RCPSYCH MAGAZINE FOR MEDICAL STUDENTS AND FOUNDATION DOCTORS

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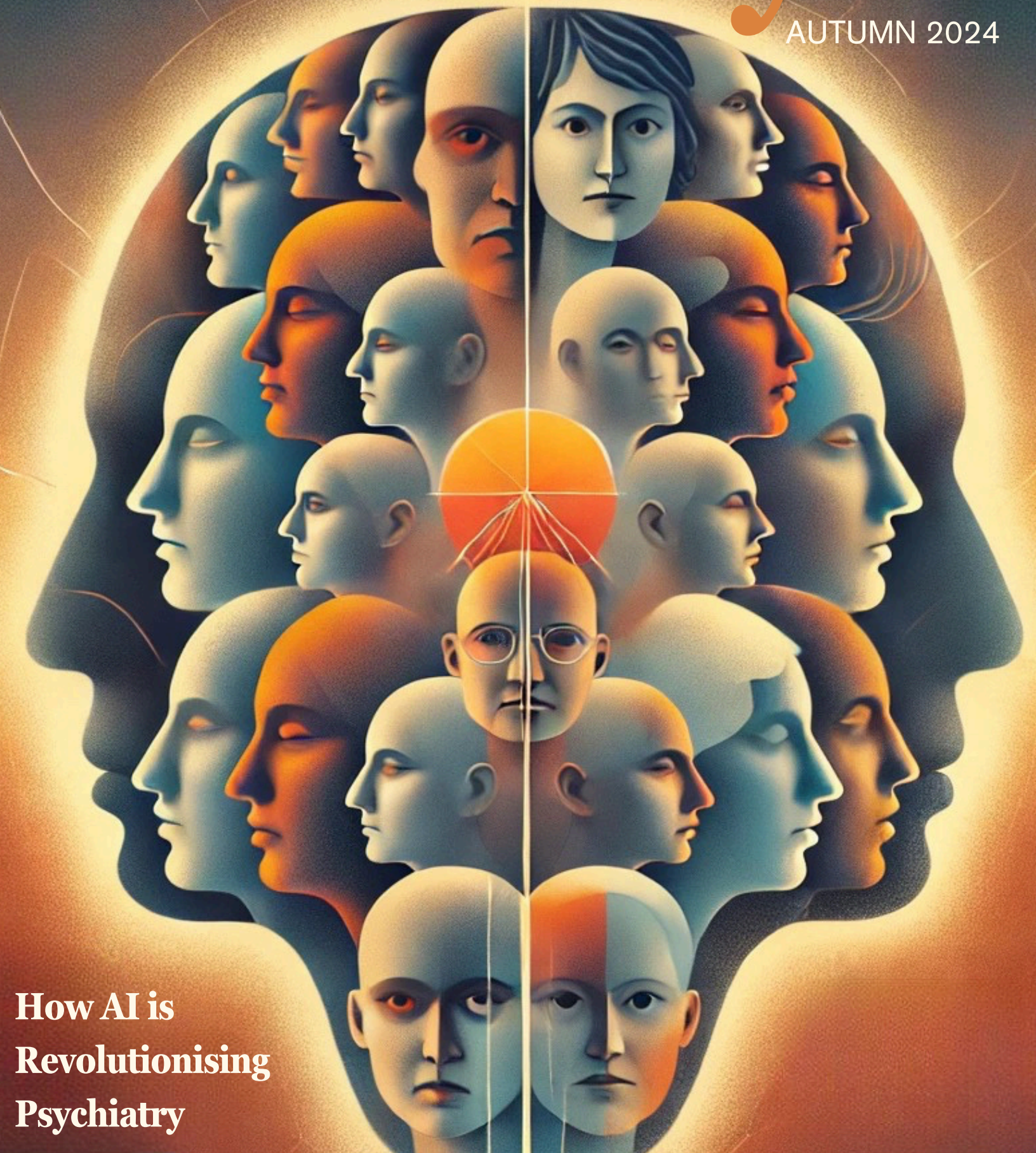

How AI is Revolutionising Psychiatry

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Above: Dollar Gill via Unsplash. Cover: ChatGPT.

FROM THE EDITORS

Welcome to the latest edition of *FuturePsych*, our first as co-editors!

We've worked hard to find something for everyone in this issue. From participatory research on metabolic disorders and a review of mental health in Gypsy, Roma and Traveller communities, to the integration of AI in psychiatry and a reconsideration of the language we use in clinical settings, this edition offers insights that will inspire and inform the next generation of psychiatrists.

We also feature personal stories from students and trainees who share their journeys and the challenges they've overcome, providing a comprehensive and relatable resource for those embarking on a career in psychiatry. We hope this issue serves as both a guide and a source of inspiration as you navigate your path in the ever-expanding field of mental health.

DR FELICITY ALLMAN
FOUNDATION DOCTOR REP

Felicity is a specialised foundation programme doctor in the Northern Foundation School, and a visiting researcher/training fellow at Newcastle University. Before medicine, she was a registered mental health nurse.

EMELIA PASTERNAK-ALBERT
MEDICAL STUDENT REP

Emelia Pasternak-Albert is a multi-award-winning medical student at King's College London GKT School of Medical Education and outgoing intercalating MPhil (Psychiatry) student at the University of Cambridge with a keen interest in child and adolescent psychiatry.

She is the Medical Student representative for the PTC, sitting on RCPsych committees such as the Choose Psychiatry Committee and the Psychiatric Trainees Committee. This is a continuation of her work with the College as she was the inaugural Child and Adolescent Faculty Psych Star during the 2022-23 academic year.

Emelia is the Communications Lead for the National Student Psychiatry Audit and Research Collaborative (SPARC), the King's College London lead for the Fulbright International Child Psychiatry Mentoring Network, and has been Vice-President of the Cambridge University Psychiatry Society and Secretary of the King's College London Psychiatry Society, organising conferences such as the National Student Psychiatry Conference 2023. Her interests include global child mental health, neurodevelopmental psychiatry, Adverse Childhood Experiences and developmental trauma, and policy work.

ONE OF FUTUREPSYCH'S EDITORS, DR FELICITY ALLMAN, ASKED CHATGPT, AN AI CHATBOT, HOW ARTIFICIAL INTELLIGENCE IS BEING USED IN PSYCHIATRY. BELOW IS ITS RESPONSE:

"Artificial Intelligence (AI) is rapidly transforming the field of psychiatry, ushering in a new era of mental health care. From revolutionizing diagnosis to personalizing treatments and enhancing access, AI is becoming an indispensable tool for mental health professionals. Here's how AI is making waves in psychiatry, offering new hope for patients and clinicians alike.

Diagnosing the Invisible: AI's Role in Early Detection
Imagine a world where the onset of depression or anxiety could be predicted with the same precision as a weather forecast. AI is turning this vision into reality. By analyzing massive datasets, predictive analytics are helping clinicians identify patterns that signal the early stages of mental health conditions. This includes everything from scrutinizing electronic health records (EHRs) to evaluating social media activity.

Natural Language Processing (NLP) is another AI-driven innovation making its mark. By analyzing speech and text, AI can detect subtle changes in language that may indicate mental distress. A shift in a person's speech patterns or the content of their online posts could reveal early signs of conditions like schizophrenia or suicidal ideation, allowing for timely intervention.

Tailored Therapy: The Rise of Personalized Treatment Plans
AI's ability to analyze vast amounts of data means that treatment plans are becoming increasingly personalized. Machine learning models can predict which therapies—whether cognitive-behavioral therapy (CBT), medication, or a combination of both—are most likely to succeed for individual patients. This approach not only improves outcomes but also reduces the trial-and-error process that can be frustrating for patients and clinicians alike.

In the realm of drug discovery, AI is proving to be a game-changer. By modeling the complex interactions within biological systems, AI is helping researchers develop new psychiatric medications that are more effective and have fewer side effects.

A New Era of Therapy: Virtual Therapists and Chatbots
The therapeutic landscape is also evolving, thanks to AI. Meet Woebot and Wysa, AI-powered chatbots that provide cognitive-behavioral therapy and other psychological support. These digital companions are available 24/7, offering patients a lifeline between traditional therapy sessions.

Virtual Reality (VR) is another technology making strides in mental health care. Combined with AI, VR is being used in exposure therapy

to treat conditions like PTSD, anxiety, and phobias. These immersive environments allow patients to confront their fears in a controlled, safe setting, making therapy more effective.

Continuous Care: Monitoring and Early Intervention
AI isn't just about treatment; it's also about continuous care. Wearable devices equipped with AI can monitor physiological indicators such as heart rate, sleep patterns, and physical activity. Subtle changes in these metrics can alert clinicians to the early signs of a mental health issue, prompting early intervention.

Digital phenotyping, a cutting-edge technique, uses data from smartphones—like typing speed, app usage, and location tracking—to monitor behavioral changes. This data can offer invaluable insights into a person's mental state, enabling proactive care rather than reactive treatment.

Breaking Barriers: AI Enhancing Access and Reducing Stigma
AI is also playing a crucial role in breaking down barriers to mental health care. Telepsychiatry, powered by AI, is bringing mental health services to remote and underserved areas, where access has traditionally been limited. Moreover, the anonymity offered by AI-driven tools helps reduce the stigma often associated with seeking mental health care, encouraging more people to seek help.

Additionally, AI is making mental health care more inclusive by adapting therapeutic content to different languages and cultural contexts. This ensures that more people around the world can access the care they need, regardless of their background.

The Data Dilemma: Ethical Considerations in AI-Powered Psychiatry
As AI continues to integrate into psychiatry, it's essential to address the ethical implications. One of the most pressing concerns is ensuring that AI systems are free from bias. In a field as sensitive as mental health, even a slight bias in AI algorithms can have significant consequences. Researchers are working tirelessly to ensure these tools are equitable and do not reinforce existing disparities.

Privacy is another critical issue. The sensitive nature of mental health data means that robust security measures are paramount. Patients need to trust that their information is safe and that AI tools are being used ethically and responsibly.

Conclusion: A New Frontier in Mental Health
AI is undoubtedly revolutionizing psychiatry, offering new tools and techniques that promise to enhance the diagnosis, treatment, and management of mental health conditions. While the potential is immense, it's crucial to navigate this new frontier with care,

ensuring that ethical considerations keep pace with technological advancements. As AI continues to evolve, it holds the promise of not just transforming psychiatry, but also improving the lives of millions of people around the world.

Felicity: *Two things came to mind after speaking to ChatGPT: does it have insight? It seems very good at demonstrating ethical concerns around its own use. Secondly, we are now living in a world that requires extra vigilance, where articles are written by computers and everything is not as it seems. It reminds me of things I've heard people say when they're experiencing paranoia, and has certainly helped me develop further empathy for those people.*

DR FELICITY ALLMAN
EDITOR

RCPSYCH RESOURCES FOR MEDICAL STUDENTS AND FOUNDATION DOCTORS

Above: Desola Lanre-Ologun Gill via Unsplash. Pg 4/5: ChatGPT.

The Royal College of Psychiatrists (RCPsych) has dedicated faculties and special interest groups (SIGs) for all the topics discussed in this edition of *FuturePsych*, including:

- Faculty of Neuropsychiatry
- Faculty of Academic Psychiatry
- Faculty of Perinatal Psychiatry
- Faculty of the Psychiatry of Intellectual Disability
- Faculty of General Adult Psychiatry
- Transcultural SIG
- Neurodevelopmental SIG
- Digital Psychiatry SIG
- Volunteering and International SIG

and many more. Become a Student Associate member of the College today, for free, and gain access to free events, networking opportunities and RCPsych publications.

We also encourage you to access RCPsych Learn, the home of the College's learning activities.

We also think you'll enjoy the RCPsych podcast, available on Amazon Music, Apple Podcasts, SoundCloud and Spotify. It's a great way to stay up-to-date for medical school and beyond.

For more information on essay prizes and bursaries that are available from the RCPsych, check out page 8.

For information on submitting to the next issue of *FuturePsych*, head to page 19.

On our back page, we've picked two upcoming events that we think you'll love to attend, but there are endless opportunities at rcpsych.ac.uk/events.

The RCPsych website has plenty of information on careers, applications and opportunities from sixth form to consultant, so stay in touch and get involved!

Jason Goodman, via Unsplash.

CO-PRODUCING THE FUTURE: THE POWER OF PARTICIPATORY RESEARCH IN PSYCHIATRY

My first placement in the specialised foundation programme was in general psychiatry with Dr Albert Michael, where I thoroughly enjoyed witnessing the significant improvement of young patients with acute psychotic disorders. This specialty had always fascinated me during medical school, where I dedicated nearly 20 weeks to placements and research electives across various trusts and universities. However, experiencing this first-hand as a doctor provided me with novel experiences, such as presenting at a Mental Health Act (MHA) Tribunal. I even assisted in delivering a clinical study as an NIHR Associate Principal Investigator.

To maximise my chances of securing a spot in academic psychiatry specialty training, I was eager to initiate my own small project, even though there was no protected time during FY1. Most successful applicants for an Academic Clinical Fellowship (ACF) in psychiatry at Cambridge are already post-doctoral, so a first-author paper would significantly bolster my application. When planning the project, I was inspired by the RCPsych conferences I had attended, which emphasised the importance of co-production. Co-production involves engaging key stakeholders, such as individuals with lived experiences and personal knowledge, to enhance the quality and impact of research.

I drew on my previous experiences in metabolic disease, public health, intellectual disability, and general psychiatry to craft a project addressing a gap in the literature. The topic focused on food security—specifically the degree to which an individual has access to safe, nutritious food—and its interactions with inherited metabolic diseases. Given that many of these individuals require specialised diets due to diet-treated illnesses, I was concerned about how the pandemic and subsequent cost-of-living crisis could affect their physical and mental health.

I chose to focus primarily on galactosaemia, a relatively well-known and well-documented metabolic disorder included in many national newborn screening programmes. There is also literature on a 'classic galactosaemia phenotype' due to its overlap with developmental disorders, intellectual disability, and autistic traits. Given the importance of dietary adherence in their lives, I was concerned about how financial difficulties and access problems could affect their mental and physical health, especially when navigating a rapidly changing retail environment with intellectual disabilities and associated developmental disorders.

To bring this project to life, I contacted Professor Emma L Giles, a

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leading UK expert in public health and a professor of integrating mental and physical health. She suggested that I submit a grant with her for Teesside University's Participatory Research Fund (PRF), designed to support co-produced projects. The only catch was that the deadline was just a few days away! I still remember sitting in the psychiatry junior's office, typing away frantically, fuelled by caffeine on a Sunday afternoon.

In the end, it all paid off. When the grant approval email popped up in my inbox a few months later, my heart skipped a beat. The project was on! We had secured funding for the Patient and Public Involvement and Engagement (PPIE) phase, which involved discussions with 7-8 individuals with galactosaemia and their caregivers, paid at the NIHR Involve rate to co-produce the survey. We collaborated with two leading charities in the field, Galactosaemia Support Group UK and Metabolic Support UK, to assist in recruiting for our online survey.

From there, I assembled a multi-disciplinary team based in the Giles 'laboratory', including an ST1 in paediatrics, a clinical academic dietitian, and a Dutch public health researcher. With the survey recently completed, we are currently undergoing data analysis. The preliminary analysis suggests unmet mental health needs in adults with galactosaemia. Once the data is fully analysed, we have funds to re-consult with individuals with galactosaemia to co-create an Easy Read to disseminate our findings back to the galactosaemia community. This experience has allowed me to understand the processes behind conducting co-produced research, enriching my skillset as an aspiring academic neuropsychiatrist.

No longer are patients still silent watchers of the scholarly quill;
But partners now in our healing art, their voices strong, their truths impart.

DR NARUT PAKUNWANICH
SFP2 DOCTOR, CAMBRIDGE

UPCOMING PRIZES AND BURSARIES FROM THE RCPSYCH

Women and Mental Health Special Interest Group Essay Prize
Deadline: 11 October 2024
Prize: £100 + free attendance at our annual conference
Eligibility: Medical students and psychiatry trainees and SAS doctors in the UK

Forensic Faculty Medical Student Essay Prize
Deadline: 18 October 2024
Prize: Monetary Prize and attendance at the faculty conference
Eligibilty: Medical students in the UK

Old Age Faculty Trainee Prize
Deadline: 1 November 2024
Prize: £150 for foundation doctors/core trainee winner and £150 for specialty trainee winner
Eligibility: Foundation doctors, core trainees and specialty trainees in the UK

Intellectual Disability Faculty Joan Bicknell Medical Student Essay Prize
Deadline: 1 December 2024
Prize: £250 and subsidised attendance at the faculty conference
Eligibility: Medical students in the UK

Spirituality and Psychiatry Essay Prize
Deadline: 31 December 2024
Prize: £300
Eligibility: All members of the College and medical students

Old Age Faculty Medical Student Essay Prize
Deadline: 31 December 2024
Prize: £250 and subsidised attendance at the faculty conference
Eligibility: medical students in the UK

Neuropsychiatry Faculty Educational Bursary
Deadline: Available throughout the year
Bursary: up to £250
Eligibility: Medical students, foundation doctors, junior psychiatric trainees (CT1-3, ST4-6), SAS doctors, based in the UK

Go to https://www.rcpsych.ac.uk/become-a-psychiatrist/med-students/awards-prizes-and-bursaries for more information on these and other opportunities available from the RCPsych, including the Psych Star Scheme for medical students. We look forward to receiving your applications!

REFLECTIONS FROM A PLACEMENT AT A MOTHER & BABY UNIT

Alex Pasarelu, via Unsplash.

The mother and baby unit (MBU) is a specialist inpatient ward for women experiencing mental health problems during the perinatal period, which spans pregnancy to one year post-birth. Mental health issues affect around 1 in 5 women during this time, and 2-4 per 1,000 women require admission to an MBU. The unit plays a crucial role in providing treatment, as mental health conditions can significantly affect the mother's relationship with her baby, impacting her confidence and belief in her ability to care for her child.

The NHS Long Term Plan builds on the Five Year Forward View for Mental Health, with the aim of transforming specialist perinatal services across England. The goal is to ensure at least 66,000 women with moderate to severe perinatal mental health difficulties receive care and support in the community. However, during my placement, it became clear that bed shortages are a significant issue. Some women had to wait for admission, and if no space became available, alternatives included temporary placement in general psychiatric wards or remaining at home with intensive support. This highlighted how staffing shortages and lack of resources directly impact patient care.

My time at the MBU highlighted the incredible support staff provide to both mothers and their infants. The team focused on nurturing the mother-infant bond while treating the women. Each patient had her own room, with a cot for her baby, creating a homely environment. Seeing babies on a psychiatric ward was an unusual but powerful reminder of the unit's purpose: to keep families together while providing specialist care.

Upon reflection, I realised how vital psychiatry placements are for medical students. I encountered a wide range of conditions, including bipolar affective disorder, schizophrenia, postpartum psychosis, severe depression, and anxiety disorders such as obsessive-compulsive disorder. The placement also offered insight into the effectiveness of various treatment options. Over the eight weeks, I observed group therapy sessions become safe spaces for patients, while activities like arts and crafts, shared meal preparation, and outdoor walks helped restore their confidence.

One patient told me that regaining her independence, whether by cooking or spending time in the garden, was key to rebuilding her self-esteem. This reinforced how essential it is for patients in perinatal psychiatry wards to have timely access to evidence-based care, ideally in an MBU close to home. Increasing awareness of perinatal mental health can lead to earlier diagnosis and support from partners, families, and employers.

Psychiatry was one of my first placements, and it was challenging at

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times. I wasn't sure what to expect, and some of my observations were difficult to process. However, after speaking with the mental health nurses about my concerns, I found it easier to view the placement as both a privilege and a learning opportunity. For any medical students who find these experiences challenging, I recommend openly discussing them with the nursing staff. Their support can make a significant difference.

ROJBIN ARJEN YIGIT
3RD YEAR MEDICAL STUDENT

Above: Robin Arjen Yigit. Below: Dr Riya Gosrani.

REVISITING PSYCHIATRIC LANGUAGE: A PATH TO GREATER COMPASSION AND EQUITY

My interest in the role of language in medical settings began with a conversation with a psychiatrist. Notably, Dr Sushrut Jadhav introduced me to a technique of converting the commonly used adjective 'homeless' into the verb 'homeless-ed'. He explained that this denominal method was purposefully employed to encourage consideration of the broader structural factors and social forces involved in homeless-ed patients' lived experiences of suffering. This insight into the power of language was striking, as the addition of only two letters to a word significantly altered modes of thinking. When a person is described as 'homeless', it appears as a static, indisputable fact because the processes involved in constituting this identity are not mentioned. However, when using the verb 'homeless-ed', I noticed more nuanced discussions among medical professionals, leading to a better understanding of factors beyond individual responsibility.

This experience highlighted the importance of language in medical practice and inspired me to experiment with language in clinical settings. The repetitive use of certain terms in medical spaces can perpetuate harm without awareness. I am not suggesting that ignorance is acceptable, but rather acknowledging that harmful linguistic processes might be difficult to intuitively recognise and therefore dismantle. I have adopted a reflexive approach, sometimes changing nouns or adjectives to verbs. While this may sound like an arduous process, the potential of this approach lies in generating new ways of thinking that were previously unimaginable.

A personal reflection from my psychiatry rotation in a London hospital illustrates this point. During a ward round, a psychiatrist introduced a newly admitted patient as a "homeless black woman with schizophrenia". I noticed that the psychiatrist almost inevitably described her tendencies towards drug abuse. Through this seamless integration, he went on to claim that the patient was a textbook example. When discussing risk factors for psychosis, he included race (specifically being Black). I remember that it was at this moment I began to question his assertion. Perhaps this reflection arose because his previous comment had already made me wonder whether the psychiatrist would have spoken more compassionately about the patient's substance misuse if dominant modes of conversation involved using the term 'homeless-ed' or the phrase 'being homeless' instead of 'homeless'.

The psychiatrist's use of 'race' as a static risk factor reflects a common practice of viewing race through a genetic lens (Lewontin, 1972), neglecting the processes that sustain racial categories. For instance, the patient was born to a Black father and a white mother,

Christina @ WOCinTechChat.com via Unsplash.

but the psychiatrist automatically classified her into the Black category. This is significant when one considers his subsequent statement, in which race itself was used to explain disease burdens in schizophrenia. The assertion that 'racial differences exist because of race' is a tautology (Goodman, 2016). The argument is invalid because the statement is constructed in such a way that the proposition is logically indisputable, reinforcing the same idea. To address this, I initiated the denominal shift from 'race' to the verb 'racialis-ed' or the phrase 'doing race'. This shift encourages consideration of the processes through which racial groups are constructed and maintained, highlighting factors often overlooked when race is treated as a fixed variable. Therefore, one might consider how racism (rather than race) contributes to adverse conditions that increase the likelihood of substance abuse and subsequent psychosis.

In conclusion, I recommend that clinicians and medical students adopt a reflexive approach to the language used in the medical field. My reflections have shown that even small changes in language can hold vast potential for promoting inclusivity and belonging.

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DR RIYA GOSRANI
FY1 DOCTOR, LONDON

WHAT I LEARNT ABOUT PSYCHIATRY: A REFLECTIVE PIECE

In the last term of my third year in medical school, I had a six-week placement in psychiatry that changed the way I think about medicine. The following article is a reflection on that experience.

Stereotypes

Throughout the placement, there was a prevailing notion among my peers that all psychiatrists did was "have mushy discussions about feelings". At the start, I believed this statement was an oversimplification. By the end, I realised that it was simply false.

Psychiatry is not heavy on X-ray machines or MRIs. Fascinatingly, it is the 'conversation' that is the main tool. When speaking with a patient, either informally or taking a history, I found myself constantly making new connections and forming new ideas about potential diagnoses. I quickly realised clinical presentations do not fit neatly into boxes as textbooks suggest.

I listened to a patient 'ramble' about his academic achievements but caught on that he was not always coherent. This, coupled with his past medical history of alcohol misuse, helped paint a clearer picture. This was possibly how he coped with the brain damage he incurred from his drinking. This taught me that rumination over what a patient says is part of the investigative process of clinical judgement. This helped me to understand that psychiatry was just as 'medicine' as any other speciality.

'Soft' and 'Hard' Approaches

How the doctors conducted themselves played a role in patient care. I saw how psychiatrists needed to be gentle to help patients open up and feel understood. However, I sometimes felt that this could come at the expense of being proactive.

In my opinion, a psychiatrist needs to be thinking about their patient with a degree of urgency. If I were to become a psychiatric patient, I would want a doctor to both comfort me and be in control. I would want the doctor to explain what was happening, what they thought was best to do, and why.

I felt fortunate to see how different doctors managed this and wondered if I would have approached the same situations differently. I appreciated the nuance and strategy required to balance using 'soft' and a 'hard' approaches depending on the situation.

Introspection and Narrative Medicine

My biggest takeaway was that psychiatry is a special field because of how introspective it is. The way we discussed patient care, such as whether it was safe to discharge patients into the community, forced me to think about the world we live in, the human connections we form, and the kind of world we are creating.

Strangely enough, I started thinking of patients as characters in their own stories. This was before I stumbled across the concept of 'Narrative Medicine'. It explained why I was so invested in patients' stories and why this psychiatry placement made me feel like this career was fulfilling an unmet literary aspiration for the first time. I found this to be truly fascinating.

Conclusion

I now realise how complex and perceptive psychiatry is as a field. I have reinvigorated my love of medicine and feel excited about psychiatry as a potential career path.

VICTOR KWONG CHIAN
4TH YEAR MEDICAL STUDENT
NEWCASTLE UNIVERSITY

POOR MENTAL HEALTH IN GYPSY, ROMA AND TRAVELLER COMMUNITIES

For my third-year research project, I conducted a systematic review on mental health and suicidality in Gypsy, Roma, and Traveller (GRT) communities across the UK, Ireland, and Europe. Historically, GRT communities have been nomadic, but they have become increasingly settled in recent times. They maintain a distinct cultural identity, characterised by a patriarchal society, a strong sense of stoicism, and a deep emphasis on family. GRT people are also significantly affected by poverty, with markedly lower educational and employment outcomes compared to the general population. Due to a variety of factors—including limited access to healthcare, health beliefs such as stoicism and fatalism, and a distrust of settled institutions—these communities experience some of the poorest health outcomes of any ethnic group in the UK (Hayanga et al., 2023; Watkinson et al., 2021). For example, GRT individuals have a life expectancy that is 5 to 20 years shorter than that of the general population in the EU and 11 years shorter in the UK (Greenfields, 2017). My review sought to determine whether the health disparities experienced by this community extend to mental health as well.

The evidence showed that GRT people have a significantly higher prevalence of psychiatric issues compared to the general population. They face elevated levels of psychiatric conditions and more severe depressive and anxious symptoms. A UK study found that, of all ethnic groups, GRT had the highest risk of having a long-term mental disorder (Hayanga et al., 2023). Another UK study similarly showed that GRT experienced the most severe anxious and depressive symptoms of any ethnicity (Watkinson et al., 2021). However, mental illness appears to be underdiagnosed in this population. Studies also indicated that GRT are more likely to attempt suicide but less likely to complete it. Notably, they are more likely to attempt suicide as a way to appeal to others, rather than with the intent to die (Zonda & Lester, 1990; Toth et al., 2018). It should be noted that the evidence is not of the highest quality, with most of the limited studies being cross-sectional and prevalence studies.

Several mechanisms can explain these findings. In Europe, GRT often live in segregated settlements with limited access to infrastructure. In the UK, the government has failed to meet targets for authorised GRT sites, trapping them in a cycle of forced eviction from unauthorised sites. They face significant barriers that prevent them from integrating into mainstream society, including systemic discrimination, prejudice, and negative media portrayal. Barriers to accessing healthcare, as mentioned earlier, make it very difficult for them to seek help. Additionally, their poorer physical health outcomes may have a detrimental impact on their mental health (Parkinson et al., 2020). The severe stigma surrounding mental health

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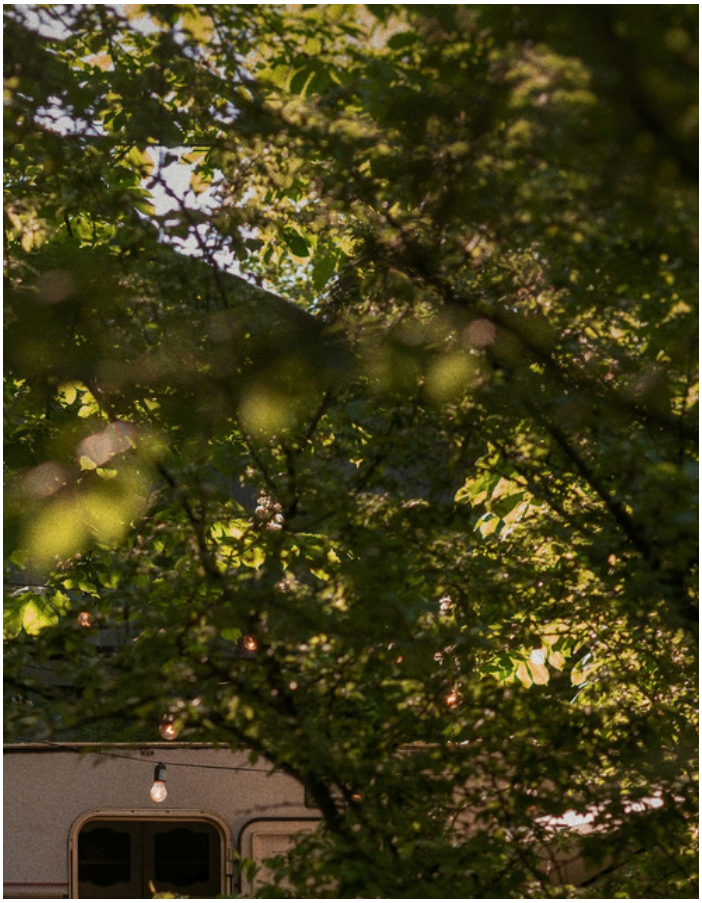
Above: Olena Bohovyk via Unsplash.



Above: Olena Bohovyk via Unsplash. Below: Arav Dagli.

within these communities can make it extremely challenging for individuals to express their suffering, leading some to view suicide as their only viable option (Tobin et al., 2020). This also explains the differing intent behind suicide attempts; for some, it may seem like the only way to convey the severity of their situation (Zonda & Lester, 1990; Toth et al., 2018).

It is appalling that, in developed societies such as the UK and the EU, a single ethnic group could be so disadvantaged and face such significant mental health disparities. A deliberate and swift change is needed to close the gaps in mental healthcare that this community faces, starting with acknowledging the scale of the problem. Additionally, higher-quality research is urgently needed to understand the underlying causes. Interventions need to be trialled and studied without delay. It is imperative that healthcare systems and governments work together to address the mental health needs of this community, which appear to be rooted in socioeconomic issues. I hope this research serves as a wake-up call to healthcare workers, researchers, and policymakers, and as a catalyst for enacting change.

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ARAV DAGLI
4TH YEAR MEDICAL STUDENT
UNIVERSITY OF MANCHESTER

‘I’M GOING TO KILL MYSELF’: DO WE ALWAYS LISTEN?

THIS ARTICLE COMES WITH A TRIGGER WARNING FOR SUICIDE

“I’m so depressed”, “I’m so OCD about things”, “I’m going to kill myself”. These phrases are commonly heard from friends, family, and colleagues in casual conversation. Despite this, I’ve noticed how rarely people stop to check on the wellbeing of someone who says these things. There’s an overlap between the natural emotions we all feel and the terms used to describe clinical mental health conditions. My aim isn’t to criticise people for using these phrases without necessarily having a diagnosis—I’ve done the same myself—but to spark discussion about how we respond to such statements, especially from the perspective of someone diagnosed with depression and anxiety.

Two years ago, I attempted suicide during a particularly difficult period of my life, and I continue to struggle with suicidal thoughts intermittently. It’s an isolating experience. In clinical settings, when I’ve expressed these feelings, professionals have always taken me seriously. Yet in everyday life, I’ve found myself becoming less open about these thoughts, especially with friends. Sadly, too many of my cries for help have been dismissed or ignored. I’ve come to realise that active listening in the clinical setting often contrasts starkly with how we listen to each other in daily conversations.

As someone who has been affected by suicide attempts, I often wonder how many others feel the same way I do when they hear someone casually say, ‘I’m going to kill myself’. Am I the only one who feels triggered? The urge to stop the conversation and ask, ‘are you okay?’ is strong, yet I hesitate, fearing how others might react. Questions race through my mind: do they mean it, or is it just a figure of speech? Should I check in on them? Will I be laughed at for taking it seriously? These comments often play on my mind long after they’ve been said.

The truth is, we can never know for sure if someone is joking or if it’s a genuine cry for help. Just as fashion or music trends change, so do the phrases people use. The increasing use of statements like ‘I’m going to kill myself’ likely reflects a need to relate to others. Yet for every ten people who casually use the phrase, there could be one who is genuinely in need of mental health support. That’s why I believe we should take every comment about suicide seriously, whether we’re in a clinical setting or not. I’m only here today because my closest friends and family took me seriously when I expressed those feelings. It’s now my responsibility to do the same for others. A simple ‘Are you okay?’ can make all the difference. Whether someone is using these words lightly or not, it’s always worth checking in—because you never know when someone really needs help.

LAURA GILL
5TH YEAR MEDICAL STUDENT
UNIVERSITY OF EDINBURGH

Above: Jerome via Unsplash. Below: Laura Gill.

HEARING THE UNSPOKEN: LESSONS FROM A PSYCHIATRIC PLACEMENT

Priscilla Du Preez via Unsplash.

I had just come home from work and crashed onto my sofa. Lately, I had been struggling even to go in. As I started drifting off to sleep, I could hear murmuring from the TV in the other room. I tried to ignore it, but the more I covered my ears, the louder it seemed to get. More murmurs. I gave in and went to turn it down, but the TV wasn't even switched on. How could that be? More murmurs. Maybe it's the radio? The voices grew louder. I couldn't think. Panic set in. Where was it coming from? I don't have a radio; it can't be the radio. Why is this happening to me? Maybe if I scream, I can drown them out.

This is the kind of experience that educators with lived experience of schizophrenia discussed during my four-week psychiatric placement in fourth year. By this point in my studies, I had encountered several devastating patient stories that helped me understand the impact of physical illness on mental well-being, but I feared it wasn't enough to avoid feeling out of my depth in psychiatry. I was right.

The placement included various components to provide a deeper insight into different aspects of psychiatry. This included mental health service wards, a mental healthcare hospital and rehabilitation facility, a memory assessment service, an overview of Child and Adolescent Mental Health Services (CAMHS), and opportunities for one-on-one discussions with individuals experiencing depression, bipolar disorder, anxiety, and schizophrenia. I found it to be a steep learning curve as it was different from previous placements. I was learning about conditions that weren't physically visible and trying to comprehend what it must feel like to have the life and mind you know slip out of your control.

I was particularly interested in learning more about schizophrenia and was fortunate to have both group and individual discussions with people at different stages of their experience with the disorder. Some were newly admitted to a ward, others had been service users for years or were in remission.

One service user shared a decade-long struggle with a delayed diagnosis due to their family's unwillingness to consider schizophrenia as a possible cause of their symptoms. Another, who had been re-admitted multiple times, explained how they felt like a failure as support from both family and healthcare facilities dwindled with each re-admission. In both cases, it seemed that their attempts to express their struggles were met with silence. It made me wonder if, as a society, we have become stagnant in our conversations about mental health. Awareness has significantly increased, but what about the next steps in the journey? This placement taught me many things: what it means to truly show no

judgement, the process of gaining trust to have difficult conversations, and most importantly, the power of listening to understand. I hope that with time, we can build on the foundation of mental health awareness and have more candid conversations about what comes next.

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Above: Nadya Osman. Below: Tharuka Nanomi Arachchige.

WHEN MONEY DOESN'T BUY HAPPINESS: A LOOK INTO WHAT REALLY AFFECTS SUBJECTIVE WELL-BEING IN UK LOW-INCOME COMMUNITIES

'Money can't buy happiness'—a timeless adage that has been debated for centuries. But what does the evidence show? As expected, poorer people are generally less happy than their wealthier counterparts. Moreover, a pattern emerges resembling a logarithmic curve—the impact of money on happiness gradually diminishes as income increases, eventually plateauing .

What exactly are researchers measuring? It's called 'subjective well-being', which refers to an individual's perception of their well-being and quality of life. This differs from 'objective well-being', which is more tangible and observable, collected via health records and demographic statistics .

Recently, the relationship between happiness and economic status has gained relevance in the context of recovering from the COVID-19 pandemic and the cost-of-living crisis. Those living in low-income households have been disproportionately affected. Based on this, it seems logical to assume that providing financial support in the form of unconditional cash transfers would improve well-being. The evidence supports this idea in low-income countries as defined by the World Health Organization (WHO), such as Malawi. However, the same cannot be said for low-income communities in high-income countries like the UK or the US. A recent study showed that even a $2000 cash transfer in the US did not significantly improve well-being.

So why don't cash transfers always work? To design the most effective and resource-efficient policies to reduce health disparities, researchers need to understand the key determinants of well-being in specific populations. I aimed to explore this question during my internship with the National Institute for Health and Care Research School for Public Health Research (NIHR SPHR).

The Method

I created a survey on the online platform Prolific Academic with questions informed by a Patient and Public Involvement group. In addition to the subjective well-being questions used by the Office for National Statistics, I focused on depressive and anxiety symptoms using the PHQ-9 and GAD-7 screening tools recommended by NICE guidelines. Data was collected from individuals with annual incomes below £30,000. When data collection was complete, it was striking to find that over half of the participants had a diagnosed mental health condition. (cont pg. 18)

What We Found

The main outcomes we measured were life satisfaction, feelings of worthwhile activities, happiness, symptoms of anxiety, and symptoms of depression. Using a standardised regression, we found that higher job satisfaction, increased household size, and higher self-perceived social status were statistically significant determinants across these measures. Conversely, education beyond secondary school and being up to date on bills or rent did not have a significant effect.

What's Next?

Health research only realises its true value when applied to real life and real communities. Cash transfers may not be sufficient to improve well-being unless the underlying determinants of well-being are addressed. For example, improving job satisfaction through workplace well-being initiatives can lead to increased overall well-being. However, theory doesn't always seamlessly translate into real-life outcomes. We need to trial specific interventions in low-income communities to learn which are most effective, where they work best, and understand the processes that drive their success. Continuing this cycle of research and policy implementation can lead to a society with fewer health disparities and increased overall physical and mental well-being.

You can find the survey and anonymous data collected here [https://osf.io/zgqek/]. Thank you to the NIHR SPHR and Dr. Laura Kudrna for providing me with this opportunity and supporting me throughout the internship.

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