Aims. Evidence supports associations between polyunsaturated fatty acids (PUFAs) such as docosahexaenoic acid (DHA) and psychosis risk. However, longitudinal PUFA trajectories in the general population have not been characterised. The aims of this study were: 1) To describe longitudinal trajectories of plasma omega-6:omega-3 ratio and DHA levels in a large general population sample; and 2) To evaluate associations between these trajectories and psychosis-spectrum outcomes in early adulthood. Based on previous research, we hypothesised that trajectories characterised by higher omega-6:omega-3 ratio and lower DHA levels would be associated with increased odds of psychosis-spectrum outcomes.
Methods. We examined a large cohort in the Avon Longitudinal Study of Parents and Children (n = 3635, 2247 [61.8%] female). Plasma omega-6:omega-3 ratio and DHA % total fatty acids were measured by nuclear magnetic spectroscopy at 7, 15, 17 and 24 years, then standardised by sex. Trajectories were evaluated using curvilinear growth mixture modelling, contemporaneously adjusting for body mass index. Psychosis-spectrum outcomes were assessed at 24 years. Psychotic experiences (PEs), At-Risk-ental-State status, psychotic disorder and number of PEs were measured using the Psychosis-Like Symptoms interview. Negative symptoms score was measured using the Community Assessment of Psychic Experiences. Associations were evaluated using logistic, negative binomial or linear regression as appropriate, adjusting for sex, ethnicity, parental social class, smoking and alcohol use. Multiple imputation was used to impute missing exposure and covariate data across ten imputed datasets.
Results. A three-trajectory solution was optimal for both omega-6:omega-3 ratio and DHA. Relative to stable average, persistently high omega-6:omega-3 ratio and persistently low DHA trajectories were associated with increased odds of PEs and psychotic disorder, with these associations explained by included covariates. In fully adjusted analyses, the persistently high omega-6:omega-3 ratio trajectory was associated with number of PEs (adjusted β 0.41, 95% confidence interval [CI] 0.05–0.78) and negative symptoms score (adjusted β 0.43, 95%CI 0.14–0.72), as was the persistently low DHA trajectory (number of PEs: adjusted β 0.45, 95%CI 0.14–0.76; negative symptoms: adjusted β 0.35, 95% CI 0.12–0.58).
Conclusion. In this first description of plasma PUFA trajectories in a large general population cohort, trajectories characterised by persistently high plasma omega-6:omega-3 ratio and persistently low plasma DHA levels were associated with psychosis-spectrum outcomes in early adulthood. In the case of number of PEs and negative symptoms, these associations were not fully explained by included covariates. Optimisation of PUFA status during development warrants further investigation as a malleable protective factor in relation to specific psychosis symptom domains in early adulthood.

Comparison of the Legal Infrastructure Governing Psychiatric Practice and Its Implementation in Tanzania and the UK

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Aims. To examine the legal framework governing psychiatric practice, specifically focusing on the Mental Health Act, within a singular psychiatric centre in Moshi, Tanzania. The primary objective was to explore the intersection of culture and legalities in shaping ethical practice within this emerging unit. Drawing on a comparative analysis of contents and the implementation of the MHA in Tanzania and in the UK, the study aims to understand the ways in which cultural contexts influence the legal and ethical dimensions of psychiatric care.
Methods. This was a multi-method study that combined literature analysis, structured interviewing, and structured reflective practice.

1. Direct comparison of the UK and Tanzanian MHA.
2. Evaluation of clinician understanding of the MHA through structured interviewing of clinicians with respect to their knowledge of the MHA, its existence, and its key components.
3. Analysis of implementation of the MHA in liaison psychiatry in both centers. Compared through unstructured interviewing and reflective practice.

Results.
1. The most striking difference is the length of the documents. The Tanzanian MHA is 27 pages while the UK MHA is 173. This additional length covers: Admission and Discharge Procedures, explanation of the Roles and Powers of Professionals, and further discussion on Safeguards and Rights of Individuals.
2. When interviewed, only 15% of Tanzanian physicians could explain what the MHA is, compared with 100% of UK physicians (N = 40).
3. In the UK, all doctors use the MHA and implement DOLS. In Tanzania, this falls under the role of liaison psychiatrists. This is likely because, the MHA is included in the UK's medical curricula but not in Tanzania's.

Conclusion. Lack of understanding of the MHA and other key laws in psychiatry is a global issue, not limited to the UK or Tanzania. However, physicians with strong understanding are more scarce in Tanzania. This scarcity puts additional pressures on psychiatric services, as psychiatrists are called to assess issues of capacity or consent that could be assessed by any doctors in the UK. However, this means that the MHA and MCA are almost solely used by psychiatrists and therefore often assessed to a very high standard. It must be considered that on reflection, I have also observed physicians with limited understanding of the MHA, capacity and consent within the NHS. Imposing a higher standard on another culture would be unethical. Efforts into educating medical students and professionals is required in the UK and Tanzania.

Association Between Problematic Online Gaming and Subsequent Psychotic Experiences in Adolescents: A Birth Cohort Study

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