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Faculty of Forensic Psychiatry Newsletter
Summer 2024

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Forensic Faculty Newsletter

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Welcome

News from the Faculty Chair

by

Dr Sandeep Mathews

Chair of the Forensic Psychiatry Faculty

Welcome to this summer's edition of our faculty newsletter. I hope every one is taking some well deserved holidays this summer. We all work in very difficult jobs and rest and recuperation is essential for our wellbeing. It is also a great period to reflect on how the year has gone so far and prioritise what we need to do for the rest of the year.

As I write this, the United Kingdom is rocked by some very disturbing news. I hope all of our faculty members remain safe. We are all human beings and hate has no place in our society. Let us all be kind and respectful to each other, regardless of where we come from.

We also have a new government in Westminster. We hope that a listening and responsive approach would be the hallmark of this government. We are encouraged by early signs.

We had a successful faculty conference in Milan in May. Many important issues of topical interest were discussed, and the faculty made important links to sister faculties across Europe. The humane treatment and services to mentally disordered offending populations who are perhaps the most vulnerable and marginalised groups in our societies is a challenge not just in the United Kingdom but internationally. There is so much we can learn and share from each other. We have also listened to feedback about the timing of the conference. As a result, we will be returning to our earlier schedule of early March. Preparations are under way for our next Faculty conference in Edinburgh in March 2025.

Great progress is being made about our strategic priorities. I must thank Josanne Holloway, Pamela Taylor and Callum Ross for having taken forward the work on the sad plight of people serving indeterminate sentences. Pamela has been active in other work including alternatives to custody. Jeremy Kenney- Herbert, David Burke and colleagues have been taking forward work on revising CR207, the college guide to job planning. Josanne and Pamela have agreed to work with the group and complete this.

The issue of delays in transfer from prisons remain as a very serious issue. Mayura Deshpande is trying hard to coordinate this work. Andrew Forrester and Matt Tovey has been active in raising this issue at various forums. They have my full support. This is an issue very important to me.

I am getting to know our new colleagues on the faculty executive. I must thank Hayley Shaw who coordinates the work of the faculty.

I must also thank Dr Josanne Holloway who has served with distinction as the Faculty chair from 2020 to 2024. I have had the privilege of not only being the finance officer with her but also being mentored by her for most of my professional life. She was also graceful to accept the role of Vice Chair along with Pamela when that role remained vacant. No words of thanks would be enough for both.

I have not forgotten the valuable role Helen Whitworth is doing as the finance officer. I must thank her contribution too.

Finally, the faculty is it's members. It is your faculty. Please feel free to let me know of suggestions on how we can improve your practice and your working lives. I thank all in the faculty, past and present, who have helped it to reach such a live and vibrant stage.

Wishing you all a fantastic summer.

Faculty of Forensic Psychiatry Conference, 14 to 17 May 2024, Milan

Dr Callum Ross, Consultant Forensic Psychiatrist, Broadmoor Hospital

The conference was extraordinarily successful. It was organised in conjunction with Italian colleagues from Milan and Bari and it enabled an amount of international collaboration to take hold.

The conference was designed, in part, around a theme of examining the interface between prison and hospital. The Faculty secured Charlie Taylor's HM's Chief Inspector of Prisons as the keynote speaker. His talk generated a great amount of interest and questions, and provided delegates with a lot of information about delays in transfer to health from prison, as set out in the report, The Long Wait. The Faculty is working to help improve this situation.

The most viewed tweet from the conference (with about 1.6k views) was about the plenary session led by Dr Jonathan Bickford (General Practitioner): 'Physical Health Inequalities in Secure Settings'. Dr Bickford's talk set out that admission to a forensic setting should provide the best opportunity to address health, setting out the advantages it provides over accessing care from under pressure community services. However, and as he described, removal from GP registration during admission results in digital inequalities in the delivery of care including exclusion from referring using the NHS e-Referral Service and from invitations to NHS cancer screening programmes, the latter arising because of inaccurate demographic data held on the NHS Spine. Dr Bickford set out examples of delayed diagnoses of cancer and of women who have never received an invitation to cervical cancer screening. Whilst the Health and Justice Information Service resolved the digital disparity for the prison estate it did not include patients restricted as a consequence of their mental ill health. Instead of reducing the health inequality, admission to a forensic mental health setting risks widening it further.

The Faculty secured participation in the conference from delegates from 17 countries. Other speakers included the President of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), and the National Guarantor of the Rights

of Persons Deprived of Personal Liberty (Italy) and President of the European Penological Centre (EPC), Roma Tre University.

Further and smaller meetings are planned. One very popular seminar in Milan examined the effect that the internet is having on the scope and breadth of forensic psychiatry, including the role of online 'suicide games', is already being adapted for further audiences.

Congratulations to Noura Al-Juffali won the junior doctor research prize and the trophy in the picture. Noura - it will be engraved soon with your name but it seems to be made from Kryptonite and we are presently trying to find a specialist laser engraver.

The conference also comprised two separate visits (by coach and by train) to two different REMS inpatient residential units:
https://www.politecnica.it/en/progetti/rems/ - in Reggio Emilia.
https://www.youtube.com/watch?v=a7E9Qby4DyM - in Castiglione.

These visits proved to be very enjoyable and informative. They were also reported in several media outlets, and one report appeared on the official website of the local Health District.

Thank you for the feedback. It was great to read the positive: "All the speakers were great and provided inspiring areas to consider for future learning and improvement" and "International collaboration is the key to our survival!". It was also helpful to read the not so positive.

We are always learning and we had our backs to the wall a bit organising this. That's why it was in May and not in March - it was either then or not at all. Most of the negative comments were reserved for the catering and we have taken all of that on board. This was no conference for the forensic epicure.

We are back to March next year and in Auld Reekie, aka Edinburgh. March 5 to March 7. We are in receive mode for submissions, so please check the Faculty website.

Legal Update

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

Responsibility, culpability and liability

Responsibility in a criminal case is dichotomised: guilty or not guilty. At sentencing though, there is a role for the judge in deciding how much blame should be attached to the offender. Determining culpability in people with mental health problems, is usually informed (but not decided) by expert mental health evidence. The first three cases highlight why formulation and not simply diagnosis is important in this exercise. Explaining how someone's mental health problems - in these cases arising out of a diagnosis of personality disorder - are associated with the behaviour leading to an offence is what the court needs to make decisions about culpability. The case of ALR widens the scope of cases associated with responsibility, to the question of liability, and bringing a claim for negligence, in the context of someone found not guilty by reason of insanity.

Personality disorder and culpability

Personality disorder is the common clinical theme in the first three cases. The judge in all cases concluded that this diagnosis did not reduce culpability because of an insufficient connection between the diagnosis and the offending. Clinically, this is hard to reconcile with what we understand about personality disorder but may reflect what the instinctive moral evaluation of personality disorder and culpability is.

R v TS [2024] EWCA Crim 815

TS was convicted of sexual and violent offences against three victims, all of whom could be said to have been vulnerable. His appeal on sentence was, in part, based on being a transgender man. This was introduced by psychiatric evidence, diagnosing gender dysphoria. The diagnoses of ADHD and borderline personality disorder were also considered although ADHD was disputed (and discounted). ASD was also diagnosed by one expert, but the court found this diagnosis did not apply. The appeal considered the extent to which TS's culpability was reduced. They found that although there was gender dysphoria and personality disorders, culpability was not reduced because there was insufficient connection between these diagnoses and the offending.

R v JEB [2024] EWCA Crim 509

JEB set fire to a flat and all three occupants died. He was convicted of murder and arson. JEB had a history of drinking alcohol, self-harming and setting fires to alleviate stress, on the background of a history of childhood sexual abuse and adult diagnoses of antisocial and borderline personality disorder. He had been treated with antidepressant and antipsychotic medication previously. Expert evidence included an opinion that his culpability was reduced by his personality disorder, symptoms of which meant that he acted impulsively and did not think through the consequences of his actions. The court found there was insufficient connection between his disorder and his actions to reduce his culpability. They found that alcohol and not personality disorder was the reason why he did what he did.

R v JM [2023] EWCA Crim 1250

JM was convicted of sexual assault and murder and sentenced to life with a minimum of 38 years. He had an extensive history of offending. JM had a traumatic childhood and diagnoses of ADHD, substance use disorders, personality disorder, depression and anxiety. At sentencing, the judge did not find that the mental health issues reduced his culpability. There was insufficient connection between the mental health problems and the offences.

Negligence, insanity and liability

ALR v G4S, Devon Partnership NHS Trust & Devon County Council [2024] EWCA Civ 138

ALR was found not guilty by reason of insanity to three murders. He had a history of mental health problems and had previously been detained under the MHA. In the two days prior to the homicides, he was arrested twice. On both occasions, health professionals had contact with him but there was no use of compulsory powers to divert him to hospital. ALR brought a civil claim for damages against the health, social care and police services involved in the two days, alleging that they were negligent. In other circumstances (guilty of murder or manslaughter) the claims would have been denied on the grounds of 'illegality' but in the proceedings to date, the claims have been allowed. ALR's right to bring a claim for damages will be finally decided in the Supreme Court. The Supreme Court will not be deciding whether he is entitled to damages but simply whether he can bring that claim.

Richard Latham, August 2024

In the Spotlight – Dr Adrian James

Q&A by Dr Ruairi Page, Consultant Forensic Psychiatrist, Active Care Group

Many congratulations, Dr James, on your appointment with NHS England as its first Medical Director for Mental Health and Neurodiversity. And a big thank you for agreeing to answer a few questions for the Forensic Faculty Newsletter, *iForensic*.

Please can I start by asking about how you have adapted to life post presidency at the College?

First of all, Ruairi, it's great to be speaking to you in particular in the context of my own faculty. I have always found that it's been a privilege to be a forensic psychiatrist.

When you have these conversations with people, if I had the chance to pick my career again, I would definitely be a Doctor, I would definitely be a Psychiatrist and I would definitely be a Forensic Psychiatrist.

This is all really dear to my heart and I am so pleased to be speaking to you and to the rest of the Faculty through the newsletter. I was really very privileged to be elected by our members to be the President and I absolutely loved that work.

I found it incredibly challenging but immensely fulfilling because these are very big issues in improving the outcomes and experiences of those suffering with mental illness and working with amazing people, psychiatrists of all disciplines, all those who work within mental health services to make a difference.

It was a pretty full-on job and I always took the view that when you finish doing it, you should definitely just walk away and you shouldn't be dabbling in things or getting in the way of your successor. Everyone has a different way of doing stuff, differing styles.

I know Lade incredibly well. I think she is doing a fantastic job, but the job of the last President is to get out of the way. I had a continuous college position for about twenty-five years. I needed a bit of a break really.

My wife did the right thing and took me on holiday to Italy immediately when I finished, which was great. I actually had six weeks off and I'd never had more than three weeks off in my thirty-nine years working for the health service! And six weeks off at Christmas. Unheard of!

And then I had another six weeks off before I started this post. And I also took four weeks off and trained as a chef. I don't yet have a formal

certificate to say I am a trained chef but I do have a certificate to say I completed the course! It has to go through being independently verified. I learnt a new skill, got out of the way of my successor and I spent more time with family, children, my grandchildren and loved ones, so I actually had a really nice time.
I miss people in the College, I miss the engagement you have in such important issues, but I didn't miss the incredible constraints it has. It's very full-on and you're never really off duty because you are ultimately accountable for everything the College does and so you have to be on it really all of the time.

Do you mind outlining your new role within NHS England and what attracted you the position?
So, as I've said already, I had more time to myself, I was chilling more, I was getting myself a bit fitter and more time with family but I always knew that I'd want to do something else. I've never really liked to dabble in things. I always want to either do things I felt were really important that can make a real difference, and really go for it, rather than doing just bits and pieces.
I was sitting up in bed and reading the paper at about half past nine in the morning, which was unheard of, and I got a call saying NHS England were thinking about this role which is a completely brand new role being the Medical Director for Mental Health and Neurodiversity.
NHS England have an overall medical director. That's Steve Powis at the moment. They have a medical director for primary care, secondary care and community care but they didn't have one for mental health and neurodiversity.
I think it was really forward-thinking of NHS England to think that's a gap and that it doesn't fit in with our overall objectives about parity of esteem, and we need to have somebody that sits within the medical directorate because a lot of the mental health work is done within the mental health directorate and sub-directorates of that, the learning disability and autism directorate.
And so, it can be a little bit separate to some of the things that go on in the medical world and they recognise that. They wanted somebody to do it. I thought about it and thought its sounds like a really interesting role. I have devoted my professional life to try and improve outcomes and experiences of those with mental illness so I thought, you know what, this is probably the best role currently that I could have where I could really do that and try and make a difference. So I thought, I still have the energy and enthusiasm to want to do something else. I'm now 62 and I think actually that my energy, my enthusiasm and my desire to innovate has improved as I've gone on. So I thought, it seems interesting, an important role and I thought that the skillset that I developed through being President and working with the amazing people that I did,

particularly through the pandemic, meant that I would actually have the skillset to be able to do the job.
And so, I thought, why not? So I applied for it and it was obviously an open process. There were other applicants. I was interviewed and got the job.
So, what is the role? It's a medical director's role within NHS England so I sit in all the medical meetings, and there hasn't been someone with a mental health, learning disability or autism background in those meetings. Steve Powis has a core medical team who lead, so I am part of that. He also has meetings with the regional medical directors obviously covering the whole of medicine in their region.
They have lots of issues in relation to mental health. Those discussions include funding for mental health services, making sure we provide the best quality of care, making sure people don't wait too long, making sure their outcomes are at least equivalent to those with physical health, and ensuring the whole interface between mental and physical health.
The huge excess mortality for those who have severe mental illness, learning disability and autism, the crossover between physical and mental health is often seen most powerfully within emergency departments. It's often not a mental health issue or a physical health issue but a combination of the two. There are huge numbers of people in general hospitals who are physically health challenged and have mental health challenges, such as dementia, so there is a huge crossover. So I am now right in the centre of all of that but whilst sitting in the medical directorate.
I guess I spend most of my time within the mental health directorate as I work very closely alongside Claire Murdoch, who is the Senior Responsible Officer for mental health for NHS England. We work as a partnership really to try to do the best job we can.

Achieving parity of esteem was such a key focus of yours in your term as President of the College. Do you have any immediate key objectives within your new position?

If I start with learning disability and autism, we know that people with learning disability in particular die twenty years younger than other people in society. That's almost entirely because they have higher physical health needs but their needs are not prioritised within the system, and we don't design the system so that they can easily access all of the services that everyone else can so we don't make appropriate adjustments.
In some services we don't even know who these people are and we don't identify those who are at greatest risk of developing a whole range of physical health problems. We don't design our services so that they can

very easily use our services so, I guess one of my main priorities is that I add that challenge to the rest of the system.

For example, there is a new hospital programme. There are new hospitals being designed at the moment, and not many of them have mental health space. But within the physical health space one of the main discussions is whether every patient's journey from coming to an outpatient appointment, coming to an emergency department, are we making sure that the needs of those with a learning disability or autism are being met? Are we making appropriate adjustments?

Are we actively contacting people, autistic people for example, who may need extra care and support to access services? They may want to access them in a particular way, they may need particular warnings about how hospitals are, they may need special spaces where they can go and be out of the hum drum of a normal hospital.

So, that's a really big part in the physical space where we need to make changes for those with learning disability and autism. But also for patients with particular forms of severe mental illness. Are they able to access to these services, particularly in the areas where we know that mortality is higher? So in cancer, respiratory, diabetes, obesity, and improving access to meet their needs.

I guess, more generally, we have got huge waiting lists for people with mental illness. We have about a million and a half people waiting and they haven't been treated in the same way as those with physical health conditions. So we need to make sure that we have the appropriate data to ensure that they are counted in a way that everybody else is counted.

We need plans to reduce those long waits; equivalent plans to physical health waits. So when they get to the top of the list, do they get the treatment that they need which is of a sufficient quality? Is it designed to attract people from all backgrounds?

One of the things I did a lot of work on related to equality, diversity and inclusion. Whilst as President, we set up various programmes promoting all sorts of quality improvement initiatives around as well as looking at this issue in relation to the Mental Health Act. We know that our services aren't sufficiently designed to be attractive to a whole range of individuals who may have very particular cultural needs.

They might, quite understandably, be quite suspicious of particular services, so we need to work with local communities to design services that they feel are ones that they are attracted to and communities will want to access. So, that is another really important part of the work that I am doing.

And, of course, I have already mentioned the Mental Health Act. One of my predecessors, Simon Wessley, conducted a review, now back in 2017, which is quite extraordinary really that, so much has happened since then.

The new Labour government have indicated that they wish to introduce new legislation. We are waiting to see if it will be in the King's Speech, so one of my priorities is to make sure that it is something that the government want to do, that they are aware exactly what it means, that it is properly funded. The changes proposed are not only legislative changes but the review also looked at services. If you want to reduce the number of people detained in hospital, you have to look at earlier intervention. You have to look at alternatives to admission, alternatives earlier in a patients journey.

We need to make sure that the legislative changes work, that we as psychiatrists can apply them and make sure that patients have as much choice and ability to challenge these important decisions and that they have as much autonomy as possible. But also where someone is at significant risk to themselves or others, that we make sure that we still have the framework that we can detain them in hospital and give them the care that they need. So, the Mental Health Act, if it is in the King's Speech, will be another big priority that will take up a lot of my time.

The other area that I am looking at, at the moment, is around ADHD pathways. Again, there are huge waiting lists for people with ADHD getting assessments, people not getting treatment. We also have shortages of various drugs. I sit on a group which looks at how we can mitigate for some of these shortages, particularly around prescribing generics where possible.

There is a whole issue around the ADHD pathway. I sit on the board that is looking at that. That was actually initiated by the Chief Executive of NHS England so there is real buy in from the centre to get this sorted so that we can provide a better service for those with ADHD and also to deal with the frustrations in the system, long waits for assessments, long waits for treatment which can be life-changing. We need to set up a much better system and I am going to be chairing the clinical reference group for that, so that is a real opportunity to make a real difference.

What I didn't know when I was appointed, nobody knew that there was going to be an election called imminently as we had thought, so I hit the ground running really with change. We have a new government. They have a real commitment towards mental health. That's been traditional over a long period of time and so I am meeting with ministers and forming good relationships with them is key.

I met the new mental health minister yesterday and it was a very positive meeting. I am meeting the Secretary of State this afternoon and I am meeting one of the other health ministers. I have just seen that a diary invite has just popped in. You find that these things just pop into your diary, then you are actually meeting the secretary of state or a minister. Of course, they have got such an important role and it is important that we engage with them and that we can support them to make real change to the benefit of our patients.

Finally, do you have any key messages for the Faculty of Forensic Psychiatry members?

I guess my main message is that I think it is a great career. As I said earlier, I would choose it again. So, a great choice. Well done! You're in the right place and it's a very challenging role. It comes with a lot of responsibility and that can be tough, but stick with it.

It is also incredibly rewarding. I guess I really want to say thank you to everybody for all the work that they do under the most challenging of circumstances. Without the commitment from members of our faculty, our patients would not get as good a service. I guess we all know, all of us, that there are times that we could provide better care for our patients. Nobody knows that more than all of us working in services, so I think that we should all have a bit of time to look at really how we can improve the services that we are providing, engaging with patients.

I know this is well known to everyone but engaging patients, trying to look at everything that we do from a patient's perspective and trying to do the very best for them. Putting patients at the very forefront of all that we do. That sometimes means acting when an individual in front of you doesn't want you to do something. It is our job to do that and that's a heavy responsibility but it is also very rewarding.

We also know that sometimes changes are not within our gift, so I would encourage everybody to get involved with issues around policy, whether that be within your own trusts or lobbying for more resources, working with the ICBs in England or the local health boards in Scotland, the different organisations in Scotland, Wales and Northern Ireland.

My role covers just England but I realise that I am speaking to a wider audience. Get involved in policy and get involved with the faculty. The faculty does a great job. It is good to see competition for executive members, people stepping forward such as yourself and doing these really important jobs around giving information to our members and making sure that they are engaged.

Engage with the faculty. Engage with the College. Look after each other. Support each other.

I've always thought that the most important thing in making your career work, first of all, is having a very clear vision around putting your patients at the centre of all you do. Having a close knit group of colleagues who you trust, who can support you, you can support them, who can challenge you in a positive spirit, that you can have fun together and develop things further. That's always been core keeping things functioning.

I've actually finished my clinical career. Just a few months ago, I decided that I would call an end. That has to happen at some point. But I am still part of a PDP peer group of forensic psychiatrists in my Trust, Devon Partnership, so I am still part of that network.

I would hope to come to the Forensic Faculty meeting at some point if I am invited. I would love to speak. There will be lots of opportunities. There are things that we all need to discuss, I guess particularly around the Mental Health Act but also about our services and what we provide for patients.

Sustainability Corner

by

Dr Dawn Washington, Lancashire and South Cumbria NHS Foundation Trust

Although I have not completely ruled out the possibility of a frequency illusion on my part due to my role, you may also have noticed increasing articles in the media regarding climate change and related issues, including in professional journals. Some of these will no doubt have covered individuals and organisations taking part in peaceful protest and non-violent direct action. Most people have at least heard about actions such as the Just Stop Oil activists who threw soup at Van Gogh's Sunflowers, for example, even if they do not fully understand the rationale. However, increasingly, health professionals are also becoming involved in climate protests.[1]

Given that the GMC's Good Medical Practice mandates that we must 'act promptly' if we think that 'patient safety or dignity is, or may be, seriously compromised,' [2] it can, and has been, argued that doctors have a duty to act, which may include taking part in such actions.[3] It is worth noting, however, that arrests for peaceful actions are now far more likely, due to draconian changes in the law, which the United Nations described as 'alarming'. [3,4] This includes the introduction of the Public Order Act, which has lowered the threshold on what is considered disruptive.[1]

In one such action, on 17 July 2022, four doctors and two nurses travelled to the European headquarters of JP Morgan in Canary Wharf and used hammers and chisels to crack panes of glass around the foyer. [1,5,6] They put up posters reading 'In case of medical climate emergency break glass'. Two days later the UK recorded its hottest day ever, at 40.3°C.[1,5,6] In June, the defendants pleaded not guilty and argued that their actions were justified because of the bank's role in funding fossil fuels.[1,5,6] Despite the judge ruling that they had no legal defence, and informing the jury they should disregard the 'political and philosophical beliefs' that led the defendants to take part in the action, after two days of deliberations, the jury failed to reach even a majority verdict on charges of criminal damage.[1,5,6] The Crown Prosecution Service has requested a retrial, which is set for February 2026.[6]

Around two-thirds of all climate protests end in acquittal once magistrates and jurors have heard the truth about the climate crisis.[1] As a result of these acquittals, politicians have put pressure on the justice system to limit the legal defences available to defendants and encouraged the use of civil injunctions to stop protests.[1] It was just such an injunction banning protests outside an oil terminal that led to retired GP Sarah Benn

receiving a custodial sentence for contempt after breaching the injunction on three occasions.[1,6]

Doctors convicted as a result of climate activism risk a GMC referral to the Medical Practitioners Tribunal Service (MPTS), which could lead to suspension or removal from the medical register.[6,7] A referral to the MPTS is mandatory if a doctor receives a custodial sentence.[6,7] In the case of Sarah Benn, this resulted in a five-month suspension. The tribunal ordered a review hearing to follow, at which she could be struck off the register.8 Dr Benn told the tribunal that she refused to remediate her conduct and intended to continue protesting until the government took the urgent action required to protect current and future generations from the effects of climate breakdown.8 The BMA is supporting Dr Benn to appeal.9 Latifa Patel, the BMA's representative body chair and workforce lead, said Dr Benn's case raised serious questions about doctors' regulation.8 She said, "We need urgent consideration on the rules as to why a doctor has been suspended for the punishment they already received for taking part in a legitimately peaceful protest, especially as the climate crisis is also a health crisis and as such doctors are understandably concerned." [8] Subsequently, doctors at the BMA annual representative meeting agreed on 'safeguarding the rights of healthcare workers and medical students engaged in activism', believing that 'such participation is fundamental to health equity and reducing inequalities'.[9] The motion called for the BMA to advocate for protections against punitive actions such as being struck off the medical register or termination of employment for doctors participating in activism.[9]

In addition, eight doctors cancelled their GMC fees to protest against the MPTS decision on Dr Benn.10 Kathy Fallon, retired GP, said, "We are not asking for doctors to have a carte blanche to protest. Rather, a criminal conviction for non-violent protest should not automatically trigger the MPTS without looking at the circumstances." [10]

Whilst this is very interesting, it may not be immediately apparent how this is applicable to us as forensic psychiatrists.

The combined threats of climate change and biodiversity loss are a global health emergency requiring urgent attention.[11] The physical health impacts are wide ranging and include direct effects of changing weather, such as heat waves causing cardiovascular events or severe dehydration; insecure food systems affecting nutritional status; and direct health effects of fossil fuel combustion, such as respiratory diseases from air pollution.11 Impacts on mental health are similarly broad and can be acute or chronic. Acute impacts can include PTSD, anxiety, substance abuse and depression.[12] Chronic mental health impacts include more mental health emergencies, an increased sense of helplessness or fatalism and intense feelings of loss.[12] It has been found that cases of

psychological traumas from any form of disaster exceed those of physical injury [40-1.13]

High temperatures increase rates of suicide, mental distress and hospitalisations for mental health conditions and have negative consequences for physical and mental health including increased mortality of people with mental illness.[13] Of particular interest to forensic psychiatrists, studies have also demonstrated a causal relationship between heat and aggression.[12,13] This relationship may be due to the impacts of heat on arousal, which results in decreased attention and self-regulation, as well as an increase in negative and hostile thoughts.[12] In addition, heat can have a negative effect on cognitive function, which may reduce the ability to resolve a conflict without violence.[12]

It is therefore clear that climate change will have negative effects on both the mental and physical health of patients and staff, putting increased pressure on services. Demand is likely to increase still further as accumulated effects of compound stress can tip a person from being mentally healthy to mentally ill.[12] Forensic services will need to respond and adapt to the changing patterns of need, providing continuity of service delivery in spite of evolving environmental pressures.[11] This will include contingency planning in the event of damage to health infrastructure through extreme weather events such as flooding, storms and wildfires. The nature of services provided in secure care, the associated risks and legalities make this a more complex undertaking than in other settings.

In addition to having to manage increased demand for care as a consequence of the climate crisis, healthcare systems are also major emitters of greenhouse gases.[14] The NHS, for example is responsible for four to five percent of England's carbon emissions.[15] Whether or not you accept that doctors have a duty to act urgently to protect the environment due to the risks that climate change poses to health as a result of GMC guidance, as doctors we can make a profound difference in reducing carbon emissions in healthcare.[14] The Net Zero Mental Health Care Guidance and Recommendations document provides numerous ideas to help us to do this.[15] However, it is my view that this is not enough. As highly trusted professionals we could, and arguably should, use our voices to lobby for legislative change and engage with and educate other professionals and members of the public. For those who may wish to become more involved in protests or other forms of activism, the GMC have recently published some key points and case examples to illustrate how their guidance applies to those who are taking part in such actions.[7] This does highlight the potential risk of being referred to the MPTS, particularly if there is a criminal conviction. However, history tells us that neither the law, nor medical regulators are always right, with the GMC recently offering a full apology for taking regulatory action against doctors who received criminal convictions under homophobic laws in the 1980s.[3]

It remains to be seen whether they need to apologise again in future for unwarranted regulatory action, this time against climate activists.

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How Healthcare Law Shapes Prison Psychiatry in Ontario

by

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Dr Kiran Patel, Assistant Professor in Forensic Psychiatry, Temerty Faculty of Medicine, Division of Forensic Psychiatry, University of Toronto.
Dr Najat Khalifa, Professor of Psychiatry, Division of Forensic & Correctional Psychiatry, Queen's University, Kingston, Canada.

Introduction

We were each Consultant Forensic Psychiatrists in the NHS before moving within the last ten years to practise in Ontario, the most populous province in Canada. We now spend much of our time in prison psychiatry, or correctional psychiatry as it is known in North America. The clinical presentations which we encounter will be familiar to those working with incarcerated persons all over the world. The criminal medico-legal provision, although different in certain areas such as relevant case law, is remarkably similar to that of the United Kingdom with near-equivalents to fitness to plead, insanity and diversion of the most unwell to secure hospitals under a separate tribunal or 'review board' system. We have found that differences from UK prison psychiatry are much more a consequence of differences in general healthcare law and from Canada being a federation of provinces which have significantly more legal jurisdiction than counties, cities or regions possess in the United Kingdom. We thought some faculty members might like to imagine practising within these parameters.

Corrections in a federation

The first thing to know about the Canadian prison or correctional system is that there isn't one system. Canada is a federation with one federal government and a government for each of the ten provinces (O'Reilly & Gray, 2014). There are also three territories in the North (Nunavut, Yukon, and Northwest Territories) which do not have their own governments but have derived powers from the federal government. Provincial governments are responsible for jails which detain defendants awaiting trial and convicted prisoners with custodial sentences up to two years less a day. Offenders handed longer sentences move into the federal system managed by Correctional Service Canada. It is not uncommon for us to have patients sentenced to precisely two years

whose sentencing reasons explain that the judge wanted to ensure detention in the federal system for better access to interventions. Occasionally, the offender themselves requests a longer sentence in order to be detained in federal custody, for diverse reasons.

The provision of healthcare, including mental, physical and dental, in federal corrections is the responsibility of the federal government. However, the majority of healthcare provision for the general population, healthcare law and the regulation of healthcare professionals are all the responsibility of the provincial governments. Consequently, there are ten different mental health acts and some differences between them are not insignificant. Notwithstanding the massive size of this country, we find prisoners are actually moved around it quite often. This means there exists the possibility – not entirely theoretical in our experience – that a mentally disordered offender can be detainable under mental health legislation in one province, but not in another, which can be an interesting proposition and even a consideration in proposed transfers.

Bifurcated mental health law

Mental health law in Ontario is 'bifurcated', meaning that in almost all circumstances the powers to detain a mentally disordered person are separate from treatment capacity legislation and patients with capacity cannot be treated without their consent*. This is, of course, different from the UK framework where persons detained under certain sections of the nations' mental health acts can be treated without consideration of their treatment capacity. It should be noted that this bifurcation of powers does not exist in every Canadian province or territory – this variation is another consequence of federation with multiple mental health acts.

To the UK-trained psychiatrist who has honed their decision-making in a more paternalistic environment, this can frustrate the instinct to provide treatment and perhaps even be a little disconcerting. Some of our patients are detainable due to psychosis but retain capacity for treatment decisions, of which a few use it to decide against having treatment. Thus, a handful of quite unwell individuals go untreated for months, if not years. Although this consequence of bifurcation challenges one version of acting beneficently, it certainly affords more autonomy to patients. This is quite a cultural shift, but the requisite re-examination of ethical principles should be a welcome challenge.

Compulsory treatment for prisoners

Notwithstanding the above limitation upon compulsory psychiatric treatment (which exists for all psychiatric patients in Ontario, not only mentally disordered offenders), such is available within provincial and federal corrections (provided substitute consent is obtained, usually from a close family member or the Office of the Public Guardian and Trustee), meaning that provision of treatment can, potentially, be swift in comparison with the UK. Diversion from the criminal justice system for treatment in secure forensic hospitals is possible in Ontario, but only if mental health defences (e.g., unfitness to stand trial or not criminally responsible on account of mental disorder) are successful. There is no equivalent to transfer under Section 47 or Section 48 of the MHA. As such, local arrangements have been set up in recent years to facilitate transfer of acutely unwell individuals from Provincial Correctional Centres to Forensic Psychiatric Services under the Mental Health Act. There is no catchment-area system to guide where patients should be placed. The Court can send them to geographically-distant placements if that is the next bed available.

In contrast, compulsory (and also voluntary) psychiatric hospital treatment of federal prisoners occurs in a Regional Treatment Centre (RTC; at which two of us work) located within the perimeter of a maximum-secure institution. We are mindful of arguments against treating very ill patients in prisons rather than external hospitals, not least regarding access to suitable therapeutic environments, and there are several challenges to providing psychiatric treatment in federal corrections (Cameron *et al*, 2021), but in the UK we were depressingly familiar with delays to hospital admission typically measured in months, as found by Sales *et al* (2023). Patients with acute psychosis make up the bulk of RTC cases, just like the bulk of Section 47 admissions in England & Wales. We can often admit a patient who is 'formed' under the Mental Health Act on the same day and it is rare for it to take longer than a day or two. Although UK forensic units offer better built environments, when prognosis is inversely related to duration of untreated psychosis there is much to be said for such speedy treatment.

<u>Medical Assistance in Dying (MAiD)</u>

A detailed account of MAiD, which was legalized in Canada in 2016, is beyond the scope of this brief reflection. Complexities in providing assisted death for prisoners and forensic patients have been well-illustrated by Jones and Simpson (2024) and deficiencies in arrangements for federal prisoners in Canada have been argued by Driftmier and Shaw (2022). Although enacting the controversial extension of MAiD solely on the grounds of mental illness has been postponed for a second time, now until 2027, MAiD nevertheless touches our world in correctional

psychiatry, even if requests are uncommon. We have participated in eligibility assessments for MAiD in which mental disorder was a factor, albeit not the primary or exclusive 'grievous or irremediable' qualifying condition, and MAiD was subsequently provided. These were certainly substantially different assessments from any we had done in the UK and were personally impactful. Making MAiD available to prisoners, including those seeking it solely for mental illness, arguably is necessary to prevent discrimination if it is available in the rest of society.

Conclusion

Moving mid-career to work in another country can be rewarding, but of course there are professional challenges. We would say that an appetite for learning and a willingness to re-examine foundations of practice are important factors for success. Relocating like this can cause a clinician to consider which are universal truths of their specialty versus the practices built up by tradition, perhaps little-questioned, in the system they are from. This is particularly true of forensic psychiatry with its dependence upon the laws of the nation and, we have learned, the province in which it is located. In our work in correctional psychiatry, it is differences in general healthcare law which have precipitated the greatest changes in our practice. Navigating these changes has been very interesting.

* The only exception being a Treatment Order which the criminal courts can impose to ensure an unfit defendant receives treatment intended to restore their fitness to stand trial.

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A comparison between the voting patterns in Wathwood medium security hospital and the general population

by

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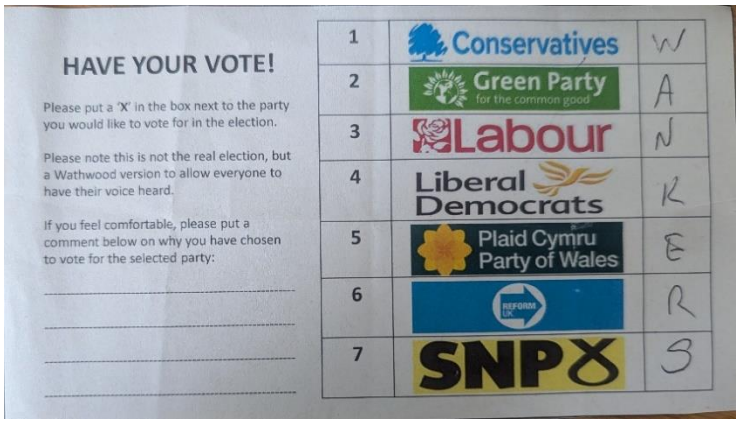
The European Convention on Human rights (ECHR), states in Article 3 of Protocol Number 1 that, 'everyone has the right to elect the government of his/her country by secret vote. Without this right there can be no free and fair elections'. (1)

Although the ECHR declared the blanket restriction on voting which applies to prisoners unlawful, this remains the case within England. Relating this to the mental health act, those under S37, S38, S44, S51(5), S45A, A46 or S47 are disenfranchised. In contrast those who are remanded under S35, S36 or S48 are not disenfranchised, along with those under S41(5) whose restrictions have come to an end. Anyone under a civil mental health act section such as S2 or S3 is eligible to vote. (2). Anyone who meets the criteria is eligible regardless of their mental capacity. (3).

The Royal College of Psychiatrists suggest that there are more than 20000 people being treated in inpatient settings who were at risk of missing their right to vote. Dr Lade Smith CBE, president of the royal college of psychiatrists, stated 'People sectioned under the Mental Health Act are the most likely to miss out on their democratic rights, due the misconception that it prevents people from voting. This is a clear example of the discrimination facing people with severe mental illness. More must be done to inform patients, health professionals and wider society about the democratic rights of people in inpatient settings, which are enshrined in law.' (4).

Wathwood hospital is an all-male 72 bedded medium security hospital in Rotherham, South Yorkshire. At the time of starting this project in the beginning of June 2024 there were 62 inpatients at Wathwood, one of whom was on trial leave elsewhere. Of the 61 people currently residing at Wathwood there were 17 people who met the criteria to vote, 28% of the

hospital population. All 17 people were offered support to register to vote, with 8 people completing registration. As there was almost three quarters of the hospital population who were not eligible to vote a 'Wathwood election' was created to encourage everyone to engage in political events, it was felt this was an important step in their rehabilitation journey. The mock election was held on the same day as the general election and all participants were made aware that this was not part of the official vote. An example of the ballot slip used is included below, which was filled in by one of the participants.



Prior to the vote the 2024 election manifestos for the main political parties were simplified, printed, and made available to all wards to aide peoples decision making. This was an important step as people have limited access to internet sessions where they would be able to access this information. 19 people chose to participate in the Wathwood election, 30.6 percent of the current inpatients. This is significantly lower than the 52% turnout for the general election. There were two spoilt ballots, we have calculated the data below without including these in the calculations.

The results for the Wathwood elections showed a 35.3% majority win for Labour, this is closely reflected in the wider population with a Labour majority of 33.7%. The local area had a higher rate of Labour votes at 49%. The second largest proportion of votes within the Wathwood patient community was for the Reform party, with 21.1% of votes. This is similar to the local area which had a rate of 28.6%. These are both higher than the whole countries total of 14.3%. The percentage of votes for the Conservative party was 5.9% lower at Wathwood compared to the national votes. The Green party gained 17.6% of Wathwood votes, which is significantly higher than the 5% of votes they gained within the local area, and higher than the country wide proportion. There were no votes for the Liberal Democrats from the Wathwood election.

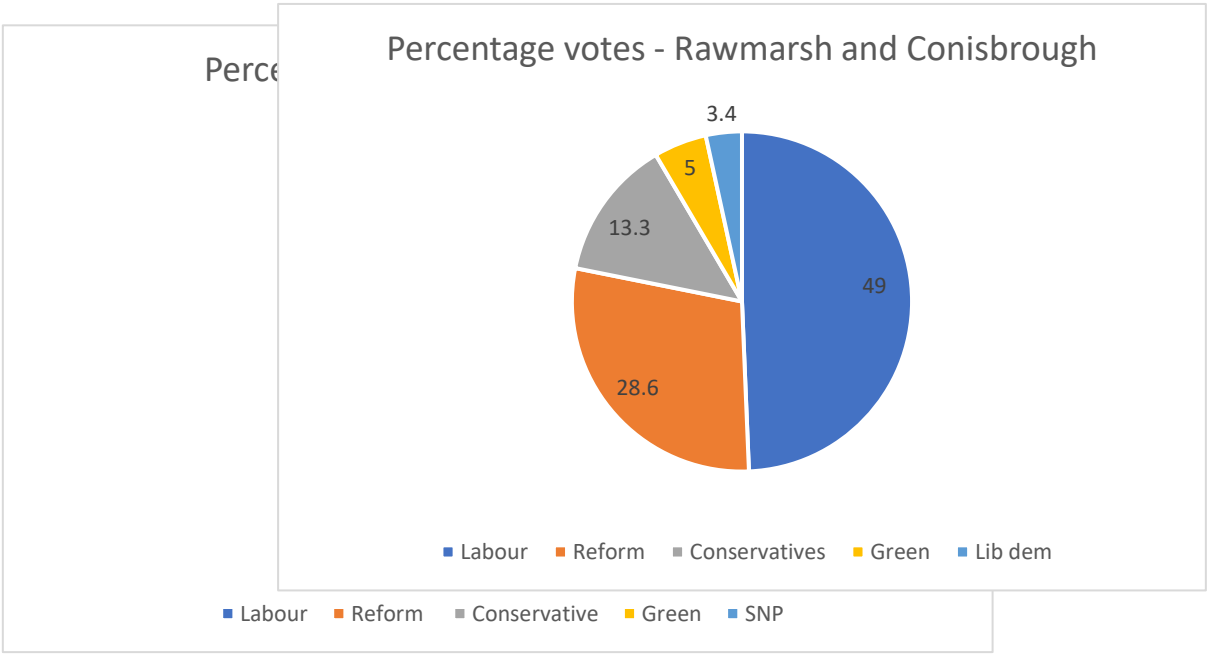
From reviewing the data it is clear that there are elements of the Wathwood results that reflect not just the local area, but the voting pattern across the whole country. There are some key differences, including the substantially increased votes for the green party, but overall the same outcome was achieved, with a majority voting in favour of Labour. It would be interesting to explore in more detail which policies are

important to our patients at Wathwood, and to gain a better understanding of factors that influenced their decision making; however, this was beyond the scope of this project.

In a population of people who experience such significant barriers to engaging in UK politics, we as clinicians must do more to support our patients in exercising their right to vote (for those who are eligible to do so). Certainly whilst completing this project, we found that the process of registering patients to vote was not at all straightforward. On the other hand, for those patients who are not eligible to vote, we must make efforts to engage them in the wider political conversation regardless, in order to ignite an interest in political events that significantly impact their lives. If the purpose of the criminal justice system is to rehabilitate individuals as functioning members of society, then surely as part of this process, we must encourage them to engage with the politics of the society that they are to re-enter.

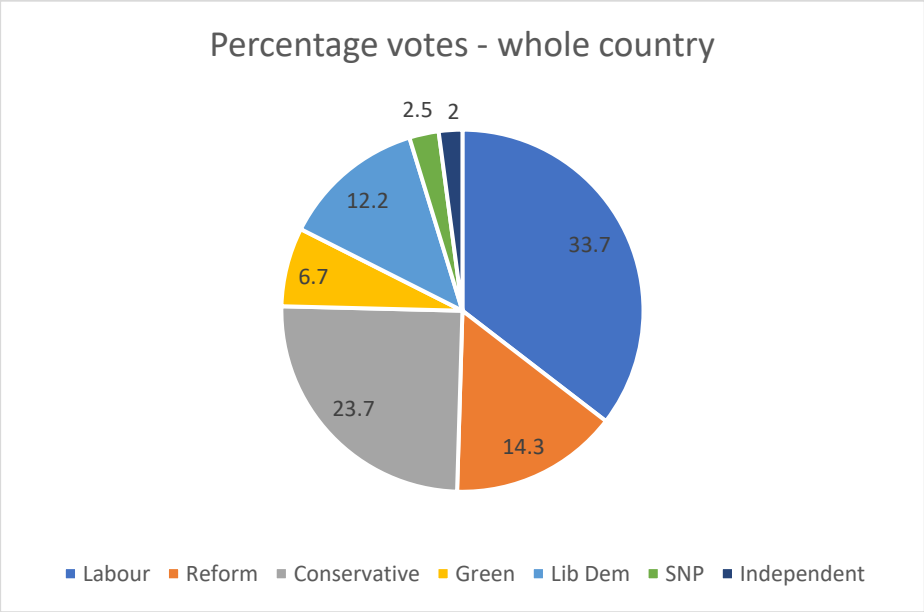
Wathwood results:

Political party	**Number of votes**	**Percentage of votes**
Labour	6	35.3
Reform	4	23.5
Conservative	3	17.6
Green	3	17.6
SNP	1	5.9



Wathwood Hospital falls within the Rawmarsh and Conisbrough constituency. General election results for this constituency are shown in the following graph (5).

These results have been compared to those of the general population, which is included in the chart to the right (5).



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Collaborative risk assessment & management planning across the forensic mental health pathway in England: introducing the NIHR-funded CORAS study

by

Dr Daniel Whiting, Clinical Associate Professor in Forensic Psychiatry, University of Nottingham & Honorary Consultant Forensic Psychiatrist, Nottinghamshire Healthcare NHS Foundation Trust

Much of the planning of care within the forensic mental health pathway in England is guided by some assessment of risk- from acutely restrictive interventions and other big decisions like entry into secure services, transfer to and from prison and other non-forensic hospital settings, and community discharge, to more day-to-day decisions such as around access to leave or certain therapeutic activities. Typically, the focus is on risk of harm to others, but many other risks are also considered.

Risk, and linked restrictive decisions, are therefore a uniquely prominent aspect of care in our settings, with a complex dual element of individual need and public safety. This is also potentially complicated for some risk-based decisions by additionally involving a range of different bodies, such as the Ministry of Justice or Mental Health Review Tribunal.

In this context, integrating shared decision-making can be challenging. Potential issues with insight and capacity might also be a barrier. Despite the complexity, collaborative risk assessment and management has been recommended for several years, such as in Department of Health best practice guidance. This aligns with overarching priorities to maximise patient-centred care, autonomy and involvement in decision-making.

Currently, which collaborative approaches to risk assessment and management are effective, and whether these are implemented in practice in forensic services, is not well understood. This is an important gap because there is potential to improve outcomes if implemented more effectively and consistently, and because it is likely to vary between groups, which may exacerbate inequality and poor outcomes.

The NIHR's Policy Research Programme is funding a piece of research to address these gaps. Led by Dr Daniel Whiting at the University of Nottingham and Professor Seena Fazel at the University of Oxford, the CORAS study will 1) examine what approaches to collaborative risk assessment and management planning are available, and what works in which scenarios, using an approach of realist review, and 2) examine whether these approaches happen in practice, and how this can be improved, using mixed methods. The research team also includes academics and methods experts from the Universities of Nottingham and Manchester, with public and patient involvement led by a co-investigator from Rethink Mental Illness.

The work kicks off in September 2024 and over the 18-months of the project the research team will be looking to engage professionals, patients and carers from across the forensic pathway and interfacing agencies, including in stakeholder work and through interviews and surveys.

If you would like to know more about the work, please contact daniel.whiting@nottingham.ac.uk

Why we work as Specialist Parole Board (PB) members - and why you might want to join us!

By
Dr Lynne Daly
Dr Kevin Murray

The prisoner, AD, was convicted of GBH in 1986, aged 21, and sentenced to discretionary life imprisonment. The victim was a 9 year old child, who was strangled with a dog lead, but survived. The motive remains unknown. The tariff expired in 1990. AD has never been released. He was diagnosed with schizophrenia in 1995. His second hospital admission was in 1999, where he has remained. In 2018, the MHT made a deferred conditional discharge and AD was referred to the Parole Board. The victim's family remain involved and attended the hearing to read their statements, which painfully described the devastation of their lives resulting from the index offence. After 3 years of adjourned hearings, it proved impossible to identify a suitable community placement and in July 2022 the panel decided not to release. AD was rereferred to the Parole Board in December 2022. He had been diagnosed with Autistic Spectrum Disorder in addition to schizophrenia, which also explained his lifelong unusual behaviours and poor communication skills. I undertook the Member Case Assessment, which is the initial review of a case on the papers. A suitable placement has now been found. It remains to be seen whether AD can be released…….

If you enjoy sorting out such tricky cases, perhaps you should consider applying to become a PB specialist member.

Not all cases are so complex - but as a psychiatric specialist member we see a wide range of cases and bring a particular expertise which is valued by our colleagues.

Which cases come to the PB & why?

The test for release for all cases is: "The Board must not give a direction [for release] unless the Board is satisfied that it is no longer necessary for the protection of the public that the prisoner should be confined".

Life and Indeterminate Sentenced Prisoners may only be released by the Parole Board after they have served their tariff period, and only if they are considered to meet the statutory test. IPP prisoners typically have much shorter tariffs but either have not yet met the test, or more commonly have been released and recalled, often because of chronic substance misuse or mental health issues.

For prisoners who are assessed as dangerous, the Extended Determinate sentence (EDS) has replaced the Indeterminate sentence for Public Protection(IPP). EDS prisoners are referred to the PB for possible early release after serving a proportion of their sentence; early release between Parole Eligibility Date (PED) and Conditional Release Date (CRD) can only be by the PB.

Most other prisoners are managed with no parole board involvement, subject to Standard Determinate Sentences. They are released at a fixed point through their sentence. If they are recalled for breach of licence or a further offence and are considered a risk to others, their case would be referred to the PB for review.

The role in more detail

As specialist psychiatrist members we see cases where there is a significant mental health concern, often prisoners who have been transferred to hospital and remitted back to prison. We have access to the dossier of evidence: 400 pages is typical, sometimes significantly more. From this we identify the risks the prisoner poses and assess the effectiveness of licence conditions and risk management plan. We participate in the hearing, by videolink in more than 90% of cases, questioning the witnesses, usually the Prison Offender Manager, the prisoner, authors of specialist psychological or psychiatric reports and the Community Offender Manager. The panel's decision is purely risk based, not what would be best for the prisoner, although we try to achieve that too.

Becoming a PB specialist member requires skill in analysing written and oral evidence and identifying and assessing the relevant risks. It requires the ability to question professional witnesses and often to lead the questioning of the prisoner, on behalf of the panel.

You will see a much broader section of the CJS than working as a hospital based RC. Your clinical practice will benefit; I learned to request the PB dossier for my transferred prisoner-patients who were post tariff. My colleagues were amazed at the information these contained which they had not previously accessed.

You will share our frustration with the exclusion from specialist support inherent in current commissioning models, which often restrict specialist forensic aftercare to MSU graduates, even though the prisoners you will see for the PB have identical or greater needs .

Perhaps the greatest pleasure as a PB specialist member is our colleagues; many from a senior legal, policing or probation background, but also from other senior roles in the public and private sectors, as well as the cohort of psychologist members.

There is much more to say about policy development, liaison with the Ministry of Justice, assessing cases "on the papers", remuneration and expected annual commitment. The PB will be launching a recruitment campaign this summer for psychiatric members; if this has whetted your appetite, you're very welcome to contact Lynne Daly or Kevin Murray for an informal discussion

Lynne.daly@paroleboard.gov.uk
Kevin.murray@paroleboard.gov.uk

Overview of Fellowship for Chairs

Fellowship eligibility

Members who have 10 years of continuous membership as of 1 January in each year can apply for Fellowship in that year. (e.g., anyone who became a Member on or before 1 January 2014 and was a continuous member can apply for Fellowship in 2024).

Applicants need to demonstrate their contributions to the three core purposes of the College:

1. Setting standards and promoting excellence in psychiatry and mental healthcare (such as examples of achieving high standards locally in service delivery, service development and innovation, research, teaching and examining).
2. Leading, representing and supporting psychiatrists (this would include, but is not limited to, all College work and work with relevant national or international organisations).
3. Working with patients, carers and their organisations (to improve services and deliver patient centred care).

Applicants are only asked to provide details under these three headings, they are not asked to give a list of their publications or research etc. We ask them to not send separate CVs but instead only complete the College's CV form.

Fellowship application process

Fellowship applicants must complete three forms:

1. A CV form in which they detail their achievements and demonstrate significant contributions to the core purposes of the College (see above)
2. A good standing form
3. A citation form which is completed by a proposer and seconder. The proposer writes a citation in support of the application (the seconder may add their own comments, but this is not mandatory). Both proposer and seconder must be Members or Fellows and must sign the form.

The Regulations state:

'If neither of the two nominators is a Chair of a Faculty, a Division or a

College International Division (as the case may be), the nomination must also be supported by such a Chair who shall be invited by the College to review and support the nomination'

Applicants can approach a Chair to support their application if they know one. If they don't, we ask them to have their application supported by two colleagues.

They then send the completed application to us and nominate the most appropriate Chair to review their application. Staff will forward the application documents to the Chair and ask that they review them and advise whether or not

they are happy to support the application. A signature is not required, email confirmation of support will suffice.

If information on the CV form is incomplete or unclear, please let us know and we can ask the applicant to improve and re-submit their application.

The deadline for submitting completed applications is 15 September each year.

Fellowship assessment process

All nominations are reviewed by the Nominations Committee, which consists of the Officers and two Council members who have been nominated to serve on the committee.

Applications are scored by each member of the Nominations Committee.

The Committee will meet in October to discuss the applications and decide

which applicants will be elected to Fellowship.

Encouraging more applicants

We would be grateful if you could encourage colleagues and committee

members who are eligible to apply for Fellowship to do so. There is no limit on the number of Fellowship applications that you can support.

We are especially keen to encourage more diversity overall.

Further support

The Membership Services team are here to answer any questions you or any potential applicants have about the Fellowship process and can be contacted on

MembershipServices@rcpsych.ac.uk

Expert Witness Matters newsletter

By Professor Keith Rix and Dr Duncan Harding

It appears that many Faculty members are unaware of the monthly Expert Witness Matters newsletter sent out by the College on behalf of Dr Duncan Harding, College Expert Witness Lead, and Professor Keith Rix.

The newsletter includes items of interest to all healthcare expert witnesses as well as items of specific interest to psychiatrists. Readers' questions and queries are answered. Readers are updated about amendments to procedural rules, such as the Criminal Procedure Rules, and accompanying practice directions that affect expert witnesses. There are links to the training available from organisations such as the Expert Witness Institute and The Academy of Experts. The newsletter links to a constantly updated annual compendium of judgments that are relevant to experts and annual compendia of judgments from 2019 are also accessible. The judgments added in June included:

June included:

Lukes v Kent & Medway NHS & Social Care Partnership Trust & Anor [2024] EWHC 753 (KB)
Negligence by police, liaison and diversion and mental health services?

R v Mazzer [2024] EWCA Crim 557
PTSD and self-defence

R v Newman [2024] EWCA Crim 415
IQ and mitigation

AM v The Secretary of State for the Home Department [2024] UKAITUR UI2024000322
Suicide risk and deportation

R v Ismael [2024] EWCA Crim 301
Unfitness to plead missed

R v Chamberlain [2024] EWCA Crim 476
Autism spectrum disorder and dangerous driving

Subscription, which is free, is straightforward. Go to https://www.rcpsych.ac.uk/improving-care/ccqi/multi-source-feedback/maep/maep-newsletter-resources and sign up.

Multisource Assessment of Expert Practice

Faculty members who assist courts and tribunals with expert evidence should already be aware of the GMC's 2024 updated guidance Providing witness statements or expert evidence as part of legal proceedings (https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/providing-witness-statements-or-expert-evidence-as-part-of-legal-proceedings). In a footnote the GMC refers to the RCPsych's Multisource Assessment of Expert Practice which can be used by psychiatric expert witnesses to obtain feedback for their annual appraisals and revalidation and to support professional development. It also refers to the College's expert witness newsletter (see above).

Once enough feedback has been collected, subscribers can generate a report on their performance on a case by case basis and also cumulatively prior to their annual appraisal. Feedback is provided against eight key domains, essential to achieving a high standard of ethical and professional practice as an expert witness. Invited feedback against these eight domains is presented alongside the MAEP subscriber's self-assessment scores, to encourage reflection and development.

In order to subscribe to MAEP go to:
https://www.rcpsych.ac.uk/improving-care/ccqi/multi-source-feedback/maep

Contributions Welcome

Thank you to the contributors of this edition.

We would welcome contributions for the next e-newsletter by Friday 17th January 2025.

If you would like to reach out to someone on the committee please do not hesitate to contact:
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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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