The Simple Physical Activity Questionnaire

The benefits of engaging in regular physical activity are well established, but getting people to act on this simple truism is a challenge. Physical activity and its structured subset, exercise, contribute to weight management, prevention and treatment of cardiovascular disease, improved sleep quality, and reduced overall metabolic risk.[1] Physical inactivity remains the fourth leading risk factor for mortality worldwide and is responsible for an estimated 3·6 million deaths per year.[2] Physical inactivity is a key modifiable risk factor contributing to the scandal of premature mortality among people living with severe mental illness. Physical activity and exercise has been shown to reduce mental health symptom severity and the likelihood of experiencing future episodes.[3]

Leading physical activity researchers have argued that health-care providers should obtain a "physical activity vital sign" on every patient they see, given that there is "no better indicator of a person's health and likely longevity" than their level of physical activity.[4] Given the dual impact of physical activity on both physical and mental health outcomes of people experiencing mental illness, accurate measurement of physical activity levels among psychiatric patients is crucial.

Because detection of improvement without accurate measurement is impossible, ensuring that mental health clinicians have access to a brief, standardised clinical tool assessing key elements of physical activity participation is of high clinical significance. Such a tool will ensure that activation and integration of physical health interventions occurs as part of routine mental health service delivery.

An international working group, including psychiatrists, psychologists, physical therapists, exercise physiologists, and epidemiologists, met in Padua, Italy, in April, 2014, to scope out the challenges experienced using existing research-focused instruments. A subsequent meeting in July, 2015, at the Institute of Psychiatry, Psychology and Neuroscience (UK), saw agreement on the final form of the Simple Physical Activity Questionnaire (SIMPAQ). SIMPAQ uses an interview format to estimate time in bed, structured exercise participation, and incidental or non-structured physical activity. People with serious mental illness are at high risk of daytime sleepiness,[5] and as such we added a specific item targeting this important contributor to physical inactivity.

SIMPAQ is currently being translated into many languages (French, German, Spanish, Portuguese, Farsi, and most Scandinavian languages). A validation study, comparing the data obtained via SIMPAQ to objective accelerometer-based measurements, will be conducted in 2016. This will occur in over 25 centres in 15 countries (including both developed and low-income and middle-income countries), and involve patients with a range of psychiatric diagnoses treated in both inpatient and outpatient settings. The English-language version of SIMPAQ is currently freely available from the project website, with versions in other languages being added as they are finalised.

Once validation is complete, SIMPAQ will hopefully become part of the routine documentation obtained in psychiatric treatment settings. It will have the sensitivity to detect small increases in physical activity and exercise participation that can be achieved by targeted interventions,[6] which can confer real clinical improvement in both mental and physical health outcomes.

We declare no competing interests.

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A research agenda for childhood bullying

For the *Lancet* **Series** on bullying see http://www.thelancet.com/series/bullying

For the **SIMPAQ** see http://www.simpaq.org

The recent *Lancet Psychiatry* Series on childhood bullying illustrates the short-term and long-term associations with depression, anxiety, psychosis, and self-harm. Patients may not disclose past histories of peer victimisation to their doctors, and Jorge Srabstein and Bennett Leventhal urge health professionals to screen for childhood bullying and participate in community-wide prevention.[1]

Srabstein and Leventhal endorse the three-tiered approach recommended by the American Academy of Child and Adolescent Psychiatry (AACAP), and the American Psychiatric Association (APA), which combines prevention, early intervention, and clinical treatment.[1] They also called for further research. This call is timely as there has been little investigation of early intervention and clinical treatment for victims and perpetrators.

Primary prevention has been relatively well studied in Europe and the USA, and a recent review found that school-based programmes can reduce bullying behaviour and victimisation by up to 20%.[2] More targeted programmes are under