Forensic Faculty Newsletter

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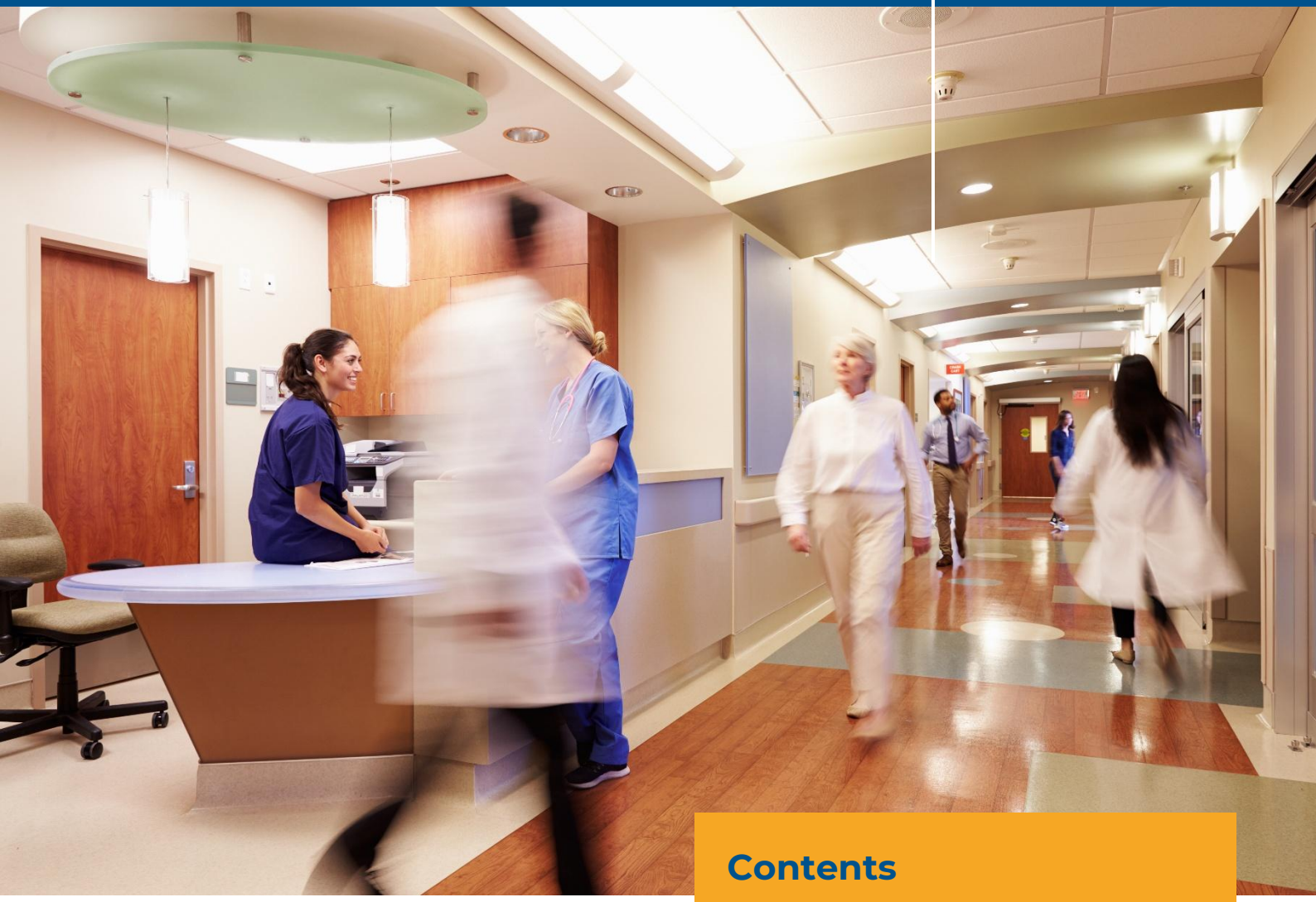

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Chair's Message

News from the Faculty Chair

by Dr Sandeep Mathews

Chair of the Forensic Psychiatry Faculty

Dear colleagues,

As summer gives into autumn, we all get back into the daily routines of our working lives, hopefully refreshed after our breaks.

As usual, the faculty is getting into it's usual rhythm of planning and organising our next annual conference in Belfast in March 2026.

Our last conference in Edinburgh was hugely successful with it's excellent academic content. It was also a fantastic city where we could all meet old friends and colleagues. Belfast is another fantastic venue and we hope we can be inclusive of all our nations in the United Kingdom by being in Northern Ireland.

In addition we are starting to plan ahead for our 2027 conference, which we hope can further strengthen our links to colleagues in Europe.

Whilst sharing the positives, we should not be blind to some of the issues which seem to blight our professional lives. I maybe speaking predominantly about our working lives in England, but I suspect this might be true elsewhere too.

This is the over bureaucratisation of our psychiatric practice. As I see it, our role as Forensic Psychiatrists is predominantly about identifying mental illnesses amongst patients involved with the criminal justice system and treating them, in a variety of settings. I note that this seemingly simple mission has increasingly been bureaucratised by admission panels and various other monitoring or oversight bodies, so much so that the role of the Responsible Clinician (which most of us are) is reduced to being the person responsible if anything untoward happens!

This lack of clinical autonomy which is creeping in worries me and fills me with anxieties for the future. In previous years, we as psychiatrists had admitting rights to hospitals where we saw a patient in prison and made a decision about the best setting to treat the patient, depending on clinical priorities.

I agree that now a days most of us work within Multi-Disciplinary Teams and some degree of oversight along with checks and second opinion is required. At the moment in some places this is being taken to the extreme where experienced psychiatrists' opinions even when arrived at following discussions with their MDT colleagues, are questioned and rejected by panels made up of a variety of professionals who are remote from the actual reality of clinical life and who are not well equipped to make a considered well informed final clinically defensible decision.

Quite often I am concerned that the members of this panel are directed by their ideological viewpoints rather than the realities of clinical life potentially compromising safety. I would welcome the views from the members of our faculty on this issue. Please do write in to either me directly or to the faculty newsletter to share your views.

In addition to this, I would also like to seek your opinions on Provider Collaboratives. It was initiated with good intentions to smoothen local decision making and provide clinical leadership and ownership. But in some places, the clinical leadership especially by psychiatrists have been eroded and it has resulted in just another layer of bureaucracy. Please share your views on this too.

As I had said in my last piece for the newsletter, we have initiated a piece of work looking back on the last quarter century of our specialty and taking stock as to where we are with a view to help navigate the future. The future is evolving around us at rapid pace with innovations in digital technology and artificial intelligence. Unless we embrace it and harness it, the emerging technologies will march on without us. We need to be able to understand the future and use it to benefit our patients.

Hope you all have a fruitful and productive few months ahead.

Yours sincerely, Sandeep

Legal Update

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

Three cases with something for everyone in the world of forensic psychiatry. I haven't covered it here because Duncan Harding and Keith Rix have done a much better job than my meagre wordcount allows in their newsletter, but every forensic psychiatrist should also read the case of Baja (Baja, R. v [2025] EWCA Crim 967).

Incapacity in mental health tribunals

KH -v- Nottinghamshire Healthcare NHS Foundation Trust; AH -v- Avon & Wiltshire Mental Health Partnership NHS Trust (HM) [2025] UKUT 128 (AAC)

The facts of each case matter less than the common theme: mental capacity and the mental health tribunal and what happens when a representative has been appointed for someone who lacks capacity and where:

· the evidence about whether the patient has subsequently regained capacity is conflicting

· the patient objects to the representative.

The judgement provides guidance on several issues: i) guidance on the tests of capacity which are relevant to tribunal proceedings ii) when capacity should be assessed iii) what happens when capacity fluctuates iv) the duties of the appointed representative including when they do not consider that it is in the patient's best interests to be represented by them.

When a detained patient refuses life-saving treatment

Nottinghamshire Healthcare NHS FT v MC [2025] EWHC 920 (Fam)

MC was a restricted patient detained under the MHA in a high secure hospital since 2005. His psychiatric diagnosis was personality disorder. He had long-standing type 1 diabetes, peripheral vascular disease, and hypertension, complicated by poor adherence and a previous leg amputation. Regular monitoring of blood pressure and blood glucose, as well as administration of diabetic treatment and any treatment for infections was part of the proposed treatment plan. MC had mental capacity with respect to refusing this plan and insisted he did not want the treatment.

His responsible clinician did not believe compulsory treatment under section 63 MHA was ethically justified but did believe it would be lawful. The Trust sought High Court approval for the decision to respect MC's refusal. Expert witnesses agreed that forced restraint could trigger cardiovascular collapse and destroy fragile therapeutic relationships.

The High Court agreed that section 63 was available to provide the physical healthcare because the refusal was a manifestation of his personality disorder. However, they also agreed that it was lawful to not provide the treatment.

When autism evidence comes late

R v MW [2025] EWCA Crim 55

MW was 18 at trial but only 16 when he set up an extremist "library" on Telegram, sharing manifestos and instructions on explosives and other weapons. He was convicted of possession and dissemination offences and given an extended determinate sentence of six years' custody plus one year's extended licence. A psychologist identified autistic traits prior to sentencing but did not make a diagnosis.

Fresh psychiatric evidence emerged after sentence when a consultant psychiatrist diagnosed autism spectrum disorder, supported by neuropsychological findings. The defence argued this explained MW's intense special interests, rigid behaviours, and flat affect at trial. The sentencing judge, unaware of the diagnosis, had described him as cold and calculating, reducing the mitigation applied for youth.

The Court of Appeal accepted the new evidence and allowed the appeal. The diagnosis did not alter culpability given the scale, seriousness, and intention of the conduct. MW's awareness of what he was doing was specifically cited. However, the sentence was partly linked to his apparent coldness and apparent maturity, and was reduced to five years without the extension, on the basis that this apparent coldness was linked to him being autistic.

Richard Latham

September 2025

Engaging with Forensic Complexity from a Non-Forensic Perspective

By Dr Karishma Hurry, CT2, Royal Cornhill Hospital, Aberdeen, Scotland

This reflective essay explores the experience of a non-forensic clinician working with a complex and ethically challenging case involving sexualised animal cruelty on a background of autism spectrum disorder (ASD), substance misuse and a history of significant trauma. Drawing upon forensic literature and psychodynamic theory, the piece reflects on the personal and professional impact of the case, the need for structured forensic frameworks and the value of trauma-informed multidisciplinary collaboration.

INTRODUCTION

As a core trainee offering crisis cover, I was asked to assess a young man whose presentation significantly challenged my clinical thinking. The unusual and disturbing nature of animal sexualised violence led me to reflect not only on the risk the patient might pose, but also on how I, as a clinician, could contain the psychological and emotional weight of the material.

UNDERSTANDING THE BEHAVIOUR: FORENSIC AND CLINICAL DISSONANCE

Sexualised animal cruelty, particularly when intentional and repetitive, is recognised in forensic literature as a significant red flag. It has been associated with emerging patterns of psychopathy and potential escalation into interpersonal violence (Hensley and Tallichet, 2009; Merz-Perez and Heide, 2004). The calm and emotionally flat way Mr X recounted his actions raised concerns regarding empathy, remorse, and affective engagement—all relevant to psychopathy (Hare, 2003). Forensic frameworks offer structured approaches to risk. The HCR-20 V3 (Douglas et al., 2013) provides a method for assessing general violence risk, while the SVR-20 (Boer et al., 1997) is tailored to sexual violence. These tools do not provide definitive predictions but offer structured, evidence-informed guidance.

Although I was not trained to administer them, understanding their principles was invaluable. It shifted my internal dialogue from 'What does this behaviour mean?' to 'How can I understand and manage the risk more systematically? 'The Psychopathy Checklist–Revised (PCL-R) (Hare, 2003) also came to mind. The absence of emotional markers during disclosure could be interpreted as a lack of empathy or remorse—core features of psychopathy. However, in individuals with ASD, emotional expression and processing can be atypical. Differentiating between affective blunting due to neurodevelopmental factors and callousness is an area of active clinical debate (Rogers et al., 2006).

A PSYCHODYNAMIC LENS: DISSOCIATION, REPETITION, AND MORAL DEVELOPMENT

From a psychodynamic standpoint, the behaviour may represent a dissociative attempt to manage overwhelming internal states. The lack of affect displayed by Mr X could suggest dissociation rather than cold indifference (Howell, 2005). Freud (1914) described repetition compulsion—the unconscious re-enactment of past trauma—as a defence against unprocessed experiences. The symbolic act of killing something fragile, followed by masturbation, may have constituted a complex and fragmented attempt at self-regulation through aggression and autoerotic release.

This behaviour might be seen not as pleasure-seeking, but as a form of communication in the absence of symbolic language—a non-verbal expression of trauma. Forensic psychodynamic theorists argue that perverse or violent acts can be understood as 'evocative representations' of disorganised affect (Adshead, 2002; Fonagy and Target, 1996). The patient's action may reflect a failed attempt at mastery—using the external

world to symbolise and disown unbearable psychic states.

Further, the apparent absence of remorse may reflect impaired moral development or a failure in early attachment relationships. Bateman and Fonagy (2004) suggest that moral emotions such as guilt, shame, and empathy are closely linked to the development of mentalisation—the capacity to reflect on one's own and others' mental states. In individuals exposed to relational trauma, the development of this reflective capacity may be disrupted, leaving them more vulnerable to acting out internal states they cannot represent symbolically.

IS SEXUALISED ANIMAL CRUELTY A PRECURSOR TO MORE SERIOUS OFFENDING?

Working with this case forced me to confront a difficult question: is sexualised animal cruelty function a precursor to more serious forms of violence? The literature does not provide a simple answer, but rather emphasises patterns, context and risk factors that elevate concern. Research indicates a significant association between childhood and adolescent cruelty to animals and later interpersonal violence, particularly among individuals who exhibit sexual arousal or emotional detachment during the act (Hensley and Tallichet, 2009; Merz-Perez and Heide, 2004).

In forensic psychology, this is sometimes referred to as the 'graduation hypothesis' (Wright and Hensley, 2003), which posits that harming animals may desensitise individuals to violence, potentially leading to more severe offences such as sexual assault or homicide. In Mr X's case, the sexual component and lack of affective response during disclosure stood out. According to the SVR-20 (Boer et al., 1997), these features—particularly deviant sexual interests and emotional detachment—are considered risk factors for sexual violence. His openness in discussing the acts could reflect a lack of insight or remorse, but from a psychodynamic perspective, it may also suggest dissociation, where the behaviour is split off from affect due to early trauma (Howell, 2005).

The question of whether this behaviour signals a pathway toward more serious offending cannot be answered with certainty—but it must be held seriously. The risk is not only statistical but

ethical: ignoring such behaviour risks minimising acts that may reflect deeply entrenched interpersonal and intrapsychic disturbance. However, over-pathologising may also alienate individuals who need relational containment, not rejection.In this sense, the behaviour is not simply a 'precursor' in a linear way, but rather a window into a disturbed internal world where aggression, sexuality, and shame have become fused. As a clinician, I must hold both possibilities: that this may remain an isolated form of self-regulation, or that it may evolve into something more dangerous without intervention. The role of multidisciplinary risk formulation becomes essential here—not just for predicting behaviour, but for understanding its meaning in context.

Ultimately, this reflection left me with a nuanced position: while not all cruelty to animals leads to further violence, when it is sexualised, repetitive, and occurs in the context of neurodevelopmental and trauma-related vulnerabilities, it should prompt serious forensic and therapeutic concern.

CONCLUSION: HOLDING THE UNTHINKABLE TOGETHER

This case challenged me on multiple levels. It exposed gaps in my training, provoked emotional discomfort and raised questions about my role in containing high-risk patients. It also deepened my appreciation for the value of forensic and psychodynamic thinking, especially when integrated with a trauma-informed approach.

As a non-forensic clinician, I bring a different lens: one that emphasises meaning, development and relational understanding. I hope this reflection demonstrates that risk is not

just a question of probability but of understanding the person behind the behaviour and that this understanding is best achieved through collaboration across disciplines.

Ultimately, containment is not just about managing others' risk—it is about collectively holding what feels uncontainable, with thoughtfulness, humility, and care.

Conversations about antipsychotic induced weight gain

By Dr Aysu Acikgoz, Resident Doctor

Antipsychotics are one of the core medications that are used in psychiatry but more so in forensic settings with many patients requiring higher doses than other psychiatric populations and even some needing more than one antipsychotic for their treatment. One of the side effects of antipsychotics is weight gain - clozapine and olanzapine being classified as the ones carrying the highest risk (1). Although the mechanisms of antipsychotic induced weight gain are not well understood, weight gain seems to result from increased food intake and reduced energy expenditure. This is an especially important topic in forensic settings as many patients get limited exercise. Additionally with treatment-resistant schizophrenia, which in my experience is very common in forensics, we are more often than not forced to use the antipsychotics that are high-risk for weight gain.

Furthermore, we may simply miss the fact that our patients have gained significant weight over time, as forensic patients tend to have relatively long stays in inpatient units. Other times, the treatment is so essential that we may weigh the pros and cons and decide not to change the existing medication regime. However, weight gain increases the mortality and affects self-image which could lead to non-concordance with treatment. Due to all these reasons, it is important to think about the management of antipsychotic induced weight gain.

Maudsley states that as an absolute minimum our patients should be weighed, alongside recording body mass index (BMI) and waist circumference. However, when the weight gain occurs the initial suggestion is to switch medications and/or initiate programmes to aid weight loss. In forensic settings this could be providing opportunities for physical activity and offering dietary support, such as healthy meal options, education on nutrition and potentially involving dieticians to help patients make informed food choices. On average these interventions will result in 3 kilograms of weight loss or more (4).

If all above fails and obesity presents a clear and immediate risk to the patient, the pharmacological methods should be considered. According to Maudsley, metformin appears to be the drug of choice for the prevention and treatment of antipsychotic induced weight gain. However, with metformin the weight loss has shown to be modest (2,4). GLP-1 agonists may ultimately prove more effective and better tolerated with some beneficial effects on other metabolic parameters. Another option could be adjunct Aripiprazole, shown to be effective for weight gain associated with clozapine and olanzapine. Interestingly, Reboxetine is also mentioned in Maudsley alongside some publications (3) for olanzapine induced weight gain with metabolic changes. Orlistat appears to be widely used in clinical practice with some success when paired with calorie restriction. Topiramate is also mentioned as reliably reducing weight and studies suggest it is more effective in prevention rather than treatment.

In summary, antipsychotic induced weight gain is an important and constant issue that needs more attention especially in forensic settings with a considerable amount of literature available to address this issue with the first line being lifestyle changes followed by medications to aid weight loss.

References:

1. Taylor, D.M., Barnes, T.R.E., & Young, A.H., The Maudsley Prescribing Guidelines in Psychiatry 14th Edition, Wiley-Blackwell, 2021

2. Aoife Carolan, Caroline Hynes-Ryan, Sri Mahavir Agarwal, Rita Bourke, Walter Cullen, Fiona Gaughran, Margaret K Hahn, Amir Krivoy, John Lally, Stefan Leucht, John Lyne, Robert A McCutcheon, Michael J Norton, Karen O'Connor,

Benjamin I Perry, Toby Pillinger, David Shiers, Dan Siskind, Andrew Thompson, Donal O'Shea, Dolores Keating, Brian O'Donoghue, Metformin for the Prevention of Antipsychotic-Induced Weight Gain: Guideline Development and Consensus Validation, Schizophrenia Bulletin, 2024;, sbae205, https://doi.org/10.1093/schbul/sbae205

3. Poyurovsky M, Isaacs I, Fuchs C, Schneidman M, Faragian S, Weizman R, Weizman A. Attenuation of olanzapine-induced weight gain with reboxetine in patients with schizophrenia: a double-blind, placebo-controlled study. Am J Psychiatry. 2003 Feb;160(2):297-302. doi: 10.1176/appi.ajp.160.2.297. PMID: 12562576.

4. Cooper SJ, Reynolds GP; With expert co-authors (in alphabetical order):; Barnes T, England E, Haddad PM, Heald A, Holt R, Lingford-Hughes A, Osborn D, McGowan O, Patel MX, Paton C, Reid P, Shiers D, Smith J. BAP guidelines on the management of weight gain, metabolic disturbances and cardiovascular risk associated with psychosis and antipsychotic drug treatment. J Psychopharmacol. 2016 Aug;30(8):717-48. doi: 10.1177/0269881116645254. Epub 2016 May 4. PMID: 27147592.

The College plans to publish documents by early next year to set out knowledge and advice on how best to support the safe use of clozapine. This will support physical monitoring of patients on this medication, ensuring risks are appropriately mitigated so that anyone who needs to take clozapine can do so safely in a timely way.

"You are from a BAME background, you're small and on top of that you're a woman, rethink forensic psychiatry" ~ Consultant

By Dr Shafia Khanum, ST4

Yes, that is exactly what one of my Consultants told me when I said I wanted to pursue forensic psychiatry as my career path. And yes, it took me by surprise but funnily and sadly enough however, they did not know that this is not the first time in my life that I have been told that, because of my culture and my gender I should not do something I have wanted to do. And so just like the many times before, it just made me more determined to pursue my interest and I'm thankful for the unintentional motivation.

But the focus of this article is not what was said to me or what my other experiences have been. Instead, I wanted to take the positives from my experiences and I wanted to write this article for the many that are like me but may not be so stubborn in their thoughts and actions to continue pursuing their dreams, just in case it can give someone else hope and inspiration. Therefore, I will tackle each theme separately and hopefully be able to show you why being a small woman from a BAME (Black and Minority Ethnic) background is not disadvantageous to me but instead these are my strengths and assets.

1) Being Female.

I genuinely think this is a blessing because I get the best of both worlds. I can relate to my female patients when they tell me their stories or approach me with their complaints, whether that is for physical health reasons or mental health reasons. I can also understand the emotions and sentiments behind the thoughts and actions. And I know what it is like to have multiple roles and responsibilities especially as a carer for children, for parents, for grandparents and for siblings and partners, leaving no time for yourself and so your self-care unfortunately may only happen at the very last minute requiring extra help from the GP or even mental health services for example. Yet still feeling guilty that firstly you have had to ask for help and secondly that you have let everyone else down because you have taken that time out for yourself. But I can also relate to my male patients as most of them seem to prefer female doctors so I am very well looked after by them, maybe it's the male protective instinct I'm not sure. Which means that it is easier for me to come to a collaborative decision with them about their care than my male counterparts for example. Plus, I can also converse with the girls but also banter with the boys both young and old which further solidifies my rapport with my patients and strengthens our therapeutic relationship. So no, my gender is not a limitation to the career I've chosen, rather it's an asset especially in forensic psychiatry where it's really important to have good rapport with your patient and a good understanding of them to minimise risk and allow robust future planning and management.

2) Coming from a BAME community.

Again, this is another blessing for me, especially when working in cities like London which are so culturally diverse. My ethnic background gives me an understanding of not only my own culture but of most of the cultures in the South Indian Subcontinent in addition to some African cultures too as they are similar. And it is so very important because many of our patients come from BAME communities but so many are still very underrepresented due to taboo, communication difficulties or just pure fear of accessing services. And I feel my appearance and presence breaks down some of those barriers for patients and carers. Plus being multilingual is a huge advantage as well because even if I

might not be able to officially translate for my patients as a doctor in a consultation, I can at least understand their language and it is so important to be able to understand

communication effectively in psychiatry because our work is all about getting a holistic understanding of our patients and sometimes even having to explore bizarre thoughts and experiences so having something lost in translation is not helpful at all. And some thoughts or experiences may be acceptable or the norm in some cultures but may be unusual in the western world, so to have an understanding of cultural/religious differences is also very helpful in my daily work of understanding and separating the person from the psychopathology. So again, my ethnicity has not been a hindrance but an advantage for me in my work, especially in forensic psychiatry where cultural appropriation and understanding is very important to achieve a holistic and psychodynamic understanding of the patient especially when patients come from very diverse backgrounds and have experiences of very different social rules and regulations to ours in the united kingdom.

3) Being small.

To be honest, I've never had an issue with my height or my size, I actually think it works in my favour because everyone thinks I'm younger than I actually am so they are a bit more careful and kinder to me, I can even say almost protective of me. Which means that I can easily build rapport with those that are younger than me or a similar age to me because I am regarded as "cool" but I can also build rapport with those that are older than me because I am regarded as "sweet". And I think the way I appear makes others see me as a new younger perspective which I have found makes me more approachable compared to my senior colleagues who are more traditional in their practice and approach which also helps my work and therapeutic relationships with both colleagues and patients, something which I am very proud of. So again, it's not a disadvantage at all, I am more than happy to be small, cool and sweet if it means that the job gets done and gets done well.

Therefore, what I'm trying to say is that people will always have an opinion but that is a superficial opinion because they may not know the true you that sits deeply inside of you. They only know what you choose to show them and that is okay, not everyone needs to know everything. So if there is something that sets your soul on fire and brings a sparkle to your eyes when you think or talk about it then pursue it and if you are told no then pursue it with a vengeance because if you really want it, you'll find a way and it is those very characteristics of yours that will be assets to your journey and success rather than a hindrance so do not let anyone tell you otherwise. Use the negative criticism as positive motivation! I know you can and will do it because I'm doing it! It's been a long journey but I'm finally living my dream! And I am thankful to every bit of criticism and every no because without them I don't think I would have been so determined to chase my dreams.

The Case of Persistent Delusions and "self-(pseudo)-putative-defence"

By Dr Gabriel Rendon, Psychiatrist and Medical Director, Capriles Clinic, Curacao

During my years after my training as a psychiatrist, in Venezuela, my interest in criminal and criminal matters led me to carry out work on interconnections between psychiatry and criminal law, particularly in relation to typical action.

We are used to evoking non-imputability (lack of criminal responsibility) as the most obvious link between the two, however, according to my perception, there are other points of convergence, such as will, free will, emotions, the reflex act and the causes of justification. In that work, I raised, through a fictitious medico-legal case (but based on real facts) these connections.

Imagine if you were a man who, for almost two decades, (has believed) to be the victim of systematic persecution. He claims that the media and others have exposed, drugged, raped, prostituted and persecuted him even when he changed countries. Despite multiple attempts to denounce it, he never received institutional attention. This accumulation of facts leads him to buy a weapon, hide it, and then use it after an alleged episode of threat. The result: three people killed and several injured in a peaceful political demonstration.

From a legal point of view, the case includes crimes such as illegal carrying of weapons and intentional homicide. The causal relationship between the behaviour of the subject and the result is confirmed, ruling out causes such as reflex action or unconsciousness. The action was undoubtedly voluntary.

As for the subjective analysis, I focused on whether there was intent and/or whether there were errors of type or prohibition. I also examined whether it could have been a legitimate defense, which requires an illegitimate aggression, necessity of the means used and lack of provocation. Although the subject felt that goods such as his honour or sexual freedom were threatened, there was no evidence of proportionality or immediacy to justify the use of lethal force.

I continued my dissertation with the figure of putative defense, which occurs when a person mistakenly believes that they are being attacked and acts in self-defence. This defense is valid if all the elements of self-defence are met except for actual aggression. In this case, the subject injured and killed people who were not related to his delusional construction.

My psychiatric opinion after the fact (32 days later) concluded that the subject suffered from Persistent Delusional Disorder also determined that the subject had a partially altered capacity for judgment, circumscribed to his delusional system, although he could distinguish between good and evil.

This opens the criminal debate on whether a person in a psychotic state can be considered motivated by the law. Knowing that killing is a crime is not enough if there is no real freedom to act otherwise, especially in contexts dominated by delusional ideas. The fact of not having an immediate evaluation and the absence of access to relatives or acquaintances weakens the diagnostic certainty, at least in relation to their mental state during the act committed.

Despite the diagnosis, the subject was convicted of qualified homicide with malice, premeditation and ignoble motives. He was sentenced to 29 years and 11 months in prison (the maximum in that country is 30 years), without being admitted to a psychiatric institution, only with the option of pharmacological and psychological treatment within the prison.

I believe that the (debatable) imputability (criminal responsibility) was ignored, but surely the attenuation of responsibility was minimized

(1 month of attenuation), and that the sentence responded more to the social impact than to an adequate clinical assessment.

It also made a reinterpretation of premeditation, in this case as a defense strategy, not as cold planning. The ignoble motives and treachery are blurred if one considers that the subject was acting in defense of goods that he perceived to be threatened. In his delusional reality, his actions made sense.

I open the discussion of whether someone with a persistent delusion can be motivated by the norm, where his reality is true (mentally). The lack of proportionality in his response does not necessarily imply a criminal will, but a profound alteration of judgment.

With this reminiscence of my work during my academic period, I invite you to reflect on the figure of the (pseudo) putative defense as a mitigating circumstance in these cases. Although it does not justify harm (to anyone), it may be key to understanding the behavior of people with chronic delusional (paranoid) disorder, thus avoiding disproportionate punitive responses that ignore the complexity of mental illness.

When Progress Stalls: Reflections on Long-Term Medium Secure Care

By Dr Loraine Marnicki, Forensic Psychiatry ST5, Essex Partnership University NHS Foundation Trust

PRELUDE

When forensic progress falters, patients and clinicians alike face the frustration of repeated cycles with little sense of progression. This article reflects on the problem of protracted forensic admissions, the barriers to progress, and the importance of holding optimism in the face of systemic inertia.

INTRODUCTION

Every consultant and senior trainee working in secure services will, sooner or later, become familiar with a small number of patients whose names remain on ward round lists month after month, with little progress. Staff rotate, resident doctors move on, yet in contrast to wider pace of change, a select few patients' journeys appear to stagnate. Their trajectories can cast a shadow of apparent futility—any favourable progress rarely sustained long enough to enable a step down to lower security—leaving the MDT with limited scope for renewed consideration or inspiration.

THE CHALLENGE OF COMPLEXITY

One such patient, whom I first encountered during my early days as a forensic psychiatry ST4, exemplifies this challenge. I will refer to him as *Bob*. Bob has longstanding diagnoses of paranoid schizophrenia, ADHD, and dissocial personality disorder. He was detained under Section 37/41 in the early 2000s and has remained in secure care ever since. Over the past two decades, Bob has moved through multiple NHS and independent units, including medium security, personality disorder pathways, and low secure units. Sustained step-down has proved elusive, with repeated returns to medium security when risks escalated.

Bob's psychotic illness has waxed and waned, with trials of antipsychotics including clozapine, and is currently stable on depot medication. However, his dissocial traits and ADHD-related impulsivity dominate the clinical picture. Aggression, verbal abuse, and property damage have been frequent, usually in response to frustration with boundaries. At times, he has requested seclusion to contain his agitation; at others, his behaviour has required long-term segregation.

Patterns are familiar. Requests for medication changes often escalate into aggression or refusals. Engagement with psychology has been sporadic, often dismissed with the refrain that he has "done it all before." Periods of stability, including brief escorted and unescorted leave, collapse under the pressure of impulsivity, volatility, and disengagement. The result is a man repeatedly described as "difficult to place," whose detention in medium security continues year after year.

THE PROBLEM OF 'STUCKNESS'

Bob's case is not unique. While most medium secure patients eventually progress and step-down, a select few become "stuck". Their risks, needs, and behaviours combine in ways that resist the forward movement the system is designed to deliver. Risk in these cases is rarely driven by psychosis alone. More often it is the interplay of treatment-resistant illness, entrenched personality traits, ADHD-related impulsivity, and a history of failed step-downs. Add the constraints of a restriction order with Ministry of Justice oversight, and momentum towards discharge can feel almost impossible to generate.

The result is a clinical cul-de-sac: patients remain detained in medium security for years, sometimes decades. Not because treatment is absent, but because no intervention shifts the

trajectory. Too risky for low secure, too disruptive for personality disorder pathways, and not ill enough for high security, the pathway narrows to prolonged containment within medium security, far beyond its intended role.

For clinicians, these cases are particularly challenging. The déjà vu of ward rounds, the repetition of risk formulations, and the sense of going in circles can erode optimism. For patients, the experience is one of frustration and hopelessness, reinforcing their perception that the system has no exit strategy. Together, these forces deepen the *stuckness*, making it as much systemic as clinical.

THE BARRIER OF THE RESTRICTION ORDER

In Bob's case, as with many others, the restriction order is both necessary and limiting. Section 41 oversight rightly safeguards the public, but in practice, Ministry of Justice approval adds another layer of complexity to already difficult decisions. Even modest steps, such as granting escorted leave or considering transfer, require detailed reports, risk assessments, and correspondence with the MOJ. While appropriate for public protection, this makes progress feel fragile and dependent on external processes.

MAPPA involvement, exclusion zones, and victim liaison obligations add further hurdles. Each serves an important purpose, but together they create inertia. Patients may experience this as punitive, heightening frustration and hopelessness. Clinicians, meanwhile, can feel their clinical judgment constrained by bureaucracy.

For Bob, this has meant that even when stability is achieved, momentum towards discharge is rarely sustained. Each incident of aggression or property damage reverberates through the system, reinforcing caution and delaying progress. *Stuckness* becomes embedded in both clinical care and the bureaucracy that governs it.

A SYSTEM UNDER PRESSURE

Bob's case highlights broader systemic pressures. Medium secure services were designed as part of a pathway: admission, stabilisation, treatment, and step-down. Yet for a small group of patients, this stalls. Low secure units are reluctant to accept restricted patients with entrenched risks. Specialist personality disorder services often break down due to volatility and non-engagement. High secure care is rarely justified once psychosis is stable and risks, though disruptive, remain containable. The result is a narrowing of options until medium security becomes the default.

Commissioners and provider collaboratives face dilemmas. Patients enduring lengthy periods in secure care occupy scarce medium secure beds, slowing admissions and increasing pressure across the system. Independent providers may offer bespoke solutions such as self-contained bungalows or low-stimulus settings, but these placements are scarce, expensive, and dependent on complex commissioning. For clinicians, this can feel like working within a system resistant to movement. Advocacy for transfers or bespoke placements is time-consuming and often frustrating. For patients, the visible absence of a realistic pathway forward reinforces the sense of being stuck.

LEARNING ABOUT STUCKNESS IN TRAINING

I became acquainted with Bob during my first few days as a forensic psychiatry registrar. I was struck by how familiar his presentation already was to the team. His cyclical behaviours—repeated incidents, frustrations, and patterns—were so well known that staff could almost anticipate them.

As a new higher trainee chairing ward round, it felt as though there was little I could offer. Every strategy seemed to have been tried before. With time, I came to see that this repetition is part of the challenge of medium secure units. Patients like Bob test our persistence. They oblige us to

revisit formulations repeatedly, to identify small opportunities for progress, and to resist therapeutic resignation.

I also learned that *stuckness* is not only individual but systemic. Restriction orders, MAPPA processes, exclusion zones, and commissioning barriers all contribute to holding patients in place. Understanding this reframes the question: "why has this patient not moved on?" into a more useful one, "what structures are keeping this patient here, and what might loosen them?" Such learning has been invaluable, reinforcing that progress take many forms—from redefining expectations, to working around systemic barriers, to holding optimism on behalf of patients when they cannot hold it themselves.

SEEKING NEW AVENUES

In Bob's case, the MDT recognised that repeating the same cycle within the same service was unlikely to bring meaningful change. Referral to the provider collaborative was made, exploring whether a new provider might offer fresh possibilities, such as self-contained bungalows or low-stimulus settings that could reduce confrontation and further segregation. Bob expressed ambivalence: sometimes requesting a move, at other times insisting he had no wish to leave hospital after so many years.

This fluctuation is common among those enduring long stays, whose sense of identity and security can become tied to institutions. Nonetheless, the possibility of a new environment has opened space for discussion and may offer motivation to engage more consistently. Independent placements are scarce, costly, and not always successful, but exploring them is essential. Even modest progress can break therapeutic inertia and demonstrate to patients that change remains possible.

FINAL THOUGHTS

Patients like Bob expose the gaps in forensic pathways, where clinical care collides with systemic barriers and progress stalls. While most patients in medium security eventually progress, a small but significant group remain for many years, often far longer than the system was designed to manage. They test our clinical skills, patience, and ability to retain therapeutic optimism through setbacks.

Forensic psychiatry in the UK has sophisticated structures to balance treatment and public protection, but restriction orders, MAPPA, exclusion zones, and commissioning constraints all contribute to inertia. Finding new avenues through provider collaboratives, bespoke placements, or reframing goals within existing services, is vital to avoid therapeutic resignation.

My experience with Bob reinforced that progress cannot be measured solely by step-down or conditional discharge. Sometimes it equates to small gains, new environments, or shifts in perspective. At other times it means persisting even when the pathway feels blocked. As consultants and senior doctors in training, these cases demand both clinical creativity and systemic advocacy, and remind us that in forensic psychiatry, holding hope is itself a therapeutic act.

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Contributions Welcome

Thank you to the contributors of this edition.

We would welcome contributions for the next e-newsletter by January 24th 2026.

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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.

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