we were there to think about their work, in the hope that this might help them. This was met with cynical sighs, restlessness, and the eventual departure of a couple of members of the group as they left as they had "things to do".

At the end of the session, I was again left feeling rather despondent, wondering how on earth I could be of any use to the team. But again, upon reflection, I soon realised that this may well have been an important clue about the team's overall experience. Was this how those attending the group felt (or more importantly, avoided feeling) in their day-to-day work - useless, hopeless, irrelevant?

As the weeks progressed, it became clear that this indeed was the case. Feeling increasingly more comfortable to talk, members of the group felt able to describe, for example, how they felt when they would attend the prison wing to conduct an assessment. Prison officers, initially expectant that the team would instantly be able to stop someone from self-harming, following the feeding back of the team's assessment would say, "Is that it? Is that all you can do? We could have told you that!".

I plucked up the courage to talk with the group about my own experience of that first reflective practice session, and said that I wondered whether they had unconsciously needed to give me a taste of what it felt like for

them to be working day to day in the prison. Much to my surprise, after an initial tense moment, this evoked a great sense of relief within the group, accompanied by a real feeling of warmth between us for the first time. I soon came to understand the value of the team coming to believe that someone from the outside could, even if briefly, put their experience into words through having picked up on a feeling. Making an observation derived from personal experience was truly appreciated and clearly had a meaningful impact upon them.

Prison mental health teams are, in my view, the unseen and unrecognised troops working at the front line of the forensic mental health system. Deprived of the usual privileges of compulsory treatment and better-resourced multidisciplinary team input afforded by dedicated mental health settings, those working within the teams often have to manage very unwell patients with extremely limited resources. There is no 'screening process' to determine who they are expected to work with. For some of these patients, 'management' can predominantly involve keeping someone alive until they get to hospital, when the wait for beds in secure settings can be painfully long. It is not surprising that, with so few visible positive outcomes, team morale can become so woefully eroded.

Prison environments that are under strain tend to allow little space for reflection, operating in ways which mean that projective processes are common. For example, in the aftermath of a serious incident such as a homicide or suicide, prison governors can be unfairly scapegoated for having failed, causing a feeling of instability within the institution. The expectations placed upon somewhat manic solutions such as the introduction of new initiatives that will save the day soon fade, especially when it is recognised that this has been at the expense of resources that could have been deployed elsewhere. Prison officers can be accused of failing in their work, and the same prison officers can then blame the mental health team for not 'doing' enough.

Although there tends to be widespread recognition that the provision of reflective practice is a 'good thing', in actuality, the allocation of a dedicated time in which these sorts of phenomena can be thought about is often not welcome. Offering staff new insights into what seems to be happening can make their day-to-day experience more painful than before. Sometimes, much to the disappointment of team managers, one outcome can be that some staff decide that they are burned out and need to leave. Although this is not always welcomed, it can nevertheless enable new staff to come in, bringing some much-needed new energy and enthusiasm.

One of the most challenging, yet interesting aspects about providing reflective practice within prisons is the way in which there is a need for the facilitator to adapt their approach in accordance with the needs of the team. Some teams respond well to a hands-off approach, in the form of the provision of a space in which to describe and reflect upon difficult experiences together. Other teams seem to elicit a more didactic stance from the facilitator. This can be in the form of elaborating upon specific links between history and psychopathology, or in some cases speaking to the complex interface between psychiatric diagnosis and offending behaviour when a specific patient is presented. In this regard, it is helpful to be able to bring one's knowledge as a psychiatrist, as well as a psychotherapist, into the discussions. These sorts of discussions sometimes lead to staff developing a renewed interest in their work. Indeed, some have over the years attended some of the courses run at the Portman Clinic, taking an interest in the value of psychoanalytic principles for their work.

One crucial element that is a common feature of all the reflective practice groups I have facilitated is a tendency towards a lack of respect for the team's work by the rest of the institution. Within some struggling prison settings, 'doing', tends to be the modus operandi (e.g. responding to suicidality solely through opening an ACCT, or to challenging behaviour with segregation at the expense of communication). Human contact and cautious decision-making can be significantly devalued, leading to a denigration of what the team represents. For these reasons, I would suggest that the most important intervention of all has been to consistently hold a position of being on the side of the team, pointing out the difficult, or sometimes impossible, work that they do, and recognising the great achievement that 'just carrying on' represents.

Of all the activities within the repertoire of a forensic psychotherapist, I have found providing reflective practice to prisons to be one of the most demanding tasks, but also probably the most rewarding and emotionally engaging. The staff teams, over time, have generally been extremely grateful for the consistent provision of these groups, and I will always think fondly of the numerous touching moments that took place over the years.

The experience of a perinatal mental health team in female prisons

By Dr Caroline Pontvert, Consultant Perinatal Psychiatrist

Dr Christy Pitfield, Principal Clinical Psychologist and Clinical lead
Perinatal Mental Health Service, Central and North West London NHS FT
HMP Bronzefield, Send, Downview

The NHS England defines the perinatal period as pregnancy and the first 12 months after childbirth. A woman will experience marked physiological and psychological changes during that time, therefore this is a period of increased vulnerability in regards to a woman's physical and mental health outcomes. In community samples, 20% of women will experience a perinatal mental health difficulty during this period (Howard & Khalifeh, 2020). The post-partum period is known to be the highest risk period for a woman's mental health (Kendell, 1987), with maternal suicide being the leading cause of death within a year after delivery (MBRRACE-UK, 2019).

It is well documented that the wellbeing of the mother is crucial to the development of her child's emotional wellbeing, physical health and resilience and that this influences their long-term health and social outcomes. The first '1001 critical days', spanning pregnancy and the first two years of a child's life is considered a crucial period for infant health outcomes.

English female prisons & population

Women make up a small proportion of the UK prison population, approximately 5% (Corston, 2007). Their routes into custody vary from men, women are more likely to be charged with non-violent offences.

Women in prison have multiple and complex needs and have higher rates of mental health, physical health and substance misuse difficulties, compared with women in the community or men in prison. They have higher rates of suicide and self- harm.

For many women, entering custody means separation from their children. This has been found to be one of the most distressing aspects of their prison experiences.

Pregnant prisoners represent less than 2% of the women's prison population (Review of operational policy on pregnancy, Mother and Baby Units and maternal separation, 2020 – MoJ).

There are 12 female prisons in England, 6 with a Mother & Baby Unit (MBU) - 64 mothers and 70 babies can be accommodated. Babies can stay up to 18 month old. A MBU placement is granted via an independently chaired multidisciplinary Admissions Board based on the social, legal & criminal context of the woman and her psychological wellbeing, in agreement with Children's Services.

Our service

Our Multidisciplinary team is based at HMP Bronzefield - with a 12 bed MBU - and operate an outreach model to HMP Send, HMP Downview and HMP East Sutton Park. It is a psychologically led service that adopts a trauma informed approach. The service is well embedded to the prison system and works closely with midwifery services.

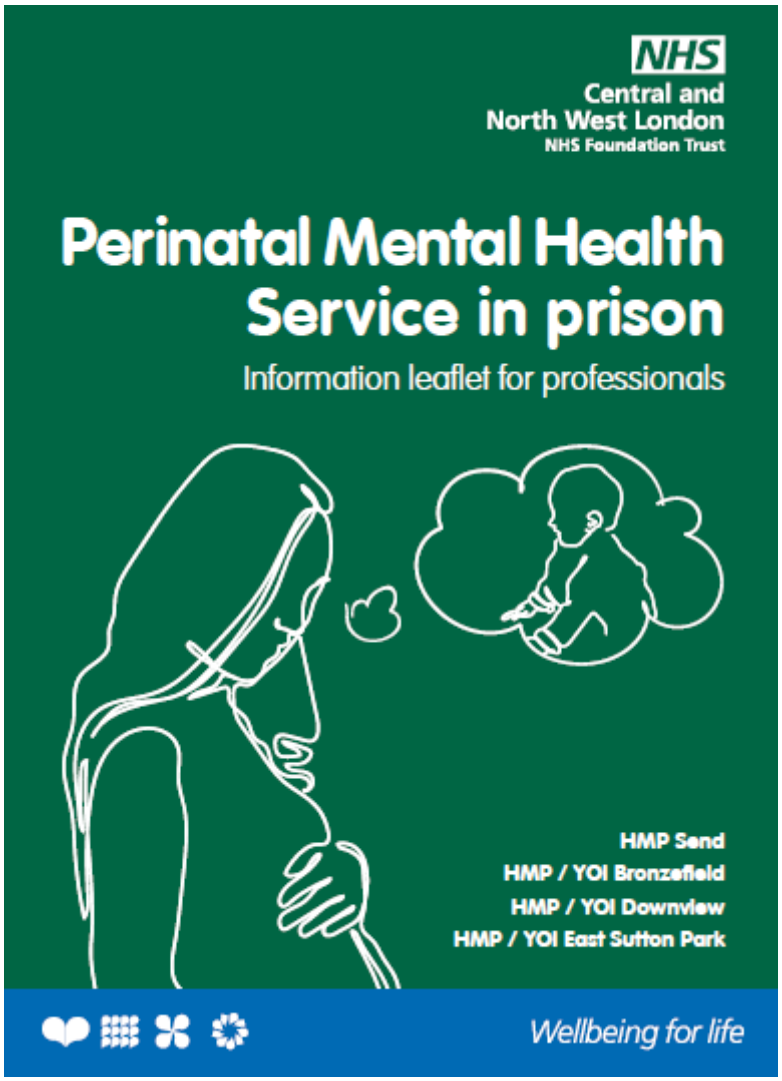
We assess all pregnant women identified during early days assessment (or any point), as they are deemed 'high-risk'. We accept referrals for all women presenting mental health difficulties during the postnatal period, either on the MBU or those who have given birth and been separated from their baby.

Female prisoners in the perinatal period

Our early observations about the women we care for are:

- The pregnant women are usually on remand: which means they are at risk of discontinuity of care at one of the most vulnerable time of their life.
- There is a high number of adverse childhood experience in their histories: their clinical presentations are complex and they typically have diagnoses of Complex PTSD or personality disorders.
- Their traumatic experiences are not secluded to their childhood, they have been victims of numerous traumatic events across the lifespan: all of these experiences impact their capacity to develop meaningful, trusting relationships with professionals.
- Our population have complex perinatal loss histories: many have experienced miscarriages, stillbirths, infant death or a child being removed from their care.
- The majority have histories of substance misuse.
- Many have long-standing untreated mental health difficulties.

We meet women at a time of their life in which they are very vulnerable, it is typical that the perinatal period reactivates previous trauma. **However, our service is developed on the assumption - confirmed every day - that being in custody while pregnant or a new mother is a unique moment in these women's lives that can become a window of opportunity for them, with the right support, to access mental health care and parenting support.**



Book review - 'The Devil you know. Stories of human cruelty and compassion' by Dr Gwen Adshead and Eileen Horne

By Dr Helen Henfrey, Specialist Registrar in Forensic Psychiatry

Dr Gwen Adshead and Eileen Horne's 2021 book titled 'The Devil you know. Stories of human cruelty and compassion' has received acclaim from, amongst others, revered author Sebastian Faulks who described it as "extraordinary". It is described as "a rare book that has the power to change minds" by the bookseller Waterstones.

Following the introduction and author's note the book tells the stories of eleven men and women – "survivors of a disaster, where they are the disaster". The first chapter follows 'Tony' a man convicted of three counts of homicide who complained of a man in the bedroom next to his shouting at night. The journey of the initial stages of therapy are described, and it becomes clear - after discussions with his primary nurse - that the man complaining of the shouting, and the man who shouted were both in fact Tony. The work of therapy goes some way to reducing his distressing nightmares and improving his mood, to allow him to be remitted to prison. This chapter talks to the importance of relationships within the multidisciplinary team and the role of multidisciplinary working within secure care. It highlights the potential gains of therapy for even those facing three life sentences. The chapter ends with 'Tony' disclosing an additional homicide, one unavailable for him to remember until the process of therapy had unlocked the walls around this memory. This development allows for a demonstration of the role of confidentiality within the doctor-patient relationship but also the need to break this.

Chapter seven describes the story of 'Ian', a man imprisoned for the sexual abuse of his two sons, now transitioning to live back in the community. The writing addresses the public fascination with child sex offenders and the role of social media and the internet in creating the modern 'obsession' with such crimes. It also introduces the UK sex offender's treatment programme and the emphasis on risk reduction, rather than rehabilitation and therapy. This chapter challenges the fundamental beliefs about "good and evil" in the context of child sex offenders without minimising or excusing the crimes committed. Its examination of the offences committed by 'Ian' is direct, bringing to the light the progression of events leading to child sex offending

in this case. The writing is unflinching, describing without judgement the crimes committed in a manner which provides a degree of humanity to the offenders without lessening the impact of their actions. The chapter concludes with 'Ian' taking his own life, reflected upon as "the act that stops all conversation".

I found this book to be more than a collection of stories, far surpassing the ghoulish genre of true crime and entering a sphere of education by storytelling – a key part of psychiatry as I see it today. Each case is described in detail, the background of each patient given due consideration, weaving together the complex themes of mental illness and crimes which repulse and fascinate in equal measure. The use of stories to illustrate and educate is a theme unique in many ways to psychiatry as a speciality and, in my opinion, there are few better examples than this book.

The portrayals of the patients are a masterclass in descriptive observation which can be taken into the real-world of psychiatry. A mental state examination describing 'Ian' as "middle-aged, with narrow shoulders and a slim frame, he had closed-cropped sandy-reddish hair and a sprinkling of freckles across the bridge of a sharp nose and was wearing jeans and a plain sweatshirt over a collared shirt" is revealing in the way that 'Caucasian male, kempt with short hair' lacks.

It also gently explains, whilst exploring the histories and treatments of each patient, the roles of different professionals in managing these highly complex cases. It provides a non-sensationalist 'through the keyhole' for a public for whom the word 'Broadmoor' conjures images of mechanical restraints, white walls and the containment of 'evil'. The book humanises those whom are cared for within forensic services, demonstrating the concepts that those working in secure care know all so well. That our patients are people, humans with families and jobs and idiosyncratic personalities with whom it is possible to build rapport, and professional relationships, whilst keeping in mind the crimes they have committed.

Most of all the book reminded me how strange this thing is that we do. The things we find ordinary –sections, index offences, delusions, hallucinations, and suicide – are not ordinary, and are in fact extraordinary happenings in the lives of our patients, their victims and the families of both. It reminds me that we are privileged in our role as observers of the most intimate parts of our patient's lives, and that hearing their stories is central to the role we play.

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Fiona Watson, Library and Archives Manager, Royal College of Psychiatrists

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Contributions Welcome

Thank you to the contributors of this edition.

We would welcome contributions for the next e-newsletter by Friday 20th January 2023.

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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