North West
School of Psychiatry

Semester 4 Handbook

MRCPsych Course

2018 – 2020

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

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Deputy course Director – Dr Dushyanthan Mahadevan, Consultant in Child and Adolescent Psychiatry

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- Uguz, F. (2016). Second-Generation Antipsychotics During the Lactation Period: A Comparative Systematic Review on Infant Safety. *Journal of Clinical Psychopharmacology*, 36(3), pp.244-252.**Error! Bookmark not defined.**

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- Child and Adolescent Psychiatry: A Developmental Approach. 4th ed. Jeremy Turk, Philip Graham, Frank C Verhulst 2007. Oxford University Press .... Error! Bookmark not defined.
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- Rutter's Child and Adolescent Psychiatry, Fifth Edition. .... **Error! Bookmark not defined.**
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- Seminars in Child and Adolescent Psychiatry (second edition) Edited by Simon Gowers, Royal college of Psychiatrists UK, Seminar Series 59
- Wiley: Handbook of Eating Disorders, 2d Edition Janet Treasure (Editor), Ulrike Schmidt (Editor), Eric van Furth (Editor) February 2003 ISBN: 978-0-471-49768-4 59
  - **Psychological treatments for children and adolescents with eating disorders: In this podcast, Professor Simon Gowers gives an overview of the different psychological therapies available for children and adolescents with eating disorders, discussing in some detail family therapy, interpersonal therapy and cognitive behavioural therapy** 59
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Session 1: Referring to Psychotherapy Services......................................**Error! Bookmark not defined.**

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4. How do you define transference? .... **Error! Bookmark not defined.**

A. The empathy shown by the therapist to the patient. .... **Error! Bookmark not defined.**

B. Defence mechanism where attention is shifted to a less threatening / more benign target. .. **Error! Bookmark not defined.**

C. Therapist’s response to the patient drawn from therapist’s previous life experiences. .... **Error! Bookmark not defined.**

D. Patient’s response to the therapist based upon their earlier relationships .. **Error! Bookmark not defined.**

E. All of the above .... **Error! Bookmark not defined.**

5. What would suggest a patient has good psychological mindedness? **Error! Bookmark not defined.**

A. Becoming very upset when talking about the past.................... **Error! Bookmark not defined.**

B. Finding it hard to step back and observe the situation objectively **Error! Bookmark not defined.**

C. Needing to be talked through assessment with lots of prompts .. **Error! Bookmark not defined.**

D. Reasonable sense of self esteem .... **Error! Bookmark not defined.**

E. None of the above .... **Error! Bookmark not defined.**

Additional Resources / Reading Materials .... **Error! Bookmark not defined.**

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McMain et al (2009) “A Randomized Trial of Dialectical Behavior Therapy Versus General Psychiatric Management for Borderline Personality Disorder” *Am J Psychiatry* 166:1365–1374 .. **Error! Bookmark not defined.**

Batement & Fonagy (2009) “Randomized Controlled Trial of Outpatient Mentalization-Based Treatment Versus Structured Clinical Management for Borderline Personality Disorder” *Am J Psychiatry* 166:1355–1364 .... **Error! Bookmark not defined.**

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1. NICE guidance (CG90): .... **Error! Bookmark not defined.**

B. Recommends Computerised CBT for mild-moderate depression . **Error! Bookmark not defined.**

C. Recommends Psychotherapy for severe depression .... **Error! Bookmark not defined.**

D. Advises not combining medication with psychological therapies . **Error! Bookmark not defined.**

E. Recommends Cognitive therapy for relapse prevention .... **Error! Bookmark not defined.**

F. Defines Short-term Psychodynamic Psychotherapy as 10-15 sessions over 3-4 months .... **Error! Bookmark not defined.**

2. Cognitive Therapy: .... **Error! Bookmark not defined.**

A. Is originally based on the work of Judith Beck .... **Error! Bookmark not defined.**

B. Identifies Cognitive Errors that lead to or maintain depressive thoughts ..... **Error! Bookmark not defined.**

C. Focuses on non-conscious thought content .... **Error! Bookmark not defined.**

D. Is enhanced by concurrent antidepressant treatment .... **Error! Bookmark not defined.**

E. Should not be used in older patients .... **Error! Bookmark not defined.**

3. Psychodynamic Therapies: .... **Error! Bookmark not defined.**

A. Have no evidence base for effectiveness .... **Error! Bookmark not defined.**

B. Are based on the model of the mind put forward by Freud .... **Error! Bookmark not defined.**

C. Seek to eradicate a patient's defences .... Error! Bookmark not defined.

D. Were among the first to link depression to loss........................ Error! Bookmark not defined.

E. Focus on the past .... Error! Bookmark not defined.

4. Psychological factors in the aetiology of depression include .... Error! Bookmark not defined.

A. Parental indifference .... Error! Bookmark not defined.

B. Social circumstance .... Error! Bookmark not defined.

C. Maternal Depression .... Error! Bookmark not defined.

D. Cognitive biases or distortions .... Error! Bookmark not defined.

E. Bereavement .... Error! Bookmark not defined.

5. Evidence of effectiveness in the treatment of depression exists for: ....Error! Bookmark not defined.

A. Psychoanalytic therapy .... Error! Bookmark not defined.

B. Interpersonal Therapy.. Error! Bookmark not defined.

C. 'Low intensity' therapy in IAPT .... Error! Bookmark not defined.

D. Mentalization based CBT .... Error! Bookmark not defined.

E. EMDR..Error! Bookmark not defined.

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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.

Syllabus Links
MRCPsych Paper A - The Scientific and theoretical basis of Psychiatry
MRCPsych Paper B - Critical review and the clinical topics in Psychiatry
MRCPsych CASC

GENERAL ADULT SEMESTER 4:

Curriculum Mapping				
Section	**Topic**	**Covered by**		
		LEP	**AP**	**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	✓		✓

Key- LEP – Local Education Programme;

AP- Academic Programme

LR – Learning Resources

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

Session 19: Psychosis - 4
Journal theme: Genetic studies in Psychosis

Learning Objectives

- To develop an understanding of the course and prognosis of schizophrenia.
- To develop an understanding of risk factors for poor outcomes.
- To develop an understanding of the relevance of duration of untreated psychosis.
- To develop an understanding of genetic studies and develop skills for critically appraising them

Expert Led Session

- Topic: Schizophrenia- course and prognosis

Case Presentation

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

Journal Club Presentation (Select 1 paper)

- Schmidt-Kastner R, van Os J, Esquivel G, Steinbusch HW, & Rutten BP. (2012). An environmental analysis of genes associated with schizophrenia: hypoxia and vascular factors as interacting elements in the neurodevelopmental model. Molecular Psychiatry; 17, 1194–1205. DOI:10.1038/mp.2011.183
- Di Forti M, et al. (2012) Confirmation that the AKT1 (rs 2494732) genotype influences the risk of psychosis in cannabis users. http://dx.doi.org/10.1016/j.biopsych.2012.06.020
- Zavos HM, Freeman D, Haworth CM, McGuire P, Plomin R. (2014). Consistent Etiology of Severe, Frequent Psychotic Experiences and Milder, Less Frequent ManifestationsA Twin Study of Specific Psychotic Experiences in Adolescence. JAMA Psychiatry; 71 (9), 1049-1057. DOI:10.1001/jamapsychiatry.2014.994

'555' Topics (Select 1 topic; 5 slides with no more than 5 bullet points)

- NICE guidelines on management of first episode psychosis – pharmacological and psychological interventions
- Risk factors for poor outcomes in Schizophrenia

- Major Schizophrenia candidate genes

Statistics '555' topic

- Interpreting Regression Results (with GxE interaction)

MCQs

1. The chemical structure of Olanzapine is:

   A. Benzizoxazole

   B. Dibenzothiazepine

   C. Thienobenzodiazepine

   D. Butyrophenone

   E. Benzobutyramide

2. Which of the following genes are thought to be involved in the aetiology of Schizophrenia according to the current evidence?

   A. COMT

   B. DISC-1

   C. DTNBP-1

   D. GABRB-2

   E. All of the above

3. Which of the following is not a predictor of course and outcome in Schizophrenia?

   A. Sociodemographic status

   B. Features of initial clinical state and treatment response

   C. First rank symptoms at baseline

   D. Family history of psychiatric disorders

   E. Premorbid personality and functioning

4. Which of the following scales is the most appropriate for assessment of extra-pyramidal side effects of antipsychotics?

   A. Barnes' scale

   B. Brief Psychiatric Rating Scale

C. Simpson-Angus Scale

D. Positive and Negative Symptom Scale

E. Unified Parkinson's Disease Rating Scale

5. Who established antipsychotic effects of Chlorpromazine?

   A. John Cane and colleagues

   B. Jean Delay and Pierre Deniker

   C. Eugene Bleuler

   D. John Cade

   E. Arvid Carlsson

Session 20: Depression- 4
Journal theme: ROC analysis studies in Depression

Learning Objectives

- To develop an understanding of the course and prognosis of Depression.
- To develop an understanding of risk factors for poor outcomes.
- To develop an understanding and skills for critically appraising Receiver Operating Characteristic Curve studies.

Expert Led Session

- Topic: Depression- course and prognosis

Case Presentation

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

Journal Club Presentation (Select 1 paper)

- Cameron I, Cardy A, Crawford J, Toit S, Hay S, Mitchell K, Sharma S, Shivaprasad, S, Winning S, Reid I (2011) Measuring depression severity in general practice: discriminatory performance of the PHQ-9, HADS-D and BDI-II. Br J Gen Pract, DOI: 10.3399/bjgp11X583209.
- Karlović D, Serretti A, Jevtović S, Vrkić N, Šerić V, et al. (2013). Diagnostic accuracy of serum brain derived neurotrophic factor concentration in antidepressant naïve patients with first major depression episode. Journal of Psychiatric Research; 47 (2), 162–167. DOI:10.1016/j.jpsychires.2012.09.017
- Hayden MJ, Brown WA, Brennan L, & O'Brien PE. (2012). Validity of the Beck Depression Inventory as a Screening Tool for a Clinical Mood Disorder in Bariatric Surgery Candidates. Obesity Surgery; 22 (11), 1666-1675. DOI: 10.1007/s11695-012-0682-4

‘555’ Topics (Select 1 topic; 5 slides with no more than 5 bullet points)
• Risk factors associated with early onset and late onset depression • Biological markers of recurrent depression • Classification of depressive disorders
Statistics ‘555’ topic
• Sensitivity, Specificity, Positive Predictive Value, Negative Predictive value
MCQs

1. In recurrent depression with a history of significant functional impairment, long term antidepressants should not be withdrawn until what duration since complete remission:

A. 3 months

B. 6 months

C. 1 year

D. 2 years

E. 3 years

2. Many risk factors have been identified in depressive disorder. Which ONE of the following statements regarding risk of developing depression is NOT true?

A. Risk is increased if there is a first degree relative with bipolar affective disorder
B. Risk is more increased in lower social classes than middle social classes following a life event
C. Risk is increased by having poor social support
D. Risk in single women doubles in the presence of poverty
E. Risk is increased in females who are heterosexual compared to males who are homosexual

3. Mrs. Jones is treated for breast cancer with Tamoxifen but is also depressed. Which of the following drugs is contraindicated in her situation?

A. Vortioxetine

B. Roboxetine

C. Fluoxetine

D. Mirtazapine

E. Venlafaxine

4. What is the approximate male : female ratio of completed suicide in England, Scotland and Wales?

A. 7:1
B. 3:1
C. 5:1
D. 1:1
E. 2:1

5. The average duration of an untreated episode of depression:

A. 3 years
B. 1 year
C. 6 months
D. 3 months
E. 1 month

Session 21: Bipolar Disorder - 4 Journal theme: Meta-analysis / systematic review on bipolar disorder
Learning Objectives
• To develop an understanding of the course and prognosis of Bipolar disorder. • To develop an understanding of risk factors for poor outcomes. • To develop an understanding of meta-analysis and systematic review and develop skills for critically appraising them.
Expert Led Session
• Topic: Bipolar disorder- course and prognosis
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 (Select 1 paper)
• Severus E, Taylor MJ, Sauer C, Pfennig A, Ritter P, et al. (2014). Lithium for prevention of mood episodes in bipolar disorders: systematic review and meta-analysis. International Journal of Bipolar Disorders; 2 (15). DOI: 10.1186/s40345-014-0015-8 • Cerullo MA, & Strakowski SM. (2013). A systematic review of the evidence for the treatment of acute depression in bipolar I disorder. CNS Spectrums; 18 (4), 199- 208. DOI: http://dx.doi.org/10.1017/S1092852913000102 • Ogawa Y, Tajika A, Takeshima N, Hayasaka Y, Furukawa TA. (2014). Mood Stabilizers and Antipsychotics for Acute Mania: A Systematic Review and Meta-Analysis of Combination/Augmentation Therapy Versus Monotherapy. CNS Drugs; 28 (11), 989-1003. DOI: 10.1007/s40263-014-0197-8.

‘555’ Topics (Select 1 topic; 5 slides with no more than 5 bullet points)
• Distinguishing between mood symptoms of bipolar disorder (type I and II), emotionally unstable personality disorder and cyclothymia • Psychological therapies in bipolar disorder – summary of evidence • Role of depot antipsychotics in bipolar disorder
Statistics ‘555’ topic
• Forest plot
MCQs
1. Using the broadest definition, prevalence of bipolar spectrum disorders in the general population has been estimated as high as: A. 0.8% B. 1.2% C. 3.9% D. 8.3% E. 10.4% 2. Age at onset of bipolar disorder: A. Has little prognostic relevance B. Is not a heritable trait C. Has been observed to be higher in more recent studies D. Is higher in women than men E. Has implications for clinical course 3. Individuals with bipolar disorder: A. Rarely receive a diagnosis of unipolar depression B. Have longer episodes of mania than depression C. Commonly have psychiatric co-morbidities D. Have fewer depressive episodes than those with unipolar depression E. Show poorer prognosis if they have predominantly manic episodes

4. When compared with bipolar I disorder, bipolar II disorder:

A. Is associated with better inter-episode functioning

B. Is similar and frequently develops into bipolar I disorder

C. Is associated with fewer affective episodes overall

D. Has a less chronic course

E. Has a significantly higher age at onset

5. Regarding the treatment of bipolar disorder:

A. Delays in initiating treatment are rare

B. The vast majority of patients respond to lithium or an anticonvulsant treatment when in a manic phase

C. Quetiapine leads to remission in over 50% of patients in the depressive phase

D. There are a number of well-tolerated treatments that are effective in all phases of the illness

E. The majority of patients are maintained on monotherapies

Session 22: General Hospital Psychiatry
Journal theme: Case report/ case series

Learning Objectives

- To develop an understanding of psychiatric assessment of patients with physical illness, liaising with colleagues in other specialties, psychiatric consequences and aspects of brain pathology; and clinical and theoretical psychiatric aspects of pain and its management.
- To develop an understanding of Case reports/case series studies and develop skills for critically appraising them.

Expert Led Session

- Topic: Overview of psychiatric presentations in general hospital / liaison psychiatry

Case Presentation

- A case of psychiatric presentation in general hospital / liaison psychiatry

Journal Club Presentation (Select 1 paper)

- Amoako AO, Brown C, Riley T (2015) Syndrome of inappropriate antidiuretic hormone secretion: a story of duloxetine-induced hyponatraemia. BMJ Case Rep. 2015 Apr 24.
- Warren R, Burrow J, Conroy D, Lukela J, Kahn DA (2014) "I didn't know cognitive therapy was deep": a case study of sudden and lasting gains in cognitive-supportive therapy of depression. J Psychiatr Pract., Sep; 20(5):379-88.
- Nagoshi Y, Tominaga T, Fukui K. (2014) Effect of aripiprazole augmentation for treatment-resistant somatoform disorder: a case series. J Clin Psychopharmacol., Jun 34(3):397-8.

'555' Topics (Select 1 topic; 5 slides with no more than 5 bullet points)

- Pathophysiological theories of chronic somatoform pain disorders.
- Pathophysiological findings in chronic fatigue syndrome
- Evidence based treatments for Chronic Fatigue syndrome

Statistics '555' topic

- Hierarchy of evidence and study designs (quantitative)

MCQs

1. Lesions in the following structure have been associated with pathological crying:

A. Temporal pole

B. Pineal gland

C. Caudate nucleus

D. Pons

E. Tegmentum

2. The following theoretical model is commonly applied to somatoform pain disorders:

A. Central demyelination theory

B. Central sensitisation theory

C. Operant sensitisation theory

D. Central operant theory

E. Operant receptive field theory

3. Diagnostic criteria for Chronic fatigue syndrome requires a duration of symptoms for at least

A. 4 weeks

B. 3 months

C. 4 months

D. 6 months

E. 12 months

4. Diagnostic criteria for Fibromyalgia requires a duration of symptoms for at least

A. 4 weeks

B. 3 months

C. 4 months

D. 6 months

E. 12 months

5. The following medication is routinely used for treating Fibromyalgia:

A. Carbamazepine

B. Vigabatrin

C. Pregabalin

D. Mirtazepine

E. Mianserin

Session 23: Organic Psychiatry
Journal theme: Neuroimaging studies

Learning Objectives

- To develop an understanding of organic psychiatric disorders. To develop an understanding of the psychiatric consequences and aspects of brain disease, damage (including stroke) and dysfunction.
- To develop an understanding of brain imaging studies and develop skills for critically appraising them.

Expert Led Session

- Topic: Overview of organic psychiatric disorders in GA psychiatry.

Case Presentation

- Any case with a theme of organic psychiatric disorder or where there are specific organic findings (e.g in brain scans) or where such disorders are a part of differential diagnoses.

Journal Club Presentation (Select 1 paper)

- Mallas EJ, Carletti F, Chaddock CA, Woolley J, Picchioni MM, Shergill SS, Kane F, Allin MP, Barker GJ, Prata DP (2016) Genome-wide discovered psychosis-risk gene ZNF804A impacts on white matter microstructure in health, schizophrenia and bipolar disorder. PeerJ. Feb 25;4:e1570.
- Hamilton J, Etkin A, Furman D, Lemus M, Johnson R, Gotlib I (2012) Functional neuroimaging of major depressive disorder: a meta-analysis and new integration of baseline activation and neural response data. Am J Psychiatry 169:693-703.
- De Wit S, Alonso P, Schweren L, et al. (2014) Multicentre voxel-based morphometry mega-analysis of structural brain scans in obsessive-compulsive disorder. Am J Psychiatry 171:340-349.

'555' Topics (Select 1 topic; 5 slides with no more than 5 bullet points)

- Psychosis in medical conditions
- Depression in medical conditions
- Anxiety in medical conditions

Statistics '555' topic

- Cluster analysis method for examining functional connectivity

MCQs

1. Patients with Phaeochromocytoma may resemble patients experiencing:

A. Depression

B. Mania

C. Psychosis

D. Panic disorder

E. OCD

2. Which of the following commonly features in early Borrelia infection?

A. Erythema nodosum

B. Flu type symptoms

C. Tinnitus

D. Polyuria

E. abdominal pain, especially at night

3. Which of the following is NOT a risk factor for hypothyroidism?

A. Age <40 years

B. Post-partum

C. Neck surgery

D. Radiation exposure

E. Amiodarone

4. Patients with untreated Borrelia infection progressing to neurological symptoms:

A. 5%

B. 10%

C. 15%

D. 18%

E. 20%

5. HSV encephalitis commonly affects the:

A. Frontal lobes

B. Temporal lobes

C. Parietal lobes

D. Brainstem

E. Corpus callosum

Session 24: Obsessive Compulsive Disorder
Journal theme: RCT studies in OCD

Learning Objectives

- To develop an understanding of OCD (aetiology, epidemiology, natural history, neurobiology, genetics, diagnostic criteria, classification, psychopathology, clinical presentation, assessment, risks) and its management (pharmacological, psychological, social).
- To develop an understanding of Randomized controlled trail and develop skills for critically appraising them.

Expert Led Session

- Topic: OCD- an overview

Case Presentation

- A case of OCD or a case in which it is a differential diagnosis.

Journal Club Presentation (Select 1 paper)

- Simpson HB, Foa EB, Liebowitz MR, Huppert JD, Cahill S, et al. (2013). Cognitive-behavioral therapy vs risperidone for augmenting serotonin reuptake inhibitors in obsessive-compulsive disorder: a randomized clinical trial. JAMA Psychiatry; 70 (11), 1190-1199. DOI: 10.1001/jamapsychiatry.2013.1932.

- Sayyah M, Sayyah M, Boostani H, Ghaffari SM, Hoseini A. (2012). Effects of aripiprazole augmentation in treatment-resistant obsessive-compulsive disorder (a double blind clinical trial). Depress Anxiety; 29 (10), 850-854. DOI: 10.1002/da.21996

- Bruno A, Micò U, Pandolfo G, Mallamace D, Abenavoli E, et al. (2012). Lamotrigine augmentation of serotonin reuptake inhibitors in treatment-resistant obsessive-compulsive disorder: a double-blind, placebo-controlled study. J Psychopharmacol; 26 (11), 1456-1462. doi: 10.1177/0269881111431751

'555' Topics (Select 1 topic; 5 slides with no more than 5 bullet points)

- Neurobiology of OCD
- Summary of NICE guidelines on OCD

- Evidence for psychological therapies in OCD- summary

Statistics ‘555’ topic

- Methods of blinding

MCQs

1. The lifetime risk of OCD is:
A. 2.1%
B. 1 %
C. 0.5 %
D. 5 %

2. Which of the following it TRUE about OCD?
A. There is evidence of increased volume of basal ganglia structures
B. Meta-analyses of brain imaging studies shows consistent findings
C. Studies have found an increase in volume of orbitofrontal cortex
D. Anterior cingulate area volume always remains normal

3. NICE recommends:
A. CBT including exposure and response prevention in OCD with mild functional impairment
B. Choice of monotherapy with an SSRI or intensive CBT alone for OCD with moderate functional impairment
C. Use of combination therapy after inadequate response at 12 weeks
D. All of the above

4. NICE recommends consideration of in-patient treatment in OCD when there is:
A. Risk of suicide
B. Severe self-neglect
C. Reversal of normal night/day patterns making attendance for daytime therapy impossible
D. A, B and C
E. Only A and B

5. All of the following statements about the CBT model for OCD is true EXCEPT:
A. According to the model, intrusive thoughts are universal, with a content indistinguishable from that of clinical obsessions

B. Avoidance is not a part of the definition of OCD

C. Excessive attentional bias on monitoring intrusive thoughts is specific to OCD

D. Rumination covers both the obsession and any accompanying mental compulsion

E. Thought-action fusion is also known as magical thinking

Further Reading

PSYCHOSIS

Guidelines

- NICE Guidance Pathway: Psychosis and Schizophrenia Pathway - : http://pathways.nice.org.uk/pathways/psychosis-and-schizophrenia
- Nice guidelines: CG178- Psychosis and schizophrenia in adults: http://guidance.nice.org.uk/CG178
- BAP guidelines: Evidence-based guidelines for the pharmacological treatment of schizophrenia: recommendations from the British Association for Psychopharmacology- https://www.bap.org.uk/pdfs/BAP_Guidelines-Schizophrenia.pdf

E-Learning

RCPsych CPD Online

- First episode psychosis: Part 1 -assessment, diagnosis and rationale
- First episode psychosis: Part 2 -treatment approaches and service delivery

Journal Articles

- Feedman, R (2003) Schizophrenia. N Engl J Med 349:1738-1749
- Woolley, J & McGuire P (2005) Neuroimaging in schizophrenia: what does it tell the clinician? APT 11: 195-202.
- Cardno A (2014) Genetics and psychosis. APT 20: 69-70
- Torrey EF (1987) Prevalence studies in schizophrenia. BJPsych 150:598-608.
- Macleod J (2007) Cannabis use and psychosis: the origins and implications of an association. APT 13:400-411.
- Martindale B (2007) Psychodynamic contributions to early intervention in psychosis. APT 13:34-42.
- Connolly M & Kelly C (2005) Lifestyle and physical health in schizophrenia. APT 11:125-132.
- Mullen P (2006) Schizophrenia and violence: from correlations to preventive strategies. APT 12:239-248
- Schleifer JJ (2011) Management of acute agitation in psychosis: an evidence-based approach in the USA. APT 17:91-100.

DEPRESSION

Guidelines

- NICE Guidance Pathway: Depression Pathway- http://pathways.nice.org.uk/pathways/depression
- Nice guidelines: CG90- Depression in adults: Recognition and management https://www.nice.org.uk/guidance/CG90
- BAP guidelines: Evidence-based guidelines for treating depressive disorders with antidepressants: A revision of the 2008 British Association for Psychopharmacology guidelines- https://www.bap.org.uk/pdfs/BAP_Guidelines-Antidepressants.pdf

E-Learning

RCPsych CPD Online

- The pharmacological treatment of resistant depression- an overview
- Dual diagnosis: the diagnosis and treatment of depression with co-existing substance misuse
- Managing depression in physically ill patients
- Prescription of ECT
- Antidepressants and psychosexual dysfunction: Part 1 – diagnosis
- Antidepressants and psychosexual dysfunction: Part 2 – treatment

Journal Articles

- Belmaker, RH & Agam G (2008). Major depressive disorder, N Engl J Med, 358: 55-68.
- Jacob KS (2009) Major depression: revisiting the concept and diagnosis. APT 15:279-285.
- Taylor D (2008) Psychoanalytic and psychodynamic therapies for depression: the evidence base. APT 14:401-413.
- Branney P & White A (2008) Big boys don't cry: depression and men. *APT 14:256-262.*
- Cowen P (2005) New drugs, old problems: Revisiting Pharmacological management of treatment-resistant depression. APT 11:19-27.
- Oakley C, Hynes F, Clark T (2009). Mood disorders and violence: a new focus, APT, 15:263-270.

BIPOLAR DISORDER

Guidelines

- Nice guidelines: CG185- Bipolar disorder: assessment and management https://www.nice.org.uk/guidance/cg185
- BAP guidelines: Evidence-based guidelines for treating bipolar disorder: revised third edition https://www.bap.org.uk/pdfs/BAP_Guidelines-Bipolar.pdf

E-Learning

RCPsych CPD Online

- The pharmacological management of mania
- Safe Lithium Prescribing: initiation and monitoring

Journal Articles

- Elanjithara T, Frangou S, McGuire P (2011) Treatment of the early stages of bipolar disorder. *APT 17:283-291.*
- Bouch J (2010) Bipolar disorder. *APT 16:317.*
- Saunders KEA & Goodwin GM (2010) The course of bipolar disorder. *APT 16:318-328.*

PERSONALITY DISORDERS

Guidelines

- Stoffers J, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K (2010) Pharmacological interventions for borderline personality disorder, The Cochrane Library, DOI: 10.1002/14651858.CD005653.pub2
- Stoffers J, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K (2010) Psychological therapies for people with borderline personality disorder**,** The Cochrane Library, DOI: 10.1002/14651858.CD005652.pub2
- NICE guideline CG78: Borderline Personality disorder: treatment and management.
- NICE guideline CG77: Antisocial Personality disorder: treatment and management and prevention.

E-Learning

RCPsych CPD Online

- The assessment of personality

Journal Articles

- Raju R, Corrigan FM, Davidson AJW, Johnson D (2012). The nature of personality disorder. APT, 18:162-172.
- Sarkar J & Duggan C (2010). Personality disorder and the Mental Health Act 1983 (amended), APT, 16:329-335.
- Thomson LDG (2010). Diagnosis and classification of personality disorder: difficulties, their resolution and implications for practice, APT, 16:388-396.
- Carroll A (2009). Assessment of personality disorder, APT, 15:389-397.
- Lewis G & Appleby L (1988) Personality disorder: the patients psychiatrists dislike. BJPsych 153:44 -49.
- Kernberg O, Yeomans F (2013). Borderline personality disorder, bipolar disorder, depression, attention deficit/hyperactivity disorder, and narcissistic personality disorder: Practical differential diagnosis. Bulletin of the Menninger Clinic. 77[1], 1-22

MENTAL HEALTH ACT & MENTAL CAPACITY ACT

E-Learning

RCPsych CPD Online

- The Mental Health Act 1983: criteria for detention
- Supervised community treatment
- Competence, capacity and decision-making ability in mental disorder
- Mental capacity Act 2005: Part 1
- Mental Capacity Act 2005: Part 2

Journal Articles

- Bindman J, Maingay S, Szmukler G (2003) The Human Rights Act and mental health legislation. BJPsych 182: 91-94.
- Brindle N & Branton T (2010) Interface between the Mental Health Act and Mental Capacity Act: deprivation of liberty safeguards. APT 16:430-437.

- Jones C, Nimmagadda S, Paul Veitch P (2013) Mental health tribunals in England and Wales: a representative's guide. APT 19:40-47.
- Hampson M (2011) Raising standards in relation to Section 136 of the Mental Health Act 1983. APT 17:365-371.
- Branton T & Brookes G (2010) Definitions and criteria: the 2007 amendments to the Mental Health Act 1983. APT 16:161-167.
- Branton T & Brookes G (2010) Compulsion in the community? The introduction of supervised community treatment. APT 16:245-252.

POST-TRAUMATIC STRESS DISORDER

Guidelines

- NICE guidelines for PTSD
- BAP guidelines: Evidence-based pharmacological treatment of anxiety disorders, post-traumatic stress disorder and obsessive-compulsive disorder: A revision of the 2005 guidelines from the British Association for Psychopharmacology https://www.bap.org.uk/pdfs/BAP_Guidelines-Anxiety.pdf

Journal Articles

- Starcevic V *(2013)* Post-traumatic stress disorder: new directions in pharmacotherapy. *APT, 19:181-190.*
- Ahmed A (2007) Post-traumatic stress disorder, resilience and vulnerability. APT, 13, 369–375.

SELF-HARM & SUICIDE

E-Learning

RCPsych CPD Online

- The psychosocial management of self-harm: Part 1
- The psychosocial management of self-harm: Part 2

BMJ Learning Module on suicidal behaviour and self-harm

- http://learning.bmj.com/learning/module-intro/cmt-self-harm.html?moduleId=10054668&page=1&locale=en_GB

Journal Articles

- Bouch J, Marshall JJ (2005) Suicide risk: structured professional judgement. Advances in Psychiatric Treatment 11: 84-91.
- Heeringen K, Mann JJ (2014) The neurobiology of suicide. Lancet Psychiatry 1:63-72.
- O'Connor RC, Nock MK (2014) The psychology of suicidal behaviour. Lancet Psychiatry 1:73-85.

ANXIETY DISORDERS

Guidelines

- NICE Guidance Pathway for GAD and panic disorder (with or without agoraphobia): http://pathways.nice.org.uk/pathways/generalised-anxiety-disorder
- NICE guidelines on GAD and panic disorder: CG113- https://www.nice.org.uk/Guidance/CG113
- BAP guidelines: Evidence-based pharmacological treatment of anxiety disorders, post-traumatic stress disorder and obsessive-compulsive disorder: A revision of the 2005 guidelines from the British Association for Psychopharmacology https://www.bap.org.uk/pdfs/BAP_Guidelines-Anxiety.pdf

E-Learning

RCPsych CPD Online

- The pharmacological management of anxiety disorders

Journal Articles

- Kessler RC, Chiu WT, Jim R, Ruscio AM, Shear C, Walters E. (2006). The epidemiology of panic attacks, panic disorder and agoraphobia in the national co-morbidity survey replication. Archives of General Psychiatry (now JAMA Psychiatry), 63(4), 415-424.
- Shader RJ, Greenblatt DJ. (1993). Use of benzodiazepines in anxiety disorders. N Eng J of Med, 328, 1398-1405.
- Hamilton, M. (1959) The assessment of anxiety states by rating scale. British Journal of Medical Psychology, 32(1), 50-55.
- Linden, .M. Zubraegel .D. Baer .T. et al. (2005) Efficacy of cognitive behaviour therapy in generalised anxiety disorders. Psychotherapy and Psychosomatics 74, 36-42.

Other resources

- Royal College of Psychiatrists leaflets

  http://www.rcpsych.ac.uk/healthadvice/problemsdisorders.aspx

- Links to the ICD10 online:

  http://apps.who.int/classifications/icd10/browse/2016/en#/V

  http://www.who.int/classifications/icd/en/bluebook.pdf (Bluebook)

  http://www.who.int/classifications/icd/en/GRNBOOK.pdf (for research criteria)

- TrOn: www.tron.rcpsych.ac.uk

OLD AGE PSYCHIATRY SEMESTER 4

Session 7: Anxiety Disorders in the Older Person

Learning Objectives

- The overall aim of the sessions is for the trainees to gain an overview of anxiety in later life.
- By the end of the session trainees should:
    - Understand the epidemiology of anxiety and anxiety disorders in the older person.
    - Understand the aetiology of anxiety and anxiety disorders.
    - Understand how anxiety disorders present in the older person, their classification, the basic assessment process and the principles of treatment of anxiety and anxiety disorders.

Curriculum Links

- Old Age Section of the MRCPsych Curriculum: 8.3, 8.4, 8.5, 8.7, 8.8, 8.9, 8.10

Expert Led Session

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

Case Presentation

- A case to be presented which highlights an older person presenting with anxiety. Please consider the learning objectives above.

Journal Club Presentation

- Burroughs, H., Bartlam, B., Ray, M., Kingstone, T., Shepherd, T., Ogollah, R., Proctor, J., Waheed, W., Bower, P., Bullock, P. and Lovell, K., 2018. **A feasibility study for Non-Traditional providers to support the management of Elderly People with Anxiety and Depression: The NOTEPAD study Protocol.** *Trials*, *19*(1), p.172.
- Contrera, K.J., Betz, J., Deal, J., Choi, J.S., Ayonayon, H.N., Harris, T., Helzner, E., Martin, K.R., Mehta, K., Pratt, S. and Rubin, S.M., 2017. **Association of hearing impairment and anxiety in older adults.** *Journal of aging and health*, *29*(1), pp.172-184.
- Crocco, E.A., Jaramillo, S., Cruz-Ortiz, C. and Camfield, K., 2017. **Pharmacological Management of Anxiety Disorders in the Elderly.** *Current treatment options in psychiatry*, *4*(1), pp.33-46.

- Bulbena-Cabré, A., Rojo, C., Pailhez, G., Buron Maso, E., Martín-Lopez, L.M. and Bulbena, A., 2018. **Joint hypermobility is also associated with anxiety disorders in the elderly population.** *International journal of geriatric psychiatry*, *33*(1), pp.e113-e119.

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

- The Use of Lithium in the Elderly
- Reversible Medical Causes of Anxiety in the Elderly

MCQs

1. Regarding the diagnosis of anxiety:

A. MMSE is a useful tool

B. The 'Worry Scale' is a carer's report tool in depression

C. HADS is a useful tool

D. Cornell is the most useful scale in the over 75s

E. None of the above are true

2. A diagnosis of Generalised Anxiety Disorder can only be made after how long?

A. 6 months

B. 3 months

C. 6 weeks

D. 3 weeks

E. 1 year

3. In the elderly, anxiety is most closely linked to which condition?

A. Schizophrenia

B. Depression

C. Alzheimer's Disease

D. Diogenes Syndrome

E. Delusional Disorders

4. A 78 year old lady has recently been started on a new medication for anxiety but has developed hyponatraemia. Which of the following has most likely caused this?

A. Lamotrigine

B. Risperidone

C. Lithium

D. Citalopram

E. Quetiapine

5. Approximately how many adults aged 65 and older experience a diagnosable anxiety disorder

A. 4%
B. 11%
C. 15%
D. 21%
E. 30%

Additional Resources / Reading Material

Website:

- RCPsych CPD online: Pharmacological management of anxiety disorders

Journal Papers:

- Badrakalimuthu, V. R., & Tarbuck, A. F. 2012. **Anxiety: a hidden element in dementia.** Advances in psychiatric treatment, 18(2), 119-128.

- Bleakley, S., & Davies, S. J. 2014. **The pharmacological management of anxiety disorders.** Progress in Neurology and Psychiatry, 18(6), 27-32.

- Hoge, E. A., Ivkovic, A., & Fricchione, G. L. 2012. **Generalized anxiety disorder: diagnosis and treatment.** BMJ: British Medical Journal, 345(7885).

- Morderkar, A., and Spence, S. (2008). **Personality disorder in older people: how common is it and what can be done?** Advances in Psychiatric Treatment, 14: 71-77.

Guidelines:

- Baldwin, D. S., Anderson, I. M., Nutt, D. J., Allgulander, C., Bandelow, B., den Boer, J. A., ... & Malizia, A. 2014. Evidence-based pharmacological treatment of anxiety disorders, post-traumatic stress disorder and obsessive-compulsive disorder: a revision of the 2005 guidelines from the British Association for Psychopharmacology. Journal of Psychopharmacology, 28(5), 403-439.

- NICE: Generalised anxiety disorder and panic disorder in adults: management. NICE guidelines [CG113].

Books:

- Jacoby R, Oppenheimer C, Dening T. (eds.), 2008. **The Oxford Textbook of Old Age Psychiatry.** Oxford University Press: Oxford. Chapter on anxiety disorders in older people.
- Stahl, SM, 2014. **Prescriber's Guide: Stahl's Essential Psychopharmacology, 6th edition** Cambridge Medicine.
- Taylor, D., Barnes, T., Young, A., 2018. ***The Maudsley Prescribing Guidelines in Psychiatry, 13th edition*.** Blackwell-Wiley, section on depression & anxiety).
- World Health Organisation, 1992. **ICD-10 : The ICD-10 Classification of Mental and Behavioural Disorders : Clinical Descriptions and Diagnostic Guidelines.** WHO

Session 8: Medico Legal Issues in Old Age Psychiatry
Learning Objectives
• The overall aim of the session is for students to gain an overview of key legislation relating to the care of older adults. • By the end of the sessions trainees should: ○ Understand the interface between the MCA and MHA. ○ Understand the principles to apply when assessing capacity, including the 2-stage test. ○ Understand the principles behind Deprivation of Liberty Safeguards (DoLS). ○ Understand the applicability of Guardianship. ○ Gain an understanding of a Lasting Power of Attorney (LPA). ○ Understand the principles of testamentary capacity.
Curriculum Links
• Old Age Section of the MRCPsych Curriculum: 8.1, 8.2, 8.3, 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 an interesting medico legal issue in a patient seen. Please consider the learning objectives above.
Journal Club Presentation
• Brenkel, M., Shulman, K., Hazan, E., Herrmann, N. and Owen, A.M., 2017. **Assessing Capacity in the Elderly: Comparing the MoCA with a Novel Computerized Battery of Executive Function.** *Dementia and geriatric cognitive disorders extra*, *7*(2), pp.249-256. • Cole, J., Kiriaev, O., Malpas, P. and Cheung, G., 2017. **'Trust me, I'm a doctor': a qualitative study of the role of paternalism and older people in decision-making when they have lost their capacity.** *Australasian Psychiatry*, *25*(6), pp.549-553.

- De Simone, V., Kaplan, L., Patronas, N., Wassermann, E. M., & Grafman, J. 2017. **Driving abilities in frontotemporal dementia patients.** Dementia and geriatric cognitive disorders, 23(1), 1-7.

- Hinsliff-Smith, K., Feakes, R., Whitworth, G., Seymour, J., Moghaddam, N., Dening, T. and Cox, K., 2017. **What do we know about the application of the Mental Capacity Act (2005) in healthcare practice regarding decision-making for frail and older people? A systematic literature review.** *Health & social care in the community*, *25*(2), pp.295-308.

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

- Legal aspects of covert medication
- Lasting power of attorney - details of the application process.

MCQs

1. Which is of the following is not a core principle of MCA 2005

A. Everyone is assumed to have capacity
B. All Practical steps needs to be taken to help the person to make the decision
C. Any decision made on behalf of a person lacking capacity should be in their best interests
D. Person cannot make a unwise decision
E. Decision made on behalf of a person lacking capacity should be least restrictive

2. A person should be able to do the following to be able to make a decision:

A. Understanding the information relevant to the decision
B. Retain the information
C. Weighing up the pros and cons of the decision
D. Communicate the decision
E. All of the above

3. Lasting Power of Attorney (LPA) can potentially cover the following area:

A. Property
B. Finances

C. Health care decisions

D. Personal welfare decisions such as where a person lives

E. All of the above

4.Which of the following is false regarding the legal rights of an attorney with a LPA for healthcare decisions:

A. Cannot consent to or refuse treatment if the donor has capacity to make the particular healthcare decision

B. Cannot make a decision relating to life-sustaining treatment if it is not explicitly specified in LPA

C. Cannot demand medical treatment that healthcare staff do not believe is necessary or appropriate

D. Cannot consent or refuse treatment if donor is detained under the Mental Health Act

E. Need not always make decisions in the donor's best interests.

5. The following are true about Deprivation of Liberty Safeguards(DOLS) except:

A. The safeguards apply to only people who lack capacity

B. A DOLS authorisation in itself authorises specific treatment

C. A person can only be deprived of their liberty if it's in their best interests to protect them from harm

D. DOLS can only be authorised if it is a proportionate response to the likelihood and seriousness of the harm

E. Applies only to people aged 18 and over

Additional Resources / Reading Material

Websites

- RCPsych CPD modules

  Competence, capacity and decision-making ability in mental disorder, mental Capacity Act 2005: Part 1, mental Capacity Act 2005: Part 2

Other resources:

- 39 Essex Street http://www.39essex.com/practice-area/court-of-protection-barristers/
- GMC – Capacity & consent tool. http://www.gmc-uk.org/news/29321.asp
- Lucy Series https://thesmallplaces.wordpress.com/author/lucyseries/ (interesting discussion and commentary on all things related to legal capacity and human rights)

- Mental Capacity Act Code of Practice (https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice).

Journal Articles:

- Abdool, R., 2017. **Covert medication: legal, professional, and ethical considerations.** *The Journal of Law, Medicine & Ethics*, *45*(2), pp.168-169.

- Braye, S., Orr, D. and Preston-Shoot, M., 2017. **Autonomy and protection in self-neglect work: the ethical complexity of decision-making.** *Ethics and Social Welfare*, pp.1-16.

- Jacoby, R., & Steer, P., 2007. **How to assess capacity to make a will.** British Medical Journal, 7611, 155

- O'Shea, T., 2018. **A civic republican analysis of mental capacity law.** *Legal Studies*, *38*(1), pp.147-163. http://eprints.whiterose.ac.uk/116359/

- Royal College of Psychiatrists, 2004. **College statement on Covert Administration of Medicines.** *Psychiatric Bulletin.* 28(10), pp385-386

- Wilson, S., & Pinner, G. 2013. **Driving and dementia: a clinician's guide.** Advances in psychiatric treatment, 19(2), 89-96.

Books and other resources:

- Dalley, G., Gilhooly, M., Gilhooly, K., Harries, P. and Levi, M., 2017. **Financial Abuse of People Lacking Mental Capacity: A Report to the Dawes Trust.** https://bura.brunel.ac.uk/bitstream/2438/15255/1/Fulltext.pdf

- Jacoby R, Oppenheimer C, Dening T. (eds.) 2000. **The Oxford Textbook of Old Age Psychiatry.** Oxford University Press: Oxford. Chapters 41-44 cover capacity, legal frameworks and driving in later life.

- The Law Society. 2015. **Deprivation of liberty: a practical guide.** The Law Society. https://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/

Curriculum Mapping				
Section	**Topic**	**Covered by**		
		LAP	**RAP**	**LR**
8.1	Demographic population changes in the UK and Worldwide	✓	✓	✓
8.2	District Service Provision	✓	✓	✓
8.3	Specialist aspects of assessment of mental health in older people	✓	✓	✓
8.4	Psychological aspects of Physical Disease	✓	✓	✓
8.5	Prevalence/ incidence, clinical features, differential diagnosis, aetiology, management and prognosis of the common disorders occurring in later life	✓	✓	✓
8.6	Suicide and attempted suicide in old age	✓	✓	✓
8.7	Psychiatric aspects of personality in old age		✓	✓
8.8	Psychotherapy with older adults	✓	✓	✓
8.9	Bereavement and adjustment disorders	✓		✓
8.10	Sleep disorder in later life			✓
8.11	Psychosexual disorders in old age			✓

KEY: LAP = Local Educational Programme

RAP = Regional Academic Programme

LR = Learning Resources

CAMHS SEMESTER 3:

Session 7: Eating Disorders

Learning Objectives

- To understand the principles and practice of assessment (including psychiatric comorbidity), diagnosis (including classification) and treatment, (therapeutic modalities, use of psychoactive medication) in patients presenting with Eating disorders in childhood and adolescence
- To understand the physical sequelae of Eating Disorders, medical management and paediatric liaison
- To understand the role of other key professional (e.g. dietician, therapists)
- To understand how services are configured for the management of Eating disorders

Curriculum Links

Eating disorders:

10.8.7.1 10.8.7.2 10.8.7.3 10.8.7.4 10.8.7.5

Expert Led Session

- To discuss assessment, including physical examination and management with reference to NICE and Junior MARSIPAN Guidance and MDT management.

Case Presentation

- To cover the key diagnostic features, with reference to ICD10/DSMV – including physical examination – calculation of BMI, %weight/height ratio and plotting on centile charts.

Journal Club Presentation

- Gowers SG1, Clark A, Roberts C, Griffiths A, Edwards V, Bryan C, Smethurst N, Byford S, Barrett B.

Clinical effectiveness of treatments for anorexia nervosa in adolescents: randomised controlled trial. Br J Psychiatry. 2007 Nov;191:427-35.

- Loeb, Katharine L, and Daniel le Grange Family-Based Treatment for Adolescent Eating Disorders: Current Status, New Applications and Future Directions. International journal of child and adolescent health 2.2 (2009): 243–254.

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

- Signs, symptoms and prevention of re-feeding syndrome.
- Therapeutic interventions for eating disorders in children and young people
- MARSIPAN Guidelines physical risk assessment in eating disorders

MCQs

1. When a child with anorexia nervosa refuses treatment that is deemed essential what do the National Institute of Clinical Excellence recommend?

A. The Mental Health Act should not be used where parents give their consent

B. Parental consent should be relied upon in cases of persistent refusal

C. A second opinion from an eating disorders specialist should be considered only as a last resort

D. If parents also refuse the treatment, the Mental Health Act should be applied

E. The Children's Act should be considered under circumstances where parents also refuse treatment

2. What is the approximate ratio of girls to boys with a diagnosis of any Eating Disorder in the UK?

A. 5:1

B.10:1

C.15:1

D.20:1

E. 25:1

3. Which of the following is true?

A. In children, BMI is a stable measure of severity of Anorexia Nervosa

B. Children with Anorexia Nervosa can present with healthy weight

C. NICE recommend low dose fluoxetine for the treatment of BN

D. During treatment patients with Anorexia nervosa should be aiming for weight gain of more than 2 kg per week

E. Oestrogen administration should not be used to treat bone density problems in children

4. What medication do NICE recommend for Bulimia Nervosa?

A. Fluoxetine

B. Olanzapine

C. Venlafaxine

D. Methylphenidate

E. Mirtazepine

5. Which of the following is not a criterion for diagnosis of Anorexia Nervosa according to ICD10?

A. Endocrine dysfunction

B. Fear of fatness

C. Over-exercise

D. Food restriction

E. Weight more than 15% below expected weight for age and height

6. All of the following are often present in both Bulimia Nervosa and Anorexia Nervosa except:

A. Food restriction

B. Self induced vomiting

C. Low weight

D. Purging

E. Episodes of overeating

7. Which of the following is a necessary early treatment for life threatening low weight in a young person with an eating disorder?

A. Feeding high calorie meals

B. Thiamine replacement

C. NG tube feeding

D. CBT

E. Psychotropic medication

8. Which of the following are features of anorexia nervosa (1 or more)?

A. Low FSH, LH an Oestradiol

B. Shortened QT

C. Delayed gastric emptying

D. Reduced Growth Hormone

E. Low T3, normal TSH

F. Normocytic, normochromic anaemia

9. Which of the following are true about the long term complications of Anorexia Nervosa?

A. Pubertal delay is common

B. Osteopenia and osteoporosis are less frequent in children and adolescents than in adults

C. Catch up growth can occur with nutritional restoration

D. Hormone replacement is recommended for teenagers with Anorexia

E. Weight gain and the establishment of healthy eating habits usually results in restoration of menstruation

10. Which of the following are true regarding the prognosis of Eating Disorders:

A. Bulimia has a worse prognosis than anorexia nervosa

B. Vomiting in Anorexia Nervosa is a predictor if poor prognosis

C. The 30 year mortality rate in women with Eating Disorders has been found to be 20%

D. The mortality rate for Eating Disorders is greater than for psychiatric in patients

E. Some bone loss experienced in Anorexia Nervosa is irreversible

Additional Resources / Reading Materials

Books

- Clinical topics in Child and Adolescent Psychiatry, Sarah Huline-Dickens RCPsych 2014
- Seminars in Child and Adolescent Psychiatry (second edition) Edited by Simon Gowers, Royal college of Psychiatrists UK, Seminar Series
- Wiley: Handbook of Eating Disorders, 2d Edition Janet Treasure (Editor), Ulrike Schmidt (Editor), Eric van Furth (Editor) February 2003 ISBN: 978-0-471-49768-4

E-Learning

- **Psychological treatments for children and adolescents with eating disorders: In this podcast, Professor Simon Gowers gives an overview of the different psychological**

therapies available for children and adolescents with eating disorders, discussing in some detail family therapy, interpersonal therapy and cognitive behavioural therapy

- http://www.psychiatrycpd.org/default.aspx?page=8284

Additional resources

- *Cr189. MARSIPAN: management of really sick patients with anorexia nervosa (2nd edn)* *www.Rcpsych.ac.uk*
- Eating disorders (CG9) http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7281

Session 8: Legal Aspects of Child & Adolescent Psychiatry

Learning Objectives

Have an understanding of broad legal frameworks and more specific aspects of the Mental Health Act, Mental Capacity Act, Children Act with respect to children and how the law interacts with children including issues relating to confidentiality, consent, care and treatment and safeguarding

Curriculum Links

- This session overlaps with aspects of the following Individual Learning Objectives as outlined in the competency based Curriculum for Core Training (2013):
  ILO 1b, 3c, 4b,4c,4d,6a,17a,17b,17c,18a

Expert Led Session

- To cover: informed consent; assessment of competence; Mental Health Act; Mental Capacity Act; Children and Families Act.

Case Presentation

- To cover: parental responsibility; consent; assessment of competence; and consideration of legal frameworks in Child and Adolescent Psychiatry
- Examples:
    - 15 year old presents following overdose and refuses investigation and/or treatment
    - Use of The Mental Health Act in Anorexia Nervosa
    - "Zone of parental control" – treatment of young person under 16, with parental agreement.
    - Challenges in treatment of young person over 16, at risk of deliberate self-harm, refusing any disclosure to carers (parents)
    - Safeguarding aspects of a clinical case: actions taken in response to disclosures/raising concerns.

Journal Club Presentation

- Competence and consent to treatment in children and adolescents. Mike Shaw, Advances in Psychiatric Treatment. 2001, vol. 7, pp. 150–159
- Seeking clarity in the twilight zone: Commentary on Adolescent decision-Making and the zone of parental control. Aaron K. Vallance Advances in Psychiatric Treatment, 2014 20:151-152
- Decision-making about children's mental health care: ethical challenges. Moli Paul, Advances in Psychiatric Treatment, 2004, vol 10, 301-311

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

- Parental responsibility and Children Act relevant to Looked After Children
- Mental Capacity Act – Key Principles and relevance to care of Young people (under 18)
- Capacity Assessment and Gillick Competence – Key principles.
- Safeguarding: How to raise concerns
- Safeguarding: Organisational Structures (National/Local);(Trust Procedures/Regional Procedures)
- What are Serious Case Reviews: What are these?

MCQs

1. The Mental Health Act (1983, amended 2007) applies to which of the following age groups:

A. 16 and over

B. 18 and over

C. 16 – 65

D. 18 – 65

E. All age groups

2. A 15 year old boy, with a full understanding of the risks/benefits of treatment, consents to treatment for ADHD. This can be offered under the framework of:

A. The Mental Health Act

B. The Children' Act

C. Gillick competence

D. The Mental Capacity Act

E. The Family Reform Act

3. What is the definition of a child in UK child protection guidance?

A. Anyone under the age of 18

B. Anyone under the age of 16

C. Anyone under the age of 14

D. Anyone under the age of 18 in full-time education

E. Anyone under the age of 16 in full-time education

4. Which of these groups of people would not automatically qualify for Parental Responsibility (PR) under The Children Act (1989)?

A. Mothers

B. Fathers

C. Adoptive parents

D. People with special guardianship

E. An individual with an order from a Family Court

5. A 14 year old girl has delirium secondary to a urinary tract infection, and has refused IV antibiotics although has allowed nurses to site a cannula. She does not have capacity to make decisions regarding this treatment, with her delirium interfering with her ability to understand information. What would be the most likely legal framework used to treat her in this situation?

A. The Mental Capacity Act

B. The Mental Health Act

C. Gillick competence

D. The Family Reform Act

E. Consent from an individual with Parental Responsibility

6. Which of the following difficulties experienced by young people does NOT count as a mental disorder under the terms of the Mental Health Act?

A. Anorexia Nervosa

B. Learning Disability

C. Autism Spectrum Disorder

D. Alcohol dependence

E. Personality Disorder

7. What age group can be treated under the Mental Capacity Act:

A. Any age group

B. Any age group if the person with Parental Responsibility is unavailable

C. 14 and over

D. 16 and over

E. 18 and over

8. Which of the following is NOT relevant when considering the compulsory treatment of 16-18 year olds?

A. Deprivation of liberty

B. The zone of parental control

C. Consent of the person with parental responsibility

D. Gillick competence

E. The Mental Health Act

9. Which of the following would NOT be used when considering IV rehydration for a 14 year old with Anorexia Nervosa?

A. The Mental Health Act

B. Treatment with consent from the person with Parental Responsibility

C. Consent from a child with Gillick competence

D. The Mental Capacity Act

E. Emergency treatment under common law

10. There are circumstances in which the confidentiality young people can expect may have to be breached, to the extent of informing those with parental responsibility.

Which of the following is NOT an important factor in making this decision?

A. The young person's age and developmental level

B. The severity of any mental disorder

C. The closeness of the relationship with the parents

D. The presence of an Autism Spectrum Disorder

E. The degree of care and protection required

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
- Clinical topics in Child and Adolescent Psychiatry, Sarah Huline-Dickens RCPsych 2011

E-Learning

- Seclusion

  In this telephone interview, Dr Stephen Elsom talks from Australia on the topical issue of seclusion as an intervention for containing uncontrolled, disturbed behaviour of psychiatric patients. He discusses the research evidence regarding the use of seclusion and current thinking surrounding this practice. He also talks about methods that can be helpful to reduce the rate of seclusion used as an intervention.

  http://www.psychiatrycpd.org/default.aspx?page=4302

Guidelines

- Mental Health Law Online

  http://www.mentalhealthlaw.co.uk/Children_and_mental_health_law
- Antisocial behaviour and conduct disorders in children and young people (QS59)

  http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7281

- A Positive and Proactive Workforce: Guidance on reducing restrictive practice in clinical and other settings. DOH http://www.skillsforcare.org.uk/Documents/Topics/Restrictive-practices/A-positive-and-proactive-workforce.pdf
- RCPsych CPD online http://www.psychiatrycpd.co.uk/learningmodules/ethicalandlegalchallenges-1.aspx

FORENSIC SEMESTER 3:

SUBSTANCE MISUSE SEMESTER 4:

Session 4: Introduction to risk assessment and risk management

Learning Objectives

- To develop an understanding of what clinical risk is
- To understand different risk assessment tools
- To develop skills in planning how to undertake a risk assessment
- To develop skills in risk formulation
- To develop an understanding of risk management

Expert Led Session

- An introduction to risk
- Risk assessment tools
- Forensic clinical interview
- Risk assessment
- Risk formulation
- Risk management

Case Presentation

Case presentation to include a risk assessment.

Journal Club Presentation

- Bonta J, Blais J & Wilson H (2014). A theoretically informed meta-analysis of the risk for general and violent recidivism for mentally disordered offenders. Aggression and violent behaviour 19(3): 278- 287 https://www.sciencedirect.com/science/article/pii/S1359178914000408

- Klepfisz G, Daffern M & Day A. (2016) Understanding dynamic risk factors for violence. Journal of psychology, crime and law. 22 (1), 124 – 137

  https://www.tandfonline.com/doi/abs/10.1080/1068316X.2015.1109091

- Brown B & Rakow T. (2015) Understanding clinicians' cues when assessing the future risk of violence: a clinical judgement analysis in the psychiatric setting. Clinical psychology & psychotherapy 23(2): 125 – 141

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

- Arson risk assessment
- Suicide risk assessment
- MAPPA
- DVLA, driving and mental health

MCQs

MCQ Questions

1. Which of the following is not an actuarial risk assessment tool?

   A. VRAG
   B. SAVRY
   C. Static 99
   D. SORAG
   E. PCL-R

2. Which is not a static risk factor?

   A. Previous violence
   B. Parental criminality
   C. Age
   D. Substance misuse
   E. Sex

3. Which of the following are principles of risk management?

   A. Victim-safety planning
   B. Supervision
   C. Scenario-planning

D. Treatment

E. All of the above

4. Which is not a feature of a truthful narrative?

    A. Able to give basic details only
    B. Able to give context
    C. Able to reproduce conversations
    D. Able to make comments about another's mental state
    E. Able to manage unexpected complications

5. Which is incorrect with regards to the HCR 20?

    A. Most commonly used risk assessment tool in the UK
    B. 10 Historical items
    C. 10 Clinical items
    D. It is a form of SPJ risk assessment tool
    E. It includes risk formulation

Additional Resources / Reading Materials

- Royal College of Psychiatrists - https://www.rcpsych.ac.uk/pdf/Camden%20risk%20assessment%20and%20management.pdf
- British Psychological Society - https://www1.bps.org.uk/system/files/Public%20files/DCP/cat-381.pdf
- RCPsych CPD online – Risk assessment and management of violence in general adult psychiatry
- Undrill G. (2007) The risks of risk assessment. Advances psychiatric treatment 13(4): 291 - 297

INTELLECTUAL DISABILITIES SEMESTER 4:

Session 4: Offenders in Intellectual Disability

Learning Objectives

- Awareness of differences in offending behaviours in ID population
- Outcome following Offence
- Treatment options for offenders with ID

Curriculum Links

13.1 Services

13.1.2 The provision of specialist psychiatric services for people with intellectual disability *Forensic ID

13.2.1 The factors which might account to the observed high rates of psychiatric behavioural disorders in this group.

13.2.2 The influence of psychological and social factors on intellectual and emotional development in people with intellectual disability, including the

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

13.2.1 The factors which might account to the observed high rates of psychiatric behavioural disorders in this group

13.3.7 The assessment, management and treatment of offenders with intellectual disability

Expert Led Session

Dr. Razzaque Lecture (and Dr Burke and Dr Gupta) + optional case vignettes

Case Presentation

Case presentation of local patient with intellectual disability presenting with offending behaviour problems. , 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 chair to pose question if patient has an IQ of 55 how will this alter i.e. pathway/management.

Journal Club Presentation

Please select one of the following papers:

- Mentally disordered detainees in the police station: the role of the psychiatrist APT March 2010 16:115-123; doi:10.1192/apt.bp.107.004507
- Ian Hall Young offenders with a learning disability APT July 2000 6:278-285; doi:10.1192/apt.6.4.278
- S. Halstead Forensic Psychiatry for People with Learning Disability APT March 1996 2:76-85; doi:10.1192/apt.2.2.76

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

Please select one of the following:

- Describe the pathway of a person with intellectual disability following a recent fire setting incident
- Describe Disability Discrimination Act and its impact on patients and clinicians. (Focus on nature of behaviours, communication ability of the patient, issues of any change.)
- Safe Guarding Formal Assessment of a behavioural problem with a view to intervention. (You can discuss this with your local ID team to guide with the task)

MCQs

1. Offenders with ID compared to other offenders:

A. Start offending at a later age
B. Frequently are convicted of single offences
C. Arson offences are over represented
D. More in severe and profound disability
E. Less likely to be convicted

2. Mentally ill offenders with ID were found to be:

A. Younger at first conviction
B. Had less admissions to psychiatric hospitals
C. Showed a high frequency of violence
D. Tended to be females
E. Committed more serious offences during the follow-up period

3. In patients with ID referred for evaluation for a report, the percentage felt not competent to stand trial is (approximately):

A. Up to 10%

B. 11 - 20%

C. 21 - 30%

D. 31 - 40%

E. 41 - 50%

4. In offenders with ID the following is the most commonly used form of psychological input/ therapy:

A. Psychodynamic Psychotherapy

B. Gestalt Therapy

C. Cognitive Behavioural Therapy

D. Response and stimulus prevention

E. Dialectical Behavioural Therapy

5. Regarding the PCL-R;

A. Low scores are related to recidivism

B. Relate to Cluster A personality disorders

C. Those in medium security have higher scores than those in high security

D. Scoring patterns in ID population are significantly different compared to the general population

E. High scores relate to aggression

Additional Resources / Reading Materials

- **William Fraser & Michael Kerr (eds) Seminars in the psychiatry of learning disability Gaskell Press 2003 ISBN 1-901242-93-5
  Chapter 16: Forensic psychiatry and learning disability by Susan Johnston
- Wm Lindsay et al (Eds) Offenders with developmental disabilities 2004. Willey ISBN: 0-471-48635-3
- Ian Hall Young offenders with a learning disability APT July 2000 6:278-285; doi:10.1192/apt.6.4.278
- S. Halstead Forensic Psychiatry for People with Learning Disability APT March 1996 2:76-85; doi:10.1192/apt.2.2.76
- Mentally disordered detainees in the police station: the role of the psychiatrist APT March 2010 16:115-123; doi:10.1192/apt.bp.107.004507
- Kalpana Dein and Marc Woodbury-Smith Asperger syndrome and criminal behaviour APT January 2010 16:37-43; doi:10.1192/apt.bp.107.005082
- David Murphy Understanding offenders with autism-spectrum disorders: what can forensic services do?: commentary on... asperger syndrome and criminal behaviour APT January 201

16:44-46; doi:10.1192/apt.bp.109.006775

- Michael A. Ventress, Keith J. B. Rix, and John H. Kent: Keeping PACE: fitness to be interviewed by the police APT September 2008 14:369-381; doi:10.1192/apt.bp.107.004093

Legal aspects in Psychiatry of Learning Disability:

This module does not currently include a specific lecture on legal aspects. You should be familiar with the Mental Health Act 1983 and Mental Capacity Act 2005 from other modules on this course. Some supplementary reading is included here:

- Asit B. Biswas and Avinash Hiremath: Mental capacity assessment and 'best interests' decision-making in clinical practice: a case illustration APT November 2010 16:440-447; doi:10.1192/apt.bp.108.006494

Psychotherapy Semester 4:

Session 4: Psychological approaches to Trauma
Learning Objectives
Recognised clinical presentation of PTSD and Complex Trauma Increase awareness of psychological treatments for PTSD and Complex Trauma
Curriculum Links
6 – Organization & Delivery of Psychiatric Services 7.1 – 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
Background review of PTSD presentation Psychological treatments for PTSD including NICE Guidance Introduction to Complex Trauma
Case Presentation
Case presentation of a patient with PTSD or Complex Trauma. To highlight aspects of psychiatric history that indicate diagnosis. 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 • Bradley R. et al (2005) 'A Multidimensional Meta-Analysis of Psychotherapy for PTSD' *Am J Psychiatry* 162:214–227 • Santiago PN, Ursano RJ, Gray CL, Pynoos RS, Spiegel D, et al. (2013) 'A Systematic Review of PTSD Prevalence and Trajectories in DSM-5 Defined Trauma Exposed Populations: Intentional and Non-Intentional Traumatic Events'. *PLoS ONE* 8(4): e59236. doi:10.1371/journal.pone.0059236 • Shalev A. Y. et al (2012) 'Prevention of Posttraumatic Stress Disorder by Early Treatment' *Arch Gen Psychiatry*. 69(2):166-176
'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 • Evidence for and against 'post-event debriefing' or single interview • Aetiology of PTSD

MCQs

1. The following treatments are indicated in PTSD:

A. EMDR
B. Debriefing
C. Psychoanalysis
D. Schema Focused CBT
E. Psychodynamic Psychotherapy

2. The following are risk factors for an increased likelihood of PTSD:

A. Male gender.
B. Introverted character.
C. Family history of Narcissistic Personality Disorder.
D. Bereavement.
E. Low educational attainment.

3. The following are part of the six diagnostic criteria for PTSD in ICD-10:

A. Exposure to any sort of trauma.
B. Occasional memories of the traumatic event.
C. Avoidance of situations that remind the person of the trauma.
D. Normal social functioning.
E. Symptoms of at least one week duration.

4. The following have been used in military circles as terms for what we now would call PTSD:

A. Shell Shock
B. Lack of Moral Fibre
C. Vietnam War Syndrome
D. Old Soldier's Syndrome
E. Battle Paralysis

5. The following statements are true of PTSD:

A. Comorbidity is unusual
B. There are detectable effects on the hypothalamo-pituitary axis
C. "flashbacks' or intrusive memories of the trauma are characteristic
D. Endogenous opioids function is affected in PTSD
E. Soldiers are at less risk of PTSD than rape victims

Additional Resources / Reading Materials

PTSD NICE Guidance CG26 (2005): to be reviewed 2018

Understanding Trauma: A Psychoanalytic Approach by Caroline Garland (1998) Karnac Books

ACROSS THE AGES SEMESTER 4:

Session 4: Impact of Mental Illness on Carers and Families

Learning Objectives

- The overall aim is for the trainee to gain an overview into the impact of mental illness on the families and carers of patients across the different age ranges.
- By the end of the session, trainees should understand the impact of longstanding mental illness on families/Carers.
- By the end of the session, trainees should how to include families/Carers in the treatment plan.
- By the end of the session, trainees should understand challenges that families face and impact of this on the therapeutic relationship between doctor/patient/family/carer.

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 (as described, ILO 1, 1a) history

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

7a: Define the role of rehabilitation and recovery services Define the concept of recovery

7a: Define the concept of quality of life and how it can be measured

7a: Awareness of disability/housing benefits that patients may be entitled to claim

7a : Demonstrate an appreciation of the effect of chronic disease states on patients and their families

7a: Demonstrate an appreciation of the impact of severe and enduring mental illness on patients, their families and carers

7a: Demonstrate an appreciation of the importance of co-operation and collaboration with primary healthcare services, social care services, and non-statutory services

Expert Led Session

- *Carer/family perspective of MH in the child, adult and older adult*

Case Presentation

2x 30 minute cases highlighting the clinical presentations focusing on family/ carer perspective, for any mental disorder, in two different age groups:

- Child and Adolescent
- Adult
- Older People

Journal Club Presentation

Choose 1:

Child and Adolescent:

- Postpartum depression predicts offspring mental health problems in adolescence independently of parental lifetime psychopathology. Tjitte Verbeek , Claudi L.H. Bockting , Mariëlle G. van Pampus , Johan Ormel , Judith L. Meijer , Catharina A. Hartman , Huibert Burger. Journal of Affective Disorders 136 (2012) 948–954

General Adult:

- Ohaeri, JU (2003) The burden of caregiving in families with a mental illness: a review of 2002. Current Opinion in Psychiatry, 16 (4), 457–465

Older Adult:

- Lee DR, McKeith I, Mosimann U, Ghosh-Nodyal A, Thomas AJ. Examining carer stress in dementia: the role of subtype diagnosis and neuropsychiatric symptoms. International journal of geriatric psychiatry. 2013 Feb 1;28(2):135-41.

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

- What is meant by a Carers assessment?

- What is meant by parenting assessment?
- Nearest relative versus next of kin
- Lasting Powers of Attorney
- Burden of Care – Social impact

MCQs

1) You are working in an ADHD clinic with an ADHD nurse, a mother and son arrive after a period of missed appointments, and both mother and son now want to recommence ADHD medication. The mother is very angry and negative about her son, and then starts crying. What 3 things do you say to her?

A. This is emotional cruelty and you will need to report her to social services
B. Untreated ADHD is a very difficult condition to live with, once he is on medication she will not have any problems
C. Living with a child with a developmental disorder is very difficult, you recommend that she speaks to her GP and requests a referral to a counsellor
D. Even when children are taking medication, there are often ongoing difficulties with behaviour, you recommend that she joins the local ADHD support group
E. You acknowledge that children with developmental disorders may not be maturing and becoming independent at the same rate as their peers and acknowledge the extra pressure this places on her

2) You are asked to see 13 year old Hannah the younger sibling of 19 year old James who has been diagnosed with schizophrenia. Hannah has been withdrawn and quiet and told her grandmother she is hearing voices. What do you do?

A. Urgently start antipsychotics, psychosis is genetic
B. Meet with Hannah alone to learn more about the impact of mental illness on the whole family
C. Tell the parents this is contagion and to ignore it
D. Assess Hannah for depression and anxiety
E. Recommend parents try to structure activities alone with Hannah

3) The following is true regarding carers of older adults:

A) They have better mental health if they have fewer than 8 people in their social network
B) They are less likely to be depressed if they are women
C) They are more likely to have osteoarthritis than non-carers
D) They consult their GP more often after the care role has ended
E) They have a lower risk of hypertension than non-carers

4) Regarding carers which statement is false:

A) There are over 6.5 million carers in the UK

B) Most carers are male

C) 3 in 5 people will be carers at some point in their lives

D) Carers provide around £120 billion worth of unpaid care annually

E) The number of carers over the age of 65 is increasing faster than any other age group

Additional Resources / Reading Materials

Child and Adolescent:

- http://www.nhs.uk/conditions/social-care-and-support-guide/pages/young-carers-rights.aspx
- http://www.youngminds.org.uk/for_parents/worried_about_your_child/young_carers
- The effect of ADHD on the life of an individual, their family, and community from preschool to adult life: V A Harpin, Arch Dis Child 2005;90:suppl 1 i2-i7 doi:10.1136/adc.2004.059006
- Kuhn, E. S., & Laird, R. D. (2014). Family support programs and adolescent mental health: review of evidence. Adolescent Health, Medicine and Therapeutics, 5, 127–142. http://doi.org/10.2147/AHMT.S48057

General Adult:

- Meeting the mental and physical healthcare needs of carers Irene Cormac & Peter Tihanyi. Advances in Psychiatric Treatment (2006), vol. 12, 162–172

Old age

Carers UK. (2015). Facts about carers. [online] Available at: https://www.carersuk.org/for-professionals/policy/policy-library/facts-about-carers-2015 [Accessed 01/08/16])