Forensic Faculty Newsletter

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ROYAL COLLEGE OF PSYCHIATRISTS

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Chair's Message

News from the Faculty Chair

by

Dr Sandeep Mathews

Chair of the Forensic Psychiatry Faculty

Dear colleagues,

I write this after our annual conference in Belfast. The conference was a success with an array of interesting presentations. One key theme which came out and was commented on by guest speakers from other countries was the variable standards in medico legal reports being seen. There were comments about people advertising themselves through YouTube videos and commenting on areas of law which is not within our expertise. This makes me wonder whether it is time to set some standards and accreditation for people who claim to be experts in medico legal practice. We aim to liaise with the bar standards board and the judiciary to explore taking this further.

Another issue I wanted to highlight was our members non engagement with the Quality network for Forensic Metal Health Services. There may be many reasons for this, but it has been an observation that the QNFMHS visits to other services are ignored by our senior colleagues and increasingly delegated to junior colleagues and colleagues from other disciplines. This is worrying as senior colleagues are better placed to point out governance failures and worrying trends in services early if they are part of the visiting team. I remember past years when senior Consultant colleagues were part of QNFMHS visits and made valuable contributions to driving up standards. Without senior engagement standards may start to slip and go unnoticed before it becomes too late. I urge everyone to be mindful of this issue.

The college and the faculty is engaging with officials from the department of works and pensions to limit and mitigate the impact of the proposed changes to benefits for people convicted of serious offences. We are following the progress of the Southport and Nottingham enquiries and are looking out for recommendations which affect our practice. We are also watchful of any issues of scapegoating in these enquiries.

I wish you all a very good spring and summer 2026.

Yours sincerely,

Sandeep

Legal Update

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

Mental disorder is commonly considered in criminal cases, but it is not always relevant. The diagnosis of a mental disorder may explain behaviour and be used to support defences or reduce culpability at sentencing. The Court of Appeal has in these three cases sent a consistent message: psychiatric evidence must be provided in a way that is properly connected to the legal issues in the case.

When culpability is reduced

R v H [2025] EWCA Crim 1628

H was convicted of attempted robbery and possession of a knife. She threatened staff in a shop and demanded money before lowering the knife and saying, "I'm sorry I need some help". She had schizophrenia, and there was evidence of mental illness at the time of the offence. An extended sentence was imposed, which was appealed. Her mental illness and its impact on the assessment of culpability were the focus.

The appeal was successful because the mental illness had been treated primarily as mitigation, when it should also have been considered in assessing culpability. The assessment of culpability turned on establishing a clear connection between the illness and the defendant's decision-making. The connection was established because she was hearing voices, acting irrationally, and not making normal judgements. The degree of culpability was reduced and the sentence recalculated.

Psychiatric evidence can reduce culpability where there is a clear link between the mental disorder and the offending. This link should be based on the evidence.

When psychiatric evidence must be "tethered" to the legal issue

R v L [2026] EWCA Crim 150

L was convicted of wounding with intent alongside others. His case was that he had acted in self-defence, could not run away (because of a tendon injury), and did not know the others were using a knife. There was a request for the trial to be adjourned to allow expert evidence on PTSD. The expert opinion referred to general PTSD symptoms, such as hypervigilance and overestimation of threat, but did not explain how this defendant's condition specifically related to his conduct in this incident. In other words, the expert report did not "tether" the disorder to the defendant's behaviour.

A key issue was that PTSD was not relevant to his claim that he did not know a knife was being used. A co-defendant, by contrast, said he believed he was about to be attacked, and his PTSD was directly linked to that belief and his actions. The appeal failed.

Psychiatric evidence will be excluded if it is not directly relevant to the legal issue that the jury must decide. If the psychiatric evidence is relevant, it must be "tethered" to the behaviour.

Loss of control and self-defence

R v O'S [2026] EWCA Crim 141

O'S was convicted of murdering her partner in 2015. She admitted the killing but claimed self-defence, which was rejected by the jury. Several years later, new evidence led to an attempted appeal. The evidence consisted of social services records demonstrating a traumatic childhood and psychiatric evidence diagnosing PTSD/CPTSD based on extensive abuse. Her argument was that her mental symptoms meant she perceived greater danger, lost control, and should therefore have been convicted of manslaughter.

The court found that the new evidence did not change the case. The mental disorder is relevant to understanding the gravity of any threat but cannot be taken into account when assessing the standard of self-restraint:

"The role of an expert psychiatrist in the defence of loss of control is very limited, and in effect is confined to explaining that a mental health condition such as CPTSD can make a threat of violence appear more grave or serious to a defendant suffering from that condition than it would to the ordinary person. Therefore the psychiatric evidence would have been admissible, but only for the very specific and limited purpose of assisting the jury on the gravity of the qualifying trigger (which would have required the judge to give them a very careful direction)."

O'S originally argued self-defence and this is different to loss of control. It was noted that they may in fact be in conflict because self-defence can imply a degree of reason that contradicts the suggestion that the person had lost control. The appeal failed.

Psychiatric evidence will not be allowed on appeal to introduce a new defence or to repair a case that was properly run at trial.

Richard Latham

April 2026

Diagnosis at the coal face- clinical and practical aspects

By Dr Olufemi Adebajo ; MRCPsych, Consultant Psychiatrist (Locum), Queen Margaret Hospital, Dunfermline, Fife.

The term 'diagnosis' has both ordinary dictionary meanings and clinical implications, for both practitioner and patient alike. The Cambridge Dictionary defines diagnosis as: a judgement about what a particular illness or problem is, after examining it'. Merriam-Webster dictionary defines diagnosis as 'the art or act of identifying a disease from its signs and symptoms'. The clinical definitions are generally similar to the semantic definitions, even if they lean on the utilitarian aspects in the patient-doctor interactions in the healthcare setting.

In psychiatric practice, the standard clinical step of collating information from a history, physical examination, and ancillary investigations into a diagnostic label is modified by the considerable complexities of imposing objectivity on what is inherently subjective, and often variegated. A psychiatric diagnosis is often more nuanced than just a label that is useful for making sense of the chaos of emotions, memories, perceptions and interpreted phenomena that constitute the kernel of a psychiatric history, even minus the corroboration of a mental state examination. Diagnoses are important because they offer several advantages. They can offer the patient an explanation for their difficulties, or their observations on their difficulties, and indeed, an explanation for their family and friends. They are a useful shorthand for communication between professionals, for planning interventions, prognostication and, increasingly commonly, a measurable tool for evaluating clinical activity and service delivery.

A diagnosis could be conceptualised as an abbreviated biographical summary, temporarily frozen in the present and reordered according to the formulae prescribed in our diagnostic manuals. This process of systematic collation of memories, feelings, observations, of self, by self and others, is subject to the vicissitudes of both positive and negative effects on the fidelity of historical evidence. Even before one accounts for the diluting influence of memory decay, recall bias and recency effects on the veracity of recall, it is difficult to imagine how effectively the human mind can distill the information of, for example, a ten-year experience, into bite-sized chunks of history, to be interpreted by the physician. I have often wondered how accurately I could describe a 30-minute drive work commute, even when aided by helpful prompts, and extrapolated this cognitive difficulty into the reality of a patient enjoined to recall their range of emotions over a 20-year period.

Even the help of semi-structured questionnaires and interview schedules can only ameliorate these natural impediments to accuracy of recall. For example, how does one honestly respond to a question requiring a quantitative estimate of mood, on a numerical scale, or a subjective one, on an ordinal scale, when the whole range of emotions is captured by all points on the scale and a point estimate does not capture the overall individual experience. This particular problem manifests often in the highly motivated individuals seeking validation of a preferred diagnosis and completing screening diagnostic questionnaires that fulfil this prophesy. The frontline physician could then be cast in the uncomfortable binary mould of a believer or sceptic rather than an objective evaluator of evidence.

In the typical outpatient clinic setting in the NHS, the above factors are magnified by the practical exigencies of our service delivery model and practices. The depth of historical information is affected by the brevity of referral letters from other pressured professionals, the reduced time available for gathering background information, and the requirement to produce care and treatment plans informed by a holistic diagnostic formulation, to the satisfaction of all.

Factitious Disorder Imposed on Another (FDIA) through the lens of the Mental Health (Care and Treatment) (Scotland) Act 2003: Mental Disorder under s 328(1) or Excluded Behaviour under s 328(2)?

Dr. Reagan Ozuzu. ST6 Specialty Registrar in Forensic Psychiatry, Blair Unit, The Royal Cornhill Hospital Aberdeen.

1. Introduction

FDIA sits uncomfortably at the intersection between psychiatry, child protection, and law. We are dealing with something that is described as a psychiatric disorder in international diagnostic systems, yet in practice it presents as a pattern of caregiving behaviour that can amount to serious abuse. That dual identity creates real tension when we are asked medico-legal questions about the caregiver.

In Scotland, the practical issue often becomes this. When we are asked whether a parent or caregiver has a "mental disorder" for the purposes of the Mental Health (Care and Treatment) (Scotland) Act 2003, are we looking at FDIA as evidence of mental illness or personality disorder under s 328(1)? Or are we really looking at behaviour that is disturbing, harmful and potentially criminal, but not in itself a mental disorder, and therefore caught by the exclusions in s 328(2)?

I do not think there is a single answer. What matters is how we reason our way through the case, and how carefully we separate diagnosis, formulation and safeguarding findings.

2. Historical evolution of the concept

The story starts with Richard Asher's description of Munchausen syndrome, where the patient fabricates illness in themselves. Later, Roy Meadow described what became known as Munchausen by proxy, shifting attention to a caregiver who presents a child as ill or induces illness.

At the same time, DSM-5-TR and ICD-11 now use the term Factitious Disorder Imposed on Another, placing the diagnosis on the caregiver and emphasising deception without obvious external reward. As a construct, FDIA has developed within ongoing medico-legal controversy. It captures a recognisable pattern, but the step from pattern to psychiatric disorder in a particular individual is not always straightforward.

3. Rarity and epidemiology

FDIA is rare, with rates in the region of 0.5 per 100,000, although figures are uncertain. While I have seen just one case where the pattern was strongly supported after extensive multi-agency investigation, some psychiatrists might not see a case in their career.

Several factors contribute to apparent low prevalence. Under-recognition is likely, as cases may be managed within child protection systems without psychiatric diagnosis. Some cases may be classified as abuse without exploration of psychological formulation.

Diagnostic conservatism is understandable given the gravity of the label. High evidential thresholds mean that many suspected cases remain unconfirmed.

4. Statutory framework: s 328 of the 2003 Act

Whenever I approach cases, I try to remind myself that the Act has its own language and logic.

Section 328(1) defines "mental disorder" subject to subsection (2) as 'mental illness, personality disorder, or learning disability, however caused or manifested'. That is broad, but it is not limitless.

Section 328(2) then states that 'a person is not mentally disordered by reason only' of certain matters. Two parts are often raised in FDIA discussions. One is part (f) "behaviour that causes or is likely to cause harassment, alarm or distress to any other person" and the other is part (g) "acting as no prudent person would act".

The phrase "by reason only" is crucial. The exclusions are not saying that someone with a mental disorder cannot behave in distressing or very imprudent ways. They are saying that behaviour alone is not enough. There has to be an underlying mental disorder, not just conduct that shocks or harms.

I also make it explicit in reports that DSM or ICD categories do not decide the statutory question. They inform clinical thinking, but the legal test remains the one in the Act.

5. The case for FDIA as a mental disorder under s 328(1)

I think it is important not to dismiss too quickly the possibility that, in some cases, FDIA does reflect mental disorder in the statutory sense.

FDIA is recognised in major diagnostic systems. That alone does not settle the legal issue, but it does tell us that mainstream psychiatry sees this as potentially arising from psychopathology. Clinically, one hypothesis is a pathological need to occupy the sick role by proxy, with the child's illness becoming central to the caregiver's identity.

Adverse childhood events are usually common among these individuals. There may be significant trauma, attachment disturbances, personality difficulties, mood instability or other comorbidities. The behaviour can be driven by enduring psychological disturbance rather than simple instrumental gain. The fact that there is deception does not rule out mental disorder. People with significant disorders of personality or mood can still lie, manipulate and plan.

From a legal perspective, the Act is concerned with the statutory definition of s328(1), not with moral blame. If we treat every FDIA case as "just abuse", we risk missing opportunities to understand and, where possible, treat the caregiver's mental disorder alongside protecting the child.

6. The case for FDIA falling within s 328(2) exclusions

That said, I also understand why many colleagues are cautious about framing FDIA automatically as a mental disorder.

Much of the behaviour in these cases can look like deliberate abuse. There can be careful fabrication, induction of symptoms, and manipulation of professionals, more like mens rea on steroids. That can resemble criminal conduct or coercive control dynamics more than illness in the usual sense. The mere fact that behaviour is extreme or incomprehensible does not make it psychiatric.

This is where s 328(2) does important work. Acting in ways that no prudent person would act, or behaviours causing distress and alarm, does not in itself amount to mental disorder. If

the only evidence offered is the harmful behaviour, and there is no convincing clinical picture of mental disorder beyond that behaviour, then relying on the Act becomes problematic.

There is also a legitimate concern about medicalising abuse. UK safeguarding guidance has tried to avoid assuming a psychiatric label and instead focuses on evidence of harm and parental behaviour. That caution reflects hard lessons about overreach and the consequences of confident but weakly supported diagnostic opinions.

7. Diagnostic and evidential difficulties

For me, this is the heart of the issue.

FDIA cases are characterised by deception and inconsistency. Interviews alone are rarely reliable. The real evidence usually lies in records,

chronologies and discrepancies across services. Even then, it is rarely clear-cut.

Iatrogenic harm adds further complexity. Children may have real symptoms caused by investigations or treatments. That muddies the waters. Over-investigation can also produce incidental findings that confuse rather than clarify.

Differential diagnosis is essential. Some caregivers are highly anxious rather than deceptive. Some misinterpret symptoms due to limited health literacy. Rarely, a caregiver may have a psychotic disorder with fixed false beliefs about the child. Others may be seeking external advantages, which points away from FDIA and toward malingering-type explanations.

The risk of both false positives and false negatives is high. A mistaken accusation can be devastating, with potential for litigation. A missed case can leave a child at risk. That is why multi-agency evidence and careful chronology building are indispensable. Psychiatric opinion is only one piece of the puzzle.

8. Practical forensic synthesis

In practice, I try to keep three strands separate.

First, diagnosis. Do the available data genuinely meet criteria for a mental illness or personality disorder in the caregiver, beyond the concerning behaviour itself? If not, I say so.

Second, formulation. How do the caregiver's psychological characteristics, history and context help us understand the behaviour? This is often more useful than a yes or no diagnosis.

Third, safeguarding findings. What has happened to the child? What is the risk of further harm? These questions can be answered even when psychiatric diagnosis remains uncertain.

When discussing s 328, I usually set out the statutory definition, consider whether there is evidence of mental disorder, and then explain that behaviour alone is not enough because of the exclusions. Where I think there is an underlying disorder, I explain why the behaviour is not the sole basis for that conclusion.

Above all, I try to avoid over-confidence. FDIA sits in a grey area. Our job is to map that grey area as carefully as possible, not to force a black and white answer.

9. Conclusion

To my mind, FDIA does sit right at the boundary between psychiatry, law and safeguarding. In some cases, it will clearly involve mental disorder within the meaning of s 328(1). In

others, what we are seeing is harmful behaviour that, without more, should not be treated as mental disorder because of the s 328(2) exclusions.

The key is not to take a fixed position in advance. Careful formulation, strong multi-agency evidence, and a clear understanding of the statutory framework are what allow us to give opinions that are clinically sound and legally defensible, while keeping the child's safety at the centre.

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Rebuilding lives; not just managing risk

Nick

Introduction:

I would like to take this opportunity to share what it really means to move on from forensics. This isn't just about identity and leaving hospital, it's about finding a way, very often on your own, to navigate through a complex system that seeks to balance recovery, public safety and personal dignity. This is more than just managing risk; it's about the human experience of rebuilding a life. I would like to highlight the challenges faced by many peers in accessing primary care and propose something that may help; I want to mention the importance of maintaining confidentiality within the tribunal process and pose some considerations when thinking about successful outcomes for peers going through the forensic pathway.

The experience of primary care

Health and offending behaviour are deeply linked. I read with much interest the recent Government initiative of up to 4,000 offenders to receive health support during probation meetings. Although one wonders of the impact on staffing and nursing workforce, this is a welcome step and the relationship between health and offending shouldn't surprise anyone on this call. We know that half of offenders on probation smoke, many struggle with addiction and most have poor mental health. They're also less likely to get cancer screenings or even register with a GP.

This ongoing relationship with the GP is crucial to manage illnesses before crisis. However, GP practices, in my experience, may seek security in taking a different and more risk-averse approach than specialist forensic clinical teams and I hear of cases where the service user is ignored when they are supported to visit the practice instead discussing matters with the support worker who is in attendance. Do they even consider the impact that this stigmatising approach can have on personal narrative, boundaries and a sense of wellbeing? I might wonder, why want to visit someone who treats me like that? I imagine a future where there is a linked-up approach where we can anticipate the same background and experience of mental illness and a level of trust that where patients attend appointment or are referred into care of the GP that forensic risk assessment has been adequately and robustly considered. To this point, I wonder if more could be done, by all of us, in terms of training and knowledge sharing with primary care to reduce stigma and work with local practices to get the needs of our clients adequately represented? Until there is a coherent and joined up approach between forensic community and GP care then for many, there is no life beyond forensics. I'm very pleased to hear the collaborative links between different Colleges including RCGP however as it stands, in my experience, this needs to be addressed even further. Many of my peers only seek help when things get critical, often ending up and placing further burden on A&E.

That's why I believe this new pilot schemes placing trained clinicians in probation offices could potentially be a gamechanger. We already know that good physical health acts is a protective factor against mental health decline. If we want safer communities, we need healthier people both physically and mentally.

Confidentiality in the tribunal process

Earlier this month, in the national press, I read of a case where a forensic patient was released from hospital after four years, without warning or explanation, with the article stressing the secretive and

dangerous nature of this tribunal process. From a service user perspective, this raises real concerns. One can imagine where the thought process of this article may lead. Tribunals are already stressful. Every tribunal I've attended involved a focus of my progress and approach to psychological therapies. If I'd known that

therapy content might later be discussed in an open and public facing forum, I fear I might have approached therapy differently and potentially missed its primary purpose and benefits. Therapy needs to remain a safe space.

A further important point in the tribunal process was an exploration with my partner outlining their thoughts and preferences. Their involvement in family interventions was discussed stressing the ongoing support derived and that we both lean into each other for our own emotional partnership. A good portion of this discharge discussion explored their consistent message about where I would be discharged to. Further questioning revolved around their accepting a certain element of responsibility for ongoing management in the likelihood of future crisis. These discussions highlighted how discharge is not just a clinical decision, it's a deeply personal one that requires trust, transparency and genuine partnership with service users and families. Tribunals should be confidential, they should be collaborative and they should be exploratory, not adversarial like in court where service users may be so afraid to blink. To avoid further negativity in the court of public opinion, we must be consistent with reporting, keep all relevant parties informed, particularly liaison teams, and ultimately remain above reproach. In the end, tribunals should help us understand our subject, not just scrutinise them.

Rebuilding lives

Once discharged, in the process of rebuilding lives, people face the double stigma: past offending behaviour linked to ongoing mental illness. That affects housing, jobs, travel, friendships and even family. Opportunities like peer support, volunteering and vocational training are vital, but stigma still shuts doors. "Benefits" massively help with dignity, financial stability for a great many both within hospital and on discharge and also provide means to engage in lifestyle opportunities but even when they are available then they don't give someone purpose or belonging. And here's a question: do we really understand what matters to our patients? Recovery is personal. It's not just about avoiding relapse or reducing risk—it's about living a meaningful life. Aspirational goals and positive outcomes should go beyond simply challenging the alarming statistics of the mortality gap getting worse. Our job should go even further than preventing early deaths; it should go beyond medical interventions. These goals may include seeing the world, building families and friendships, continuing education, maybe if we can support them to forge careers and hopefully at some point a long and healthy retirement. These are the things that we can all live for and give life value and dignity. A wise man once said, Treat a man as he is, and he will remain as he is. Treat a man as he could be, and he will become what he should be.

Conclusion

So, becoming an ex-forensic patient isn't just about discharge; it's about finding a way to create a life beyond the label. It means improving care in GP clinics up and down the country, breaking offending cycles by preventative care before crisis, maintaining confidence in existing good practice and offering real chances for inclusion. Above all, it means continuing to see the person, not just the offence or the diagnosis, and supporting them to achieve their aspirations supported by and beyond fore

New Free eBooks Available!

The Faculty have selected a collection of ebooks, which members can now access via the College Library:

1. *Seminars in Forensic Psychiatry*
2. *Forensic Aspects of Neurodevelopmental Disorders*
3. *Navigating Mental Health in the Male Open Prison: Pains, Power and Peer Support*
4. *Secure Recover: Approaches to Recovery in Forensic Mental Health Settings*
5. *Prevention of Suicide in Prison: Cognitive Behavioural Approaches*

The Library has a collection of over 30,000 ebooks available to all members via RCPsych OpenAthens accounts. If you don't yet have an Athens account, you can set one up by getting in touch with the Librarian at infoservices@rcpsych.ac.uk.

The Art of Mindful Beeing

We are writing to share details of a newly launched project – *The Art of Mindful Beeing* – which we hope will encourage RCPsych members, their colleagues, friends and families, service users and College staff to get out in nature this summer – whether you are in an urban or rural area – to photograph bees - bumblebees, honey bees and solitary bees.

You are invited to submit your photos to be considered for an exhibition later in the year, as well as to add to our 'Bee Map' showing where bees have been sighted across the UK and around the world during this project.

We will also be hosting an online event in the autumn to talk about the project, share some of the submissions and offer guidance on introducing nature-based therapies into your services.

What is the purpose of *The Art of Mindful Beeing*?

- To celebrate our wild bees and all our insects.
- To help more psychiatrists to become interested in bees and more knowledgeable about insects and wildlife in general.
- To share information about nature-based therapies and their positive impact on wellbeing of psychiatrists and their patients.
- To raise awareness around clinical sustainability and the importance of biodiversity.
- To help psychiatrists and their teams to get actively involved in nature-based therapies and in making better habitats for bees and other pollinating insects.

More information can be found on the College's website including:

· Resources and guides to help you identify bees

· Nature-based therapies

· Details of how to submit to the project

Weblinks:

About the project
How to submit to the project
Nature-based therapies
Resources and guides
The Mindful Beeing exhibition
The Bee Gallery and Bee Map

Disclaimer:

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Contributions Welcome

Thank you to the contributors of this edition.

We would welcome contributions for the next e-newsletter by Friday 28th August 2026.

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.

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