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Kent Journal of Psychiatry

Dedicated to Psychiatry trainees and trainers

- Efficacy of 5-Hydroxytryptophan, Niacin, and Pyridoxine in Mild to Moderate Depression: A Prospective Clinical Study
- Effectiveness of Balint Groups as Reflective Practice for Nurses in Clinical Settings: A Narrative Review and Reflection on Implementation in a Liaison Mental Health Service
- Heller Syndrome: A Case Report
- Linking Cannabis Use to Acute Admissions to Mount Carmel Hospital
- National Mental Health Strategy for England: Proposal for Three-Pronged Transformation Plan
- The Therapeutic Black Hole: Psychiatry, Autonomy and the Limits of Compulsion for Suicidal Prisoners with Personality Disorder

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Editorial

This issue aims to capture psychiatry at its most clinically alive: exploratory biological treatments for depression, a rare Heller syndrome case challenging diagnostic delay and polypharmacy, Balint groups as reflective containment for nurses, cannabis-associated acute admissions, a forensic meditation on suicidal prisoners with personality disorder, and bold proposals for England's mental health transformation. Together, these papers remind us that psychiatry is not a narrow technology of diagnosis and prescribing, but a discipline of evidence, relationship, ethics, law, public health and service design.

This wider conversation arrives at a restless moment for UK mental health services. England is consulting on a new cross-government mental health strategy, explicitly seeking practical evidence across health, education, workplaces, local government and communities, while the Royal College of Psychiatrists' recent elections have reflected a profession asking sharper questions about identity, influence, workforce, standards and the future of psychiatric leadership. The opportunity is considerable: to move beyond slogans and fragmented pilots into a serious national settlement for mental health - psychiatrist-led, academically grounded, humane, measurable, and brave enough to protect both patients and psychiatry itself.

Efficacy of 5-Hydroxytryptophan, Niacin, and Pyridoxine in Mild to Moderate Depression: A Prospective Clinical Study

S. Rasheed, I. Dogar, D. Fatima, H. Yazdani

Abstract

Objective

To evaluate the efficacy of a fixed-dose combination of 5-hydroxytryptophan (5-HTP), niacin, and pyridoxine in adults with mild to moderate depression.

Methods

This prospective, non-randomised interventional study was conducted in a tertiary-care psychiatry outpatient department. Adults aged 18–65 years meeting DSM-5 criteria for mild to moderate major depressive disorder were enrolled. Participants received oral 5-HTP (100 mg), niacin (5 mg), and pyridoxine (2 mg) daily for 12 weeks. Depression severity was assessed using the 17-item Hamilton Depression Rating Scale (HAM-D17).

Results

Of 185 enrolled participants, 99 (53.5%) completed 12-week follow-up. Mean HAM-D17 scores decreased significantly from 16.8 ± 4.3 at baseline to 3.9 ± 4.6 at week 12 ($p < 0.001$). Clinical response occurred in 83.8% and remission in 61.6% of completers.

Conclusions

The supplement combination was associated with significant symptomatic improvement in mild to moderate depression. Randomised controlled trials are required to confirm efficacy.

Keywords

Depression; 5-hydroxytryptophan; Niacin; Pyridoxine; Nutraceuticals; HAM-D

Introduction

Depression is among the leading causes of global disability and is associated with reduced quality of life, increased healthcare utilisation, and suicide risk [1,2,3]. Although selective serotonin reuptake inhibitors (SSRIs) are widely prescribed, delayed onset of action, adverse effects, incomplete remission, and high relapse rates remain substantial limitations [4,5,6].

5-Hydroxytryptophan (5-HTP), the immediate precursor of serotonin, bypasses the rate-limiting step of tryptophan hydroxylation and may enhance central serotonergic activity. Pyridoxine (vitamin B6) acts as a cofactor in serotonin synthesis, while niacin (vitamin B3) supports neuronal energy metabolism via NAD/NADP pathways [8–10]. Deficiencies of B vitamins have been associated with depressive symptoms and impaired neurocognitive function [11,12,13,14]. Despite growing interest in nutraceutical approaches, evidence on the combined efficacy of these agents remains limited. This study aimed to evaluate the effectiveness of a standardised combination of 5-HTP, niacin, and pyridoxine in mild to moderate depression.

In recent years, increasing attention has been directed toward nutritional and metabolic contributors to depression, particularly in populations where micronutrient deficiencies are prevalent and access to psychiatric care is limited. Emerging evidence suggests that disturbances in monoamine synthesis, mitochondrial dysfunction,

and elevated homocysteine levels may interact to exacerbate depressive symptoms, especially in early or less severe illness stages [11, 12, 13, 14]. Nutraceutical interventions targeting these pathways may therefore offer a pragmatic adjunct or alternative to conventional pharmacotherapy, with potential advantages in tolerability, cost, and patient acceptability. However, clinical data evaluating combined serotonin precursors and vitamin cofactors in well-defined depressive populations remain scarce, underscoring the need for systematic investigation.

Methods

Study Design and Setting

This prospective, non-randomised clinical trial was conducted in the outpatient psychiatry department of DHQ/Allied Hospital-II, Faisalabad Medical University, over six months following ethical approval.

Participants

Adults aged 18–65 years newly diagnosed with major depressive disorder according to DSM-5 criteria were included. Depression severity was classified as mild to moderate using baseline HAM-D17 scores. Exclusion criteria included severe depression, comorbid psychiatric disorders, current antidepressant use, pregnancy or lactation, history of serotonin syndrome, and medical conditions affecting serotonin metabolism.

Intervention

Participants received once-daily oral capsules containing:

- 5-HTP 100 mg
- Niacin 5 mg
- Pyridoxine 2 mg

The intervention duration was 12 weeks.

Outcome Measures

The primary outcome was change in HAM-D17 score from baseline to week 12. Secondary outcomes included:

- **Response:** ≥50% reduction in HAM-D17
- **Remission:** HAM-D17 ≤7
- **Clinical Global Impression–Severity CGI-S)** in a subset of participants
- **Adverse events**

Statistical Analysis

Data were analysed using SPSS v23. Continuous variables were expressed as mean ± SD and categorical variables as frequencies and percentages. Paired t-tests assessed pre–post changes in HAM-D17 scores. Chi-square tests examined associations between socio-demographic variables and treatment response. Statistical significance was set at $p \leq 0.05$.

Results

Baseline Characteristics

A total of 185 participants were enrolled (mean age 38.5 ± 13.4 years), with females comprising 74.1%. Baseline mean HAM-D17 score was 16.3 ± 4.5.

Table 1: Baseline Socio-demographic and Clinical Characteristics (n = 185)

Variable	Category	n (%) / Mean ± SD
Age (years)	Mean ± SD	38.5 ± 13.4
Gender	Female	137 (74.1)
	Male	48 (25.9)
Residence	Urban	111 (60.0)
	Rural	74 (40.0)
Marital status	Married	108 (58.4)
	Single	41 (22.2)
	Divorced/ Widowed	36 (19.5)
Education	≤ Primary	79 (42.7)
	≥ Middle	106 (57.3)
Socioeconomic status	Low	101 (54.6)
	Middle/ High	84 (45.4)
Baseline HAM-D17	Mean ± SD	16.3 ± 4.5

Treatment Outcomes

Ninety-nine participants completed 12-week follow-up. HAM-D17 scores declined significantly over time.

Table 2: Change in HAM-D17 Scores Over 12 Weeks (n = 99)

Time Point	Mean Ham-D17	SD
Baseline	16.8	4.3
Week 4	9.5	6.7
Week 8	6.9	6.4
Week 12	3.9	4.6

Mean reduction at week 12 was 12.9 points (95% CI: 11.2–14.6; $p < 0.001$). Response was observed in 83.8% and remission in 61.6% of completers.

Subgroup Analysis

Socio-demographic variables were not significantly associated with treatment response.

Table 3: Treatment Response by Socio-demographic Subgroups

Variable	Subgroup	Responders n (%)	Non-responders n (%)	P
Gender	Female	62 (83.8)	12 (16.2)	.43
	Male	21 (77.8)	6 (22.2)	
Residence	Urban	50 (84.7)	9 (15.3)	.15
	Rural	33 (73.3)	12 (26.7)	
Education	≤ Middle	39 (73.6)	14 (26.4)	.18
	≥ Matric	44 (88.0)	6 (12.0)	

CGI-S and Discontinuation

CGI-S ratings (n = 30) showed marked improvement, with 86.7% achieving normal or borderline status by week 12.

Table 4: CGI-S Ratings Before and After Treatment (n = 30)

Initial CGI-S	Final CGI-S	N (%)
4-6	1-2	26 (86.7)
Missing	--	4 (13.3)

Early discontinuation occurred in 86 participants, mainly due to loss to follow-up.

Table 5: Reasons for Early Discontinuation (n = 86)

Reason	N (%)
Lost to follow-up	57 (66.3)
Early symptom resolution	20 (23.3)
Adverse effects	4 (4.7)
Relocation/ change of physician	5 (5.8)

Discussion

This study found that a 12-week regimen of 5-hydroxytryptophan (5-HTP), niacin, and pyridoxine was associated with a statistically and clinically significant reduction in depressive symptoms among adults with mild to moderate major depressive disorder. The mean reduction in

HAM-D17 scores exceeded established thresholds for clinical relevance and was accompanied by high response and remission rates, comparable to those reported in early antidepressant trials [15,16]. The gradual improvement observed across follow-up visits aligns with known timelines of serotonergic modulation, suggesting a sustained therapeutic effect rather than transient symptom relief [17].

The observed benefit is biologically plausible given the complementary mechanisms of the intervention. 5-HTP directly enhances central serotonin synthesis, while pyridoxine acts as a critical enzymatic cofactor in serotonin production, and niacin supports neuronal energy metabolism through NAD/NADP pathways [8,9,10,11,24]. Deficiencies of B vitamins are common in low-resource settings and have been independently linked to depressive symptoms and impaired neurotransmitter function [11,12,13,14,25]. In this context, a nutraceutical combination may represent a feasible, low-cost adjunct or early intervention for depression, particularly where access to standard pharmacotherapy is limited [19,26]. However, the absence of a control group and high attrition necessitate cautious interpretation, and randomised controlled trials are required to confirm efficacy and safety.

Conclusion

A 12-week regimen of 5-HTP, niacin, and pyridoxine was associated with significant symptom reduction in mild to moderate depression. Controlled trials are required before clinical implementation.

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*Rest of the references are available on request

About the authors

Dr Sidra Rasheed - Psychiatry resident; Dr Duaa Fatima - Psychiatry resident; Dr Habib Yazdani - Psychiatry resident; and Professor Imtiaz Dogar are based at the Psychiatry Department, Faisalabad Medical University/Allied Hospital II, Faisalabad.

Effectiveness of Balint Groups as Reflective Practice for Nurses in Clinical Settings: A Narrative Review and Reflection on Implementation in a Liaison Mental Health Service

Derya Nurlu

Abstract

Balint groups are structured reflective practice groups designed to explore the emotional and relational dimensions of clinical encounters. Although widely used in medical training, particularly among psychiatrists and general practitioners, their application within nursing practice has received relatively limited research attention despite nurses' central role in patient-facing care.

This narrative review examines the effectiveness of Balint groups as reflective practice for nurses working in clinical environments and provides a reflective account of implementing a Balint group within a liaison mental health nursing team in a UK teaching hospital. Literature searches were conducted across PubMed, Google Scholar and ResearchGate using keywords including "Balint group," "nursing," and "reflective practice." A one-year pilot Balint group programme for liaison mental health nurses was also reviewed.

Existing literature suggests that Balint groups may improve empathy, reflective capacity and understanding of clinician–patient relationships. Informal feedback from the pilot group suggested that nurses valued the opportunity to reflect on emotionally challenging encounters and develop alternative perspectives on patient behaviour. Challenges included inconsistent attendance due to shift patterns, concerns regarding confidentiality and difficulty maintaining focus on the nurse–patient relationship.

Balint groups may represent a valuable reflective practice intervention for nurses working in emotionally demanding clinical settings. Further empirical research focusing specifically on nursing populations is required to determine their effectiveness and identify optimal implementation strategies.

Introduction

Reflective practice is widely recognised as an important component of professional development in healthcare. Clinicians frequently encounter emotionally complex situations that require not only technical expertise but also the ability to understand interpersonal dynamics and reflect on their own emotional responses to patients. Within mental health practice, the clinician–patient relationship represents a central component of therapeutic work.

Balint groups represent one of the most established approaches to structured reflective practice in medicine. Developed by psychoanalyst Michael Balint in the 1950s, these groups were originally designed to support general practitioners in understanding the psychological aspects of consultations. Balint introduced the concept of "the doctor as a drug," highlighting the importance of the clinician's emotional presence in therapeutic relationships [1].

Over time, Balint groups have become integrated into medical education and psychiatric training programmes internationally. Participation in these groups has been associated with improved empathy, communication skills and clinicians' capacity for reflective practice [2]. Despite this evidence base, most research examining Balint groups has focused on physicians rather than nurses.

This emphasis overlooks the important role of nurses in patient-facing care. Mental health nurses frequently spend extended periods interacting with patients and often manage emotionally demanding clinical situations. However, structured reflective practice opportunities such as Balint groups are less commonly available within nursing teams.

Liaison mental health nurses working in acute hospital settings encounter particularly complex clinical demands. Their roles often involve rapid psychiatric assessment, risk evaluation and collaboration with multidisciplinary teams while managing high patient volumes and time pressures. These conditions may increase emotional burden and highlight the importance of accessible reflective practice structures.

This article aims to review the effectiveness of Balint groups as reflective practice for nurses and to present a reflective account of implementing a Balint group programme within a liaison mental health nursing team in a UK teaching hospital.

Background

Balint Groups

Balint groups are structured case discussion groups that focus on the relational aspects of clinical encounters rather than clinical management or diagnostic decision-making. Groups typically consist of six to twelve healthcare professionals who meet regularly under the guidance of a trained facilitator.

During sessions, a participant presents a clinical encounter that they experienced as challenging or emotionally significant. The group then reflects on the clinician's emotional responses and explores the interpersonal dynamics present within the interaction. Through this reflective process, participants may gain insight into both their own reactions and the psychological experiences of patients.

Balint proposed several principles that underpin this approach. First, most clinical encounters contain psychological elements that influence the consultation. Second, clinicians' emotional responses may provide valuable information about patient experiences. Third, the clinician–patient relationship itself has therapeutic value [1].

Research suggests that Balint groups can enhance clinicians' ability to reflect on emotional responses and strengthen empathy within patient care [3]. Participation in Balint groups has also been associated with increased professional satisfaction and reduced emotional exhaustion among healthcare professionals [6].

Reflective Practice in Nursing

Reflective practice has long been recognised as an essential element of nursing education and professional development. Nurses frequently encounter emotionally demanding situations involving distress, crisis and interpersonal conflict. Opportunities to reflect on these experiences may therefore support both professional learning and emotional wellbeing.

Mental health nurses often manage complex patient interactions involving behavioural disturbances, trauma histories and psychosocial stressors. The ability to understand relational dynamics and reflect on emotional responses may therefore play a significant role in effective patient care.

However, reflective practice within nursing teams often occurs informally and may focus primarily on clinical decision-making rather than emotional processing. Structured reflective approaches such as Balint groups may therefore provide a valuable framework for exploring the psychological dimensions of clinical work.

Previous studies have suggested that Balint groups may help nurses develop greater insight into therapeutic relationships and enhance their capacity to mentalise patient interactions [5]. Despite these potential benefits, empirical research examining Balint groups specifically within nursing populations remains limited.

Methods

Study Design

We employ a narrative review methodology combined with a reflective account of implementing a Balint group programme within a clinical service. Narrative reviews allow integration of findings from heterogeneous literature and are particularly useful when examining emerging topics where empirical evidence may be limited.

Literature Search

A literature search was conducted using PubMed, Google Scholar and ResearchGate. Search terms included combinations of "Balint group," "nursing," "reflective practice," "clinical empathy," and "mentalisation." Articles examining Balint groups among healthcare professionals were reviewed, with attention given to studies addressing reflective practice and clinician–patient relationships.

Pilot Balint Group Implementation

A pilot Balint group programme was implemented within the Liaison Mental Health Team at Lewisham University Hospital. Weekly one-hour sessions were offered to liaison mental health nurses over a one-year period.

Group sizes ranged from two to six participants, depending on clinical availability and shift patterns. The group was facilitated by a trainee psychiatrist undertaking senior psychiatric training and supervised by a consultant psychiatrist within the service.

Discussion

The findings from this narrative review and pilot implementation suggest that Balint groups may represent a valuable reflective practice intervention for nurses working in emotionally demanding clinical environments. Although most empirical research has focused on physicians, the principles underlying Balint methodology appear highly relevant to nursing practice.

Participants in the pilot group reported that the sessions helped them develop new perspectives on challenging clinical situations. Reflecting collectively on patient interactions allowed clinicians to reconsider the meaning of behaviours that initially appeared confusing or frustrating. This reflective process appears consistent with the concept of mentalisation described in Balint group literature, in which clinicians develop greater awareness of both their own emotional responses and the possible psychological experiences of patients [4].

The opportunity to verbalise emotional reactions also emerged as an important benefit of the group experience. Participants frequently described discussing situations such as managing aggressive behaviour, responding to complaints or coping with patient deaths. In many clinical environments, these experiences may not be openly discussed due to time pressures or organisational culture. Balint groups therefore provide a protected space in which clinicians can articulate emotions that might otherwise remain unaddressed.

Another important observation concerned the development of collegial support among participants. Hearing colleagues describe similar experiences appeared to normalise emotional reactions and reduce feelings of professional isolation. Previous studies have suggested that such peer reflection may contribute to improved job satisfaction and reduced burnout among healthcare professionals [6].

However, the implementation of Balint groups within nursing services presents several practical challenges. Attendance variability was one of the most significant issues observed during the pilot programme. Nursing shift patterns and service demands resulted in fluctuating group membership, which made it difficult to establish stable group dynamics.

Concerns regarding confidentiality also emerged during the early stages of the programme. Some participants initially expressed uncertainty regarding whether discussions might be communicated to management. Establishing trust therefore required clear communication about the purpose of the group and reassurance that sessions were intended solely as reflective practice rather than performance evaluation.

Maintaining the focus of discussion on the nurse–patient relationship also proved challenging. Participants occasionally shifted discussions toward organisational pressures such as workload or interdepartmental conflict. While these issues were clearly relevant to participants' experiences, they sometimes diverted attention away from the relational exploration central to Balint methodology. Skilled facilitation therefore plays an important role in guiding discussions and maintaining the reflective focus of the group.

Despite these challenges, the pilot programme suggests that nurses generally valued the opportunity to participate in structured reflective discussions. The findings therefore support the potential value of Balint groups as a reflective practice model for nursing teams, particularly within high-intensity clinical settings such as liaison psychiatry.

In future research, we aim to evaluate the impact of Balint groups on measurable outcomes including empathy, burnout and professional satisfaction among nurses. Qualitative work exploring participants' experiences in greater depth may also provide valuable insights into how Balint groups influence clinical practice and professional wellbeing.

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Conclusion

Balint groups provide a structured reflective practice framework that focuses on the emotional and relational aspects of clinical encounters. While widely used within medical education, their potential benefits for nursing staff remain underexplored.

The findings from this narrative review and pilot implementation suggest that Balint groups may support emotional processing, reflective capacity and collegial support among nurses working in demanding clinical environments. However, successful implementation requires attention to practical challenges including attendance consistency, psychological safety and facilitator training.

Further empirical research focusing specifically on nursing populations is required to determine the effectiveness of Balint groups and identify optimal strategies for integrating them into clinical practice.

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About the authors

Dr Derya Nurlu is a Higher Psychiatry Resident at Oxleas NHS Foundation Trust

Marked Clinical Improvement in Childhood Disintegrative Disorder Following High-Dose Benzodiazepine Therapy: A Case Report

J. Schulte, I.S. Ribeiro, Ö. Korkmaz, H. Waked, M. Abdallah

Abstract

Childhood disintegrative disorder (CDD) or Heller's Syndrome is a regressive neurodevelopmental presentation interpreted within the contemporary autism spectrum framework. It is a rare developmental disorder characterised by mostly normal early childhood development followed by significant regression in areas such as communication, social interaction, and motor skills.

We report a case of CDD in a 16-year-old male who was admitted to the emergency child psychiatry department due to aggressive behaviour, loss of language and motor abilities, stool and urine incontinence, and focal epilepsy. After more than 10 years of follow-up in a child neurology department with multiple psychopharmacological trials, the patient was transferred to our child psychiatry department, where the diagnosis of CDD was made. He subsequently showed significant improvement with relatively high doses of benzodiazepines combined with intensive multimodal therapeutic management as the primary treatment.

Keywords

Heller Syndrome, Childhood Disintegrative Disorder (CDD), Pervasive Developmental Disorder (PDD), Autism

Introduction

Childhood Disintegrative Disorder (CDD), or Heller Syndrome, is a very rare developmental disorder with an estimated prevalence of 1.7 per 100,000 [1]. An earlier estimate from the U.S. state of North Dakota is approximately 1.2 per 100,000 [2].

The disorder was first described in 1908 by the Austrian educator Theodor Heller as Dementia Infantilis [3]. Since then, it has been referred to as Heller Syndrome, disintegrative psychosis, and Childhood Disintegrative Disorder (CDD). In the ICD-10, the syndrome is listed under code F84.3, "Other childhood disintegrative disorder."

The disorder is defined by a period of typical development followed by a "definite loss of previously acquired skills in several areas of development over the course of a few months" [4]. According to the diagnostic criteria, children with Heller Syndrome typically lose interest in their environment, exhibit stereotyped and repetitive motor mannerisms, and show autistic-like abnormalities in social interaction and communication [4].

A comparison of cases of Heller Syndrome (CDD) with autism [5] revealed that patients with Heller Syndrome had the lowest IQs, were more often mute, and had a poorer prognosis.

Heller Syndrome affects males more frequently, with a ratio of four males to one female [6]. Volkmar et al report that the mean age of onset ranges from 24 to 42 months [5], while Volkmar reports a mean age of 3.36 years [6] . There are also reports of cases with a significantly later onset, though still within childhood [7]. Furthermore, different onset patterns have been observed: both insidious onset over weeks to months and abrupt onset over days to weeks [6,7]. In some cases, there was a premonitory phase "during which the child became more active, anxious, and restless" [6].

Little is known about the aetiology of Heller Syndrome. In some cases, the onset could be temporally associated with a significant life event—such as the birth of a sibling, which is typical for the age group—or with various medical conditions. However, these associations may simply reflect the family's attempt to make sense of the child's sudden regression [7]. There is a "pattern of EEG abnormalities and seizure disorder" [6]. Mouridsen cautioned professionals to be particularly mindful of possible diagnosable neurological disorders when the child is older at the time of diagnosis [8].

Case Report

A 16-year-old male patient was admitted to our hospital through a child neurology department in a neighbouring city, where he had been receiving treatment for focal epilepsy. The reason for the patient's transfer to our clinic was progressively worsening auto-aggressive behaviour, as well as aggression toward clinical staff and family members. The neurology department reported that the aggression showed no clear pattern and was resistant to several medications.

At the time of admission, the patient was receiving three antipsychotics (Pipamperone 120 mg daily, Levomepromazine 75 mg daily, and Paliperidone 50 mg intramuscularly once every three weeks), Diazepam 4.5 mg daily, two antiepileptic medications (Lamotrigine 300 mg twice daily and Lacosamide 300 mg twice daily), and one alpha-2 adrenoceptor agonist (Clonidine 75 µg ½ tablet three times daily).

The patient is the first child of a mother who was 24 years old and a father who was 33 years old at the time of his birth. The pregnancy was mostly normal, though episodes of bleeding were reported. The mother denied the use of alcohol, nicotine, or medications during pregnancy. Birth was spontaneous and unremarkable. The patient was breastfed until two years of age. Complementary feeding began with pureed foods at four months and solid foods at six months.

The parents reported noticing mildly delayed development, particularly in speech and comprehension, starting after the age of two. The patient could crawl and walk before 18 months of age. He formed three-word sentences before age two and achieved daytime and night time continence before age three.

According to the parental report, the patient's first abnormalities appeared at age four, when he developed urinary and faecal incontinence, followed by the first seizure episodes. More recently, his expressive and receptive language abilities declined drastically, leaving him able to repeat only three to four words ("hello," "goodbye," "food").

The patient was first admitted to a child neurology clinic at age six. Comprehensive neurological and radiological investigations—including blood tests, cranial MRI, and genetic testing—were unremarkable. Various antiepileptic medications were trialled until a beneficial therapeutic effect was achieved with the combination of Lacosamide and Lamotrigine.

Upon admission to our intensive child psychiatric unit, the patient required placement in a time-out room due to severe aggression toward himself and others. Subsequently, he required five- to seven-point mechanical restraints by court order. To objectively assess behaviour and functioning, we implemented the NOSIE-30 scale, an instrument with established validity, reliability, and sensitivity to change [9]. The scale consists of 30 items rated on a five-point scale, based on behaviour observed during the preceding three days, completed independently by two informants. The items form six subscales: Social Competence, Social Interest, Personal Neatness, Irritability, Manifest Psychosis, and Retardation (Inactivity), from which Total Positive, Total Negative, and Total Patient Assets scores can be derived [10]. The patient's initial total row score was 62.

Intensive multimodal therapy with one-to-one support was initiated but showed no clear improvement. A reduction in two antipsychotics (Pipamperone and Paliperidone) produced minimal

benefit. Afterwards, Olanzapine treatment was initiated. The dose was titrated to 15 mg daily, resulting in relatively better clinical outcomes.

To further optimise treatment, we attempted to taper the daily Diazepam dose. Despite slow tapering, the patient developed severe auto-aggressive behaviours requiring repeated physical restraints. Diazepam was therefore replaced with Lorazepam. After adjusting and stabilising the Lorazepam dose at 6 mg daily, we achieved substantial behavioural control. Minimal sedation was observed, and aggressive behaviours decreased markedly. NOSIE-30 ratings demonstrated a 26% overall reduction, with a 36% reduction in Irritability and a 20% reduction in Social Competence and Social Interest.

Discussion

The patient met the diagnostic criteria for Childhood Disintegrative Disorder (CDD) in DSM-5 [11,12], showing loss or regression in all major developmental domains—receptive and expressive language, social or adaptive behaviour, play with peers, motor skills, and previously established bowel and bladder control—after apparently normal development during the first two years of life. In addition to these regressions, he demonstrated abnormal functioning across all required behavioural domains, including impaired nonverbal communication, failure to develop peer relationships, lack of social and emotional reciprocity, inability to initiate or sustain conversation, and restricted, repetitive, and stereotyped behaviors such as repetitive head bobbing. These symptoms could not be better explained by any other general medical condition or diagnosed mental disorder.

At age six, the patient was enrolled in a special-needs school focusing on physical and motor development and was followed regularly by the neurology department. According to parental reports, he exhibited slow but continuous decline in language and motor abilities over time. His most recent symptoms, primarily aggressive behaviors, resulted in school suspension in April 2025.

One major differential diagnosis considered was excited catatonia (EC). Although EC shares several features with the present case—including overlapping symptoms and a good response to high-dose lorazepam—we presented the case at our Mental Health Centre's Morbidity and Mortality Conference (13). The conference included clinicians from the Clinic for Child and Adolescent Psychiatry, the Clinic for Psychosomatic Medicine and Psychotherapy, and the Clinic of Psychiatry and Psychotherapy.

Following multidisciplinary discussion, the consensus was that the clinical presentation is more consistent with childhood disintegrative disorder (CDD) rather than EC. Excited catatonia is typically characterised by excessive and purposeless motor activity in both the upper and lower limbs (hyperkinesis), restlessness, stereotypies, impulsivity, frenzy, and combativeness (14). In contrast, the motor activity observed in our case was more global and largely purposeful. In addition, the loss of major developmental domains persisted even after a period of clinical stabilisation.

A major challenge in this case was the delayed diagnosis. Although symptom deterioration began early and pediatric neurological care was initiated at age six, psychiatric diagnosis and treatment did not begin until ten years later. This delay may reflect unfamiliarity with the disorder and the absence of established treatment guidelines.

Another concern was psychopharmacological polypharmacy. The patient received benzodiazepines alongside antipsychotics and antiepileptics. However, concerns about potential drug interactions and serious adverse effects, such as severe sedation, respiratory depression, or paradoxical disinhibition, did not arise. A follow-up evaluation of the patient in our acute ward 12 weeks later showed stable behavior, with almost no use of physical restraints during the preceding eight weeks.

Conclusion

We report a case of CDD with progressive regressive behaviours that did not respond to multiple antipsychotic trials. Significant improvement was achieved through a relatively high dose of benzodiazepine (Lorazepam 6 mg daily), allowing the patient to attend one hour of schooling and expand his spoken vocabulary. The CDD occurred alongside focal epilepsy, requiring coordinated management across paediatrics, child neurology, and child and adolescent psychiatry.

More than a century after Heller first described this syndrome, little remains known about its aetiology, course, and optimal treatment. No standardised therapeutic guidelines currently exist, although symptom-oriented pharmacological management is feasible. Despite this, caregiver burden remains high. Heller Syndrome appears to be extremely rare, possibly rarer than autism, with which it is often compared. It has been suggested that unfamiliarity, under-recognition, and lack of diagnostic guidelines may contribute to underdiagnosis and low prevalence estimates [8].

Raising public and professional awareness and establishing formal treatment guidelines would support earlier recognition, improve clinical management, and reduce the burden on patients and families.

Disclosure

The authors declared no conflicts of interest. Written consent was obtained from the patient/kin of the patient.

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Rest of the references and appendices are available on request

About the Authors

Jule Schulte is based at the Department of Psychology, University of Siegen, Siegen, NRW, Germany.

Isadora Silva Ribeiro, Özge Korkmaz, Hnadi Waked & Morsi Abdallah are based at the Department of Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy, Klinikum Lüdenscheid, Märkische Hospitals, Lüdenscheid, NRW, Germany.

Morsi Abdallah is affiliated with the University of West Virginia Medical School, Morgantown, WV, USA

Linking Cannabis Use to Acute Admissions to Mount Carmel Hospital

R. Gambin, A. Bellizzi, T.A. Mallia, J. Schembri, A. Camiller

Abstract

Background

Cannabis is the most widely used illicit substance globally, with increasing consumption following legislative changes in countries such as Malta. Evidence suggests an association between cannabis use and acute psychiatric presentations, particularly psychosis. This study aimed to investigate the prevalence of cannabis use among acute psychiatric admissions and its association with clinical presentations at Mount Carmel Hospital.

Methods

A retrospective observational study was conducted of all acute psychiatric admissions to Mount Carmel Hospital between January and February 2024. Patient records were reviewed to extract demographic data, admission characteristics, psychiatric diagnoses, and substance use history, including urine toxicology results. Descriptive and comparative analyses were performed to assess the prevalence of cannabis use and its association with psychiatric diagnoses.

Results

A total of 504 patients were included, with a mean age of 43.3 years; 72.4% were male. Cannabis use was identified via urine toxicology in 13.3% of patients, while 29.2% of admissions were clinically associated with cannabis use. Psychotic disorders were among the most common diagnoses (n=80), second only to substance and alcohol use disorders (n=161). Limitations in toxicology screening were observed, with incomplete testing across the cohort.

Conclusion

Cannabis use was associated with a substantial proportion of acute psychiatric admissions. Improved screening and further research are needed.

Background

Cannabis is the most commonly used illicit substance worldwide, and its use has been on the rise, partly due to changing legal frameworks and increased social acceptance in various countries. In Malta, cannabis remains a popular drug, particularly among young adults. Medical cannabis was legalised in Malta in 2018 and recreational cannabis was legalised in December 2021 with specifications regarding possession, use and cultivation, making Malta the first European nation to do so. With these drastic changes to Maltese legal framework and culture, it is imperative to understand the potential mental health implications associated with its consumption.

Research has consistently shown a link between cannabis use and various mental health issues [1,2,3]. Acute psychiatric disorders such as psychosis, anxiety, and depression have all been associated with cannabis use. Direct links have been made between cannabis use and earlier-onset and treatment-resistant psychotic symptoms [4,5,6,7,8,9], especially in adolescent use [10]. The relationship is complex and may be influenced by several factors, including the age of onset, frequency and quantity of use, genetic predispositions, and the presence of other mental health conditions. Studies have suggested that early and heavy use of cannabis can exacerbate pre-existing mental health conditions or contribute to the onset of new psychiatric disorders. Furthermore, there is research to suggest that emergency presentations for psychotic episodes

increase following the legalisation of non-medical cannabis use [11].

Mount Carmel Hospital, Malta's primary mental health facility, handles a significant number of acute psychiatric admissions each year. As the country navigates changes in cannabis policy, it is crucial for healthcare providers and policymakers to have a clear understanding of how cannabis use may impact acute psychiatric admissions. This research seeks to investigate the prevalence of cannabis use among patients admitted acutely to Mount Carmel Hospital (MCH) and to assess whether there is a significant correlation between cannabis use and acute psychiatric admissions.

By examining the local context at Mount Carmel Hospital, this study will provide valuable insights specific to Malta, contributing to the global body of research on cannabis and mental health while also addressing the unique needs and circumstances of the Maltese population.

Aims

The primary aim of this study is to determine the proportion of acute psychiatric admissions at Mount Carmel Hospital associated with cannabis use.

Specific objectives include:

● Identifying the prevalence of cannabis use among patients acutely admitted to Mount Carmel Hospital.

● Examining the types of psychiatric conditions diagnosed in cannabis-using patients.

● Assessing any patterns or trends in the data that may suggest a correlation between cannabis use and specific psychiatric disorders.

● Providing evidence-based recommendations for clinical practice and future research within the context of Malta.

Method

Study Design

A retrospective observational study of patient records from Mount Carmel Hospital.

Sample

Patients acutely admitted to Mount Carmel Hospital over a specified 2-month period, from January to February 2024.

Ethical Considerations

● Anonymisation of patient data to ensure confidentiality.
● Approval from Mount Carmel Hospital's data protection officer prior to data collection was acquired, as well as approval from the clinical chair.

The list of patients admitted to MCH from January to February 2024 was acquired from hospital management.

The following data was collected from iSoft, ECS and patient notes:

● Patient demographics (age, gender, ethnicity).
● Admission details, including Mental Health Act (MHA) status and reason for admission.
● Details of cannabis use (frequency, duration, and quantity).
● Psychiatric diagnoses at the time of admission.
● Any co-occurring substance use.

The following inclusion criteria were used:

● Patients admitted acutely to Mount Carmel Hospital between January and February 2024.
● Documentation of cannabis use in the patient records, including iSoft toxicology results, psychiatric notes and discharge letters.

The following patients were excluded:

● Patients with no documentation of substance use history as described above.

Cannabis use was defined using two sources:

● Biological evidence: a positive urine toxicology screen for THC on admission.
● Clinical documentation: clinician-recorded history of cannabis use or explicit mention in medical notes that cannabis use was considered relevant to the presentation.

'Clinically associated with admission' was defined as documentation in admission or discharge letters indicating that cannabis use may have contributed to or exacerbated the presenting psychiatric condition. This judgment was not based on a standardised assessment tool.

Data analysis included:

● Descriptive statistics to summarise the prevalence of cannabis use among the sample.
● Comparative analysis to examine differences in psychiatric diagnoses between cannabis users and non-users.

Results

504 patients were admitted to MCH in the two-month period between January and February 2024. 365 of this number were male (72.42%). The mean age of the data sample was 43.33, with the eldest patient being 80 years old and the youngest being 12 years old.

54 (10.71%) of the patients' files were not found during data collection.

81.15% (n=409) of the data sample were Maltese nationals.

26.98% (n=136) were admitted to MCH involuntarily under the Mental Health Act. 24% (n=121) were new admissions to MCH.

32.24% of patients (n=163) did not have a urine drug screen recorded on admission. Urine toxicology for synthetic cannabinoids was not tested in 321 of the patients in this cohort (63.69%).

13.29% of patients (n=67) had a positive urine frontline for THC on admission. 114 patients had a positive urine frontline for cocaine, 40 for opiates and 5 for amphetamines. Out of the total patient cohort, THC use was associated with hospital admission and diagnosis in 147 cases, amounting to 29.17%.

A summary of the patient cohort's diagnoses on discharge can be found in the table 1. There were a number of discharge letters that were not available on the Electronic Case Summary record (n=51), due to the patient still being admitted or being on leave from the hospital.

Table 1: Cohort diagnoses on discharge of patients.

Diagnosis	No. of Patients
Psychosis/Schizophrenia/ Schizoaffective disorder	80
Bipolar Affective Disorder	43
Substance/ Alcohol Use Disorder	161
Acute Stress Reaction	13
Dementia	7
Suicide attempt/ Suicidal ideation	26
Depression	30
Intellectual Disability	9
Anxiety Disorder	17
Personality Disorder	28

Statistical Analysis of Cannabis Use and Psychiatric Diagnoses

Comparative analyses were conducted to examine the association between cannabis use and psychiatric diagnoses among the study population.

A subgroup analysis comparing patients with a positive urine toxicology screen for THC to those with negative screens demonstrated that psychotic disorders were more frequent among THC-positive patients (20.0%) compared to THC-negative patients (13.0%). However, this difference did not reach statistical significance (OR = 1.64, 95% CI: 0.81–3.31, p = 0.23).

A strong association was observed between THC-positive urine toxicology and clinical documentation of cannabis use as relevant to the admission (OR = 143.21, 95% CI: 19.5–1050, p < 0.001). Patients with a positive THC screen were significantly more likely to have cannabis use recorded in clinical notes in relation to their presentation compared to those with negative screens.

The wide confidence interval for this association likely reflects the relatively small number of THC-positive cases within the sample. Despite this, the lower bound of the confidence interval remained well above 1, indicating a statistically significant association.

Discussion

Out of the total patient cohort, THC use was linked to hospital admission in 147 cases, amounting to 29.17%. This inference was made by going through the medical notes for the admission, and considering these in the light of the patient's history of THC use, reason for admission and diagnosis on discharge. A diagnosis of substance-induced psychosis was specified in 14 discharge letters; however, it is widely known that THC use can exacerbate pre-existing mental illness, especially psychotic disorders, and not just result in de novo psychosis [4,5,6,7,8,9,10,11].

80 out of 504 patients had a diagnosis of a psychotic disorder in this cohort. This was the second most common diagnosis, with substance and alcohol related disorders having the highest prevalence in the cohort (n=161). These links may be underrepresented due to the number of missing files and the number of patients who did not have their urine frontline checked during admission. Regardless of this limitation, a considerable number of the admissions in this time period (almost one third) could be associated, at least in part, to THC use.

Additionally, as in all cases of substance misuse, longstanding THC use may also result in other psychosocial problems that may lead to an increased likelihood of hospital admission in vulnerable cohorts. Patients struggling with cannabis-use disorder have increased odds of interpersonal, socioeconomic, legal and health-related problems, especially homelessness, unemployment, financial debt and police contact [12,13,14]. Regular cannabis users have also been associated with more emergency department visits, higher risk of serious injury and disturbed sleep [14].

This study identified a higher proportion of psychotic disorders among patients with positive THC urine toxicology compared to those without; however, this association did not reach statistical significance. This may be attributable to limited statistical power, given the relatively small number of patients with confirmed THC-positive screens, as well as incomplete toxicology testing across the cohort. Nonetheless, the observed trend is consistent with existing literature suggesting an association between cannabis use and psychosis.

A strong association was observed between THC-positive toxicology results and clinical documentation of cannabis use as relevant to the admission. This finding is expected, as clinicians are more likely to record substance use as contributory when supported by objective toxicology results. As such, this association should be interpreted with caution, as clinical attribution of cannabis use may not be independent of toxicology findings.

More broadly, these results highlight the challenges of accurately characterising substance use in acute psychiatric settings. The discrepancy between biologically confirmed cannabis use (13.3%) and clinically documented cannabis-related presentations (29.17%) suggests that reliance on either method alone may lead to under- or over-estimation. Incomplete toxicology screening

further limits the ability to draw firm conclusions regarding the true prevalence of cannabis use and its relationship with psychiatric diagnoses.

Taken together, these findings support an association between cannabis use and acute psychiatric presentations, particularly psychotic disorders, while underscoring the limitations of retrospective observational data in establishing causal relationships.

32.24% of patients (n=163) did not have any urine drug screen recorded on admission. Urine toxicology for synthetic cannabinoids was not tested in 321 of the patients in this cohort (63.69%). This highlights a major need for improved testing for all substance use on admission to MCH. It is common practice for a urine frontline test to be carried out at MCH once the patient is admitted, and for another urine sample to be sent for formal toxicology screen at Mater Dei Hospital (MDH) for confirmation. However, this may be a major limiting step, as samples frequently get lost in transit, become 'soiled', or contaminated, by the time they arrive at the lab. Most admissions to MCH are reviewed initially at A&E (MDH) and so it should be emphasised that a urine toxicology screen, to include testing for synthetic cannabinoids, should be carried out before the patient is transferred to MCH.

Furthermore, at present, the test for synthetic cannabinoids must be requested separately from the rest of the urine drug screen on the current software (iSoft), and thus it is commonly missed by clinicians, especially at A&E. This is evident in the results, where a larger number of patients (321) did not have the test for synthetic cannabinoids compared to the 163 who did not have a regular urine drug screen. As a final point on this, there are a number of patients who decline urine drug screens on admission and thus, this cohort may account for a proportion of the resulting number of omitted tests. Ways to improve patient compliance with urine drug screening include reassurance that no legal action will be taken for positive results and expressing concern regarding possible interactions with medications. However, this highly depends on the patient's presenting mental state on admission, as well as the therapeutic rapport the clinician is able to establish at this stage. Even for patients who are admitted under the Mental Health Act, there is no way to oblige the individual to provide a sample and ensure that this sample is genuine.

Another limitation includes the number of missing files for the data sample. Just over 10% of the files were unobtainable from the medical records department at MCH. This could be for a number of reasons, including files being requested by other clinicians doing research or being taken to different wards depending on patient transfers. A major drawback of having physical medical records is that they may become misplaced, whereas with a digitised system, data collection would be more straightforward.

The high proportion of missing toxicology data may have led to an underestimation of cannabis use prevalence. Patients who were not tested may systematically differ from those who were tested (e.g., less severe presentations or reduced clinical suspicion of substance use), introducing potential selection bias. Similarly, missing patient files may have resulted in incomplete capture of substance use histories and diagnoses, further limiting the reliability of observed associations.

Conclusions

A significant cohort of patients admitted to MCH were found to have a urine drug test positive for THC. Cannabis use was associated with admission and diagnosis in almost one third of cases (29.17%), despite evident concerns regarding the regularity of urine drug screens being carried out on admission.

Recommendations

Improvements in urine drug test screening for patients admitted to MCH:

- By improving A&E and psychiatric doctors' awareness of the need for this screen before admission.

● Possibly adding synthetic cannabinoids to the regular urine drug screen panel would ensure that this is less likely to be forgotten in the process of booking urine drug screens.

Improved public education about the adverse effects of cannabis use, including campaigns by both Mental Health Services and the Public Health Department, is essential in the landscape of widespread use of THC-containing substances. These educational campaigns should be directed towards the general public, but especially towards school-age children and young adults.

Further local research comparing the prevalence of mental health conditions in individuals who use cannabis regularly and those who do not would be useful in future educational endeavours. Future studies using prospective designs and standardised measures of substance use are needed to better clarify the relationship between cannabis use and acute psychiatric presentations

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About the authors

Dr Rachel Gambin, Dr Analise Bellizzi, Dr Tamara Attard Mallia, Dr Jamie Schembri & Dr Aloisia Camilleri are based at the Malta Mental Health Services, Mount Carmel Hospital, Attard, Malta.

National Mental Health Strategy for England: Proposal for Three-Pronged Transformation Plan

Naveed Kausar & M Aamer Sarfraz

Introduction

The Department of Health and Social Care has launched a national call for evidence to inform the development and implementation of a new cross-government mental health strategy for England. The consultation seeks practical examples and implementation evidence from mental health services, wider health services, local government, education and training settings, workplaces and community settings, including learning from the UK and internationally. It is therefore an important opportunity not merely to describe current pressures, but to submit clinically grounded, academically robust and operationally deliverable proposals capable of reshaping prevention, access, treatment, crisis care, recovery and accountability across the whole mental health system [1].

England does not require another mental health strategy that merely reconfigures pathways, rebrands services, launches time-limited awareness campaigns or commissions transient pilot programmes. It requires a National Mental Health Transformation Mission: a cross-government, clinically rigorous, educationally ambitious and academically anchored programme that shifts the country from late-presenting, fragmented, crisis-driven care toward early, relational, community-based, evidence-led mental health provision across the entire life course. The current government's call for evidence explicitly seeks practical examples from mental health services, wider health services, local government, education, workplaces and community settings, and aligns the proposed strategy with the broader NHS shifts from hospital to community, analogue to digital and sickness to prevention [1,2].

The epidemiological imperative is now incontrovertible. The Adult Psychiatric Morbidity Survey for England demonstrates that common mental health conditions among 16–24-year-olds rose from 17.5% in 2007 to 25.8% in 2023/24, with younger adults also significantly more likely to report non-suicidal self-harm and to screen positive for disordered eating symptoms, PTSD and ADHD [3]. The OECD has further argued that effective mental health policy must extend beyond specialist services into primary care, schools and workplaces, where evidence-based prevention and early intervention can mitigate both human suffering and macroeconomic loss [4].

The strategy should therefore be organised around three interdependent national prongs: clinical transformation, educational transformation, and academic and research transformation.

1. Clinical Prong: Rebuild Mental Health Care Around Early Access, Continuity, Complexity and Recovery

1.1 Establish a National Network of Neighbourhood Mental Health Centres

Every local population should have access to a visible, walk-in, multidisciplinary Neighbourhood Mental Health Centre, operating extended hours and integrated with 24/7 crisis support. These centres should co-locate psychiatric assessment, brief evidence-based intervention, prescribing, psychological therapy, addiction support, family intervention, employment support, housing advice, physical health monitoring, peer support and social prescribing. This would convert the rhetoric of "care closer to home" into tangible

clinical infrastructure with defined governance, staffing ratios and outcome accountability.

These centres should synthesise the best international evidence from assertive community psychiatry, youth mental health hubs, crisis alternatives, primary care psychiatry integration, WHO rights-based community mental health guidance and NHS community mental health transformation programmes. WHO guidance is unequivocal that modern mental health systems should be person-centred, recovery-oriented, rights-based and community-embedded, rather than dominated by institutional or fragmented models of care [5].

1.2 Introduce a "No Wrong Door" Mental Health Access Standard

Patients should not need to self-triage into the correct service category - primary care, NHS Talking Therapies, CMHT, CAMHS, crisis services, autism/ADHD pathways, substance misuse services or social care - before receiving appropriate help. The first clinical contact should become the right door.

Practical proposals:

• Same-day digital or telephone triage with clinical risk stratification for urgent presentations.

• Face-to-face biopsychosocial assessment within 72 hours for high-risk or functionally deteriorating cases.

• Seven-day access for moderate but sustained functional impairment.

• Direct escalation into specialist psychiatry for psychosis, bipolar disorder, severe depression, eating disorders, personality disorder complexity, perinatal illness, neurodevelopmental complexity, substance misuse comorbidity and suicide risk.

• A named clinician or care coordinator with defined caseload limits for people with complex or enduring illness.

• An end to "referral rejected" culture: where a service cannot accept a patient, it must actively transfer clinical responsibility with a warm handover, and not passively bounce risk back to the GP, family or patient.

• Ensure sufficient inpatient capacity for severe and complex illness. Community care is only safe when backed by timely access to adequate, therapeutic, consultant-led inpatient beds for patients whose acuity, risk or complexity cannot be safely managed at home.

• Free clinicians from avoidable administration. Psychiatrists should spend their time on assessment, diagnosis, treatment, risk management and supervision; routine letters, forms, coding and correspondence should be handled by trained admin staff or safely governed AI tools, with clinician oversight.

1.3 Build a Serious National Programme for Severe Mental Illness

The strategy must not become solely an anxiety, wellbeing and resilience document. It must explicitly and proportionately prioritise psychosis, bipolar disorder, severe depression, eating disorders, complex trauma, personality disorder, perinatal mental illness, dual diagnosis, neurodevelopmental comorbidity and forensic-risk complexity.

Each locality should provide:

• Assertive community treatment with fidelity to the international ACT model for the most unstable and high-risk patients.

• Early Intervention in Psychosis services with assertive outreach, family intervention and cognitive remediation.

• Clozapine optimisation clinics, lithium monitoring registers and long-acting injectable antipsychotic services.

• Consultant psychiatrist input for complex psychopharmacology.

• Embedded physical health clinics addressing cardiovascular, metabolic and respiratory comorbidity within mental health services.

• Individual Placement and Support employment services integrated into clinical teams.

• Housing First pathways for individuals experiencing homelessness, psychosis, addiction and repeated crisis admissions.

• Rehabilitation psychiatry for patients trapped in long-stay wards, out-of-area placements or institutional drift.

• Proper dual-diagnosis services with integrated treatment for mental illness plus alcohol and substance use disorders.

This is also a mortality equity issue. People with severe mental illness in England die on average 15–20 years earlier than the general population, predominantly from preventable physical illness; NHS England guidance now mandates annual physical health checks with supported follow-up interventions for this population [6,7].

1.4 Make Employment, Housing and Social Function Core Clinical Outcomes

Mental health services should not measure success solely through symptom rating scales, contact volumes, bed occupancy or discharge rates. Recovery characteristically involves meaningful occupation, stable accommodation, supportive relationships, daily structure, valued social roles and a sense of purpose.

Individual Placement and Support has one of the most robust evidence bases in psychiatric rehabilitation. Across 28 randomised controlled trials, IPS achieved an average competitive employment rate of 55% compared with 25% in control conditions, and a meta-analysis demonstrated that people receiving IPS were 2.4 times more likely to gain competitive employment [8]. IPS should therefore be embedded in CMHTs, Early Intervention in Psychosis teams, forensic step-down services, bipolar disorder services, personality disorder services and youth mental health hubs as a core intervention, not an optional adjunct.

1.5 Reform Crisis Care So Emergency Departments Are No Longer the Default Psychiatric Waiting Room

The strategy should create a tiered crisis ecosystem with graded intensity:

• 24/7 psychiatric urgent care centres with direct admission capability.

• Crisis cafés and safe havens operating outside conventional hours.

• Mobile crisis response teams with ambulance and police diversion protocols.

• Short-stay crisis units with 23–72 hour stabilisation capacity.

• Intensive home treatment teams functioning as a genuine alternative to inpatient admission.

• Crisis houses and peer-led respite services.

• Real-time bed management systems to eliminate out-of-area placements.

• Dedicated crisis pathways for children and young people that avoid prolonged waits in paediatric emergency departments.

Short-stay mental health crisis units have demonstrated evidence for reducing emergency department waiting times and inpatient admission rates [9]. NHS England has also invested in crisis cafés, safe havens and crisis houses as alternatives to emergency department attendance and inpatient admission, though implementation fidelity and coverage remain variable [10].

1.6 Make Inpatient Care Safer, More Therapeutic and Less Coercive

Inpatient wards should be conceptualised as high-acuity clinical environments requiring skilled consultant psychiatrist leadership, not as containment spaces for system failure.

Every ward should implement:

• Safewards or equivalent evidence-based conflict-reduction models.

• Daily consultant-led biopsychosocial formulation and structured risk review.

• Trauma-informed practice operationalised through environmental design, staff training and relational security protocols.

• Autism-informed sensory environments with routine sensory assessments.

• Proper therapeutic groups and meaningful occupational programmes delivered seven days per week.

• Rapid psychiatric review at admission and at transition points.

• Family and carer involvement as the default practice unless specifically contraindicated.

• Independent monitoring of restraint, seclusion, sexual safety, racism, violence, absconding and post-discharge suicide.

• A discharge and rehabilitation plan initiated by a consultant psychiatrist from the first day of admission.

Safewards exemplifies an implementable evidence-based intervention: the cluster randomised controlled trial demonstrated significant reductions in conflict and containment events, and NHS England's summary highlights decreased conflict frequency, improved patient experience and release of staff time for therapeutic activity [11,12].

1.7 Integrate Primary Care and Psychiatry Through PCN-Level Consultant Psychiatrist Leadership

Every Primary Care Network or neighbourhood cluster should have protected consultant psychiatrist time for:

• Structured case discussion with GPs and primary care mental health workers.

• Medication review and optimisation advice.

• Diagnostic clarification for complex presentations.

• Risk formulation and safety planning.

• Shared care protocols for ADHD, bipolar disorder, psychosis and complex depression.

• Supervision of nurses, clinical pharmacists and psychological practitioners.

• Rapid advice to prevent both unnecessary specialist referrals and unsafe non-referrals.

Collaborative care has a strong evidence base for depression and anxiety. Cochrane evidence demonstrates that collaborative care is associated with significant improvement in depression and anxiety outcomes compared with usual care, with effect sizes that are clinically meaningful and sustained at follow-up [13]. The critical implementation lesson is that integration must be structured: shared care plans, scheduled follow-up, Interprofessional communication and specialist psychiatric support with clear lines of clinical accountability.

1.8 Deploy Digital and AI Tools as Regulated Clinical Aids, Not Substitutes for Relational Care

Digital tools should support access, self-management, routine outcome measurement, safety planning, appointment navigation and supervised psychological therapy. They must not become a covert rationing mechanism or a

replacement for relational clinical care delivered by trained professionals.

NICE has conditionally recommended digitally enabled therapies for depression and anxiety disorders, but these technologies deliver CBT-based techniques and require active support from NHS Talking Therapies clinicians [14]. NHS England's digitally enabled therapy criteria similarly describe these tools as therapist-assisted interventions, not autonomous replacements for human care [15]. The governing principle should therefore be: digitally enabled, clinically governed, humanly supervised.

1.9 Treat Suicide Prevention as a Public Health System, Not a Poster Campaign

The national strategy should adopt the WHO LIVE LIFE framework with full operational commitment:

• Limit access to means through population-level interventions.

• Promote responsible media reporting with evidence-based guidelines.

• Foster socio-emotional life skills in young people through structured curriculum delivery.

• Ensure early identification, structured assessment, evidence-based management and assertive follow-up for people affected by suicidal behaviour and self-harm.

• Build real-time suicide and self-harm surveillance linked to clinical services.

• Provide postvention support for families, schools, workplaces and clinical teams.

• Ensure learning from deaths leads to system redesign through structured review processes, not ritualised blame or defensive practice.

WHO identifies these as key evidence-based multisectoral interventions for national suicide prevention, with demonstrated effectiveness across diverse country contexts [16].

2. Educational Prong: Make Mental Health Literacy, Resilience and Early Help Part of National Infrastructure

2.1 Build a Whole-School Mental Health Model, Not a School Counselling Add-On

Schools should not become mini-CAMHS, but they must become mentally healthy institutions with universal and targeted components.

Every school and college should have:

• A whole-school mental health lead with protected time and senior leadership status.

• Mental Health Support Team access with clear clinical supervision arrangements with access to a consultant psychiatrist.

• Anti-bullying, anti-racism and online-harm policies operationally linked to safeguarding systems.

• Curriculum content covering emotion regulation, sleep hygiene, relationships, digital hygiene and substance-use education.

• Rapid referral pathways into neighbourhood mental health centres with defined response times.

• Parent education sessions delivered through evidence-based programmes.

• Staff wellbeing support and clinical supervision structures.

• Clear pathways for neurodivergent pupils and emotionally based school avoidance.

• Early identification and support for eating disorder risk, self-harm, trauma and anxiety disorders.

England already has a Mental Health Support Team programme in schools and colleges.

NHS England reports 714 operational MHSTs as of May 2025, and the government has stated that all pupils should have access to school mental health support by 2029/30 [17,18]. The strategy must ensure this does not become a thin layer of low-intensity provision disconnected from CAMHS, SEND, paediatrics and family support services.

2.2 Create a National Mental Health Literacy Curriculum

From primary school through university, young people should learn:

• The distinction between normal psychological distress and mental illness.

• Recognised categories of mental illness and their prevalence.

• When and how to seek appropriate help.

• How sleep, physical activity, relationships, bullying, trauma, poverty, substance use and online life affect mental health.

• How to support a peer without adopting a therapeutic role.

• How to recognise warning signs of self-harm, psychosis, mania, eating disorder symptoms and suicidal crisis.

• How to navigate the mental health service system.

• How to evaluate and use digital mental health tools safely.

The OECD identifies mental health literacy and stigma reduction as evidence-based interventions deliverable across schools, workplaces and primary care settings, with demonstrated impact on help-seeking behaviour and early intervention [4].

2.3 Build Youth Mental Health Hubs for Ages 11–25

The child/adult service transition boundary remains one of the most consequential design failures of mental health care. Adolescence and early adulthood constitute the developmental period when most mental illnesses emerge, yet services divide people at 18 as though human development respects commissioning boundaries.

Each locality should develop youth mental health hubs for ages 11–25, overseen by a consultant psychiatrist, providing:

• Walk-in access without threshold criteria.

• Evidence-based psychological therapy.

• Family intervention and systemic practice.

• Substance misuse support integrated within the hub.

• Sexual health service links.

• Neurodevelopmental assessment and post-diagnostic support.

• Employment, education and training support.

• Eating disorder screening and early intervention.

• Early psychosis and bipolar disorder pathways.

• Peer support with appropriate training and supervision.

Australia's headspace model is internationally influential because it provides youth-friendly, integrated support for young people aged 12–25 and aims to intervene early by reducing structural and perceptual barriers to access [19]. England should learn from both its demonstrated strengths and documented limitations: soft access must be matched by clinical depth, specialist supervision and clear escalation pathways.

2.4 Train the Public-Sector Workforce in Practical Mental Health Competence

The strategy should create mandatory mental health capability frameworks for:

- Teachers and school staff.
- Social workers.
- Police officers.
- Probation staff.
- Housing officers.
- Jobcentre work coaches.
- Debt advisers.
- University academic and pastoral tutors.
- Ambulance clinicians.
- Prison officers.
- Primary care reception and care navigation teams.
- Human resources and occupational health staff.

This should not be generic "mental health awareness training." It should cover: recognition of common and severe mental health conditions, professional boundaries, escalation protocols, trauma-informed communication, suicide risk first response, neurodiversity, psychosis and mania red flags, and crucially, how not to cause iatrogenic harm.

2.5 Create a National Parent and Family Mental Health Offer

Many conditions reach services at advanced stages because families observe changes but cannot differentiate between normal adolescent development, psychological distress, neurodivergence, substance misuse, trauma responses or emerging mental illness.

The strategy should fund:

- Parent psychoeducation groups for anxiety, self-harm, ADHD/autism, eating disorders and emotionally based school avoidance.
- Family intervention for psychosis and bipolar disorder delivered to evidence-based fidelity standards.
- Carer education programmes embedded in every CMHT and CAMHS service.
- Digital family psychoeducation modules with evidence-based content.
- Carer crisis telephone lines with clinical backup.
- Family-inclusive discharge planning as standard practice.

2.6 Make Workplaces Part of the Mental Health System

Workplaces should function as early detection and supported recovery settings with access to a consultant psychiatrist.

Government should mandate for larger employers and incentivise for smaller employers:

- Trained mental health leads with defined responsibilities.
- Evidence-based sickness absence and return-to-work pathways.
- Rapid occupational health access with mental health competence.
- Anti-bullying and psychological safety standards with audit mechanisms.
- Manager training in mental health supportive practice.
- Reasonable adjustments for mental illness and neurodivergence.

• IPS-style employment support for people with severe mental illness.

• Protection against punitive sickness management processes for people in relapse.

The OECD identifies workplace interventions, including online programmes and CBT-based universal approaches, as part of the evidence-based policy suite for preventing and treating mental ill health, with favourable cost-effectiveness profiles [20].

3. Academic and Research Prong: Turn England Into a Learning Mental Health System

3.1 Create a National Mental Health Learning System

Every service should generate usable learning in real time.

England needs a national mental health data and research architecture, supervised by a professor of psychiatry, linking:

• Primary care mental health data.

• NHS Talking Therapies outcomes.

• CAMHS activity and outcomes.

• CMHT caseloads and interventions.

• Crisis service utilisation.

• Inpatient activity and safety data.

• Ambulance and police mental health contacts.

• Social care records.

• Housing status.

• Employment outcomes.

• Education data.

• Mortality and suicide registry data.

• Patient-reported outcome measures and experience data.

The WHO and OECD both emphasise that mental health reform requires evidence-based interventions, systematic surveillance, rigorous evaluation and implementation capacity [4,5,16]. England should go further and become the first country to operate mental health services as a true learning system: every pathway measured, every unwarranted variation visible, every innovation evaluated against meaningful outcomes.

3.2 Make Outcome Measurement Clinically Meaningful

Routine outcome measurement should not become a bureaucratic compliance exercise.

It should measure what matters to patients and clinicians:

• Symptom change using validated instruments.

• Functional recovery.

• Quality of life.

• School and work participation.

• Housing stability.

• Physical health parameters.

• Medication safety and monitoring.

• Relapse rates.

• Crisis service utilisation.

• Suicide and self-harm incidents.

• Therapeutic alliance.

• Coercion and restraint events.

• Carer experience and burden.

• Equity stratified by ethnicity, deprivation, neurodivergence, gender and geography.

Measurement-based care should be mandatory in major clinical pathways but interpreted clinically through collaborative discussion rather than applied mechanically as a performance management tool.

3.3 Fund Implementation Science, Not Just Discovery Science

The problem in mental health is not merely insufficient knowledge of effective interventions. Often, we know what works and systematically fail to implement it with fidelity, adequate workforce, clinical supervision and service continuity.

The academic prong should fund:

• Implementation trials of neighbourhood mental health centres.

• Comparative effectiveness evaluation of PCN psychiatry integration models.

• Real-world pragmatic trials of digital therapies with attention to therapeutic process.

• AI safety, clinical governance and algorithmic fairness studies.

• Crisis alternatives evaluation with health economic analysis.

• IPS scale-up studies addressing implementation barriers.

• Physical health intervention trials for severe mental illness populations.

• Anti-racism and culturally adapted care research.

• Suicide prevention implementation studies with quasi-experimental designs.

• Longitudinal outcomes for autism/ADHD and mental health pathways.

3.4 Establish National Centres of Excellence for Service Redesign

England should create regional academic-service partnerships with protected research infrastructure in:

• Community psychiatry and recovery-oriented systems.

• Suicide prevention and postvention.

• Youth mental health and developmental psychiatry.

• Digital and AI mental health with clinical governance.

• Severe mental illness and physical health equity.

• Addiction and dual diagnosis.

• Neurodevelopmental mental health across the lifespan.

• Inpatient safety and coercion reduction.

• Psychiatric rehabilitation and social recovery.

• Perinatal and family mental health.

These centres should not function as ivory towers. Their core task should be to produce implementable service models, workforce curricula, fidelity tools, evaluation dashboards and annual national benchmarking reports.

3.5 Commission Independent Annual Public Reporting

The strategy should mandate publication of a yearly State of the Nation Mental Health Report, reporting:

• Waiting times stratified by condition and age group.

• Crisis response times against standards.

• Suicide and self-harm trends with demographic breakdown.

• Inpatient safety indicators.

• Out-of-area placement numbers and durations.

• Severe mental illness physical health and mortality gap data.

• CAMHS access, waiting times and transition outcomes.

• ADHD/autism assessment waiting times and post-diagnostic support availability.

• Equity indicators across all protected characteristics.

• Workforce vacancies, retention rates and caseload data.

• Spend per head by Integrated Care Board.

• Outcomes, not merely activity counts.

This would prevent mental health policy from being governed by anecdote, media outrage cycles and ministerial press releases, replacing these with systematic public accountability.

Cross-Cutting Enabling Reforms

Funding and Commissioning

• Ring-fence mental health funding with transparent per-head local reporting against population need.

• Shift payment systems from activity-based tariffs to outcomes and continuity of care.

• Pool budgets across NHS, local authority, housing, employment, education and justice for high-complexity populations.

• Fund prevention seriously, but not through displacement of severe mental illness investment.

• Terminate the cycle of short-term pilots; fund fewer service models for longer durations and evaluate them with methodological rigour.

Workforce

• Expand psychiatry, mental health nursing, psychotherapy, occupational therapy, social work, and peer-support roles with funded training places.

• Urgently restore consultant psychiatrist leadership in clinical systems with defined authority and accountability.

• Create advanced community psychiatry fellowships with academic and implementation science components.

• Train GPs and PCN teams in shared mental health care through structured educational programmes.

• Build supervision structures for non-specialist staff; task-sharing without clinical supervision is unsafe dilution, not capacity building.

• Make retention a national priority through manageable caseloads, reflective practice, staff safety, career progression pathways and administrative simplification.

Equity

• Implement the Patient and Carer Race Equality Framework with fidelity and accountability mechanisms.

• Measure and publicly report racial disparities in detention, restraint, diagnosis, access and clinical outcomes.

• Provide culturally adapted psychological therapies with evidence of effectiveness.

• Commission dedicated services for refugees, asylum seekers, LGBTQ+ populations, care-experienced people, people in the justice system and people with learning disability or autism.

• Integrate poverty, housing insecurity, debt and domestic abuse into mental health pathways with direct intervention, not passive "signposting."

What Must Be Avoided

• Digital tools deployed as rationing disguised as innovation.

• Awareness campaigns launched without corresponding treatment capacity.

• Hubs established without psychiatrists, clinical governance or escalation pathways.

• Prevention invoked as justification for neglecting severe mental illness.

• "No wrong door" rhetoric maintained while services continue rejecting referrals.

• Fragmented pilots that expire after two years without evaluation or sustainable funding.

• Outcome dashboards measuring contacts rather than clinical recovery.

• Workforce substitution without training, clinical supervision and professional accountability.

The Three Transformative Asks

If the government wants a strategy with structural force, it should commit to three national missions:

1. A Neighbourhood Mental Health Service for every community:

open-access, multidisciplinary, consultant-supported and functionally integrated with primary care, crisis care, housing, employment, addiction services and social care.

2. A Life-Course Prevention and Education Programme:

whole-school mental health, youth hubs, workplace mental health, family education, suicide prevention and public mental health literacy delivered through statutory infrastructure.

3. A National Mental Health Learning System:

routine outcomes measurement, real-time suicide and self-harm surveillance, service benchmarking, implementation science funding and annual independent public accountability.

That combination - clinical seriousness, educational prevention and academic discipline - would give England something more ambitious than another strategy document. It would give the country a mental health operating system capable of continuous improvement, transparent accountability and sustained reduction in preventable suffering.

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About the authors

Dr Naveed Kausar is a Consultant Psychiatrist at Oxleas NHS Foundation Trust.

Prof M Aamer Sarfraz is based at Canterbury Christ Church University, Kent.

The Therapeutic Black Hole: Psychiatry, Autonomy and the Limits of Compulsion for Suicidal Prisoners with Personality Disorder

Simon Gracious

Abstract

The management of prisoners who express persistent suicidal intent yet retain decision-making capacity presents a complex ethical and clinical challenge for forensic psychiatry. This dilemma frequently arises among individuals diagnosed with personality disorders, where chronic psychological suffering and elevated suicide risk coexist with intact cognitive capacity. This paper examines the interaction between clinical evidence, UK mental health law and prison mental-health systems in such cases. It argues that the Mental Capacity Act 2005 and the Mental Health Act 1983 create a structural impasse when capacitous prisoners refuse treatment despite ongoing suicide risk. Drawing on empirical research on prison mental health and human-rights jurisprudence, the paper proposes the concept of a "therapeutic black hole" to describe situations in which severe psychological distress meets legal and systemic limits on psychiatric intervention. A model of managed support is proposed to guide psychiatric practice in these circumstances, emphasising sustained engagement, suicide-prevention strategies and systemic reform rather than coercive treatment.

Introduction

Suicide within custodial settings remains a major public health and ethical concern. Rates of suicide in prisons in England and Wales are substantially higher than those observed in the general population, reflecting the high prevalence of psychiatric morbidity among incarcerated individuals [1,2]. Personality disorders are particularly common within prison populations, with epidemiological studies suggesting that most prisoners meet criteria for at least one personality disorder diagnosis [1,3].

Within forensic psychiatric practice, clinicians occasionally encounter prisoners who express persistent suicidal intent while retaining full decision-making capacity and declining psychiatric intervention. These cases present a profound dilemma. The psychiatrist's professional obligation to prevent suicide appears to conflict with the legal principle that capacitous individuals have the right to refuse medical treatment.

This dilemma is particularly evident in individuals diagnosed with emotionally unstable personality disorder (EUPD), also known as borderline personality disorder. Chronic suicidality and recurrent self-harm are well-recognised features of the condition [4]. However, these behaviours do not necessarily imply impaired decision-making capacity.

Consequently, clinicians may encounter situations in which a prisoner's suffering is severe and suicide risk substantial, yet the legal basis for compulsory psychiatric intervention remains uncertain. This paper examines this tension through three perspectives: clinical evidence regarding suicidality in personality disorder, the interaction between the Mental Capacity Act and the Mental Health Act, and structural limitations within prison mental-health services. It proposes the concept of the therapeutic black hole as a framework for understanding the resulting clinical impasse.

Suicide and Personality Disorder

Personality disorders are strongly associated with suicidal behaviour. Longitudinal studies estimate that approximately 8–10% of individuals with borderline personality disorder die by suicide, while many more engage in repeated self-harm or suicide attempts throughout their lifetime [5,6].

The mechanisms underlying suicidality in personality disorder differ in important respects from those seen in mood disorders or psychotic illness. Rather than arising primarily from episodic mental illness, suicidality in borderline personality disorder is frequently chronic and associated with emotional dysregulation, interpersonal instability and persistent feelings of hopelessness [4].

Importantly, these symptoms do not necessarily impair cognitive decision-making capacity. Individuals with personality disorder may retain the ability to understand relevant information, weigh potential consequences and communicate decisions regarding treatment.

Forensic psychiatry literature has long recognised the challenges involved in managing chronic suicidality in this population. Clinicians may experience strong emotional responses when treating individuals with personality disorder, including anxiety, frustration and therapeutic pessimism [7]. Such dynamics may influence clinical judgement and risk management strategies.

Within prison settings, these clinical difficulties may be amplified by environmental factors such as isolation, restricted autonomy and the psychological impact of long custodial sentences [2].

Legal Frameworks: Capacity and Compulsion

The management of suicidal prisoners who retain decision-making capacity is shaped primarily by two statutes within UK law: the Mental Capacity Act 2005 (MCA) and the Mental Health Act 1983 (MHA).

Mental Capacity Act

The MCA establishes a presumption of capacity and affirms the right of capacitous adults to refuse medical treatment, even where refusal may result in death. This principle has been confirmed in legal decisions, including Re C (Adult: Refusal of Medical Treatment) and Re B (Adult: Refusal of Medical Treatment) [8,9].

Accordingly, if a prisoner retains decision-making capacity and refuses psychiatric treatment, clinicians generally cannot impose treatment solely on the basis that intervention may reduce suicide risk.

Mental Health Act

The Mental Health Act provides a separate framework allowing compulsory detention and treatment for individuals with a mental disorder where necessary for their health or safety or for the protection of others.

Personality disorder qualifies as a mental disorder under the Act. However, legislative amendments emphasise that detention must involve the availability of appropriate medical treatment.

Where a prisoner refuses all interventions and no realistic therapeutic programme exists, the justification for detention may become difficult to sustain. Some commentators have argued that detaining individuals with personality disorder primarily to manage suicide risk risks transforming therapeutic detention into preventive custody [10].

Human Rights and the Duty of Care

Despite respect for autonomy, the state retains obligations to protect prisoners from preventable harm.

Under Article 2 of the European Convention on Human Rights, authorities must take reasonable steps to safeguard life where they know or ought to know of a real and immediate risk. This principle was emphasised in Keenan v United

Kingdom, which examined the suicide of a prisoner with mental illness [11].

Similarly, Kudla v Poland established that prisoners must receive adequate medical and psychiatric care where necessary [12].

However, human-rights jurisprudence does not require authorities to impose treatment on capacitous individuals. Instead, the obligation is to ensure that prisoners are not exposed to conditions that amount to inhuman or degrading treatment and that reasonable steps are taken to mitigate foreseeable risks.

In practice, psychiatrists may therefore remain responsible for monitoring risk and maintaining engagement even where treatment is refused.

Prison Mental Health Systems

The prison environment significantly shapes the management of suicidal prisoners.

Research consistently demonstrates that prisons contain disproportionately high numbers of individuals with mental illness and personality disorder [1]. Suicide remains one of the leading causes of death in custody. In England and Wales, suicide rates among prisoners are several times higher than those observed in the general population [2].

Although prison systems employ structured suicide-prevention procedures such as ACCT (Assessment, Care in Custody and Teamwork), these measures primarily focus on observation and crisis management rather than long-term psychological treatment [13].

Evidence-based therapies for personality disorder, such as dialectical behaviour therapy and mentalisation-based therapy, are not widely available in many custodial settings [14,15].

Consequently, prisoners with chronic suicidality frequently receive monitoring rather than sustained therapeutic intervention.

The Therapeutic Black Hole

The interaction between clinical, legal and institutional factors can produce what may be described as a therapeutic black hole.

This situation arises when four conditions converge:

1. Persistent suicidality
2. Preserved decision-making capacity
3. Absence of a treatable acute mental illness
4. Limited access to effective psychological therapies

When these conditions occur simultaneously, traditional psychiatric interventions become ineffective or legally unavailable. The patient cannot be compelled into treatment, yet clinicians cannot ethically disengage given the ongoing risk of suicide.

The concept therefore describes a structural gap in psychiatric practice where severe distress coexists with limited therapeutic options and legal restrictions on intervention.

Recognising this phenomenon may help clinicians understand the limits of psychiatric intervention and focus on strategies that prioritise safety, engagement and systemic reform.

Managed Support: A Clinical Framework

In such circumstances, the psychiatrist's role may shift from curative treatment toward **managed support**.

This framework emphasises:

Ongoing clinical engagement

Maintaining therapeutic contact even when treatment is declined.

Structured suicide-prevention measures

Regular multidisciplinary review and risk monitoring.

Environmental and social support

Addressing factors such as isolation, inactivity and lack of meaningful engagement.

Advocacy for systemic reform

Improving access to specialist personality-disorder services within prison systems.

This approach recognises the limits of coercive psychiatry while preserving the clinician's duty of care.

Conclusion

Suicidal prisoners with personality disorder who retain decision-making capacity represent one of the most challenging dilemmas in forensic psychiatry. Legal frameworks prioritise autonomy while permitting compulsory treatment only where appropriate therapeutic interventions exist.

When prisoners refuse treatment and effective therapies are unavailable, clinicians may encounter situations in which neither coercion nor traditional therapeutic approaches provide a satisfactory solution.

The concept of the therapeutic black hole highlights the structural nature of this problem. Addressing it will require both careful ethical reflection and greater investment in specialist psychological services within prison mental-health systems.

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About the Author

Dr Simon Gracious is an Acting Consultant Psychiatrist at Oxleas NHS Foundation Trust