Spring Edition, 2022/23

Psychiatry-Trent

The Trent Division eNewsletter

Contents

Dr Sidra Chaudhry and Dr Kris Roberts Co-editors, Psychiatry Trent

Editorial

Dr Sidra Chaudhry

Dr Kris Roberts

Dear Colleagues, Welcome to the Spring 2023 Edition of the Trent Division eNewsletter. As 2023 begins to take shape, we hope the early weeks of the New Year have treated you kindly. We would like to extend our best wishes to all members, both new and continuing, as well as our thanks to all those who contributed to this edition.

Changes are afoot. We extend our hearty congratulations to Dr Shubulade Smith, CBE, for her victory in the recent Royal College Presidential elections. She is a force for change and her intentions to nurture and support Psychiatrists, address the treatment gap and ensure fairness for all feel especially pertinent at the current time.

Junior Doctors have of course, just this week, voted in favour of Industrial Action in an event that will affect us all in the coming months. In record numbers, 98% of votes endorsed strike action (from a turnout 77.49%); an unequivocal mandate. We note the response of the Royal College and echo their sentiment, as we extend our thanks, admiration and respect to all of our Junior Doctor colleagues in the Trent Division for their professionalism and passion whilst delivering high-quality care in a challenging post-Pandemic landscape.

With that in mind, we encourage any of you to recognise good work amongst your colleagues with a nomination to our Trent Hall of Fame. It's a small acknowledgement of some of the good work going on in the Division. It's important that we value each other, and this is a great way of spreading some positivity.

We also continue to encourage submission on any topic about which you are passionate. We are happy to guide anyone wishing to contribute to the newsletter. It's a great way to keep your CV's evolving, with a certificate provided for your portfolio.

We have a fantastic range or articles once more this time around as our contributor's grapple with contemporary issues, reflect on their journeys within Psychiatry, and even offer a moment of reflection with a poem. I hope you enjoy them.

In the Trent Division, the calendar continues to develop – please keep an eye on what promises to be a busy and rewarding conference season. Enjoy this edition - we hope to see you soon at one of our events!

Best wishes, Sidra and Kris

Get Involved!

If you would like to submit an article for inclusion in the next edition, please send it to (Trent@rcpsych.ac.uk).

The division welcomes articles of local interest relating to psychiatry. We encourage trainees to get involved as well as patients and carers.

Submissions could be along the following lines:

Interest articles
Are you personally involved in any local work that you would like to increase awareness of? Is there a topic in mental health which you find interesting and would like to share with your colleagues? Do you have a personal experience within psychiatry you'd like to share?

Event articles
Would you like to share a review/feedback from a conference or other mental health related event that you've attended?

Opinion pieces/blog articles
Are there any issues in mental health that you are passionate about and wish to discuss with a wider audience?

Cultural contributions
This could be in the form of artwork, photography, poetry or an article relating to your insights, interpretations and observations of relevant popular culture, the arts and theatre.

Research/audits
Have you been involved in any innovative and noteworthy projects that you'd like to share with a wider audience?

Patient and carer reflections
This should be a few paragraphs detailing a patient or carer's journey - you may have a patient whose story you would encourage to share; or it could be a case study including a patient's perspective. Confidentiality and Data Protection would need to be upheld.

Instruction to Authors
Please consider your articles to be as precise as possible. As a guideline, articles on interesting topics, research/audits, good practice and opinion pieces may be up to 1000-word limit which may include up to around 5 essential references. Articles on events or conferences should be within 500 words. Please follow Instructions for Authors of BJPsych for reference style. Authors must obtain written permission from the original publisher if they intend to use tables or figures from other sources, and due acknowledgement should be made in the legend.

Authors are expected to be aware of and comply with best practice in publication ethics. Please declare any conflict of interest related to the article.

Disclaimer:

The opinions expressed in this newsletter are those of individual authors and do not necessarily represent the views of the Royal College of Psychiatrists

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Chair's Column by Dr Shahid Latif

Dr Shahid Latif
Trent Division Chair

Welcome to the spring newsletter of our Division.

We are keen to hear from our members please email us at Trent@rcpsych.ac.uk with your suggestions for future events, topics and how we can get more members involved in our divisional activities.

I encourage you to use our Twitter account @rcpsychTrent to communicate with your peers, share best practices and raise the profile of psychiatry in the Trent region, currently with 1079 members.

Thank you to our joint e-newsletter editors, Dr Kris Roberts and Dr Sidra Chaudhry for their input and for putting together this edition in partnership with our members and the division staff, Marie Phelps and Zsuzsanna Csombordi.

Events

The College has now moved to a hybrid approach to events with some events being held face to face and some taking place virtually. During 2022 the division has held a number of virtual events and we are hoping to hold the 2023 winter conference face to face.

The division has held the following events since our spring edition:

Trent Medical Student and Trainee Event – 13 July 2022 – arranged by our Psychiatric Trainee Committee Representatives, Dr Deepa Krishnan, Dr Emma McPhail and Dr Kris Roberts. This was a popular event with over 200 delegates registering and we received lots of positive feedback. The event is available to view on our website: Trent Medical Student and Trainee Webinars (rcpsych.ac.uk)

Careers Fair – Leicester Grammar School – 27 September 2022 – attended by 3 committee members, Dr Shahid Latif, Dr Nisha Balan and Amala Jesu and a local member, Dr Deepak Sirur. The event went very well and there was lots of interest from students and their parents. This is an area that the committee is looking into as we're keen to engage with students early in their studies and increase the awareness of psychiatry as a career path.

The Endocannabinoid System Mental Health Webinar – 21 October 2022 – arranged by Dr Niraj Singh, Sustainability Champion Committee Member. The online event was attended by 57 members. A range of topics were covered including medical cannabis education, prescribing medical cannabis and project twenty21 drug science.

Trent Division Winter Conference - 4 November 2022 – arranged by Dr Santosh Mudholkar, CPD lead, who put together an engaging programme. We decided to hold the event online and we were joined by 40 members. The topics covered were; homicide inquiries - past, present and future, talks around coroners inquests, public health strategy and RCPsych, impact of suicide on clinicians, Deans update, menopause and mental health and the climate crisis and mental health.

Mental Health Act Section 12 and Approved Clinician Courses

Bookings are open to book your place please visit our website.

Chair's Column continued by Dr Shahid Latif

Executive Committee
We currently have a number of opportunities for members to join our Executive Committee. It's a fantastic opportunity to build on the work of the College, to help support fellow colleagues and to network.

Vacancies
There are currently the following vacancies within the Trent Division Executive Committee:

Regional Advisor for Leicestershire, Northamptonshire and Rutland

General Adult Regional Representative x2

Eating Disorders Regional Representative

Neuropsychiatry Regional Representative

Old Age Psychiatry Regional Representative

Find out more about our Regional Advisors and Specialty Representatives roles, including full job descriptions (PDF). Further information is available on the College website.

Please email trent@rcpsych.ac.uk for further information.

Job Description Approval Process: the division hosts an electronic job description approval process and during 2022 we received and reviewed 35 job descriptions from Trusts within the Trent region.

The Trent Regional Specialty Representatives and Regional Advisors review and grant final approval to local Trust job descriptions. This is important work as it helps to quality assure the job descriptions, ensuring the psychiatrists and specialty doctors roles are manageable and result in the best outcomes for service users.

Find out more about the process via our website: Job description approval process | Royal College of Psychiatrists (rcpsych.ac.uk)

Hall of Fame Nominations

We are proud to announce the winter 2022/23 nominees in the Trent region.

Purpose

The aim of the nominations are to recognise and appreciate medical students, doctors of all training grades (foundation, core trainees, higher trainees, SAS doctors, consultants and physician associates), managers, nurses, social workers and support workers (or even teams, if not individuals) for their contribution towards psychiatry in the region. This would in turn help us tell people that they are valued and appreciated for the work they do.

Nominations

James Parker, psychiatric nurse and current clinical lead for the Nottinghamshire Eating Disorders Service (NEDS)

"James is the longest serving member of NEDS. He is the calm contained foundation of our team and who we turn to for advice and support. He's a true professional and one of the few clinicians I know who has used the treatments we offer, such as ACT to better himself. He does not just tell people what they need to do; he does it himself. He's the real deal."

Dr Sudheer Lankappa FRCPsych
Consultant Psychiatrist Nottinghamshire Healthcare NHS Foundation Trust
and Honorary Clinical Associate Professor, University of Nottingham, School of Medicine

"Many psychiatrists recognise Dr Lankappa within Trent region, either having trained or worked with him. After completing SHO and SpR training in Sheffield (Trent Psychiatry Rotation) he moved to Nottingham in 2009 as consultant. A very popular trainer, mentor, clinical academic and an excellent clinician, well-liked by patients and carers. Has established excellent network in the region supporting many clinicians with professional difficulties. As such a very approachable person which attracts individuals to reach out to him for advice.

His portfolio of achievements is extensive. As a trainee he was awarded Professor Erwin Stengel Memorial Prize in 2008. The following year, he received BIPA Trainee Research Prize. In 2015 he was awarded RCPsych Psychiatric Team of the Year for outstanding contribution to sustainability on 'Reducing Pharmaceutical Waste to Improve Sustainability in Mental Healthcare.' Within his Trust, he received Unsung Hero for Outstanding Service Contribution and Recognition Award (OSCAR). Under his supervision, trainees have won numerous prizes at national, regional and local conferences for audit and quality improvement projects." *Dr Rahul Gandhi*

Sharon McGinty, Community Psychiatry Nurse

"Sharon works for the Early intervention in Psychosis services at Bassetlaw Mental Health Services. She has excellent knowledge of presentations of first episode psychosis and outlines of management. She has an amazing blend of assertiveness and softness in her manner which helps building a brilliant rapport with patients. She often goes above and beyond her duties , though remaining in professional boundaries to help patients. I am aware of times when she has guided a elderly patient who was lost in the hospital back to A&E so she could get back home, driving a patient to pharmacy to enable him to collect his medications and driving to a patient's daughters address to ensure that the patient is safe at her new address. She is always mindful about the overall safety and recovery of the patients. She has often helped out with other teams when they have struggled with staff numbers and hence patient safety was a risk. " *Dr Anu Priya*

Working with the Armed Forces Community—A Quality Improvement Initiative by Dr Rebecca Bennett

Dr Rebecca Bennett BMBS Meng (Hons), Psychiatry Core Trainee and Military Veteran (REME)

Gemma Saunders BSc (Hons), Armed Forces Network Lead and Cognitive Behavioural Therapist for IAPT

Potentially up to 60% of military personnel who experience mental health problems do not seek help[1]. Many reasons for this have been hypothesized including stigma, practical issues with seeking care, a culture of resilience and feeling treatments are ineffective. This combined with the impact mental ill—health can have on a service person's career (e.g. being medical downgraded and deemed unfit to carry a live weapon if they are prescribed medication or enter into therapy), can act as a further barrier to help—seeking. This may mean that mental health disorders are in fact more prevalent than reported.

There are an estimated 5 million veterans in the UK, and a further 20,000 personnel leave the forces each year. Veterans' mental health problems may be exacerbated by post-service factors, such as the difficulty in making the transition to civilian life, marital problems, and a loss of social support networks. Younger veterans are at high risk of suicide n the first two years after leaving service. Ex-service personnel are also vulnerable to social exclusion and homelessness, both of which are risk factors for mental ill health[2].

Within the catchment area of Derbyshire Healthcare NHS Foundation Trusts (DHCFT), we have approximately 125,000 veteran and family members[3]. Serving personnel continue to be managed by the Army Medical Services, however veterans with mental health issues are managed via civilian GPs, who may refer to secondary services for additional support or recommend self-referral to talking therapies (IAPT). As a Trust we have developed several initiatives to improve the identification, signposting and support available for such personnel. We hope that by building alliances with external organizations, our understanding and enhancement of the patient pathway will further improve care for veterans and their families as well as making DHCFT a lead employer of ex-military staff in the region.

Improvements

The primary focus for the development of our veterans' services was the growth of our Armed Forces Staff Network. Following the appointment of a new network chair, the involvement of an executive lead with personal military links and expansion to include representation from local veteran organizations, we have been able to forge a thriving community who have been able to enact real change. We have developed good links with the NHS Military Transition,

Information and Liaison Service (now Op Courage) and a member of the team attends our meetings. As a result, we can seek additional advice easily and quickly if required. Additionally, we have also developed a good network of support organizations including Project Nova, Stand To (a Derbyshire Veterans' Hub) and links to other Trusts (including UHDB, DCHS, Leicester and Sussex and Medway) where our knowledge and ideas can be shared.

We have attempted to make the work of the Armed forces Network more recognizable. As a result, members have the option to wear "Armed Forces Community" lanyards and can use our accreditation logos in their email signatures. Additionally, there are posters, leaflets and signs distributed around our two main Trust sites in Derby.

Working with the Armed Forces Community—A Quality Improvement Initiative continued by Dr Rebecca Bennett

We also advertise events via email, Trust intranet and social media. These efforts helped to promote the work of the network as well as encourage discussion of veteran issues.

We have hosted our own service of remembrance for the Falklands 40th Anniversary, marked Armed Forces Week with gifts for all network members and stood with Trust and our Network leads and allies in reflecting on the Ukraine conflict in a tree-planning ceremony.

For Armistice this year, our armed forces community members will represent our network across the county which includes our Network Chair speaking to the Fire Service about moral injury and presenting a wreath at their parade. We hold regular 'tea and chat' events where veteran staff members can get together and discuss pertinent topics (similar in style to the British Legion Breakfast Clubs) as well as a bi-monthly staff forum to discuss policy and veterans' issues. This calendar of events aims to be a focus for staff members to unite and reflects as well as offering positive support to all.

To improve the general understanding of veteran specific issues, we present in the Trust Academic meeting to over 100 doctors of various grades, about how to signpost veterans for additional support. We will also be including a military mental health presentation as part of the Trust induction to ensure all new staff starting at the Trust have a better understanding of the needs of our Armed Forces Community. Further training has been provided by Sussex and Medway NHS foundation Trust, several of our network members are Service Champions, giving those that have completed the course a greater understanding of military issues and how help can be provided.

We have worked hard to develop collaborations with the local Reserve Units, cadets and local military charities.

The Trust sponsored the recent charity bike ride of the Reserve Unit, 103Bn REME. We also presented on a drill night about how to identify common mental health conditions, basic self-help tips and where to go for more support. We aim to include them in the activities that we organize, to further improve wellbeing and strengthen working relationships. Our Trust policies reflect our support of Reserve personnel and military families with regards to leave, and we are committed to working closely with the CTP and Step Into Health, to actively employ service leavers. We have worked hard to gain awards and accreditation from Veterans Services.

We have also now been classified as a 'Veteran Aware' Trust due to the work we have done in raising awareness of veteran's issues and we have been awarded our silver award status accreditation from the Employee Award Scheme which recognises the support we offer for staff and patients with military links.

Key points

[1] Collaborate and communicate with local veterans' organizations and NHS services
[2] Apply for accreditation as this will guide you as to how you can improve
[3] Forge relationships with local Reserve Units
[4] Encourage staff with military links your Armed Forces Network
[5] Promote your work through posters, email, websites and social media

Working with the Armed Forces Community—A Quality Improvement Initiative continued by Dr Rebecca Bennett

Summary

We have worked hard over the past six month to improve the Armed Forces Network to develop relationships, improve knowledge and enhance the patient pathway. This has been reflected in the awards and accreditations we have achieved as a Trust. Furthermore, a survey was conducted in 2021 which showed that over 92% of respondents had not heard of the Veterans Service 'Op Courage' and 73% did not know who to ask in the Trust if they had specific questions. We sent out a similar survey in 2022 which showed 100% of respondents felt more confident in understanding the needs of veterans and 92% felt they now knew who to ask if they had questions regarding veteran specific issues or where to go to find out more information, a significant improvement.

Although we have made great gains, like our counterparts in the rest of the UK, we strive to do more. Our staff are passionate about what they do in their roles and the care they provide to our armed forces community. We hope these efforts will serve as a foundation for the future growth of the network and the Trusts support of current and ex-military personnel.

References

[1] Stigma as a Barrier to Seeking Health Care Among Military Personnel With Mental Health Problems, Marie-Louise Sharp, Nicola T. Fear, Roberto J. Rona, Simon Wessely, Neil Greenberg, Norman Jones, Laura Goodwin Epidemiologic Reviews, Volume 37, Issue 1, 2015, Pages 144-162

[2] Fear NT, Jones M, Murphy D et al (2010). What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. The Lancet (2010) 375 (9728): 178-1797

[3] STAND TO Report on Veterans and the Criminal Justice System—Derbyshire Feasibility Study 2020-21 (online) Accessed at: https://daas.uk.com/uploads/1/2/2/0/122012279/veteran_cj_feasibility_report_2021-converted.pdf

Photos

Figure [1] Members of 103 Bn REME at the Falklands 40 Remembrance service—14 June 2022, Kingsway Hospital

Figure [2] Some of our Armed forces Community members and guests at the Falklands Remembrance Service, 14 June 2022

Figure [3] Representing the Armed Forces Community Staff Network at the Tree Planting Ceremony at Kingsway Hospital

Figure [4] A member of the Network enjoying his branded mug

Behind locked doors: A reflection on forensic psychiatry from a medical student by Jessica Rae, 4th year Medical Student

Behind locked doors are faces, real people with real stories, smiling and saying “morning”, comparing favourite football teams, watching Harry Potter movies and singing Christmas carols. Yet, they are behind barred windows and doors with multiple locks, CCTV cameras scanning every inch of the place due to the nature of their crimes and in order to keep themselves and the public safe.

The media loves to portray only what will be a gripping story of ‘monstrous killers’ and those ‘notorious’ for their offences, feeding the public with carefully chosen, emotive, words until those behind locked doors are no longer viewed as humane. It fails to highlight the traumatic histories and the stories of hope and recovery from mental illness. As a medical student it has been challenging to grapple both with the serious crimes these people have committed whilst at the same time feeling compassion towards their mental health challenges and past traumas. How does one reconcile these two elements?

The high security nature of these prisons and some psychiatric hospitals creates some barriers for the public to understand what goes on inside. This can build up many stereotypes, preconceived ideas and stigma surrounding forensic psychiatry. My own personal experience before commencing a forensic psychiatry placement was that of fear of the unknown accompanied with interest surrounding what the role of healthcare professionals is within these walls. My knowledge was limited to what I had seen on films and in the media along with stories from other medical students. Spending time with doctors, social workers and nurses visiting prisoners or patients on their wings was enlightening. Fascinating in the sense that we could go in and have a chat with these people, hear how difficult it had been for them to sleep, how they felt they were being bullied by other inmates and also hear about their hopes and plans for life outside of prison or the hospital, similar to conversations with patients in a general hospital bed, and yet with the disturbing knowledge that they had murdered, sexually assaulted, or committed arson. One’s moral compass goes into overdrive trying to resolve all this information.

When looking at the pillars of ethics and the duty of doctors to ensure fairness between all patients, to do good and not harm, we are called not to judge but to treat them as a person to the best of our ability with their best interests at heart. It intrigues me to see how forensic psychiatrists have abundant compassion to help those who have committed what the public domain deems ‘unforgiveable’ crimes and help them along the road of recovery whilst the rest of the world seems to shout that all they deserve is to be locked up and the key thrown away. This seems to be the beauty of psychiatry, the flexibility of not a one size fits all model but a journey with each patient to understand their personhood and work towards building up skills and addressing difficulties alongside medication to help patients improve their mental health and their lives holistically.

What I have seen in my psychiatry placement is the mentality of not giving up on people, caring for them in a way that takes satisfaction in the small victories and can see the slow progress as progress and not failure. It was amazing to talk to some people within Rampton hospital who had been admitted there for many years and yet were doing Maths degrees and running marathons. I will take this further into my career to not give up on any patient, to see their whole personhood and have empathy for those I care for. I think forensic psychiatry placements for medical students are immensely beneficial and crucial for reflection and improvement of future practice, both within a general and mental health setting. It would be helpful to see more opportunities for medical students to gain a deeper understanding of what goes on behind these locked doors and hidden faces.

A medical student's perspective on psychiatry by Alisha Krishan

Psychiatry is to a medical student as marmite is to a toast muncher. Before doing a placement in it, I had so many preconceptions, whether that be from films such as the green mile or shutter island, or from personal experience and witnessing family and friends go through difficult times. It was incredibly daunting for the majority of us, due to the complete lack of experience and discussion around psychiatry compared to other specialties. Being introduced, within the space of an hour on a dreary teams call, to psychiatric history taking, mental state examinations and taking a full risk assessment was like alien speak! Then being told I was placed on the high dependency ward, alone, for the 6 weeks was yet another hurdle. Nevertheless, unlike some of my colleagues, I was very excited for this new venture. It was interesting to see how everyone reacted differently; some thought it was even more important than some aspects of physical health, others thought they were intrinsically linked, and unfortunately, some did not see its total relevance and struggled as they could not 'see' the illness.

As a student, I felt very shielded from the severities of mental health. There is constant discussion of myocardial infarctions, bowel obstructions, sepsis, and the correct pathways to go about this, whether that is a full A-E assessment, checking someone's airways, heart, abdomen etc. However, I felt there was a level of tiptoeing around psychiatry or just avoidance due to possibly the difficulty and stigma that is present. It was tough to have gone from this to a full-time placement in it. I really appreciated this though, because not only did we have great members of the MDT teaching us, we also had 'expert patients' who were essentially patients who have gained good control of their conditions either through medication or therapies (or both) and were happy to teach medical students from experience. This provided such a good, safe place to practice some of the more sensitive and challenging aspects of psychiatry such as risk assessing in my case, or even getting a detailed personal history. It was the small things that you don't tend to think about such as the language you use, and creating the fine balance between being caring and getting the correct facts, without being patronising or seeming as though you don't care and are ruthless.

Another common misconception within students was that in psychiatry it is hard sometimes to see fast improvement in a patient. If you do, it is a break-through and are few and far between. I don't know where this idea stems from exactly, but I definitely went into it with this in the back of my mind. A particular patient that had a lasting impact on me, let's call her 'Aarti', was one I met on the very first day. She was catatonic due to a severe episode of depression, and subsequently was not eating, drinking, talking and barely moving. The staff on the ward were unaware as to why this had occurred, as she arrived like this, so the focus was on just getting her out of the catatonic state, then focussing later on what happened and how to prevent relapse. Throughout my time on the unit, I saw the compassion from staff towards Aarti, and how even still the strong rapport that was created. I also had the opportunity to go to one of her ECT sessions (which again destroyed many of my prior preconceptions, with it being extremely controlled and calm, with great before and aftercare). On my very last day on the psychiatry rotation, I sat in with Aarti and her mother in a discussion about discharging her home. Not only was she eating, drinking, talking, walking and giggling with her mum, she was full of personality and zest. Her mother was overjoyed at the situation and I was in pure shock. I am not saying every case goes this way and each person has their own journey with mental health, it was more an example for me to understand that people can be treated and there can be progress in shorter spaces of time than some can imagine.

As I and a few others had an interest in the speciality, we were lucky enough to gain varying opportunities, with some of us going out into community on home visits, some spent time on the mother and baby units, and some went onto CAMHS.

A medical student's perspective on psychiatry continued by Alisha Krishan

I have an interest in forensic psychiatry, so got to spend a day in a Category C men's prison and young offender's institute. Since doing this, I am also in the middle of a placement at a high security psychiatric hospital. Both of these have been incredibly insightful and I overall just feel lucky to have had the opportunity to have spent a prolonged period in the mental health services. It is a unique place and I think not enough people have an awareness of the work that is done, in the same ways as other parts of the health service. Of course, there are issues with it and lack of funding and perhaps some organisational and systemic issues, but overall I am proud of the care I have seen, and am looking forward to one day hopefully contributing to it in some shape or form.

See me. Hear me. A poem by Dr Natasha Harris

See what I see,
See my sorrow.
Close your eyes-
So I can open mine
And show you.

In the corners of my thoughts,
Shadows are a 'dancing:
Burning through my eyes and ears,
Whispering and glancing.

Hear what I hear,
Half my burden.
But your ears are closed now-
Have they always been so?

You may not quite understand,
Some may never understand
Others laugh and jeer.
But the shadows dance away-
Frivolous and jeering.

Film/ movie review by Dr Murat Ince

Lars and the Real Girl

Release date: 12 October 2007 (USA) Director: Craig Gillespie
Review scores: IMDb: 7.3/10, Rotten Tomatoes: 81%
Cast: Ryan Gosling, Emily Mortimer, Paul Schneider, Patricia Clarkson (as the doctor)
This review contains some minor spoilers but not enough I hope to affect enjoyment. If you wish to read no further, just add the movie to your list of arty movies involving mental illness worth watching as a group.

Lars lives in a small town and he is lonely. He lives in the converted garage of his brother's home, which is the former family home where they grew up. There is a past family tragedy that casts some light on this state of affairs. Lars goes to work. He comes home. He says practically nothing. He spends no money. He repeats the same day over and over. He has no love life. His social life consists of excruciating office banter or equally discomfiting diners with his brother and sister-in-law.

One day, Lars orders a sex doll over the internet. Not just any doll: this one costs thousands of dollars. The film is about what happens next. From this set up you might be expecting humour, lewdness and adventure. What you get is a deeply melancholic tragedy which nevertheless is uplifting and inspiring. This is not to say that the comedic elements inherent to the set up are entirely ignored. They remain subtly, but importantly, in the background and add to the overall flavour of this complex and nourishing piece of film.

The film is, in part at least, about the nature of delusion and community. It carries its philosophy lightly and there's no preaching or anything, though there is much that could be interpreted about why Lars goes through this process. Especially about loss, repetition and closure. It is a slow burner and not the sort of movie I'd normally bother with; I prefer stuff that is not work related. Or slow paced. But I thought this movie was well worth the time. It has stayed with me for the past few years. Not in a traumatising way. More as something with a soul.

If you are going to compile a list of movies and films that psychiatrists will find relevant, thought provoking and even enjoyable this would be a great addition. Ryan Goslings style of acting is well cast here, showing his depth if not much range; his muted method is well fitted to this role.

A final gem which I find myself returning to often is the performance of the town doctor. I think she managed to embody the tact, containment and compassion which for me are core traits of good psychiatrists. This in itself is worth noting, if only for the acting/filmmaking ability on display. The actress did a lot with practically no lines. Rather like Lars. The narrative itself, the pacing, as well as the choices of shots and music mean that with this movie less is more. Perhaps there is a lesson here for newly minted psychiatrists like me, trying to develop the art of masterful inactivity.

The implications of advanced dementia on the management of physical pathologies: a reflection on communication and vulnerability in a high dependency setting by Dr Joshua Ramalingam

'The single biggest problem in communication is the illusion that it has taken place.' – George Bernard Shaw

As doctors and medical professionals, the importance of clear communication in providing optimal patient care is no novel sentiment. From our first days as medical students we are subjected to interdisciplinary workshops, practical feedback sessions and essay assignments whereby we dissect the very meaning of the word 'communication' into its constituent components with the intention of best understanding it.

This focus on clear channels of thought and the efficient sharing of knowledge is by no means misplaced. Of all the myriad subspecialties under the umbrella of medicine, psychiatry has the capacity to challenge our ability to communicate with patients like no other, testing those skills that we have worked so hard to hone throughout our training and into our professional careers. Breakdown in communication can have implications that resonate beyond the realms of psychiatry and into the world of physical health.
I wish to share with you an experience that exemplifies just this, while highlighting the vulnerability of those patients suffering from certain psychiatric disorders.

I am a Foundation Year 2 doctor with an interest in psychiatry currently working an anaesthetics rotation on a Step Down Unit. This unit serves as a stepping stone between surgical theatres and the wards for those patients who have additional monitoring requirements post-operatively. We also receive a number of patients from the intensive care unit as part of their journey back to normality.

At handover one evening prior to the commencement of a night shift, the day team highlighted one patient in particular to me. This was an elderly lady with advanced Lewy Body dementia who had been admitted to the ward several days previously for an operation to relieve an obstructed, infected kidney stone.

I had interacted with this lady on multiple occasions prior to the evening in question, and while unable to verbally converse with others in any meaningful capacity on account of her advanced dementia, she appeared docile and gentle in her temperament. As a team we had been both shocked and horrified by the result of a CT scan performed days previously, which had shown a significant fracture to her hip as an incidental finding. On further investigation there appeared to be no evidence of this injury on record, raising clear safeguarding concerns. I was starkly reminded of the vulnerability of this poor women who, owing to her psychiatric condition, was unable to protect herself from harm, or even to properly communicate her suffering.

On the night in question, I was made aware of this lady at handover as she was experiencing an episode of hypotension. She had been reviewed by the day team several hours earlier who had assessed her and commenced a vasopressor to improve her blood pressure. The cause of this hypotensive episode had been investigated and was believed to be sepsis driven. It was only several hours later that blood tests indicated that substantial blood loss had occurred. It then transpired, on discussion with those assisting with her personal care that this patient had experienced an episode of melaena hours previously. Had we known this information sooner, it would have potentially expedited the process of correctly identifying this to be an occult upper gastrointestinal bleed.

Ultimately it was decided that this lady would not be suitable for the endoscopic intervention required to treat the underlying bleed and so her further care was administered in accordance with the end of life pathway. While this outcome was likely to have been inevitable given the event of such a bleed in this frail patient with multiple comorbidities, this experience illustrated to me the significance of the role communication plays in the delivery of care. In this scenario, my own clinical reasoning was informed by the dialogue and working diagnosis communicated at handover.

The implications of advanced dementia on the management of physical pathologies: a reflection on communication and vulnerability in a high dependency setting continued by Dr Joshua Ramalingam

The potential for greater efficiency with regards to the exchange of pertinent information between professionals responsible for different elements of patient care was also a point to consider. However, crucially, the patient's own inability to convey her thoughts, feelings and symptoms obscured what would otherwise have been a more transparent diagnosis.

My experiences on the Step Down Unit have therefore lent me some perspective on the implications of communication on patient care. I recognise there are levels to communication, and while I appreciate extended lucid conversation to be an unrealistic aim in such patients, I am left contemplating whether more information could have been elucidated from more fundamental means of communication such as body language by an eye more astute than my own. This experience serves to illustrate the profound barriers presented to communication by certain psychiatric disorders and the potential detriment that can be posed to patient health as a result, while giving an insight into the extreme vulnerability experienced by those suffering from such illnesses. On a personal level, I found this to be a humbling experience, the lessons gleaned from which I hope to carry with me and apply during my future career in psychiatry.

Mental Health Apps: a review of studies conducted in the UK by Dr Madhvi Belgamwar, Dr Divyanish Divyanish, Dr Sasha Bhatty and Dr Irangani Mudiyanselage

INTRODUCTION

With advancing technology, there are many online resources available for people with mental health problems. Smartphone software applications (apps) are an emerging resource for mental health conditions that take note of symptoms such as appetite, sleep patterns and weight. The majority of the UK population use mobile phones and are aware of the simple technology of downloading and navigating apps effectively (1).

AIMS

This study aims to appraise the literature available only in the UK and lists individual Mental Health Apps mainly for disorders such as Depression, Anxiety, ADHD, Autism and Dementia for patients, carers and clinicians for either assessment or treatment.

METHODOLOGY

We searched the databases Cinahl, Medline, PsycInfo, Embase, Pubmed, Google Scholar, Cochrane and Nice guidelines in September 2021, using the following search terms: Mobile applications for anxiety disorder, depressive disorder, Autistic disorder, Asperger's syndrome, Attention deficit hyperactive disorder and Dementia. The search was not limited by publication date or by article type. A total of 515 articles were identified.
After manually removing 157 duplicate articles, a total of 358 studies remained, the abstracts for these 358 study articles were screened. Study articles including systematic reviews conducted outside the UK and not based on the UK population were excluded, leaving 42 remaining records. A total of 8 studies were deemed eligible and were included for the final evaluation.

Exclusion criteria:

1. Studies conducted outside the UK and patients/ participants enrolled from outside the UK

2. Studies involving multiple apps and non apps technology.

3. Duplicate studies studying the same app

4. Other disorders as per International Classification of Diseases (ICD- 11) criteria and personality disorders

5. Apps not targeting assessment or treatment.

6. Apps used for population below the age of 18 / all apps used for CAMHS were excluded.

Inclusion criteria:

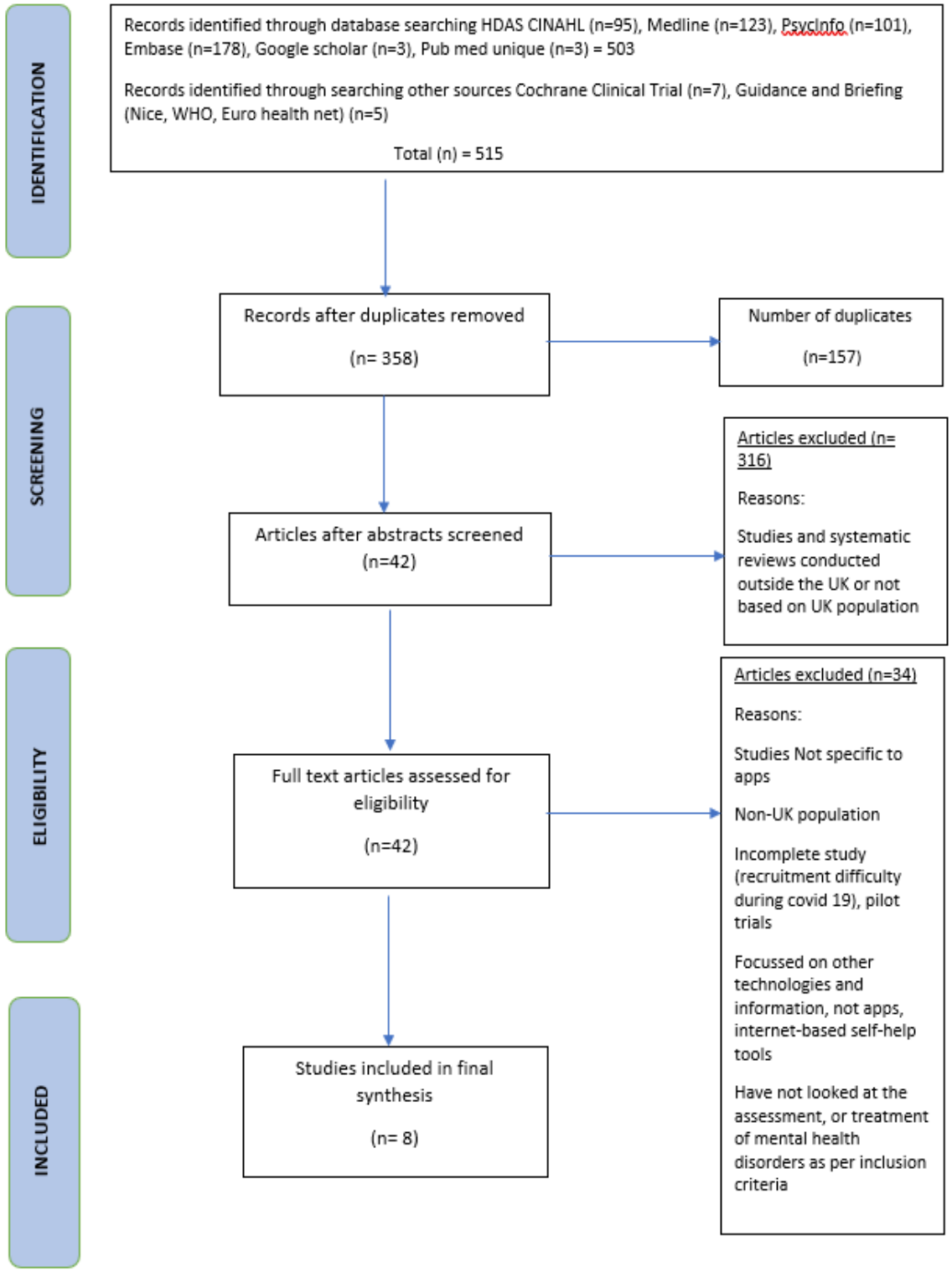
1. Mobile apps for assessment including research and treatment of mental health disorders- anxiety disorder, depressive disorder, Autistic disorder, Attention deficit hyperactive disorder and Dementia in the UK.

2. Studies conducted on apps available in the UK for the above-mentioned disorders

3. Articles available in the English language

4. Population of 18 years of age and above and all genders

Mental Health Apps: a review of studies conducted in the UK continued by Dr Madhvi Belgamwar, Dr Divyanish Divyanish, Dr Sasha Bhatty and Dr Irangani Mudiyanselage



Mental Health Apps: a review of studies conducted in the UK continued by Dr Madhvi Belgamwar, Dr Divyanish Divyanish, Dr Sasha Bhatty and Dr Irangani Mudiyanselage

RESULTS

Authors	Type of Study	Name of App	Salient Features of App
Cunningham et al. (2)	Cohort study	Memory tracks	• Caregiver support app linking memorable songs to care tasks • Helps trigger memory, manage agitation and assist with care and daily routines • Can be used by caregivers • Available to download from IOS and Google Play
Doherty et al (3)	Protocol	BrightSelf	• Screen's psychological well-being during pregnancy • Need to be part of research study for use • Aims to support maternal health and well-being and depression during pregnancy
Strauss et al (4)	Uncontrolled study	Headspace	• App used for easy access to mindfulness sessions • Widely used for stress, anxiety, sleep and mindfulness • Contains audiobooks • Available on both IOS and Android for a fee
Lancaster et al (5)	Observational Study	Mezurio	• Allows for interactive and scientifically valuable measurement tasks • Enables exact monitoring, disease progression and therapeutic response • Need to be part of research study for use
Critten et al (6)	Case Study	Our Story	• Aims to stimulate and share LTM memories of people with mild/moderate dementia • Needs quiet space and assistance for older adults to use app • Available to download for free on IOS
Carl et al (7)	RCT	Daylight	• Aims to provide bite sized interactive smartphone sessions including online CBT • Available to download for free on IOS and Google Play
Velayudhan et al (8)	Poster presentation	YOD	• Provides information and support for YOD patients and carers • Signposts to services and organisations locally, regionally and nationally • Available to download on IOS and Google Play
Shafran et al (9)	RCT	Moodmate	• Allows for monitoring of mood including online workouts and self-care skills teaching • Aims to encourage individuals becoming low/anxious, to actively seek treatment

Mental Health Apps: a review of studies conducted in the UK continued by Dr Madhvi Belgamwar, Dr Divyanish Divyanish, Dr Sasha Bhatty and Dr Irangani Mudiyanselage

DISCUSSION

Previous research indicates that most people with common mental health disorders do not seek treatment, and those that do, often wait a long time before doing so (10). Delaying treatment can lead to negative consequences for those with anxiety and depression (11), therefore simple interventions to reduce the time it takes for people who are symptom monitoring and treatment seeking to receive treatment are of potential value.

The incidence of depression and anxiety has soared in the pandemic—by more than 25% globally in 2020, according to the *Lancet*. That, combined with more people using online services, has led to a boom in mental-health apps (12). Additionally, as per the Cybercrew statistics, 87% of the UK population owned a smartphone in 2020 (1).

This study therefore aims to narrow down and look at the apps only studied for the UK population and ones that are available to download/ being used at the time of this study in the UK. In fact, we found apps that are currently being used by some of the NHS mental health Trusts, thus allowing it to be available for NHS patients.

Digital mental health programmes in general offer the ability to respond quickly and efficiently and can reach people over great distances with minimal mobility requirements, thus, guided by a rigorous evidence-based approach, digital health solutions might be the "killer app" to help combat the behavioural and psychosocial difficulties (13). For the NHS population where there is a waiting list, the apps may offer a solution.

NHS England currently provides free access to a number of wellbeing apps to support the mental health and wellbeing of NHS staff. These are Stayalive (suicide prevention), Bright sky (abusive relationships), Worklife Central (for carers, families and wellbeing), Headspace (for stress and sleep), Unmind (mental wellbeing) and Zero Suicide Alliance (free online learning sessions) (14).

STRENGTHS

All apps listed are relevant for the UK population and are already in use by many mental health NHS trusts, which suggests safety of apps.

Furthermore, out of all studies chosen, there is no conflict of interest whatsoever for all authors.

In addition, the apps could be used as a mode of assessment or treatment, whilst waiting for treatment especially with long waiting lists.

LIMTATIONS

We are aware that the apps included here may not be suitable for the population outside the UK and some are used only for research purposes and therefore not available to download for assessment or treatment purposes.

Additionally, there may be problems with inconsistent privacy practices, as shown by an analysis conducted by Tangari et al (15); clinicians and patients should be aware of these and read further about App privacy or its third-party partners during normal app usage.

There is also a need for further research to incorporate the apps into evidence based NICE guidelines to ensure patients that it's a part of an interim care plan.

Finally, we are aware that Apps would be beneficial for those who are technologically able, have access to a smartphone, and have a level of motivation to work through apps, clearly these are limitations.

Mental Health Apps: a review of studies conducted in the UK continued by Dr Madhvi Belgamwar, Dr Divyanish Divyanish, Dr Sasha Bhatty and Dr Irangani Mudiyanselage

RECOMMENDATIONS

More research and evidence are required on the use of apps for mental health in general, as well as on how to incorporate these apps into national guidelines for assessment, treatment and support of patients, carers and healthcare professionals. We also require further evidence on the development of technology that will in turn improve apps for providing better mental health care and support.

This review did not focus on apps for individuals under 18 or from countries outside the UK and this would be an interesting field of research that requires further exploration.

ACKNOWLEDGEMENTS

A special thanks to Mr Simon Rose, a lived experience educator and equal network adviser for his contribution to provide voice of service users.

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Effect of physical inactivity and sedentary behaviour on mortality in patients with schizophrenia by Dr Simon J. Taylor

Introduction

The life expectancy of those with a diagnosis of schizophrenia is approximately 20 years less than that of the general population and this gap is widening. This difference has been the case for over a century but it is no longer mycobacterium tuberculosis that is taking its toll but non-communicable diseases characterised by the metabolic syndrome, cardiovascular disease, respiratory disorders and malignancies. Unhealthy lifestyles, in particular smoking, diet and inactivity have been identified as important contributory factors. The former has been targeted with the introduction of smoking bans in psychiatric hospitals and it is not uncommon that patients receive dietary advice, but physical activity advice seems as much about helping people

Health benefits of physical activity in adults. Strong evidence that physical activity reduces rates.
All-cause mortality
Coronary Heart diseases
Hypertension
Stroke
Metabolic syndrome
Type 2 diabetes
Breast cancer
Colon cancer
Depression
Falling

Box 1

structure their time, socially integrate or to lose weight, rather than the wider health benefits which are potentially extensive (Lee, 2012), see Box 1. Health benefit accrue even in the presence of established pathology such as type 2 diabetes or cardiovascular disease or in the face of raised BMI independent of weight loss.

In an attempt to quantify these health benefits in the world population Lee (2012) examined worldwide data concerning the level of physical inactivity. He estimated that about 9% of premature mortality worldwide was attributable to lack of physical activity. This translated into about 5.3 million deaths worldwide in 2008 which was almost exactly the same as the 5 million attributed to smoking. This estimate was based on calculation of the population attributable fraction (PAF) for the effect of physical inactivity on all-cause mortality and a number of common non-communicable diseases. PAF is an estimate of the proportion of new cases in a population that would not have occurred if a causal risk factor was absent. It provides policy makers with a useful estimate of the potential effect of eradication or reduction of a particular risk factor in a population.

There is also a growing literature about the adverse effects of sedentary behaviour (Chau, 2013), see Box 2. In addition, there is growing evidence that the deleterious effect of sedentary behaviour on health acts independent of the levels of physical activity (Chau, 2013).

Health effects of sedentary behaviour in adults.
All-cause mortality
Coronary Heart diseases
Type 2 diabetes
Breast cancer
Colon cancer
Endometrial cancer

Box 2

This paper not only attempts to quantify the effect of physical inactivity on mortality in schizophrenia by estimating PAF, but also attempts to examine the effect of excessive sedentary behaviour. This should help focus mental health care providers on the priorities that may begin to address the currently widening mortality gap.

There are various methods of calculating PAF (Rockhill, 1998). Where there are many confounding variables formula 2 (below) gives a more accurate estimation although this depends on a knowledge of the proportion of cases exposed to a specific risk factor.

Effect of physical inactivity and sedentary behaviour on mortality in patients with schizophrenia continued by Dr Simon J. Taylor

Formula for calculation of population attributable fraction (PAF) (Rockhill, 1998)

Formula 1 using unadjusted relative risk RRv

$$PAF\ (\%) = \frac{P\alpha\ (RRv - 1)}{P\alpha\ (RRv - 1) + 1} \times 100$$

Pα = the proportion of people in the source population that are exposed to the risk factor

Formula 2 using adjusted relative risk RRφ. This is better when there is confounding factors.

$$PAF\ (\%) = \frac{P\varepsilon\ (RR\varphi - 1)}{RR\varphi} \times 100$$

Pε = proportion of the cases exposed to the risk factor. This can be calculated from studies. For the purposes of the calculations in patients with schizophrenia in which this data is unknown we have calculated an adjustment factor. This is the added extent that the risk factor in question occurs in cases compared with the overall population. For physical inactivity Lee (2012) calculated the adjustment factor in each study for each outcome and then estimated the prevalence of inactivity in cases. For all-cause mortality this was 1.22 (0.07), i.e., the for effect of physical inactivity on all-cause mortality the estimate of Pε = Pα x 1.22.

The WHO recommendations, suggest a minimum level of physical activity per week of 150 minutes of moderate physical activity or 75 minutes of vigorous physical activity. This is quantified as 600 MET mins per week. Although there is a dose response curve with regard to the health benefits of physical activity, this 600 MET mins cut-off, at which there are significant health benefits, is the cut-off that Lee (2012) used to define "inactive". This paper will use the same cut off. There is also a dose response curve with regard to the effects of sedentary behaviour. In a meta-analysis on all -cause mortality, there was evidence of marked increase in the slope of this curve with more than 10 hours of sedentary time (Chau, 2013). This paper will use this cut off.

Material and Method

Firstly there was a need to examine the level of physical activity and sedentary behaviour in people with schizophrenia. Two systematic searches were undertaken, see Boxes 3 and 4.

Search strategy:
Physical AND activity AND schizophrenia in EMBASE, Medline and PsycInfo, in title or abstract, limit 2006 to 2016.

↓

151 with duplicates removed

↓

Abstracts examined. Inclusion criteria were that there was a measure of physical activity in schizophrenia patients published in the English language. Abstracts for poster presentations and reviews were excluded. Randomised control trials were included if they examined levels of physical activity at baseline.

↓

30 articles. ←———— *12 other articles found from references and review articles.*

↓ ←———— *4 additional articles from sedentary behaviour search (see below).*

↓

↓

6 articles in which the proportion of patients with >=600MET mins per week was reported or from which this could be calculated.

Box 3

Search strategy:
(sedentary OR sitting) AND schizophrenia in EMBASE, Medline and PsycInfo, in title or abstract, limit 2006 to 2016.

↓

100 with duplicates removed

↓

Abstracts examined. Inclusion criteria were that there was a measure of sedentary behaviour or time in schizophrenia patients in English language. Abstracts for poster presentations and reviews were excluded. Randomised control trials were included to examine levels of sedentary behaviour if measured at baseline.

↓

6 articles. ←———— *4 other articles found from references and review articles.*

↓ ←———— *3 additional articles from physical activity search.*

↓

↓

3 articles in which there was a proportion of patients with a measure sedentary behaviour was reported.

Box 4

Smoking

To examine the effect of smoking to compare with the effect of both physical inactivity and sedentary behaviour three divergent studies have been used covering different populations over different times. The reason for this is because relative risk not only is influenced by duration of follow-up but also potentially markedly by which cohort is followed. No attempt was made to follow a specific search strategy to identify these studies. Their characteristics are summarised in Table 3. Smoking prevalence in people with schizophrenia is taken as 44.6% (Royal College of Physicians, 2013).

Effect of physical inactivity and sedentary behaviour on mortality in patients with schizophrenia continued by Dr Simon J. Taylor

Calculation of PAF

In order to calculate PAF using formula 2, the proportion of cases exposed to the risk factor is needed. This is not available for patients with schizophrenia but has been estimated. For physical inactivity Lee (2012) calculated an adjustment factor, notably the ratio of the prevalence of physical inactivity in the population and the proportion in cases where this information was available. This was then applied to the populations were this was not known to estimate the proportion of cases exposed.

Results

Only six papers reported the proportion of patients with more than 600 MET mins per week. And only three papers examining sedentary behaviour. The characteristics of the studies are outlined in Tables 1, 2 and 3.

Characteristics of studies for physical activity (PA) Table 1.

Study	n	Age, (SD) years	Male	Diagnosis	Diagnostic criteria	Setting	Was PA primary outcome measure	PA measure	>=600 met min per week %
Vancampfort et al, 2016	100	38.1 (11.8)	64%	schizophrenia	DSM V	OP	no	interview (1)	39%
Janney et al, 2015	46	45.6 (9.8)	37%	schizophrenia and schaffect	DSM IV-TR	OP	yes	accelerometer	33%
Snethen et al, 2014	44	50.6	89%	schizophrenia and schaffect	DSM IV, SCID	mixed	no	accelerometer	47%
Vancampfort et al, 2013	80	36.8 (10.1)	69%	schizophrenia	DSM IV	mixed	no	SRG (2)	59%
McLeod et al 2009	125	40.3 (12.4)	65%	schizophrenia	DSM IV	OP	yes	SRG (3)	49%
Faulkner et al, 2005	35	39.7 (10.7)	63%	schizophrenia and schaffect	DSM IV	OP	no	accelerometer & SRG (2)	26%

SRQ = Self report questionnaire.
1. Physical activity vital sign.
2. International Physical Activity Questionnaire.
3. Australian Activity Survey

Study characteristics for sedentary behaviour (SB) Table 2

Study	n	Age, (SD) years	Male	Diagnosis	Diagnostic criteria	Setting	Was SB primary outcome measure	SB measure	Proportion above cut off
Vancampfort et al, 2012	76	35.9 (10)	71%	schizophrenia	DSM IV	IP	yes	SRG (1)	25% >10.4 hours sitting per day
Janney et al, 2015	46	45.6 (9.8)	37%	schizophrenia and schaffect	DSM IV-TR	OP	yes	accelero meter	75 % > 658 mins per day (2)
Stubbs et al, 2016	199	44 (9.9)	61%	schizophrenia	DSM IV	IP	no	accelero meter	55% > 9.7 hours per day (3)

SRQ = Self report questionnaire.
1. International Physical Activity Questionnaire.
2. Mean time was 756 (140) minutes per day, median 709 mins.
3. Count rate indicates sitting, reclining or lying down.

Effect of physical inactivity and sedentary behaviour on mortality in patients with schizophrenia continued by Dr Simon J. Taylor

Table 3

Study	Prevalence of smoking in population	Prevalence of smoking in deaths	RRυ (relative risk unadjusted)*	RRφ (relative risk adjusted)*	Adjustment factor
Banks (2015) m	8%	11.6%	3.30	2.82	1.45
f	7%	9%	3.34	3.08	1.28
total	7.7%	10.5%	-	2.96	1.36
Jacobs (1999)**	50%	62%	1.43	1.8	1.24
Kenfield (2008)	28.3%	28.9%	2.77***	2.81	1.02

* this is relative risks with respect to never smoked
** >10 cigarettes a day
*** this is adjusted for age but Lee (2012) found that in a sensitivity analysis those using age adjusted RR and crude RR were generally similar.

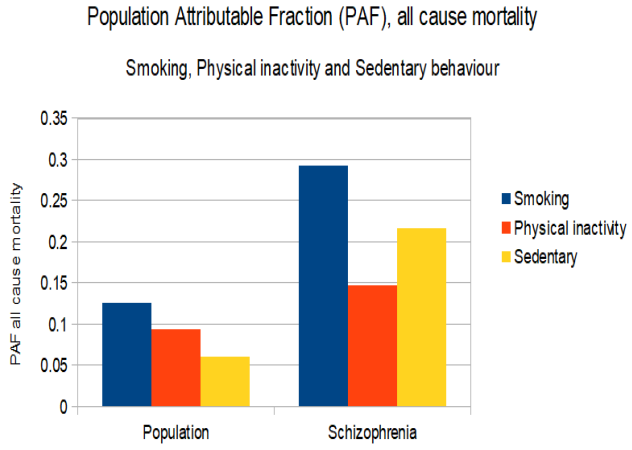
In the studies examining physical activity there were a total of 430 patients with schizophrenia or schizoaffective disorder. Their average age was 40.2 years and 64.6% were male. The proportion with less than 600 MET mins per week was 55.3%. In the studies examining sedentary behaviour there were a total of 321 patients with schizophrenia or schizoaffective disorder. Their average age was 42.3 years and 60% were male. About 50% had more than 10 hours although the different studies used 9.7 hours, 10.4 hours and 11 hours as their cut off between the most sedentary group within their study populations.

Table 4

	Smoking /Banks		Smoking /Jacobs		Smoking /Kenfield		Physical Inactivity		Sedentary Behaviour	
	population	schizophrenia	population	schizophrenia	population	schizophrenia	population	schizophrenia	population	schizophrenia
Pα	19.2%*	44.6%**	19.2%	44.6%	19.2%	44.6%	35.2%***	55.3%	14%****	50%
Pε	26.1%	60.6	23.8%	55.3%	19.6	45.5	42.9%	67.4%	24%	85.5%
adjustment factor	1.36	1.36	1.24	1.24	1.02	1.02	1.22***	1.22***	1.71	1.71
RRυ	3.32		1.42		2.77		1.47		1.41	
RRφ	2.96		1.8		2.81		1.28		1.34	
PAF unadjusted	30.8%	50.9%	7.5%	15.8%	25.4%	44.1%	14.2%	20.6%	5.4%	17%
PAF adjusted	17.3%	40.2%	10.6%	24.6%	12.6%	29.3%	9.4%	14.7%	6.1%	21.7%

Pα = prevalence or risk factor in population
Pε = prevalence of risk factor in deaths
RRυ = relative risk, unadjusted
RRφ = relative risk adjusted
* This is the figure from UK, WHO m =19.9, f =18.4 http://www.who.int/gho/tobacco/use/en/
** ash (2013)
*** Lee (2012)
**** This is derived from the two studies that have their most sedentary group as sitting >= 10 hours (van de Ploeg, (2012) and Chau

Effect of physical inactivity and sedentary behaviour on mortality in patients with schizophrenia by Dr Simon J. Taylor



(2013))

Graph 1 (PAF adjusted and "Smoking" in "Population" from Kenfield)

Discussion

It is difficult to escape the conclusion that the combination of physical inactivity and sedentary behaviour is at least as important as smoking in contributing to the higher mortality rate of our patients with schizophrenia. This is an area that needs urgently prioritising with interventions that increase the level of physical activity and reduce sedentary behaviour. This may represent particular challenges in a population already disadvantaged socially and for whom negative symptoms of avolition and social withdrawal are common. There are a variety of studies that are beginning to demonstrate interventions that may be effective and incorporating such interventions in the treatment of people with schizophrenia is increasingly becoming an urgent priority. There is also increasing evidence for additional benefits in terms of psychological health, core symptoms, functioning and neurocognition (Firth, 2015), which can only benefit our patients' quality of life.

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‘Meet the member’ series by Dr Amala Jesu

Dr Amala Jesu

Biography

My interest in Medicine was instilled by my parents who saw it as a noble profession and from a very young age I wanted to become a doctor. I completed Medicine in Tamil Nadu, one of the southern states in India in 2003. Soon after graduation I came to the UK for postgraduate training. After doing some locum jobs in psychiatry I entered the run through programme in psychiatry in 2008. During my core training years I became inspired by the work done by late Prof Bhaumik and his team in Leicester, and chose to do higher specialist training in ID. I have continued to be actively involved and contributed to local researches and educations in Leicester./ Outside work I love travelling and reading books. I have always enjoyed learning new skills, (this being classical dance and music in recent times) and it has helped me to stay motivated and balanced.

What made you choose psychiatry?

I graduated in India at a time when exposure to psychiatry and mental health was very limited. As a specialty it wasn’t very sought after amongst medics and most gravitated towards acute clinical specialties. This was also largely related to the stigma around mental illness. I however have always been fascinated by human emotions and behaviours. I have enjoyed listening to people’s stories even whilst working in acute hospital placements. After moving to the UK for post graduate training I had the opportunity to shadow clinicians in a few medical specialties, such as general medicine and paediatrics, but didn’t enjoy the experience and couldn’t see myself working in those specialties.

In my first experience as a clinical observer in a busy mental health hospital in London, I was able to see the impact of mental illness on people’s health and wellbeing, and the pivotal role of mental health professionals. To be able to treat and make a difference to the mental wellbeing of people felt very rewarding and motivated me to pursue a career in psychiatry.

Tell us about your current professional role?

I have been working as a consultant psychiatrist in ID for over 8 years. My clinical role is community based, working with adults who have ID and associated mental health problems and behaviours that challenge. My special interest areas include assessment/management of autism and ADHD. My other interest areas include teaching medical students and training core/higher trainees in psychiatry. I work closely with the local clinical leads and have been involved in the development of care pathways within our service. I also recently became the chair of the East midlands regional clinicians ID group (EMRC). This group plays a pivotal role in sharing local experience, training/job opportunities and providing support for ID clinicians in the region.

What would you say to someone considering a career in psychiatry?

Psychiatry is an incredibly rewarding specialty, and I would encourage anyone with an interest to do a placement in Psychiatry. For example, Foundation doctors can ask for this in FY1 and FY2 or it could be a non-training post too. It is essential that you are a keen listener with good communication skills and compassionate. Remember, however, that working in psychiatry has its own challenges. Your health and wellbeing are very important and taking time out for yourself will give you the much-needed resilience to handle the pressures that work may throw at you.

What does your role as ID Regional Representative at the College involve?

Becoming a member of the Trent Division has given me great networking opportunities with the college. ID services in the region have always had strong links with the college and I aspire to make a positive difference to our specialty and the people we serve.

‘Meet the member’ series — continued by Dr Amala Jesu

What would you say to someone considering a career in psychiatry?

Psychiatry is an incredibly rewarding specialty, and I would encourage anyone with an interest to do a placement in Psychiatry. For example, Foundation doctors can ask for this in FY1 and FY2 or it could be a non-training post too. It is essential that you are a keen listener with good communication skills and compassionate. Remember, however, that working in psychiatry has its own challenges. Your health and wellbeing are very important and taking time out for yourself will give you the much-needed resilience to handle the pressures that work may throw at you.

What does your role as ID Regional Representative at the College involve?

Becoming a member of the Trent Division has given me great networking opportunities with the college. ID services in the region have always had strong links with the college and I aspire to make a positive difference to our specialty and the people we serve.
Through Trent division, I was recently involved in promoting psychiatry at a careers fair in a Leicester school along with few other division members. There was huge interest amongst students and numerous pupils got in touch post event, regarding an insight into psychiatry and work experience opportunities.

What do you enjoy most about being involved in the work of the College?

It is easy to feel isolated and alone when you are a consultant. Developing strong links with the college gives a sense of belonging and part of a peer group. It is also empowering to know that you are contributing to key decisions affecting the practice of psychiatry. It has been insightful to see first-hand, the outstanding work that is delivered by college, be it recruitment, training or support in any other area. It is also inspiring to see other fellow psychiatrists’ work and learn from each other.

About the MTI Training opportunities by Dr Fabida Aria

Do you have vacant psychiatry posts in your employing body?

If you have:

- Vacant CT3 psychiatry training posts
- Converted ST posts
- Trust grade posts with sufficient educational training content

the RCPsych Medical Training Initiative (MTI) could be for you.

RCPsych can match you with a qualified psychiatrists from a low—or middle—income country, looking to experience training in the UK for two years. We will support you every step of the way, provide GMC sponsorship and coordinate your application to the Academy of Medical Royal Colleges (AoMRC) for visa sponsorship. Applications for employing bodies are now open for posts beginning from August 2023.

For more information visit rcpysch.ac.uk/training/MTI or email mti@rcpsych.ac.uk

“ We are proud to welcome MTI doctors to LSCFT. We value their diversity, experience and contribution to patient care and to the wider educational Community. We fee; privileged to be able to support MTIs with their personal and professional development whilst working with our teams.”

Director of Medical Education

Dr Fabida Aria, MTI Specialist Advisor

Royal College of Psychiatrists -Trent Division

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The Royal College of Psychiatrists is the professional body responsible for education and training, and setting and raising standards in psychiatry.

The Trent Division is made up of members from Leicestershire, Lincolnshire, Derbyshire, Nottinghamshire, South Yorkshire and the Humber.

We would like to thank all members for their contributions towards Trent Division activities throughout the year.

Trent Division

Deadline for next edition
Submit your articles for the Summer edition by 31st May 2023 at trent@rcpsych.ac.uk

Royal College of Psychiatrists - Trent Division E-Newsletter

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