Winter Edition, 2023/24

Psychiatry-Trent

The Trent Division e-Newsletter

Contents

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

Editorial

Dr Sidra Chaudhry *Dr Kris Roberts*

Dear Colleagues,

Welcome to another action-packed edition of the Trent Division E-Newsletter. We hope that this edition finds you in health and happiness! The year 2024 started on a high note with five RCPsych members being recognized for their contributions towards mental health services and psychiatry in the 2024 New Years Honours. These include Professor Timothy Kendall, Professor Bienvenido Arturo Langa Ferreira, Professor Ulrike Schmidt, Dr Edward Day and Dr Muhammad Saleem Khan Tareen. A very hearty congratulations to them all! Read more about this here.

The months of December 2023 and January 2024 also saw the longest junior doctor industrial action in the history of the NHS. We would like to extend our gratitude and support towards junior doctors for their valuable contributions day in and day out despite all challenges that have come their way.

The Trent Division Hall of Fame is the perfect platform to show some appreciation to the teams and colleagues you work with. Recognition, appreciation and support make one feel valued and increases their motivation to keep up to their high levels of excellence especially in today's landscape and climate.

This edition is special because it has a variety of content of different genres. We have tried to make content interesting and different to routine to appeal to all kind of readers. If you'd also like to contribute towards the newsletter, please do not hesitate to get in touch. We would love to hear what you'd like to see in future editions!

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

Back to contents page

Chair's Column by Dr Shahid Latif

Dr Shahid Latif
Trent Division Chair

Welcome to the winter newsletter of our Division and I wish you all a happy 2024.

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.

I'm pleased to report that the Trent Division provided 6 divisional events for our members during 2023. A big thank you to all involved in helping to make our divisional events such a success. Please look out for our events planned for 2024, which are available to book online at: Upcoming events in the Trent Division | Royal College of Psychiatrists (rcpsych.ac.uk)

I would also like to congratulate the Sheffield PsychSoc for hosting a very successful National Student Psychiatry Conference 'Me, Myself and I' which took place on 13 and 14 January 2024 at the University of Sheffield. We're looking forward to working more closely with them in the future.

When you get a moment please do take a look at the **'Coffee with the Trent Division'** series below and also take a look through the many ways in which you can get involved with our division.

'Coffee with the Trent Division' interviews, are hosted by our RCPsych Trent Division Chair, Dr Shahid Latif. The aim of these interviews is to give members an insight into the types of roles available at the college and also to learn more about the members behind the roles.

- Mr Paul Rees, RCPsych CEO (2016-2023)
- Professor Subodh Dave, RCPsych Dean
- Dr Helen Crimlisk, RCPsych Leadership and Management Committee Chair and Trent Division member
- Dr Adrian James, RCPsych President (2020-2023)
- Dr Deepa Krishnan, RCPsych Trent Division Quality Improvement Lead

We do hope that you are inspired to join us, our vacancies are published on our website and you can contact the Divisions Committee Manager, Marie Phelps, by emailing Trent@rcpsych.ac.uk

How you can get involved

Attending an event or training session: we work hard to provide great events and training sessions at which you can gain CPD points, keep your knowledge up to date and network with other members in the region. **Find out about upcoming events.**

Contributing to the Division's news updates or speaking at an event: We'd love to hear from Division members who'd like to contribute an article to our news updates or speak at one of our events. If you'd like to, please email Trent@rcpsych.ac.uk

Taking part in Divisional Prizes: Prizes for the best poster presentations in one of the following topics; quality improvement, audit or research by (Student Associates and FY1-2), (CT1 -3 trainees), (ST4-6 trainees and specialty grade doctors) are awarded at the winter conference. **Find out more about divisional prizes.**

Division Engagement Survey: please take the time to complete our division engagement survey to help us to support our divisions.

X: Please use our X account **@rcpsychTrent** to communicate with your peers, share best practices and raise the profile of psychiatry in the Trent region, currently with 1138 members.

Contact us: Please email Trent@rcpsych.ac.uk

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:

- Academic Secretary
- Academic Psychiatry Regional Representative
- General Adult Psychiatry Regional Representative x2
- Rehabilitation and Social Psychiatry Regional Representative
- Perinatal Psychiatry Regional Representative
- Regional Advisor for Leicestershire, Northamptonshire and Rutland

e-Learning vacancies

- Deputy Editor CPD eLearning/Trainees Online (TrOn)

For further information on the role, or how to apply, please visit: https://www.rcpsych.ac.uk/members/posts-for-members/detail/deputy-editor-cpd-elearning-trainees-online-(tron)

- Trainees online (TrOn) Trainee Editor

For further information on the role, or how to apply, please visit: Trainees Online (TrOn) Trainee Editor (rcpsych.ac.uk)

- Trainees Online (TrOn) Neuroscience Trainee Editor (rcpsych.ac.uk)

For further information on the role, or how to apply, please visit: https://www.rcpsych.ac.uk/members/posts-for-members/detail/trainees-online-(tron)-neuroscience-trainee-editor

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 2023 we received and reviewed 49 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)

Upcoming events

- **17 April 2.00—3.30PM online via Zoom:** ***Trauma, Dissociation and DID 9Dissociate Identity Disorder) webinar***

The RCPsych Trent Division welcome Dr Beena Rajkumar to deliver a 1.5 hour webinar on Trauma, Dissociation and Dissociative Identity Disorder. The webinar format will allow for a 1 hour presentation on this topic followed by a 30 minute Q&A session with delegates. The key learning outcomes from this presentation are:

1. Understanding the impact of trauma on one's sense of self.
2. Understanding the different forms of dissociation (biological and psychological).
3. Ways in which they can be managed.

This event will be recorded and available to watch on demand for 2 months from the date of the event.

Hall of Fame nominations & Prizes

Hall of Fame

We are proud to announce the 2023/24 winter nominations 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.

Nomination

- **Dr Louise Egan, Sheffield Health and Social Care Foundation Trust**

"Louise was appointed as a Specialist Adult Psychiatrist into the Early Intervention Service at Sheffield Health and Social Care Foundation Trust where she Leads one of the sub teams, playing an active role in supporting clinical care, governance, education and improvement and has gone on to become a valued member of the Medical Community.

She has taken on the role of SAS Advocate, supporting SAS psychiatrists in SHSC organising and delivering wellbeing, leadership and developmental opportunities for the SAS community.

She has also played a key role in supporting the arrangements for Industrial Action cover modelling how flexible and proactive SAS Drs can be in ensuring the right balance between supporting colleagues to strike and maintaining patient safety.

As SAS Advocate she is in contact with regional and national colleagues supporting education and development opportunities for SAS Drs. She has coordinated the response for SAS week. She has shown flexibility and a mature approach to self development and takes up enthusiastically new opportunities to support the SA community and also her team.

She has supported QI initiatives in EIS and supports junior trainees and undergraduates in the team. She represents SAS Drs on a number of committees, proactively advocating for them and reminding colleagues of their potential and the risk of them being overlooked. As a result SHSC has a number of SAS Drs who have taken on senior roles in education, research and several are pursuing AC and CESR routes. She has brought the SAS community together and organised a number of SAS specific events." *Anonymous*

Prizes

We are proud to announce the winter 2023/24 winners in the Trent region.

Purpose

The Trent Division has established annual prizes at the Winter Conference for the best poster presentation in one of the following topics: quality improvement, audit or research by Student Associates and FY1-2, CT1-3 Trainees and ST4-6 trainees and specialty grade doctors.

Winners

- **Student Associate and FY1-2 1st place:** Michael Deeran
- **Student Associate and FY1-2 2nd place:** Oscar Han and Changmin Doh
- **CT1-3 Trainee 1st place:** Dr Jon Turvey and Dr Taofeeq Elias
- **ST4-6 Trainee and Specialty Grade Doctors 1st place:** Dr Rob Heminway and Dr Adam Trist
- **ST4-6 Trainee and Specialty Grade Doctors 2nd place:** Dr Roopa Rudrappa

Congratulations to all winners!

Psychiatric Trainees Committee by Dr Elena Titova—Chaudhry, Dr Rebecca Bennett, Dr Kiron Griffin

Trent Representatives—Who we are?

Dr Rebecca Bennett

Rebecca.bennett6@nhs.net

CT3 at Kedleston Low Secure Unit, Derbyshire

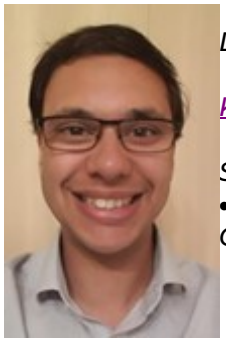
- *Workforce Committee*
- *SEPSIG PTC Rep*

Dr Elena Titova-Chaudhry

Elena.titova-chaudhry@nhs.net

ST6 General Adult Psychiatry, Nottingham

- *QI Committee*
- *Evolutionary SIG Rep*



Dr Kiron Griffin

Kiron.griffin2@nhs.net

ST4 CAMHS, Nottingham

- *Curricula and Assessment Committee*

What is the PCT?

RCPsych Psychiatric Trainees' Committee (PTC), a committee of around 40 representatives from across the UK (and various other groups such as military and international medical graduates) who have been elected or co-opted to represent the around 6000 psychiatry trainees in UK.

PTC representatives sit on 90% of college committees and represent the views of current psychiatric trainees. Further to this, the college asks the PTC for trainees' views on all aspects of training so the PTC can be a good way to get your voice heard.

We are very involved with the educational aspect of training, including representing trainees in relation to exams (recently the digitisation of the MRCPsych) and the new Curriculum and associated e-portfolio. We also work with the Choose Psychiatry committee in their fantastically successful campaign to share our passion in this specialty. If something impacts trainees within the College, we are likely there making sure we are representing you.

We have an informal WhatsApp group with access to all PTC reps across the UK so can often get answers quickly. We also sit on many Core Trainee groups across the region so have access to a lot of resources. If in doubt, just ask!

Strategy & Projects

The strategy for the PTC has recently been released to cover the main issues that the PTC will focus on for 2023-2024.
These issues include:

- Continuing to explore psychotherapy competencies and advocate for trainees in this area
- Continuing to explore and advocate for exam resources.
- Continuing to advocate for trainees around Industrial Action
- To be involved on issues around Physician Associates

Psychiatric Trainees Committee continued by Dr Elena Titova—Chaudhry, Dr Rebecca Bennett, Dr Kiron Griffin

Alongside this the PTC are completing a project on Study Leave to understand discrepancies between the regions and how trainees can be supported to get the most benefit from their entitlement.

Annual Trainee Conference

Every year the PTC run an Annual Trainee Conference. Last year's theme was 'Psychiatry beyond the prescription' and it had some fantastic speakers in areas such as nutritional psychiatry, the anti-psychiatry movement and MDMA assisted therapy. 2024 Trainee Conference will take place in Leeds on 25-26 April 2024. The theme is 'Next Generation' and bookings are now open via the RCPsych website.

"The Registrar"

The Registrar is the magazine of the PTC and is published between 2-3 times per year (on-line and paper version). Writing a piece for The Registrar, is a great opportunity to contribute to your trainee committee and see your name in print. PTC particularly love hearing about innovative projects that fit with our agenda of increasing recruitment to psychiatry and improving training - and about interesting things psychiatrist do outside of their clinical work, for example in volunteering, sports or music.

Resources & opportunities

There are plenty of opportunities available for psychiatry trainees. Most of this information can be found on the college website. Below are some of the things that have been advertised recently:

- European Federation of Psychiatric Trainees Exchange Programme
- Leadership and Management Fellowship Scheme
- RCPsych Parliamentary Scholar Programme
- Prizes and Bursaries for Trainees
- Conferences & Webinars.

If you are preparing for college membership exams, the college provides access to the Trainees Online (TrON) information portal that can help provide a basis for revision. There is also access to the College Library for literature searches and loan of books which is great if you are preparing a research project.

Trent Division Events

Trent Medical Students Conference is planned for 10 May 2024. This will be a virtual half a day event.

Getting involved

There are lots of ways in which you can get involved and support the PTC and your fellow trainees.

Becoming a member will give you opportunities to:

- network
- play a part in initiatives to raise the standard of training
- represent trainees on other College committees
- support trainees across the UK.

There are currently no vacancies within the Trent division however vacancies will likely arise in 2024 and be advertised on the college website, so keep an eye out!

‘Unhinged web-weaver: Spider’ movie review by Dr Ioana Toma

Supervised by Dr Chinwe Obinwa

***‘Unhinged web-weaver’*: Spider**

Release date: 3 January 2003(UK)
Director: David Cronenberg

Review scored: IMDb 6.8/10, Rotten Tomatoes: 85 %
Adapted from Patrick McGrath’s 1990 novel „Spider“
„Clothes maketh the man; and the less there is of the man, the more the need for the clothes“. With these words, we are made aware of the disintegration of self and existential despair, both remarkably depicted in this unnerving film about a man’s attempt to reconstruct and unravel a traumatic event dating back to his childhood.

They are uttered by Terrance, an old inhabitant of a dour boarding accomodation whose residents manifest various degrees of mental illness, when he noticed the multiple layers of clothing that Spider, the main character, was wearing.

In this minimalist psychological thriller, we are offered an overload of disturbing imagery of a very unique, particular psychotic wavelength. This sits at the core of the movie that sketches various themes such as phenomenology of schizophrenia, the unreliable character of memory and how these are generated by dysfunctional families and childhood trauma.

In the 1980’s derelict, almost menacing East London, Spider, by his real name Dennis Cleg, came to live after having been released from a secure mental institution near London. He is depicted as a lonely, strange man, seemingly coming from the periphery of life, who wanders around the local urban area where he once lived, desperately trying to piece together the events that led to his mother’s death. Little are we told about the factual circumstances. Much of his story is veiled and recolleted through his own ’twisted’ lenses, distorted by the webs of delusional memory.

The turning point in the plot constitutes an evening back in his childhood when he goes to the „Dog and Beggar“, the local pub, to fetch his father for dinner. There he encounters Yvonne, an indecent woman who shows him her naked breast while mockingly laughing at him. This event, coupled with his Oedipian infatuation with his mother and the tense interactions with a distant father, causes the child to „hallucinate“ that his mother was murdered by his father and replaced by Yvonne. These intricate relationships, on the grounds of the child’s peculiar sensitivity and subjective manner of deciphering his very own reality, are elements which constitute the nucleus of a latent schizophrenogenic process.

Psychodynamic approaches to schizophrenia point towards family theories of mental disorders that develop as a result of pathological interactions or faulty communication. The emotional conflicts between parents followed by periods of apparent tranquil and even romantic encounters shatter the base of security within the boy, rendering him confused and dumbfounded. Another approach involves the marital schism and skewed families, with a prominent split between parents that lead one parents to be overly close to the child of the opposite gender.[1] There is no triadic relationship within the family; it only consists of dyads that overlap and create a fissure in Spider’s subconscious.

This fissure is the genesis of his main conflict by which all the women he significantly interacts with, starting with the mother and ending with his landlady from the boarding house, are replaced by „the prostitute”. All these characters all played by the same actress. This bears resemblance to the Frégoli syndrome, one of the delusional misidentification syndromes where one single person, usually a persecutor, appears disguised as different, unrelated individuals.[2]

The phenomenology of emerging and pervasive mental illness is aesthetically suggested by Spider’s behaviour. We are offered powerful visual means of non-verbal language, such as the tobacco stained fingertips that nervously scribble unintelligible signs into a minuscule diary, the whispery mumbling of a language that he employs as communication and the olfactory hallucination that ultimately points to the clue of his mother’ s death. Spider is physically creating webs in his bedroom, a habit he had from when he was a child, a symbolic act by which he incessantly re-creates and re-organizes the lines of vision, logic and emotion that become concentric elements of his own truth.

„Spider“ has an immersive atmosphere within which the meanders of memory, the limits of perceived reality and the remote frontiers of the human psyche intersect and create an unsettling and powerful example of a character study film.

‘Unhinged web-weaver: Spider’ movie review continued

by Dr Ioana Toma

Acknowledgements

To the Royal College of Psychiatrists’ Philosophy Special Interest Group and its chair, Dr Anastasios Dimopoulos, who facilitated the opportunity to discuss the phenomenology of schizophrenia by using this movie.

References

1. P Kumar, S.C. Tiwari, , Family and Psychopathology: An Overview Series-1: Children and Adults’, Delhi Psychiatric Journal, Vol. 11 No.2, 2008

2. Oyebode, F. Psychopathology of Rare and Unusual Syndromes, Cambridge: Cambridge University Press, pg 1-5, 2021

Magic, mischief and mayhem or a genuine initiative of a person-centred approach by Dr Ioana Toma

Yasmeen Sardar, Occupational Therapy Assistant
Megan Cauldwell, Occupational Therapist
Dr Ioana Toma, Specialty Doctor in Forensic Psychiatry to
Dr Chinwe Obinwa, Consultant Forensic Psychiatrist

Once upon a time there was a pharaoh. She encountered in the woods two pigs who needed a shelter, and kindly offered them a barn upon relying on a fairy' s generosity and compassion. They were offered a warm cosy place, and plenty of water and food to nourish themselves after a strenuous journey. That was the moment when the plot unfolded, and a strive for superiority shaped the narrative line.

This is a brief overview into a short story devised by a patient from a Forensic Low Secure Unit with the aim of adapting it into a play. The idea has been created during one of his Arts and Crafts group sessions facilitated by the Occupational Therapy (OT) team members. In the last 18 months there has been a noticeable decline in his cognitive functioning. Following this a series of assessments and tests have been completed. The outcome was a formal diagnosis of Early Onset Dementia of Alzheimer' s type. Considering the above circumstances, his weekly OT Arts and Crafts sessions were facilitated in a space which was quiet and private. By doing so, this allowed them to work in a much controlled and contained environment to preserve his dignity and allow him the time and space to concentrate properly on his script.

He expressed a desire to build it up by allocating staff members from the OT team to enact in it, and to use them as characters. It was also his idea to craft papier-mâché masks and props for the play for all four characters in order to create as much authenticity as to immerse into the atmosphere...He has appeared to benefit greatly from this, and this approach has engendered a deeper therapeutic relationship between him and the OT.

During his time on the unit, the patient has participated in various meaningful OT sessions facilitated by the Team. Prior to his formal dementia diagnosis being given he has regularly accessed the community by having cycling sessions in the nearby parks, food shopping and cooking, visiting various museums and enjoying shopping at Primark, all to aid and build his skills within his own productivity, self-care, and leisure.

Following a noticeable decline in his cognitive presentation the OT team completed various Occupational Assessments including a Model of Human Occupation Screening Tool (MOHOST) an assessment which looks at an individual' s volition (their motivation for occupation), habituation (pattern of occupation), communication and interaction skills, motor and processing skills, and their environment to gain an overview of occupational functioning. [1, 2] Other assessments used included a Road Safety and Awareness Assessment, Hot Drinks Assessment, Self-Care Assessment, and various Community Based assessments. His community leaves were discussed by the MDT and the outcome of this meeting was that he at present time would no longer be suitable to have access to the wider community pending ongoing assessment and treatment for his own safety and staff escorts safety.

Subsequent to this leave suspension the OT team have worked with him following 1:1 sessions and created a bespoke personalised Occupational Therapy activities programme which he is able to access without community leaves. This included nature photography on hospital grounds, learning to play on new musical instrument, brain training activities such as IQ puzzles and quizzes, painting and drawing and many more.

Going back to our play, it is not difficult to guess what happened with the pigs. The warm and cosy barn was not enough for their aspirations. They realized the fairy and the pharaoh possessed all the power over the kingdom, and they wanted some of it. But how? Only by stealing the fairy' s magic wand, a symbolic representation of infallible power that has the potential to provide an easy and immediate way to deal with problems. They then turned themselves into humans...who went to the pharaoh and presented themselves as magicians. Their trick was soon uncovered by the pharaoh, who prompted them to revert back to their original appearances, but instead they turned the pharaoh and the fairy into pigs to see how much chaos they could cause in the kingdom.

Magic, mischief and mayhem or a genuine initiative of a person-centred approach continued by Dr Ioana Toma

In the book *Art Therapy and Clinical Neuroscience*, edited by Noah-Hass Cohen and Richard Carr, there is a chapter which describes how individuals with mild cognitive impairment from an adult day centre have been offered various types of art therapy. This included music and embodied art therapies, such as movement and dramatic gestures in order to stimulate memory and preserve cognitive faculties through repetition, cueing, playfulness and humour. [3]The additional imagery techniques, in our case represented by crafted masks and sensory lights created an interactive framework within which social participation and the novelty-seeking quality of art-making enhanced higher cortical functions.

Furthermore, prior research suggests that human brain continuously undergoes structural and functional reorganization in response to mental exercise and brain fitness, and the concept has been extended to older adults. Neural plasticity specific changes include development of new neurons, strengthening of existing connections between them and growth of new synapses.[4]

Our patient repeatedly stated how much he wanted to write a story and convert it into a lively experience, a play that can easily be performed within a comfortable, casual environment. This provided him with a sense of control and ownership, and the interplay between various perceptual modalities reinforced his visuospatial abilities and language skills. In time, it became more than just leisure or occupation, it has developed into a therapeutic stimulation and individualized treatment, an efficient antidote to the isolation and other debilitating effects that a severe and enduring disorder can lead to.

In light of the above, we strongly believe that our patients are full of agency and power, and if provided with the adequate means in the right circumstances, can bring about a positive impact for themselves and others. The patient has decided to enact the play on his birthday. Sensory lights were used to project onto the ceiling, sound systems that imitated pig noises, magic wand sound and a microphone were given to enhance auditory effects and create an unearthly atmosphere. The audience were exhilarated, and the play left them all with an unalterable impression that the magic wand is a necessary symbolic toolkit we all need into our journey of bettering ourselves as human beings.

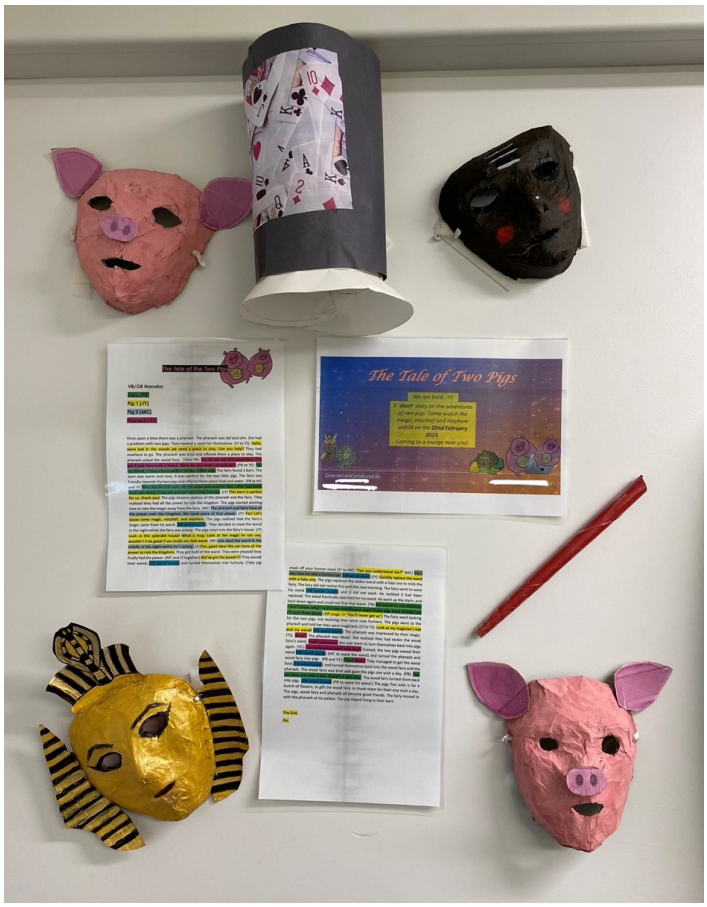
References

1. Kielhofner G (ed.) (2008) Model of Human Occupation: Theory and Application, 4th ed. Philadelphia: Lippincott, Williams and Wilkins.

2. Taylor RR (2017) Kielhofner's Model of Human Occupation: Theory and Application. Philadelphia: Wolters Kluwer Health.

3. Art Therapy and Clinical Neuroscience, edited by Noah-Hass Cohen and Richard Carr, 15 Oct 2008. Chapter 14: Alzheimer's Disease: Art, Creativity and the Brain edited by Anne Galbraith, Ruth Subrin, and Drew Ross, pg 254-259.

4. Cai L, Chan JS, Yan JH, Peng K. Brain plasticity and motor practice in cognitive aging. Front Aging Neurosci. 2014 Mar 10;6:31.



Inside the prison walls: a trainee's experience in Forensic Psychiatry by Dr Taofeeq Elias

Intrigued by the intricacies of the criminal mind, my journey brought me to a medium secure unit during my third year of core psychiatry training, where I was assigned to forensic psychiatry for my fifth rotation. The unit housed individuals at various stages of the criminal justice system, their faces telling stories that extended beyond their transgressions, encapsulating dreams and aspirations.

The pivotal moment arose when my clinical supervisor and I were scheduled for a forensic assessment within a prison, focusing on a young man accused of a serious offense. In the absence of any photographs of the accused, my imagination painted a daunting figure based on the detailed descriptions in the preassessment documents, featuring the haunting images of the murder weapon and the crime scene.

Realizing the gravity of uncovering potential signs of increasing risk, I saw the images from the preassessment documents as a visual narrative, heightening my awareness of the profound responsibility embedded in psychiatric assessments to prevent serious harm to the public. This young man has been under the care of secondary mental health services for several years leading up to the index offence.

Stepping into the prison for the first time, the disparity between my expectations and reality was stark. Instead of intimidating guards and menacing inmates, I encountered young, friendly prison officers. Yet, an indescribable unease lingered as I walked through the corridors and stairs, accompanied by thoughts of, 'I hope they won't lock me in here.' I couldn't pinpoint the source of this feeling.

Meeting the accused shattered my preconceived notions. Far from exuding menace, he appeared broken and consumed by remorse, struggling to engage in conversation under the weight of his shattered life. This encounter transformed my initial apprehension into empathy, highlighting the enduring consequences faced by individuals burdened with regret.

Reflecting on the preassessment documents, and subsequent interview, I envisioned the accused's past under the care of a community mental health team in the UK. Questions about the potential impact of over a decade of secondary health services and the influence of more assertive treatments lingered, I wondered if more interventions could have been implemented. While the direct link between his offense and mental health remained elusive, the undeniable role of mental health in his situation became apparent.

As psychiatrists, our duty extends beyond diagnosis to providing the best chance for a meaningful life in the long term. The intertwining of mental health and criminal behaviour calls for a comprehensive approach, urging us to appreciate the significance of thorough risk assessments in psychiatric evaluations. Stressing the importance of providing optimal care to prevent severe consequences benefits both patients and society.

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

Affiliations

Derbyshire Healthcare NHS Foundation Trust, Hartington Unit, Royal Hospital, Calow, Derbyshire, S44 5BL

Abstract

Objective. The life expectancy of those with a diagnosis of schizophrenia is approximately 20 years less than the general population. Lifestyle factors such as lack of physical activity and excess sedentary behaviour have been identified but no attempt has been made to quantify the importance of these factors in increased mortality. This paper addresses this by estimating the Population Attributable Fraction (PAF) associated with these. Method. Two systematic reviews were undertaken in order to estimate the prevalence of both physical inactivity and sedentary behaviour in schizophrenia patients. Using this and the relative risk for mortality associated with physical inactivity and sedentary behaviour PAF was estimated. For comparison, that attributed to smoking was also estimated in this population. Results. Population Attributable Fraction for physical inactivity was 14.7% and sedentary behaviour 21.7%. Conclusions. Although individually these were less than PAF for smoking, which ranged from 24.6% to 40.2%, the combination of lack of physical exercise and sedentary behaviour makes a comparable impact as smoking on life expectancy in people with schizophrenia.

Keywords

Mortality, population attributable fraction, schizophrenia, physical activity, sedentary behavioural.

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 (Saha, 2007). 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 across the UK and it is not uncommon that patients receive dietary advice, but physical activity advice seems as much about helping people 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.

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

In an attempt to quantify these health benefits in the world population Lee (2012) examined world wide data concerning the level of physical inactivity. He estimated that about 9% of premature mortality world wide was attributable to lack of physical activity. This translated into about 5.3 million deaths world wide 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. Population attributable fraction 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 a growing literature about the adverse effects of sedentary behaviour (Chau, 2013). The rise in this has also been identified as a significant problem in public health (Wilmot, 2012), 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).

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

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.

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

Formula 1 using unadjusted relative risk RRυ

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

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 (WHO, 2004), adopted by many nations (DoH, 2011), 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. One MET is the measure of basal metabolic rate for an individual and level of physical activity is measured in multiples of this, with for example cycling average speed equating to 4 METs (moderate) and fast swimming equating to 8 METs (vigorous). 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.

With regard to sedentary behaviour, there are various methodological differences between studies, for example self reported versus objective accelerometer reported and the use of different cut offs for the most sedentary group. Results often divide the study population into quartiles and then quote relative risks comparing the least sedentary quartile with the most. 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. Abstracts were examined for the inclusion and exclusion criteria specified for each. Additional papers were found from the references of these papers. Four additional papers were found that were relevant to physical activity from the search strategy for sedentary behaviour and three were found vice versa. Basic information about demographics, diagnostic group and criteria along with method of measurement of physical activity was recorded on a structured data extraction form.

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

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

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 in order 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 that the situation is complicated, as Doll et al (2004) demonstrated, because relative risk not only is influenced by duration of follow-up but also potentially markedly by which cohort is followed. Studies rather than meta-analyses were examined to allow examination of prevalence of smoking in the whole study population but also in cases to allow the calculation of PAF using formula 2, as evidently there are multiple potential confounding factors when examining the effects of smoking on health. No attempt was made to follow a specific search strategy to identify these studies for the reason given above. Their characteristics are summarised in Table 3. Smoking prevalence in people with schizophrenia is taken as 44.6% (Royal College of Physicians, 2013).

Calculation of PAF

In order to calculate PAF using formula 2, the proportion of cases exposed to the risk factor is needed. This is 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. This method has been applied here too. There is an assumption that this ratio will be the same for patients with schizophrenia. A similar adjustment factor was calculated from two studies of sedentary behaviour in the general population that had a 10 hour cut off for all cause mortality as it was possible to calculate both the proportion of the whole study population so exposed and the proportion in cases. This was also calculated from the three smoking studies. Again there is an assumption that these ratios, the adjustment factors, will be the same in patients with schizophrenia as in the other study populations.

Results

Only six papers reported the proportion of patients with more than 600 MET mins per week. Many of the papers compared average levels of physical activity with control groups but it was impossible to calculate proportions. Both questionnaire and accelerometer methodology was used. Similarly for only three papers examining sedentary behaviour, various methods of measurement were used, and often average times were only reported with only three papers reporting the proportion above a certain cut off. For two papers the patients were divided into quartiles and one reporting the proportion above the median sedentary time. Although none of these times were exactly 10 hours, there was an approximation to this that enabled the studies to be included. The characteristics of the studies are outlined in Tables 1 and 2.

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

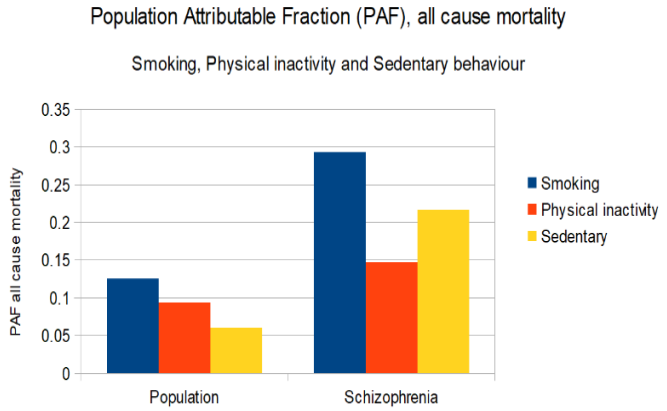
Three studies examining all-cause mortality and smoking were examined. These were chosen as they represented divergent populations and there was sufficient information to allow PAF using formula 2 to be used. For each study a different adjustment ratio was calculated.

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. Of those who self reported, 45.9% had more than 600 MET mins per week physical activity and for those using an accelerometer 40 % did. Overall 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. There was a significantly greater proportion of sedentary behaviour in the two studies using objective measurements with only the top quartile of the self reporting group reporting more than 10.4 hours. There were big differences in the level of sedentary behaviour. Overall 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.



(2013))

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

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 continued by Dr Simon J Taylor

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

Table 5

	Coronary heart disease	Type 2 diabetes	Breast cancer	Colon cancer	All-cause mortality
Prevalence of inactivity in world population.	35.2%	35.2%	38.8% (women only)	35.2%	35.2%
Prevalence of inactivity in world population eventually developing outcome.	42.2%	43.2%	40.7%	42.9%	42.9%
Adjustment ratio	1.20	1.23	1.05	1.22	1.22
Prevalence of inactivity in schizophrenia.	55.3%	55.3%	55.3% *	55.3%	55.3%
Prevalence of inactivity in schizophrenia eventually developing outcome	66.4%	68%	58.1% *	67.5%	67.5%
RRυ	1.33	1.63	1.34	1.38	1.47
RRφ	1.16	1.2	1.33	1.32	1.28
PAF unadjusted, world population.	10.4%	18.1%	11.6%	11.8%	14.2%
PAF adjusted, world population.	5.8%	7.2%	10.1%	10.4%	9.4%
PAF unadjusted, schizophrenia.	15.4%	25.8%	15.8% *	17.4%	20.6%
PAF adjusted, schizophrenia.	8.9%	11.3%	14.4% *	16.4%	14.7%

RRυ = relative risk, unadjusted
RRφ = relative risk adjusted
* these figures are based on the patient population as a whole with regard to physical inactivity levels and are extrapolated.

Discussion

Only six papers could be found from which the proportion of patients not fulfilling accepted levels of physical activity could be found. Although (Faulkner, 2005) found limited agreement between self report and objective accelerometer measures, there was only a slightly higher proportion of the self reporting population reporting adequate amounts of physical activity compared with accelerometer measures, 45.9% and 40% respectively. Unsurprisingly the study with the lowest average age had the highest level of activity. There is little difference when the studies of exclusively community living patients are compared with those studies that included a proportion of inpatients. One study (Janney, 2015) selected patients with a higher BMI (>27) who wished to loose weight and this study reported a slightly lower level of baseline physical activity. Overall these findings are similar to (Ratliff, 2012) reporting 48% of patients reporting at least one episode of moderate or vigorous physical activity per week but Brown (1999) reported only 17% having engaged in one episode of physical activity in the previous week and using the >10,000 steps a day (Tudor-Locke, 2004) standard for adequate physical activity only 8% of outpatients (Beebe, 2013) fulfilled this.

McCreadie (2003) however using the Scottish Physical Activity Questionnaire reported that 57% of males and 60% of females considered themselves as physically active, although no objective measure was reported. It seem therefore that the overall estimate of the proportion of physically inactive patients of 55.3% is probably representative.

The studies of sedentary were more divergent when average times are reported. The reason for the differences may be differing study designs. One study (Janney, 2015) examined only patients with a BMI >27 and another (Speyer, 2014) with abdominal obesity based on waist measurement. These reported the higher average sedentary times of 756 and 606 minutes a day respectively. It was indeed the formed study that reported >75% had sedentary time of >658 mins a day, included in the analysis above. In a study of 22 patients, under the care of a community rehabilitation team, with schizophrenia (unpublished) that used a 24 hour chart to assess daily routines, the average sedentary time recorded was 605 minutes a day with 13 of the 22 (59%) patients having >=10 hours. It seems that the figure used of 50% of patients with 10 or more hours sedentary time seems a reasonable estimate.

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

In the calculations of PAF (formula 2) using adjusted relative risks, the assumption has been made that the ratio of exposure in the patient population to cases in the patient population is the same as the ratio of the exposed population in general to cases in the general population. In addition, it has not been possible to calculate confidence intervals. Despite this 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 in this group. 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.

Ethical approvals

n/a

Acknowledgements

Non

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Regional Armed Forces Network News by Dr Rebecca Bennett

Dr Rebecca Bennett

CT3 Doctor, Nottinghamshire Healthcare, Trent Psychiatric Trainees' Committee (PTC) Representative, Military Veteran (REME) & Armed Forces Network Clinical Dyad, DHCFT

There are a number of active Armed Forces Networks across the Trent Division. These networks aim to support staff and service users that are part of the Armed Forces Community. The Armed Forces community in the UK refers to individuals who are currently serving or have previously served in the British Armed Forces, as well as their families and dependents. This community encompasses a broad range of people, including active-duty personnel, veterans, reservists, and their relatives.

If your Trust would like assistance in improving the support you offer to the Armed Forces Community, I would recommend contacting the Veterans Covenant Healthcare Alliance (VCHA) via their website - https://veteranaware.nhs.uk/ or by reviewing the standards set by the Defence Employer Recognition Scheme which can be found on the government website (www.gov.uk).

Derbyshire

Armed Forces Network Chair (DHCFT) – Gemma Saunders gemma.saunders7@nhs.net
Armed Forces Network Chairs (DCHS) – Mel Dyke melanie.dyke@nhs.net & Christine Duffy christine.duffy@nhs.net

Recently, Derbyshire Healthcare NHS Foundation Trust has been awarded The Defence Employer Recognition Scheme gold award, which recognises the Trust's ongoing commitment to our armed forces community, as an employer. The key points of our gold campaign included:

- Signing the Armed Forces Covenant first in 2018 and again in July 2023
- Establishing good rapport with defence representatives
- Proactively demonstrating that the armed forces community are represented fairly as part of the Trust's recruitment and selection process.
- Providing up to 15 days paid leave for Reservists and Adult Cadet Volunteers to accommodate and support training and mobilisation.
- Working with the local Reserve centre and continuing to offer mutual support.
- Actively ensuring the Trust's workforce is aware of their positive policies towards defence people. For example, through internally publicised positive HR policies.
- Continuing to collaborate and network with partner organisations and providers across Derbyshire to improve support for the armed forces family.

Regional Armed Forces Network News continued by Dr Rebecca Bennett

Events

Reserves Day – The Trust celebrated Reserves Day in partnership with the University of Derby and providers in Derbyshire.

Charity Events – This year staff took part in the Robin Hood Half marathon raising over £1000 for Scotty's Little Soldiers, a charity which aims to support bereaved military children.

Leadership Day, 13th September 2023 – network members joined with colleagues from Lincolnshire to take part in a Military Experience Leadership Day hosted by the HQ 7th Light Mechanised Brigade Combat Team at Chetwynd Barracks in Nottinghamshire.

Tea & Chat events – The network arranges monthly informal online gatherings for our NHS staff who are veterans, reservists, CFAVS, immediate family members of serving/veterans, to enable them to discuss issues in a relaxed environment.

Armistice – Brunch & Derby City Remembrance Service – A number of events were arranged to commemorate armistice include a brunch at the Rolls Royce Nuclear academy and representatives from both DCHS and DHCFT laying a wreath as part of the Derby City Remembrance parade.

Regional Armed Forces Network News continued by Dr Rebecca Bennett

Nottinghamshire

Network Co-Chairs - Harjit Bailey, Harjit.Bailey@nottshc.nhs.uk & Wendy Smith, Wendy.Smith2@nottshc.nhs.uk
Network Deputy Chair - Ben Seaman, Benjamin.Seaman@nottshc.nhs.uk
If you are part of our Armed Forces Community and would like to our network, please email ArmedForces@nottshc.nhs.uk .

Nottinghamshire Healthcare NHS Foundation Trust is a Veteran Aware organisation in recognition of our commitment to improving NHS care for the Armed Forces Community. Our Trust also holds a Gold Award for the Defence Employer Recognition Scheme meaning we support the Armed Forces Community as an employer.

Our Trust currently offers our Armed Forces Community:

- 10 days paid special Leave for Reservists and Cadet Force Adult Volunteers
- Strong framework to support mobilisation of Reservists
- Flexibility in granting leave for service spouses and partners before, during and after a partner's deployment.
- Positive employment practices.

Nottinghamshire Healthcare also currently has 13 members of staff trained as Service Champions who actively advocates for and supports the needs, rights, and well-being of military personnel, veterans, reservists, and their families.

Events

Breakfast Clubs - Nottinghamshire County Council works with the area's district and borough councils to host Breakfast Clubs for the Armed Forces Community throughout the county. These provide safe and understanding spaces in which to chat with other members of the Armed Forces Family and your area's Armed Forces Champion.
For more information: https://www.nottinghamshire.gov.uk/council-and-democracy/council-structure/armed-forces-hub/breakfast-clubs

Reserves Day and Armed Forces Day Flag Raising, 23 June 2023 - This was a great opportunity for those within the Armed Forces Community to join together to raise the Armed Forces flag to celebrate the Reservist Day and Armed Forces Day.

Nottinghamshire County Council Boots and Berets Awards, September 2023 - Held at Nottingham Forest Football Club, the evening brought recognition to organisations and individuals who went above and beyond in their support for the Armed Forces community.

NHS Nottingham and Nottinghamshire Integrated Care System (ICS) Health and Care Awards, 24 October - The Veteran Care Through Custody (VCTC) project, a unique partnership between the Offender Health team at Nottinghamshire Healthcare and the veteran's charity Care after Combat, won the Lord-Lieutenant's Partnership Award and was announced as the overall winner of the awards. Huge congratulations to everyone involved, particularly two of our network members Jane Jones and Simons Ralls.

Regional Armed Forces Network News continued by Dr Rebecca Bennett

Remembrance Day - Colleagues across the Trust marked Remembrance Day. There was an Armed Forces breakfast club, flag raisings, and two-minute silences held across our sites.

Leicestershire

Armed Forces Network Chair (LPT) - Brendan Daly, brendan.daly2@nhs.net
If you want more information about the help and support available through LPT email us at lpt.armedforces@nhs.net

In June 2017 LPT signed up to the Armed Forces Covenant and across all our services, we are working hard to ensure veterans, reservists, military families and staff are supported by our services. In Nov 2019 LPT was awarded the Armed Forces Covenant Gold award and in June 2019 LPT became the first Community and Mental Health Trust in England to become a member of the VCHA. We were successfully re-accredited in 2022. We are also a member of the Step into Health programme, which encourages serving personnel to transition to careers in the NHS.

LPT is committed to supporting the mental health and wellbeing of Armed Forces veterans, as well as their families and helping to reduce the stigma around mental illness associated with military experience.

Events

Peer Support Services - Our Buddy2Buddy cafe style virtual cafes aim to connect, support and empower veterans and their families. The informal sessions, provide a safe space to relax and share experiences to support your emotional wellbeing. Run by our armed forces service and funded through LPT's Raising Health charity, the Buddy2Buddy project recognises the additional risk of social isolation through the pandemic and the disproportionate impact this can have on the mental wellbeing of Armed Forces veterans.

Regional Armed Forces Network News continued by Dr Rebecca Bennett

Swimming with dogs - Over the summer, a number of ex-service personal took part in a series of unique NHS-supported open water swimming sessions with award winning rescue dogs, to help them with post-traumatic stress disorder (PTSD). The veterans took part in a series of relaxing floating and towing experiences in the water with the specially trained Newfoundland dogs. Leicestershire Partnership NHS Trust's charity Raising Health secured £4,880 of funding, to hold six courses for those who have left the armed forces and need mental health support.

Remembrance Day, Friday 10 November - Armed Forces Networks from Leicestershire Partnership NHS Trust (LPT) and University Hospitals of Leicester NHS Trust (UHL) came together to host a Service of Remembrance for veterans, NHS staff and partners, and members of the public. Wreaths were laid by representatives from LPT, UHL and the Leicestershire Integrated Care Board (ICB) at the Secret Garden on the Glenfield Hospital site.

Lincolnshire

Armed Forces Network Chair – Doug Wing, doug.wing@nhs.net

Doug is the Operational Lead for the Midlands OpCourage Partnership, and the Lincolnshire network focusses a lot of promoting the work of this NHS service.

Support to the Armed Forces Community

Support for the Armed Forces community in the UK involves various services and resources, including healthcare, housing assistance, employment support, mental health services, educational opportunities, financial aid, and specific charities or organizations dedicated to assisting current and former military personnel and their families. The aim is to provide assistance and recognition for the sacrifices made by those who have served their country and to offer support in different aspects of their lives as they transition into civilian life or continue their service.

OpCourage - Op Courage is the NHS service that provides specialist care for those Armed Forces veterans suffering from a mental health crisis. Call 0300 323 0137 or email mevs.mhm@nhs.net (includes the Op-Courage URGENT care and support service for the Midlands). Visit the OpCourage website for more information.

Fighting with pride - Fighting With Pride supports the health and wellbeing of LGBT+Veterans, service personnel and their families – in particular those most impacted by the ban on LGBT+ personnel serving in the Armed Forces prior to January 2000. This maybe particularly pertinent due to the recently published Independent Review by Lord Etherton into the service and experience of LGBT veterans who served in HM Armed Forces between 1967 and 2000

Veterans' Gateway - run by a number of organisations, including the Royal British Legion, to help members of the armed forces community to find the support they need. Contact 0808 802 1212 or Text 81212.

For more services available, please see the accompanying QR codes.

Regional Armed Forces Network News continued by Dr Rebecca Bennett

VETERAN AWARE

An aid to support patients who are members of the Armed Forces community

Little Troopers
Military Children

SSAFA
Support & Advice

Help for Heroes
Live Well

Veterans Gateway
Directory of Services

Op RESTORE
Physical Injuries

Op COURAGE
Mental Health

Op Fortitude
Homelessness

Op NOVA
Criminal Justice

Defence Medical Welfare Service
Healthcare Charity

Royal British Legion
Support & Advice

Blind Veterans UK
Sight Loss Charity

BLESMA
The Limbless Veterans Charity

Hover your smartphone camera directly over the QR code, or use the hyperlink to be taken directly to the website

Regional Armed Forces Network News continued by Dr Rebecca Bennett

VETERAN AWARE

"Have you, or anyone in your immediate family, ever served in the British Armed Forces?"

Regular – Individuals currently serving
Reservists – Volunteer Reservist & Regular Reservist
Veterans – Those who have served for at least one day in the Armed Forces, as a Regular or as a Reservist
Families of Regular, Reservists and Veterans – Spouses, civil partners, partners, and children for whom they are responsible, but can extend to parents, and other family members
Bereaved – The immediate family of Service Personnel and Veterans who have died

"Those who serve in the Armed Forces, whether Regular or Reserve, those who have served in the past, and their families, should face no disadvantage compared to other citizens in the provision of public and commercial services. Special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved"
Armed Forces Covenant

Inequality to access physical healthcare for mental health patients by Kate Huntington

Discussing and focussing on inequalities in accessing healthcare is of paramount importance if we wish to address and improve this. Everyone in the general population is at risk of physical health issues and all people should have equal access to primary and secondary care healthcare services to address such concerns. Why therefore should patients living with mental health conditions struggle with inequitable access and thus different access to such healthcare?

It would appear there are a number of contributory factors.

People with serious mental illness compared to the general population have an increased likelihood of preventable and treatable comorbidity such as cardiovascular disease (CVD), hypertension, obesity and diabetes causing increased morbidity as well as mortality (M et al., 2011, De Hert et al., 2018). Therefore, access to physical healthcare for those with mental illness is vital to reduce the risk of onset and progression of disease, improve morbidity and mortality risk, and to increase life expectancy.

What are the barriers preventing them from accessing and receiving the healthcare they need?

One major challenge is the stigma surrounding mental health. Many individuals with mental health conditions face discrimination or judgment, which can make them hesitant to seek help for their physical health needs. This stigma can also be present within the healthcare system itself, leading to inadequate care or dismissive attitudes towards patients with mental health issues (Henderson et al., 2013, Knaak et al., 2017). Healthcare staff may sometimes discriminate against patients with mental health issues due to a lack of understanding or knowledge about mental health conditions. There may be misconceptions or stereotypes surrounding mental illness that can influence the attitudes and behaviours of staff.

Another factor could be the huge workload and time constraints that healthcare staff often face resulting in rushed interactions potentially neglecting the additional mental health needs of patients. A lack of proper training and education around mental health issues can further contribute to this discrimination . Of course not all healthcare staff discriminate against patients with mental health conditions. The majority of healthcare professionals are compassionate and **Dedicated** to providing equitable, holistic care to all patients. Addressing and eliminating discrimination requires ongoing education, training, and awareness within the healthcare system to ensure that patients with mental health conditions receive the same level of care and respect as those with physical health conditions.

A further barrier may be the lack of integration that exists between mental health and physical health services. In many healthcare systems, mental health and physical health are treated as separate entities, potentially resulting in more fragmented care. This can make it difficult for patients with mental health conditions to navigate and receive comprehensive healthcare that addresses both their physical and mental well-being. Additionally, there may be a shortage of mental healthcare professionals within primary care settings, making it challenging for patients to access the specialised care they require.

Additionally, there may be a lack of awareness and knowledge amongst healthcare providers about the more specific healthcare needs of patients with mental health conditions. This may result in misdiagnosis, underdiagnosis, or the overlooking of physical health concerns in such individuals. Perhaps if healthcare providers had some additional training giving them further knowledge about the unique healthcare needs of patients with mental health conditions there would be an improvement in the overall healthcare experience for these patients.

Moreover, those with mental health conditions are often more likely to be unemployed. This may be due to the symptoms of their condition affecting their ability to work consistently, stigma and discrimination in the workplace, and limited access to appropriate mental health care and support. It is important to address these barriers to create inclusive work environments for everyone.

During my first week of medical placement at Rampton Hospital I was exposed to the National High Secure Deaf Service. I saw patients with mental illnesses living with communication issues related to hearing difficulties including profound deafness. These people did not only require help in managing their mental health conditions but also a translator to allow them to be able to understand what members of the multidisciplinary team were saying. Deaf people are likely to have even greater difficulty in accessing physical healthcare due to the complexity of their condition and the fact that they are deaf. This makes it extremely challenging for individuals with specific needs to access the appropriate care and support

Inequality in accessing physical healthcare for mental health patients continued by Kate Huntington

they require. It's important organisations and healthcare systems prioritise inclusivity and provide resources to try and address these gaps.

Creating a more equitable healthcare system for mental health patients is crucial. It requires a comprehensive approach that tackles the different barriers and disparities that exist. By working together, we can strive for a society where everyone, regardless of their mental health, has equal access to the care they need for better physical and mental health outcomes.

To address these barriers, we need to consider how to resolve the issues discussed above. This may include promoting the integration of mental health and physical health services, improving access to affordable healthcare, and enhancing education and training for healthcare providers as well as reducing the stigma surrounding mental health. Hopefully, this will allow patients with mental health conditions to receive the physical healthcare they require, leading to improved overall health outcomes.

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Spotlight on Services: The National High Secure D/deaf Service

by Dr Kris Roberts[1], Dr GS Kaler[1], Kelly Davison[1], Darren Lount[1], Jason Lowe[1] and Jemima Waller[2]

[1] Nottinghamshire Healthcare NHS Foundation Trust
[2] University of Nottingham, 4th year medical student

For the first of our new feature shining a light on some of the Specialist Services available in the Trent region, we discover some insights into the National High Secure D/deaf Service, located in Rampton Hospital, on Grampian Ward.

With thanks to Grampian Ward Nursing team: Darren Lount, Jason Lowe and Kelly Davison and their consultant, Dr GS Kaler.

Inpatient Services

Rampton Hospital is one of the three national High-Secure hospitals in England and Wales that operates at the interface between psychiatry and the criminal justice system. It offers specialist assessment, treatment and care for adults with a range of psychiatric disorders and associated co-morbidities.

Within this environment, they house the inpatient arm of the National D/deaf Service on Grampian Ward, offering comprehensive input for up to a maximum of 10 D/deaf males. The multi-disciplinary team is comprised of experts with specialist experience in D/deaf mental health. This is important; this patient group has unique needs based in the incredibly rich, vibrant and fascinating culture that has evolved within the D/deaf community, of which you can read more below.

This culture underpins and informs D/deaf communication, interactions and beliefs. Without an acceptance and understanding of this culture, the aim of holistic care for patients from this linguistic minority is not possible. Deaf culture is embraced on Grampian Ward as they seek to provide equitable access to mental health care for their patients and their families.

D/deaf Culture

The Nottinghamshire Healthcare NHS Foundation Trust website details more information about D/deaf culture and its' integral diversity; an important first step in understanding the needs of their patients[1]:

"The cultural model ('D') defines Deafness as an ***identity****, something which has its own language (British Sign Language) and own customs. People who align with this model would usually be immersed in the Deaf culture and would often embrace their Deafness such as attending Deaf Clubs and socialising within the Deaf community. It is also a term usually used to reference a group of people who were born deaf or became deaf early on in life, often pre-lingually.*

On the other end of continuum is the medical model *which perceives deafness ('d') as a medical issue or pathology that requires intervention or treatment in order to 'fix' it. People who align with this model may have lost their hearing as opposed to being born deaf and may seek to 'cure' their deafness by utilising assistive technology such as hearing aids or cochlear implants. Whilst the model outlines the two distinct positions regarding D/deafness and ascribes the onset of deafness to where an individual would be placed on the continuum, positioning can be fluid."*

Access

Access to equitable health care has always been the biggest barrier for D/deaf patients. There is a linguistic and cultural dissonance in the provision and design of services, and the needs of the D/deaf population[2]. It continues to provide significant challenges. In a hearing world, information is largely supplied in written English; for many D/deaf patients, their first language is British Sign Language (BSL).

On Grampian ward, embracing the complexities of D/deaf culture has led to the development of a range of communication approaches. Adapted therapies, accommodating varying learning styles, include extensive pictorial representation, role play and the use of Technology. Specialised literature and booklets, developed in part with the University of Lancaster, also aids patient understanding. Access to qualified BSL interpreters, who can support patients to have their needs met, is crucial.

To this end, there is a routeway for Grampian Ward staff working with D/deaf patients to learn BSL up to Level 2, with funding for external training to Level 3, to ensure adequate exposure of patients to people to whom they can discuss their care. The wider Rampton staff have mandatory Deaf Awareness Training, too, highlighting the needs of this patient group.

Patient Challenges

The issues with inadequate access and inequitable health care for D/deaf patients has been highlighted above, but their challenges begin prior to any interaction with the National D/deaf Service. Deafness is a heterogeneous condition with far-reaching effects in multiple domains, but especially in social, emotional, and cognitive development[3]. There are even challenges specific to unique groups within the D/deaf com-

Spotlight on Services: The National High Secure D/deaf Service by Dr Kris Roberts[1], Dr GS Kaler[1], Kelly Davison[1], Darren Lount[1], Jason Lowe[1] and Jemima Waller[2]

pared with D/deaf children of D/deaf parents, for example.

For D/deaf patients, isolation is common. There can be issues with having their feelings understood and for children, there can be a paucity of opportunities for social and incidental learning. There can be a pervasive sense that they are being dismissed, or that they don't matter. Prelingually Deaf patients have an average reading age of 5 to 7 years.

This can lead to understandable challenges. In some cases – but not all - sense of self can be disrupted, frustration can build, impulsiveness can rise. Problematic interactions can occur, mistrust of family and professionals can develop - particularly of hearing professionals. Higher rates of mental illness are reported in D/deaf populations.

Within this, for those patients interfacing with Mental Health Services, there is the potential for difficulties in building a therapeutic rapport, and even for misdiagnosis or mis-management.

D/deaf offenders are over-represented in the prison population[4]. Within the D/deaf population, there are higher rates of sexual offending than in the hearing population. If convicted, D/deaf patients can be cast out by their community, and their sense of isolation is increased. Historically, there were issues with over-sentencing, perhaps as a result of a perceived lack of empathy, and then a woeful provision of D/deaf support in prisons and secure settings. Even identifying D/deaf prisoners nationally, with reporting systems that are not integrated, has provided challenges.

Focus on D/deaf Patients

The development of the National D/deaf Service has gone some way to improving this predicament. Aside from Grampian Ward, the National Services also comprises the D/deaf Prison In-Reach Service.

Referrals are accepted nationally via the Responsible Clinician. If accepted, psychiatric and psychological assessments are provided, and the patient will be moved to a prison within 75 miles of Rampton. There are various hubs for different categories of D/deaf patients, including Young Offender Institutions.

The service aims for integrated care and coordinate communication between the Prison Service, NHS England, other Mental Health or Support Services, and even with probation teams and multi-agency public protection arrangements (MAPPA) post-discharge.
Risk-reducing programmes pertinent to D/deaf offender populations are offered. This includes anger management, sexual offending programmes and violence reduction.

The Future

The service continues to try and reach as many D/deaf service users as it can and offer support, guidance and specialised assessment, education and therapeutic interventions.

Want to Know more?

Try the following links:
Royal National Institute for Deaf People: RNID - National hearing loss charity
Try a free, non-accredited BSL course: Doncaster Deaf Trust (doncasterdeafsign.org.uk)

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Rampton Hospital: The Good, The Bad and The Ugly (a medical students perspective) by Savannah Rowe 5th year medical student

When I first informed my friends and family that I would be undertaking a short placement at Rampton Hospital I was met with a variety of responses. Some thought it was a great opportunity to foster my interest in psychiatry and test out forensic psychiatry as a sub-specialty. Some feared for my safety and thought I was crazy to voluntarily attend a high security psychiatric hospital. Some simply thought it was very "keen" of me to be undertaking extra medical placements. Perhaps it was a combination of all three.
I had previous experience on psychiatric placements – nine weeks with a psychiatric liaison team and four weeks on an inpatient CAMHS ward, so had already decided to pursue a career in psychiatry. I had always been interested in forensics and felt that a placement at Rampton would help me to decide if I could seriously consider it as a subspecialty.

My first impression upon arriving to Rampton was daunting – a massive hospital surrounded by huge fences housing some of the most mentally ill patients in the country. I had also let curiosity get the better of me so had already googled some of the high-profile patients. I was very excited but equally nervous - my previous experience meant that I had met many psychiatric patients with various presentations, but I had never been in such a high security environment. The first item on my itinerary was a ward round on the male personality disorders ward. Patient after patient came in and discussed their treatment and to my surprise, they all seemed so... mellow. These men had extensive histories of violence and aggression yet upon meeting them they all seemed to be relatively calm and reasonable. This seemed to be such a contrast to what I had been expecting from high-secure patients. Throughout my time at Rampton I found it almost easy to forget that I was in a high-secure psychiatric hospital with very high-risk patients. I couldn't help but notice how similar the patients seemed to those in other medium-secure units I had visited. However, every so often you were reminded of the level of risk that comes with a high-security hospital. A patient I had met in the morning seemed to be calm and pleasant yet had to be restrained that afternoon after an incident that put staff at risk. It seemed to me that there was a delicate balance between calm and chaos, and it was impossible to predict which way the scales would tip each day.

I found that the most striking difference between my previous experience and Rampton hospital was the degree of self-harm that the patients inflicted upon themselves. Throughout my previous psychiatric placements, more so on my CAMHS placement, I had witnessed self-harm. This mainly consisted of head-banging or ligatures but on a few occasions the higher risk patients would cut themselves or insert items into wounds. At Rampton, the frequency and degree of self-harm was far more intense. It was shocking how patients could use the smallest items to inflict such severe, life-threatening damage. Pens could be swallowed, bra wires could be inserted into wounds, the tiniest piece of plastic could be used to cut open an abdomen. Some patients were placed in mechanical restraints for their own safety or put on 2:1 nursing. Though I had met many patients with a history of self-harm and suicide attempts I was not prepared for the violent, intense nature of the self-harm at Rampton. I feel that, as medical students, we are often sheltered as doctors may shy away from taking us to review the most difficult psychiatric patients – whether that is for our sake or their own. Encountering the tougher side of psychiatry was a very useful experience and I think it is vital that I am aware of all aspects of the specialty if I am to seriously consider it as a career.

I came across many hard truths during my short time at Rampton, one of which being the length of admission for some patients. I was told the average admission was approximately 4-5 years long with patients usually then being discharged for further care in a medium secure unit. Treating a patient for 4 years just so they are well enough to be discharged to yet another treatment centre is a reality I had not yet encountered. I met a patient on the women's ICU who had been at Rampton for 11 years. She had an extensive history of self-harm, a history of aggression to staff and patients and was so high risk that she had spent the majority of her 11-year admission in long-term seclusion. She had been refusing to eat since December and as a result was being fed with an NG tube. To improve her quality of life they converted one wing on the ward into her own seclusion area to allow her space to move around and access to the outdoors. The clinicians seemed to be at a loss for what to do next - they had exhausted every option and at this point their biggest concern was keeping her alive day to day. As a medical student or a clinician there is an innate want to help people who are suffering. A psychiatric hospital is a place that patients go to receive treatment and get *better*. Yet I heard many patients refer to Rampton Hospital as 'the end of the road' and 'the last resort'. Hopelessness was an emotion I had witnessed many times within psychiatry – patients at their lowest points, seeing no way forward. However, at Rampton, the hopelessness seemed much more significant, almost justified in some ways. A high security psychiatric hospital *is* the last resort in many cases - once you are

Rampton Hospital: The Good, The Bad and The Ugly (a medical students perspective) continued by Savannah Rowe 5th year medical student

admitted there is a limited escalation of care and very few options available. I questioned whether I could see myself in a career that can be so devastating and remain dedicated to treating patients for years with seemingly little impact. Whether I could handle the reality of being 'the last resort' for a patient.

I understand that a career in forensic psychiatry comes with a high level of risk, a distressing environment and often feelings of helplessness. I have also seen how it can be extremely rewarding and challenging, every day is different and you are always learning new things. The teams are close-knit, extremely supportive and filled with a variety of specialties. You are able to get to know the patients very well and though you may not see rapid improvement it is important to appreciate the small steps made each day. Despite the difficult, eye-opening experiences that I encountered at Rampton, I left excited and even more eager to pursue a career in psychiatry.

‘Meet the member’ series by Dr Sophia Senthil

Dr Sophia Senthil

Perinatal Psychiatrist, MBBS, MRCPSych, PG Certificate in Leadership & Management (Keele), CCT in General Adult Psychiatry

What made you choose psychiatry?

During my medical student years, I was intrigued by how psychiatry as a speciality connects with people attempting to understand in aspects of background and context why, and how they become unwell, informing the approach to their treatment.

Having spent nearly 20 years working in mental health, I realise another speciality would not have given me similar rewarding experience, and as this is a profession which draws on scientific, medical, and interpersonal skills in day to day working. and help people realise their potential which is often linked with their recovery.

Tell us about your current professional role?

I am a perinatal psychiatrist; I work in community setting with women who are pregnant and have had their babies up to 2 years postpartum. My role involves supporting and advocating women who suffer from mental illnesses during one of the sensitive periods of their life sometimes rendering them vulnerable. My role extends to ensuring unborn babies and infants have a right emotional and physical environment to thrive and flourish, while supporting and guiding women and their partners adequately.

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

Psychiatry is one of esteemed profession, and indeed it is a speciality that deserves privilege and honour where we listen to people’s stories, while remaining compassionate and ensuring right leadership approach working within your team and systems containing your emotions, and intervening and supporting when required. It nurtures your curiosity as scientific understanding of illness and their treatment is evolving rapidly, and a speciality where you can identify your niche, and strengths as you progress enabling you to develop both as a person and professional.

What does your role as CPD Lead and Mentoring Lead at the College involve?

I was elected early this year as executive member of general adult faculty of the college and nominated to work in executive role within Trent division. I joint chair academic secretary within the faculty and lead CPD events within Trent division.

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

I enjoy being part of delivery latest developments in service provision, training and education taking shape and being implemented, being able to advocate for gaps for individual patients and families and supporting trainees and medical students develop their full potential as psychiatrist and doctors.

Royal College of Psychiatrists -Trent Division

Royal College of Psychiatrists
21 Prescot Street
London
E1 8BB

Phone: 0121 803 9075

Email: Trent@rcpsych.ac.uk

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 2024 at trent@rcpsych.ac.uk

Royal College of Psychiatrists - Trent Division E-Newsletter

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