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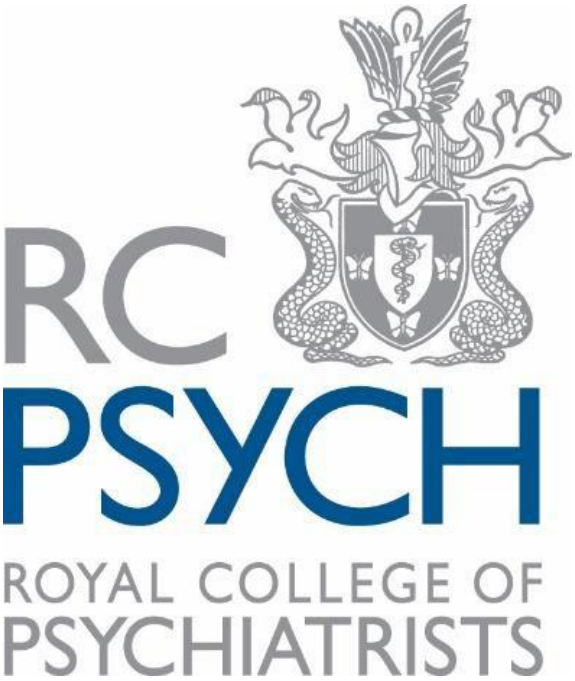

Faculty of Forensic Psychiatry Newsletter
Summer 2021

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Forensic Faculty Newsletter

Summer 2021

In this issue

Welcome

News from the Faculty Chair

by Dr Josanne Holloway

Chair of the Forensic Psychiatry Faculty

I hope you all remained safe and enjoyed the summer. The Faculty has been involved in contributing to a number of consultations both as a Faculty and as part of a College response. I very much want us to represent the Faculty membership and, whenever we can, canvas your views as Faculty members. Please do try and respond to the surveys and questionnaires we send out (usually via Catherine Langley) as this is an opportunity for you all to influence developments and shape policy. We are also very keen to ensure that the voice of our patients and their carers are reflected in responses we make, and Alain and Sheena play an active part in ensuring this happens.

Here are some of the recent issues and consultations we have been involved in.

We were very concerned about how the term *Acute Behavioural Disturbance* was being used. We wanted to highlight the importance of using de-escalation rather than restraint in individuals who were highly aroused because of the risks associated with restraint. We were also concerned that the risk that adverse consequences of an incident (including death) where a mentally disordered individual was aroused and restrained might be being attributed to the aroused individual rather than the use of inappropriate restraint in this situation. We are working with emergency doctors and the police federation (amongst others) on this issue. The disproportion use of the term with male BAME individuals was also a concern.

Another area of work is updating the College document on the expert witness. A small group are working on a draft for consideration by the College policy group.

The Faculty has been involved in discussions around the College role and Closed Supervision Units in prisons. This highlighted the issue of long-term seclusion in mental health units and Panchu Xavier is taking the lead to look at this issue. Please contribute to the discussion and work in this important area.

The Forensic Faculty contributed to the College submission to the Parliamentary Justice Committee Inquiry into Prison Mental Health and then I represented the College with colleagues from the Royal College of General Practitioners and the Royal College of Nurses and gave oral evidence to the parliamentary committee. It was fortuitous that the College statement on Mental Health Treatment Requirements (in which Pamela Taylor played a crucial role) was being launched and I took the opportunity to highlight this with the Parliamentary Group. We have developed good links with the chair of the Secure Environments Group at the Royal College of GPs and hope to work closely with them on areas of common interest.

More recently, we contributed to the consultation on the use of force. The issues we raised were around: Concerns around definitions: What is negligible; if medication is used to reduce arousal, is this considered chemical restraint? Will it come within the definition; should pain be part of the definition around restraint?

There are also concerns around conflict between NICE and code regarding the definition of chemical restraint, concerns around missing the wood for the trees regarding identifying hot spots or issues if the definition of restraint is too wide and concerns around the significant amount of increased and more detailed record keeping, especially if the definition of restraint includes regular and routine activities e.g. guidance with some pressure etc. This will impact on time available to provide quality care to individuals.

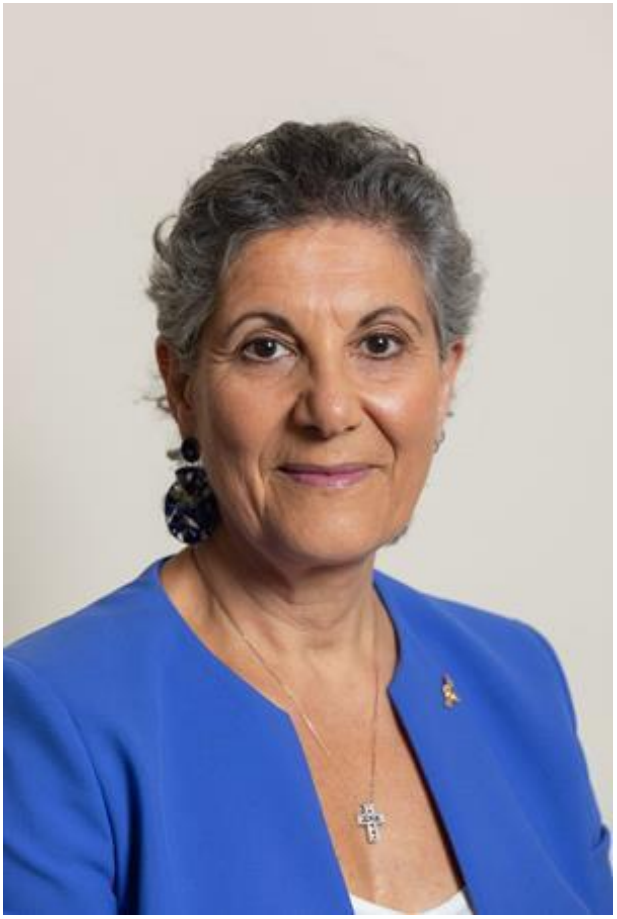
There are concerns around the use of body worn cameras and confidentiality, including how any footage might be used and the privacy of other patients who may be caught up in video. We wondered why the guidance excluded for example private sector providers, outpatients and A&E. We discussed restraint and medication when/if both were used and whether the college should take a lead in producing guidance and we also wondered whether there should there be some statutory guidance for family to be involved in any debriefing following a restraint and whether other professionals outside health were being subject to similar reporting duties in relation to the use of force.

Other work from the Faculty includes contributing to the Commission on Personality Disorder, looking at issues around providing police statements and looking at the role of psychiatrists and the parole board.

The Faculty executive team also discussed the annual faculty conference and, like many if not all other faculties, agreed that the 2022 conference should be virtual. However, we noted that, though there were some

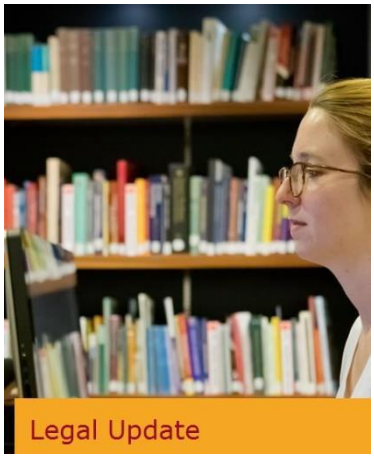
advantages to holding a virtual conference, we also were aware of the opportunities that the conference provided especially for newer members of the Faculty to meet and collaborate and would want to restart non-virtual annual meetings as soon as we could.

Hope you all continue to enjoy what is left of the summer.



Legal Update

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



Here are three cases with a theme of prisons, including a case from Ireland. They are not all explicitly about mental health care in prisons but provide a trio of judgements on troubling but familiar issues: prisoners locked in their cells for most of the time, prisoners with mental disorders unable to access hospital care because of bed availability and prisoners detained in highly restrictive environments such as Close Supervision Centres.

R (on the application of AB) (Appellant) v Secretary of State for Justice (Respondent) [2021] UKSC 28

Read it for a legal analysis of the lawfulness of solitary confinement for children in our prisons.

What was the issue?

The Supreme Court considered two issues. Whether solitary confinement for people under 18 is always inhuman and degrading and if not whether there is a test of when it might be justified in exceptional circumstances which make such treatment strictly necessary. The case concerned a man who had been detained as a child at Feltham Young Offenders' Institution. He had committed several offences by the time he was fifteen. At Feltham, he was locked in a single cell for approximately 23 hours a day. The Young Offender Institution Rules 2000 and Article 3 of the European Convention were the main legal considerations as well as the United Nations Convention on the Rights of the Child (UNCRC).

What was the upshot?

The Court did not find that there was automatically a breach of article 3 when solitary confinement is used for people under 18. Whilst the Court acknowledged that existing law means that solitary confinement should only be used exceptionally and when genuinely necessary, especially in the case of people under 18, they did not agree to the proposition that a breach of article 3 inevitably followed if solitary confinement was used in the absence of exceptional circumstances rendering it strictly necessary. AB's appeal failed on both issues.

S.M. And The Governor Of Cloverhill Prison And The Director Of The Central Mental Hospital [2020] IEHC 639

Read it for a judicial interpretation of a familiar issue for professionals working in prison mental health

What was the issue?
SM developed mental health problems in his childhood which worsened in his early twenties. He stabbed and killed a man he lived with. He was remanded to Cloverhill Prison. He was assessed and needed transfer to the Central Mental Hospital because of his psychotic state. No bed was available. He remained in a vulnerable prisoner wing and was in receipt of care from a mental health team in the prison. He was only taking medication sporadically. The question was whether SM was entitled to an order of habeas corpus under article 40.4 of the Irish Constitution: was SM lawfully deprived of his liberty or was his detention unlawful because of a failure to provide appropriate medical treatment? Even if that detention was unlawful an order of habeas corpus – ordering release – may not have been justified.

What was the upshot?
The court accepted that he did need treatment in hospital but that he was receiving some treatment in prison. The court noted that there was no evidence that his deterioration in prison would make treatment in hospital more difficult. The breach of his rights to bodily integrity and/or medical treatment was not considered sufficiently egregious, exceptional, or fundamental to render his detention unlawful. Several factors were highlighted including that he was receiving some treatment. He was not released from detention.

Mandates of the Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment; and the Working Group on Arbitrary Detention (Letter dated 10 March 2021) with UK government response (21 May 2021)

Read it if you would like to enhance your knowledge of Close Supervision Centres (CSCs) in prisons

This letter raised concern about the conditions of detention in CSCs and the possibility of breaches of international, human rights standards. The conditions were likened to solitary confinement. Attention was drawn to the (ironic) fact that CSCs can be accredited as Enabling Environments by the RCPsych despite allegations of human rights violations from prisoners. Several questions were posed about the specific case of Kevan Thakrar as well as some more general questions about CSCs. Attention was drawn to

UK government obligations under the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) and the International Covenant on Civil and Political Rights (ICCPR).

The UK government response was lengthy and rejected the comparison with solitary confinement and described the CSC units as providing a safe, decent, and healthy regime. They also rejected the suggestions that location in a CSC was ever a form of punishment. The involvement of mental health professionals in determining risk and providing treatment was highlighted.

Bio – Exec Committee Member

by Dr Matthew Tovey

Consultant Forensic Psychiatrist, Midlands Partnership NHS Foundation Trust

So, Dr Page has kindly asked me to put together a piece introducing myself to the Forensic Faculty membership as a new(ish) member of the Forensic Faculty Executive Committee. On asking what sort of content he would like, I was told "I don't know, you're the first". Everyone loves being the guinea pig!

I thought perhaps a bit about my background, and then my priorities during my tenure. I read medicine at the University of Nottingham and graduated in 2008. I completed my Foundation jobs in the West Midlands and thought I might be a paediatrician before completing an old age psychiatry job with an inspiring consultant, Dr Prabhakaran, in my FY2 year which immediately changed my mind towards psychiatry. I felt at 'home' in this field. I started my Core Training in the West Midlands and heard of forensic psychiatry and thought it sounded fascinating; had I not been a doctor, I probably would have been a barrister. So, this specialism looked perfect!

I started my Specialty Training in the West Midlands (I haven't moved around much!) in 2013 and thoroughly enjoyed it. During my ST6 year, I chaired the Psychiatric Trainees' Committee during the turbulent times of the junior doctors' contract crisis and oversaw the beginnings of the 'Supported and Valued' work. It was this position that gave me a string insight into the workings of the College and drove my desire to continue undertaking College work into my consultant career. I also noticed that many College committee members were much more senior than I and felt this needed to be changed. I became an elected member to Council in 2017.

I became a consultant in 2016 working across the Hatherton Centre MSU, a number of prisons and the community for Midlands Partnership NHS Foundation Trust. In 2018, I became our Trust's medical lead for prison psychiatry as we deliver psychiatric care across 19 prisons. In 2020, I became our Trust's Chief Clinical Information Officer (CCIO) and later in the year was elected to the Forensic Faculty Executive Committee.

I have been impressed with the breadth of work that the Faculty engages with and our positive impact. In terms of my priorities, you'd expect these to follow my history and so I am keen to support trainees to have an

excellent training programme and to feel valued within the College. I am passionate to improve the mental health care of our prisoners and to ensure that our prison psychiatrists feel supported; as this is an area that can feel quite isolating and distant from some other services.

I am also passionate about digital transformation and digital inclusion and feel that prisoners should not be left out of this revolution. I have supported the College in its response to the recent White Paper to ensure consideration will be given to enabling prisoners to have assessments virtually where this facilitates their access to prompt care where an in person assessment would delay their care.

Ultimately, as an elected member of the Forensic Faculty, I am here to represent your views to the Faculty and wider College. So, whilst I have my own priorities, it would be great if you would let me know yours. I can be contacted on **Matthew.Tovey@mpft.NHS.uk** or twitter **@drmtovey**

I look forward to hearing from you.

My experience as an ST4 trainee within a specialist personality disorder service

by Dr Mitesh Joshi, ST4 Forensic Psychiatry, Nottinghamshire Healthcare NHS Foundation Trust

As a new ST4 trainee within forensic psychiatry, the start of my higher training was within a personality disorder service within Arnold Lodge, a medium secure unit in the East Midlands. Whilst this may not be a typical placement to start as a trainee, the experience I gained within the specialist service gave rise to many learning opportunities and will form a valuable part of my training. I wanted to share some of my reflections over the last few months.

The men's personality disorder service within Arnold Lodge is split into 2 wards, each with 12 beds. Typically, patients are initially admitted to the acute ward and progress to the rehabilitation ward. Referrals to the service come from a wide catchment area across the whole of the East Midlands and the unit is the only one of its kind offering this service. Patients can also be transferred from other units and prisons.

As a trainee, I took part in the assessment of patients who were referred to the service. One important consideration was in assessing their suitability for treatment. This involved a careful assessment of the patients understanding of their personality difficulties and their readiness for change and undertaking treatment. This was something I was not familiar with from previous placements as a trainee. I was able to appreciate the importance of gauging if a patient is ready to engage in a rigorous programme of attending morning meetings, engaging in group therapy programmes, and living with other patients on the ward. The team had to at times make difficult decisions regarding a patient's suitability for admission. For example, a patient may be more suitable for undertaking further treatment within the prison setting such as the Offender Personality Disorder (OPD) pathway and may not require a transfer to hospital. Some patients, following admission, did struggle with the ward structure and the demands of personality disorder treatment. This led to some patients being discharged when no longer benefiting from treatment and posing acute risks to patients and staff.

All the patients on the ward would have a structured individual weekly timetable of different therapeutic activities including groups treatment which were based on a multi modal therapy format. I was able to take part in co-leading some of the groups which focussed on trust and self-awareness, emotional regulation and managing change. I saw the benefit of these groups in which patients spent time working through sessions together and were required to complete work between sessions and consolidate their learning. Having previously not worked with patients in a group setting, whilst initially anxiety provoking, became a satisfying and enjoyable experience overall. This was especially in sessions where patients were able to engage well and discuss issues together and patients helping other patients who were relatively new to treatment.

From prior experiences, I found many patients with personality disorder lacked the basic understanding regarding their diagnosis. I was able to undertake some 1-1 psychoeducation sessions using a structured short programme developed by the service. This involved an exploration of the different aspects of their personality problems which the patient highlighted and how these may be grouped together and related to their specific diagnosis. I found this exercise extremely useful in approaching what can be a difficult topic for clinicians and patients alike. It also highlighted the importance of helping patients have a good understanding of their diagnoses, how this was formulated and the wider hope of improving their engagement and progression. In addition, I was also able to undertake the International Personality Disorder Examination (IPDE) course which allowed me to further develop my skills in the assessment and diagnosis of personality disorders.

There were a number of challenges in working with patients with long standing personality difficulties. This included the risk assessment of patients who can be settled for periods but can quickly become unsettled with the associated risks to themselves, staff and other patients increasing very acutely. Patients living closely together on the ward lead to various interpersonal difficulties that needed to be carefully monitored and managed by skilled ward staff involving issues of bullying, intimidation, and trading between patients. I saw very good examples of the multi-disciplinary team who were able to build good therapeutic relationships with patients but were also able to maintain appropriate boundaries. Staff were alert to the potential of splitting within teams and how to address this when it might be starting to occur. Reflective practice sessions were also routinely arranged to address difficulties that staff experienced and how the team might manage these together.

The growing complexity of patients within inpatient psychiatry wards was also seen within the service. Whilst patients had a primary diagnosis of personality disorder, some also had a co-morbid diagnosis of schizophrenia. Further inpatient assessments also found patients meeting the diagnosis of an autistic spectrum disorder. One patient with a previous diagnosis of ADHD in childhood required re-assessment and treatment being re-started. This led to a notable improvement in his ability to concentration and engage in his treatment. The team were also required to manage a number of different treatment pathways for patients which included patients progressing down from high security service and prisoners nearing the end of their sentence and deciding if treatment in hospital was required to continue or not. Despite the challenges, I was involved in the care of one patient who was able to, following a prolonged period within medium security, gain escorted leave, engage with his treatment groups and then progress and move onto low secure services. This was immensely satisfying to see.

Overall, in my time in the personality disorder service I was able to be part of a team providing treatment for a group of patients with complex needs. Whilst working with patients with personality disorder can post many challenges and frustrations, I saw great examples of the multi-disciplinary approach that went a long way in helping deliver good care. I have learnt a great deal from my time within the personality disorder service which I hope to continue to develop going forward. I would recommend any forensic psychiatry trainees to arrange to spend some time within a personality disorder service during their training. This would be a great opportunity to see the workings of this specialist service, which they may not otherwise get to experience.

GMC Work

by

Dr Rafiq Memon, Consultant Forensic Psychiatrist, Birmingham and Solihull Mental Health NHS Foundation Trust

There is a little-known registration panel of the General Medical Council. It is about doctors, be it from the UK or elsewhere, making applications to join the medical register. If there are areas of concern, the Assistant Registrar can seek the panel's advice before making a final decision as to the application. Specific questions are asked for the panel to respond to. Advice provided is in effect strong advice but not binding. Limited registration was abolished a very long time ago. And so there is a binary outcome in the end, either the doctor is registered or the doctor is not registered.

There are a range of areas that either individually or in combination fall under the panels remit. This can be to do with knowledge, skills or experience e.g. degradation of knowledge and skill following a break in practice. There can be issues in relation to conduct, performance, health, criminal conviction or caution, English language, or a determination by another healthcare regulator. And these issues can arise from anywhere in the world.

The panel receives an evidence bundle in each case which can sometimes run to hundreds of pages. Information includes that provided by the applicant and that provided by the investigation and intelligence team of the GMC. A three member panel discusses the issues and they come to a consensus. Pre-pandemic the hearings were held up in Manchester but over the last year or more moved online. Assistance is provided by a panel secretary and legal advisor. But the applicant is invariably not present. Statute law, case law, guidance and the panel members own judgment is applied in the decision-making process. The chair of the panel prepares the written advice.

There are a range of reasons why I have enjoyed this work over the last seven years. It is extracurricular and different to the day job but of benefit to the wider NHS and public. I can work at national level concerning doctors across all medical specialties and not just psychiatry. There are interesting colleagues, both medical and non-medical. There is material about medical education and training from other jurisdictions and

from outside the English-speaking world. I learn to argue, counter argue and weigh up. Teamwork is used to arrive at reasoned conclusions. A contribution to patient and public safety is made. There is an annual day of training provided. And ultimately panel work can be a springboard to other things.

Further reading

- Medical Act 1983, particularly section 1
- Good Medical Practice by the GMC
- Professional discipline and healthcare regulators: a legal handbook by Christopher Sallon QC et al

Reflections from my placement in Ashworth Hospital

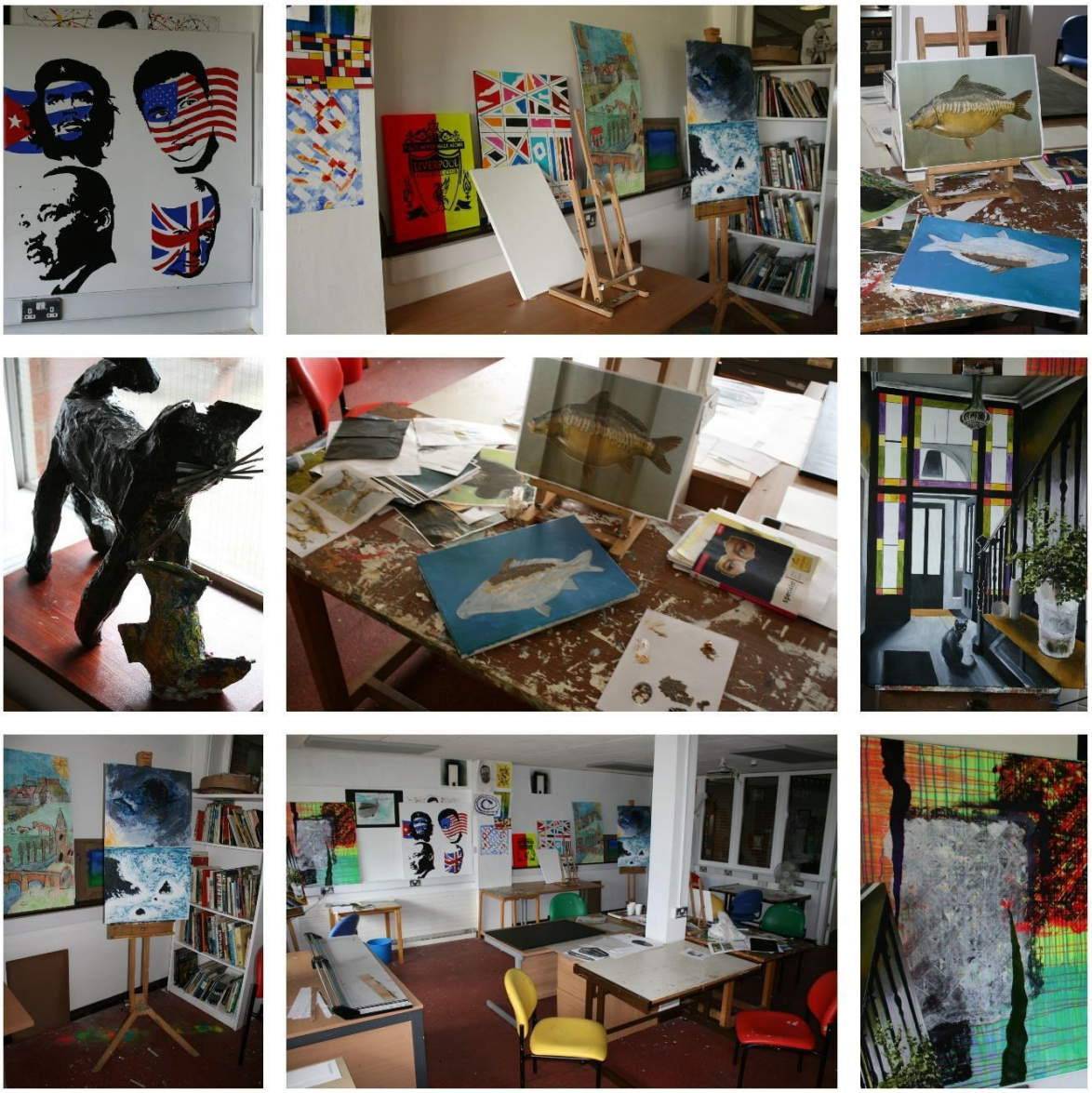
by Dr Niamh Sweeney, ST5 in forensic psychiatry, Ashworth Hospital

Returning from maternity leave to Ashworth Hospital has been an exciting and comfortable transition back into working life. There is ample support from very experienced consultants and colleagues.

Ashworth Hospital is one of the three high secure hospitals in England and situated in Maghull, near Liverpool. It has capacity to care for over 200 male patients from the North of England, North Wales, and West Midlands. There are dedicated assessment wards, as well as personality disorder and mental illness wards. At first, I remember feeling intimidated by the rigorous security procedures, but understood their necessity. It was difficult to appreciate the balance between providing a therapeutic yet secure environment, but with time, this has become clearer.

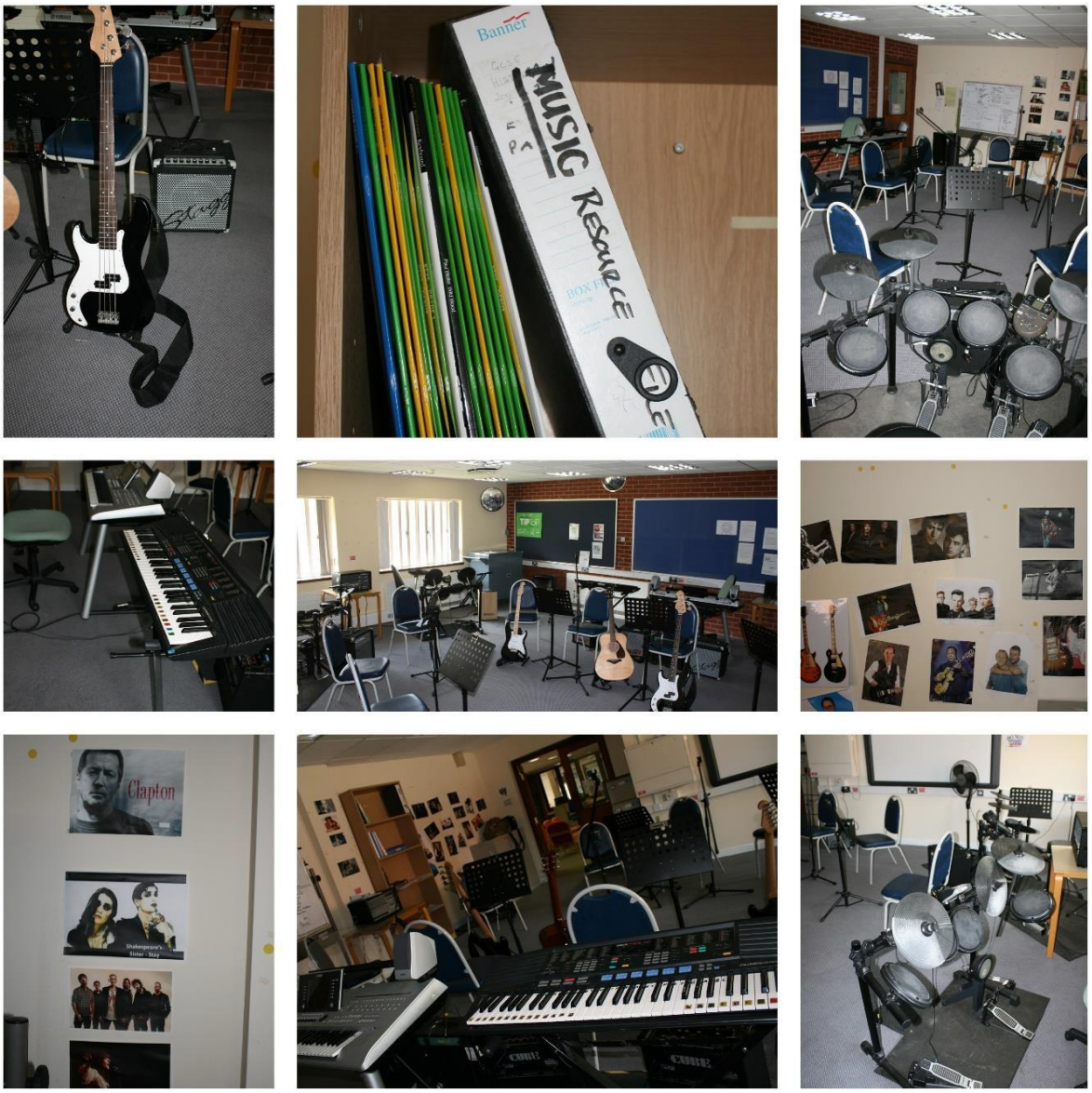
My team has patients on high and medium dependency mental illness wards. Through attending Patient Clinical Team Meetings (PCTMs), reviewing patients and supervision, I have learned about how clinical teams

promote patient autonomy and quality of life, while managing significant risks and optimising treatment.



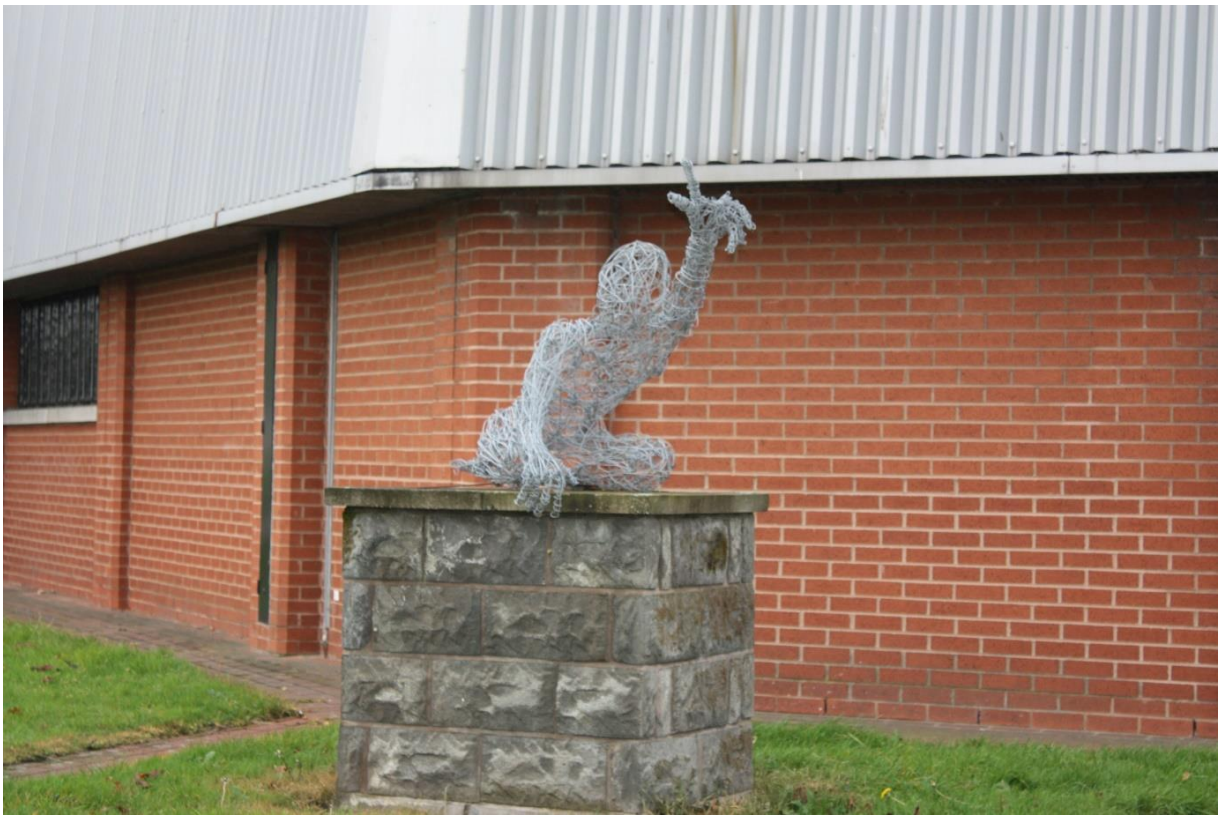
Before my placement in Ashworth Hospital, I did not fully appreciate how patients with serious risks were managed safely and wondered what impact the various security measures would have on providing compassionate, patient-focused care. There are a small number of patients whose risks are so great, they require care in Long Term Segregation (LTS) however, this is used for the shortest amount of time possible. The Positive Intervention Program Team (PIPs) is made up of experienced nurses who have specialist training in de-escalation and control and restraint. They support patients in LTS accessing time out of their room to promote physical activity and to tend to their personal and health needs. There are a variety of services available within the secure perimeter, some of which are available to individuals in LTS too, including: a gym and swimming pool; library and

educational facilities; workshops; gardening and horticultural activities and a vast expanse of green space (including a full-sized outdoor football pitch). Additionally, Ashworth Hospital have a Restrictive Practice Forum who regularly review the use of long-term segregation and ward-based practices. The use of restrictive practice is also often reflected upon in PCTMs.



While the nature of many mental illnesses is that of relapse and remission, and while there are those who recover quickly and move on to conditions of lesser security, there are those whose progress is much slower. These patients' illnesses are typically more enduring and less responsive to treatment. This was not news to me before my placement in Ashworth Hospital and I had often wondered how patients and clinical teams maintain hope in such circumstances. What I have noticed is that even the smallest gains are noted, teams take a much more longitudinal view than I have previously encountered and there is strong sense of leadership,

encouragement, and teamwork amongst the multi-disciplinary team. There are also a number of patients whose progress and risks appear static; in these cases, the clinical teams work hard to maintain their quality of life. Previously, the idea of someone being detained and unwell for so long has been an uncomfortable one, however witnessing the compassionate care those patients receive in Ashworth Hospital has eased this significantly. There is also a practice of regularly reviewing previous plans and past history to ensure no treatment avenues are overlooked. Furthermore, positive stories are often shared of previous patients who appeared especially treatment resistant who recovered and went on to be discharged.



I have also spent some time with one of the personality disorder consultants. Her genuine empathy and patience is inspiring. I hope that by observing her communicating with individuals with personality disorders and discussing patients with her, I have improved my own communication skills and management style.

In addition to hospital-based work, I have participated in numerous referrals supervised by experienced consultants. These referrals have come from both prison and hospitals, and I have enjoyed visiting a variety of different establishments across the country. Seeing referrals has allowed me to develop skills in liaising with outside professionals, information gathering, practice formulating risks and deepened my understanding of when someone requires admission to a high secure hospital.

Overall, I have thoroughly enjoyed my experience in Ashworth Hospital. I would encourage any trainees with an interest in forensic psychiatry to spend some time there, even if they prefer working in less secure environments. The insights and experiences I have gained will no doubt shape my future practice.

National clinical audit of anti-libidinal medication prescribing practice

by Dr Callum Ross, Consultant Forensic Psychiatrist, Broadmoor Hospital

Sexual offending is a complex and emotive subject that has a profound impact on society. There is pressure on policy makers to intervene but limited evidence for meaningful intervention. Sexual assault and abuse incur huge costs to the NHS and society, and it is estimated that the annual cost of adult and child sexual abuse to the health services in the UK is over £180 million.

WHY WE NEED THIS STUDY.

About one-fifth of the 78,750 (August 2021) people in UK prisons have a conviction for a current or previous sexual offence. To date, the primary treatment approach for those with sexual convictions has been psychological. But current treatment programmes have shown limited, if any, ability to address sexual preoccupation.

It is evident that psychiatry could be doing more than it is just now to investigate whether medications can assist this group of people and to better assist in their risk management.

WHAT IS THE AIM OF THIS STUDY?

We aim to examine the current prescribing and monitoring practice of medications with anti-libidinal properties in the UK by surveying all those who might prescribe these medicines in forensic inpatient and outpatient settings, and in prisons.

We aim to gather data about the national prescribing practice for the purpose of quality improvement. The study is a clinical audit of an aspect of routine clinical practice. But it is an area of practice where there is an uncertain balance between the potential benefits (such as reduction of the risk of sexual offences) and the potential harms (Khan et al. Cochrane Database of Systematic Reviews 2015, Issue 2. Art. No.: CD007989). It should help us understand areas where current practice warrants attention and how practice standards might be refined.

WHAT IS AN 'ANTI-LIBIDINAL' MEDICATION?

We define medications with anti-libidinal properties to be interventions that reliably exert an inhibitory effect on sexual interest and behaviour. Drugs that suppress testosterone activity have the strongest claim to inclusion in this category. In the UK, the only medications licensed for treatment of problematic sexual arousal and behaviour are cyproterone acetate and triptorelin. Cyproterone acetate is licensed for the treatment of hyper-sexuality in males and sexual deviation in males. Triptorelin is licensed for male hyper-sexuality with severe sexual deviation. The former is given as a tablet and the latter by intramuscular injection. Three selective serotonin reuptake inhibitors (SSRIs) also qualify as medications with anti-libidinal properties and are considered here in the Practice Standards.

WHY SHOULD I TAKE PART?

A forensic psychiatrist is likely to have only a small number of patients, if any, who are prescribed anti-libidinal medication. The greater the participation by forensic psychiatrists who are treating people with such medication is, then the greater the confidence we will have that the aggregated data will provide a representative picture of current prescribing practice in this specialist area. This will allow clinicians to reflect on their own practice in the light of a better understanding of the nature of national practice.

HOW WILL THE STUDY BE CONDUCTED?

The study is a Quality Improvement Project which has the support of the Forensic Faculty and has been developed in close collaboration with the Prescribing Observatory for Mental Health (POMH-UK).

This announcement is your opportunity to take part and learn more. We would like to ask those of you who are particularly interested to contact us by completing our short Registration Form. Those of you who register your interest will be invited to take part in a Webinar due to take place in the autumn. The Webinar will be recorded and made accessible for others to access later.

At about the same time as our Webinar runs, colleagues in POMH-UK will communicate the intention to roll out the study to their POMH leads in healthcare organisations. In doing so, member trusts and employing organisations will be made aware of the study commencing and will have the opportunity to raise it for discussion in local audit committees.

Thereafter, and at the start of 2022, the survey will begin. It will run over a three-month period. All Faculty members will receive an invitation to take part and instructions about how to complete the online survey. Webinar attendance and survey completion will each be eligible for Continuing Professional Development purposes.

IS THERE ANY MORE READING I CAN DO NOW?

Yes, the online CPD module, now a little old, is available here: Assessment and treatment of sexually abnormal behaviour (rcpsych.ac.uk)

ANY QUESTIONS?

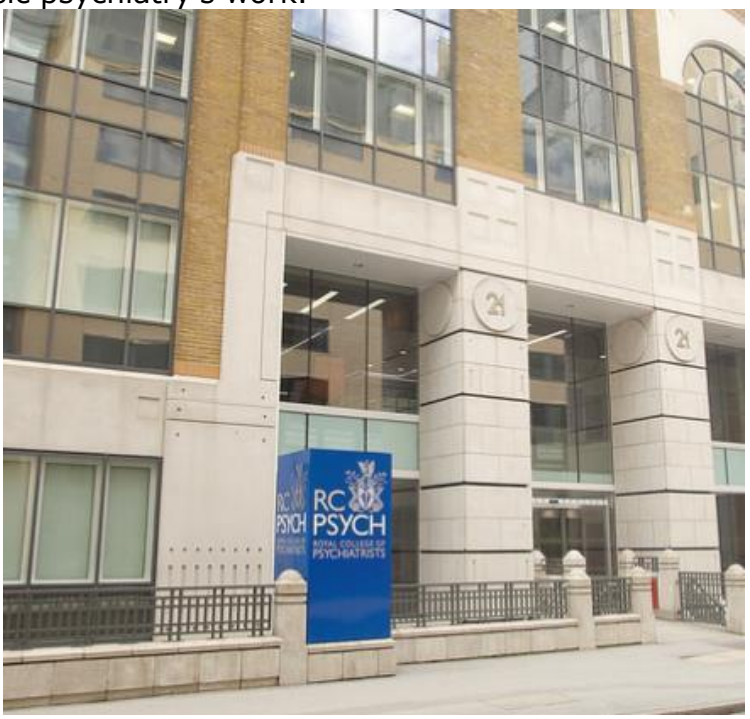
Please email me: callum.ross@westlondon.nhs.uk

Contributions Welcome

Thank you to the contributors of this edition.

We would welcome contributions for the next e-newsletter by Friday 19th November 2021.

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:

Dr Ruairi Page
Consultant Forensic Psychiatrist
ruairi.page@nhs.net

Dr Helen Whitworth
Consultant Forensic Psychiatrist
helenwhitworth@nhs.net

Dr Niamh Sweeney
ST5 Forensic Psychiatry
niamh.sweeney@nhs.net

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