North West
School of Psychiatry

Semester 4 Handbook

MRCPsych Course

2020 – 2022

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

Course Director - Dr Latha Hackett, Consultant in Child & Adolescent Psychiatry

Deputy Course Director - Dr Dushyanthan Mahadevan, Consultant in Child & Adolescent Psychiatry

List of Contributors

Course Director

Dr Latha Hackett, Consultant in Child and Adolescent Psychiatry

Latha.hackett@mft.nhs.uk

Deputy Course Director

Dr Dushyanthan Mahadevan, Consultant in Child & Adolescent Psychiatry

Dushyanthan.Mahadevan@elht.nhs.uk

Module Leads

Across the Ages	Dr Latha Hackett	Latha.hackett@mft.nhs.uk
CAMHS	Dr Neelo Aslam	Neelo.aslam@mft.nhs.uk
Forensic	Dr Victoria Sullivan &	Victoria.sullivan@gmmh.nhs.uk
	Dr Amit Sharda	Amit.Sharda@lancashirecare.nhs.uk
General Adult	Dr Sally Wheeler &	sally.wheeler@gmmh.nhs.uk
	Dr Swanand Patwardhan	Swanand.Patwardhan@gmmh.nhs.uk
Intellectual Disabilities	Dr Sol Mustafa	sol.mustafa@nhs.net
Old Age	Dr Anthony Peter	Anthony.peter@lancashirecare.nhs.uk
Psychotherapy	Dr Adam Dierckx	Adam.Dierckx@gmmh.nhs.uk
Substance Misuse	Dr Patrick Horgan	Patrick.Horgan2@gmmh.nhs.uk

Trust Leads

CWP	Dr Matthew Cahill	matthew.cahill1@nhs.net
GMMH (NMGH)	Dr Swanand Patwardhan	Swanand.Patwardhan@gmmh.nhs.uk
GMMH (Prestwich)	Dr Catrin Evans &	Catrin.Evans@gmmh.nhs.uk
	Dr Emily Mountain	Emily.Mountain@gmmh.nhs.uk
Lancashire Care	Dr Clare Oakley	Clare.Oakley@lancashirecare.nhs.uk
Mersey Care	Dr Indira Vinjamuri	indira.vinjamuri@merseycare.nhs.uk
	(covering for Dr Yenal Dundar)	
NWBH	Dr Yogesh Sharma	Yogesh.Sharma@nwbh.nhs.uk
Pennine Care	Dr Ema Etuk	ema.etuk@nhs.net

Medical Education Managers (MEM's)

CWP	Jonathan Ruffler	jonathan.ruffler@nhs.net
GMMH	Sam Abbott	sam.abbott@gmmh.nhs.uk
Lancashire Care	Jacqueline Welding	jacqueline.welding@lancashirecare.nhs.uk
Mersey Care	Dawn McLoughlin	dawn.mcloughlin@merseycare.nhs.uk
NWBH	Ian Bithell	ian.bithell@nwbh.nhs.uk
Pennine Care	Kimberley McDowell	kimberley.mcdowell@nhs.net

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 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)

- Nicodemus K, Marenco S, Batten A, Vakkalanka R, Egan M, Straub E, Weinberger D (2008) Serious obstetric complications interact with hypoxia-regulated/vascular-expression genes to influence schizophrenia risk. Molecular Psychiatry 13, 873-877.
- 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.
- Cardno A, Rijsdijk F, Murray R, McGuffin P (2002) A twin study of genetic relationships between psychotic symptoms. Am J Psychiatry 159:539-545.

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

- Cost comparison of antipsychotics
- Tardive Dyskinesia
- Clozapine monitoring

Statistics '555' topic

- Correlation co-efficients and regression curve

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)

- Leentjens A, Verhey F, Luijckx G-J, Troost J (2001) The validity of the Beck Depression Inventory as a screening and diagnostic instrument for depression in patients with Parkinson's disease. Movement Disorders 15(6), 1221-1224.
- 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

'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
- Role of psychotherapy in long term treatment of depression

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
- Nice guidelines – Treatment of acute mania
- Role of depot antipsychotics in bipolar disorder

Statistics '555' topic

Inter rater reliability and test-retest reliability

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

- Internal and external validity

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

- Types of randomization

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)

- Foa E, et al. (2005) Randomized, placebo-controlled trial of exposure and ritual prevention, Clomipramine and their combination in the treatment of obsessive-compulsive disorder. Am J Psychiatry 162: 151-161
- Carey P, Vythilingum B, Seedat S, Muller J, Ameringen M, Stein D (2005) Quetiapine augmentation of SRIs in treatment refractory obsessive-compulsive disorder: a double-blind, randomized, placebo-controlled study. BMC Psychiatry 5:5. doi:10.1186/1471-244X-5-5.
- Kamijima K, Murasaki M, Asai M, Higuchi T, Nakajima T, Taga C, Matsunaga H (2004) Paroxetine in the treatment of obsessive-compulsive disorder: randomized, double-blind, placebo-controlled study in Japanese patients. Psychiatry Clin Neurosci 58(4): 427-433

'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- http://www.bap.org.uk/pdfs/Schizophrenia_Consensus_Guideline_Document.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 (update)- http://www.nice.org.uk/nicemedia/live/12329/45890/45890.pdf
- BAP guidelines: Evidence-based guidelines for treating depressive disorders with antidepressants: A revision of the 2000 British Association for Psychopharmacology guidelines- http://www.bap.org.uk/pdfs/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: CG38- Bipolar disorder: The management of bipolar disorder in adults, children and adolescents, in primary and secondary care- http://www.nice.org.uk/guidance/CG38
- BAP guidelines: Evidence-based guidelines for treating bipolar disorder: revised second edition - http://www.bap.org.uk/pdfs/Bipolar_guidelines.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.*

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.

SELF-HARM & SUICIDE

E-Learning

RCPsych CPD Online

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

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 (with or without agoraphobia): CG113- http://www.nice.org.uk/nicemedia/live/13314/52601/52601.pdf
- BAP guidelines: Evidence-based guidelines for the pharmacological treatment of anxiety disorders: recommendations from the British Association for Psychopharmacology- https://tavaana.org/sites/default/files/Reading%201_3.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 Engl 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.

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.

POST-TRAUMATIC STRESS DISORDER

Guidelines

- NICE guidelines for PTSD
- BAP guidelines for anxiety disorders

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.

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

Bibliography

- Gelder M, Andreason N, Lopez-Ibor J, Geddes J (Eds.) 2012. New Oxford textbook of Psychiatry. Oxford University Press.
- Stein G & Wilkinson G (Eds.) 2007. Seminars in General Adult Psychiatry (2nd Ed). The Royal College of Psychiatrists. Gaskell, London.
- Semple D & Smyth R (Eds.) 2013. Oxford Handbook of Psychiatry. Oxford University Press.
- Brown T & Wilkinson D (Eds.) 2005. Critical Reviews in Psychiatry (3nd Ed). The Royal College of Psychiatrists. Gaskell, London.
- Taylor D, Paton C, Kapur S (Eds) (2014). Maudsley guidelines, 11th Ed. Wiley-Blackwell, London.
- Bazire S (2014) Psychotropic Drug Directory, Lloyd-Reinhold Communications, London.
- Zigmond T (2012) A clinician's brief guide to the Mental Health Act, 2nd Ed. RCPsych Publications, London.
- Brindle N, Branton T, Standfield A, Zigmond T (2013) A clinician's brief guide to Mental Capacity Act, RCPsych Publications, London.
- DoH Code of Practice Mental Health Act 1983 (2008) TSO, London.
- David A, Fleminger S, Michael K, Lovestone S , Mellers J (2009) Lishman's Organic Psychiatry: A Textbook of Neuropsychiatry, 4th Ed. Wiley-Blackwell, London.
- Lloyd G and Guthrie E (Eds) 2012 Handbook of Liaison Psychiatry. Cambridge Medicine.
- Guthrie E and Creed F (Eds) 1996. Seminars in Liaison Psychiatry. College Seminar Series. Gaskell. London.

CAMHS

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

- Incidence of anorexia nervosa in young people in the UK and Ireland: a national surveillance study Petkova, Simic, Nicholls, Ford et al BMJ open, 2019, 9.
- A randomised controlled multicenter trial of treatments for adolescent anorexia nervosa including assessment of cost-effectiveness and patient acceptability – the TOuCAN trial. Gowers, Clark, Roberts et al Health Technology Assessment 2010; Vol. 14: No. 15

'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

- The application of mental health legislation in younger children. Thomas, Chipchase, Rippon, McArdle, BJPsych Bulletin, 2015, 39, 302-304
- 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

Old Age

Session 7: Anxiety Disorders in the Older Person

Learning Objectives

- The overall aim of the session is for trainees to gain an overview of anxiety in later life
- By the end of the sessions 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 later life, their classification, the basic assessment process and the principles of treatment of anxiety

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

- Balasubramaniam, M., Joshi, P., Alag, P., Gupta, S., Maher, S., Tampi, D., Gupta, A., Young, J. and Tampi, R., 2019. Antidepressants for anxiety disorders in late-life: A systematic review. The American Journal of Geriatric Psychiatry, 27(3), p.S125.

- Nilsson, J., Sigström, R., Östling, S., Waern, M. and Skoog, I., 2019. Changes in the expression of worries, anxiety, and generalized anxiety disorder with increasing age: A population study of 70 to 85-year-olds. International journal of geriatric psychiatry, 34(2), pp.249-257.

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

- Benzodiazepines in the elderly
- Medical causes for 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

Online:

- 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.

- Beaunoyer E, Landreville P, Carmichael PH. Older Adults' Knowledge of Anxiety Disorders. The Journals of Gerontology: Series B. 2019 Jun 14;74(5):806-14.

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

- Byers, A.L., Yaffe, K., Covinsky, K.E., Friedman, M.B. and Bruce, M.L., 2010. High occurrence of mood and anxiety disorders among older adults: The National Comorbidity Survey Replication. Archives of general psychiatry, 67(5), pp.489-496.

- Canuto, A., Weber, K., Baertschi, M., Andreas, S., Volkert, J., Dehoust, M.C., Sehner, S., Suling, A., Wegscheider, K., Ausín, B. and Crawford, M.J., 2018. Anxiety disorders in old age: psychiatric comorbidities, quality of life, and prevalence according to age, gender, and country. The American Journal of Geriatric Psychiatry, 26(2), pp.174-185.

- Chen X, Pu J, Shi W, Zhou Y. The impact of neuroticism on symptoms of anxiety and depression in elderly adults: The mediating role of rumination. Current Psychology. 2020 Feb;39(1):42-50.

- Creighton AS, Davison TE, Kissane DW. The factors associated with anxiety symptom severity in older adults living in nursing homes and other residential aged care facilities. Journal of aging and health. 2019 Aug;31(7):1235-58.

- Creighton, A.S., Davison, T.E. and Kissane, D.W., 2016. The prevalence of anxiety among older adults in nursing homes and other residential aged care facilities: a systematic review. International Journal of Geriatric Psychiatry, 31(6), pp.555-566.

- Domènech-Abella, J., Mundó, J., Haro, J.M. and Rubio-Valera, M., 2019. Anxiety, depression, loneliness and social network in the elderly: Longitudinal associations from The Irish Longitudinal Study on Ageing (TILDA). Journal of affective disorders, 246, pp.82-88.

- F Masana M, Tyrovolas S, Kollia N, Chrysohoou C, Skoumas J, Haro JM, Tousoulis D, Papageorgiou C, Pitsavos C, B Panagiotakos D. Dietary Patterns and Their Association with Anxiety Symptoms among Older Adults: The ATTICA Study. Nutrients. 2019 Jun;11(6):1250.

- Granier KL, Segal DL, Coolidge FL. Relationships among Executive Dysfunction, Constructive Worrying, and Worry Responses in Older Adults. The International Journal of Aging and Human Development. 2019:0091415019896227.

- Grenier S, Payette MC, Gunther B, Askari S, Desjardins FF, Raymond B, Berbiche D. Association of age and gender with anxiety disorders in older adults: A systematic review and meta-analysis. International journal of geriatric psychiatry. 2019 Mar;34(3):397-407.

- Gottschalk, M.G. and Domschke, K., 2016. Novel developments in genetic and epigenetic mechanisms of anxiety. Current opinion in psychiatry, 29(1), pp.32-38.

- Gulpers BJ, Voshaar RC, van Boxtel MP, Verhey FR, Köhler S. Anxiety as a risk factor for cognitive decline: a 12-year follow-up cohort study. The American Journal of Geriatric Psychiatry. 2019 Jan 1;27(1):42-52.

- Hellwig S, Domschke K. Anxiety in Late Life: An Update on Pathomechanisms. Gerontology. 2019;65(5):465-73.

- Hohls JK, Wild B, Heider D, Brenner H, Böhlen F, Saum KU, Schöttker B, Matschinger H, Haefeli WE, König HH, Hajek A. Association of generalized anxiety symptoms and panic with health care costs in older age—Results from the ESTHER cohort study. Journal of affective disorders. 2019 Feb 15;245:978-86.

- Lee, L.O., Gatz, M., Pedersen, N.L. and Prescott, C.A., 2016. Anxiety trajectories in the second half of life: Genetic and environmental contributions over age. Psychology and aging, 31(1), p.101.

- Monaco MR, Di Stasio E, Zuccalà G, Petracca M, Genovese D, Fusco D, Silveri MC, Liperoti R, Ricciardi D, Cipriani MC, Laudisio A. Prevalence of Obsessive-Compulsive Symptoms in Elderly Parkinson Disease Patients: A Case-Control Study. The American Journal of Geriatric Psychiatry. 2020 Feb 1;28(2):167-75.

- Payette, M.C., Belanger, C., Léveillé, V. and Grenier, S., 2016. Fall-related psychological concerns and anxiety among community-dwelling older adults: Systematic review and meta-analysis. PLoS one, 11(4).

- Santabárbara, J., Villagrasa, B., López-Antón, R., Olaya, B., Bueno-Notivol, J., de la Cámara, C., Gracia-García, P., Lobo, E. and Lobo, A., 2019. Clinically relevant anxiety and risk of Alzheimer's disease in an elderly community sample: 4.5 years of follow-up. Journal of affective disorders, 250, pp.16-20.

- Shukla, R., Prevot, T.D., French, L., Isserlin, R., Rocco, B.R., Banasr, M., Bader, G.D. and Sibille, E., 2019. The relative contributions of cell-dependent cortical microcircuit aging to cognition and anxiety. Biological psychiatry, 85(3), pp.257-267.

- Thomas R, Chur-Hansen A, Turner M. A Systematic Review of Studies on the Use of Mindfulness-Based Cognitive Therapy for the Treatment of Anxiety and Depression in Older People. Mindfulness. 2020 Mar 2:1-1.

- Van Assche, L., Van de Ven, L., Vandenbulcke, M. and Luyten, P., 2020. Ghosts from the past? The association between childhood interpersonal trauma, attachment and anxiety and depression in late life. Aging & mental health, 24(6), pp.898-905.

- Wu M, Mennin DS, Ly M, Karim HT, Banihashemi L, Tudorascu DL, Aizenstein HJ, Andreescu C. When worry may be good for you: Worry severity and limbic-prefrontal functional connectivity in late-life generalized anxiety disorder. Journal of affective disorders. 2019 Oct 1;257:650-7.

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:

- Dening T., Thomas A., 2013. The Oxford Textbook of Old Age Psychiatry, 2nd edition. Oxford University Press.
- Ishikawa RZ, Vyas C, Okereke O. Anxiety Disorders among Older Adults: Empirically Supported Treatments and Special Considerations. In Clinical Handbook of Anxiety Disorders 2020 (pp. 175-189). Humana, Cham.
- 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, 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
• 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)
• Covert medication – ethical and legal aspects. • MHA or MCA? • Liberty protection safeguards – and update on the key changes? • Guardianship
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

Online:

- RCPsych CPD modules
  Competence, capacity and decision-making ability in mental disorder, mental Capacity Act 2005:

  Part , mental Capacity Act 2005: Part 2

- GMC – Capacity & consent tool. http://www.gmc-uk.org/news/29321.asp

- https://www.39essex.com/resources-and-training/mental-capacity-law/

- https://thesmallplaces.wordpress.com/author/lucyseries/ (interesting discussion and commentary on all things related to legal capacity and human rights)

- https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

- https://themaskedamhp.blogspot.com/

- https://autonomy.essex.ac.uk
- https://www.scie.org.uk/
- http://www.mentalhealthlaw.co.uk
- http://www.bailii.org/
- https://www.mentalcapacitylawandpolicy.org.uk/
- https://mentalhealthcop.wordpress.com/
- https://www.lawsociety.org.uk/support-services/documents/deprivation-of-liberty---a-practical-guide/
- http://londonadass.org.uk/wp-content/uploads/2019/06/2019.01.30-MCA-COP-DoLS-Workshop-and-Surgery-Update-on-the-MCA-MHA.pdf
- https://www.cascaidr.org.uk/2017/04/04/guardianship-in-england/
- http://www.celticknot.org.uk/dir/20121206DoLSvGuardianship.pdf

Journal Articles:

- Abdool, R., 2017. Covert medication: legal, professional, and ethical considerations. The Journal of Law, Medicine & Ethics, 45(2), pp.168-169.
- Bishop, Elmari. “Practice Guidance The Interface between the Mental Health Act 1983 and the Mental Capacity Act 2005.” [ONLINE] Available at: https://proceduresonline.com/trixcms/media/4395/the-interface-between-the-mental-health-act-1983-and-the-mental-capacity-act-2005-adults.pdf. [Accessed 8 June 2020].

- 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.

- Craigie J, Bach M, Gurbai S, Kanter A, Kim SY, Lewis O, Morgan G. Legal capacity, mental capacity and supported decision-making: report from a panel event. International journal of law and psychiatry. 2019 Jan 1;62:160-8.

- Curley A, Murphy R, Plunkett R, Kelly BD. Concordance of mental capacity assessments based on legal and clinical criteria: A cross-sectional study of psychiatry inpatients. Psychiatry research. 2019 Jun 1;276:160-6.

- Dixon J, Laing J, Valentine C. A human rights approach to advocacy for people with dementia: A review of current provision in England and Wales. Dementia. 2020 Feb;19(2):221-36.

- Dixon J, Laing J, Valentine C. A human rights approach to advocacy for people with dementia: A review of current provision in England and Wales. Dementia. 2020 Feb;19(2):221-36.

- Gill, S., Blair, M., Kershaw, M., Jesso, S., MacKinley, J., Coleman, K., Pantazopoulos, K., Pasternak, S. and Finger, E., 2019. Financial capacity in frontotemporal dementia and related presentations. Journal of neurology, 266(7), pp.1698-1707.

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

- Jayes M, Palmer R, Enderby P, Sutton A. How do health and social care professionals in England and Wales assess mental capacity? A literature review. Disability and rehabilitation. 2019 Feb 6:1-2.

- Jayes, M., Palmer, R., Enderby, P. and Sutton, A., 2019. How do health and social care professionals in England and Wales assess mental capacity? A literature review. Disability and rehabilitation, pp.1-12

- Keene AR, Kane NB, Kim SY, Owen GS. Taking capacity seriously? Ten years of mental capacity disputes before England's Court of Protection. International journal of law and psychiatry. 2019 Jan 1;62:56-76.

- Mackenzie, J.A. and Wilkinson, K.E. eds., 2020. Assessing Mental Capacity: A Handbook to Guide Professionals from Basic to Advanced Practice. Routledge.

- Martin, W., 2017. Obstacles in the assessment of intuitive decision-making capacity. Philosophy, Psychiatry, & Psychology, 24(4), pp.329-331.
- Murray, B.J., 2017. Mental capacity: different models and their controversies. BJPsych Advances, 23(6), pp.366-374.

- 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/

- Ruck Keene A. Going beyond the Mental Capacity Act in assessing capacity: recognising and overcoming biases and stereotypes. The Mental Elf. 2020 Mar 26.
- van der Plas, E., David, A.S. and Fleming, S.M., 2019. Advice-taking as a bridge between decision neuroscience and mental capacity. International Journal of Law and Psychiatry, 67, p.101504.
- Wessely S, Lloyd-Evans B, Johnson S. Reviewing the Mental Health Act: delivering evidence-informed policy. Lancet Psychiatry. 2019;6(2):90-1.
- Wessely, S., Lloyd-Evans, B. and Johnson, S., 2019. Reviewing the Mental Health Act: delivering evidence-informed policy. Lancet Psychiatry, 6(2), pp.90-91.
- Wilson, S., & Pinner, G. 2013. Driving and dementia: a clinician's guide. Advances in psychiatric treatment, 19(2), 89-96.
- Zhong R, Sisti DA, Karlawish JH. A pragmatist's guide to the assessment of decision-making capacity. The British Journal of Psychiatry. 2019 Apr;214(4):183-5.

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
- Act, M.C., 2019. Codes of Practice: Updated 2016,(2016). London: The Stationery Office. Online at: https://www. gov. uk/government/publications/mental-capacity-act-code-of-practice. Accessed, 27.
- Dening T., Thomas A., 2013. The Oxford Textbook of Old Age Psychiatry, 2nd edition. Oxford University Press.
- Royal College of Psychiatrists, 2004. College statement on Covert Administration of Medicines. Psychiatric Bulletin. 28(10), pp385-386

MCQ answers

Anxiety disorders

1. **E**
2. **A**
3. **B**

4. **D**

5. **B**

Medico-legal

1.**D**

2.**E**

3.**E**

4.**E**

5.**B**

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

Across the Ages
Coming Soon

Forensic

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

ID

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 2010 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

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 & update 2018) Understanding Trauma: A Psychoanalytic Approach by Caroline Garland (1998) Karnac Books

Substance Misuse

4: Recovery Concepts, Psycho-social Treatments and Service Development

Learning Objectives

- To understand principle of recovery and how this is implemented with drug and alcohol services
- To gain knowledge of some of the basic concepts of motivation interviewing
- To gain knowledge about how services for drug and alcohol are developed
- To understand what ancillary services are frequently used with alcohol and drug services

Curriculum Links

11.5 Impact of drug and alcohol use on Public Health

11.10 Motivational Interviewing

Expert Led Session

- Review models of dependence/addiction
- Review evidence base and psychosocial treatments for people with substance misuse problems
- Overview of various interventions that are offered in substance misuse: brief interventions, mapping techniques (e.g., ITEP), motivational interviewing overview
- Useful to use youtube clips below for teaching session

Case Presentation

- Presentation of a person who had significant substance misuse problem +/- comorbid mental illness who has recovered and resources employed to effect and maintain this recovery

Journal Club Presentation

- Heather, N. (2017). Q: Is Addiction a Brain Disease or a Moral Failing? A: Neither. *Neuroethics,* 10(1), 115-124.
- Hibbert, L., & Best, D. (2011). Assessing recovery and functioning in former problem drinkers at different stages of their recovery journeys. *Drug and Alcohol Review,* 30(1), 12-20

- 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.

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

- Overview of non statutory services (e.g., AA, NA, SMART, GamCare)
- Risks associated with substance misuse in prisoners
- Harm minimisation approaches in substance misuse services
- Gambling disorder – diagnosis and treatment

MCQs

1. Which of the following is not an example of change talk:

A. Desire: I would like to stop using alcohol

B. Ability: I could stop alcohol use

C. Reason: Alcohol worsens my psoriasis

D. Accomplishment: I finally stopped alcohol

E. Need: I have got to stop alcohol

2. Prochaska and DiClemente's stages of change include the following except:

A. Contemplation

B. Preparation

C. Maintenance

D. Relapse

E. Persistence

3. Who of the following is most closely linked with Motivational Interviewing:

A. Carl Jung

B. Carl Rogers

C. David Winnicott

D. Aaron Beck

E. Melanie Klein

4. All of the following are key principles of Motivational Interviewing except:

A. Roll with resistance

B. Express empathy
C. Develop discrepancy
D. Support self efficacy
E. Strengthen safety behaviour

5. Which of the following is true of needle exchange programmes in the UK
A. Pharmacies are unable to provide this service
B. It is only available to people prescribed opioid substitute medications
C. It is only available in urban centres with populations greater than 50000
D. Only qualified nursing staff can dispense equipment
E. It reduces injection risk behaviours among people who inject drugs, in particular self- reported sharing of needles and syringes, and frequency of injection

EMI Questions

Potential mechanisms to manage resistance:

A. Simple reflection
B. Amplified reflection
C. Double sided reflection
D. Shifting focus
E. Reframing
F. Agreement with a twist
G. Emphasising personal control
H. Coming alongside
I. Reaction
J. Summarizing

1a. This approach enables the validity of the client's raw observation to be regarded but tries to interpret the observation in a new way.
1b. This may be considered when someone says "I am my own man, I do not need you to tell me what to do"
1c. The following exchange highlights this approach:
Client:" I have been able to use more heroin than other people in my town"
Therapist: "Perhaps you are simply immune to the effects of heroin".

Mutual aid groups/Services:

A. Alcoholics Anonymous (AA)
B. SMART Recovery
C. GamCare
D. Frank
E. Teen Challenge UK
F. British Doctors' and Dentists' Group
G. Narcotics Anonymous (NA)
H. Breaking free
I. Kaleidoscope
J. Discover

2a. Founded in 1997, This is one of the leading providers of information, advice and support for anyone affected by this pattern of disordered behaviour.
2b. This is a science-based programme to help people manage their recovery from any type of addictive behaviour. It began in 1994.
2c. This is a free drug advice service that is aimed at parents and children in particular. It is available 24 hours a day and online and by text message

MCQ Answers

Q1 D
Q2 E Stages of change are
Pre-contemplation contemplation preparation action maintenance relapse precontemplation
Q3 B Client centred interpersonal relationship is often quoted as one of the key influences for MI
Q4 E
Q5 E

EMI 1
(1) E
(2) G
(3) B
EMI 2
(1) C
(2) B
(3) D

Additional Resources / Reading Materials

Books

- Miller, W. R., & Rollnick, S. (2012). Motivational interviewing : helping people change (3rd ed.). New York, NY: Guilford Press. (any edition reasonable)

E-Learning

Drink and Drug News- local update on substance misuse with recovery focus

- https://drinkanddrugsnews.com/

Harm minimisation

- http://www.prenoxadinjection.com/
- https://www.harmreduction.co.uk/resources

Motivation interviewing

- http://www.youtube.com/watch?v=80XyNE89eCs
- http://www.youtube.com/watch?v=URiKA7CKtfc
- http://www.youtube.com/watch?v=s3MCJZ7OGRk
- http://www.youtube.com/watch?v=_KNIPGV7Xyg

Mutual aid groups

- https://www.alcoholics-anonymous.org.uk/
- https://smartrecovery.org.uk/
- http://www.bddg.org/

Journal Articles

- Best, D., Albertson, K., Irving, J., Lightowlers, C., Mama-Rudd, A., & Chaggar, A. (2015). The UK Life in Recovery Survey 2015 : the first national UK survey of addiction recovery experiences. Project Report. Sheffield. Helena Kennedy Centre for International Justice. Sheffield Hallam University.
- Best, D. W., & Lubman, D. I. (2012). The recovery paradigm: A model of hope and change for alcohol and drug addiction. *Australian family physician*, *41*(8), 593.
- Blaszczynski, A., & Nower, L. (2002). A pathways model of problem and pathological gambling. Addiction, 97(5), 487-499.
- Campbell, A., Finch, E., Brotchie, J., & Davis, P. (2007). The International Treatment Effectiveness Project Implementing psychosocial interventions for adult drug misusers.
- Dees, S. M., Dansereau, D. F., & Simpson, D. D. (1997). Mapping-enhanced drug abuse counseling: Urinalysis results in the first year of methadone treatment. *Journal of Substance Abuse Treatment*, *14*(1), 45-54.

- Degenhardt, L., Larney, S., Kimber, J., Gisev, N., Farrell, M., Dobbins, T., et al. The impact of opioid substitution therapy on mortality post-release from prison: retrospective data linkage study. *Addiction*. 109(8), 1306-1317.
- Faculty of Addictions Psychiatry, R. C. o. P. (2014). Gambling: the hidden addiction. Faculty report FR/AP/01. Future trends in addictions – discussion paper 1.
- Flores, P. J. (2004). *Addiction as an attachment disorder*. Jason Aronson.
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