# iForensic

Faculty of Forensic Psychiatry Newsletter
Autumn 2020

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Forensic Faculty Newsletter

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# Welcome

## News from the Faculty Chair

by

Dr Josanne Holloway

Chair of the Forensic Psychiatry Faculty

Who would have thought this time last year we would be wearing masks, socially distancing and hand washing scrupulously; that digital innovation would have been so quickly implemented into clinical practice and that psychiatrists and psychologists would be wearing scrubs. It has been a difficult time particularly for our trainees, patients, and their carers. The upside has been that a significant number of patients have welcomed an increase in ward based activities and a Rethink Report gathering views from people in secure care and their families highlighted fewer untoward incidents during COVID and a feeling of staff and patients working together – every cloud has a silver lining let us hope these positive initiatives continue even post pandemic.

One of my main objectives as chair for my tenure is around meaningful engagement with Faculty members and for our patients and their carers. We have excellent patient and carer representatives in Alain Aldridge and Sheena Foster. Please use your regional representatives (and trainees, your trainee and PTC representatives Christian Brown, Leah Riley, and Niamh Sweeney) who attend exec meeting, as a source of information and opportunity to be involved in Faculty business.

Next year's Faculty conference will be run completely remotely on 3, 4 and 5 March 2021. Andrew Forrester, Academic Secretary has the programme ready to share.

The Faculty is currently involved in several initiatives. The strategy morning at our Executive meeting this month was about **Prison mental health care**. Jo Rance, Senior Mental Health Implementation & Clinical Support Manager (Health and Justice Team in NHSE and NHSI) spoke about commissioning challenges and success while Steffan Davies and Huw Stone, Prison Network Co-chairs, discussed the challenges around meeting

the Quality Standards for Prison Health Care and Rachel Daly provided a case study to highlight some of the practical difficulties in providing mental health care within the prisons. Following the meeting, we agreed to set up a task and finish group to identify two or three SMART objectives we could focus on to support improved mental health care for prisoners. The highlighted barriers to effective care included: timely transfer in and out of custody; mental health follow-up following release from custody and supporting mental health wellbeing including through maintaining effective mental health care during the COVID pandemic.

A related area is the role of psychiatrists in the parole process for prisoners with mental health conditions. We have been approached by colleagues on the Parole Board to work with them to improve mental health input into the system. The areas highlighted were around the provision of useful reports to the Parole Board and the organisation of community mental health follow-up for released prisoners.

Professor Pamela Taylor and I also had a meeting with the Ministry of Justice following concerns raised about the difficulties in maintaining a balance between infection control and a regimen to maintain mental health wellbeing. Concerns were raised around the inconsistent use of PPE and social distancing within the prisons; the confusion that can arise when Trusts and the prison services issue different guidance around issues, for example, CPR and the appropriate PPE. We also highlighted the risks associated with prisoners released from custody and deemed to have no fixed abode.

The Faculty remains concerned about **inequality of access to therapeutic communities** for prisoners with a mental health condition for which they are currently prescribed psychotropic medication. There is some indication that this has been relaxed however this does not appear to be consistent across the prison estate as colleagues who work within the prisons remain concerned that the problem remains.

An area of concern shared by the Forensic Faculty, the Child and Adolescent Faculty and the Adolescent Forensic Special Interest Group is the **Age of Criminal Responsibility** (ACR). This is the minimum age that a child can be prosecuted and punished by law for an offence. The UK has the lowest age of criminal responsibility in Europe and one of the lowest in the world. In England, Wales, and Northern Ireland the ACR is 10 while that in Scotland is 12. The UN Committee on Human Rights of the Child consider 12 to be the absolute minimum. The Adolescent Forensic SIG are holding a conference on 7 December 2020 on this issue. The Adolescent Forensic SIG are taking the lead in lobbying for the ACR to be increased, The Forensic Faculty is supporting this, and Professor Pamela Taylor has been leading on

this for the Faculty. We understand that the House of Commons Justice Committee will be asking the Ministry of Justice to consider this question.

We have been approached by the **Prevent Policy Team** to meet with them to address any issues or concerns we may have. The College is arranging a cross-Faculty meeting with Prevent.

One area which I think would be useful for the Faculty to take up is that of **Community Treatment Requirements** as part of a community sentence. There are three types of Community Treatment requirements: Mental Health Treatment Requirement (MHTR); Drug Rehabilitation Requirement (DRR) and Alcohol Treatment Requirement (ATR). These were introduced in the Criminal Justice Act of 2003. However, they are very rarely used and in 2018, of all the requirements commenced under community orders, only 0.4% (690) were for MHTRs, 4% (7772) were for DRRs and 3% (5079) were for ATRs. Considering the mental health morbidity both in prison and in the community, this is disappointing especially when this is a 39% decrease since 2009. There are a number of barriers that have been identified which may be contributing to the low take up of Community Treatment Requirements including lack of clarity on the clinical criteria, lack of availability and access to community services and lack of awareness amongst both criminal justice and health professionals. I would be interested to know if Faculty members would consider this issue something that would be worth addressing within the Faculty.

The Faculty is also involved in updating a number of College reports including that on expert evidence, Forensic pathways for adults with intellectual disability involved in the criminal justice system and recommendations for the provision of services for childbearing women.

Please feel free to contact me through Stella Galea if you have any issues, concerns or initiatives that you feel the Faculty need to take up. I wish you all a very happy Christmas and hope that you can all spend time with loved ones safely. Looking forward to 2021.

Contact Josanne c/o Stella Galea, Faculty & Committee Manager
stella.galea@rcpsych.ac.uk

# Legal Update

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

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

As an expert witness, you have an obligation to be open about any adverse comments or findings against you, whether it is by the General Medical Council or in the form of judicial comment or criticism.

These cases summarise three circumstances in which expert evidence has been the subject of comment, criticism or sanction. They hopefully highlight some of the traps to avoid when acting as an expert.

**Dr A, Medical Practitioners Tribunal Service, 2019**
***Read it*** *if* you have any involvement in Mental Health Tribunals

<u>What was the issue?</u>
Dr A was an independent expert who had provided reports including for a Mental Health Tribunal for a patient who had instructed him directly. Dr A had also taken on a quasi advocacy role for the patient who was deemed to be vulnerable. Concerns were raised with the GMC about Dr A by the medical director of the Trust where the patient was detained. The concerns raised and then considered included:

- Inadequate assessments.
- Failure to take (their own) adequate medical history.
- Inappropriately asking for money from the patient.
- Blurring the boundaries between the role as expert and advocate.
- Communication and conduct problems with clinical staff.
- Dishonesty in giving opinions about the patient’s partner.
- Contacting tribunal members after a decision.

<u>What was the upshot?</u>
Dr A was suspended for six months but has retired. The complaints were probably extreme and unusual but there were outcomes of importance:

- Take extreme care if you accept instructions from the person you are reporting on, including being sure of their capacity to instruct you and enter into a contract with you.
- Do not give opinions on family members whom you might have had some contact with.
- Do not dispose of your written notes after an assessment.
- Do not rely on another doctor's or expert's history; take your own.
- Show how you address the risk of confirmation bias; include evidence contradicting your opinion.

**R v Foy [2020] EWCA Crim 270**

***Read it*** if you've ever felt certain of your opinion

What was the issue?

Mr Foy was convicted of murder and appealed on the basis of new psychiatric evidence on diminished responsibility. Diminished responsibility had been explored by the defence before the original trial but had not been pursued at the trial as the diagnosis made was substance-induced psychotic disorder and substance use disorders (lack of specific intent was pursued). New evidence suggested that the diagnosis was an acute, transient psychotic disorder exacerbated by abuse of cocaine. The Crown instructed a second expert who found the psychotic episode to have been likely to have arisen from substance use.

What was the upshot?

The application to consider new evidence was refused and the appeal dismissed. Several observations on the expert evidence were included – albeit without significant criticism:

- Avoid giving the impression that your opinion is the only possible opinion.
- Tread with extreme care before criticising other experts.
- Avoid commenting on the credibility of people you interview or other witnesses.
- Do not give opinions on matters outside of your expertise.
- Be cautious when interpreting toxicological evidence.

**Thimmaya v Lancashire NHS Foundation Trust [2020] 1 WLUK 437**

***Read it*** if you do any expert witness work

What were the issues?

This case did not involve a psychiatric expert. Ms Thimmaya had brought negligence proceedings against the Trust following surgery. A costs order

was sought against the expert witness for Ms Thimmaya, Dr B, whose evidence was criticised for the following reasons:

- They were wholly unable to articulate the test to be applied in determining breach of duty in a clinical negligence case.
- That they were not generally competent as an expert.
- That they were not competent in this case because they had only carried out this particular surgical procedure twice.
- They were not fit to be giving expert evidence because they were off sick from their clinical (but not medico-legal) work.

What was the upshot?

Dr B was ordered to pay costs of £88,801.68. Again, this judgement implies some messages that we, as forensic psychiatrists, might be advised to take note of:

- When you act as an expert, you do not need to be legally qualified but you need to know the legal tests you are addressing.
- Give consideration - particularly in relation to unusual clinical situations - as to what your experience is in a specific case and whether you can justify your role as an expert.
- If you become unwell so that you are not fit to give evidence or continue in a particular case then you must make this clear.

# What's it like to retrain in forensic psychiatry?

by

Dr Mandip Jheeta
ST4 Forensic Psychiatry, Bracton Centre, Oxleas NHS Foundation Trust

**My story so far**
I share my thoughts and experiences after recently starting retraining in forensic psychiatry. I previously completed my core and higher training in general adult psychiatry in the West Midlands, before taking up a consultant post for 2½ years, primarily on an acute female inpatient unit in Birmingham. After completing the national interview process, I joined the South-East London training scheme in February 2019.

**First impressions**
By far the most positive and striking difference between general and forensic psychiatry has been working in a full MDT. My previous general adult inpatient ward rounds usually had 3 or 4 professionals (me, a nurse and SHO, and often psychologist or occupational therapist). We now have at least 8 members of the MDT in ward round. It is a true MDT, and the first time in several years having a social worker directly in the MDT.

**A challenge to professional identity**
By far the hardest aspect of retraining has been the challenge and shock to my sense of professional identity. I hadn't really thought too much about professional identity before. Until, my clinical and non-clinical roles, responsibilities and expectations changed overnight. Probably the hardest thing has been the sudden change from feeling relatively skilled and expected to deal with complex problems and situations, to having a different role and not feeling as expert or skilled in my new specialty. It probably took a few months for the new role to stop feeling strange and

unfamiliar (which was also partly due to moving regions), and 6 months to feel fully settled.

**Other positives**

It has been valuable to have general adult and consultant experience. Clinically, it has helped to have managed a broad range and depth of general adult patients and situations. Professionally, it is nice to retrain and focus on improving other skills. For example, as a consultant, I often got caught up in busy clinical work and struggled to take SPA (supporting professional activities) or non-clinical time. So I now have a greater appreciation of special interest sessions, our 2 separate academic/ professional programmes per week, and the feeling of having more 'space to think'.

**Do you need to retrain?**

Before applying, I asked some training programme directors (TPDs) and clinical directors this question. The clinical directors said that they would consider appointing someone with a General Adult CCT for some jobs e.g. prison or possibly community forensic posts, but that I would be very likely 'outcompeted' for these and other (e.g. MSU) posts by someone with more relevant experience and qualifications. The TPDs were encouraging, but some were not sure if it was strictly necessary to complete another higher training programme. I am aware that numerous consultants have previously switched from general to forensic psychiatry. However, this seems to be a less common and feasible option for newer generations of psychiatrists. Ultimately, I felt that the career opportunities and prospects would likely be better after gaining a separate Forensic CCT, with the associated advantages of e.g. having a consolidated formal training package and peer group.

**Could retraining become more popular?**

This may not be part of any trend, but there are 3 of us ex-consultants (2 general adult & 1 learning disability) on our training scheme. I do wonder whether dual or retraining may become more popular. Particularly, if people are seeking greater options and variety during long careers, including from rising retirement ages.

**It's definitely been worth it**

Overall, I'm happy with my new specialty. The biggest hurdle has been having to evolve and develop a new or different professional identity. However, it's also great to work in a new, fascinating and rewarding specialty. And be able to contribute to ideas, discussions and helping patients from having other professional experiences, perspectives and skills. Retraining after being a consultant is an uncommon career move, but I'm really pleased to have made the switch.

# Thoughts on a career in forensic psychiatry

by

Jane Moffat
Year 4 Medical Student, Keele University

Following a period of reflection after the premature birth of my daughter, I decided to pause my career as a lawyer and study medicine. Initially, my healthcare interests were centred around neonatology, maternal-infant health, public health and bioethics. I am now in my penultimate year. Over time, my interests have evolved, particularly following a placement during my 3rd year on the acute female inpatient ward at a mental health hospital in the midlands. The experience challenged me to think about whether a career in forensic psychiatry might be an option, particularly given the links with law and public service, including court based work.

During my mental health placement, I found that I enjoyed the focus on history taking and mental state examination, particularly with acute patients. By contrast with other areas of medicine, verbal and non-verbal communication seemed to be indispensable to the investigative process, as well as being the fundamental basis for diagnosis. I found myself fascinated by alternative mental states, including consideration of their organic causes and the environmental and social factors which influence mental health. I enjoyed the humanness of the interactions with the acute mental health patients, whom I feel are often stigmatised or even feared in society.

I am keen to find my home in a medical field that allows me to integrate the skills I built up prior to studying medicine, and possibly even continue the practice of law. A detailed knowledge of the criminal justice system and laws, as well as the statutes governing mental health, including the Mental Health Act, would seem to be at the heart of forensic psychiatry. In addition to the clinical side, I am attracted to the inter-disciplinary nature and multi-

functional aspects of forensic psychiatry, with the possibility to work on the wards and in the court room.

On the negative side, I can imagine that vigorous challenge and cross-examination by prosecuting or defending barristers in court, would require thick skin and an ability to leave the job at work. In my early years of legal practice, having felt at times swamped by paper work, I wonder whether the document intensive nature of court based forensic psychiatric work might at times become tiresome, but I guess every job has a downside and hopefully the clinical aspects would balance this out.
On the positive side, I am attracted by the ongoing nature of the relationship between doctor and patient required by forensic psychiatric practice. There would seem to be a need for an ongoing assessment over time of the risks which a patient presents to him or herself and others. Finally, forensic psychiatry would seem to offer an interesting and varied array of work, not only in relation to different mental health conditions cutting across all walks of life, but also as between legal issues which mental health conditions present.

Only time will tell but I am hopeful that I have found an area of practice, which is right at the intersection of law and medicine, to really explore over the next few years, with a view to specialising further down the track.

# What's it like to work in a forensic inpatient unit during the coronavirus pandemic?

by

Dr Georgina Mills
Specialty Doctor in Forensic Psychiatry
Arnold Lodge MSU, Leicester

As a specialty doctor working in a medium secure unit in the midst of a viral pandemic, first worries seemed overly selfish; Am I going to be redeployed?! Will I have to dust off the stethoscope and pitch up at the local general hospital hoping to beat this virus on the front line?

It's only been four years since finishing my foundation training years, yet still the thought of attempting to hear a heart murmur, pretending I know what is glaringly obvious on the chest x-ray or re-learning how to place a cannula was enough to spark anxiety.

Luckily rumours were unfounded, and I found myself continuing to work in what seemed like a strange and new environment.

The hospital meeting as the virus ramped up was unfavourably placed on a Friday afternoon, so instead of hiding in my office catching up on admin, as one would usually do by the end of the week, I found myself heading down to see how we would fight this virus!

OK, so no one really thought we would prevent the virus getting into the hospital, but it did seem much debate was over how we were going to protect our patients from it. But was that feasible? Surely, if the media was right, we were all destined to be infected anyway. But here we were considering when and how we would stop 117 leave and family visits and whether we should accept new admissions. Wow, I thought, this is serious!

At this point we had only been told to stay home if we had symptoms so there was much discussion about the legality of preventing our patients' from having leave or visits. Of course, this was made much easier once lockdown came into place and low and behold, we could hold our hands up and say, "Sorry it's not our decision- blame Boris!"

We all anticipated the uproar from the patients when we had to pass on the news that things were changing. Not only was leave cancelled, but less activities were becoming available to them- no group psychotherapy sessions, no hairdresser, less access to sports and leisure. We had to cut short of stopping shop access.

The first time I recognised the impact of corona on the patients was when we had to inform one of the women's ward of the restrictions. We gathered as an MDT for the ward meeting and hoped for the best. But it didn't erupt as we expected! A few complaints here and there but the main concern, "Will our families still be able to bring us in our Easter eggs?!" Ah, I thought, I'm not the only one who's first reaction to the pandemic was selfish!

So, it seemed our worries about needing to build more seclusion suites and ordering more Accuphase were unwarranted. There were a few more incidents of aggression but nothing the well-equipped hospital couldn't manage. I wasn't being called more often to rush down and review any newly secluded leave-deprived patients than before and just carried on with my normal day-to-day work.

Patients were accepting of the rules and taking up the extra support offered if needed. It seemed we may have underestimated our patients who were clearly adaptable. "If anything," one patient had said to me, "it's you lot who have to deal with it- we're used to all the rules and being locked up!"

And what about dealing with the virus itself? Luckily, we have only had one confirmed case in the unit so far (touch wood!), so it seems acting early from that first meeting may have had an impact. Of course, there were procedures put in place for all coronavirus-related eventualities and we managed this well. Even using enforced shielding on incapacitated high-risk patients went without major incident.

As lockdown come in force, I noticed many changes in the running of the place. Many meetings had limited attendees, and some got cancelled all together. Ward rounds were conducted by Microsoft Teams and face to face reviews of patients were limited. But the biggest change seemed to be in the staffing.

Staffing was a big concern for the hospital- what if all the nursing staff got sick at once? What if a whole MDT had to self-isolate?! Suddenly it seemed many were no longer deemed 'essential' or could do their work from home - including the consultants! So off they trotted to their safe home havens whilst the rest of us plodded on.

Of course, there were grumbles from the front-liners (myself included)! It not only felt like we were holding down the fort waiting for the proverbial to hit the fan, but what a lonely job it had become; no lunch with the Assistant Psychologists or coffee breaks with the PAs. Even a lunch time wander to the local park was now prohibited.

I do seem like I am complaining now and maybe in some ways I am. It was hard (and still is). But at the end of the day I was pleased and proud to be continuing to do a job I loved whilst many of my ‘non-essential’ working friends had to spend their time entertaining screaming toddlers or risk pressure sores from endless hours of Netflix. It’s nice to be thought of as an essential worker- even if not in the classic coronavirus-fighting-ICU-doctor fashion. And anyway, who can complain when I never had to be redeployed to the Nightingale hospital!

# A warm welcome to our new carers representative

Sheena Foster
Carers Representative, Forensic Psychiatry Faculty

Hello everyone. I'm now the carers representative on the Faculty and thought you might like to know a little about me; why I wanted to be involved, what other things I'm involved in and what I'm hoping to influence during my time on the Faculty.

First, I struggle with the word representative as I cannot represent all carers. I can only speak from my own experience of having a son in a high and now a medium secure service. I do, however, have a network of carers I can check things out with. Generally speaking if I don't know the answer I can probably find someone who does.

I'm afraid I don't have any reason to jump up and down regarding my son's care which is one of the reasons why I wanted to be involved in the Faculty. I do recognise the influence the College has and it seems to me that if change is to happen then I'd like to be in the place where it's possible! I cannot influence my son's care as it is his journey, I can only work to improve services.

About five years ago I became a Friends and Family Rep. in the Forensic Quality Network and then joined the Advisory Group. I particularly like the reviews because of the conversations that are had leading to improvement but found I like understanding how things fit together strategically which is made possible by the Advisory Group. Last year I was appointed to the AS Clinical Reference Group which again furthered my interest in how secure services operate and how things fit together. It's a bit like a jigsaw – you need all the pieces before you get the picture.

My main focus is carers and I believe that only by working with carers and family members can you work effectively with patients because they have so much information that can be used. It's too easy to use confidentiality to push carers aside and it does happen. I guess I'd like to influence some change in the way carers are viewed in secure services. What needs to happen to make carers feel part of the team that supports the patient?

I also find it fascinating that carers can be involved in the index offence, continue to support and visit their relative yet no one ever thinks it's

important to bring the family together at the point of admission. Why could some of the principles of Open Dialogue not be employed at this point? Why is family work not seen as important and could this approach move patients through the service more quickly in these particular circumstances? Why does no one want to answer these questions?

For the last few years I've been lucky to be involved in the National Secure Programme which has brought me into contact with patients, carers and professionals all passionate for change which leaves me feeling optimistic. I was involved at one point in developing the Secure Carers Toolkit which was launched by the College. So, if you're curious about what I look like simply go to [NHS England » Carer support and involvement in secure mental health services]() and look at the foreword. Not only will you know what I look like but you've got some bedtime reading. Enjoy!

# The Virtual CASC – A Candidate's Experience

by
Dr Mica Quinn
CT3 in Psychiatry, The Hatherton Centre, Stafford
Junior Doctor Representative and LNP representative for Staffordshire

The first ever virtual CASC was completed in September 2020. The Royal College has lauded it as a success overall, with a reported 98% of candidates able to complete the exam. What was it like for those of us actually taking it?

Unlike my peers who were desperate to take the CASC online rather than face-to-face, I wasn't entirely convinced.

Yes, it may be less stressful to be examined by someone not actually sitting in the room with you. But what about the unknown? It would be a new, unfamiliar system, how would it work? Could I do the exam with my work laptop? How would empathy travel across the ether under exam conditions? How would they ensure exam conditions? Would they expect us to do physical examinations? Would my internet connection hold up?

Thankfully the College had anticipated and prepared for some of these anxieties. We were able to test laptop compatibility and check relevant software downloads in a very simple process prior to the exam which offered some reassurance. FAQs and a webinar to watch a full virtual CASC station with live chat Q&A were also helpful (although the problematic freezing during the Chief Examiner's welcome speech did not bode well for the actual virtual CASC!).

'Onboarding' was a new term for me, in essence it meant allowing us the opportunity to log on and utilise the exam platform (Practique) prior to exam day, ensuring we were confident in practical processes such as how to exit one 'room' (i.e. station) and enter the next.

My onboarding went very smoothly and I was reassured regarding my systems-related anxieties. However, I was horrified to discover how small the simulated patient appeared onscreen alongside my own image, the examiner and the invigilator all crowded together in a row. Apparently it was not possible on this platform to hide or minimise the examiner and invigilator. It was a little off-putting.

With some of my anxieties alleviated I hunkered down with my revision preparing for the big day.

Unfortunately two weeks before the big day, I received an 'URGENT' email from the examinations team informing me that due to anticipated problems following the onboarding sessions, my examination was to be pushed back to the subsequent week. My anxiety went through the roof. In addition to working full time, oncall duties, managing family life and revising/practicing every spare minute I would now need to rearrange my carefully planned study leave, exam leave, reorganise oncall shifts that week and possibly the long weekend away I'd planned. All without knowing exactly what day my exam would be on.

I finally received my exam date over a week later. Fortunately, despite being stretched thinly with many doctors still shielding, the medical staffing team, my consultant and colleagues bent over backwards to accommodate all the last minute changes. I am very grateful and fortunate to be working in the Trust and team that I do during this difficult period.

The virtual CASC itself for me went relatively smoothly, although do I appreciate that this wasn't the case for some of my peers. There were the inevitable delays in starting both the exam and individual stations where you stare awkwardly at the other people in your 'room' just waiting. In two stations I was allowed additional seconds when I was unable to hear the patient's responses due to technical issues. In one station we lost the examiner completely for a good 5 minutes, just as I'd finished reading the instructions and was about to start my tasks. All issues you would expect in the first attempt at a major OSCE-type examination.

Then there are the problems that you and the College don't anticipate. For example, in the lunch break I had to beg the council's tree surgeons not to prune the tree outside my office window for the next 2 hours as I would

not be able to hear the patient's response, they very kindly sympathised and agreed!

I do appreciate all the time and effort that went into making this examination happen, and that we are all working in extraordinary times. However, I do feel that much of the additional stress could have been avoided by more timely and clearer communications to the candidates. I say this not only as a slightly disgruntled candidate (spoiler alert, I passed the CASC!) but as a former head of communications of an FTSE 250 company. Communication is key!

The Chief Examiner has acknowledged that the virtual CASC was a very stressful experience for everyone involved, but particularly for candidates taking the examination. Hopefully lessons will be learned and issues will be ironed out moving forward.

I'm also intrigued to see post-COVID whether the CASC remains online or switches back to the traditional format.

## RCPsych Future Archives competition, we want YOU to write history

As we leave an eventful 2020 behind, the RCPsych prepares to celebrate its 180th anniversary in 2021. Anniversaries are not just for celebration, but also for reflection and contemplating our past, present and future.

We want everyone, yes, everyone (patients, carers, junior doctors, consultants, psychologists, nurses and anyone else interested in mental health), to send us their perceptions and experiences of psychiatry and mental health services at the present time. All entries will be preserved in the RCPsych archives, creating a holistic mosaic of psychiatry in 2020/21 for future generations. You'll also be competing for iPad prizes and a chance to speak at the College's next international congress!

**Competition now open!**

Find out more: Future archive (rcpsych.ac.uk)

# Contributions Welcome

## Thank you to the contributors of this edition.

## We would welcome contributions for the next e-newsletter by Friday 26th March 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:

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If you're a tweeter, please follow **@rcpsychForensic** for Faculty news, conference information and important College updates.