North West
School of Psychiatry

Semester 1 Handbook

MRCPsych Course

2018 – 2020

A Psychiatry Medical Education Collaborative between mental health Trusts and Health Education North West.

Course director – Dr Latha Hackett, consultant in child and Adolescent Psychiatry

Deputy course Director – Dr Gareth Thomas, consultant in Old Age Psychiatry

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Contents

Brief guidelines for case conference presentation

The objectives of case conference are:

1. To provide a forum to discuss complex/interesting cases in a learning atmosphere.
2. To develop your ability to present cases in a concise and logical manner.
3. To develop your presentation skills.

Guidelines for presenters:

1. Please use PowerPoint for the presentation (or if you are using other tools make sure that they are compatible with your local IT facilities).
2. You have to present a case that is relevant to the theme of the day on which you are presenting.
3. Please meet with your educational/clinical supervisor at least 4-6 weeks prior to the presentation to identify an appropriate case to present. If there is no suitable case in the team that you work in, you may have to approach other teams/consultants to identify a case.
4. Cases can be chosen for their atypical presentation, diagnosis, complexity or for exploring management options.
5. It would be helpful if you can identify specific clinical questions that would you would like to be discussed/answered at the end of the presentation.
6. We would recommend the following structure for the presentation:
    - Introduction (include reasons for choosing the case)
    - Circumstances leading to admission (if appropriate)
    - History of presenting complaint
    - Past Psychiatric history
    - Medical History/ current medication
    - Personal/family History
    - Alcohol/Illicit drugs history
    - Forensic history
    - Premorbid personality
    - Social circumstances
    - Mental state examination
    - Investigations
    - Progress since admission (if appropriate)
    - A slide with questions that you would you like to be discussed
    - Discussion on differential diagnosis including reasons for and against them.
    - Management / treatment
7. The structure of the presentation can vary as long it is logical and concise. Please build into the presentation some natural points to stop and discuss the case.
8. 8. Important: Please ask a senior member of your team who knows the case to attend on the day you are presenting.

Brief guidelines for journal club presentation

The objectives of journal club presentation are:

1. To learn to perform a structured critical appraisal of a study.
2. To learn to make appropriate use of evidence in making decisions about the care of your patients.
3. To prepare for the MRCPsych exams.
4. To develop your presentation skills.

Guidelines for presenters:

1. Please use PowerPoint for the presentation (or if you are using other tools make sure that they are compatible with your local IT facilities).
2. Please select one of the 3 papers listed for the week from the School of Psychiatry handbook to present.
3. Email the paper to your local co-ordinator at least a week before the presentation so that it can be circulated in time.
4. As the presenter you are expected to both present the paper and critically review it.
5. We would recommend the following structure for the presentation: Background to study, methods, analysis, results, conclusions, critical appraisal of the study and implications for clinical practice
6. The most important part of the presentation is the critical appraisal. This should include aspects such as:
    - Purpose of the study
    - Type of study
    - Subject selection and any bias
    - Power calculation (could the study ever answer the question posed)
    - Appropriateness of statistical tests used
    - Use of relevant outcomes
    - Implications of findings
    - Applications of findings/conclusions in your area
    - Directions for further research
7. Use standardized critical appraisal tools.
8. Please discuss the paper and the presentation with your educational/clinical supervisor prior to the presentation.

General Adult Curriculum Mapping				
Section	**Topic**	**Covered by**		
		LAP	**RAP**	**LR**
7.1	Disorders in adulthood			
7.1.1	Unipolar depression	✓		✓
7.1.2	Bipolar depression	✓		✓
7.1.3	Schizophrenia	✓		✓
7.1.4	Anxiety disorders	✓		✓
7.1.5	OCD	✓		✓
7.1.6	Hypochondriasis		✓	✓
7.1.7	Somatization disorder		✓	✓
7.1.8	Dissociative disorders		✓	✓
7.1.9	Personality disorders	✓		✓
7.1.10	Organic psychoses	✓		✓
7.1.11	Other psychiatric disorders	✓		✓
7.2	Perinatal Psychiatry		✓	✓
7.3	General Hospital Psychiatry		✓	✓
7.4	Emergency Psychiatry*		✓	✓
7.5	Eating Disorders			
7.5.1	Anorexia nervosa		✓	✓
7.5.2	Bulimia nervosa		✓	✓
7.6	Psycho-sexual disorders			
7.6.1	Non-organic sexual dysfunction, etc.		✓	✓
7.6.2	Gender Identity Disorders		✓	✓
-	Mental Health Act 1983	✓		✓

General Adult Links to Critical Appraisal Checklists	
Study	**Checklists**
Randomized Controlled Trial	1. CONSORT Checklist 2. SIGN Checklist 3. CASP Checklist
Case-control Study	1. SIGN Checklist 2. CASP Checklist
Cohort Study	1. SIGN Checklist 2. CASP Checklist
Meta-analysis & Systematic Review	1. PRISMA statement 2. SIGN Checklist 3. CASP Checklist
Qualitative study	1. CASP Checklist
Economic study	1. SIGN Checklist 2. CASP Checklist
Diagnostic study	1. SIGN Checklist 2. CASP Checklist

General Adult
Session 1: Psychosis-1
Journal theme: Randomised Controlled trials on Psychosis

Learning Objectives

- To develop an understanding of the clinical presentation of psychotic illnesses.
- To develop an understanding of aetiological theories and epidemiology of Schizophrenia.
- To develop an understanding of possible complications of antipsychotic medication.
- To develop an understanding of Randomised Controlled trials and develop skills for critically appraising RCTs.

Expert Led Session

- Schizophrenia-aetiological theories and epidemiology

Case Presentation

- A case of Schizophrenia (any subtype) /Schizoaffective disorder / Delusional disorder / Acute and transient psychotic disorder / First-episode psychosis/ Schizotypal disorder.

Journal Club Presentation

Please select one of the following papers:

- Grant PM, Huh GA, Perivoliotis G, Stolar NM, Beck AT. (2012). Randomized Trial to Evaluate the Efficacy of Cognitive Therapy for Low-Functioning Patients With Schizophrenia. *Arch Gen Psychiatry.* 69(2):121-127. doi:10.1001/archgenpsychiatry.2011.129. http://archpsyc.jamanetwork.com/article.aspx?articleid=1107449

- Majer IM, Gaughran F, Sapin C, Beillat M, Treur M. (2015) Efficacy, tolerability, and safety of aripiprazole once-monthly versus other long-acting injectable antipsychotic therapies in the maintenance treatment of schizophrenia: a mixed treatment comparison of double-blind randomized clinical trials. *Journal of Market Access & Health Policy*. 2015;3:10.3402/jmahp.v3.27208. doi:10.3402/jmahp.v3.27208. 10.3402/jmahp.v3.27208

- Leucht C, Heres S, Kane J, Kissling W (2011). Oral versus depot antipsychotic drugs for Schizophrenia – A critical systematic review and meta-analysis of randomised long term trials. Schizophrenia Research Journal. https://doi.org/10.1016/j.schres.2010.11.020

'555' Topics (5 slides on each topic with no more than 5 bullet points)

Please select one topic:

- Management of QTc prolongation for patients on antipsychotics
- Management of hyperprolactinaemia for patients on antipsychotics
- Neuroleptic malignant syndrome

Statistics '555' Topic

Please select one topic:

- Types of randomisation
- Intention to treat analysis

MCQs

1. A long duration of untreated psychosis is strongly associated with which of the following:

A. Ethnicity
B. Insidious onset
C. Level of Education
D. Living alone
E. Rural residence

2. What is the most likely long term effect of delirium:

A. Accelerated decline in cognition and function
B. Better physical outcomes in future
C. Increased chance of late-onset psychosis
D. Increased hospital readmission rates
E. Increased likelihood of future episodes of delirium

3. Which of the following depot antipsychotics has a mandatory requirement of observing the patient for at least 3 hours after administration in a hospital setting:

A. Fluphenazine decanoate

B. Olanzapine embonate
C. Paliperidone palmitate
D. Pipothiazine palmitate
E. Aripiprazole maintena

4. Which of the following statements is FALSE about ICD-10 criteria of Schizophrenia:

A. A. Symptoms must be present for at least 6 months
B. Neologism is included in the symptoms
C. Organic brain disorder, alcohol and drug related intoxication, dependence or withdrawal are exclusion criteria
D. One of the criteria is: persistent hallucinations in any modality, when accompanied by delusions (which may be fleeting or half-formed) without clear affective content, or when accompanied by persistent over-valued ideas.

5. Which of the following antipsychotic has least effect on QTc interval:

A. Aripiprazole
B. Quetiapine
C. Risperidone
D. Sulpiride
E. Olanzapine

General Adult

Session 2: Depression-1

Journal theme: Meta-analysis and Systematic review on Depression

Learning Objectives

- To develop an understanding of the clinical presentation of Depression.
- To develop an understanding of aetiological theories and epidemiology of Depression.
- To develop an understanding of possible complications of antidepressant medications.
- To develop an understanding of Meta-analysis and Systematic review and develop skills for critically appraising Meta-analysis and Systematic review.

Expert Led Session

- Depression - aetiological theories and epidemiology

Case Presentation

- A case of major depressive disorder / severe depression with psychotic symptoms / dysthymia / recurrent depressive disorder

Journal Club Presentation

Please select one of the following papers:

- Jelovac A, Kolshus E, McLoughlin DM. (2013). Relapse Following Successful Electroconvulsive Therapy for Major Depression: A Meta-Analysis. *Neuropsychopharmacology*; 38, 2467–2474; doi:10.1038/npp. http://www.nature.com/npp/journal/v38/n12/pdf/npp2013149a.pdf
- Turner P, Kantaria R, Young AH (2014). A systematic review and meta-analysis of the evidence base for add-on treatment for patients with major depressive disorder who have not responded to antidepressant treatment: a European perspective. J Psychopharmacol. 28(2):85-98.
- Sim K, Lau WK, Sim J, Sum MY, Baldessarini RJ. (2015). Prevention of Relapse and Recurrence in Adults with Major Depressive Disorder: Systematic Review and Meta-Analyses of Controlled Trials. *International Journal of Neuropsychopharmacology*; 1–13. doi:10.1093/ijnp/pyv076. http://ijnp.oxfordjournals.org/content/ijnp/early/2015/08/09/ijnp.pyv076.full.pdf

'555' Topics (5 slides on each topic with no more than 5 bullet points)

Please select one topic:

- Association between depression and suicide
- A common public perception is that antidepressants are 'addictive'. Discuss the validity of this.
- Key features of the stepped care approach to the treatment of depression in the current NICE guideline for Depression.

Statistics '555' Topic

- Formulating research questions and literature search parameters

MCQs

1. Which of the following is not a well-recognised symptom of depressive illness:

A. Ruminations of guilt
B. Thought broadcast
C. Irritability
D. Thoughts of worthlessness
E. Hypersomnia

2. David has chronic back pain and depression that is not responding to SSRI antidepressants.

Which one of the following is the best antidepressant of choice in this situation?

A. Vortioxetine
B. Trazodone
C. Venlafaxine
D. Bupropion
E. Amitriptyline

3. Which of the following factors is NOT associated with risk of repetition of attempted suicide?

A. No previous psychiatric treatment
B. Alcohol or drug abuse
C. Previous attempts at self-harm
D. Personality disorder
E. Criminal record

4. Which of the following medications has RCT evidence for reduction of suicide rate?

A. Citalopram
B. Imipramine
C. Aripiprazole
D. Bupropion
E. Lithium carbonate

5. Which ONE of the antidepressants below is safest to use in an individual who becomes depressed following a myocardial infarction, as concluded from the SADHART trial?

A. Fluoxetine
B. Mirtazapine
C. Amitriptyline
D. Sertraline
E. Citalopram

General Adult

Session 3: Bipolar Disorder-1

Journal theme: Case-control studies on Bipolar

Learning Objectives

- To develop an understanding of the clinical presentation of Bipolar disorder.
- To develop an understanding of aetiological theories and epidemiology of Bipolar disorder.
- To develop an understanding of possible complications of mood-stabilizer medications.
- To develop an understanding of case-control studies and develop skills for critically appraising case-control studies.

Expert Led Session

- Bipolar affective disorder- aetiological theories and epidemiology

Case Presentation

- A case of type I bipolar disorder / type II bipolar disorder / cyclothymia / bipolar disorder with psychotic symptoms / rapid cycling bipolar disorder/ unipolar mania.

Journal Club Presentation

Please select one of the following papers:

- Prieto MP, Schenck LA, Kruse JL, Klaas JP, Chamberlain et al. (2016). Long-term risk of myocardial infarction and stroke in bipolar I disorder: A population-based Cohort Study. Journal of Affective Disorders; 194, 120–127. .
  DOI: http://dx.doi.org/10.1016/j.jad.2016.01.015.

- Leung MM, Lui SS, Wang Y, Tsui CF, Au AC et al. (2016). Patients with bipolar disorder show differential executive dysfunctions: A case-control study. Psychiatry Research; 238: 129–136. DOI: http://dx.doi.org/10.1016/j.psychres.2016.01.055

- Alberta U, Coria D, Agugliaa A, Barbaroa F, Lanfrancob F et al. (2013). Lithium-associated hyperparathyroidism and hypercalcaemia: A case-control cross-sectional study; 151 (2); 786–79. doi:10.1016/j.jad.2013.06.046

'555' Topics (5 slides on each topic with no more than 5 bullet points)

Please select one topic:

- Genes associated with Bipolar disorder
- Atypical antipsychotics as mood stabilizers – a rough guide
- Mood stabilizers and teratogenicity

Statistics '555' Topic

- Confounding factors and methods to control confounding

MCQs

1. The following statements about bipolar disorder are true except :

A. The lifetime risk of bipolar disorder lies between 0.3% and 1.5%.
B. The prevalence in men and woman is the same.
C. Majority of bipolar patients, particularly women, begin with a manic episode.
D. The age of onset is earlier in bipolar disorder than in major depressive disorder.
E. An onset over the age of 60 is more likely to be associated with organic brain disease.

2. Which of the following most closely reflects the risk of Bipolar Disorder in a first degree relative of an affected proband?

A. 0.3-1.0%
B. 1-2%
C. 5-10%.
D. 15%
E. 20%

3. 48 year old woman is stable stabilised on Lithium Carbonate. She has developed hypertension. Which of the following antihypertensive has the least potential for interaction with Lithium?

A. Losartan
B. Frusemide
C. Ramipril
D. Atenolol
E. Bendroflumethazide

4. Factors associated with a change of polarity from unipolar to bipolar include all except:

A. Hypersomnia and psychomotor retardation.
B. Absence of psychotic features.

C. Younger age of onset.

D. Family history of bipolar disorder.

E. Antidepressant induced hypomania

5. Select one incorrect statement regarding bipolar depression in comparison with unipolar depression.

A. Slower in onset

B. More frequent

C. More severe and shorter.

D. Cause greater socio-economic burden

E. More likely to be associated with psychotic symptoms

General Adult
Session 4: Mental Health Act
Journal theme: Studies on MHA - Any method

Learning Objectives

- To develop an understanding of the aspects of the Mental Health Act relevant to general adult psychiatry (especially Sections 2, 3, 4, 5(2), 5(4), 136 and Supervised Community Treatment).

Expert Led Session

- Salient points – Sections 2,3,4, 5(2), 5(4), 135, 136
- Extra information on other sections – to be used at presenter's discretion

Case Presentation

- A case focusing on aspects of MHA including Section 5(2), Section 136, Section 2 & 3 and Supervised Community Treatment (CTO).

Journal Club Presentation

Please select one of the following papers:

1. Burns T, Rugkåsa J, Molodynski A, Dawson J, Yeeles K et al. (2013). Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. The Lancet; 381 (9878), 1627–1633. doi:10.1016/S0140-6736(13)60107-5

2. Owen GS, Szmukler G, Richardson G, David AS, Raymont V, Freyenhagen F, Martin W, Hotopf M (2013) Decision-making capacity and medical in-patients: cross-sectional, comparative study. BJPsych, 203 (6) 461-467.

3. Brown PF, Tulloch AD, Mackenzie C, Owen GS, Szmukler G, Hotopf M. (2013). Assessments of mental capacity in psychiatric inpatients: a retrospective cohort study. BMC Psychiatry; 13:115. **DOI:** 10.1186/1471-244X-13-115. http://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-13-115

'555' Topics (5 slides on each topic with no more than 5 bullet points)
Please select one topic: • Application of Section 2 vs. Section 3 • Section 136: who can use, when is it appropriate to use, duration of lawful detention, place of safety, possible outcomes • Synopsis of one important MHA legal case.
Statistics '555' Topic
• Processes for developing NICE guidelines - brief summary
MCQs
1. To prevent deprivation of liberty occurring: A. There is no requirement to consider what restrictions are placed before entry into a care home B. Involvement of advocacy services should be avoided C. It is vital to consider all aspects of the care plan D. There is no need to involve carers or relatives in planning care 2. The deprivation of liberty safeguards: A. Were introduced to prevent deprivation of liberty in a person's own home B. Facilitate protection of people other than the relevant person from harm C. A primary care trust may be responsible for providing the appropriate standard authorisation D. The supervisory body issues an urgent deprivation of liberty authorisation. 3. The 2007 amendments to the Mental Health Act abolished the following classifications: A. Mental illness B. Psychopathic disorder C. Mental impairment D. Severe mental impairment E. All of the above. 4. Under the amended Act, a patient can be detained if the following conditions for treatment are met: A. Treatment is legal

B. Treatment is offered by a psychiatrist

C. Treatment is available and appropriate

D. Treatment has an effect on risk

E. Treatment will cure the mental disorder

5. The provision in the amended Act that helps to uphold the human rights of a patient with personality disorder is:

A. Ease of discharge

B. Provision of statutory advocacy service

C. Right to refuse treatment if the patient possesses capacity

D. Regular contact with 'nearest relative'

E. More frequent tribunal hearings

General Adult
Session 5: Self Harm and Suicide
Journal theme: Survey on Suicide and Self-harm

Learning Objectives

- To develop an understanding of various facets of self-harm and suicide (aetiology, epidemiology, neurobiology, genetics, clinical presentation, risk assessment) and their management (pharmacological, psychological, social).
- To develop an understanding of surveys and develop skills for critically appraising surveys.

Expert Led Session

- Suicide and self-harm - aetiological theories and epidemiology

Case Presentation

- A case of presentation of overdose to A&E / repeated self-harm / suicide attempt

Journal Club Presentation

Please select one of the following papers:

- Spiersa N, Bebbingtona PE, Dennisa MS, Brughaa TS, McManusa S, et al. (2014). Trends in suicidal ideation in England: the National Psychiatric Morbidity Surveys of 2000 and 2007. Psychological Medicine; 44 (1), 175-183. DOI: http://dx.doi.org/10.1017/S0033291713000317
- Carr MJ, Ashcroft DM, Kontopantelis E, Awenat Y, Cooper J, et al. (2016). The epidemiology of self-harm in a UK-wide primary care patient cohort, 2001–2013. BMC Psychiatry series; 16:53. DOI: 10.1186/s12888-016-0753-5
- Windfuhr K, & Kapur N. (2011). Suicide and mental illness: a clinical review of 15 years findings from the UK National Confidential Inquiry into Suicide. Br Med Bull; 100 (1): 101-121. Doi:10.1093/bmb/ldr042

'555' Topics (5 slides on each topic with no more than 5 bullet points)

- Factors associated with suicide risk and rates of suicides in Schizophrenia, Bipolar disorder and depressive disorder.
- Substance misuse and suicide risk
- Emotionally unstable personality disorder and risk of suicide

Statistics '555' Topic

- Audit versus Survey

MCQs

1. What is the single strongest predictor of completed suicide?

A. Mental illness

B. Previous self-harm

C. Recent bereavement

D. Having a neurodegenerative physical illness

E. Family history of suicide

2. A patient is refusing life-saving treatment for severe blood loss after cutting her wrists. Under the law in England and Wales, whose responsibility is it to assess capacity to make a decision to refuse treatment?

A. A consultant psychiatrist

B. A clinical psychologist

C. Any psychiatrist who is approved under Section 12(2) of the Mental Health Act

D. The clinician proposing the treatment

E. The duty AMHP (Approved Mental Health Professional)

3. Which of the following are the TWO periods of highest risk of suicide? (please pick two)

A. As an inpatient, during the first week of admission

B. At home, during the first week following discharge

C. During the last week of admission when discharge is imminent

D. At home, after the first week following discharge has passed and there is less support

E. In the emergency department, while waiting for an inpatient bed

4. There is RCT evidence for reduction in suicide risk with which of the following medications? (please pick two)

A. Aripiprazole

B. Sodium valproate

C. Clozapine

D. Topiramate

E. Lithium

5. What is the most current estimate of lifetime risk of suicide for individuals with schizophrenia?

A. 1%

B. 2%

C. 5%

D. 10%

E. 15%

General Adult
Session 6: Anxiety Disorders-1
Journal theme: Cohort studies on Anxiety Disorders

Learning Objectives

- To develop an understanding of anxiety disorders* (aetiology, epidemiology, natural history, neurobiology, genetics, diagnostic criteria, classification, psychopathology, clinical presentation, assessment, risks) and its management (pharmacological, psychological, social). [* Other than OCD and PTSD]
- To develop an understanding of cohort studies and develop skills for critically appraising cohort studies.

Expert Led Session

- GAD and panic disorder - aetiological theories and epidemiology

Case Presentation

- A case of generalised anxiety disorder/ panic attacks/ panic disorder/ agoraphobia/ social phobia/ specific phobias

Journal Club Presentation

Please select one of the following papers:

- Foldes-Busque G, Denis I, Poitras J, Fleet RP, Archambault P, Clermont E Dionne CE (2013) A prospective cohort study to refine and validate the Panic Screening Score for identifying panic attacks associated with unexplained chest pain in the emergency department. BMJ Open 2013; 3:e003877 doi: 10.1136/bmjopen-2013-003877.

- Vogelzangs N, Beekman ATF, Jonge P, Penninx B (2013) Anxiety disorders and inflammation in a large adult cohort. Transl Psychiatry. 2013 Apr; 3(4): e249. doi: 10.1038/tp.2013.27

- Watkins LL, Koch GG, Sherwood A, Blumenthal JA, Davidson JRT, et al. (2013). Association of Anxiety and Depression with All-Cause Mortality in Individuals with Coronary Heart Disease. J Am Heart Assoc; 2: e000068. Doi: 10.1161/JAHA.112.000068.

'555' Topics (5 slides on each topic with no more than 5 bullet points)

Please select one topic:

- Neurochemistry of anxiety
- Aetiology of GAD
- Principles of CBT for treatment of panic attacks

Statistics '555' Topic

- Prevalence and Incidence

MCQs

1. Which one of below is not true of body dysmorphic disorder (BDD):

A. First described by Morselli

B. DSM-IV classifies BDD as a somatoform disorder

C. ICD-10 classifies BDD under hypochondriacal disorder

D. Severe BDD is usually treated with SSRI and CBT as first line

E. Commonly associated with morbid jealousy.

2. All of the following anxiety disorders are more common in females, except:

A. Agoraphobia

B. Social phobia

C. Panic disorder

D. Generalised anxiety disorder

E. None of the above

3. All of the below are poor prognostic factors for OCD, except:

A. Early onset

B. Male

C. No compulsions

D. Family history of OCD

E. Longer duration

4. Which of the following is recommended by NICE as first line treatment for PTSD?

A. SSRI antidepressants

B. Counselling

C. Eye Movement Desensitization and Reprocessing

D. Combination of CBT and SSRI antidepressant

E. Quetiapine

5. Which of the following statement is FALSE?

A. Quetiapine has clear RCT evidence for efficacy in Generalised anxiety disorder.

B. Escitalopram is licenced for treatment of OCD

C. Treatment duration of at least 3 months is usually recommended for treatment of OCD

D. Antipsychotics should not routine be combined with antidepressants for treatment of anxiety disorders

E. Paroxetine, Escitalopram and Citalopram are all licenced for treatment of panic disorder

Old Age

Session 1: Cognition

Learning Objectives

- The overall aim is for the trainee to gain an overview of cognition.
- By the end of the session trainees should:
    - Understand the link between the cognitive domains and brain regions
    - Appreciate the theory of a bedside cognitive assessment
    - Have an awareness of common cognitive syndromes
    - Be able to reflect on the limitations of cognitive assessment tools

Curriculum Links

- Old Age Section of the MRCPsych Curriculum: 8.3

Expert Led Session

- A Consultant led session based on the learning objectives listed above

Case Presentation

- A case to be presented which highlights the importance of a robust assessment, including some interesting findings in the cognitive assessment process in the older person

Journal Club Presentation

- Cecato, J.F., Martinelli, J.E., Izbicki, R., Yassuda, M.S. and Aprahamian, I., 2017. **A subtest analysis of The Montreal Cognitive Assessment (MoCA): which subtests can best discriminate between healthy controls, mild cognitive impairment and Alzheimer's disease?.** *International psychogeriatrics*, *29*(4), pp.701-701.
- Krishnan, K., Rossetti, H., Hynan, L.S., Carter, K., Falkowski, J., Lacritz, L., Cullum, C.M. and Weiner, M., 2017. **Changes in Montreal cognitive assessment scores over time.** *Assessment*, *24*(6), pp.772-777.
- Roalf, D.R., Moore, T.M., Mechanic-Hamilton, D., Wolk, D.A., Arnold, S.E., Weintraub, D.A. and Moberg, P.J., 2017. **Bridging cognitive screening tests in neurologic disorders: A crosswalk between the short Montreal Cognitive Assessment and Mini-Mental State Examination.** *Alzheimer's & dementia: the journal of the Alzheimer's Association*, *13*(8), pp.947-952.

'555' Topic (5 slides with no more than 5 bullet points per slide)
• Bedside Testing of the Frontal Lobe **or** the Parietal Lobe • Normal age-related changes in cognitive function
MCQs
1. Which of the following is not a bedside frontal lobe test? A. Abstract thinking B. Go-No-Go C. Cognitive estimates D. Verbal fluency E. Clock drawing **2. Which of the following is an objective rating scale for cognition?** A. MOCA B. GDS C. DASS21 D. Cornell E. MUST **3. All are features of Gerstmann Syndrome except:** A. Right-left disorientation B. Anosognosia C. Finger agnosia D. Dyscalculia E. Dysgraphia **4. Which of the following is seen in Wernicke's aphasia?** A. Effortful speech B. Telegraphic speech C. Intact repetition D. Impaired comprehension E. Nystagmus **5. The following brain region is associated with semantic memory:**

A. Thalamus

B. Hippocampus & entorhinal cortex

C. Anterior temporal lobe

D. Dorsolateral prefrontal cortex

E. Cerebellum

6. Which of the following is not a test of executive function?

A. Luria Task

B. Wisconsin Card Sorting Test

C. Stroop Test

D. Graded naming test

E. Verbal fluency

Additional Resources / Reading Material

Websites:

- Montreal Cognitive Assessment (MOCA) available at: www.mocatest.org
- RCPsych CPD Online Modules: Bedside Assessment of Cognition.

Journal Papers:

Tang, M. and Reitz, C., 2017. Genetics of Alzheimer's disease: an update. *Future Neurology*, *12*(4), pp.237-247.

- Kipps, CM., & Hodges, JR., 2005. **Cognitive assessment for clinicians**. *Journal of Neurology, Neurosurgery & Psychiatry,* 76 (suppl 1), i22-i30.
- Giri, M., Zhang, M., & Lü, Y. (2016). **Genes associated with Alzheimer's disease: an overview and current status.** *Clinical Interventions in Aging*, *11*, 665–681. http://doi.org/10.2147/CIA.S105769
- Shaik, S. S., & Varma, A. R., 2012. **Differentiating the dementias: a neurological approach.** *Progress in Neurology and Psychiatry,* 16(1), 11-18.
- Takas, A., Koncz, R., Mohan, A. and Sachdev, P., 2017. **Forgetfulness, stress or mild dementia? Cognitive assessment of older patients.** https://medicinetoday.com.au/2017/may/feature-article/forgetfulness-stress-or-mild-dementia-cognitive-assessment-older-patients/

- Young, J., Meagher, D., & MacLullich, A., 2011. **Cognitive assessment of older people.** *BMJ*, 343, d5042.

Guidelines:

- NICE CG42 – Dementia https://www.nice.org.uk/guidance/Cg42

Other resources:

- Hodges, J.R., 2017. ***Cognitive assessment for clinicians*****.** Oxford University Press.
- Jacoby R, Oppenheimer C, Dening T. (eds.), 2008. ***The Oxford Textbook of Old Age Psychiatry***. Oxford University Press: Oxford. Chapters on psychometric assessment, biological aspect of ageing and clinical cognitive assessment..
- Larner, A.J. ed., 2017. ***Cognitive screening instruments*****.** Springer.
- Volkman, N., Cohen, N. and Vroman, G., 2018. Misinterpreting Cognitive Decline in the Elderly: Blaming the Patient. In ***Human Error in Medicine*** (pp. 93-122). CRC Press.

Old Age

Session 2: Alzheimer's Disease

Learning Objectives

- The overall aim is for the trainee to gain an overview of Alzheimer's disease.
- By the end of the session trainees should:
    - Understand the epidemiology of Alzheimer's disease.
    - Understand the risk factors, genetics, neuropathology, neurotransmitters and neuroimaging associated with Alzheimer's Disease.
    - Understand the clinical features of Alzheimer's disease, the assessment process and the principles of management.
    - Understand the impact on carers associated with disorders like Alzheimer's Disease.

Curriculum Links

- Old Age Section of the MRCPsych Curriculum: 8.1, 8.2, 8.3, 8.4, 8.5

Expert Led Session

- A Consultant led session based on the learning objectives listed above

Case Presentation

- A case to be presented which highlights the diagnostic process and/or Alzheimer's Disease and/or BPSD (behaviour that challenges). Please consider the learning objectives above.

Journal Club Presentation

- Gitlin, L.N., Arthur, P., Piersol, C., Hessels, V., Wu, S.S., Dai, Y. and Mann, W.C., 2018. **Targeting Behavioral Symptoms and Functional Decline in Dementia: A Randomized Clinical Trial.** *Journal of the American Geriatrics Society*, *66*(2), pp.339-345
- Sabia, S., Dugravot, A., Dartigues, J.F., Abell, J., Elbaz, A., Kivimäki, M. and Singh-Manoux, A., 2017. **Physical activity, cognitive decline, and risk of dementia: 28 year follow-up of Whitehall II cohort study.** *Bmj*, *357*, p.j2709.
- Sommerlad, A., Ruegger, J., Singh-Manoux, A., Lewis, G. and Livingston, G., 2017. **Marriage and risk of dementia: systematic review and meta-analysis of observational studies.** *J Neurol Neurosurg Psychiatry*, pp.jnnp-2017.
- Tricco, A.C., Ashoor, H.M., Soobiah, C., Rios, P., Veroniki, A.A., Hamid, J.S., Ivory, J.D., Khan, P.A., Yazdi, F., Ghassemi, M. and Blondal, E., 2018. **Comparative effectiveness and safety of cognitive**

enhancers for treating Alzheimer's disease: systematic review and network meta-analysis. *Journal of the American Geriatrics Society*, *66*(1), pp.170-178.

- Tampi R, Hassell C, Joshi P, Tampi D. 2018. **Analgesics in the Management of Behavioral and Psychological Symptoms of Dementia: A Systematic Review.** The American Journal of Geriatric Psychiatry. 31;26(3):S143-4.
- White, N., Leurent, B., Lord, K., Scott, S., Jones, L. and Sampson, E.L., 2017. **The management of behavioural and psychological symptoms of dementia in the acute general medical hospital: a longitudinal cohort study.** *International journal of geriatric psychiatry*, *32*(3), pp.297-305.

'555' Topic (5 slides with no more than 5 bullet points per slide)

- The use of antipsychotic medication and the risks associated in patients with dementia
- The NINCDS-ADRDA or NIA-AA criteria

MCQs

1. The prevalence of dementia in the general UK population older than 65 is approximately:

A. 1-2%

B. 2-4%

C. 7%

D. 10%

E. 15-20%

2. In Alzheimer's Disease, the gene for Amyloid Precursor Protein (APP) is found on the long arm of chromosome:

A. 1

B. 12

C. 21

D. 19

E. None of the above

3. Which of the following statements regarding biomarkers in Alzheimer's disease is true:

A. The first biomarker change in Alzheimer's disease is reflected by a decrease in CSF tau levels

B. β amyloidosis can only be detected in venous plasma samples

C. Amyloid-β accumulation is not sufficient to cause disease progression

D. PET imaging is estimated to be able to predict changes 25 years prior to symptoms

E. All individuals that have positive biomarker results progress at the same rate.

4. The 'anti-dementia' drug that blocks NMDA receptors is:

A. Rivastigmine

B. Galantamine

C. Memantine

D. Donepezil

E. All of the above

5. Which of the following combination of APOE alleles confers the highest risk of developing Alzheimer's disease?

A. 2:2

B. 2:3

C. 3:3

D. 3:4

E. 4:4

Additional Resources / Reading Materials

Websites:

- https://www.rcpsych.ac.uk/ CPD Online
- capacity, empowerment and conflicts of interest
- inappropriate sexual behaviour in dementia

Guidelines

- https://www.nice.org.uk/guidance/Cg42

Journal papers:

- Banerjee S., 2009. **The Use of Antipsychotic Medication for People with Dementia: Time for Action.** DOH.
- Cooper, S., & Greene, JDW., 2005. **The clinical assessment of the patient with early dementia.** Journal of Neurology, Neurosurgery & Psychiatry, 76 (5), v15-v24.
- Etters, L., Goodall, D., & Harrison, B. E., 2008. **Caregiver burden among dementia patient caregivers: a review of the literature.** Journal of the American Academy of Nurse Practitioners, 20(8), 423-428.

- Loy, C. T., Schofield, P. R., Turner, A. M., & Kwok, J. B., 2013. **Genetics of dementia.** The Lancet.
- Jack, C.R., Bennett, D.A., Blennow, K., Carrillo, M.C., Dunn, B., Haeberlein, S.B., Holtzman, D.M., Jagust, W., Jessen, F., Karlawish, J. and Liu, E., 2018. **NIA-AA Research Framework: Toward a biological definition of Alzheimer's disease**. Alzheimer's & Dementia, *14*(4), pp.535-562.
- Mortimer, A. M., Likeman, M., & Lewis, T. T., 2013. **Neuroimaging in dementia: a practical guide.** Practical neurology, 13(2), 92-103.
- Tang, M. and Reitz, C., 2017. **Genetics of Alzheimer's disease: an update.** *Future Neurology*, *12*(4), pp.237-247.
- Treloar, A., Crugel, M., Prasanna, A., Solomons, L., Fox, C., Paton, C., & Katona, C., 2010. **Ethical dilemmas: should antipsychotics ever be prescribed for people with dementia?** The British Journal of Psychiatry, 197(2), 88-90.
- Watkin, A., Sikdar, S., Majumdar, B., & Richman, A. V., 2013. **New diagnostic concepts in Alzheimer's disease.** Advances in psychiatric treatment, 19(4), 242-249.

Other resources

- **Dementia UK update** (2nd edition), 2007. Alzheimer's Society. https://www.alzheimers.org.uk/sites/default/files/migrate/downloads/dementia_uk_update.pdf
- Jacoby R, Oppenheimer C, Dening T., 2008. **The Oxford Textbook of Old Age Psychiatry.** Oxford University Press: Oxford. Chapters on Alzheimer's disease, pharmacological treatment of dementia.
- Taylor, D., Barnes, T., Young, A., 2018. ***The Maudsley Prescribing Guidelines in Psychiatry, 13th edition*.** Blackwell-Wiley.
- World Health Organisation, 1992. **ICD-10 : The ICD-10 Classification of Mental and Behavioural Disorders : Clinical Descriptions and Diagnostic Guidelines.** WHO.

CAMHS

Session 1: Assessment in Child and Adolescent Psychiatry

Learning Objectives

- Undertake assessments of children and young people; to communicate effectively with children and young people across the age range; to take a developmental history; to formulate and prepare a plan and identify appropriate interventions.
- Describe how the emphasis of assessments in CAMHS may be different to that in Adult Mental Health.

Curriculum Links

Child Psychiatry:

10.1 10.2 10.3 10.4 10.5 10.6

Expert Led Session

- This should include consideration of room setting e.g. with appropriate toys and other developmentally appropriate materials/approaches, the differences and similarities between adult and child psychiatry, pointers on taking a developmental history, ICD 10, bio-psychosocial formulation and risk assessment

Case Presentation

- To highlight multi-disciplinary/multiagency nature of work (should include discussion of school observation/assessment)
- To highlight bio-psychosocial formulation
- To highlight Multi-axial formulation in Child and Adolescent Psychiatry
- Those trainees who are not currently in a CAMHS post should contact their local CAMHS team for the suitable case for presentation.

Journal Club Presentation

- Practitioner Review: Self-harm in adolescents, Ougrin D, Tranah T, Leigh E, Taylor L, Asarnow JR. Journal of Child Psychology and Psychiatry, 2012, 53:4,337– 350, April 2012.

- The Clinical Application of the Biopsychosocial Model in Mental Health: A Research Critique: Álvarez, AS; Pagani, M; Meucci, P (2012) American Journal of Physical Medicine & Rehabilitation, 2012, 91:13, S173–S180

'555' Topics (1 slide on each topic with no more than 5 bullet points)

- Risk assessment domains and formulation
- Local Safeguarding process and organisational structure
- Conduct Disorder – Diagnostic Criteria /Management

MCQs

1. Patient should routinely have a neurological examination if they present with all except:

A. History of an episode of fainting

B. History of seizures

C. Developmental delay

D. Dysmorphic features

E. Abnormal gait

2. A physical risk assessment for patients with Anorexia Nervosa should include all except:

A. Assessment of BMI and weight

B. Assessment of heart rate

C. Assessment of temperature

D. Assessment of hydration status

E. Assessment of EEG abnormalities

3. During an assessment of a 14 year old patient with depression in primary care, which of the following would prompt you to refer to tier 2 or 3 CAMHS:

A. Mild depression in those who have not responded to interventions in tier 1 after 2-3 months

B. Active suicidal plans

C. Referral requested by the young person

D. Moderate to severe depression

E. All of the above

4. Assessment of ADHD commonly include all except:

A. ADOS

B. School observations

C. History from parents/carers

D. Connors assessment

E. History from patient

5. Mental state examination of a 15 year old patient should include all the following except:

A. Assessment of appearance and behaviour

B. Family history

C. Assessment of speech

D. Assessment of insight

E. Assessment of cognition

6. The multi axial diagnostic formulation scheme of ICD 10 include:

A. Axis III: psychiatric disorder

B. Axis II: medical conditions

C. Axis IV: adaptive functioning

D. Axis I: psychiatric disorder

E. Axis VI: medical conditions

7. An assessment of a 3 year old with suspected Autistic Spectrum Disorder must include:

A. A home visit

B. A detailed mental state examination

C. Observation of the child interacting with others

D. All of the above A-C

E. None of the above A-C

8. CAMHS assessments in patients with speech delay should routinely include all except:

A. Family tree

B. Family history of ASD / Aspergers

C. Developmental history

D. Details of whether the patient had the combined MMR vaccine

E. Medical history

9. The presence of a disorder can be explained in terms of all except:

A. Predisposing factors

B. Precipitating factors

C. Perpetuating factors

D. Petulant factors

E. Protective factors

10. In regards to initial CAMHS assessment of children under 5 with speech delay:

A. You should not see them without the presence of their parent/carer in the room

B. You should aim to get the child sat down in a chair for the majority of the assessment

C. You should observe them playing and play too if appropriate

D. You should avoid difficult topics

E. You should use more directed questioning

Additional Resources / Reading Materials

Reading Resources

1. Managing Self Harm in Young People

http://www.rcpsych.ac.uk/files/pdfversion/CR192.pdf

2. Practice Parameters for the Psychiatric Assessment of Children and Adolescents. J. Am. Acad. Child Ado/esc. Psychiatry. 1995,31:1386-1402. J. Am. Acad. Child Ado/esc. Psychiatry. 1997.36(10 Supplement):45-20S.

3. Practice Parameter for the Assessment of the Family. J. Am. Acad. Child Adolesc. Psychiatry, 2007;46(7):922Y937

4. Wolpert, M., Ford, T., Trustam, E., Law, D.,Deighton, J., Flannery, H., and Fugard R. J. B. (2012) Patient-reported outcomes in child and adolescent mental health services (CAMHS): Use of idiographic and standardized measures, Journal of Mental Health, 21:2, 165-173

Books

Child and Adolescent Psychiatry. Robert Goodman and Stephen Scott. Third Edition, Wiley-Blackwell Child and Adolescent Psychiatry: A Developmental Approach. 4th ed. Jeremy Turk, Philip Graham, Frank C Verhulst 2007. Oxford University Press

- NICE clinical guideline 133 Self-harm: longer-term management Clinical case scenarios for health and social care professionals

E-Learning

RCPsych TRon Module

1. Overview of child and adolescent psychiatry

Assessment and treatment of children and adolescents; disorders usually first diagnosed in infancy, childhood and adolescence; developmental disabilities; effects of adult mental illness on children and young people, including effects of maternal mental health; effect of depression on parental functioning and interactions and impact on child development and functioning; cultural variations in aetiology and management; short- and long-term effects of negative life events on development and functioning e.g. maternal loss, child abuse, chronic or life-threatening illness; interaction between psychiatric disorder and physical illness in children and adolescents; physical presentation of psychiatric disorder and psychiatric presentation of physical disorder.

(Syllabus: 10 – introduction, 10.1, 10.2, 10.5)

1. The neurological examination

   The neurological examination is often approached with trepidation by psychiatrists but can be done quickly and reliably with practice. The best approach is to keep doing them as often as possible, but in order for them to be useful, and conducted without fear, it's advantageous to have an understanding of what you are trying to achieve. In this podcast Professor Adam Zeman, Professor of Cognitive and Behavioural Neurology at the University of Exeter Medical School, explains to Dr Raj Persaud how to conduct a neurological examination.

   http://www.psychiatrycpd.org/default.aspx?page=20900

Journal Articles

- The Child and Adolescent Psychiatric Assessment (CAPA).

  Angold A, Prendergast M, Cox A, Harrington R, Simonoff E, Rutter M.

Psychol Med. 1995 Jul;25(4):739-53.

CAMHS

Session 2: Attention Deficit Hyperactivity Disorder (ADHD)

Learning Objectives

- Describe signs, symptoms and differential diagnosis of Attention Deficit Hyperactivity Disorder, and treatment options.

Curriculum Links

ADHD:

10.1 10.2 10.3 10.6 10.7 10.8.3.1 10.8.3.2 10.8.3.3 10.8.3.4 10.8.3.5

Expert Led Session

- This should consider aspects of assessment, formulation, evidence base, NICE guidelines of assessment and intervention, differential diagnosis, co-morbidities, consequences of non-treatment and impact on substance misuse.

Case Presentation

- To highlight points in assessment, use of questionnaires, use of Quantified behavioural (Qb) test, multisource information gathering, differential diagnoses and formulation.

Journal Club Presentation

- Treatment of Children With Attention-Deficit/Hyperactivity Disorder (ADHD) and Irritability: Results From the Multimodal Treatment Study of Children With ADHD (MTA) Lorena Fernandez de la Cruz, PhD, Emily Simonoff, MD, James J. McGough, MD, Jeffrey M. Halperin, PhD, L. Eugene Arnold, MD, MEd, Argyris Stringaris, MD, PhD, MRCPsych J Am Acad Child Adolesc Psychiatry 2015;54(1):62–70.
- Long-Term Outcomes of ADHD: Academic Achievement and Performance L. Eugene Arnold1, Paul Hodgkins2,3, Jennifer Kahle4, Manisha Madhoo5, and Geoff Kewley6. Journal of Attention Disorders 1–13 © 2015 SAGE Publications
- Study of user experience of an objective test (QbTest) to aid ADHD assessment and medication management: a multi-methods approach
  Charlotte L. Hall, Althea Z. Valentine, Gemma M. Walker, Harriet M. Ball, Heather Cogger, David Daley, Madeleine J. Groom, Kapil Sayal and Chris Hollis

BMC PsychiatryBMC series – open, inclusive and trusted201717:66
https://doi.org/10.1186/s12888-017-1222-5

'555' Topics (1 slide on each topic with no more than 5 bullet points)

- Medical treatment in ADHD, types of medication, pharmacokinetics, pharmacodynamics, side effect profile.
- Formal assessment tools in ADHD assessment; pros and cons.
- NICE Guidelines for ADHD .

MCQs

1. A four year old boy is brought to clinic with his parents. They report that he is inattentive at school, will not sit and play with his siblings at home and on one occasion let go of his mother's hand whilst shopping and ran out into the road. Following assessment and diagnosis, what would your initial management step be?

A. Refer patient for individualised CBT

B. Refer family for Family Therapy

C. Refer family to parent training and education sessions

D. Commence 5mg methylphenidate daily, titrating up weekly until improvement is seen

E. None of the above

3. The parents of a 5 year old girl recently diagnosed with ADHD have cancelled their second group parent training and education session. They tell you this is because their 11 year old son has learning disabilities and is wheelchair bound. They have no extended family or close friends to help with child care arrangements on the days required. What would you advise?

A. Offer to commence medication for the patient as they will not be able to attend the parent training and education sessions

B. Offer to hold individualised parent training and education sessions on a day that would better suit them

C. Discharge the family from your case load as they have missed two consecutive appointments

D. Ask them to contact children and family services to arrange child care whilst they attend the training sessions

E. None of the above

4. You have assessed a 7 year old boy with suspected ADHD in clinic. You would like to get further information about his behaviour in school from his teachers. Which of the following regarding consent to discuss the case with school is correct?

A. You will need to document that you have obtained consent from the patient's parents or carers before you contact the school for information

B. You will need to document that you have obtained consent from the patient before you contact school for information

C. You don't need consent to request information with school

D. You don't need consent to request information from school as long as you don't discuss treatment with them

E. You will need verbal consent from the patient's parents or carers before you contact the school for information

5. Following assessment of an 8 year old boy, you diagnose severe ADHD with severe impairment of functioning in both social and academic domains. What would be your initial step in management?

A. Refer family to Family Therapy

B. Refer patient for CBT

C. Refer family to parent training and education

D. Commence the patient on medication

E. None of the above

6. You wish to complete a pre-drug treatment assessment on a 7 year old girl with diagnosed severe ADHD. Which of the following is NOT routinely required?

A. Record of height and weight plotted on centile chart

B. ECG

C. Heart rate and blood pressure plotted on a centile chart

D. Mental health and social assessment

E. Assessment of cardiovascular symptoms

7. You have been seeing a 12 year old boy with ADHD. Parent training/education sessions proved ineffective. With the parents' consent you commenced the patient on low dose methylphenidate, 5mg daily. At the following review the methylphenidate is not working and the patient's behaviour continues to be impairing his social and academic functioning. You are happy that your diagnosis remains correct. He does not describe any side effects on questioning. What would your next step in treatment be?

A. Consider commencing low dose bupropion as an adjunct to methylphenidate

B. Consider stopping methylphenidate and commencing Atomoxetine

C. Stop medication and review diagnosis again

D. Consider stopping methylphenidate and commencing low dose dexamfetamine

E. Consider increasing the dose of methylphenidate

8. NICE guidance suggests that modified release preparations of methylphenidate should be considered for all the following reasons, except:

A. Convenience

B. To increase adherence

C. To help in facilitating schools who cannot safely store medication

D. Patients with co-morbid tic disorder

E. Reducing stigma

9. ICD 10 diagnosis of hyperkinetic disorder includes all the following criteria, except:

A. Inattention, hyperactivity and/or impulsivity persistent for at least 3 months

B. Symptoms are pervasive across situations

C. Symptoms are not caused by other disorders such as autism or affective disorders

D. Symptoms cause impairment in social, academic or occupational functioning.

E. All of the above

10. Adverse effects of Methylphenidate can include all, except:

A. Raised blood pressure

B. Anorexia

C. Insomnia

D. Growth acceleration

E. Exaggeration of tic disorders

Additional Resources / Reading Materials

Books

- Rutter's Child and Adolescent Psychiatry, Fifth Edition.
  Sir Michael Rutter , Dorothy Bishop, Daniel Pine, Steven Scott , Jim S. Stevenson, Eric A. Taylor, Anita Thapar

- Child and Adolescent Psychiatry. **Robert Goodman** and **Stephen Scott**. Third Edition, Wiley-Blackwell
- Attention Deficit Hyperactivity Disorder" by Professor Russell Barkley.

E-Learning

- Attention deficit hyperactivity disorder in children and adolescents. In this podcast Professor Heidi Feldman, from the Stanford University School of Medicine, talks with Dr Raj Persaud on attention deficit–hyperactivity disorder (ADHD) in children and adolescents; referring to her recent clinical review of the disorder published in the New England Journal of Medicine. http://www.psychiatrycpd.org/default.aspx?page=20527
- Neurobiology of ADHD, by Dr Katia Rubia
- http://www.psychiatrycpd.org/podcasts/neurobiologyofadhd.aspx

Guidelines

- Attention deficit hyperactivity disorder (ADHD) (CG72) http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7281

Further Reading Resources

Evidence-based guidelines for the pharmacological management of attention deficit hyperactivity disorder: Update on recommendations from the British Association for Psychopharmacology Blanca Bolea-Alamañac1, David J Nutt2, Marios Adamou3, Phillip Asherson4, Stephen Bazire5, David Coghill6, David Heal7, Ulrich Müller8, John Nash9, Paramalah Santosh10, Kapil Sayal11, Edmund SonugaBarke12 and Susan J Young2 for the Consensus Group

Journal of Psychopharmacology 1–25, 2014

Forensic

Session 1: Psychiatry and the Criminal Justice System

Learning Objectives

- To develop an understanding of the structure and organisation of the criminal justice system
- To develop an understanding of the mental health of prisoners and understand the complexities of their treatment
- To develop an understanding of the structure and organisation of secure psychiatric services and the different levels of security
- To develop an understanding of the framework around the management of mentally-disordered offenders

Curriculum Links

12.2 Psychiatry and the criminal Justice System

12.2.1 The role of the psychiatrist in the assessment of mentally disordered offenders: during arrest, prior to conviction; prior to sentencing

12.3 Practising psychiatry in a secure setting

12.3.1 The role of security in a therapeutic environment

12.3.2 The essential components of a forensic service

12.3.3 Knowledge of the prevalence of psychiatric disorder in prison populations, suicide in prisoners and psychiatric treatment in prison settings

12.3.4 Risk management planning in forensic psychiatric practice

12.3.5 Managing mentally disordered offenders discharged into the community

Expert Led Session

An introduction to the criminal justice system. To include:

- Police detention and diversion
- Prison structure and organisation and prison categories
- Mental health care in prison
- Pathways into secure settings
- MAPPA

Case Presentation

Case presentation on ‘progression through the criminal justice system to hospital’.

- If trainee has a suitable case of a mentally-disordered offender then they may present this.
- The trainee can come to the Edenfield Centre where a suitable case can be found for them – to access case notes and / or meet patient (if appropriate)

Journal Club Presentation

Please select one of the following papers:

- Fazel S, Fiminska Z, Cocks C & Coid J, Patient outcomes following discharge from secure psychiatric hospitals: a systematic review and meta-analysis, BJPsych 2016, 208: 17 – 25 http://www.ncbi.nlm.nih.gov/pubmed/26729842
- Fazel S & Baillargeon J, The health of prisoners, Lancet 2011 377: 956 – 65 http://www.ncbi.nlm.nih.gov/pubmed/21093904
- Shaw J, Baker D, Hunt IM et al, Suicide by prisoners: national clinical survey, BJPsych 2004, 184: 263 – 7 http://www.ncbi.nlm.nih.gov/pubmed/14990526
- Bhui K, Ullrich S, Kallis C & Coid J, Criminal justice pathways to psychiatric care for psychosis, BJPsych 2015, 1 – 7 http://bjp.rcpsych.org/content/early/2015/11/09/bjp.bp.114.153882

'555' Topic (5 slides with no more than 5 bullet points)

Please select one topic:

- Relational security
- Procedural security
- Structural security
- Levels of security – high / medium / low
- Mental health in reach teams

MCQs

1. What is the relative risk of psychosis in prisons compared to the general population?

A. 5

B. 10

C. 20

D. 100

E. 2

2. How many homicide offenders have active psychiatric symptoms at the time of committing the homicide?

A. 1 in 10

B. 1 in 5

C. 1 in 3

D. 1 in 2

E. 1 in 4

3. The rate of suicide is highest in:

A. Service users in the community

B. Sentenced prisoners

C. Service users in general psychiatric wards

D. Older prisoners facing long sentences

E. Remand prisoners

4. Which is the most common psychiatric condition in prisoners?

A. Depression

B. Personality disorder

C. Psychopathy

D. Psychosis

E. Neurosis

5. What is the prevalence of major depression in male prisoners?

A. 10%

B. 12%

C. 25%

D. 3.7%

E. 50%

EMI Questions

Mental Health Act:

A. Section 35

B. Section 36
C. Section 37
D. Section 38
E. Section 45A
F. Section 47 / 49
G. Section 48 / 49
H. Section 41

Match the description to the correct section under part III Mental Health Act 1983:

1. Interim Hospital Order
2. Removal to hospital of a sentenced prisoner
3. Remand to hospital for a report
4. Hospital direction and limitation direction
5. Removal to hospital of an un-sentenced prisoner
6. Hospital order
7. Restriction Order
8. Remand to hospital for treatment

Mental Health Act:

A. Section 35
B. Section 36
C. Section 37 +/- 41
D. Section 38
E. Section 45A
F. Section 47 / 49
G. Section 48 / 49

For each of the following scenarios, which section of the Mental Health Act 1983 would be most appropriate to admit the patient under?

1. Bob is 2 years into a 17 year sentence for armed robbery. Whilst in prison he becomes unwell – he worries that the prison officers are poisoning his food, believes there are cameras in his cell and has become aggressive and violent. He refuses to accept treatment because he believes it is part of the conspiracy to poison him.

2. Sharon has been found guilty of burglary and is in HMP anywhere. She reports experiencing distressing command hallucinations to harm herself and others. She is being cared for on the hospital wing and has attempted to hang herself. Treatment is ineffective.

3. Peter kills his next door neighbour because he believes that he is the devil and was planning to harm his children. He experienced command hallucinations from God instructing him to do so. He goes to Court, where it is accepted that Peter suffers from paranoid schizophrenia and psychiatrists recommend admission to hospital. However he is found guilty of murder.

4. Annabelle has a known history of bipolar affective disorder. She stopped taking her medication and during a manic episode set fire to her flat. This is her fourth fire-setting episode when she has been manic. She frequently disengages from her CMHT and stops taking her medication. You are of the opinion that she requires admission to hospital to stabilise her mental state and complete some work around her fire-setting and compliance. Which section would you recommend to the Court?

5. Simon is a member of the Jelly Baby Street gang. He has an extensive criminal record with offences for violence, theft, carrying weapons and possession of illicit substances. He is not known to mental health services. He has been convicted of a section 18 wounding with intent (GBH) after he stabbed a rival gang member in the face for giving him a funny look. Whilst on remand he develops an acute psychotic illness during which he becomes aggressive as he believes that the dentist has planted a monitoring device in his teeth. He has removed several teeth looking for this. You believe he should be admitted to hospital and are asked to prepare a court report for sentencing. Which section would you recommend?

6. Sandeep has appeared in court charged with assault, for which she is on bail. She has a known history of schizoaffective disorder and is showing signs of relapse. She does not engage with the community team when unwell and will not accept treatment voluntarily. She won't engage in assessments as to whether her offence was related to her mental disorder. You are of the opinion that she requires admission to hospital urgently.

Additional Resources / Reading Materials

<u>Books</u>

- Chapters 3, 5 & 24 in 'Forensic Psychiatry: Clinical and ethical issues' Gunn J & Taylor P, (2013) CRC Press
- Chapters 1, 2, 3, 17 & 18 in 'Practical Forensic Psychiatry,' Clark T & Rooprai DS (2011) Hodder Arnold
- Chapters 8 & 17 in 'Oxford Specialist Handbook: Forensic Psychiatry,' Eastman N, Adshead G, Fox S et al (2012) Oxford Medical Publishing

E-Learning

- RCPsych CPD online: 'Suicides in prison'

Journal Articles

- Birmingham L (2001) Diversion from custody. Advances in Psychiatric Treatment 7: 198 – 207
- Birmingham L, Gray J, Mason D et al (2000) Mental illness at reception into prison. Criminal Behaviour and Mental Health 10(2); 77 - 87
- Coid JW (1998) Socio-economic deprivation and admission rates to secure forensic services. Psychiatric Bulletin 22: 294 – 297
- Coid JW, Hickey N, Kahtan N et al (2007) Patients discharged from medium secure forensic psychiatry services: reconvictions and risk factors. British Journal of Psychiatry 190: 223 - 229
- Department of Health (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the Criminal Justice System. London: Department of Health
- Hassan L, Birmingham L, Harty M et al (2011) Prospective cohort study of mental health during imprisonment. British Journal of Psychiatry 198: 37 – 42
- Liebling A (1995) Vulnerability and prison suicide. British Journal of Criminology 35: 173 – 187
- Lyall M & Bartlett A (2010) Decision making in medium security: can he have leave? Journal of Forensic Psychiatry and Psychology 21 (6): 887 – 901
- Royal College of Psychiatrists (2004) Psychiatrists & Multi-Agency Public Protection Arrangements: Guidelines on representation, participation, confidentiality & information exchange. London: Royal college of Psychiatrists
- Shaw J, Hunt IM, Flynn S et al (2006) Rates of mental disorder in people convicted of homicide. National clinical survey. British Journal of Psychiatry 188: 143 – 147

Substance Misuse

Session 1: Diagnosis and Treatment for People with Alcohol Problems

Learning Objectives

- Assessment, diagnosis and treatment of people with alcohol problems
- To develop awareness of complications associated with alcohol use
- To understand some of the practical aspects of managing people with alcohol problems
- To gain awareness of local provisions and guidelines

Curriculum Links

11.1	Basic pharmacology and epidemiology
11.3	Problem drinking; alcohol dependence; alcohol-related disabilities. In-patient and out-patient detoxification
11.4	Biological, psychological and socio-cultural explanations of drug and alcohol dependence
11.7	The assessment and management of alcohol misusers
11.8	Culturally appropriate strategies for the prevention of drug and alcohol abuse

Expert Led Session

- Concepts of harmful use/dependence
- Management of alcohol withdrawals with reference to local guidelines

Case Presentation

- Exploration of alternatives to admission for person with alcohol withdrawals – why admission would be needed
- Highlight assessment and management of comorbid physical symptoms in person with alcohol problems
- Liaison with local alcohol services for follow up

Journal Club Presentation

- Van den Brink, W., Aubin H.J., Bladström A., Torup L., Gual A., Mann K. (2013) Efficacy of as-needed nalmefene in alcohol-dependent patients with at least a high drinking risk level: results from a subgroup analysis of two randomized controlled 6-month studies. *Alcohol and alcoholism*, 48(5), 570-8.
- Schwarzinger, M., Pollock, B., Hasan, O., Dufouil, C., Rehm, J., Baillot, S. Luchini, S. (2018). Contribution of alcohol use disorders to the burden of dementia in France 2008–13: a nationwide retrospective cohort study. *The Lancet Public Health,* 3(3):e124-e132.
- Wood, A., Kaptoge, S., Butterworth, A., Willeit, P., Warnakula, S., Bolton, T., Danesh, J. (2018). Risk thresholds for alcohol consumption: combined analysis of individual-participant data for 599 912 current drinkers in 83 prospective studies. *The Lancet,* 391(10129), 1513-1523.

'555' Topics (5 slides on each topic with no more than 5 bullet points)

- Alcohol Related Brain Damage
- Screening for alcohol use
- Foetal alcohol syndrome
- Long term physical complications from alcohol use

MCQs

1. Which of the following statements about Disulfiram is false:

A. Previous history of CVA is a contraindication

B. Disulfiram use will result in an decrease in accumulation of acetaldehyde in the blood stream

C. A loading dose can be used for initiation

D. Disulfiram may have a role in the treatment of cocaine dependence

E. Hepatic cell damage is a recognised adverse effect of Disulfiram

2. The following are true of Wernicke Encephalopathy except:

A. Classic triad is ocular motor abnormalities, cerebellar dysfunction, and altered mental state

B. Only 20% of patients present with the full triad

C. Altered mental state occurs in 40%

D. Altered mental state symptoms include: mental sluggishness, apathy, impaired awareness of an immediate situation, an inability to concentrate, confusion or agitation

E. Ocular motor abnormalities occur in 30%

3. Which of the following is not a reason to consider inpatient setting for alcohol detoxification based on NICE guidelines:

A. Previous detoxification was inpatient setting

B. Have a score of more than 30 on the Severity of Alcohol Dependence Questionnaire

C. Have a history of epilepsy, or experience of withdrawal-related seizures or delirium tremens during previous assisted withdrawal programmes

D. Need concurrent withdrawal from alcohol and benzodiazepines

E. Consider a lower threshold for inpatient or residential assisted withdrawal in vulnerable groups, for example, homeless and older people

4. Features required for a diagnosis of dependence within ICD 10 include the following except:

A. A strong desire or sense of compulsion to take the substance

B. Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use

C. A physiological withdrawal state when substance use has ceased or have been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms;

D. Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses

E. Returning to substance use after a period of abstinence leads to more rapid reappearance of features of dependence than with non-dependent individuals

5. The following are correct calculation of units of alcohol (percentages are in vol/vol) corrected to nearest whole number:

A. 750 mls of 11% wine is 8 units

B. 6 Litres of 4.5% cider is 18 units

C. 5 cans of 330 mls of 4.8% lager is 8 units

D. 3 cans of 440 mls of 7.5% strong lager is 10 units

E. 2 bottles of 700 mls of 17% fortified wine is 24 units

EMI Questions

Drugs used in Alcohol Dependence:

A. Disulfiram

B. Acamprosate

C. Naltrexone

D. Nalmefene

E. Diazepam

F. Oxazepam

G. Lorazepam

H. Vitamin B compound strong

I. Thiamine

J. Baclofen

1a. Which medication should not be given if serum creatinine >120 micromol/L)

1b. Which medication used for detoxification should be avoided in patients with impaired liver function

1c. Which medication acts as a partial agonist on Kappa opioid receptors

Investigations for people with alcohol use:

A. Gamma-glutamyl transferase (GGT)

B. Mean corpuscular volume

C. Carbohydrate-deficient transferrin (CDT)

D. Total bilirubin

E. Albumin

F. INR

G. Magnesium

H. Globulin

I. Alkaline phosphatase

J. Platelet Count

2a. This marker has Sensitivity of 50 to 70% in the detection of high levels of alcohol consumption in the last 1 to 2 months but false positive with hepatitis, cirrhosis, cholestatic jaundice, metastatic carcinoma, treatment with simvastatin and obesity.

2b. This is used in the calculation of the Maddrey's Discriminant Function for Alcoholic Hepatitis.

2c. A reduction in this can lead to increased risk of seizures and can be related to use of proton pump inhibitors.

Additional Resources / Reading Materials

Books

- Chapter 17 in Cowen, P., Harrison, P. J., Burns, T., & Gelder, M. G. (2012). Shorter Oxford textbook of psychiatry (6th ed.). Oxford: Oxford University Press
- Edwards, G. Alcohol: The World's Favorite Drug. Institute of Psychiatry London
- McGrath, P. Back from the Brink: The Autobiography
- Sigman, A. Alcohol Nation: How to protect our children from today's drinking culture

E-Learning

Blue Light Project: A manual for 'Working with Change Resistant Drinkers

- https://www.alcoholconcern.org.uk/Handlers/Download.ashx?IDMF=8ec66a11-104f-4f02-aed8-892e23522c14

E-learning for Healthcare (e-LfH)

- http://portal.e-lfh.org.uk/Registration
    - Alcohol Identification and Brief Advice

Epidemiological data on Drug and Alcohol Treatment in England

- https://www.ndtms.net/default.aspx

Epidemiological Public Health Data England (Alcohol given as example)

- https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/1/gid/1938132984/pat/6/par/E12000002/ati/101/are/E08000003

GP learning resource centre

- http://www.smmgp.org.uk/
- http://www.smmgp.org.uk/html/featured-videos.php

Royal College of General Practitioners learning resource

- http://elearning.rcgp.org.uk/course/index.php
    - Alcohol: Identification and Brief Advice
    - Alcohol: Management in Primary Care

Royal College of Psychiatrists CPD Online

- Alcohol and the brain
- Alcohol-related brain damage
- Driving and mental disorders

Royal College of Psychiatrists Faculty of Addictions Psychiatry

- http://www.rcpsych.ac.uk/workinpsychiatry/faculties/addictions.aspx

Journal Articles

- Anton, R. F., O'Malley, S. S., Ciraulo, D. A., Cisler, R. A., Couper, D., Donovan, D. M., et al. (2006). Combined pharmacotherapies and behavioral interventions for alcohol dependence: the COMBINE study: a randomized controlled trial. *JAMA*, *295*(17), 2003-2017.
- Group, P. (1998). Matching alcoholism treatments to client heterogeneity: treatment main effects and matching effects on drinking during treatment. Project MATCH Research Group. *Journal of Studies on Alcohol,* 58(1), 7- 29.
- Home Office. Great Britain. (2012). The Government's alcohol strategy. Norwich: TSO.
- Ijaz, S., Jackson, J., Thorley, H., Porter, K., Fleming, C., Richards, A., Savović, J. (2017). Nutritional deficiencies in homeless persons with problematic drinking: A systematic review. *International Journal for Equity in Health*, 16(1), 71.
- Lifestyle Statistics Health and Social Care Information Centre. (2008). Statistics on alcohol : England, 2013. London: Department of Health.
- Mann, K., Lemenager, T., Hoffmann, S., Reinhard, I., Hermann, D., Batra, A., et al. (2013). Results of a double-blind, placebo-controlled pharmacotherapy trial in alcoholism conducted in Germany and comparison with the US COMBINE study. *Addiction Biology*, *18*(6), 937-946.
- Miller, W., & Wilbourne, P. (2002). Mesa Grande: A methodological analysis of clinical trials of treatments for alcohol use disorders. *Addiction,* 93(3), 265-277.
- National Institute for Health and Care Excellence. (2010). Alcohol use disorders: diagnosis and clinical management of alcohol related physical complications CG 100. London: National Institute for Health and Care Excellence.
- National Institute for Health and Care Excellence. (2011). Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence CG 115. London: National Institute for Health and Care Excellence.
- National Institute for Health and Care Excellence. (2014). Alcohol use disorders: preventing harmful drinking PH24. London.
- Office of National Statistics. (2017). Alcohol-specific deaths in the UK: registered in 2016. In Office of National Statistics. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/registeredin2016
- Office of National Statistics. (2017) Statistics on Alcohol England, 2017. https://www.gov.uk/government/statistics/statistics-on-alcohol-england-2017

- Palmer, R. H., McGeary, J. E., Francazio, S., Raphael, B. J., Lander, A. D., Heath, A. C., et al. (2012). The genetics of alcohol dependence: advancing towards systems-based approaches. *Drug and alcohol dependence*, 125(3), 179-191.
- Riley, E. P., Infante, M. A., & Warren, K. R. (2011). Fetal Alcohol Spectrum Disorders: An Overview. *Neuropsychology Review*, 21(2), 73-80.
- Palpacuer, C., Duprez, R., Huneau, A., Locher, C., Boussageon, R., Laviolle, B., & Naudet, F. (2018). Pharmacologically controlled drinking in the treatment of alcohol dependence or alcohol use disorders: a systematic review with direct and network meta-analyses on nalmefene, naltrexone, acamprosate, baclofen and topiramate. *Addiction*. 113(2), 220-237.
- Pryce, R., Buykx, P., Gray, L., Stone, T., Drummond, C., & Brennan, A. (2017). Estimates of Alcohol Dependence in England based on APMS 2014, including Estimates of Children Living in a Household with an Adult with Alcohol Dependence Prevalence, Trends, and Amenability to Treatment. https://www.sheffield.ac.uk/polopoly_fs/1.693546!/file/Estimates_of_Alcohol_Dependence_in_England_based_on_APMS_2014.pdf

Intellectual Disability

Session 1: History Taking and Communication in Patients with an Intellectual Disability

Learning Objectives

- Awareness of the difficulties encountered in assessing patients with an intellectual disability
- Use of other forms of communication rather than just verbal
- The importance and role of the developmental history
- To develop an understanding of how patients with an intellectual disability can present with conditions such as a mental disorder

Curriculum Links

13.3 Clinical

13.3.1 Assessment and communication with people with intellectual disability.

13.3.2 The presentation and diagnosis of psychiatric illness and behavioral disorder in people with intellectual disability, including the concept of diagnostic overshadowing

13.2.2 Aetiology. The influence of psychological and social factors on intellectual and emotional development in people with intellectual disability, including the concept of secondary handicap.

Expert Led Session

- Assessment, interviewing & gathering information in adults with Intellectual disability

Case Presentation

- Case presentation of local patient with intellectual disability, identified by tutor or specialist in post. (This does not have to be an inpatient and discussion with the local ID team may be appropriate in advance to identify such a case). Brief discussion on aetiology as applicable to the case in a formulation type summary

Journal Club Presentation

- Assessment of mental health problems in people with autism Xenitidis K., Paliokosta E., Maltezos S. and Pappas V. (2007). Advances in Mental Health and Learning Disabilities 1, 4, 15-22.
- A guide to intellectual disability psychiatry assessments in the community. Advances in psychiatry Treatment November 1, 2013 19:429-436
- Learning disability in the accident and emergency department. Advances in Psychiatric Treatment January 2005 11:45-57

'555' Topics (5 slides on each topic with no more than 5 bullet points)

Please select one of the following:

- Assessment of the agitated patient in the emergency room setting (focus on environment, style of communication, getting informant history etc)
- How to assess for a mental illness in a patient with a Intellectual disability (Focus on depressed mood or psychosis depending on confidence of chair- possible mute patient, signs and how they differ, role of biological symptoms and effect on routine)
- How to perform a full Developmental History (Focus on all aspects of development and issues of schooling, statement of educational needs, support and current functional ability etc)

MCQs

1. With regard to people with intellectual disabilities, which of the following is false:

A. Diagnosis of intellectual disability is dependent on significantly sub-average IQ and associated deficits in adaptive behaviour with onset occurring before 18 years of age
B. The prevalence of intellectual disability in the general population is 3%
C. Mental health problems are more common than in the general population
D. Mental health problems always present as challenging behaviour
E. The philosophy of normalisation supports people with intellectual disabilities accessing generic health services.

2. According to ICD-10, the following is not a degree of mental retardation:

A. Borderline
B. Moderate
C. Profound
D. Severe
E. Mild

3. Disruptive and dissocial behaviour occurs more commonly in which of the following category?

A. Mild intellectual disability

B. Moderate intellectual disability

C. Severe intellectual disability

D. Profound intellectual disability

E. Equally common across all categories

4. The prevalence of epilepsy in the intellectual disability population is approximately:

A. 1-2%

B. 5-10%

C. 10-15%

D. 20-25%

E. 50%

5. The communication style that does not interfere with assessment in the intellectual disability population is:

A. Denial

B. Fabrication

C. Engagement

D. Digression

E. Suggestibility

Additional Resources / Reading Materials

Books

Intellectual Disability Psychiatry: A Practical Handbook. Edited by Angela Hassiotis, Diana Andrea Barron and Ian Hall.(2010) Wiley Publications.

The Psychiatry of Intellectual Disability. Edited by Meera Roy, Ashok Roy & David Clark. 2006 *Radcliffe Publishing Ltd.*

Royal College of Psychiatrists. DC-LD: Diagnostic Criteria for Psychiatric Disorders for Use with Adults with Learning Disabilities/mental Retardation (Occasional paper) http://www.rcpsych.ac.uk/publications/collegereports/op/op48.aspx

E-Learning

http://www.gmc-uk.org/learningdisabilities/

Journal Articles

Cooper, A., Simpson, N. (2006). Assessment and classification of psychiatric disorders in adults with learning disabilities. *Psychiatry,* 5: 306-11.

Cooper, S.-A., van der Speck, R. (2009) Epidemiology of mental ill health in adults with intellectual disabilities. *Current Opinion in Psychi*

Psychotherapy

Session 1: Referring to Psychotherapy Services

Learning Objectives

Identify relevance to psychotherapy of particular aspects of the psychiatric history.
Account for psychiatric presentation in psychological terms.
Know when to refer patients appropriately to specialist services
Understand that psychotherapies have an empirical evidence base underpinning referral for treatment

Curriculum Links

6 – Organization & Delivery of Psychiatric Services
7.1.x.4 – Psychological aspects of treatment
9.0 – Psychotherapy
9.1.1 – Dynamic Psychotherapy
or 9.3 CBT or 9.4 other modalities *

*Depending on case material and therapy described.

Expert Led Session

What happens in a specialist psychotherapy assessment and why?
What therapies are indicated for which common conditions? – To include reference to the current evidence base. NICE Guidance and its limits / omissions.

Case Presentation

Case presentation of a local patient referred for psychotherapy. Case to be identified by tutor/chair/specialist in post.
To highlight aspects of psychiatric history that indicate referral to psychotherapy.
To highlight aspects of history that would be relevant for specialist psychotherapy assessment.
To highlight factors that suggest good or bad prognostic signs for therapy outcome.

Journal Club Presentation

The paper should preferably be selected in discussion with the chair / presenter of the expert led session

- Schöttke H. et al (2017) "Predicting psychotherapy outcome based on therapist interpersonal skills: A five-year longitudinal study of a therapist assessment protocol" *Psychotherapy Research* 27(6): 642–652

- Clarke et al (2013) "Cognitive analytic therapy for personality disorder: randomised controlled trial" *BJP* 202:129-134
  (with accompanying Editorial) Mulder & Chanen (2013) "Effectiveness of cognitive analytic therapy

for personality disorders" *BJP* 202:89-90

- Lorentzen et al (2013) "Comparison of short- and long-term dynamic group psychotherapy: randomised clinical trial" *BJP* 203:280-287

- Leichsenring & Rabung (2008) "Effectiveness of Long-Term Psychodynamic Psychotherapy: A Meta-Analysis" *JAMA* 300(13): 1551-1565

'555' Topics (5 slides on each topic with no more than 5 bullet points)

Select one of the following:
- Important aspects of psychiatric history to include in referral
- Positive predictors of engagement with therapy
- Relative contraindications to therapy
- Potential adverse effects of therapy

MCQs

1. The following theorists are correctly matched with the concepts that they introduced:

A.	Sigmund Freud	The Subconscious
B.	Melanie Klein	The Paranoid-Schizoid Position
C.	David Malan	The Two Triangle technique
D.	Herbert Rosenfeld	Containment
E.	Anna Freud	The Ego

2. Defences:
A. Are always pathological.
B. Reduce anxiety.
C. Enhance conscious insight.
D. Are universal.
E. Develop later in childhood.

3. A psychotherapy formulation:
A. Leads to a diagnosis.
B. Ignores the past.
C. Is only applicable in psychotherapy.
D. Is theory neutral.
E. Makes predictions.

4. How do you define transference?

A. The empathy shown by the therapist to the patient.

B. Defence mechanism where attention is shifted to a less threatening / more benign target.

C. Therapist's response to the patient drawn from therapist's previous life experiences.

D. Patient's response to the therapist based upon their earlier relationships

E. All of the above

5. What would suggest a patient has good psychological mindedness?

A. Becoming very upset when talking about the past
B. Finding it hard to step back and observe the situation objectively
C. Needing to be talked through assessment with lots of prompts
D. Reasonable sense of self esteem
E. None of the above

Additional Resources / Reading Materials

Jessica Yakeley (2014)"Psychodynamic psychotherapy: developing the evidence base" APT 20:269-279

Chess Denman (2011) "The place of psychotherapy in modern psychiatric practice" APT 17:243-249

Across The Ages

Session 1: Psychosis Across the Ages

Learning Objectives

- The overall aim is for the trainee to gain an overview into the similarities and differences of psychosis across the different age ranges.
- By the end of the session, trainees should understand the commonality and differences in presentation of psychosis in different age groups.
- By the end of the session, trainees should understand the aetiology of psychosis in different age groups.
- By the end of the session, trainees should understand the assessment and treatment process for psychosis in the different age groups.

Curriculum Links

1b: Recognise how the stage of cognitive and emotional development may influence the aetiology, presentation and management of mental health problems

2a: Be familiar with contemporary ICD or DSM diagnostic systems with the ability to discuss the advantages and limitations of each

2a: State the typical signs and symptoms of psychiatric disorders as they manifest across the age range, including affective disorder; anxiety disorders; disorders of cognitive impairment; **psychotic disorders**; personality disorders; substance misuse disorders; organic disorders; developmental disorders; and common disorders in childhood

2a: Use the diagnostic system accurately in identifying specific signs and symptoms that comprise syndromes and disorders across the age range

2b: Describe the various biological, psychological and social factors involved in the predisposition to, the onset of and the maintenance of psychiatric disorders across the age range, including trauma

3a: Develop an individualised assessment and treatment plan for each patient and in collaboration with each patient

3a: Be able to explain to patients, families, carers and colleagues the process and outcome of assessment, investigation and treatment or therapeutic plan

3c: Accurately assess the individual patient's needs and whenever possible in agreement with the patient, formulate a realistic treatment plan for each patient for adult patients with common presenting problems.

3c: Be able to do the above with psychiatric problems as they present across the age range

3c: Consider the impact of the mental illness in an adult patient directly and indirectly on children and young people in the adult's care or who are likely to come into contact with the adult.

7a: Define the clinical presentations and natural history of patients with severe and enduring mental illness

Expert Led Session (incorporating case discussion)
• A Consultant led session based on the learning objectives above focussing on Psychosis across the ages • Session coordinated by LEP Lead, with panel of 3 Expert Consultant Colleagues, representing child, old age and general/liaison psychiatry
Journal Club Presentation
Choose 1 only: **Child and Adolescent:** • Adult Outcomes of Child- and Adolescent-Onset Schizophrenia: Diagnostic Stability and Predictive Validity Chris Hollis, Ph.D., MRCPsych. (Am J Psychiatry 2000; 157:1652–1659) • Double-blind comparison of first- and second-generation antipsychotics in early-onset schizophrenia and schizo-affective disorder: findings from the treatment of early-onset schizophrenia spectrum disorders (TEOSS) study. Sikich L1, Frazier JA, McClellan J, Findling RL, Vitiello B, Ritz L, Ambler D, Puglia M, Maloney AE, Michael E, De Jong S, Slifka K, Noyes N, Hlastala S, Pierson L, McNamara NK, Delporto-Bedoya D, Anderson R, Hamer RM, Lieberman JA. Am J Psychiatry. 2008 Nov;165(11):1420-31. doi: 10.1176/appi.ajp.2008.08050756. Epub 2008 Sep 15. **General Adult:** • The Myth of Schizophrenia as a Progressive Brain Disease, Robert B. Zipursky, Thomas J. Reilly, Robin Murray. Schizophrenia Bulletin vol. 39 no. 6 pp. 1363–1372, 2013, doi:10.1093/schbul/sbs135. Advance Access publication November 20, 2012 • Köhler, S., van Os, J., de Graaf, R., Vollebergh, W., Verhey, F., & Krabbendam, L. (2007). Psychosis risk as a function of age at onset. Social psychiatry and psychiatric epidemiology, 42(4), 288-294. **Older Adult:** • Brunelle, S., Cole, M. G., & Elie, M. (2012). Risk factors for the late-onset psychoses: a systematic review of cohort studies. International journal of geriatric psychiatry, 27(3), 240-252.

'555' Topics (5 slides on each topic with no more than 5 bullet points)

Choose one:

- Choice of antipsychotic treatment in the three age groups
- Differences in Psychological interventions for psychosis in the three age groups
- Differences of Social interventions for psychosis in the three age groups

MCQs

1) If you are working with a 15 year old boy who is presenting with auditory hallucinations and a belief that they are being followed, which 4 question areas are most relevant?

A. Family history of psychosis
B. Recent drug use, including cannabis
C. Recent decline in motivation, academic performance and self-care
D. Recent change in affect
E. Recent change in concentration and energy levels

2) You learn that your patient has a strong family history of psychosis, is hearing voices in external space, and believes that thoughts are being put into his head from the television. Which of the following areas form part of your ongoing assessment?

A. Thyroid function test
B. Test of Prolactin Levels
C. Test of visual fields
D. Detailed early developmental history
E. Urine drugs screen

3) People with Schizophrenia have an increased rate of:

A. Premature death
B. Diabetes
C. Heart disease
D. Smoking
E. All of the above

4) Which of the following statements is FALSE with regards to cognitive impairment in schizophrenia:

A. It is consistent with the neurodevelopmental theory of schizophrenia
B. It is present in drug-naïve patients
C. It is present in the majority of patients with schizophrenia

D. It is not clearly related to specific symptoms

E. It is only found in chronic elderly patients

5) Schizophrenia in older adults is most accurately described by the term:

A. Late-onset schizophrenia

B. Very-late onset schizophrenia

C. Paraphrenia

D. Dementia praecox

E. Delusional disorder

6) All but the following are described as risk factors for late-onset psychosis:

A. Sensory impairment

B. Social isolation

C. Polypharmacy

D. Male gender

E. Age-related deterioration of frontal and temporal lobes

Additional Resources / Reading Materials

Child and Adolescent:

- TrOn module: overview of child and adolescent psychiatry
- https://www.aacap.org/App_Themes/AACAP/docs/resources_for_primary_care/cap_resources_for_medical_student_educators/Pediatric%20Psychosis.ppt

Emerging psychiatric syndromes associated with antivoltage-gated potassium channel complex antibodies Prüss H, Lennox BR. J Neurol Neurosurg Psychiatry 2016;0:1–6. doi:10.1136/jnnp-2015-313000

Old age

Karim, S., & Byrne, E. J. (2005). Treatment of psychosis in elderly people. Advances in Psychiatric Treatment, 11(4), 286-296.)

Schizophrenia Michael J Owen, Akira Sawa, Preben B Mortensen. The lancet Vol 388 July 2, 2016