North West
School of Psychiatry

Semester 2 Handbook

MRCPsych Course

2020 – 2022

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 & Adolescent 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. 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

Syllabus for MRCPsych

Syllabus for MRCPsych critical review

MRCPsych Paper A -The Scientific and theoretical basis of Psychiatry

MRCPsych Paper B - Critical review and the clinical topics in Psychiatry

MRCPsych CASC

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

General Adult

Session 7: Personality Disorders
Journal theme: Any method

Learning Objectives

- To develop an understanding of personality disorders (aetiology, epidemiology, natural history, neurobiology, genetics, diagnostic criteria, classification, psychopathology, clinical presentation, assessment, risks) and their management (pharmacological, psychological, social).

Expert Led Session

- Personality disorders – an overview

Case Presentation

- A case focusing on any personality disorder or where it is differential diagnosis.

Journal Club Presentation

Please select one of the following papers:

- Nose M, Cipriani A, Biancosino B, Grassi L, Barbui C (2006) Efficacy of pharmacotherapy against core traits of borderline personality disorder: Meta-analysis of randomized controlled trials. Int Clin Psychopharmacol 21: 345–353.
- Clarke S, Thomas P, James K (2013) Cognitive analytic therapy for personality disorder: randomised controlled trial. BJPsych 202:129-134.
- Lieb, K., Völlm, B., Rücker, G., Timmer, A., & Stoffers, J. M. (2010). Pharmacotherapy for borderline personality disorder: Cochrane systematic review of randomised trials. The British Journal of Psychiatry, 196(1), 4-12.

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

Please select one topic:

- Schizoid personality disorder vs Schizotypal Disorder
- Dissocial personality disorder - diagnostic criteria
- Co-morbidities in people with personality disorders

Statistics '555' Topic

Standardised mortality rate, Kaplan-meier survival curve interpretation and survival statistics

MCQs

1. Which of the following is NOT a personality disorder in ICD-10?

A. Schizoid personality
B. Paranoid personality
C. Emotionally unstable personality
D. Schizotypal personality
E. Anankastic personality

2. What is the estimated prevalence of personality disorders in the prison population?

A. 5-20%
B. 20-40%
C. 40-60%
D. 60-80%
E. 80-95%

3. A 36 year old man is visited at home by his GP. There is very little furniture, no television, no ornaments or pictures on the wall. He is indifferent to these observations, stating he has no need of those things. He has limited contact with his family and does not have any friends. He is clear he does not feel lonely or depressed. Which of the following personality disorders could he have?

A. Histrionic
B. Antisocial
C. Paranoid
D. Schizotypal
E. Schizoid

4. Which of the following is recommended in the management of emotionally unstable personality disorder?

A. Selective Serotonin Reuptake Inhibitors
B. Minimum inpatient stay of one month
C. Eye movement desensitisation and reprogramming
D. Structured clinical management
E. Polypharmacy

Session 8: Psychosis-2
Journal theme: Economic studies on psychosis

Learning Objectives

- To develop an understanding of the psychopathology and diagnosis in schizophrenia
- To develop an understanding of possible complications of antipsychotic medication
- To develop an understanding of Economic studies and develop skills for critically appraising them.

Expert Led Session

- Schizophrenia: psychopathology and diagnosis

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)

- Jones PB, Barnes TR, Davies L, Dunn G, Lloyd H, Hayhurst KP, Murray RM, Markwick A, Lewis SW (2006) Randomized controlled trial of the effect on Quality of Life of second- vs first-generation antipsychotic drugs in schizophrenia: Cost Utility of the Latest Antipsychotic Drugs in Schizophrenia Study (CUtLASS 1). Arch Gen Psychiatry. 63(10):1079-87.
- Knapp M1, Windmeijer F, Brown J, Kontodimas S, Tzivelekis S, Haro JM, Ratcliffe M, Hong J, Novick D; SOHO Study Group (2008) Cost-utility analysis of treatment with olanzapine compared with other antipsychotic treatments in patients with schizophrenia in the pan-European SOHO study. Pharmacoeconomics, 26(4):341-58.
- Achilla E, & McCrone P. (2013). The Cost Effectiveness of Long-Acting/Extended-Release Antipsychotics for the Treatment of Schizophrenia: A Systematic Review of Economic Evaluations. Applied Health Economics and Health Policy; 11 (2), 95-106. http://link.springer.com/article/10.1007/s40258-013-0016-2.

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

Please select one topic:

- Prodromal symptoms in first episode psychosis
- Clozapine- common and uncommon side effects
- Evidence base for High Dose Antipsychotic Therapy

Statistics '555' Topic

- Types of economic evaluation, QALY and DALY

MCQs

1. Which of the following subtype of schizophrenia is classified in DSM but not in ICD 10:

A. Hebephrenic
B. Post schizophrenic depression
C. Catatonic
D. Disorganised
E. Undifferentiated

2. The followings are risk factors for developing tardive dyskinesia except:

A. Old age
B. Male sex
C. Affective disorder
D. History of EPSEs
E. Prolonged use of antipsychotics

3. A 35 years old female patient with Schizophrenia describes, that her husband has been replaced by his "Double" who is identical in appearance but is not the same person. What is this phenomenon called?

A. Capgras Syndrome
B. Couvade Syndrome
C. Fregoli Syndrome
D. Othello Syndrome
E. De Clerambault

4. A young man presents with confusion, agitation and auditory hallucinations. His reflexes are brisk and symmetrical. He is not tremulous. His CT head scan is normal. His CSF shows raised proteins, normal glucose concentration and a small number of lymphocytes. What is the most likely diagnosis:

A. Acute relapse of schizophrenia
B. Alcohol intoxication
C. Catatonic stupor
D. Herpes simplex virus encephalitis
E. Neurosyphilis

5. When assessing a patient in a prison, which of the following would suggest a Ganser state?

A. Confabulation
B. Disorientation to time, place and person
C. Self mutilation
D. Sudden outbursts of violence
E. Visual pseudo hallucinations

Session 9: Depression-2
Journal theme: RCT on depression

Learning Objectives

- To develop an understanding of the psychopathology and diagnosis in Depression.
- To develop an understanding of possible complications of antidepressant medications.
- To develop an understanding of Randomized Controlled Trials and develop skills for critically appraising them.

Expert Led Session

- Topic: Depression- psychopathology and diagnosis

Case Presentation

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

Journal Club Presentation (Select 1 paper)

- Hypericum Depression Trial Study Group (2002) Effect of *Hypericum perforatum* (St John's Wort) in Major Depressive Disorder- a randomized controlled trial. JAMA 287:14, 1807.
- John Z, Schatzberg A, Stahl S, Shah A, Caputo A, Post A (2010) Efficacy and Safety of Agomelatine in the Treatment of Major Depressive Disorder: A Multicenter, Randomized, Double-Blind, Placebo-Controlled Trial. Journal of Clinical Psychopharmacology 30:2, 135-144.
- Lincoln NB, Flannaghan T (2003) Cognitive Behavioral Psychotherapy for Depression Following Stroke- a Randomized Controlled Trial. Stroke 34, 111-115.

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

Please select one topic:

- Augmentation of antidepressant drug treatment – overview
- Association of depression and physical health problems (e.g. stroke, diabetes, obesity, pain)
- Antidepressants induced hyponatraemia

Statistics '555' Topic

- Concealment and Randomization
-

MCQs

1. Glucocorticoid receptor hypothesis is associated with which of the following (choose one answer):

A. Depression

B. Generalised anxiety disorder

C. Dementia

D. Mania

E. Schizophrenia

2. 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

3. Which of the following statements about unipolar depression is TRUE?

A. Unipolar depression is three times more likely in females than in males.

B. Relatives of patients with unipolar depression do not have increased rates of bipolar disorder or schizoaffective disorder.

C. In twin studies, concordance rate for unipolar disorder but not bipolar disorder is higher in monozygotic than dizygotic twins.

D. The familial segregation of mood disorders fits a simple Mendelian pattern.

E. There is no evidence to suggest that depressive disorder in later life is associated with parental separation, especially divorce

4. Which of the following abnormalities in monoamine neurotransmission is not found in depression?

A. Decreased plasma tryptophan

B. Increased brain 5-HT reuptake sites

C. Increased D2 receptor binding

D. Clinical relapse after tryptophan depletion

E. Decreased brain 5-HT1A receptor binding

5. Which of the following antidepressants is associated with increased risk of cardiovascular defects in foetus, when used in the 1st trimester?

A. Duloxetine

B. Sertraline

C. Mirtazapine

D. Venlafaxine

A. E. Paroxetine

Session 10: Bipolar Disorder-2
Journal theme: Qualitative studies on bipolar disorder

Learning Objectives

- To develop an understanding of the psychopathology and diagnosis in Bipolar disorder.
- To develop an understanding of possible complications of mood-stabilizer medications.
- To develop an understanding of Qualitative studies and develop skills for critically appraising them.

Expert Led Session

- Bipolar disorder- psychopathology and diagnosis

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

- Clatworthy J, Bowskill R, Rank T, Parham R, Horne R (2007) Adherence to medication in bipolar disorder, a qualitative study exploring the role of patients' beliefs about the condition and its treatment. Bipolar Disorders, 9(6), 656-664.
- Healey C, Peters S, Kinderman P, McCracken C, Morriss R (2009) Reasons for substance use in dual diagnosis bipolar disorder and substance use disorders: A qualitative study. Journal of Affective Disorders, 113(1-2), 118-126.
- Michalak EE, Yatham LN, Kolesar S, Lam RW (2006) Bipolar Disorder and Quality of Life: A patient-centred perspective. Quality of Life Research, 15(1), 25-37.

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

- Pharmacological treatment in Bipolar Depression and Rapid cycling Bipolar Disorder
- Lithium side- effects and toxicity
- Risk of bipolar disorder in families of affected individuals

Statistics '555' Topic

- Types of sampling (including sample size and power)

MCQs

1. The experience of two years of hypomania symptoms that do not meet the criteria for a manic episode is known as:

A. Dysthymic disorder
B. Cyclothymic disorder
C. Rapid Cycling disorder
D. Personality disorder
E. Bipolar disorder NOS

2. The Cognitive deficits associated with Bipolar Disorder includes:

A. Executive functioning deficits
B. Verbal learning and memory
C. Difficulties in sequencing of motor acts
D. Processing and psychomotor skills including fine motor skills
E. All of the above

3. Which of the following statements is FALSE- Compared to Bipolar 1 disorder, Bipolar 2 disorder patients experience:

A. More chronic symptoms with more major depressive episodes
B. More episodes with shorter inter-episodic intervals
C. Slightly less substance abuse
D. More anxiety especially social phobia
E. Tend to recover to their pre-morbid levels of psycho-social functioning between episodes.

4. Which of the following statements is FALSE about Rapid Cycling bipolar disorder:

A. History of antidepressant induced hypomania is a risk factor
B. Evidence of low thyroxin levels is found even when not under treatment

C. Lasts less than 2 years in 50% of cases

D. Patients cycle between hypomania and depression each week

E. Is not genetically inherited in families with bipolar disorder

5. Which of the following statements is TRUE regarding Cyclothymia:

A. Is more common in males

B. Prevalence around 5%

C. Usual age of onset is between 35-40 years

D. Results in a diagnosis of bipolar disorder in a third of patients

E. Mood stabilisers are usually ineffective

Session 11: Mental Capacity Act
Journal theme: Any method

Learning Objectives

- To develop an understanding of the aspects of the Mental Capacity Act (including Deprivation of Liberty Safeguards) relevant to general adult psychiatry.

Expert Led Session

- Topic: General principles of MCA 2005 & Deprivation of Liberty

Case Presentation

- A case focusing on aspects of MCA or MCA/MHA interaction or DOLS.

Journal Club Presentation

- Brown P, Tulloch A, Mackinzie C, Owen G, Szmukler G, Hotopf M (2013) Assessments of mental capacity in psychiatric inpatients: a retrospective cohort study. BMC Psychiatry 13:115
- Okai D, Owen G, McGuire H, Singh S, Churchill R, Hotopf M (2007) Mental capacity in psychiatric patients- Systematic review. BJPsych 191: 291-297.
- Cairns R, Brown P, Grant-Peterkin H, Khondoker M, Owen G, Richardson G, Szmukler G, Hotopf M (2011) Judgements about deprivation of liberty made by various professionals: comparison study. The Psychiatrist, 35, 344-349.

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

- MCA and the Bournewood case

- Advance decisions to refuse treatment and advanced statement - salient points
- Liberty Protection Safeguards – changes in DOLS

Statistics '555' Topic

Hierarchy of evidence (case report through to meta analysis

MCQs

1. Which of the following statements about the MCA 2005 is FALSE:

A. A person must be assumed not to have capacity unless it is established that he has capacity.

B. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

C. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

D. An act done, or decision made, under this Act for on behalf of a person who lacks capacity must be done, or made, in his best interests.

E. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

2. The Court of Protection has powers to:

A. Decide whether a person has capacity to make a particular decision for themselves.

B. Make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make such decisions.

C. Appoint deputies to make decisions for people lacking capacity to make those decisions

D. Remove deputies or attorneys who fail to carry out their duties.

E. All of the above.

3. Section 2(1) of the MCA, 2005 defines 'lack of capacity' as:

A. For the purpose of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

B. For the purpose of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain, except alcohol or drug use.

C. For the purpose of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind.

D. For the purpose of this Act, a person lacks capacity in relation to any decision if at the material time he is unable to make a decision for himself because of any psychiatric disorder.

E. For the purpose of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the brain.

4. A person is unable to make a decision if they cannot**:**

A. Understand the 'relevant' information about the decision to be made

B. Retain that information in their mind

C. Use or weigh that information as part of the decision-making process

D. Communicate their decision (by talking, using sign language or any other means)

E. All of the above conditions must be met.

5. Which of the following statements is FALSE: It might be necessary to consider using the MHA rather than the MCA if:

A. It is not possible to give the person the care or treatment they need without carrying out an action that might deprive them of their liberty.

B. The person may need to be restrained in a way that is not allowed under MCA.

C. It is not possible to assess or treat the person safely or effectively without treatment being compulsory.

D. If the person has a known chronic psychiatric illness.

E. The person needs treatment that cannot be given under MCA.

Session 12: Post-traumatic Stress Disorder
Journal theme: Meta-analysis/Systematic Review on PTSD

Learning Objectives

- To develop an understanding of PTSD (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 Randomised control trials

Expert Led Session

- Topic: Post-Traumatic stress disorder

Case Presentation

- A case of PTSD or a case where PTSD is a differential diagnosis.

Journal Club Presentation

- Seidler GH, Wagner F (2006) Comparing the efficacy of EMDR and trauma-focused cognitive behavioural therapy in the treatment of PTSD: a meta-analytic study. Psychological Medicine, 11, 1515-1522.
- Hoskins M, Pearce J, Bethell A, Dankova L, Barbui C, et al. (2015). Pharmacotherapy for post-traumatic stress disorder: systematic review and meta-analysis. The British Journal of Psychiatry; 206 (2); 93-100; DOI: 10.1192/bjp.bp.114.148551
- Watts BV, Schnurr PP, Mayo L, Young-Xu Y, Weeks WB. (2013). Meta-Analysis of the Efficacy of Treatments for Posttraumatic Stress Disorder. J Clin Psychiatry; 74 (6): e541-e550. DOI:10.4088/JCP.12r08225

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

- NICE guidelines for medications in PTSD
- Eye Movement Desensitization and Reprocessing (EMDR)
- PTSD- co-morbidity and suicide risk

Statistics '555' Topic

Confounding factors, bias and methods to control and reduce

MCQs

1. Which of the following psychological intervention can be effective for the treatment of post-traumatic stress symptoms in children and young people who have been sexually abused?

A. Psychodynamic psychotherapy
B. CAT
C. Trauma focused CBT
D. IPT
E. Single episode debrief

2. Which antidepressant is licensed for the treatment of PTSD?

A. Sertraline
B. Mirtazepine
C. Venelafaxine
D. Amitrytalline
E. Meclobamide

3. Which of the following is a DSM IV symptom of PTSD?
A. Pain
B. Substance misuse
C. Palpitations
D. Emotional blunting
E. Agitation

4. Which of these statements is true regarding acute stress reaction and PTSD?
A. Acute stress disorder only occurs in the elderly population and children
B. Acute stress disorder describes symptoms in someone who was not present at an incident, while PTSD takes place only in those who were present
C. PTSD is not diagnosed until after 4 weeks following the traumatic event
D. Acute stress disorder and PTSD can be diagnosed at any time after the stressful event
E. All acute stress disorder patients develop PTSD

5. Which of the following is recommended as first line treatment for PTSD in adults?
A. Mirtazepine
B. EMDR
C. Citalopram
D. Mirtazepine
E. Risperidone

CAMHS
Session 3: Autism Spectrum Disorder (ASD)

Learning Objectives

- Signs and Symptoms of Autism spectrum disorder including the triad of impairments
- Diagnostic criteria for diagnosis of ASD including the DSM 5 and ICD 10
- Causes of ASD and psychological theories of ASD including Theory of mind, Central coherence deficit and executive function.
- Interventions in ASD

Curriculum Links

Autism Spectrum Disorders:

10.8.8.1 10.8.8.2 10.8.8.3 10.8.8.4 10.8.8.5

Expert Led Session

- To cover Aetiological theories of ASD, NICE guidelines in ASD, Interventions in ASD

Case Presentation

- This should include detailed assessment which includes developmental history, information from multiple sites and multiaxial formulation (ICD 10 or DSM 5 criteria used), cover signs and symptoms, triad of impairment and interventions offered

Journal Club Presentation

- Huerta, M., Bishop, S. L., Duncan, A., Hus, V., & Lord, C. (2012). Application of DSM-5 criteria for autism spectrum disorder to three samples of children with DSM-IV diagnoses of pervasive developmental disorders. American Journal of Psychiatry, 169(10), 1056-1064.

  McPartland, J. C., Reichow, B., & Volkmar, F. R. (2012).

- Risi, Lord, Gotham, Corsello, Chrysler et al. (Sept. 2006) Zwaigenbaum, L., Bryson, S., Lord, C., Rogers, S., Carter, A., Carver, L., & Yirmiya, N. (2006). Combining Information from Multiple Sources in the Diagnosis of Autism Spectrum Disorders. Journal of Am Academy of Child & Adolescent Psychiatry, 45(9) 1094-1103

- Berihun Assefa Dachew (a1), Abdullah Mamun (a2), Joemer Calderon Maravilla (a3) and Rosa Alati Pre-eclampsia and the risk of autism-spectrum disorder in offspring: meta-analysis (a3) Br J Psychiatry. 2018 Mar;212(3):142-147. doi: 10.1192/bjp.2017.27. Epub 2018 Jan 24.
- Jonathan Green,a,d,* Tony Charman,e Helen McConachie,f Catherine Aldred,a,g Vicky Slonims,h Pat Howlin,i Ann Le Couteur,f Kathy Leadbitter,a Kristelle Hudry,e Sarah Byford,j Barbara Barrett,j Kathryn Temple,f Wendy Macdonald,c Andrew Pickles,b and the PACT Consortium, Parent-mediated communication-focused treatment in children with autism (PACT): a randomised controlled trial, Lancet. 2010 Jun 19; 375(9732): 2152–2160. doi: 10.1016/S0140-6736(10)60587-9

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

Interventions used in ASD and their evidence base to cover - One slide each for the following:

- Behavioural intervention e.g. riding the rapids,
- Speech and language interventions such as Early communication workshops, more than words, talkability groups
- Sleep disorders in ASD and interventions
- Social Stories in ASD

MCQs

1. The M:F ratio of Childhood Autism is:

A. 1:1

B. 2:1

C. 3:1

D. 4:1

2. The prevalence of Autism Spectrum Conditions in a school based study in UK was: A. 99 per 10,000

B. 70 per 10,000

C. 9 per 10,000

D. 1 per 10,000

3. The clinical features of Childhood Autism as described by Kanner include all the following except:

A. Autistic aloneness

B. Delayed or abnormal speech

C. An obsessive desire for sameness

D. Onset in the first one year of life

4. The following are true about the aetiology of Autism except:

A. Higher concordance among MZ twins.

B. Increased rate of perinatal complications.

C. Decreased brain serotonin levels

D. Condition is 50 times more frequent in the siblings of affected persons

5. Which of the following is false for Rett's syndrome:

A. Occurs only in boys

B. Onset between the ages of 7 and 24 months

C. Often develop autistic features and stereotypies

D. X linked dominant disorder

6. The following is false for Seizures in Autism:

A. Can affect quarter of autistic individuals with generalised learning disability

B. Affects 5% of autistic individuals with normal IQ

C. In autistic individuals with normal IQ the seizure onset is usually in early childhood.

D. In autistic individuals with generalised learning disability the seizure onset is usually in early childhood

7. The following is true about the epidemiology of Autism:

A. Prevalence is decreasing in recent years

B. Associated with high socio-economic status

C. More common in boys

D. No hereditary risk

E.

8. All the following are first line support for a child with childhood autism except:

A. Communication skills workshop

B. Behavioural support

C. Counselling and advice to parents

D. Anti-psychotic medication.

9. The following can be used in the diagnosis of a child with Autism except:

A. Autism diagnostic Inventory (ADI)

B. Autism Diagnostic Observation Schedule (ADOS)

C. Social Responsiveness Scale (SRS)

D. Check list for Autism in Toddlers (CHAT)

10. Which of the following drugs can be used in short term treatment of severe aggression in Autism under specialist supervision:

A. Risperidone

B. Diazepam

C. Lorazepam

D. Promethazine

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

E-Learning

- Autism, ethnicity and maternal immigration
- Autism has been the subject of intense public and professional attention in recent years. One of the biggest questions is what causes it. Like the discoveries made about schizophrenia in the late 20th century, we are learning that autism too has genetic and environmental determinants. Here Dr Daphne Keen discusses her paper (Keen et al, 2010) which attempts to answer the question of whether maternal immigration and ethnicity, together or in tandem, are implicated as being risk factors in young children who develop autism.

http://www.psychiatrycpd.org/default.aspx?page=10591

Guidelines

- Autism in children and young people (CG128)

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

www.nas.org.uk

CAMHS
Session 4: Anxiety and Depression

Learning Objectives

□ Describe how anxiety and depression may present and it's management in childhood and adolescence and the relevance of somatisation as a communication between children and their carers.

Curriculum Links

Anxiety disorders including OCD:

10.8.4.1 10.8.4.2 10.8.4.3 10.8.4.4 10.8.4.5

Affective Disorders:

10.8.5.1 10.8.5.2 10.8.5.3 10.8.5.4 10.8.5.5

Expert Led Session

□ Variable presentations (with reference to developmental age) and differential diagnosis of anxiety and depression, treatment options, evidence base for treatment, NICE guidelines for depression.

Case Presentation

□ Key diagnostic features (anxiety/depression/mixed disorder) and highlight aspects of management (including risk assessment) with reference to NICE guidance

Journal Club Presentation

- Outcomes of Childhood and Adolescent Depression Richard Harrington, Hazel Fudge, Michael Rutter, Andrew Pickles, Jonathan Hill, Arch Gen Psychiatry. 1990;47(5):465-473.
- Fluoxetine, Cognitive-Behavioral Therapy, and Their Combination for Adolescents With Depression Treatment for Adolescents With Depression Study (TADS) Randomized Controlled trial; Treatment for Adolescents With Depression Study (TADS) Team - JAMA. 2004;292(7):807-820.

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<tr><td>‘555’ Topics (1 slide on each topic with no more than 5 bullet points)</td></tr>
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- Evidence based psychological interventions in the treatment of anxiety disorders and depression in children and adolescents.
- Medication treatment in Anxiety and Depression and cautions
- Nice Guidance Anxiety Disorders/Depression

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MCQs

Anxiety

1. Treatment of social anxiety disorder in children and young people include all except which?

A. Group CBT

B. Individualised CBT

C. Psychoeducation

D. Skills training for parents

E. Mindfulness based therapy

2. What percentage of children and adolescents in the UK have clinically significant anxiety disorders?

A. 2-4%
B. 4-8%
C. 8-12%
D. 12-15%
E. 15-20%

3. The following regarding specific phobias are true, except:

A. Fear of animals peaks at 2-4 years of age

B. Fear of the dark peaks at 4-6 years of age

C. Fear of war is most common in adolescents

D. Fear of death peaks at 5-10 years of age

4. According to ICD10, separation anxiety can include all except:

A. Repeated nightmares involving separation

B. Preference to sleep away from home

C. School refusal

D. Getting up frequently at night to check on parents/carers

E. Persistent and unrealistic worry that harm will come to their parents/carers

5. The diagnosis of Generalised anxiety disorder in childhood includes all except:

A. Onset before 18 years of age

B. Multiple anxieties occurring across at least 2 situations

C. Feeling worn out and irritable

D. The anxiety must not be due to another condition or substance abuse

E. Occurring for over 12 months

Depression

1. The prevalence of depression in 11 – 15 year olds in the UK is:

A. 0.1% - 1%
B. 2% - 8%
C. 11% - 15%
D. 16% - 20%
E. 21 – 30%

2. A 12 year old girl is referred to the CAMHs team with symptoms of moderate – severe depression. What is your first-line treatment?

A. Commence citalopram

B. Commence fluoxetine

C. Offer a specific psychological therapy

D. Admit to an inpatient unit

E. Refer back to GP for management of symptoms

3. The below are all risk factors for completed suicide except:
A. Previous suicide attempt
B. Presence of substance/alcohol abuse

C. Presence of psychiatric disorder

D. Strong religious beliefs

E. Lack of social support

4. The use of medication in adolescents who self-harm:

A. SSRIs is recommended for reducing self-harming behaviour

B. Flupentixol is recommended for reducing self-harming behaviour

C. Is always indicated when it occurs in the context of mental illness

D. There is no evidence that medication reduces self-harming behaviour

E. Risperidone is indicated in the presence of self-harming behaviour

5. Select the correct statement from the below regarding self-harming behaviour amongst adolescents:
A. Is common under 10 years of age

B. In community surveys, it is described by 80% of the adolescent population

C. Is more common in girls than boys

D. The majority of adolescents who self-harm wish to kill themselves

E. Only around 75% of adolescents who self-harm seek help

6. Among adolescents who self-harm, risk factors for later suicide include all except:

A. Depression

B. Unclear reason for act of deliberate self-harm

C. Psychosis

D. Female gender

E. Male gender

.

7. Depression in children and adolescents can present in different ways. Please match the incorrect statement:

A. Adults – change of appetite with associated weight loss or weight gain. Children – similar to adults

B. Adults – loss of confidence, self esteem. Children – similar to adults

C. Adults – somatic syndrome may or may not be present. Children – somatic

complaints are frequent in children

D. Adults – depressive mood for most of the day. Children – mood irritable or depressed

E. Adults – disproportionate self blame and feelings of excessive guilt or inadequacy.

Children – excessive or inappropriate guilt not usually present.

8. Please select the correct statement regarding suicide amongst children and adolescents in the UK:

A. Suicide is common under the age of 12 and gets progressively rarer after

B. There are roughly five suicides per million children aged 5 – 14 per year

C. Since the mid 1990's suicide rates have increased by around 20% in both males and females

D. More female children than male children commit suicide

E. Most adolescent suicide are carefully planned in advance

9. You assess a 14 year old male who has self-harmed in the A&E department. All of the following suggest serious suicidal intent except:

A. Extensive premeditation

B. Other people informed beforehand of his intention

C. Suicide note left

D. Carried out in isolation

E. He informed someone of his actions soon after the event

10. An 8 year old girl is referred to you. For the past month she has been performing poorly in school, complains of being bored for most of the time, has run away from home on 3 occasions, and has been taken to the GP by her mother due to generalised abdominal pain, for which no

cause can be found. She has a younger sibling who is 3 years old. Suggest the most likely diagnosis:

A. Factitious disorder

B. ADHD

C. Depression

D. Sibling rivalry disorder

E. Atypical autism

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

E-Learning

- Anxiety disorders in children
- Approximately one in ten children suffer from anxiety disorders, and in this podcast Professor Ronald Rapee gives a broad overview of the different kinds of anxiety disorders common in children. He also discusses how anxiety disorders in children compare with those in adults, and highlights the nature of findings from epidemiological studies. He talks about some of the steps in diagnosis, and the aetiology behind anxiety disorders, including genetic and behavioural factors. Treatment is also touched on as well as some of the pitfalls to beware of when diagnosing and treating anxiety in children.

http://www.psychiatrycpd.org/default.aspx?page=4873

Guidelines

- Depression in children and young people (CG28)
- Self-harm (CG16)
- Post-traumatic stress disorder (PTSD) (CG26)
- Obsessive compulsive disorder (OCD) and body dysmorphic disorder (BDD) (CG31)
- Social anxiety disorder: recognition, assessment and treatment01 [CG159]
  http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7281

Old Age

Session 3: Other Neuro Degenerative Disorders

Learning Objectives

- To overall aim is to gain a basic overview of common neuro-degenerative disorders including Lewy Body Dementia, fronto-temporal dementia (FTD), Creutzfeldt-Jakob disease (CJD), and dementia in Parkinson's disease. Vascular dementia is also incorporated in this session.
- For each of the disorders listed above, by the end of the session, the trainee should understand the basic epidemiology, aetiology, clinical presentation and basic management principles.

Curriculum Links

- Old Age Section of the MRCPsych Curriculum: 8.1, 8.3, 8.4, 8.5, 8.11

Expert Led Session

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

Case Presentation

- A case to be presented which highlights one of the neurodegenerative disorders named above.

  Please consider the learning objectives above.

Journal Club Presentation

- Meng YH, Wang PP, Song YX, Wang JH. Cholinesterase inhibitors and memantine for Parkinson's disease dementia and Lewy body dementia: A meta-analysis. Experimental and therapeutic medicine. 2019 Mar 1;17(3):1611-24.
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- Pendlebury, S.T., Rothwell, P.M. and Study, O.V., 2019. Incidence and prevalence of dementia associated with transient ischaemic attack and stroke: analysis of the population-based Oxford Vascular Study. The Lancet Neurology, 18(3), pp.248-258.

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

- Dementia in Huntington's Disease
- Common presentations in FTD
- Management of psychosis in Parkinson's disease

MCQs

1. **A 38 year old man presents with a seizure on a background of increasing memory impairment, migraines, apathy and unsteady gait.**

   Which genetic mutation is most likely?

   A. NOTCH3
   B. MAPT
   C. Presenilin-1
   D. C9ORF72
   E. SNCA

1. **A 62 year old woman is struggling with poor balance and muscle spasms. She has difficulty controlling her left hand which she describes as feeling 'out of control'. MRI brain shows asymmetrical atrophy of the superior parietal lobe.**

   Which of the following is most closely associated with the primary diagnosis?

   A. Logopenic PPA
   B. Semantic PPA
   C. Posterior cortical atrophy
   D. Non-fluent PPA
   E. Cerebral amyloid angiopathy

3. **A man with Parkinson's Disease develops psychotic symptoms. Which antipsychotic drug treatment has the best evidence base?**

   A. Quetiapine
   B. Amisulpride
   C. Haloperidol
   D. Risperidone
   E. Clozapine

4. **A 43 year old gentleman presents with unwanted movements that started in his hands and now involve his limbs and face. He is also struggling with low mood and obsessional thoughts. Genetic analysis reveal multiple CAG repeats on chromosome 4.**

   A brain MRI is most likely to show:

   A. Caudate atrophy
   B. Cerebellar atrophy
   C. Multiple white matter intensities
   D. Putaminal infarct
   E. Lacunar infarct

5. A 70 year old man has been given a diagnosis of Lewy Body Dementia. According to recognised criteria, which of these is a core clinical feature?

A. Hyposmia

B. REM sleep disorder

C. Severe sensitivity to antipsychotic agents

D. Postural instability

E. Orthostatic hypotension

Additional Resources / Reading Material

Online:

- Trainees Online (TrON): Neuropathology: Part 1 – dementia
- RCPsych, CPD Online modules:
    - Neuroimaging in dementia
    - Early onset dementias
    - Neuropsychiatric problems in Parkinson's disease
    - Hungtington's disease

Landmark papers

- Román, G.C., Tatemichi, T.K., Erkinjuntti, T., Cummings, J.L., Masdeu, J.C., Garcia, J.H., Amaducci, L., Orgogozo, J.M., Brun, A., Hofman, A. and Moody, D.M., 1993. Vascular dementia: diagnostic criteria for research studies: report of the NINDS-AIREN International Workshop. Neurology, 43(2), pp.250-250.

- Gorno-Tempini, M.L., Hillis, A.E., Weintraub, S., Kertesz, A., Mendez, M., Cappa, S.F., Ogar, J.M., Rohrer, J.D., Black, S., Boeve, B.F. and Manes, F., 2011. Classification of primary progressive aphasia and its variants. Neurology, 76(11), pp.1006-1014.

- Rascovsky, K., Hodges, J.R., Knopman, D., Mendez, M.F., Kramer, J.H., Neuhaus, J., Van Swieten, J.C., Seelaar, H., Dopper, E.G., Onyike, C.U. and Hillis, A.E., 2011. Sensitivity of revised diagnostic criteria for the behavioural variant of frontotemporal dementia. Brain, 134(9), pp.2456-2477.

Journal Papers:

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- Das, S., Zhang, Z. and Ang, L.C., 2020. Clinicopathological overlap of neurodegenerative diseases: A comprehensive review. Journal of Clinical Neuroscience.

- Ducharme, S., Pearl-Dowler, L., Gossink, F., McCarthy, J., Lai, J., Dickerson, B.C., Chertkow, H., Rapin, L., Vijverberg, E., Krudop, W. and Dols, A., 2019. The Frontotemporal Dementia versus Primary Psychiatric Disorder (FTD versus PPD) Checklist: A bedside clinical tool to identify behavioral variant FTD in patients with late-onset behavioral changes. Journal of Alzheimer's Disease, 67(1), pp.113-124.

- Ferrari, R., Manzoni, C. and Hardy, J., 2019. Genetics and molecular mechanisms of frontotemporal lobar degeneration: an update and future avenues. Neurobiology of aging, 78, pp.98-110.

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- Harris, J.M., Saxon, J.A., Jones, M., Snowden, J.S. and Thompson, J.C., 2019. Neuropsychological differentiation of progressive aphasic disorders. Journal of neuropsychology, 13(2), pp.214-239

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- Johnen, A. and Bertoux, M., 2019. Psychological and Cognitive Markers of Behavioral Variant Frontotemporal Dementia–A Clinical Neuropsychologist's View on Diagnostic Criteria and Beyond. Frontiers in neurology, 10.

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- Stahl, SM, 2017. Prescriber's Guide: Stahl's Essential Psychopharmacology, 6th edition Cambridge University Press.

- 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.

Session 4: Delirium

Learning Objectives

- The overall aim of the session is for the trainee to gain an overview of delirium
- By the end of the sessions the trainee should:
    - Understand the epidemiology of delirium and the associated risk factors.
    - Have an awareness of the basic physiological and psychological changes associated with delirium
    - Have an understanding of the clinical features of delirium and the principles of assessment and management.
    - Understand the prognosis of patients diagnosed with delirium.

Curriculum Links

- Old Age Section of the MRCPsych Curriculum: 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 challenges in assessment and management of a patient presenting with possible or probable delirium. Please consider the learning objectives above.

Journal Club Presentation

Journal papers:

- Hov, K.R., Neerland, B.E., Undseth, Ø., Wyller, V.B.B., MacLullich, A.M., Qvigstad, E., Skovlund, E. and Wyller, T.B., 2019. The Oslo Study of Clonidine in Elderly Patients with Delirium; LUCID: a randomised placebo-controlled trial. International journal of geriatric psychiatry, 34(7), pp.974-981.
- Morandi, A., Di Santo, S.G., Zambon, A., Mazzone, A., Cherubini, A., Mossello, E., Bo, M., Marengoni, A., Bianchetti, A., Cappa, S. and Fimognari, F., 2019. Delirium, dementia, and in-hospital mortality: the results from the Italian Delirium Day 2016, a national multicenter study. The Journals of Gerontology: Series A, 74(6), pp.910-916.
- Van Den Boogaard, M., Slooter, A.J., Brüggemann, R.J., Schoonhoven, L., Beishuizen, A., Vermeijden, J.W., Pretorius, D., De Koning, J., Simons, K.S., Dennesen, P.J. and Van der Voort, P.H., 2018. Effect of haloperidol on survival among critically ill adults with a high risk of delirium: the REDUCE randomized clinical trial. Jama, 319(7), pp.680-690.
- Woodhouse, R., Burton, J.K., Rana, N., Pang, Y.L., Lister, J.E. and Siddiqi, N., 2019. Interventions for preventing delirium in older people in institutional long-term care. Cochrane Database of Systematic Reviews, (4).

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

- Delirium or dementia?
- Delirium tremens
- The anticholinergic burden scale

MCQs

1. Which of the following is most frequently observed in delirium?
A. Hallucinations
B. Disturbed sleep-wake cycle
C. Labile mood
D. Increased motor activity
E. Systematised delusions

2. Delirium increases the risk of developing dementia:
A. No increase
B. Five-fold
C. Eight-fold
D. 20-fold
E. 30-fold

3. **Which of the following is not a risk factor for delirium?**
A. Recent surgery
B. Poor sight
C. Terminal illness
D. Pre-existing memory problems
E. Intellectual disability

4. **Which is a clinical feature common to both dementia and delirium:**
A. Rapid onset
B. Global cognitive impairment
C. Clouding of consciousness
D. Clear consciousness
E. Gradual onset over 6 months

5. Which assessment rating tool does NICE recommend using to assess for delirium:
A. MOCA
B. CAM
C. MMSE
D. ACEIII
E. DAS21

6. **Which drug is not associated with an increased risk of delirium:**
A. Calcium channel blocker
B. Antihistamines
C. Benzodiazepines e.g. lorazepam
D. Tricyclic antidepressant
E. Antipsychotics

Additional Resources / Reading Materials

Websites:

- RCPsych CPD Online: Delirium in older people: assessment and management
- http://www.europeandeliriumassociation.com/
- http://www.scottishdeliriumassociation.com/
- https://deliriumnetwork.org/resources/
- https://drshibleyrahman.wordpress.com/
- https://www.the4at.com/
- https://www.youtube.com/watch?v=BPfZgBmcQB8&feature=youtu.be
- https://deprescribing.org/

Guidelines

- Delirium: prevention, diagnosis and management, NICE guidelines [CG103].https://www.nice.org.uk/guidance/cg103

Landmark studies

- Breitbart, W., Marotta, R., Platt, M.M., Weisman, H., Derevenco, M., Grau, C., Corbera, K., Raymond, S., Lund, S. and Jacobsen, P., 2005. A double-blind trial of haloperidol, chlorpromazine, and lorazepam in the treatment of delirium in hospitalized AIDS patients. Focus, 153(2), pp.231-340.

Journal Papers:

- Aguiar, J.P., Brito, A.M., Martins, A.P., Leufkens, H.G. and Alves da Costa, F., 2019. Potentially inappropriate medications with risk of cardiovascular adverse events in the elderly: A systematic review of tools addressing inappropriate prescribing. Journal of clinical pharmacy and therapeutics, 44(3), pp.349-360.

- Barboza, M.S., Cittadini, J., de Hertelendy, M., Farías, M.S. and Loiacono, N., 2017. Liaison Psychiatry: Playing “Hide and Seek” with Delirium. In Psychiatry and Neuroscience Update-Vol. II (pp. 457-463). Springer, Cham.

- Burton, J.K., Siddiqi, N., Teale, E.A., Barugh, A. and Sutton, A.J., 2019. Non-pharmacological interventions for preventing delirium in hospitalised non-ICU patients. Cochrane Database of Systematic Reviews, (4).

- Campbell, A.M., Axon, D.R., Martin, J.R., Slack, M.K., Mollon, L. and Lee, J.K., 2019. Melatonin for the prevention of postoperative delirium in older adults: a systematic review and meta-analysis. BMC geriatrics, 19(1), p.272.

- Dalmau, J., Armangué, T., Planagumà, J., Radosevic, M., Mannara, F., Leypoldt, F., Geis, C., Lancaster, E., Titulaer, M.J., Rosenfeld, M.R. and Graus, F., 2019. An update on anti-NMDA receptor encephalitis for neurologists and psychiatrists: mechanisms and models. The Lancet Neurology.

- Davis, D.H., Muniz Terrera, G., Keage, H., Rahkonen, T., Oinas, M., Matthews, F.E., Cunningham, C., Polvikoski, T., Sulkava, R., MacLullich, A.M. and Brayne, C., 2012. Delirium is a strong risk factor for dementia in the oldest-old: a population-based cohort study. Brain, 135(9), pp.2809-2816.

- De Vincentis, A., Gallo, P., Finamore, P., Pedone, C., Costanzo, L., Pasina, L., Cortesi, L., Nobili, A., Mannucci, P.M. and Incalzi, R.A., 2020. Potentially Inappropriate Medications, Drug–Drug Interactions, and Anticholinergic Burden in Elderly Hospitalized Patients: Does an Association Exist with Post-Discharge Health Outcomes?. Drugs & Aging.
- Fiedler, S.M. and Houghton, D.J., 2018. An In-depth Look into the Management and Treatment of Delirium. In Clinical Approaches to Hospital Medicine (pp. 89-107). Springer, Cham.
- Finucane, A.M., Jones, L., Leurent, B., Sampson, E.L., Stone, P., Tookman, A. and Candy, B., 2020. Drug therapy for delirium in terminally ill adults. Cochrane Database of Systematic Reviews, (1).
- Fong, T.G., Tulebaev, S.R. and Inouye, S.K., 2009. Delirium in elderly adults: diagnosis, prevention and treatment. Nature Reviews Neurology, 5(4), p.210.
- Garcez, F.B., Apolinario, D., Campora, F., Curiati, J.A.E., Jacob-Filho, W. and Avelino-Silva, T.J., 2019. Delirium and post-discharge dementia: results from a cohort of older adults without baseline cognitive impairment. Age and Ageing, 48(6), pp.845-851.
- Haley, M.N., Casey, P., Kane, R.Y., Dārziņš, P. and Lawler, K., 2019. Delirium management: Let's get physical? A systematic review and meta-analysis. Australasian journal on ageing, 38(4), pp.231-241.
- Heneghan, C. and O'Sullivan, J., 2020. Antipsychotics for preventing and treating delirium: not recommended. BMJ Evidence-Based Medicine.
- Janssen, T.L., Alberts, A.R., Hooft, L., Mattace-Raso, F.U.S., Mosk, C.A. and van der Laan, L., 2019. Prevention of postoperative delirium in elderly patients planned for elective surgery: systematic review and meta-analysis. Clinical interventions in aging, 14, p.1095.
- Jones, R.N., Cizginer, S., Pavlech, L., Albuquerque, A., Daiello, L.A., Dharmarajan, K., Gleason, L.J., Helfand, B., Massimo, L., Oh, E. and Okereke, O.I., 2019. Assessment of instruments for measurement of delirium severity: a systematic review. JAMA internal medicine, 179(2), pp.231-239.
- Kojima, T., Matsui, T., Suzuki, Y., Takeya, Y., Tomita, N., Kozaki, K., Kuzuya, M., Rakugi, H., Arai, H. and Akishita, M., 2020. Risk factors for adverse drug reactions in older inpatients of geriatric wards at admission: Multicenter study. Geriatrics & Gerontology International, 20(2), pp.144-149.
- Kotfis, K., Szylińska, A., Listewnik, M., Strzelbicka, M., Brykczyński, M., Rotter, I. and Żukowski, M., 2018. Early delirium after cardiac surgery: an analysis of incidence and risk factors in elderly (≥ 65 years) and very elderly (≥ 80 years) patients. Clinical interventions in aging, 13, p.1061.
- LaHue, S.C., James, T.C., Newman, J.C., Esmaili, A.M., Ormseth, C.H. and Ely, E.W., 2020. Collaborative Delirium Prevention in the Age of COVID-19. Journal of the American Geriatrics Society, 68(5), p.947.
- Lawson, R.A., McDonald, C. and Burn, D.J., 2019. Defining delirium in idiopathic Parkinson's disease: A systematic review. Parkinsonism & related disorders, 64, pp.29-39.
- Lindroth, H., Bratzke, L., Twadell, S., Rowley, P., Kildow, J., Danner, M., Turner, L., Hernandez, B., Brown, R. and Sanders, R.D., 2019. Predicting postoperative delirium severity in older adults: The role of surgical risk and executive function. International journal of geriatric psychiatry, 34(7), pp.1018-1028.
- Miller, C., Teale, E. and Banerjee, J., 2018. Cognitive Impairment in Older People Presenting to ED. In Geriatric Emergency Medicine (pp. 199-207). Springer, Cham.

- Neerland, B.E., Neufeld, K.J. and Slooter, A.J., 2019. Pharmacological Management of Delirium. JAMA psychiatry, 76(9), pp.983-983.

- Nikooie, R., Neufeld, K.J., Oh, E.S., Wilson, L.M., Zhang, A., Robinson, K.A. and Needham, D.M., 2019. Antipsychotics for treating delirium in hospitalized adults: a systematic review. Annals of internal medicine, 171(7), pp.485-495.

- Nikooie, R., Oh, E.S., Zhang, A., Robinson, K.A. and Needham, D.M., 2020. Do neuroleptics still have a role in patients with delirium?. Annals of internal medicine, 172(4), pp.295-296.

- Oh, E.S., Needham, D.M., Nikooie, R., Wilson, L.M., Zhang, A., Robinson, K.A. and Neufeld, K.J., 2019. Antipsychotics for preventing delirium in hospitalized adults: a systematic review. Annals of internal medicine, 171(7), pp.474-484.

- Partridge, J.S., Crichton, S., Biswell, E., Harari, D., Martin, F.C. and Dhesi, J.K., 2019. Measuring the distress related to delirium in older surgical patients and their relatives. International journal of geriatric psychiatry, 34(7), pp.1070-1077.

- Rhodes, C., Tokazewski, J., Christensen, K., Holman, M., Eimers, A. and Peifer, M., 2019. Clinician Decision Support Initiative to Decrease Outpatient High-Risk Medicine Prescriptions in the Elderly. Journal of General Internal Medicine, pp.1-3.

- Sepulveda, E., Leonard, M., Franco, J.G., Adamis, D., McCarthy, G., Dunne, C., Trzepacz, P.T., Gaviria, A.M., de Pablo, J., Vilella, E. and Meagher, D.J., 2017. Subsyndromal delirium compared with delirium, dementia, and subjects without delirium or dementia in elderly general hospital admissions and nursing home residents. Alzheimer's & Dementia: Diagnosis, Assessment & Disease Monitoring, 7, pp.1-10.

- Shenvi, C., Kennedy, M., Austin, C.A., Wilson, M.P., Gerardi, M. and Schneider, S., 2020. Managing delirium and agitation in the older emergency department patient: the ADEPT tool. Annals of Emergency Medicine, 75(2), pp.136-145.

- Sillner, A.Y., Holle, C.L. and Rudolph, J.L., 2019. The overlap between falls and delirium in hospitalized older adults: a systematic review. Clinics in geriatric medicine, 35(2), pp.221-236.

- Slooter, A.J., Otte, W.M., Devlin, J.W., Arora, R.C., Bleck, T.P., Claassen, J., Duprey, M.S., Ely, E.W., Kaplan, P.W., Latronico, N. and Morandi, A., 2020. Updated nomenclature of delirium and acute encephalopathy: statement of ten Societies. Intensive care medicine, pp.1-3.

Books:

- Dening T., Thomas A., 2013. The Oxford Textbook of Old Age Psychiatry, 2nd edition. Oxford University Press.

- Taylor, D., Barnes, T., Young, A., 2018. The Maudsley Prescribing Guidelines in Psychiatry, 13th edition. Blackwell-Wiley.

- Stahl, SM, 2017. Prescriber's Guide: Stahl's Essential Psychopharmacology, 6th edition Cambridge University Press.

- World Health Organisation, 1992. ICD-10: The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines. WHO.

MCQ answers
Other neurodegenerative disorders
1. A **2. D** **3. E** **4. A** **5. B**
Delirium
1. B **2. C** **Davis, D.H., Muniz Terrera, G., Keage, H., Rahkonen, T., Oinas, M., Matthews, F.E., Cunningham, C., Polvikoski, T., Sulkava, R., MacLullich, A.M. and Brayne, C., 2012. Delirium is a strong risk factor for dementia in the oldest-old: a population-based cohort study. Brain, 135(9), pp.2809-2816.** **3. E** **4. B** **5. B**

Across the Ages
Coming Soon

Forensic

Session 2: The Link between Crime and Mental Disorder

Learning Objectives

- To develop an understanding of the types of offences committed by mentally disordered offenders
- To develop an understanding of the aetiology of certain crimes including violent offences, sex offences, criminal damage and fire-setting
- To develop an understanding of the ranges of offences committed by offenders with schizophrenia, affective disorder and personality disorder.
- To develop an understanding of genetic and gender-specific factors in offending

Curriculum Links

12.1 Relationship between crime and mental disorder

12.1.1 Knowledge of the range of offences committed by mentally disordered offenders. Specific crimes and their psychiatric relevance particularly: homicide; other crimes of violence (including infanticide); sex offences; arson; and criminal damage.

12.1.2 The relationship between specific mental disorders and crime: substance misuse; epilepsy; schizophrenia; bipolar affective disorder; neuro-developmental disorders; personality disorders.

12.1.4 Mental disorders and offending in special groups: young offenders; female offenders; offenders from ethnic minorities; offenders who are deaf or have other physical disabilities.

Expert Led Session

'Offences committed by mentally-disordered offenders' To cover topics including:

- Sexual offending
- Fire-setting
- Violence
- Offences against the property

Case Presentation
Case presentation on ‘A mentally-disordered offender’ Options for case presentation: • 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) • To use ‘The report of the inquiry into the care and treatment of Christopher Clunis’ as the basis of the case presentation.
Journal Club Presentation
Key points to be summarised from the following three papers: Keers R, Ullrich S, DeStavola B & Coid J. (2014) Association of violence with emergence of persecutory delusions in untreated schizophrenia. Am J Psychiatry 171:3: 332 – 339 • Sarkar J & Di Lustro M (2011) Evolution of secure services for women in England. Advances in Psychiatric Treatment 17, 323 – 31 http://apt.rcpsych.org/content/17/5/323.abstract • Chang Z, Larsson H, Lichtenstein P & Fazel S, Psychiatric disorders and violent reoffending: a national cohort study of convicted prisoners in Sweden, Lancet Psychiatry 2015, 2: 891 – 908 http://www.ncbi.nlm.nih.gov/pubmed/26342957
‘555’ Topic (5 slides with no more than 5 bullet points)
The biology of crime including: • Genetics • Gender • Young offenders • Special group – either deaf patients / ethnic minorities / older adults / physical disabilities

MCQs

1. Which is the most prevalent personality disorder in prisoners?

A. Borderline

B. Anankastic

C. Narcissistic

D. Paranoid

E. Antisocial

2. Which of the following is true for female offenders?

A. Less likely to have a psychiatric disposal

B. Higher rate of reoffending than men

C. Less likely to self-harm than men

D. Violent offences are more common than crimes of passion

E. More likely to offend against family

3. Which is the most common mental disorder found in arsonists?

A. Learning disability

B. Personality disorder

C. Psychosis

D. Alcohol misuse

E. Depressive disorder

4. What percentage of violence is attributable to psychosis

A. 1%

B. 5%

C. 10%

D. 25%

E. 50%

5. Which of these genes is not linked to violence?

A. Dopamine transporter gene

B. Serotonin transporter gene

C. Monoamine-oxidase A (MAO-A) gene

D. Monoamine-oxidase B (MAO-B) gene

E. Catechol-O-methyltransferase (COMT) gene

EMI Questions

Stalking:

A. Rejected

B. Public-Figure

C. Intimacy-Seeking
D. Incompetent-Suitor
E. Psychotic
F. Resentful
G. Predatory
H. Psychopathic
I. Private Stranger
J. Acquaintance

Which of the above subtypes of stalking, is demonstrated in the following scenarios?

1. James is a 22 year old man who has recently started working stacking shelves in the local supermarket. One Sunday he saw Jenny, who was doing her regular weekly shopping and she smiled at him warmly. Over the following weeks he changes his shift patterns to that he always works on Sundays. He follows her home to ensure that she gets there safely and starts to leave her flowers and presents by her car in the car-park. He takes pictures of her without her knowing and puts them on Facebook as his new girlfriend.

2. Steven lives in a block of flats and notices a new tenant (Sally) has moved into the flat beneath him. He starts to take her post from the communal mailbox so that he can find out more information about her such as her phone number. He starts to make anonymous phone calls during which he makes sexual and violent comments. He follows her to work so that he can best determine when she is alone.

3. David is a 32-year-old stock-broker who lives in a penthouse apartment. He was in a 9-month relationship with Jasmine, who broke up with him 12 months ago as she was frustrated that she rarely saw him. David was angry that had the gall to break up with him and since then has rung her several times each day; sometimes he asks her to re-consider but often he leaves abusive messages or silence on her answerphone. He has gone around to her flat in the middle of the night with flowers, although he broke her window on one occasion. He was angry that she didn't come to his brother's wedding as his guest 2 months ago. He has posted private pictures of her on the internet.

4. Sandra is a 40 year old single woman. 3 years ago she met Olly Murs backstage at a concert. Since then she has become "his biggest fan." She buys any magazines or newspapers that he is in, has several copies of all his CDs and DVDs and goes to as many concerts as she can. She lost her job because she took so much time off pursuing this interest. She recently

found out where he lives and spends all of her time at his house so that she can see him when he leaves and follow him. She looks through his rubbish, where she found some lipstick and she saw a female leave his house. She has sent threats to this woman that Olly is 'hers' and to leave him alone.

5. Aimee is an aspiring model. 6 months ago at a casting she met Sarah and leant her some makeup. Sarah was given the job and signed up to an agency. Aimee believes that Sarah must have got the job for reasons other than merit. She is angry that Sarah stole the job from her. Since then she has anonymously posted death threats on Twitter and Facebook. She waited outside Sarah's house for her to come out and threw a tin of paint on her. She phoned Sarah's model agency pretending to be Sarah and cancelled jobs. She hacked into her email and sent abusive messages to the boss of the model agency.

Sex Offender Treatment:

A. Selective Serotonin Reuptake Inhibitor (SSRI)

B. Anti-androgen

C. Luteinising Hormone Releasing Hormone (LHRH) agonist / Long-acting Gonadotropin Releasing Hormone (GnRH) agonist.

D. Oestrogens

Match the anti-libidinal medication used in the treatment of sex offenders to the mechanism of action:

1. Medroxyprogesterone acetate
2. Fluvoxamine
3. Cyproterone Acetate
4. Goserelin
5. Leuprolide
6. Premarin

Additional Resources / Reading Materials

Books

- Chapters 8, 9, 10, 11, 12, 19, 20 & 21 in 'Forensic Psychiatry: Clinical and ethical issues' Gunn J & Taylor P, (2013) CRC Press
- Chapters 10, 11, 12 & 13 in 'Practical Forensic Psychiatry,' Clark T & Rooprai DS (2011) Hodder Arnold
- Chapter 15 in 'Oxford Specialist Handbook: Forensic Psychiatry,' Eastman N, Adshead G, Fox S et al (2012) Oxford Medical Publishing

E-Learning

- RCPsych CPD online: 'Genetics for psychiatrists'
- RCPsych CPD online: 'Neurodevelopmental model of schizophrenia'
- RCPsych CPD online: 'Psychiatric aspects of homicide'

Journal Articles

- Bennett D, Ogloff J, Mullen P et al (2012) A study of psychotic disorders among female homicide offenders Psychology, Crime and Law 18(3), 231 – 243
- Chitsabesan P, Kroll L, Bailey S et al (2006) Mental health needs of young offenders in custody and in the community. British Journal of Psychiatry 188: 534 – 540
- Dein K, Woodbury-Smith M (2010) Asperger syndrome and criminal behaviour. Advances in Psychiatric Treatment 16: 37 – 43
- Devapriam J, Raju LB, Singh N et al (2007) Arson: characteristics and predisposing factors in offenders with intellectual disabilities. British Journal of Forensic Practice 9(4): 23 – 27
- Eronen M (1995) Mental disorders and homicidal behavior in female subjects. American Journal of Psychiatry 152: 1216 – 1218
- Fazel S & Benning R (2009) Suicides in female prisoners in England and Wales. British Journal of Psychiatry 194: 183 – 184
- Fazel S, Sjostedt, Langstrom N et al (2007) Severe mental illness and risk of sexual offending in men: a case-control study based on Swedish national registers. Journal of clinical psychiatry 68(4), 588 – 596
- Ferguson CJ & Beaver KM (2009) Natural born killers: the genetic origins of extreme violence. Aggression and Violent Behaviour 14, 286 – 94

- Gannon TA (2010 Female arsonists: key features, psychopathologies and treatment needs. Psychiatry 73(2): 173 – 189

- Gordon H & Grubin D (2004) Psychiatric aspects of the assessment and treatment of sex offenders. Advances in psychiatric treatment 10: 73 – 80

- Gudjonsson GH & Henry L (2003) Child and adult witnesses with intellectual disability: the importance of suggestibility. Legal and Criminological Psychology 8(2): 241 – 252

- Holland T, Clare CH & Mukhopadhyay (2002) Prevalence of criminal offending by men and women with intellectual disability and the characteristics of offenders: implications for research and service development. Journal of Intellectual Disability Research 46(S1): 6 – 20

- Kolko DJ & Kazdin AE (1991) Motives of childhood firesetters: firesetting characteristics and psychological correlates. Journal of child psychology and psychiatry 32: 535 – 550

- Long C, Hall L, Craig L et al (2010) Women referred for medium secure inpatient care: a population study over a six-year period. Journal of Psychiatric Intensive Care 7(1): 17 – 26

- Mohandie K, Meloy J R, McGowan MG et al (2006) The RECON typology of stalking: reliability and validity based upon a large sample of North American Stalkers Journal of Forensic Science 51(1), 147 – 155

- Monahan J, Steadman HJ, Silver E et al (2001) Rethinking risk assessment: The MacArthur study of risk assessment and violence. Oxford: Oxford University Press.

- Mullen P, Pathe M & Purcell P (2001) The management of stalkers. Advances in psychiatric treatment 7: 335 – 342

- Talbot J (2008) No One Knows: Experiences of the criminal justice system by prisoners with learning disabilities and difficulties. London: Prison reform trust

ID

Session 2: Mental Disorders in Intellectual Disability

Learning Objectives

- Recognising and identifying how the presentation of mental disorders differs in ID population
- Importance of collateral information from various sources
- Role of medication/ doses/side effects

Curriculum Links

13.1 Services

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

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

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

13.3.4 The application of psychiatric methods of treatment in intellectual disability including drug treatments. The application of a multidisciplinary approach to the management of mental health problems in people with intellectual disability

Expert Led Session

Dr Patel's presentation - Mental disorders

Case Presentation

Case presentation of a local patient with intellectual disability, identified by tutor or specialist in post. If there is neither a specialist consultant nor tutor in post **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

Please select one of the following papers:

- Cooper S.A., Smiley E., Morrison J., Williamson A. and Allan L. (2007) Mental ill-health in adults with intellectual disabilities: prevalence and associated factors. British Journal of Psychiatry 190, 1, 27-35.

- Hurley A.D. (2006) Mood disorders in intellectual disability. Current Opinion in Psychiatry 19, 5, 465-469.

- Cooper S.A. Melville C.A. and Enfield S.L. (2003) Psychiatric diagnosis, intellectual disabilities and Diagnostic Criteria for Psychiatric Disorders for Use with Adults with Learning Disabilities/Mental Retardation (DC-LD). Journal of Intellectual Disability Research 47, supplement one, 3-15.

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

Please select one of the following:

- Assessment of the Psychotic patient in the community setting (focus on environment, style of communication, getting informant history etc.)

- Perform a risk assessment in a patient with a moderate Learning disability who is presenting with self-injurious behaviour (Focus on nature of behaviours, communication ability of the patient, issues of any change.)

- What are the roles of a community ID nurse, speech and Language therapist and an Occupational therapist in the ID team?(You can discuss this with your local ID team to guide with the task)

MCQs

1. In individuals with severe learning disability, self-injurious behaviour has a peak occurrence between the ages of:

A. 10-15 yrs
B. 15-20
C. 20-25
D. 25-30
E. 35-40

2. Self-injurious behaviour is common in which of the following:

A. Cri du chat syndrome
B. Angelman syndrome
C. Downs Syndrome
D. Cornelia de Lange syndrome
E. Lesch Nyhan syndrome

3. Prevalence of depression in ID is around:

A. 1%
B. 2-4%
C. 5-15%
D. 16-25%
E. 26 -35%

4. Which of the following apply to the PAS-ADD:

A. Was developed from the SCID
B. Focuses exclusively to Axis II Disorders
C. Designed for completion by carers with knowledge of psychopathology
D. Each item is rated on a 6 point scale
E. It comprises a life events and a problems section

5. In patients with ID and schizophrenia compared with patients with ID alone, the following were noted:

A. Impaired mobility
B. High birth weight
C. Gestation beyond 38 weeks
D. Impaired hearing
E. Low rates of obstetric complications

Additional Resources / Reading Materials

Books

Seminars in the psychiatry of learning disabilities – second edition (2003), The Royal college of Psychiatrists, Gaskell

Psychiatric and behavioural disorders in developmental disabilities and mental retardation (2001), Edited by Nick Bouras, Cambridge University Press, 1999. Reprinted 2001.

Practice guidelines for the assessment and diagnosis of mental health problems in adults with intellectual disability (2001) Deb, S., Matthews, T., Holt, G., & Bouras, N. published by Pavillion for the European Association for mental Health in Mental Retardation.

Sturmey, P. (1995) DSM-III-R and persons with dual diagnoses: conceptual issues and strategies for future research, *Journal of intellectual Disability Research*, 39, 357-364

Corbett, J. A. (1979) Psychiatric morbidity and mental retardation. In: F. E. James and R. P. Snaith (Eds.) *Psychiatric illness and Mental Handicap*, London: Gaskell.

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Roy A, Matthew H, Martin D and fowler V (2002) HoNOS-LD: Health of the Nation Outcome scale for people with Learning Disabilities, Kidderminster: British Institute of Learning Disabilities

Journal Articles

Bouras, N. and Drummond, C. (1992) Behaviour and psychiatric disorders of people with mental handicaps living in the community. *Journal of Intellectual Disability Research*, **36**, 349-357.

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Diagnostic Criteria for Psychiatric Disorders for adults with learning disabilities (DC-LD) (2003) *Journal of Intellectual Disability Research*, 47, supplement 1.

Psychotherapy

Session 2: Psychological approaches to EUPD

Learning Objectives

- The overall aim of the session is to understand emotionally unstable personality disorder from a psychological /psychotherapy perspective.
- By the end of the session the trainee should have an understanding of the psychological aspects of this diagnosis.
- By the end of the session the trainee should have a more detailed understanding of at least one of the newer therapy approaches to EUPD.

Curriculum Links

2.x – Human Development
6 – Organization & Delivery of Psychiatric Services
7.1.9.1-5 – 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

Developments in the psychological understanding of EUPD: aetiology and presentation
What therapies are indicated for EUPD? – To include reference to the current evidence base. NICE Guidance and its limits / omissions.
Learning points for general mental health work

Case Presentation

- Case Presentation of patient with Emotionally Unstable Personality Disorder
- Preferably a patient who has had / is having psychological therapy for this.
- Good level of detail about background history essential

Journal Club Presentation

Please select one of the following papers:

Clarke et al (2013) “Cognitive analytic therapy for personality disorder: randomised controlled trial” *BJPsych* 202:129-134
(with accompanying Editorial) Mulder & Chanen (2013) “Effectiveness of cognitive analytic therapy for personality disorders” *BJPsych* 202:89-90

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

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

Doering et al (2010) “Transference-focused psychotherapy *v.* treatment by community psychotherapists for borderline personality disorder: randomised controlled trial” *BJPsych* 196:389-395

Bamelis et al (2014) Results of a Multicenter Randomized Controlled Trial of the Clinical Effectiveness of Schema Therapy for Personality Disorders *Am J Psychiatry* 171: 305 – 322

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

Select one of the following:
- Signs & Symptoms of Emotionally Unstable Personality Disorder
- Biological aetiology of EUPD
- Drug treatments in EUPD

MCQs

1. The following are symptoms of Emotionally Unstable Personality Disorder (EUPD):

A. Unstable or unclear self-image
B. Callous unconcern for others
C. Increased impulsivity
D. Intense anger and aggression
E. Unstable and intense relationships

2. EUPD is group in 'Cluster B' of DSM-IV along with:

A. Antisocial PD
B. Schizotypal PD
C. Narcissistic PD
D. Dependent PD
E. Histrionic PD

3. The following have been recommended by NICE in the treatment of EUPD:

A. Brief Dynamic Psychotherapy
B. Mentalization Based Treatment
C. Mindfulness Based Therapy
D. Olanzepine
E. Dialectical Behaviour Therapy

4. The following statements about EUPD are true:

A. EUPD is more commonly diagnosed in women
B. EUPD is a lifelong condition if untreated
C. Psychoanalysis is an effective treatment for EUPD
D. EUPD is easily distinguished from mood disorder
E. Almost all patients with EUPD have a history of abuse
F. Patients with EUPD have a lower risk of death by suicide compared to those with mood disorder
G. Admissions to hospital lasting more than six months adversely affect prognosis.
H. Prescribing antidepressants for unstable mood symptoms can be helpful
I. EUPD can be co-morbid with mood disorder
J. Severity of symptoms can be rated with the Zanarini scale

Additional Resources / Reading Materials

NICE on Borderline Personality Disorder – Clinical Guideline 78 & Quality Standards

Borderline Personality Disorder: An evidence based guide for generalist mental health professionals by Anthony Bateman & Roy Krawitz Oxford (2013)

Choi-Kane *et al* "What works in the treatment of Borderline Personality Disorder" *Curr Behav Neurosci Rep* (2017) 4:21–30

Substance Misuse

Session 2: Diagnosis and Treatment of People with Drug Misuse

Learning Objectives

- Assessment, diagnosis and treatment of people with Drug Misuse
- To develop working knowledge of principles of opioid substitution treatment
- To increase awareness of other substances commonly misused
- To develop awareness of complications associated with Drug Misuse

Curriculum Links

11.1	Basic pharmacology and epidemiology
11.2	Considerations for prescribing and treatment modalities; Legal restrictions on prescribing
11.4	Biological, psychological and socio-cultural explanations of drug and alcohol dependence ; Cultural factors in the use and abuse of drugs
11.5	Impact of drug and alcohol use on Public Health
11.6	The assessment and management of drug misusers
11.8	Culturally appropriate strategies for the prevention of drug and alcohol abuse

Expert Led Session

- Epidemiology /Context
- Opioid related mortality morbidity
- Assessment
- Treatment with opioid replacement treatment
- Detoxification
- Risks with opioid replacement treatment

Case Presentation

- A case of someone with polysubstance misuse
- Highlight physical complications of injecting substances

Journal Club Presentation

- Abrahamsson, T., Berge, J., Öjehagen, A., & Håkansson, A. (2017). Benzodiazepine, z-drug and pregabalin prescriptions and mortality among patients in opioid maintenance treatment—A nation-wide register-based open cohort study. *Drug and Alcohol Dependence,* 174, 58- 64.
- Lofwall, M. R., Walsh, S. L., Nunes, E. V., Bailey, G. L., Sigmon, S. C., Kampman, K. M., ... & Oosman, S. (2018). Weekly and monthly subcutaneous buprenorphine depot formulations vs daily sublingual buprenorphine with naloxone for treatment of opioid use disorder: a randomized clinical trial. JAMA internal medicine, 178(6), 764-773.
- Sordo, L., Barrio, G., Bravo, M. J., Indave, B. I., Degenhardt, L., Wiessing, L., ... & Pastor-Barriuso, R. (2017). Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *bmj*, *357*.

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

- Novel psychoactive substances
- Pain management in people with opioid dependence
- Substance misuse problems in young people
- Ethics of opiate substitution treatment

MCQs

1. Common term for illicit diazepam:

A. Plant food

B. Blues

C. Spice

D. Horse

E. Whizz

2. The following are true of Novel psychoactive substances except for:

A. GHB (gamma-hydroxybutyrate) and GBL (gamma-butyrolactone) act similarly to hallucinogens such as LSD

B. Mephedrone is part of the cathinone family of drugs

C. Piperazines substances have stimulant effects

D. Paramethoxyamphetamine (PMA) is an methylenedioxymetamphetamine (MDMA) like substance but associated with higher risks of death than MDMA

E. Ketamine use can result in haemorrhagic cystitis

3. The following are true of methadone except for:

A. Cases of QT interval prolongation and torsade de pointes have been reported during treatment with methadone, particularly at high doses (>100mg).

B. Typical starting doses are in the range of 10 to 30 mgs

C. Methadone tablets are the preferred formulation for commencing treatment in opioid dependence

D. Use of Cimetidine may lead to potentiation of opioid activity due to displacement of methadone from protein binding sites

E. Peak plasma levels occur 1-5 hours after a single dose of Methadone Mixture 1mg/1ml

4. The following are true about opioid substitution treatment except for:

A. Reduces the risk of death among heroin users

B. Suppresses illicit use of heroin

C. Reduces involvement in crime among heroin users participating in treatment

D. Reduces the risk of Blood Bourne Virus transmission, including in prisons

E. Promotes abstinence from all drugs

5. For long term treatment of pain using opioids – the following dose of oral morphine or equivalent should not be exceeded

A. 10 mg

B. 40 mg

C. 80 mg

D. 120 mg

E. 240 mg

EMI Questions

Medication used in treatment of opioid dependence:

A. Hyoscine butylbromide

B. Naloxone

C. Codeine phosphate

D. Clonidine

E. Buvidal

F. Suboxone
G. Loperamide
H. Oxycodeine
I. Fentanyl
J. MXL morphine capsules

1a. This medication is a long acting buprenorphine formulation
1b. This medication can be used to reduce risk of injecting behaviour
1c. This medication is frequently used for symptomatic relief of abdominal cramps during opioid detoxification

Analgesics of misuse:

A. Fentanyl
B. Diacetylmorphine
C. Codeine
D. MXL
E. Diconal
F. Buprenorphine
G. MST Continus
H. Tramadol
I. Methadone
J. Oramorph

2a. This drug which exerts it effect via conversion to morphine can result in opioid toxicity at usual doses in CYP2D6 ultra-rapid metabolisers
2b. This compound has effects on serotonin reuptake as well as effects on opioid receptors
2c. This compound is approximately 80 times more potent than morphine and is available as lozenges and transdermal formulation

MCQ Answers

Q1 B is usual term used

Q2 A is false GHB and GBL similar mechanism of action to alcohol

Q3 C Rarely use tablets as there is increased risk of injecting with these hence tend to use methadone mixture

Q4 E is false

Q5 D risk of harm increases substantially at doses about 120 mgs oral morphine but with no increased benefit

EMI 1

(1a) E

(1b) F In addition to buprenorphine this contains naloxone which is not active orally but is if injected

(1c) A

EMI 2

(2a) C

(2b) H

(2c) A

Additional Resources / Reading Materials

Books

- Nestler, E. J., Hyman, S. E., & Malenka, R. C. (2009). *Molecular neuropharmacology : a foundation for clinical neuroscience* (2nd ed. ed.). New York ; London: McGraw-Hill Medical.
- Welsh, I. Trainspotting.

E-Learning

Drug Alerts

- https://findings.org.uk/
- http://michaellinnell.org.uk/drugwatch.html
- https://wearetheloop.org/drug-alerts/

European reports on substance misuse

- http://www.emcdda.europa.eu/

Epidemiological data on Drug and Alcohol Treatment in England

- https://www.ndtms.net/

Government information - Guidance for healthcare professionals on drug driving

- https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals

GP learning resource centre

- http://www.smmgp.org.uk/

Neptune (Novel Psychoactive Treatment: UK Network) E-learning modules

- http://neptune-clinical-guidance.co.uk/e-learning/

Pain resources

- Action on Addiction
    - https://idhdp.com/mediaimport/38281/130607_pain_management_report__final_embargoed_13_june.pdf
- Opioid Aware:
    - https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware
- Living well with pain:
    - http://livewellwithpain.co.uk/

Public Health England Information

- https://www.gov.uk/government/organisations/public-health-england

Resource for drug advice

- http://www.talktofrank.com/

Royal College of Psychiatrists CPD Online

- Buprenorphine in opiate dependence
- GHB: what psychiatrists need to know
- Helping the addicted doctor
- Hepatitis C and mental illness
- Safe and effective opiate replacement therapy
- Stimulants: epidemiology and impact on mental health
- Stimulants: treatment approaches and organising services
- Substance misuse in older people

Royal College of Psychiatrists information

- Drugs and alcohol: information for young people
    - https://www.rcpsych.ac.uk/healthadvice/parentsandyouthinfo/youngpeople/drugsandalcohol.aspx

- Substance misuse in older people: an information guide
    - https://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr211.aspx

Society for the Study of Addiction

- http://www.addiction-ssa.org/

US National institute on Drug Misuse

- https://www.drugabuse.gov/drugs-abuse

Journal Articles

- Action on Addiction. (2013). The Management Of Pain In People With A Past Or Current History Of Addiction.
- Advisory Council on the Misuse of Drugs. Time limiting opioid substitution therapy advice. 6 Nov 2014. https://www.gov.uk/government/publications/time-limiting-opioid-substitution-therapy.
- Baldwin, D. S., Aitchison, K., Bateson, A., Curran, H. V., Davies, S., Leonard, B., et al. (2013). Benzodiazepines: risks and benefits. A reconsideration. *Journal of Psychopharmacology*, 27(11), 967-971.
- Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health.
- Costella, A., Harris, H., Mandal, S., & Ramsay, M. (2017). Hepatitis C in England: 2017 report.
- Degenhardt, L., Larney, S., Randall, D., Burns, L., & Hall, W. (2014). Causes of death in a cohort treated for opioid dependence between 1985 and 2005. *Addiction*, *109*(1), 90-99.
- DTB. (2016). QT interval and drug therapy. *BMJ*, 353, i2732.
- EMCDDA. (2013). Drug prevention interventions targeting minority ethnic populations: issues raised by 33 case studies: Publications Office of the European Union, Luxembourg.
- EMCDDA. (2018). European Drug Report: Trends and Developments: Publications Office of the European Union, Luxembourg http://www.emcdda.europa.eu/publications/edr/trends-developments/2018.
- Faggiano, F., Vigna-Taglianti, F., Versino, E., & Lemma, P. (2003). Methadone maintenance at different dosages for opioid dependence. *Cochrane Database of Systematic Reviews*, (3).

- Gossop, M., Marsden, J., Stewart, D., & Kidd, T. (2003). The National Treatment Outcome Research Study (NTORS), 4-5 year follow-up results. *Addiction,* 98(3), 291-303.
- Home office (2019). Drug Misuse: Findings from the 2018/19 Crime Survey for England and Wales. https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2018-to-2019-csew.
- Marsden, J., Stillwell, G., James, K., Shearer, J., Byford, S., Hellier, J., ... & Mitcheson, L. (2019). Efficacy and cost-effectiveness of an adjunctive personalised psychosocial intervention in treatment-resistant maintenance opioid agonist therapy: a pragmatic, open-label, randomised controlled trial. *The Lancet Psychiatry*, *6*(5), 391-402.
- Mattick, R. P., Breen, C., Kimber, J., & Davoli, M. (2009). Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. *Cochrane database of systematic reviews*, (3).
- Mujtaba, S., Romero, J., & Taub, C. C. (2013). Methadone, QTc prolongation and torsades de pointes: Current concepts, management and a hidden twist in the tale *Journal of cardiovascular disease research*, 4(4), 229-235.
- National Institute for Health and Care Excellence. (2007). Drug misuse – opioid detoxification CG52. London: National Institute for Health and Care Excellence.
- National Institute for Health and Care Excellence. (2012). Opioids in palliative care: safe and effective prescribing of strong opioids for pain in palliative care of adults CG140. London: National Institute for Health and Care Excellence.
- Office of National Statistics. (2018). Deaths Related to Drug Poisoning in England and Wales, https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2018registrations.
- Office of National Statistics. (2014). Number of deaths related to drug poisoning where buprenorphine and/or methadone was mentioned on the death certificate by underlying cause, England and Wales, deaths registered between 2007-2012.
- The Royal College of Psychiatrists. (2018). Our Invisible Addicts, 2nd edition. College Report CR211.
- Royal College of Psychiatrists (2012). Practice standards for young people with substance misuse problems.

- Sordo, L., Barrio, G., Bravo, M. J., Indave, B. I., Degenhardt, L., Wiessing, L., ... & Pastor-Barriuso, R. (2017). Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *bmj*, *357*.
- Strang, J. (2012). Medications in recovery: re-orientating drug dependence treatment. *National Treatment Agency, London*.
- Strang, J., Metrebian, N., Lintzeris, N., Potts, L., Carnwath, T., Mayet, S., et al. (2010). Supervised injectable heroin or injectable methadone versus optimised oral methadone as treatment for chronic heroin addicts in England after persistent failure in orthodox treatment (RIOTT), a randomised trial. *Lancet,* 375(9729), 1885-1895.
- Trescot, A. M., Datta, S., Lee, M., & Hansen, H. (2008). Opioid pharmacology. *Pain Physician,* 11(2 Suppl), S133-153.
- United Kingdom Focal Point at Public Health England. (2013). United Kingdom Drug Situation 2013 Edition.